Tewkesbury Domestic Homicide Review

Executive Summary of the Overview Report

Into the homicide of Rosie on 18th February 2014

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Report completed: 27th January 2015

Tribute To Rosie (pseudonym) from her family

While Rosie was only 20 years old when her life was cruelly taken from her, she did more it that time than many others will do in their full lifetime. She was a wonderful daughter, sister, aunty and friend who lived life to the full. Style and fashion was her passion and we hope that her legacy will live on through the College students being sponsored.

She was a real treasure and will be sadly missed by her friends, family and many who did not know her. Her friend and manager said: "Rosie was the most vibrant, fun, vivacious, talented, warm, outgoing and beautiful young lady, a true inspiration for others to follow." this just about sums Rosie up.

We really appreciate the time and effort put in to this review by all concerned. We hope that the recommendations will be implemented and will result in the reduced suffering by others, the saving of lives and other families not having to endure the nightmare that we have been through.

Section One: Introduction

1. This Domestic Homicide Review examines the circumstances surrounding the death of Rosie (pseudonym), who was 20 years of age and lived in the Borough of Tewkesbury in Gloucestershire.

1.1. Rosie and Paul (pseudonym) met in February 2013 and they began going out together. The relationship was at times volatile due to Paul's aggressive behaviour.

1.2. On Friday 14th February 2014, Rosie ended the relationship. Over the next few days Paul became increasingly irate in text messages and on the telephone at Rosie's refusal to communicate with him. On the afternoon of Tuesday 18th February 2014, Paul pawned a DVD player for £5. He then purchased an 8inch kitchen knife for £3 and walked around Gloucester City centre before making his way to the hair dressers where Rosie worked.

1.3. He entered the salon at 5.47p.m. and following a brief exchange of words, repeatedly stabbed Rosie (14 separate wounds), in front of terrified staff and customers. He then left the premises, discarding the knife in a nearby building site and caught a taxi to a relative's house.

1.4. Attempts were made by police and paramedics to resuscitate Rosie, however these were unsuccessful and she was pronounced dead in the hospital a short time later.

1.5. Paul was arrested during the early hours of 19th February 2014. He was interviewed and subsequently charged with Rosie's murder. Following assessments regarding his mental health, he pleaded guilty to the murder and was sentenced to life imprisonment with a minimum tariff of 24 years.

Section Two: The Review Process

2.1. This summary outlines the process undertaken by the Tewkesbury Domestic Homicide Review Panel in reviewing the death of Rosie.

2.2. The Domestic Homicide Review (DHR) was recommended by the Tewkesbury Borough Community Safety Partnership on 12th March 2014, in line with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011, After the Criminal Proceedings were completed, the DHR was commissioned on 25th July 2014.

2.3. The Home Office was informed of the intention to conduct a DHR on 13th March 2014.

2.4. The process began on the 29th August 2014, with an initial Review Panel meeting of all agencies that potentially had contact with the victim Rosie or perpetrator Paul, prior to the point of Rosie's death, and it concluded on 26th January 2015.

2.5. Rosie's family and Paul's solicitor were contacted at the commencement of the Review. Rosie's father agreed to be the family contact with the Domestic Homicide Review and he confirmed the family wanted to be involved with the Review.

2.6. Paul was interviewed during the Review and confirmed that he would like to be involved with the Review. Initially he asked that the Review consider two psychiatric reports which had been commissioned by his defence team for his trail, later he changed his mind and refused the Review access to these documents. He did not want any of his family to be contacted by the Review. Paul's mother was contacted by the Review in her capacity as a victim and to check on her welfare.

2.7. Rosie's family were informed about the specialist support they could receive from the charity, "Advocacy After Fatal Domestic Abuse" (AAFDA) and a leaflet was left with them. Rosie's father confirmed the family had received advice and support from the police Family Liaison Officer and from the Homicide Support Service. The family has registered a charitable trust in Rosie's name and has already received advice from AAFDA. The Charitable Trust has three aims:

- Support and fund a young hairdresser in Gloucestershire.
- Support "Increase the Peace " project which aims to promote peace and divert young people away from Anti Social Behaviour (ASB), gun/knife crime and gang association in Gloucester.
- Work with Gloucestershire Domestic Abuse Support Service, to reduce the level of domestic abuse and improve the safety of victims and their families.

2.8. On 16th January 2015 Rosie's mother, father and sister were informed of the outcome of the Review and read sections of the draft Overview Report relating to the analysis, lessons learnt, recommendations and conclusions.

2.9. The agencies participating in the Review are:-

Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited

Co-ordinated Action Against Domestic Abuse (CAADA)

Cheltenham Borough Homes

Crown Prosecution Service South West

Gloucestershire Clinical Commissioning Group

Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group

Gloucestershire Domestic Abuse Support Service

Gloucestershire Hospitals NHS Foundation Trust

Gloucester City Council Housing Service

Gloucestershire County Council (Children and Young People's Service)

Gloucestershire Multi-Agency Risk Assessment Conference

Gloucestershire Constabulary

HM Courts & Tribunals Service

Info Buzz

Independent Police Complaints Commission (IPCC)

Information Commissioners' Office (ICO)

Tewkesbury Borough Council

Tewkesbury Borough Community Safety Partnership

2gether NHS Foundation Trust (NHS)

2.9.1 Domestic Homicide Review Panel

David Warren QPM, Independent Chair

Kevin Dower, Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited.

Claire Wilson, Gloucestershire Clinical Commissioning Group NHS Trust

Detective Chief Inspector Steve Bean, Gloucestershire Constabulary

Stella Potente, Gloucestershire County Council (Children and Young People Services)

Amanda Wilsdon, Info Buzz

Sally Morrissey, Gloucestershire Domestic Abuse Support Services

Ashley Bayliss Gloucestershire City Council Housing Services

Pat Dabbs, Gloucester Community Safety Partnership

Faye Kamara, Gloucestershire Public Protection Bureau

Jon Burford, Gloucestershire Hospitals NHS Foundation Trust

Valerie Garside, Tewkesbury Borough Council

Alison Curson, 2gether NHS Foundation Trust (NHS)

Administrator

Fiona Halsey Tewkesbury Borough Council

2.10. The agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. Where organisations had no involvement or insignificant involvement, they informed the Review accordingly. In line with the Terms of Reference, the DHR has considered all contacts in detail during the period from 1st January 2013 and the death of Rosie on 18th February 2014, as well as all events, prior to 1st January 2013, which are relevant to violence, harassment, stalking or domestic abuse.

2.11. Of the nineteen agencies contacted about this Review, three responded that they had had no contact with the victim or perpetrator. One organisation, Information Commissioner's Office (ICO), whilst having had no direct contact with either Rosie or Paul, has provided advice to assist the Review on the Data Protection Act / Domestic Violence Disclosure Scheme (DVDS). A second organisation, Co-ordinated Action Against Domestic Abuse (CAADA) has confirmed a review of national training relating to Data Protection and the DVDS. The IPCC has shared its Report on its investigation into the police contact with Rosie prior to her death. The Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group which co-ordinates domestic abuse strategies across the county of Gloucestershire has set a number of recommendations to address lessons learnt within this Review.

2.12. Twelve agencies completed either an Independent Management Review (IMR) or a report with information indicating some level of involvement with Rosie or Paul.

2.12.1. **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

The then Gloucestershire Probation Trust's first involvement with Paul followed his sentencing on 3rd December 2010 to a Suspended Sentence Order (SSO) for offences of threatening behaviour, fear of provocation of violence (public order act 1986). The sentence was for twelve weeks imprisonment suspended for two years and included requirements of 18 months supervision, unpaid work and low level drug treatment.

He was assessed as posing a medium risk of serious harm to the public, there was no evidence of previous behaviour that would have been a cause for concern of domestic abuse. The assessment showed him as not being in a relationship.

There were good levels of engagement and compliance, with work in supervision focused on his substance misuse. It included drug testing. Information, was subsequently received from the Multi Agency Risk Assessment Conference (MARAC) on 11th November 2011, indicating a relationship with an ex-partner, Kate, (pseudonym) with whom there were ongoing concerns regarding domestic abuse. On receipt of this information his supervising officer increased his reporting to twice weekly and commenced structured work on domestic abuse as part of his supervision plan. Paul continued to engage in work with his supervising officer throughout the order including the work on domestic abuse.

2.12.2. **Cheltenham Borough Homes (CBH)**

Between June 2010 and July 2013 Paul's ex-partner Kate, who lived in Cheltenham Borough Homes (CBH) accommodation, had a series of contacts with staff members of CBH, Cheltenham Borough Council (CBC), and several other agencies, to seek help, report, or make them aware of on-going abuse from her ex-partner Paul.

A number of actions were taken including MARAC, an arranged move, and "sanctuary" works to assist and protect Kate from Paul.

2.12.3. **Gloucestershire Clinical Commissioning Group**

Paul and Rosie were registered with GP practices in different towns and as neither Paul nor Rosie informed their GP practices, they were unaware of their relationship.

Paul's GP practice knew of his violent nature, as the practice had received a copy of a MARAC report in October 2012. This followed an assault by Paul on his mother, who was also a patient at the practice.

On 27th December 2012 Paul was seen by his GP following an attempt to hang himself. In view of his admitted alcohol and drug use, Paul was advised to contact the Independence Trust.

2.12.4. **Gloucestershire County Council Children and Young Peoples Service**

There has been no involvement from Children and Young People's Services with Rosie. Paul, however had been known at various points in his life, although no significant interventions were detailed. Records indicated that he grew up, in the care of his mother, with a younger half-brother. His mother's relationships had been volatile at times, resulting in her contacting the police on a number of occasions.

2.12.5. **Gloucestershire Crown Prosecution Service South West (CPS).**

While the CPS had prosecuted Paul on the occasions he appeared before Gloucestershire Magistrates courts, they had no direct dealings with him and had no lessons to learn or recommendations to make. Nevertheless the CPS has provided opinion to the DHR on the likelihood of Paul being detained in custody or being given bail, if he had been arrested by the police for the offences committed by him on 15th February 2014.

2.12.6. **Gloucestershire Domestic Abuse Support Service (GDASS)**

Gloucestershire Constabulary regularly refers victims of domestic abuse to GDASS, which provides a county wide service including an Independent Domestic Violence Adviser (IDVA) service in Gloucestershire. In July 2013 GDASS received a standard Domestic Abuse Stalking & Harassment - Risk Assessment Form (DASH) from the police, in respect of Rosie, after Paul had been arrested for grabbing Rosie around the neck. When contacted, Rosie said she did not need support at that time, as she felt it was a one off incident and Paul had apologised.

A second DASH referral for Rosie, was made to GDASS in respect of the incident of the 14th February 2014 but this was only received after her death.

GDASS had in 2012 received referrals from the police, in respect of Kate, Paul's previous partner and in respect of his mother. However Paul's details were not retained due to Data Protection advice that restricted GDASS to retaining only records of referred victims. GDASS therefore had no records to identify Rosie's assailant Paul, as having featured in the two previous separate referrals

2.12.7. **Gloucestershire Hospitals NHS Foundation Trust**

Rosie's contact with the hospital trust was for minor unrelated health issues between 2007 and 2013 only.

The Trust however has records relating to Paul having 29 contacts over 20 years. After the age of 12 these were predominantly, in the Emergency Department (ED), for injuries, but also for self-harm and hearing voices. The four contacts prior to the homicide were during his relationship with Rosie and include a visit in October 2013 when Rosie accompanied him to ED He reported 2 years of depression and that he was hearing voices, telling him to assault people and harm himself. He said they were getting worse and he was worried about having enemies and about stabbing. An emergency mental health assessment classified him as high risk and he was referred to the mental health liaison team (2gether NHS Trust). This was the only occasion where both Paul and Rosie were seen together at hospital.

The Trust also had a number of contacts with Paul's previous partner Kate, while they were in a relationship. The first such contact was in July 2010 when Kate had an arm injury after an assault by Paul. A DASH form was completed and escalated to a MARAC. This resulted in a safety plan for Kate and alerts were placed on her record. Kate attended ED twice more in 2010 with further arm injuries with three follow up visits to the fracture clinic.

2.12.8. **Gloucester City Council Housing Service**

In August 2013, Paul who had previously made a sole housing application to Cheltenham Borough Council added Rosie's name to his application for social housing as his fiancee. Following this in October 2013 he sought housing advice from Gloucester City Council. He listed Rosie as his fiancee, although she was never seen with him and Gloucester City Council Housing Services had no contact with her of any kind.

In January 2014 Paul was eventually helped to access a suitable bedsit for himself.

2.12.9. **Gloucestershire Multi-Agency Risk Assessment Conference**

Paul's previous partner, Kate, was the subject of three high risk DASH referrals to MARAC, all involving Paul as the perpetrator. In 2012 a further referral was made to the MARAC, in respect of an incident involving Paul and his mother. While that incident was deemed to be of a standard risk, because of Paul being a high risk to Kate, this risk transferred to his mother.

2.12.10. **Gloucestershire Constabulary**

Between 2008 and February 2014 Paul was arrested 23 times for a variety of offences. These included domestic abuse related offences, criminal damage, failing to surrender to custody, possession of Class 'A' drugs, theft from motor vehicle and drunk and disorderly. He was involved in 24 violent incidents; 3 involving 'Rosie', 12 involving his ex-partner (Kate), 2 involving his ex-partner (Clare), 3 involving his mother, and 4 incidents of violence involving unconnected persons. Paul was subject to arrest on 13 of these occasions with disposal using the following sanctions:

2008	Cautioned
2009	No further Action (NFA)
2009	Charged with Criminal Damage, 2 x Section
2010	4 Public Order Act offences
2011	2 x NFA
2012	Charged with Harassment, Criminal Damage, Breach of Bail
2013	NFA, and charged with Drink Drive, 3 Assaults, Possession of weapon, Theft of Motor vehicle
2014	Murder

Whilst there was a positive response from the police to a number of the incidents involving Paul and his former partners, opportunities were missed in terms of taking positive action against him for some offences, including harassment of Kate in particular.

Specific incidents involving Rosie included:

- In the early hours of 20th July, 2013, a CCTV operator saw Paul and Rosie arguing outside a Gloucester nightclub. Paul was seen to place his hands around Rosie's neck. The police were called and Paul was detained, he was kept in custody overnight, then released, as Rosie did not wish to made a complaint. Officers checked the next morning that she had not changed her mind, prior to releasing him. A standard DASH was completed and a domestic abuse database entry was made. Although a standard DASH relating to Paul's mother had been escalated a few months earlier to high risk, because of his history of violence towards his ex partner Kate, it was not done in this incidence.

- On the 17th November 2013 the Police were called to a public house where Paul had assaulted three men. Paul was stopped driving Rosie's car a short distance away. She was a front seat passenger. Paul was arrested for offences of assault, drink & drive, possession of an offensive weapon and unauthorised taking of Rosie's car. He was later charged with a number of offences, including three common assaults, possession of an offensive weapon, drink drive and theft of Rosie's car.

- On 15th February 2014 Rosie contacted the police to ask for advice in relation an incident in which Paul had stolen her bank card and withdrawn £300. She explained that she had been trying to end her relationship with him for some time but he would not accept it. She said he had threatened to beat her, to throw acid in her face as well as making threats to her family. Rosie was unaware of Paul's address, saying he's"here there and everywhere". A medium risk DASH was later completed and enquiries were made at his mother's address, to trace Paul but without success, he was not circulated as "wanted".

2.12.11. **Her Majesty's Court Service (Gloucestershire)**

Paul appeared before magistrates courts in Gloucestershire on nine occasions, between January 2010 and February 2013, for a wide variety of offences including harassment in connection with a previous partner, Kate. On one occasion a case against him for criminal damage to another previous partner's property was dismissed after she refused to give evidence.

2.12.12. **[2]gether Mental Health NHS Trust**

Paul was first referred to East Gloucestershire NHS Trust Child & Family in 1996 when he was 4 years of age, by his Health Visitor following reports from his mother, that she was struggling with his disruptive behaviour. His parents had separated, but Paul had witnessed long term physical violence and verbal abuse of his mother by his father. His assessment by two mental health professionals concluded that he was emulating his father's behaviour.

In December 2001 when Paul was10 years of age, a further referral to Child & Family Services was made via the Health Visitor, as he had become increasingly angry at school and home. Again, this appeared to be related to contact with his father (who he had not seen for 3-4 months).

The next contact with trust services, came in March 2008 when Paul was 16. He was assessed by a Child & Adolescent Mental Health Services Clinical Nurse Specialist following an overdose of 16 paracetamol tablets. He described a "tumultuous" relationship with his mother and acknowledged both smoking and dealing in cannabis.

In October 2013, Paul then 22 years of age, self-presented to a hospital Emergency Department complaining of depression and hearing voices. He was seen by the Mental Health Liaison Team and it was noted that whilst Paul described generalised symptoms of paranoia, no evidence of psychosis could be determined by any of the practitioners he saw. He did describe use of illicit substances and alcohol historically but denied recent usage. After a number of assessments, it was concluded that he experienced problems with anger management and impulsivity associated with anxiety, poor stress coping strategies and background substance misuse. His auditory hallucinations were of a pseudo nature and the generalised paranoia was in the context of stress, past trauma and social circumstances. The assessment concluded that there did not appear to be any evidence of functional psychosis or mental illness.

Section Three: Terms of Reference

3.1. The purpose of the statutory Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- 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.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic abuse homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

3.2**. Overview and Accountability:**

3.2.1 The decision for Tewkesbury to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Tewkesbury Community Safety Partnership on 12th March 2014 and the Home Office informed of that decision on 13th March 2014.

3.2.2. The Home Office "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the Review. In this case a decision was made to delay the commencement of the Review until after the conclusion of the criminal trial.

3.2.3. This Domestic Homicide Review which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.3. **The Domestic Homicide Review will consider:**

3.3.1. Each agency's involvement with the following from1st January 2013 (together with any other contact relevant to violence, harassment, stalking, domestic abuse or mental health issues prior to that date) and the death of Rosie (pseudonym) on18th February 2014,

a. The victim, Rosie (pseudonym) 20 years of age at time of her death, of Tewkesbury
b. The perpetrator, Paul (pseudonym) 22 years of age at date of incident, of Cheltenham

3.3.2. Whether there was any previous history of abusive behaviour towards the deceased or any previous partner of the perpetrator, and whether this was known to any agencies.

3.3.3. Whether family, friends or colleagues want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

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

3.3.5. Could improvement in any of the following have led to a different outcome for Rosie considering:

(a) Communication and information sharing between services.

(b) Information sharing between services with regard to the safeguarding of adults and children.

(c) Communication within services.

(d) Communication to the general public and non specialist services about available specialist services.

3.3.6. Whether the work undertaken by services in this case are consistent with each organisation's:

(a) Professional standards.

(b) Domestic Abuse policy, procedures and protocols.

3.3.7. The response of the relevant agencies to any referrals relating to Rosie concerning domestic abuse or other significant harm from 1st January 2013 or to any referrals relating to the perpetrator prior to that date. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

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

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

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

(d) The quality of any risk assessments undertaken by each agency in respect of Rosie, or Paul**.**

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

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

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

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

3.3.12. The review will consider any other information that is found to be relevant.

Section Four: Key Issues

4.1. The DHR provided an opportunity to analyse the information obtained from agencies, from Paul and from Rosie's family and friends.

4.2. The Review considered whether any of the nine protected characteristics of the Equality Act influenced decisions made by organisations in their contacts with either Rosie or Paul. The Panel is satisfied that there were no equality issues evident in the agencies contacts. Paul, who is mixed race, confirmed to the Review Chair that he never experienced any form of racial discrimination; he did however believe that his complaints about suffering from depression were not properly addressed. That has been considered by the Review.

4.3. The Review acknowledges that Paul displayed violent tendencies to women with whom he was or had been in a relationship and there was an element of this being learnt behaviour from the violence he had witnessed his mother being subjected to by his father, however the Panel also recognises that Paul has a long history of violence to men as well.

4.4. The key issues in this Review are Paul's mental health, his propensity for violence particularly towards women, the number of occasions that different victims refused to support a prosecution and the response of the agencies in dealing with these matters.

4.5. **Paul's mental health and treatment.**

4.5.1. As is described in paragraph 2.12.12 of this Report, from the age of 4, Paul's behaviour was of such concern to his mother that she had to seek professional help. He was assessed by two mental health professionals who concluded he was emulating his father's behaviour. This was in the context of witnessing long term physical violence and verbal abuse of his mother by his father. A similar conclusion was reached when he was 10 years of age, when as a result of his increasing angry behaviour at home and at school, he was the subject of a second referral. When he was 16 following an overdose of 16 paracetamol tablets, he was assessed and given counselling for his regular cannabis use.

4.5.2. As he grew older he increasingly came to the attention of the police. Custody records detailed that he declared he suffered from depression. On two occasions he was checked by medical personnel to ascertain if he was fit to be kept in custody.

4.5.3. In October 2013 when he was 22 years of age, Paul self-presented to the Emergency Department at his local Hospital and was seen by the Mental Health Liaison Team. He complained of general symptoms of paranoia but no evidence of psychosis could be determined by any of the practitioners he saw. He did admit to historic use of illicit substances and alcohol. After a number of assessments, it was concluded that he experienced problems with anger management and impulsivity associated with anxiety, poor stress coping strategies and background substance misuse. It was noted that auditory hallucinations he described, were of a pseudo nature and the generalised paranoia was in the context of stress, past trauma and social circumstances. There did not appear to be any evidence of functional psychosis or mental illness at the point the assessment was completed. He was signposted to the Lets Talk Service and encouraged to formally register with a GP to facilitate access to anger management resources. The Mental Health Trust sent him a letter clearly explaining this to him.

4.5.4. When he was visited in prison after being convicted of Rosie's murder, he told the DHR Chair that he felt his mental problems had never been taken seriously. He asked the Review to consider two psychiatric reports which had been prepared for his trail, however when he unsuccessfully appealed against his sentencing tariff, he changed his mind and his solicitor was unable to release the documents.

4.5.5. Throughout his time in prison since the offence, he has continued to maintain that he has mental health symptoms including sleeplessness, hallucinations, hearing voices, and suicidal ideas. There is evidence of repeated and detailed examination of his mental state by various doctors and nurses, including mental health practitioners. At no point did any of these professionals have concerns that he showed evidence of severe or enduring mental illness. However, prior to sentencing he was diagnosed with reactive depression and treated with antidepressants. His mood considerably improved after receiving the life sentence and there is some evidence that he then stopped attending for reviews and reported less symptoms. There was a third party report that he told another prisoner that he wanted to convince the doctors that he was mentally ill before he was sentenced.

4.6. **Paul's propensity for violence particularly towards women.**

4.6.1. While Paul has been arrested for violence against men on three occasions, he has been arrested 21 times in relation to violence, threats or harassment towards women. All but one of those incidents related to women he knew, i.e. his mother and three partners. It is evident that there were many more violent incidents towards at least two of these women which were never reported to the police. It is noted, that he was brought up in an environment where his mother was violently abused by his father and by a subsequent partner.

4.7. **The number of occasions that different victims refused to support a prosecution against Paul.**

4.7.1**.** Paul's mother contacted the police three times regarding Paul either threatening her or causing damage to her property, on each occasion she was clear she did not want him prosecuted, but only wanted the "incident logged" or "for advice to be given". From records kept by the Children and Young Peoples Service, it is apparent that as a child, Paul was regularly abusive towards his mother, but no complaints were made to the police.

4.7.2. Kate, Paul's ex-partner contacted the Police 12 times about Paul's behaviour towards her or her property. She make a complaint which resulted in a prosecution in respect of only two of these incidents. On the other ten occasions, once the police had dealt with the immediate situation, she declined to make a formal complaint or refused to speak further to the officers. A number of the incidents of physical violence were so severe that she required repeated hospital treatment. She complained of continued harassment by text and by stalking her home with incidents of criminal damage and threatening behaviour. She admitted to an IDVA that she was afraid of what Paul might do.

4.7.3. Clare, another of Paul's ex-partners contacted the Police on one occasion in relation to criminal damage to her property. He was arrested and charged but when the case came to court Clare refused to give evidence and the case was dismissed. On a second occasion he was arrested in breach of his bail conditions by visiting her house but she was not there at the time. Clare told the police IMR author that she was never the victim of domestic abuse by Paul. Their relationship lasted no more than three months.

4.7.4. The Police attended three incidents involving Rosie and Paul prior to the homicide. The first was when Paul was seen on CCTV putting his hands around Rosie's neck. He was arrested but Rosie refused to make a complaint. On the second occasion, Paul was arrested whilst driving her car after assaulting three men in a public house. He was charged with a variety of offences including the theft of her car. This was not recognised as a domestic abuse incident. On the third occasion initially Rosie sought only advice, but later decided to make a complaint to support a prosecution in respect of the theft of her bank card which had been used to obtain £300. She made a statement to officers, which detailed the theft and his threatening text messages. Additionally she included details of three previous assaults on her by Paul, which she had not previously reported.

4.8. The response of the agencies in dealing with matters relating to Paul.

4.8.1. The organisations participating in the Review have been most thorough in identifying a significant number of lessons learnt from this homicide. Those lessons are listed in the following section of the executive summary, but the following are of particular significance;

- Kate should have been moved by CBH to a new location further away from where she previously lived.

- Kate's repeated refusal to make a complaint against Paul, masked, the seriousness of the physical assaults, that included an attempt to strangle and a threat to burn her,

in addition to the persistent stalking and harassment she suffered. Recommendations have been made to ensure officers better understand the traumas and fears of victims; and to improve supervisory practice to avoid situations, that happened when on one occasion in the case, when a police Inspector instructed that Paul should be arrested, yet no action was taken.

- Whilst police intelligence held on Paul indicated that he posed a number of risks including being high risk for domestic abuse against his mother and previous partners, this was not reflected in the later DASHs completed in connection with Clare and Rosie.

- After Rosie decided to make a statement of complaint on 16th February 2014, officers looked for Paul at his mother's home, but due to the hour of the night, did not pursue enquiries at other addresses he was known to visit. If he had been arrested, would he have been out on bail by the 18th February and still have murdered Rosie, or if he had been detained in custody would he have committed the offence at a later date?

- Data Protection advice given to GDASS, that they could not retain information relating to perpetrators, meant that although they had received referrals relating to previous victims of Paul, his details were held not on record. When Rosie's standard DASH was received it therefore could not trigger a reference to Paul being a previous offender. It is noted that GDASS receive an average of 3000 referrals a year and no single member of staff could be expected to remember names of all perpetrators. The Review has brought this issue to the attention of he Information Commissioner's Office.

4.8.2. With regard to Paul's mental health issues the Review panel is satisfied that he was and is being treated with the appropriate level of professional care.

Section Five: Effective Practice/Lessons to be learnt

5.1. Only the following agencies that had contacts with Rosie or Paul have identified effective practice or lessons they have learnt during the Review.

5.2. **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

5.2.1. Proportionate actions were taken with regard to the case management of Paul. In particular, the revision of the supervision and risk management plan in the light of new information regarding domestic abuse. There had clearly been good engagement with Paul on the part of the supervising officer as evidenced by the high levels of compliance during the supervision element of his Suspended Sentence Order. However, an opportunity for further supervision was missed when he was sentenced to unpaid work only on 3rd July 2012. It is the policy of this service to recommend to courts considering unpaid work only, that when there is a background of domestic abuse a period of supervision should be added.

5.3. **Cheltenham Borough Homes (CBH)**

15.3.1. Paul's ex-partner Kate was subject to formal risk assessment through MARAC, and CBH involvement with the knowledge, understanding and engagement with this was prompt and responsive.

5.3.2. Nevertheless there are signs that those involved in the case did not always recognise that they were faced with a complex domestic abuse situation or appreciate that there may be many reasons why Kate was still in contact with her ex-partner, or act in a way that may not have followed a normal pattern, or be what the officer might have expected. There is also evidence to show that other factors, such as anti-social behaviour at her property drove decisions or opinions on Kate's situation.

5.3.3. There was not a single point of contact for Kate, who was involved with a number of sections across the organisation. A single point of contact would help support a victim centred approach.

5.3.4. The CBH Domestic Abuse Champion has a wealth of knowledge and experience, but whilst there were initially three Champions only one is still employed by CBH.

5.3.5. Whilst most actions in this case were prompt and were well intentioned, the decision to move Kate within the same area was, with hindsight, inappropriate. As a result moves of this type no longer happen the same way.

5.3.6. From the review, it is acknowledged that clear guidelines, for when CBH manages victims of domestic abuse who owe a housing debt, need to be implemented. Kate was denied access to several services when it is clear that the rechargeable debt was related to a domestic abuse situation.

5.3.7. The CBH policy on domestic abuse is presently incorporated within the Anti-Social Behaviour policy statement however; this review identifies the need for there to be a stand-alone policy.

5.4. **Gloucestershire County Council Children and Young People's Service**

5.4.1. The series of incidents and threats reported by Paul's mother may have been given insufficient attention. Another vulnerable child was supported to stay in the household for a period, as a looked after child, although the arrangement was temporary and no concerns were reported about that child at the time.

5.4.2. The more direct concern about Paul's violent behaviour to Kate may be an indicator for subsequent events. However the limited involvement of social care services was consistent with practice at that time. The threshold for child protection procedures was not met, and Kate's children were reported to not present any concern. Current practice and knowledge would suggest a more proactive approach be taken to offering support and guidance to Kate.

5.4.3. There has been a significant shift to a wider understanding of the impact of domestic abuse on children and families. Increased alertness to the needs and experiences of the children in the household would be expected. The introduction of the Gloucestershire

MASH also increases the likelihood of more effective information sharing and risk management.

Note Re Gloucestershire MASH: This is a multi-agency safeguarding hub consisting of police, education, health, social care, adult and children's services, all co-located currently in Cheltenham. Information is shared across all agencies according to the information sharing protocols in place which have to be "Haringey Compliant" to meet OFSTED requirements. Whilst MASH is still in its infancy in Gloucestershire early indications are good in terms of ensuring our response is appropriate taking into account all historical knowledge and any previous history. This is particularly beneficial where domestic abuse is a feature as any police information will inform our risk assessment.

5.5. **Gloucestershire Domestic Abuse Support Service**

5.5.1**.** Had GDASS been able to link Paul with previous clients this would have shown that he had a history of abusing women, also that his previous victims had been assessed as high risk victims. Although Rosie would not engage with GDASS services, the knowledge that Paul had that history of abusing women, added to the fact that during the incident he had put his hands round Rosie's neck would have resulted in the DASH being re-evaluated to a high risk case with a referral to MARAC.

5.6. **Gloucester City Council Housing Service**

5.6.1. It is evident that there was no statutory homeless duty to accommodate Paul either as a single person or as part of a couple with Rosie. Individually or together they had no vulnerability under the Housing Act 1996.

5.6.2. There was no indication that there was a problematic relationship between the couple which required referral or liaison with any other agency.

5.6.3. The process of screening those in housing need by Customer Services staff rather than Homeless Officers led to confusion in this case. Customer Services staff routinely telephoned "Homeless" colleagues for advice, but may not have given all the relevant information needed to give appropriate advice.

5.6.4. It is not appropriate to consider an absent partner part of an enquiry without written consent from the individual concerned.

5.7. **Gloucestershire Multi-Agency Risk Assessment Conference**

5.7.1. Actions should be bespoke to each case rather than simply generic.

5.7.2. MARAC meetings need to be limited around cases to ensure that appropriate focus can be placed on each case. A day going through a large number de-values the process and impacts on effectiveness.

5.8. **Gloucestershire Constabulary**

5.8.1. There was a need identified that there should be a system of auditable action to ensure that, subject to risk assessment, officers should establish detail of a relevant incident by way of face to face meetings with victims.

5.8.2. There was evidence of a lack of an effective exit plans / signposting for all mental health affected prisoners and sharing of information with other agencies (where appropriate).

5.8.3. The need for effective use of the Stalking & Harassment tool kit within the DASH was highlighted.

5.8.4. The need for supervisors to take time to enact positive action / agreeing safety plans was identified.

5.8.5. Unclear records show the importance of officers making timely and accurate pocket notebook entries.

5.8.6. The Review identified the need to raise the level of risk when a standard matter is committed by high risk offender.

5.8.7. The need for appropriate consideration of the use of the Domestic Violence Disclosure Scheme was identified. (DVDS had not been introduced until March 2014)

5.8.8. Control Room personnel missed opportunities to pass relevant information on to operational officers attending incidents.

5.8.9. The submission of relevant intelligence was not constantly in accordance with Gloucestershire Constabulary policy.

5.8.10. The handover of information and actions where offender is wanted (in Domestic Abuse cases) was not in line with Constabulary practice procedures.

5.8.11. In relation to detainees in custody, new risk assessment procedures were introduced on 6th October 2014. These include prompts to ask more questions; additional questions are also being asked on the paper based system; Custody Officers are being reminded of the need for risk assessment on entry and release from custody. Detainees are being provided with literature regarding specialist support agencies upon release.

5.8.12. Gloucestershire Constabulary has opened a new custody facility which will be employing a medical professional 24/7 within the custody block. Detainees will now be assessed according to their vulnerability.

5.8.13. In this case the DASH was not correctly completed at the relevant time.

5.9. **HM Courts & Tribunals Service**

5.9.1. This Review has provided HM Courts & Tribunals Service with the opportunity to identify a general lesson to be learnt - that with the advent of new legislation and guidance on domestic abuse, (e.g.: Domestic Violence Protection Orders and Domestic Violence Disclosure Scheme - Clare's Law), training for magistrates and other court personnel needs to be reviewed and updated.

5.9.2. The service will also take heed of the Probation Service's recommendation that a supervision requirement is considered on any community orders imposed following domestic abuse charges.

5.10. **[2]gether NHS Foundation Trust**

5.10.1. Although Paul has persistently complained of depression and mental health problems, the IMR has shown that he was carefully assessed and there was no evidence of acute symptoms that required secondary or tertiary levels intervention.

5.10.2. It was fully explained to him that services did not think that he had a severe mental illness and practical ways of managing his anger were discussed. It was also made clear to him that he was responsible for any actions he might take and their consequences. This information, as well as being discussed face to face, was further supported by a letter to him.

5.11 **Gloucestershire Hospitals NHS Foundation Trust**

5.11.1 Those accompanying patients assessed as "high risk" on the Emergency Mental Health Risk Assessment should be advised separately about their personal safety.

Section Six Conclusions

6.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Rosie or Paul in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?

- Will the actions they take improve the safety of domestic abuse victims in Gloucestershire in the future?

- Was Rosie's death predictable?

- Could Rosie's death have been prevented?

6.2. The Review Panel is satisfied that the IMRs have been open, thorough and questioning from the view point of the victim. The organisations have used their participation in the Review to identify and address lessons learnt from their contacts with Rosie and Paul in line with the Terms of Reference (ToR).

6.3. The Panel is of the opinion that the agreed recommendations appropriately address the needs identified in the lessons learnt. The Panel also recognises that the individual agencies represented on the review, now have or are in the process of, completing comprehensive domestic abuse strategies and putting policies in place. Provided those recommendations, strategies and policies are fully and promptly implemented, they will improve the safety of future domestic abuse victims in Tewkesbury in particular and Gloucestershire in general. The Review also notes that as a result of Her Majesty's Inspectorate of Constabulary (HMIC) inspection, Gloucestershire Constabulary has already initiated key changes to the way the Constabulary deals with victims of domestic abuse.

16.3.1 The Panel is clear that the thorough review undertaken highlights the importance of effective risk assessments to identify the likelihood of harm for all those at risk from the perpetrator.

6.4. Was Rosie's death predictable?

6.4.1. Paul had a long history of violence towards women, and whilst not all of the incidents were known to any one agency, he was known to the MARAC members and to the police to pose a number of risks, including a high risk of domestic abuse against his mother and previous partners. He had "put his hands around" the necks of two women, Kate once and Rosie twice. He had seriously assaulted Kate to the extent of her needing hospital treatment and had made threats of violence against them both and against his mother. In 2008 he had been arrested for public order offences and possession of an offensive weapon, in 2010 he had threatened nightclub door staff with a metal pole and on two other occasions, one in 2010 and one in 2013 had been arrested for attacking two and three men respectively on his own. On the later occasion he was also charged for possessing an offensive weapon.

6.4.2. The Review Panel therefore concludes that if all of this evidence had been known to any one agency, it would have been predictable that Paul would at some stage critically injure or kill someone. It was not considered to be predictable that it would be Rosie that he killed.

6.5. Could Rosie's death have been prevented? The Panel considered the following issues to be particularly relevant:

6.5.1. While Paul was known to the MARAC to be a high risk perpetrator towards more than one victim, it would appear that there was never any consideration by any agency, that he might meet the threshold for a referral to a Multi-Agency Public Protection Arrangements (MAPPA). The DHR Panel recognises that that his victims routinely refused to support action against him and this may have masked the number and the seriousness of his harassment, threats and violence towards them.

6.5.2. If Paul had been arrested for the offences of the 15th February 2014, would he still have murdered Rosie? It would have been open to a custody officer to either bail or detain Paul to await an appearance in court for these offences, but that even if he had been kept in police custody to attend court, it was probable he would still have been given bail at court. The Panel accepts that even if he had been remanded in custody, he may still have killed Rosie at a later date.

6.5.3. After the incident of the 20th July 2013, a standard DASH was completed, with a request for GDASS to be notified. GDASS, on receipt of the standard DASH, and with no knowledge of Paul's history of violence, contacted Rosie. She declined their assistance. The Panel considered if the police had raised the standard risk DASH to high risk, by virtue of the transfer of risk through Paul being a known high risk perpetrator, (as they had previously done in relation to abuse committed against Paul's mother); would GDASS's contact with Rosie have been different? This event occurred before the introduction on 8th March 2014 of the Domestic Violence Disclosure Scheme, so it is unlikely that GDASS could have done more to engage with Rosie.

6.5.4. The Review Panel therefore concluded Rosie's death could not, at that time, have been prevented.

7. **Section Seven Recommendations**

7.1. National

7.1.1. That the Information Commissioner provides clarification/guidance re the legality of domestic abuse specialist support services being able to retain information relating to perpetrators of domestic abuse, to enable them to provide information, via the police, to safeguard vulnerable new partners of the perpetrators, under Domestic Violence Disclosure Scheme (Clare's law).

Completed (see Appendix 1)

7.1.2. That CAADA reviews the national training given to IDVAs and to domestic abuse support services relating to the Data Protection Act and the Domestic Violence Disclosure Scheme (Clare's law)**.**

7.2. Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group.

7.2.1 .A public awareness campaign should be rolled out encouraging third parties including friends and family aware of domestic abuse to contact the police and/or independent local specialist support services.

7.2.2. Encourage companies and organisations to implement HR workplace policies in relation to domestic abuse.

7.2.3. Encourage companies and organisations to appoint key members of staff as Domestic Abuse Champions.

7.3 **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

7.3.1. A reminder should be given to probation staff to continue to advise the courts that the probation service provides a comprehensive service to the courts including written reports as well as oral advice in regard to sentencing options. Probation staff are on hand to provide this. The courts are not bound to act on this advice. However, the probation service recognises the need to remind courts of the advisability of including a supervision requirement in cases where there is evidence of domestic abuse.

7.3.2. A senior National Probation Service (NPS) manager will write to HM Courts and Tribunal service in Gloucestershire to advise Magistrates and Judges of the benefits to risk management, of always adding a supervision requirement for offenders with a background of domestic abuse where a stand-alone unpaid work requirement is being considered.

(For offences committed post 1st February 2015 the supervision requirement becomes part of a Rehabilitation Activity Requirement as per the Offender Rehabilitation Act 2014).

7.4. **Cheltenham Borough Homes**

7.4.1. Domestic Abuse Awareness training is arranged for front line staff. This will enable staff to recognise and respond appropriately to victims of domestic abuse.

7.4.2. Identify key staff to act as “domestic abuse champions,” to become a single point of contact for identifying victims and provide the necessary training to enable them to facilitate the role.

7.4.3. Review existing processes and guidelines where “housing debt” may be a barrier to a victim receiving appropriate support of obtaining a move to a safe environment and to ensure each case is given appropriate consideration.

7.4.4. Ensure victims records include full information and records of contract, including confirmation that the victim’s situation has been assessed and that the record are maintained that provide the rationale behind the decision.

7.4.5. To adopt a stand-alone Domestic Abuse Policy to include appropriate processes and guidelines.

7.5. **Gloucestershire County Council Children and Young People’s Service.**

17.5.1. Gloucestershire County Council, where they are the lead professional, will speak to all children in a domestic abuse household following a domestic abuse incident.

17.5.2 Agencies need to consider the safeguarding needs of all children in a domestic abuse household following a domestic abuse incident and take the appropriate action according to the agreed Gloucestershire Safeguarding Children’s Board Levels of Need document and complete a DASH form as appropriate.

7.6. **Gloucestershire Domestic Abuse Support Service**

7.6.1. That DASHs are sent through to GDASS as quickly as possible to enable contact with the victim to be made promptly at the time when they are most vulnerable.

7.7. **Gloucester City Council Housing Service**

7.7.1. There is a need to ensure that written consent from every adult, listed as an applicant on any approach for homeless assistance, is obtained. This is currently the case for all households approaching for statutory homeless assistance, but not for those who do not meet the vulnerability homeless criteria (as outlined in the Housing Act 1996 as amended). In future the Gloucester City Council Housing Service will require written consent before proceeding with any non-statutory assistance to non-priority households.

7.7.2. There should be in depth housing and homelessness expertise available to clients at the point of first contact. This is necessary to extract relevant information from clients, and offer the most appropriate advice for a range of situations. Customer Services Officers have a generalised knowledge of council services and cannot offer sufficient expertise in this area. The two tier system of customer service screen, with reference to Homeless Officers for advice on difficult cases, fails homeless customers as it inevitably relies on a précis of the customer’s situation by telephone which may not include relevant factors. Homeless officers should therefore be the first contact for anyone facing homeless crisis.

7.7.3. The initial enquiry pro-forma should be amended to include a prompt to consider local connections to the Gloucester area to ensure appropriate details are considered.

7.7.4. Implement a local Domestic Abuse policy linked to Countywide Policy, at CHIG (countywide housing implementation group) to formulate consistent local policies across the county

7.7.5. Implement regular refresher training on Domestic Abuse for all front line housing staff.

17.8. **Gloucestershire Multi-Agency Risk Assessment Conference**

7.8.1. That MARAC meetings are held within 48 hours of any incident where possible to ensure early intervention. (This is now the agreed protocol)

7.9. **Gloucestershire Constabulary**

7.9.1. Analysis of intelligence is required regularly, in order to feed into the Constabulary's intelligence (NIM) processes so as to identify those most at risk of causing harm.

7.9.2. Force Control Room Managers should ensure that all relevant information pertaining to the threat and risk of harm to and from the perpetrator is captured through careful management of the initial call and the record of that information is made available to the attending officers at the time.

7.9.3. Incidents of Domestic Abuse must not be closed without the attending officers confirming (within the incident itself) that a Risk Assessment has been completed and submitted to a supervising officer.

7.9.4. In consultation with the Crown Prosecution Service, officers in the case are expected to ensure that applications for Restraining Orders are made in appropriate cases.

7.9.5. Supervisors to ensure that any incident identified as Domestic Abuse is fully updated detailing the fact that a DASH has been completed.

7.9.6. The Constabulary Training Department to re-enforce the understanding by officers of the definition of Domestic Abuse and to ensure that where an alleged crime is reported, it is appropriately recorded as a crime.

7.9.7. Gloucestershire Constabulary considers using Body Worn Video devices in an operational capacity.

7.9.8. Evidence-led prosecutions must be a consideration for all Domestic Abuse allegations.

7.9.9. The Constabulary will consider and scope a process whereby offenders who have come to notice on multiple occasions with multiple partners in circumstances which reveal a repeated unwillingness to prosecute are subject to an investigative review in order to maximise evidence-led prosecutions.

7.10. HM Courts & Tribunals Service

7.10.1. HM Courts & Tribunals Service will conduct a review of our service to victims and witnesses, in conjunction with Gloucestershire Constabulary Witness Care Unit and Victim Support – to be concluded by 31st January 2015.

7.10.2. HM Courts & Tribunals Service will meet with Probation managers to discuss the consideration of supervision requirements on any community orders imposed following domestic abuse charges, by 31st January 2015.

7.10.3. HM Courts & Tribunals Service will conduct a review of domestic abuse training for magistrates and staff, and implement any changes or refresher training required by 31st March 2015.

Appendix 1 Action Plan

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
That the Information Commissioner provides clarification/guidance re: the legality of domestic abuse specialist support services being able to retain information relating to perpetrators of domestic abuse, to enable them to provide information, to the police, to safeguard vulnerable new partners of the perpetrators, under Domestic Violence Disclosure Scheme (Clare's law).	National	ICO to review the Data Protection Act and the Domestic Violence Disclosure Scheme. Paper sent to review from the ICO and now appendix F ICO paper sets out that agencies can consider on a case by case basis to retain information relating to domestic abuse perpetrators for the safety of individual victims. Information about domestic abuse perpetrators can be passed to the police on the grounds of safeguarding victims of domestic abuse ICO paper to be shared with relevant agencies in Gloucestershire who support victims of domestic abuse- with particular regards to retention of perpetrator in-	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group.	ICO paper has been forwarded to Home office for circulation and information. The same paper has been shared with CAADA to influence future training programmes	December 2015	27/01/2016

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
		formation. All agencies across the partnership to be reminded of the Domestic Violence Disclosure Scheme- particularly 'Right to know'(Clare's law)				
That the Home Office and Co-ordinated Action Against Domestic Abuse (CAADA) considers the current advice given to many domestic abuse support services that they would be breaching the Data Protection Act if they retain details of perpetrators on their data bases and how this affects the implementation of the Domestic Violence Disclosure Scheme (Clare's law).	National	CAADA to review advice and training provided to specialist domestic abuse services and IDVAs	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group	National training programme has been rewritten and will be provided to agencies from beginning of February 2015	Completed	27/01/2015
A public awareness rolling programme should be undertaken to encourage 3rd parties including friends and family aware of domestic abuse to contact the police and / or independent local specialist support services.	Gloucestershire Wide Cross Agency	A multi-agency communications plan to be developed and agreed by the partnership for campaign activity over the next 4 years in line with the commissioning strategy	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group	Plan to be agreed June 2015	Delivery of new campaign June 2015	On going
Encourage companies and organisations to implement HR workplace policies in relation to domestic	Gloucestershire Wide	Two conferences to be held inviting employers from across the county to learn more about	Gloucestershire Domestic Abuse and Sexual Violence Commission-	Funding has been granted by the Office of the Police and Crime Commissioner for Gloucester-	September 2015	271/2016

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
abuse.		their responsibility to safeguard their employees from domestic abuse, sexual violence stalking and harassment	ing Steering Group and partners supported by Office of Police and Crime Commissioner for Gloucestershire	shire to support this action.		
That all agencies are encouraged by the Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group to have a Domestic Abuse policy for their employees to adhere to when either they receive a disclosure or are a victim themselves. The Partnership also encourages agencies to identify domestic abuse champions in their organisation to support a coordinated response	Gloucestershire Wide	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group to provide the agencies with a skeleton template making clear references to the Commissioning Strategy 2014-2018	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group		September 2015	27/01/2016
Agencies need to consider the safeguarding needs of all children in a domestic abuse household following a domestic abuse incident and take the appropriate action according to the agreed Gloucestershire Safeguarding Children's Board Levels of Need document and complete a DASH form as appropriate.	Gloucestershire Wide	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group to ensure all relevant partnership agencies are aware of the need to implement this recommendation.	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group	Policy to be adopted by all relevant agencies.	1st September 2015	26/01/2016

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
A reminder should be given to probation staff to continue to advise the courts that the probation service provides a comprehensive service to the courts including written reports as well as oral advice in regard to sentencing options. Probation staff are on hand to provide this. The court are not bound to act on this advice. However, the probation service recognises the need to remind courts of the advisability of including a supervision requirement in cases where there is evidence of domestic abuse.	Local – Gloucester wide - National Probation Service	A training update will be worded and circulated to all staff	National Probation Service			31/03/2015
A senior National Probation Service (NPS) manager will write to HM Courts and Tribunal service in Gloucestershire to advise Magistrates and Judges of the benefits to risk management, of always adding a supervision requirement for offenders with a background of domestic abuse where a stand-alone unpaid work requirement is being considered.	Local – Gloucester wide	Senior Probation manger to write letter.	National Probation Service			28/02/2015
Domestic Abuse Aware-	Local - Cheltenham	Develop training pro-	Cheltenham Bor-		31/12/2015	26/01/2016

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
ness training to be arranged for front line staff. This will enable staff to recognise and respond appropriately to victims of domestic abuse.	Borough Homes	gram. Hold DA awareness sessions for all staff. Develop promotional material. Identify colleague/ roles for additional training. Set up training strategy	ough Homes			
Identify key staff to act as "domestic abuse champions," to become a single point of contact for identifying victims and provide the necessary training to enable them to facilitate the role.	Local - Cheltenham Borough Homes. Also multi agency.	Links to other CBH recommendation. Identify key staff. Provide training. Raise awareness within CBH of these main contact points.	Cheltenham Borough Homes.		1/4/2015 – identify staff 31/12/2015 – provide training	31/12/2015
Review existing processes and guidelines where "housing debt" may be a barrier to a victim receiving appropriate support of obtaining a move to a safe environment and to ensure each case is given appropriate consideration.	Local - Cheltenham Borough Homes.	Identify policies affected. Consult relevant teams on changes. Encapsulate within DA policy. Provide guidance to teams affected by any change to policy/process	Cheltenham Borough Homes		31/12/2015	26/01/2016
Ensure victims records include full information and records of contact, including confirmation that the victim's situation has been assessed and that the record are maintained that provide the rationale behind the decision.	Local - Cheltenham Borough Homes	Identify systems currently used to record information. Develop one reporting system. Ensure staff aware of how to correctly record information. Ensure systems in place to handle information appropriately.	Cheltenham Borough Homes		01/07/2015	01/07/2015

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
		Build in audit process				
To adopt a stand-alone Domestic Abuse Policy to include appropriate processes and guidelines.	Local - Cheltenham Borough Homes	Review ASB policy. Identify best practice. Consult with tenants. Write policy Share outcome with neighbouring RSL's.	Cheltenham Borough Homes			01/04/2015
All Children should be spoken to alone, by a Social Care professional following volatile incidents in the family home. Also ensure that the child is referred to the appropriate therapeutic support to address any unmet need.	Local - Gloucestershire County Council Children and Young People's Social Care	Ensure that this forms part of Practice Standards across all Social Care Teams.	Gloucestershire County Council Children and Young People's Social Care	Summary of Learning points from this DHR taken to the Operational Leadership Team with the recommendation for sign off to ensure this forms part of Social Care Practice Standards. Information shared at the Getting To Good Managers Meetings. Team Managers to share with their staff at team meetings and supervision	04/03/15. W/C 09/03/15 W/C 16/03/15	04/03/15 13/03/15. 31/03/15 Integral Part of Practice Standards
That DASHs are sent through to GDASS as quickly as possible to enable contact with the victim to be made quickly after the event when they are most vulnerable.	Local Gloucestershire wide		Gloucestershire Domestic Abuse Support Service and Gloucestershire Constabulary			01/04/2015
There is a need to ensure that written consent from every adult, listed as an applicant on any approach for homeless assistance,	Local Gloucester City	Staff briefing to emphasise the importance of consent. Amend policies on non-priority advice and assistance	Gloucester City Council Housing Services	Staff briefing Policy amendment	30/11/2014	Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
is obtained. This is currently the case for all households approaching for statutory homeless assistance, but not for those who do not meet the vulnerability homeless criteria (as outlined in the Housing Act 1996 as amended). In future the Gloucester City Council Housing Service will require written consent before proceeding with any non-statutory assistance to non-priority households.						
There should be in depth housing and homelessness expertise available to clients at the point of first contact. This is necessary to extract relevant information from clients, and offer the most appropriate advice for a range of situations. Customer Services Officers have a generalised knowledge of council services and cannot offer sufficient expertise in this area. The two tier system of customer service screen, with reference to Homeless Officers for advice on difficult cases, fails homeless customers as it inevitably relies on a pré-	Local - Gloucester City	Arrange for service to be provided by Homeless staff	Gloucester City Council Housing Services	Meet with Customer Services and senior management to discuss weakness of assessments by staff without specific working knowledge of homelessness. Determine date to cover service	30/09/2014	completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
cis of the customer's situation by telephone which may not include relevant factors. Homeless officers should therefore be the first contact for anyone facing homeless crisis.						
The initial enquiry proforma should be amended to include a prompt to consider local connections to the Gloucester area to ensure appropriate details are considered.	Local - Gloucester City	Re-draft proforma	Gloucester City Council Housing Services	Re-draft proforma and brief staff	30/11/2014	completed
Implement local DA policy linked to Countywide Policy	Local - Gloucester city and Gloucester wide via link to countywide policy	Raise at CHIG (countywide housing implementation group) to formulate consistent local policies across the county	Gloucester City Council	Secure agreement from districts Work with Countywide DA Coordinator	Early 2015	30/03/2015
Implement regular refresher training on Domestic Abuse for all front line housing staff	Local - Gloucester City	Arrange training – and re-schedule on a regular basis	Gloucester City Council	Arrange training	Early 2015	30/03/2015
Introduction of a process to address repeat offenders with repeat victims in cases where support for prosecution is limited.	Gloucestershire Constabulary- Gloucestershire wide	The Constabulary will consider and scope a process whereby offenders who have come to notice on multiple occasions with multiple partners in circumstances which reveal a repeated unwillingness to prosecute are subject to an investigative review in order to maximise evidence-led prose-	Gloucestershire Constabulary	Public Protection Bureau (Safeguarding) will commence a scoping process to determine the feasibility of a single department reviewing cases of multiple discontinued prosecutions involving the same offender.	Sept 2015	01/09/2015

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
		cutions.				
Analysis of intelligence is required regularly, in order to feed into the Constabulary's intelligence (NIM) processes so as to identify those most at risk of causing harm.	Gloucestershire Constabulary- Gloucestershire wide	The police IMR identified a significant number of issues, relating to how officers and call handlers have dealt with domestic abuse incidents, which have been detailed as lessons learnt. Gloucestershire Constabulary has introduced a new policy "Policing Domestic Abuse - How To?" This guidance document compliments an ongoing comprehensive training programme introduced in 2014 aimed at improving the quality of service delivered to victims of domestic abuse. Tackling Domestic Abuse as a force priority is clear to all staff, re-enforced through force intranet messages, bulletins by Chief Officer Group members, Professional Development Review supervision, rolling screen messages and master-class academic presentations. It is an-	Gloucestershire Constabulary	A weekly internal Public Protection Bureau intelligence meeting has taken place since January 2013. The meeting is chaired by DCI (Safeguarding-Public Protection), and is supported by a strategic analyst and an intelligence officer from the Public Protection Bureau. This information informs fortnightly tasking.	01/04/2015	Completed but regular analysis is ongoing.

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
		ticipated that training will be completed by mid-2015.				
Force Control Room Managers should ensure that all relevant information pertaining to the threat and risk of harm to and from the perpetrator is captured through careful management of the initial call and the record of that information is made available to the attending officers at the time.	Gloucestershire Constabulary - Gloucestershire wide		Gloucestershire Constabulary	Call handling training now includes specific training on all intelligence systems to enable the call taker to assess risk and harm to determine the grading of the incident. There is regular assessment of the operators' performance through a QA process which includes whether the operator has utilised these systems correctly. If not then feedback is given immediately and if there is no improvement then operators are placed on a development plan and have supportive mentoring. Force Control Management have confirmed that all call handlers and Control Room operators, including Supervisors have been trained in how to respond to domestic abuse incidents. The learning programme is built into the training schedules for new staff to the department.		Completed
Incidents of Domestic Abuse must not be closed	Gloucestershire Constabulary- Glouces-		Gloucestershire Constabulary	The Constabulary control room will create the inci-		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
without the attending officers confirming (within the incident itself) that a Risk Assessment has been completed and submitted to a supervising officer.	tershire wide			dent on STORM and can only be closed down by a supervisor within the Constabulary control room. DASHs must be signed off by a Sergeant or Inspector depending on the level of risk. Officers are expected to highlight on the DASH what actions have been taken to address the risks. Policing Domestic Abuse; How-to? Guidance Page 10 sets out the requirements of supervisors. The guidance also provides a helpful non-exhaustive list of safety measures available to officers		
In consultation with the Crown Prosecution Service, officers in the case are expected to ensure that applications for Restraining Orders are made in appropriate cases.	Gloucestershire Constabulary- Gloucestershire wide	Police bulletin to be drafted advising officers of this issue. Furthermore, Staff training to ensure it is captured in force training.	Gloucestershire Constabulary	Staff Development Unit confirms that current Domestic Abuse training, now underway since October 2014, are being well received. The Case Studies session includes a reference to the use of Restraining Orders. Bulletin is being prepared for publication.	On going	01/04/2015
Supervisors to ensure that any incident identified as Domestic Abuse is fully updated detailing the fact that a DASH has been completed.	Gloucestershire Constabulary- Gloucestershire wide		Gloucestershire Constabulary	Force Control Supervisors who close Domestic Incidents are fully aware of what is expected from officers prior to the closure. This forms part of		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				FCR training. The How-To Guide makes it clear. Officers have undertaken DA training provided by our Staff Development Unit which informs them of their role and responsibilities in responding to domestic abuse and how to complete the DASH risk assessment from which is focused on victim's safety and associated risks. The last page of the DASH also allows for staff to outline what safety measures have been put in place to protect the victim. All DASHs are signed off by a supervisor.		
The Constabulary Training Department to re-enforce the understanding by officers of the definition of Domestic Abuse and to ensure that where an alleged crime is reported, it is appropriately recorded as a crime.	Gloucestershire Constabulary - Gloucestershire		Gloucestershire Constabulary	Our Staff Development Unit has delivered and continues to deliver a range of training across the Constabulary about domestic abuse which includes specific inputs to Special Constables, PCSOs, Force Control Room staff and response officers. This has been delivered through face to face classrooms sessions, NCALT packages and Master-classes.		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				The How To Guide makes is clear on Page 14, the importance of recording a crime, once sufficient information is made known and regardless of whether the victim wishes to pursue the matter or not. The training currently being delivered also explores issues in relation to Honour Based Violence, and Forced Marriage. Furthermore, Initial training (Student Officers, Specials and PCSOs) – are introduced to safeguarding topics including HBV, FM & FGM.Quarterly Operational Learning days have been used for reminding and reinforcing messages on HBV, FM & FGM to frontline officers. NCALT packages have been mandated with completion rates in the 90% region for all. ICIDP programme has 2 full sessions on these topics. Regular law and policy updates on the Constabulary intranet.		
Gloucestershire Constabulary consider using Body	Local - Gloucestershire Constabulary	In consultation with Chief Supt, agreement	Gloucestershire Constabulary	Await outcome of scoping exercise.	Ongoing	

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
Worn Video devices in an operational capacity		given that the Constabulary intend to scope its uses and may consider a piloting of its use in the future.				
Evidence-led prosecutions must be a consideration for all Domestic Abuse allegations.	Local - Gloucestershire Constabulary	Focus to be given to all operational officers of the benefits of seeking an evidence-led prosecution where appropriate – this is to address those cases, where through a lack of formal complaint, have often traditionally resulted in No Further Action	Gloucestershire Constabulary	Through our Staff Development Unit, the importance of enhanced investigative practice is to be re-enforced. This will be demonstrated through improved sanctions.	Ongoing	
HM Courts & Tribunals Service will conduct a review of our service to victims and witnesses, in conjunction with Gloucestershire Constabulary Witness Care Unit and Victim Support – to be concluded by 31st January 2015.	Regional - HM Courts and Tribunal service in Gloucestershire and Gloucestershire Constabulary	HM Courts and Tribunal service in Gloucestershire to contact Gloucestershire Constabulary Witness Care Unit and Victim Support	HM Courts & Tribunals Service		31/01/2015	31/01/2015
HM Courts & Tribunals Service will meet with Probation managers to discuss the consideration of supervision requirements on any community orders imposed following domestic abuse charges, by 31st January 2015.	Regional - Gloucestershire wide. HM Courts & Tribunals Service and Bristol Gloucestershire, Somerset and Wiltshire Probation	HM Courts and Tribunal service in Gloucestershire to contact National Probation Service	HM Courts & Tribunals Service		31/01/2015	31/01/2015
HM Courts & Tribunals Service will conduct a review of domestic abuse	Regional - Gloucestershire wide. HM Courts & Tribu-	HM Courts and Tribunal service in Gloucestershire	HM Courts & Tribunals Service		31/03/2015	31/01/2015

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
training for magistrates and staff, and implement any changes or refresher training required by 31st March 2015.	nals Service					