SAFER STRONGER DONCASTER PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Fred

Died December 2017

OVERVIEW REPORT

Chair David Hunter

Author Carol Ellwood & Ged McManus

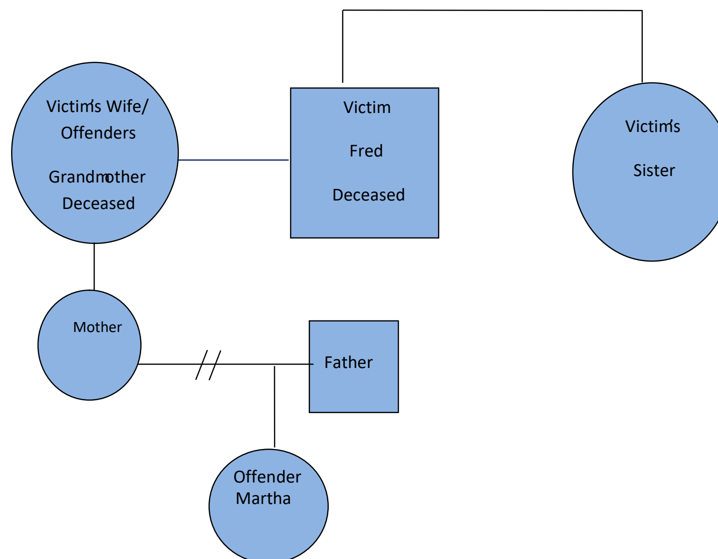
CONTENTS

	Section	Page
1.	Introduction	3
2.	Timescales	5
3.	Confidentiality	6
4.	Terms of reference	7
5.	Method	9
6.	Involvement of family and the wider community	10
7.	Contributors to the review	12
8.	The review panel members	13
9.	Chair and Author of the overview report	16
10.	Parallel reviews	17
11.	Equality and diversity	18
12.	Dissemination	20
13.	Background information [The facts]	21
14.	Chronology	26
15.	Overview	32
16.	Analysis using the terms of reference	40
17.	Conclusions	50
18.	Learning Identified	53
19.	Recommendations	58
20.	Appendix A Events Table	61
	Appendix B Action Plans	69

1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to and supported Fred a resident of Doncaster prior to his death in December 2017.

1.2 Fred was the Step-Grandfather of the perpetrator Martha. Fred had been in a long-time relationship with Martha's Grandmother, and had brought up Martha's Mother and her three siblings as children. At the time of his death in December 2017 Fred was living on his own. The below genogram details the family relationships.



1.3 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer'.[1]

1.4 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly,

[1] Home Office Guidance Domestic Homicide Reviews December 2016.

what needs to change in order to reduce the risk of such tragedies happening in the future'.

1.5 The panel offer its sincere condolences to Fred's family.

1.6 The report was seen by Fred's sister who did not wish to provide a tribute for the report.

2. TIMESCALES

2.1 On 18 January 2018 the Safer Stronger Doncaster Partnership determined that the death of Fred met the criteria for a domestic homicide review [DHR]. The Home Office was informed on 01 February 2018 and a week later acknowledged there would be a delay in commencing the review.

2.2 The commissioning process for an independent chair and availability of panel members meant that the first meeting of the review panel did not take place until 30 May 2018.

2.3 The DHR covers the period 13 February 2015 to late December 2017. The start date was chosen because Martha was issued with a 12 month suspended custodial sentence under the supervision of South Yorkshire Community Rehabilitation Company. The panel felt that this two year period gave sufficient and proportionate depth to the review.

2.4 The domestic homicide review was presented to the Safer Stronger Doncaster Partnership on 24th January 2019 and concluded on 30th May 2019 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014.

3.2 Fred's sister wished to be an integral part of the review and was seen during the process by the Chair and Independent Author. On 9 November 2018 Fred's sister met with the panel and provided further information for the review. Her contribution to the review appears as appropriate.

3.3 This table shows the age and ethnicity of the victim and perpetrator; there were no identified other key individuals for the review.

3.4 The victim's family chose the pseudonym Fred. The panel allocated the pseudonym Martha to the perpetrator

Name	Relationship	Age	Ethnicity
Fred	Victim	72	White British Male
Martha	Perpetrator	38	White British Female

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 30 May 2018. They were shared with Fred's family who were invited to comment on them. At that stage the family had not engaged with the review. However, when Fred's sister was seen the terms of reference were discussed and she felt they dealt with the issues.

4.2 The review covers the period 13 February 2015 to late December 2017.

The purpose of a DHR is to:[2]

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.

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Fred as a victim of domestic abuse, and Martha as a perpetrator of domestic abuse. Was your response, including risk assessment and monitoring, reached in an informed way? The indicators of domestic abuse should include any evidence of controlling and, or coercive behaviour and/or financial abuse.
2. Were practitioners:

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

- Sensitive to Fred and Martha’s needs?
- Knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3. Did your agency follow its, and any multi-agency, domestic abuse and safeguarding procedures; if not why not, and were any gaps identified?
4. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Fred or Martha?
5. What knowledge or concerns did Fred’s family, friends, [employers] and the community have about his victimisation, including the reasons, and did they know what to do with it?
6. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Fred or Martha, including management oversight and supervision, or on your agency’s ability to work effectively with other agencies?
7. What learning has emerged for your agency?
8. Are there any examples of outstanding or innovative practice arising from this case?
9. Does the learning in this review appear in other domestic homicide reviews commissioned by Doncaster?

5. METHOD

5.1 South Yorkshire Police notified the Safer Stronger Doncaster Partnership on 28 December 2017 of the homicide and that the case potentially met the criteria for a domestic homicide review. A meeting held on 18 January 2018 determined that the criteria had been met for a Domestic Homicide Review to be undertaken.

5.2 The first meeting of the review panel decided the review period should begin on 13 February 2015 to late December 2017.

5.3 The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made.

5.4 The written material was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.5 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed.

6. INVOLVEMENT OF FAMILY, FRIENDS, VISIT TO MARTHA, NEIGHBOURS AND THE WIDER COMMINUITY

6.1 The family liaison officer from South Yorkshire Police delivered letters from the review chair to Fred's sister and nephew, informing them of the review and inviting them to contribute after the trial. Also delivered at the same time was the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse[3] leaflet. Additionally, the terms of reference for the review were included.

6.2 In the absence of contact from Fred's sister and nephew, the panel chair contacted Fred's sister through Victim Support Services, and she agreed to be seen by the panel chair and author. This visit took place at her home in August 2018. She provided useful background information on the relationship between Fred and Martha, the details of which are included within Paragraph 14.1.

6.3 No contact was received from Fred's nephew, this was discussed with Fred's sister when seen by the panel chair and author and she stated that her son had had limited contact with his Uncle, but she agreed to try and obtain any alternative contact details for him.

6.4 No further details were available for Fred's nephew and so the panel chair asked South Yorkshire Police to re-contact Fred's nephew to see if he wished to be engaged with the review. The Family Liaison Officer in the case agreed to speak with Fred's nephew and deliver a further letter in relation to the review. The panel chair has not received any contact from Fred's nephew.

6.5 The panel chair wrote a letter to Martha's Mother informing her about the review and inviting her to contribute to the review. No contact has been received from Martha's Mother.

6.6 Fred's sister attended the panel meeting on 9 November 2018 and provided additional information in relation to Fred which has been included within the report.

6.7 The panel chair wrote to Martha informing her about the review and inviting her to contribute. On 14 November Martha was seen by the report author and Manager of DRASACS in the presence of her Offender Manager.

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[3] www.aafda.org.uk A centre of excellence for reviews into domestic homicides and for specialist peer support

Martha provided additional information which has been included within the report.

7. CONTRIBUTORS TO THE REVIEW.

7.1 This table show the agencies who provided information to the review.

Agency	IMR[4]	Chronology	Report
South Yorkshire Police	✓		
South Yorkshire Community Rehabilitation Company (CRC)	✓		
Sheffield Diocese	✓		
Rotherham, Doncaster and South Humberside NHS Trust (RDaSH)	✓		
Doncaster Rape and Sexual Assault Counselling Service. (DRASACS)[5]		✓	✓
GP			✓
Doncaster Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)	✓		
Riverside Homes	✓		
Doncaster Children's Services Trust (DCST)[6]			✓
St Legers Home			✓
Changing Lives[7]			✓

7.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to

[4] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.
[5] Doncaster Rape and Sexual Abuse Counselling Service (DRASACS) is an independent charity that has been helping victims of sexual violence since 1987. DRASACS is a member of the British Association for Counselling and Psychotherapy (BACP).

[6] Doncaster Children's Service Trust (DCST) was established in October 2014, prior to this the commission of Children's Services was undertaken by and known as Doncaster Metropolitan Borough Council (DMBC).
[7] Changing Lives is a community-based resource centre for women, providing social, educational, recreational, counselling and support services in a safe, confidential and accessible space in Doncaster.

learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members

Name	**Job Title**	**Organisation**
Sharon Baldwin	Case and Policy Review Officer	South Yorkshire Police
Sarah Biggin	Independent Sexual Violence Adviser (ISVA) Manager	Doncaster Rape and Sexual Abuse Counselling Service (DRASACS)
Ian Boldy	Designated Nurse Safeguarding Adults	NHS Doncaster Clinical Commissioning Group (CCG)
Stephen Beckett - Carroll	Deputy Director	South Yorkshire Community Rehabilitation Company
Jackie Coombes	Counselling Service Manager	Doncaster Rape and Sexual Abuse Counselling Service (DRASACS)
Carol Ellwood	Support to Panel chair and author	Independent
Andrea Hamshaw	Workforce Development Officer & Domestic Homicide Review Co-ordinator	Doncaster Metropolitan Borough Council
David Hunter	Panel Chair	Independent
Stacey Grayson	Case Review & Policy Officer	South Yorkshire Police
Julie Jablonski	Housing Safeguarding Partnership Manager	St. Leger Homes
Pat Johnson	Lead – Safeguarding Adults	Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Cal Lacey	Independent Domestic Violence Adviser (IDVA)	Domestic Abuse Services, Doncaster Metropolitan Borough Council

	Manager	
Linda Langthorne	Safeguarding Advisor for the Church of England's Sheffield Diocese	Sheffield Diocese
Ged McManus	Support to Panel chair and author	Independent
Donna Perry	Lead Investigator	Rotherham, Doncaster and South Humberside NHS Trust (RDaSH)
Karen Shooter	Domestic and Sexual Abuse Theme Manager (DHR Manager)	Doncaster Metropolitan Borough Council
Colin West	Area Manager	Riverside Homes

8.2 The chair of the Safer Stronger Doncaster Partnership was satisfied that the panel chair was independent. In turn, the panel chair believed there was sufficient independence and expertise of the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met four times and matters were freely and robustly considered. Outside of the meetings the chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

9.2 David Hunter was appointed as the Domestic Homicide Review Chair. David is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Before retiring from full time work in 2007 he served in the armed forces and police service. He did not serve in South Yorkshire.

9.3 David Hunter was assisted by Ged McManus and Carol Ellwood, both of whom are independent practitioners. Ged McManus has experience of chairing and authoring Domestic Homicide Reviews and is an independent Chair of a Safeguarding Adult Board. Between 1986 and 2005 Ged McManus worked for South Yorkshire Police, a contributor to this review. Carol Ellwood has recently retired from thirty years public service during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 Carol Ellwood was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison.

9.4 The independent authors have not previously undertaken a domestic homicide review in Doncaster. The chair completed two DHRs in Doncaster; 2014 and 2015.

10. PARALLEL REVIEWS

10.1 Her Majesty's Coroner for Doncaster opened and adjourned an inquest into Fred's death pending the outcome of the criminal trial. HM Coroner confirmed the inquest later concluded on the basis of a suspension under Schedule 1 of the Coroners and Justice Act 2009 given the outcome of the criminal trial. Therefore, a full inquest was not necessary due to the evidence that was heard during the course of the criminal proceedings.

10.2 South Yorkshire Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.3 In mid-June 2018, following a four day trial at Sheffield Crown Court Martha was convicted of the murder of Fred and received life imprisonment, to serve a minimum of 13 years.

10.4 RDaSH have undertaken a Serious Incident Review in respect of their contact with Martha. The chair is not aware that any other agency has conducted a review or investigation into Fred's death nor intends to do so.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[8]

11.3 No agency held information that indicated Fred or Martha lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them.[9]

11.4 Fred was prescribed an anti-depressant on 6 May 2016, there is no further information held by the GP as to the reason for this prescription. No further prescriptions were issued. The DHR panel did not see any information that identified that Fred had any mental health impairment.

11.5 On 9 May 2016 Martha's GP records state that she had 'low mood' and was 'tearful'. Martha was prescribed an anti-depressant. On 27 June 2016 Martha's GP records state that she had a telephone conversation which recorded that Martha was 'in a better mood'. Martha was last prescribed anti-depressants on 22 December 2016. The DHR panel did not see any information that identified that Martha had any mental health impairment.

11.6 Fred is white British with English being his first language. Fred was not in a relationship at the time of his death and was living on his own. Fred has previously been married and had two children from this relationship. Fred did not have contact with these children, and they have not been seen as part of the review. Following his divorce, Fred married the Maternal

[8] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.
[9] Mental Capacity Act 2005

Grandmother of Martha and remained in this relationship until her death several years ago.

11.7 Martha is white British with English being her first language. Martha is not known to have been in a relationship at the time of the homicide. Martha has three children, who reside with their Maternal Grandmother (Martha's Mother). Martha is known to have attended at the Community Café at a local church, but there is no information held in relation to her religious beliefs.

11.8 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provides that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Martha's misuse of drugs is not, therefore, covered by the Act.

11.9 It should be noted that although addiction to alcohol nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 [care and support] assessment is completed. As will be seen later this may have been an option.

12. DISSEMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

Fred's Family

All agencies of Safer Stronger Doncaster Partnership

South Yorkshire Police and Crime Commissioner

Offender Manager and Offender Supervisor of Martha

DA Tactical Group

Doncaster Children's Services Trust

13. BACKGROUND INFORMATION [THE FACTS]

13.1 Fred is the step-Grandfather of Martha by way of marriage to Martha's Grandmother. At the time of their marriage Martha's Grandmother had four children from a previous relationship. Fred adopted the youngest child and brought up all four children up as his own. See genogram at 1.2.

13.2 Martha was born into a large extended family and is one of three children that her Mother had. Martha also has three children, all of whom reside with their Grandmother (Martha's Mother) on a residence order.

13.3 After leaving school Fred started work as an apprentice mechanic, before becoming a lorry driver. Fred continued working as a lorry driver until his retirement. Fred worked hard for a living, he was never unemployed and owned his own property in the local area.

13.4 Martha lived a chaotic lifestyle. She used illicit drugs, was involved in criminal behaviour and had alleged to agencies that she had been in a relationship where there was domestic abuse, in which she told them – **'she gave as good as she got'.** South Yorkshire Police have one recorded incident of domestic abuse between Martha and a previous partner from 2002, where Martha is recorded as the perpetrator. Due to this lifestyle and concerns, Martha and her children were involved with Children's Social Care. Martha's children were placed with her Mother who was eventually granted a Residence Order for all three of Martha's children.

13.5 In December 2012 Doncaster Metropolitan Borough Council (DMBC)[10] and South Yorkshire Police were informed of allegations of past sexual abuse, by an adult (not Martha) who alleged Fred was the perpetrator. Fred was not seen by the Police in relation to these allegations, there were no criminal proceedings and it is not known if Fred was aware that the allegations had been made. Martha was seen by DMBC and she signed a written agreement for her children to have no contact with Fred. Martha did not allege to DMBC during this contact that she was a victim of past sexual abuse.

13.6 During the completion of the initial assessment DMBC were informed by another adult female that she had been the victim of past sexual abuse when they were a child and that Fred was the perpetrator. These latter allegations were not reported to the Police.

[10] Doncaster Metropolitan Borough Council Children's Social Care Services ceased to exist in October 2014. From this date and independent company took over the provision of Children's Social Care In Doncaster. This company are Doncaster Children's Services Trust (DCST).

13.7 Fred's sister, when seen by the panel chair and author, as well as during the meeting with the panel expressed her upset and anger about her own family not being spoken to by any professional in relation to the allegations of sexual abuse involving Fred. Fred's sister felt that this lack of contact and knowledge prevented her and her family being able to implement any safeguarding measures or identify any further victims of sexual abuse.

13.8 On 3 February 2015 Martha appeared at Court and was given a Community Order with a Drug Rehabilitation Requirement (DRR) under the Supervision of South Yorkshire Community Rehabilitation Company. The Supervision Order was granted for twelve months, and the DRR was granted for nine months. Martha's involvement with agencies involving this Community Order is covered in Section 15.

13.9 In early 2015 Martha started to attend a Community Café held at a local church (Church of England) and over a period of time Martha became friends with the Vicar and his wife. This friendship developed, and Martha began to help at the café.

13.10 In February 2016 Martha's engagement with the South Yorkshire Community Rehabilitation Community ended as her Community Order had come to an end. Martha continued to be involved with Drug and Alcohol Services[11] who worked with her during 2016 & 2017 to address her drug usage. This included Martha being placed on the Structured Day Programme with New Beginnings[12].

13.11 In May 2016 Martha and Fred were coincidentally prescribed anti-depressants by their G.P. Martha and Fred attended the same medical practice. Fred was prescribed the medication once; no information is held as to why the medication was prescribed. Martha's medical records state that she was 'low mood' and 'tearful' when initially prescribed the anti-depressants. During a telephone consultation with Martha on 27 June 2016 Martha's GP records state she was – 'better in mood'. There is no further information held in these entries. The last time Martha was prescribed her medication is recorded as being on 22 December 2016.

[11] Doncaster Drug and Alcohol Services were provided by RDaSH who subsequently joined with ASPIRE – which is a partnership organisation set up by RDaSH and the Registered Charity – 'The Alcohol & Drug Service' (ADS).

[12] New Beginnings is an integrated specialist detoxification service and structured day programme based in Doncaster.

13.12 There are entries in some agency records that in 2016 Martha made allegations of past sexual abuse by Fred when she was a child. At the time some of these allegations were made, agencies were aware that Martha was living with Fred. These allegations were not reported to the Police. Below is a table listing these allegations –

Date	Allegation	To which agency	Action taken
16.03.14	Martha stated she was sexually abused as a child. Perpetrator not identified by name. Martha stated she may benefit from counselling.	ASPIRE (now part of the Alcohol and Drug Service)	Entry to discuss further regarding signposting/counselling
08.01.15	During consultation Martha spoke about past abuse as a child by her Grandfather. Martha stated she had been receiving counselling. Perpetrator not identified by name.	RDaSH	No action taken – entry acknowledges that Martha receiving counselling.
During 2015	Martha alleged she had sexual intercourse with Fred to fund her drug dependency.	Vicar and wife.	No action taken.
15.07.16	Martha alleged past sexual abuse by her Grandad. Martha stated she was currently living with Grandad. Perpetrator not identified by name. Martha also alleged that there had been an incident two months ago when her Grandad had 'tried again' and had asked her for sex for money.	Riverside Homes	Counselling form completed for DRASACS.
21.09.16	Martha provided information in relation to sexual abuse as a child. Perpetrator not identified by name.	DRASACS	Martha was signposted to DRASACS ISVA service.
07.01.17	12 week review with Martha. Vulnerability to	Riverside	No action taken.

Date	Allegation	To which agency	Action taken
	sexual abuse no longer identified as area of risk as Martha had stated she had not had contact with Grandfather for six months. Grandfather not named.	Homes	
Nov 17	Martha involved in incident at the Community Café when she is reported to have gone 'ballistic' when asked about her Grandad (Fred) stating that she was going to kill him and look on the Internet.	Vicar and his wife.	No action taken.

13.13 During 2016 and 2017 Martha was signposted for counselling with DRASACS; however, Martha missed many of the appointments which resulted in her case being repeatedly closed. Martha's view of her signposting to DRASACS appears in section 15.

13.14 Martha also lived in several properties provided by Riverside Homes as part of her engagement with services to address her drug usage. A range of services were provided with these accommodations including supported housing, with staff on duty 24 hours a day, seven days a week along with mandatory alcohol and drug testing. These periods of time and types of accommodation are covered within Section 15.

13.15 In February 2017 Martha was involved in a number of incidents at New Beginnings where she was volatile and agitated during group meetings. During the last incident Martha was asked to leave New Beginnings. Martha went to live at the Vicarage. This is covered within Section 15.

13.16 There is limited agency information held in relation to Fred. He had a small amount of contact with Health Professionals during the timescales of the review, the majority of which are not relevant for this review.

13.17 In late December 2017 South Yorkshire Police received a call from a relative that Fred had been found deceased at his home address. Fred was found with in excess of 120 stab wounds to his upper body, there was also

evidence that he had been beaten with his walking stick and doused in bleach. On 28 December 2017 Martha was arrested on suspicion of murder of Fred. Martha was interviewed and later charged with Fred's murder.

13.18 In mid-June 2018, following a four day trial at Sheffield Crown Court, Martha was found guilty of Fred's murder. Martha was sentenced to life imprisonment to serve a minimum of 13 years.

14. CHRONOLOGY

14.1 Background

Fred
Fred was born in South Yorkshire and was brought up with his sister in a loving family home. Fred attended schools in the local area, left at the age of fifteen and started a job as an apprentice mechanic. After several years Fred began to drive lorries for several large food stores and he remained in this job until his retirement. Fred was a hardworking man who was never out of employment during his working life. He owned his own property and saved the majority of the money that he earned. Fred had two children from his first marriage, but this marriage ended when the children were young, and Fred had no further contact with them. Fred's second marriage lasted for many years until his wife's death. At the time of this marriage his wife had four children from a previous relationship, one of these being the Mother of Martha. Fred had been registered with his GP medical practice since 1990, he was not a frequent attender. Fred's sister described him as a quiet man, who was very private about his personal life, keeping things to himself. Fred did not have a large circle of friends, but he did on occasions meet some friends at a local café. Enquiries to identify these friends for this review have been unsuccessful. However, his family stated that he stopped seeing these friends, in his later life, because he had no spare money as he gave it all to Martha to fund her drug use. Fred had limited contact with his own family, which his family said was due to him either working or 'being busy in his own home'. Fred shared an allotment with a family member, where he would spend a lot of his spare time. That family member did not respond to invitations to see the review. However, the statement made by the family member, to the police post the homicide, has been seen by the review and did not help the DHR panel's understanding of events.

Martha
Martha is the step-granddaughter to Fred. Her maternal grandmother married Fred when Martha's Mother was a young child. Martha's Grandmother had four children from a previous relationship before her marriage to Fred. Fred brought all of these children up as his own during the time of their marriage. Agency records show that Martha had violent tendencies since the age of 13 years and had convictions for violence since 2002. Martha had alleged to agencies that she had, as a child witnessed domestic abuse. Information within DMBC records indicate that there had been domestic abuse within a previous relationship of Martha's. Martha lived a chaotic lifestyle which involved the use of illicit drugs and involvement in criminality, some of this behaviour was addressed through the criminal justice system. When seen by the author and DRASACS Manager, Martha admitted to having used drugs from the age of 11years. Martha stated that after leaving school she had started training to be a Social Worker but left college during her second year of studies as a result of her violent behaviour. Martha has three children of her own, all of whom reside with her Mother under a residence order - this has been a long-term arrangement, through Doncaster Children's Services Trust, due to Martha's life style described above. Since 2004 Martha had been a patient with the Doncaster Drug and Alcohol Service and had mainly been in receipt of services for support for illicit drug use and withdrawal. There were times during this contact that Martha was in custody. During her time with Drug and Alcohol Services Martha underwent a period of detoxification in New Beginnings. There is also evidence within the records that Martha made allegations of past sexual abuse. This is covered further in Section 15.

Fred and Martha's Relationship
Not a lot is known about the relationship between Fred and Martha. Fred became Martha's step-Grandfather following his marriage to her Grandmother, when Martha's Mother was a young child. The review has established that there were occasions during the timescale of the review when Martha, as an adult, lived with Fred. The exact dates and times are not known. Fred's Landlord provided information during the homicide investigation around Fred's tenancy which included a lapse in his rent payments during 2017, and information that Martha was living in the flat with Fred in the weeks before his death. Information provided from the Diocese stated that Fred had helped Martha decorate at least one property that she was moving into from his home. Fred's sister stated that she knew Fred would regularly give Martha money to fund her illicit drug taking, and that in the end Fred became a desolate man with no savings or money. Fred's sister stated that he then borrowed money from their Mother and herself, telling them it was for basic provisions but that she (his sister) knew he was really giving the money to Martha. This financial exploitation was not reported to the Police. The Vicar and his wife stated that Martha openly spoke about her relationship with Fred in respect of her frustration or annoyance that she had to help fund food and travel costs as Fred spent his own money on his own drug use. However, they did also acknowledge that Martha contradicted herself by alleging that she had sex with him for money to fund her own drug use. The Police investigation found no evidence of Fred's drug use and the DHR panel have found no evidence of this. Following the death of Fred and during the criminal trial, Martha alleged that Fred had sexually abused her as a child. These allegations were not reported to the Police by Martha whilst Fred was alive. There are entries within some agency records that Martha had made allegations to them that she was sexually abused by her 'Grandfather' as a child. There is limited information recorded as to the identity of whom Martha was referring to as 'Grandfather.' These allegations are covered in further detail within Section 15. The author and Manager of DRASACS visited Martha and spoke with her in the presence of her Offender Manager. Martha stated that she had been a victim of sexual abuse since the age of 5 years. Martha named Fred as the

perpetrator of the abuse. Martha confirmed that she had never reported the allegations to the Police; however, she was unable to state why she had never reported these allegations when asked. Martha confirmed that when she had told professionals about the sexual abuse allegations, she was referring to Fred. Martha accepted that she had been referred to DRASACS but stated that she found the referral process and contact difficult. This is covered later within the report.

14.2 Events Table

14.2.1 A detailed events table is produced at Appendix A which contains important events which help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review, from witnesses that were seen during the homicide review and from the memories and recollections of Fred's family.

14.2.2 The below is a summary of key events contained within the table at Appendix A.

Date	Events Pre-TOR timescale
28.12.12	DMBC received allegations of sexual nature against Fred. Martha is not the victim. Records stated that Martha had contact with Fred. Initial assessment. Martha signed written agreement; her children no contact with Fred.
Jan 2013	SYP speak to victim of sexual abuse; Fred named as suspect. No formal complaint. Fred not seen. NFA.
06.03.14	Martha was seen by ASPIRE[13]. Martha disclosed abuse as a child.
08.01.15	Martha seen by RDaSH. Martha disclosed childhood abuse by her Grandfather.
Date	**Events within TOR timescale**
Early 2015	Martha attended Community Café at a local Church. Became friends with Vicar and his wife. Disclosed she had sex with Fred in exchange for drugs.
13.02.15	Martha given suspended custodial sentence, under SYCRC supervision.

[13] Doncaster Drug and Alcohol Services were provided by RDaSH who subsequently joined with ASPIRE – which is a partnership organisations set up by RDaSH and the Registered Charity – 'The Alcohol & Drug Service' (ADS).

28.07.15	RDaSH – Martha recorded as illicit drug free.
24.11.15	RDaSH – Martha reported to be using illicit drugs.
22.03.16 to 26.05.16	Martha failed to attend nine appointments with RDaSH Substance Misuse.
10.05.16	Martha arrested and tested positive for illicit drugs.
23.06.16	Changing Lives put Martha on counselling waiting list.
11.07.16	Martha attended RDaSH Substance Misuse Consultation She reported attending church, finds helpful.
15.07.16	Martha offered accommodation at Garnham House. During assessment Martha alleged past sexual abuse with her Grandad.
26.07.16	Riverside Homes undertook initial assessment and support plan with Martha. Vulnerability to sexual abuse identified as risk.
07.09.16	RDaSH consulted with Martha following her request to stop her reduction of methadone immediately.
21.09.16	Martha attended DRASAC, disclosed abuse as a child and witnessing domestic abuse.
26.10.16	Martha given first strike by Riverside Homes; tested positive Heroin/Cocaine.
Late 2016	Martha attended Community Café, cleaned and washed up. Cleric noted positive difference. She looked to the Church for moral and practical support.
16.11.16	Martha given second strike by Riverside Homes; tested positive Heroin/Cocaine.
Dec 16	Martha missed four appointments with New Beginnings.
08.01.17	Martha given third strike by Riverside Homes; tested positive Heroin/Cocaine and notice given.
19.01.17	Martha found Great Grandmother deceased. Attended address with her Grandfather. This incident, which was given by Martha to Professional's is disputed by Fred's sister, who informed the Independent Author that she had asked Fred to check the welfare of their Mother as concerns had been raised by her son. It was not long after this conversation Fred's sister attended at her Mother's address, where her son and Fred were already in attendance and their Mother had been found deceased. Martha was not at the address.
23.01.17	Martha transferred from the intense accommodation service to the dispersed service.
Feb 2017	Martha attended two group sessions at New Beginnings. Presented as volatile and agitated at times.
Feb 17	Martha moved to live at the Vicarage.
20.02.17	RDaSH held Multi-Disciplinary Team meeting in relation to Martha.

March – November 17	Incidents of Martha not collecting prescriptions. Stated distance to travel from the Vicarage was too great
16.03.17	Telephone contact with Martha by RDaSH. Martha confirmed that she was still staying at the Vicarage.
07.04.17	Martha left vicarage moved to Address 1 Doncaster.
22.05.17	Riverside Homes: Martha to floating support service.
July 17	Fred reported to Landlord that he had been locked out of his flat by Martha. Locks changed by Landlord.
12.09.17	Riverside Homes withdrew floating support service with Martha due to none engagement.
02.11.17	Martha tested clear for illicit drug use when seen by RDASH. Martha's prescribed medication was reduced to a weekly pick-up.
Nov 17	While at Community Café, Martha made threat to kill Fred.
16.12.17	Fred informed Landlord that Martha had moved into the flat.
Dec 17	Martha helped at Church during Carol Service.
Late Dec 17	Fred visited his sister: said he would not give Martha any more money.
Late Dec 17	Fred found deceased at home.

15. OVERVIEW

15.1 Introduction

15.1.1 This section of the report summarises what information was known to the agencies and professionals involved with the victim and perpetrator. The structure adopts a chronological approach in which each issue of significance is described, and the input of each agency considered. The events are cross referenced to table one. Detailed analysis of the contacts appears at section 16.

Events predating the timescale of the DHR

15.2.1 Since 2004 Martha had been involved with Doncaster Drug and Alcohol Services. There was a pattern of behaviour during this time of Martha testing positive for illicit drug use, missed appointments and prescriptions not being collected. There is evidence of a strained relationship with her Mother linked to the care of her children, who were also born during this time.

15.2.2 In December 2012 DMBC were notified by South Yorkshire Police of allegations of sexual abuse being disclosed by an adult [not Martha]. These incidents are alleged to have occurred when the victim was a child. Fred was named as the alleged perpetrator.

15.2.3 South Yorkshire Police spoke to the victim, whom did not wish to make a complaint. Fred was not notified of the allegations and no further criminal action was taken.

15.2.4 DMBC undertook an initial assessment as Martha's children were at that time in contact with Fred and living with her Mother. Martha signed a written agreement with DMBC for her children to have no contact with Fred. Martha did not make any allegations of being a victim of past sexual abuse as a child.

15.2.5 During the initial assessment DMBC were informed by another adult of allegations of sexual abuse by Fred when they were a child. These allegations were not reported to the Police. It is understood that Fred was not notified of these allegations.

15.2.6 In March 2014 and January 2015 entries in RDaSH records indicated that Martha had received counselling in relation to sexual abuse from her Grandfather, when she was a child. The Grandfather's identity was not recorded.

15.3 Events within the timescale of the DHR

2015

Note: During 2015, Fred did not come to the attention of any agency and therefore the following entries all relate to Martha.

15.3.1 On 3 February 2015 Martha appeared at Court and was given a Community Order with a Drug Rehabilitation Requirement (DRR) under the Supervision of South Yorkshire Community Rehabilitation Company. The Supervision Order was granted for twelve months, and the DRR was granted for nine months. The offence for which Martha appeared at Court for is not relevant for this review. The DRR meant Martha had to work closely with the local drugs team and her Caseworker. This also included several court reviews of her progress at Doncaster Magistrates' Court.

15.3.2 Early in 2015 Martha also started to visit a local church which held a Community Café every Tuesday morning. The café provided free refreshments, toiletries, clothing and household goods that had been donated by the local businesses and individuals. Over a period of time Martha became friends with the Vicar and wife at the Church. The Vicar and his wife were aware of Martha's drug addiction and engagement with Drug and Alcohol Services. Martha had also told them about her background and lifestyle including her criminal behaviour.

15.3.3 As the friendship developed between Martha, the Vicar and his wife, Martha began to help in the café. During this time Martha told them that she was living with her Step-Grandfather (Fred) and that she had sex with him in exchange for money to fund her drug dependency.

15.3.4 In February 2015 Martha stated she wanted to go New Beginnings and although she made a positive start on the programme, Martha very quickly began to miss appointments. When seen by a Nurse prescriber in March 2015 it was established that she was continuing to use heroin which was incompatible for the treatment she was currently on. Martha commenced a methadone programme. Martha was living with Fred at this time.

15.3.5 Towards the end of March 2015 Martha requested support with housing. Martha was seen by a drug worker who offered her an appointment that day at Wharf House[14]. Martha did not progress this placement.

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[14] Wharf House (Riverside Homes) provides accommodation and support for single people who are homeless in Doncaster.

15.3.6 Throughout March to June 2015 there is a history of Martha missing appointments with the Drug and Alcohol Services. In order to communicate with Martha, the Caseworker ensured that Martha's appointment date and times were attached to the prescriptions that she collected.

15.3.7 On 10 June 2015 it was acknowledged that Martha had made a slow start to her Drug Rehabilitation Requirement, despite this Martha insisted she wanted to go into drug rehabilitation. Records stated that Martha was still living with Fred and that she was making some attempt to reduce her heroin usage. There were times that when she was seen she was drug free.

15.3.8 In June, her Caseworker began some therapeutic work with Martha in the form of mapping recovery – 'Balancing Change' and setting SMART goals. Martha was advised to attend the 'Talking Shop' which offers access to psychological therapy in Doncaster.

15.3.9 In July 2015 Martha had further positive engagement with her Caseworker who was supporting her to look at motivation targets. Martha was offered support with housing and benefits and during consultations Martha stated she wanted to make a fresh start; however due to her drug usage Martha did not meet the criteria for admission to New Beginnings at that time.

15.3.10 In August and September 2015 Martha spoke about her depression with her Caseworker and stated that this sometimes made her feel like using heroin. Martha stated she was not on prescribed anti-depressants but that she was going to talk to her G.P.

15.3.11 Throughout September to November 2015 the Drugs Team continued to work with Martha towards drug rehabilitation and suggested that she carry out a detoxification programme at New Beginnings before going straight into a rehabilitation unit. The Caseworker continued to pursue rehabilitation with Martha and discussed with her the difficulties of this under her current circumstances surrounding her drug usage.

15.3.12 During consultation with her case worker on 10th December 2015 Martha's mood was low and she was tearful, it was recorded that Martha had a genuine desire to stop taking heroin and that following an increase in her methadone usage towards the end of 2015 Martha's heroin usage began to decrease.

2016

Note: During 2016 (save for paragraph 15.3.17), Fred did not come to the attention of any agency.

15.3.13 At the start of 2016 Martha stated she had experienced loneliness over the Christmas period which had led her to use heroin. Martha continued to work towards rehabilitation and detoxification and towards the end of January 2016 Martha was recorded to have been finding life more manageable.

15.3.14 The DRR imposed by the Courts in February 2015 ended in February 2016 and Martha had no further contact with South Yorkshire Community Rehabilitation Company.

15.3.15 Martha missed several appointments with her Caseworker during February 2016. On 8 March 2016 Martha's Caseworker spoke to her on the telephone and Martha stated she did not realise she had to attend appointments regularly now that the DRR had ended.

15.3.16 On 12 May during a medical review meeting with her Caseworker Martha stated that she had been volunteering at the local church and that she had started a computer course through the local library. Martha also stated that she had moved address which was the reason she had not received her appointment letters and had therefore missed her appointments.

15.3.17 In May 2016 Fred and Martha were prescribed anti-depressants within several days of each other. Fred and Martha were both registered at the same medical practice; however, there is no available information to state if there was any link between these two appointments and prescription of medication.

15.3.18 In June 2016 Martha was placed on the waiting list for New Beginnings. On 23 June Martha attended an open day at New Beginnings, which resulted in her missing her appointment with her Caseworker. Her Caseworker discussed this with Martha, and she expressed her keenness to start the programme and that she was willing to reduce her methadone quicker in order to start the programme.

15.3.19 At the end of June Martha was assessed for the New Beginnings programme but during the consultation she tested positive for heroin. Martha was asked to complete some written work to demonstrate her commitment to the programme and a further appointment was arranged. On 30 June Martha was accepted onto the programme.

15.3.20 On 4 July 2016 Martha disclosed to the case worker at New Beginnings that she was staying with her Grandfather. Martha stated this was not ideal and claimed that Fred was allowing other family members to use drugs in the house. Martha also alleged to her to her case worker past sexual abuse by her Grandfather. The caseworker made a referral to DRASACS and Garnham House[15].

15.3.21 Martha stated that she had difficulty with the referral process to DRASACS stating that she was not ready to talk about her abuse when the first contact was made, and that when she did feel ready to see a professional from DRASACS, she was placed on a waiting list, or provided with an appointment time, rather than being seen straight away, which would have been her preferred option. Martha blamed this process, (as opposed to her own self-will) as a means of her to continue with her drug taking as a diversion to addressing her needs.

15.3.22 Martha continued to attend group sessions during July within the structured day care, these were mostly of a therapeutic benefit. Records state that Martha found the 'feelings group' upsetting and the 'honesty group' frustrating as she did not get anything out of it.

15.3.23 On 15 July Martha attended an eligibility assessment with Riverside Homes following the referral to Garnham House. During the assessment Martha alleged past sexual abuse from her Grandad with whom she was currently living. Martha alleged the abuse occurred when she was aged 5-7 years old. Martha also alleged that there had been an incident two months ago when her Grandad had 'tried again' and had asked her for sex for money.

15.3.24 On 25 July Martha moved into Garnham House. Martha was also contacted by DRASACS and an appointment arranged for 1 August 2016. Martha did not attend this appointment and the case was closed.

15.3.25 On 26 July 2016 an initial assessment and support plan was undertaken with Martha at Garnham House in line with Riverside Homes support planning procedures. During the assessment a vulnerability to past sexual abuse was identified. Martha informed the worker that she would have no further contact with her Grandfather.

15.3.26 Throughout August and September 2016 records stated that Martha engaged well with agencies and she was participating positively in

[15] **Intense accommodation** (supported housing that is staffed 24/7 and mandatory drug and alcohol screening twice per week is conducted). Riverside Homes intense accommodation and dispersed services operate a 3 strike procedure which means that a customer can only provide a positive screening result on 3 occasions before the eviction process is triggered.

meetings. Martha's methadone was reduced, and she was changed to weekly collection. Martha self-referred to DRASACS, saying she felt pressured to attend last time. When seen by DRASACS Martha alleged past sexual abuse as a child by her Grandfather.

15.3.27 Martha's behaviour changed during October. New Beginnings noticed that she looked to be 'under the influence' during meetings and Garnham House also reported concerns. Martha became aggressive when these matters were addressed. It is believed that this behaviour was linked to recent contact that Martha had been having with her Mother and children.

15.3.28 On 26 October Martha was issued with her first 'strike' by Riverside Homes as a result of her testing positive for heroin and cocaine. On 16 November 2016 Martha was issued with a second strike by Riverside Homes having tested positive for heroin and cocaine.

15.3.29 In November and December Martha became disruptive during group work at New Beginnings. The IMR Author for RDaSH records that these incidents occurred at a time when Martha was coming towards the end of the structured day programme.

2017

15.3.30 On 3 January 2017 Martha finished on the structured day programme at New Beginnings. Riverside Homes held a twelve week review with Martha on 7th January 2017, her vulnerability to sexual abuse was no longer identified as Martha informed them that she had not had contact with her Grandfather for six months.

15.3.31 On 8 January 2017 Martha was issued with her third 'strike' by Riverside Homes having tested positive for heroin and cocaine. Martha was issued with a 'notice to determine' and informed that is may affect her offer of a place on the dispersed service[16].

15.3.32 On 19 January 2017 Martha informed staff from Riverside Homes that she had been to Great Grandmother's home with her Grandfather and had found her deceased. Records state that Martha had been helping her Grandfather with arrangements. This account given by Martha is disputed by Fred's sister.

[16] **Dispersed service** (a Riverside Homes property in the Bentley area of Doncaster with a 6 month tenancy. This service is not staffed but clients can access the staff team 24/7 via telephone. Drug and alcohol screening is mandatory once per week).

15.3.33 On 23 January 2017 Martha moved out of intense accommodation and into accommodation under the dispersed service with Riverside Homes. During February 2017 Martha attended two group sessions at New Beginnings where she presented as volatile and agitated. A further incident occurred on 9 February which resulted in Martha being asked to leave due to her behaviour towards staff and peers. Martha stated that she found these group sessions too big, which made her feel uncomfortable in discussing her own views and feelings. Martha left New Beginnings stating she was going to stay at the Vicarage. New Beginnings contacted the Vicarage later that evening to check on Martha's welfare.

15.3.34 From March 2017 onwards there are repeated entries in RDaSH records of Martha not collecting her prescription from the designated pharmacy. This was discussed with Martha when she was seen by the Doctor or case worker, which Martha explained was due to the distance she had to travel from the vicarage to collect the prescription.

15.3.35 On 8 May 2017 Martha 'left' the accommodation provided by the 'Dispersed Service' at Riverside Homes, although she had been residing at the Vicarage for a significant period of time since February 2017. Martha's engagement with the dispersed service was recorded as sporadic for the entirety of her time but it was recorded that she was receiving a large amount of support from the local Vicar and his wife.

15.3.36 On 22 May 2017 Martha moved into a St Leger property with access to the 'floating support service[17].' Martha was not screened for substance misuse during the time on the floating service as this is not an abstinence based service. Martha's engagement with the service was sporadic from the beginning. The floating support service was withdrawn on 12 September 2017 due to non-engagement.

15.3.37 From May 2017 onwards there are repeated incidents of Martha not collecting her prescription at the designated pharmacy. This was dealt with by her case worker and Dr ****, which included a reduction in her weekly pick up times and continued drug testing. Martha stated to her case worker that she purchased Subutex[18] tablets when she was unable to get to the pharmacy.

[17] **Floating support service** (support within the client's own home, no mandatory drug or alcohol screening).

[18] Buprenorphine, sold under the brand name Subutex, among others, is an opioid used to treat opioid addiction. It is a prescription only medicine in the UK.

15.3.38 On 14 August 2017 Martha was visited at home by her floating support worker where it was noticed that she had visible marks on her face. Martha informed her worker that she had been involved in a recent incident with 'a historical male' where she had been locked in her flat. Martha stated she had contacted the Police but left before they arrived. The Police do not have a record of this call from Martha. This incident resulted in the 'Risk from Others' category on Riverside Homes' risk assessment to be increased. Martha did not identify who the 'historical male' was. During the visit as part of the review Martha stated that this male was Fred.

15.3.39 In November 2017 Martha was involved in an incident at the Community Café at the Church when she was reported to have gone 'ballistic' when asked about her Grandad (Fred) stating she was going to kill him. The exact date of this incident is not known. It is known from Fred's sister that his physical and personal appearance worsened in the last few months of his life.

15.3.40 In December 2017 Martha helped during a Carol Service at the Church. Five days prior to his death Fred had visited his sister and told her that he had told Martha he was not going to give her any more money.

15.3.41 In late December 2017 Fred was found deceased at his home address. South Yorkshire Police commenced a murder investigation. Martha was subsequently arrested and charged with Fred's murder.

16. ANALYSIS USING THE TERMS OF REFERENCE

16.1 Term 1

What indicators of domestic abuse did your agency have that could have identified Fred as a victim of domestic abuse and Martha as a perpetrator of domestic abuse[19] and was your response, including risk assessment and monitoring reached in an informed way? The indicators of domestic abuse should include any evidence of controlling and, or coercive behaviour and/or financial abuse?

16.1.1 The DHR panel were satisfied that information was known to agencies that identified evidence of domestic abuse within the relationship[20] between Fred and Martha. There were no incidents of domestic abuse or concerns about the relationship of Martha and Fred reported to the Police. In particular the police do not have a record of the August 2017 domestic incident she told her floating support worker she had reported to the police.

16.1.2 No agency completed a DASH[21] risk assessment, or where information was known, recognised that the dynamics within their relationship amounted to domestic abuse. The DHR panel identified that had a DASH been undertaken with Martha it would have identified Fred as a perpetrator rather than a victim of domestic abuse, due to the allegations of sexual abuse made by Martha.

16.1.3 With the exception of the Police, partner agencies undertake a DASH for high risk cases only and with the information known to agencies at the time the case would not have met the criteria for a referral to MARAC[22].

16.1.4 Information provided by Fred's family to the panel chair and author identified that Fred was a victim of financial abuse and that Martha was the perpetrator. The family did not know that the financial abuse of Fred was a form of domestic abuse and that these concerns could have been

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[19] Domestic Abuse definition – 'Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional abuse.'

[20] Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in laws or stepfamily.

[21] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) risk identification, assessment and management model.

[22] MARAC – Multi-Agency Risk Assessment Conference – a multi-agency meeting where agencies discuss the risk of future harm to people experiencing domestic abuse and draw up an action plan to manage that risk.

reported to Professionals for safeguarding and investigation. The financial abuse of Fred was not known to agencies.

16.1.5 Economic abuse can be a barrier for victims accessing support, particularly if the victim is male. Financial abuse is also highlighted within the Care Act, as it can be present differently from other forms of domestic abuse, such as physical abuse. Research undertaken by SafeLives[23] in conjunction with Age UK provides information on the prevalence of domestic abuse within the older population and the need for agencies to be aware of the dynamics of domestic abuse when responding to incidents involving the older population.

16.1.6 The risk assessments undertaken by South Yorkshire Community Rehabilitation Company with Martha were informed by Martha's 10 convictions of violence recorded between 1993 and 2008. She was assessed as presenting a medium risk of serious harm to children, due to her past behaviour, the public, known adults and staff (due to assaults on police). The risks were assessed to be most likely in the forms of violence and/or abusive behaviour or emotional harm through her lifestyle and previous behaviour towards her children. This was considered to be most likely to occur when Martha was challenged or confronted.

16.1.7 There was evidence of this behaviour with Martha during group work at New Beginnings in February 2017 when she presented as volatile and agitated. The risk assessment undertaken by South Yorkshire Community Rehabilitation Company did not identify any specific known adults, this included no awareness of a risk, direct or indirect towards any named family members.

16.1.8 Riverside Homes identified that Martha was at risk of sexual abuse during an initial assessment with her on 26 July 2016 when Martha alleged past sexual abuse with her Grandfather and a recent incident when she alleged that her Grandfather had recently offered her money for sex. Martha informed her worker that this matter 'had been dealt with.' There was no further questioning or information gathered to understand what Martha meant by this comment. The DHR panel identified that had further information been obtained it would have identified that the matter should have had a DASH completed and the sexual abuse allegations reported to the Police.

16.1.9 Riverside Homes generated a support plan for Martha which contained actions and objectives to manage the risk, with the objective being –

[23] http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

'Martha to remain safe from sexual abuse.' The risk rating attached to the objective was scored at 'unlikely' but 'serious.' The actions attached to the objective were –

- Martha not to visit or contact her Grandfather
- Martha to attend counselling with DRASACS
- Martha to talk to staff if feeling low.

16.1.10 A DASH was not undertaken with Martha, the IMR Author from Riverside Homes stated that Martha did not want one completing and would not co-operate with this. This decision was based on the fact that Martha had capacity to make this choice, and the policy in place at that time supported that outcome. The DHR panel have identified from the review that there is a need for an overarching multi-agency domestic abuse policy to ensure that there is consistent practice across all front-line practitioners in responding to domestic abuse and the completion of a DASH, even where the victim is not compliant.

16.1.11 During a second risk assessment with Martha on 16 October 2016 it was noted that Martha was still at risk of sexual abuse but that she had had no contact with her Grandfather since her last risk assessment. Martha told her worker that she was attending counselling, but the review identified that Martha had had limited contact with DRASACS and missed many appointments which resulted in her case being repeatedly closed. It is evident that the lack of engagement with DRASACS, which contrasted with what Martha was informing workers, was not known to those agencies who were working with and supporting Martha. The review identified that there was a lack of questioning and professional curiosity by agencies, as they accepted the information that Martha chose to give them, which had they explored would have identified a change in circumstances that would have led to an updated risk assessment.

16.1.12 By January 2017 Martha was reporting to Riverside Homes that she had had no contact with her Grandfather for six months and that she had completed her counselling with DRASACS, the latter of which is now known not to have occurred. Based on this information provided by Martha, Riverside Homes recorded that Martha's vulnerability to sexual abuse was no longer identified as an area of risk. However, on 19 January 2017 Riverside Homes were aware that Martha had been in contact with her Grandfather as she had been with him when they had visited her Great Grandmother's address and found her deceased. This information did not instigate a review of the risk assessment to Martha even though earlier risk assessments had identified that Martha was at risk of sexual abuse from her Grandfather. This was a vulnerable time for Martha as she had recently moved to dispersed accommodation, she had been issued with her third strike by Riverside Homes for testing positive for illicit drugs, her

Great Grandmother had died, and she was in contact with her Grandfather whom she had alleged had sexually abused her. The DHR panel felt that a further risk assessment should have been undertaken at this time; in addition, the DHR panel did not find any evidence within the review which identified Martha as a vulnerable adult with Care and Support needs as defined by the Care Act 2014.

16.1.13 When the floating support worker visited Martha at her home in August 2017 it was identified that Martha had recently been involved in an incident with someone whom Martha described as 'a historical male.' This incident resulted in Martha receiving injuries to her face. The risk assessment identified that 'risk to others' was an area of need for Martha. Martha did not identify the male during the visit and there was no further information gathered from Martha to inform any ongoing risks that were present. The information held by Riverside Homes on the previous assessments with Martha, would have been known to the floating support worker at that time, and further questioning of Martha may have led to the identification of this male to inform the risk assessment and requirement for completion of a DASH or referral to support agencies. No agency had any information which would have identified who the male was involved in this incident.

Term 2

16.2 Were practitioners:

- **Sensitive to Fred and Martha's needs?**
- **Knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?**
- **Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?**

16.2.1 Agencies had in place policies and procedures which identified what action was expected of them if they had concerns about a victim or a perpetrator of domestic abuse; however, as Fred and Martha were never identified as such by an agency these policies and procedures were not implemented. The true extent of the relationship between Fred and Martha was not understood by any one agency. There were pieces of information available to agencies involved with Martha, but no-one had a full, or sought to gather, a full understanding of their relationship. Not one agency identified that the financial relationship between Fred and Martha could have been an indicator of domestic abuse.

16.2.2 Fred's contact with agencies during the timescales of this review was limited and related purely to medical procedures which are not relevant for

the review. There is no evidence that any of these contacts identified any potential indicators of domestic abuse.

16.2.3 In May 2016 Fred and Martha were both prescribed anti-depressants within several days of each other. At that time Fred and Martha were registered at the same medical practice. There was no available information for the DHR panel to establish if there was any connection between these medical appointments and subsequent prescriptions being issued.

16.2.4 Martha's vulnerability was known to agencies in relation to her long-term alcohol and substance misuse, offending behaviour and child safeguarding concerns surrounding her own children. This was particularly evident in February 2015 when Martha was required to engage with Drug and Alcohol Services and undertake a Drug Rehabilitation Requirement as part of a Community Order imposed by Doncaster Magistrates' Court.

16.2.5 The South Yorkshire Community Rehabilitation Company within their IMR recognised that there could be tension when working with vulnerable people between respecting the service user's personal history - and as in this case, allowing Martha to cease engaging with the Cognitive Behaviour Therapy because it was "too difficult". This decision resulted in the CRC not gaining further information to undertake a more accurate risk assessment in relation to Martha.

16.2.6 The Community Rehabilitation Company identified within their IMR that the caseworker had provided Martha with flexibility by allowing her to re-arrange appointments which could be seen as being sensitive to her needs; however the IMR author highlighted that service users of the Community Rehabilitation Company are subject of Court mandated contact and therefore issues about how they wish to engage with the Community Rehabilitation Company are not as fluid as they might be for other agencies.

16.2.7 The DHR panel established that agencies involved in the review, with the information that they knew, were sensitive to the needs of Fred and Martha. Martha had been referred to DRASACS but for reasons covered within the report Martha did not maintain this contact. The DHR panel acknowledged the views of Martha that she found the referral process difficult when she was referred to support services, including her non-engagement and placement on a waiting list. The DHR panel have identified this as an area of learning.

16.2.8 Overall, the DHR panel felt that those agencies who received disclosures by Martha that she has been abused by her grandfather did not fully consider the wider child protection implications of what she said. It appears Martha's children were protected. However, no agency who knew seems to have considered whether he had access to other children or vulnerable adults. This suggests that their level of knowledge and training could be improved.

Term 3

16.3 Did your agency follow its, and any multi-agency, domestic abuse and safeguarding procedures; if not why not and were any gaps identified?

16.3.1 As Fred and Martha were not identified as a either a victim or perpetrator of domestic abuse, no referrals or safeguarding procedures in respect of domestic abuse were used. No agency completed a DASH in respect of either person. The past sexual abuse alleged by Martha was not recognised as ongoing abuse, despite Martha alleging that she had recently had sex with her Grandfather for money.

16.3.2 Martha was risk assessed as a medium risk to children by the South Yorkshire Community Rehabilitation Company, and their policy requires a home visit should be conducted in the first month. Martha was 'sofa surfing' with friends during this time, and whilst this might have been a reason not to undertake the visit, as her own children were being cared for by her Mother, it did not consider the risk to any children in the properties she was staying. When, eventually, a home visit was undertaken Martha was staying at Fred's flat, although he was not present during the visit.

16.3.3 The Diocesan Safeguarding Children Policy included guidance for clergy in relation to offering hospitality to any known offenders: **'Hospitality should be offered carefully and with thought to the impression given to other people. Clergy in particular should be careful of the perception any assistance they offer so that the individual is not accorded trust. In particular no accommodation in clergy premises, whether owned by the Diocese or parish should be offered by clergy before seeking advice from the Diocesan Safeguarding Adviser and the relevant Archdeacon'.** The Vicar and his wife did not follow this policy when they allowed Martha to reside at the Vicarage during 2017.

16.3.4 DMBC were notified by South Yorkshire Police of allegations involving in Fred in 2012. South Yorkshire Police spoke with the alleged victim, who at that time was not willing to support a prosecution. Fred was not notified or spoken to by the Police in respect of these allegations.

16.3.5 DMBC, based on the information provided by South Yorkshire Police undertook an initial assessment, during which, DMBC received a further disclosure of past sexual abuse from a, now, adult female. This latter disclosure was not notified to the Police by DMBC, and therefore, there was no criminal investigation in respect of these latter allegations.

16.3.6 This lack of sharing of information prevented an opportunity for a criminal investigation to be undertaken and appropriate intelligence to be recorded on Police systems.

16.3.7 The review has identified that no one completed a DASH for either Fred or Martha and although agencies had in place policies and procedures for responding to domestic abuse there was no overarching multi-agency domestic abuse policy in place to ensure that there was a consistent approach by front line practitioners when responding to incidents and concerns for domestic abuse.

Term 4

16.4 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Fred and Martha?

16.4.1 There were no identified issues in respect of Fred and Martha regarding their race, culture, linguistic, faith or other diversity needs. Martha was known to have a previous conviction for a racial incident, this was not within the timescales of this review, nor relevant for further consideration.

16.4.2 It is known that Martha was attending at the local church and that she was believed to be developing her Christian faith. This belief was the foundation for the friendship that the Vicar and his wife developed with Martha, which was an acceptance in a non-judgemental way of Martha's past and current lifestyle without taking cognizance of the potential risks that Martha posed to individuals, or acknowledging the risks that Martha alleged others presented to herself.

16.4.3 There were no opportunities for agencies to consider whether Fred had any faith beliefs.

Term 5

16.5 What knowledge or concerns did Fred's family, friends and (employers) and the community have about his victimisation, including the reasons, and did they know what to do with it?

16.5.1 Fred's sister had no knowledge of Martha's allegations of past sexual abuse relating to Fred until after the death of Fred. When seen by the independent chair and author she was adamant that had she known about them whilst Fred was alive she would have taken Fred to the Police Station for the matter to have been investigated, even if that meant Fred may have received a custodial sentence if the allegations were found to be substantiated.

16.5.2 Fred's sister was fully aware that Fred was regularly giving Martha money to fund her drug addiction, to the extent she claims, that Fred eventually gave away all of his savings and saw him become a 'desolate' and vulnerable man who was being 'fleeced' by Martha. In the last few years of his life Fred's sister stated that Fred would regularly ask her and their Mother (now deceased) to lend him money, which he claimed was to buy basic essentials, however; she stated she knew that he was giving this to Martha to supply her drug addiction.

16.5.3 Fred's sister did not know that this 'financial' relationship between Martha and Fred was a form of domestic abuse and that she could have highlighted her concerns to professionals whilst Fred was alive for advice, guidance and intervention.

16.5.4 In the last year or so of his life Fred was fairly isolated; he retired from work and seemed to live a relatively solitary life. The DHR panel have been unable to identify the friends that Fred used to meet at a local café.

16.5.5 In the last few months of Fred's life his sister said his physical and personal appearance noticeably deteriorated. A nephew who saw him shortly before his death described Fred as, 'clean but looked a little scruffy and unkempt in his general appearance'. The same nephew knew that Fred had a very significant sum of money after his second wife died and that this 'disappeared' into that side of the family over a relatively short period. As stated previously while the 'disappearing money' seemed to be viewed with suspicion, it was not recognised as potential financial abuse.

Term 6

16.6 Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Fred and Martha, including management oversight and supervision, on your agency's ability to work effectively with other agencies?

16.6.1 Martha's period of case management with South Yorkshire Community Rehabilitation Company was shortly after the Transforming Rehabilitation programme was implemented in June 2014. Referral pathways with 'Operating Partners' who could support with accommodation, finance benefits and debt were in the process of being established and therefore not easily accessible. A referral for mentoring was made for Martha, but this was not attended and was not pursued by the Senior Rehabilitation Officer (SRO).

16.6.2 The SRO allocated Martha's case was suitably qualified and experienced and would have been holding up to 50 other cases, many of which would have had more overt risk concerns. The IMR Author from South Yorkshire Community Rehabilitation Company stated that they would have expected

there to have been more analytical and investigative approach to some of the work Martha was undertaking with her drug work. An example of this was that Martha was finding the cognitive behavioural work emotionally difficult there was no enquiries about why this was and if there were any new risks factors emerging. Martha was also assessed as posing a medium risk to children; however, on one occasion she missed an appointment, which Martha informed her SRO was because she was 'caring for her nieces'. There was no evidence within the agency records of follow up questioning in relation to this or assessment of any potential risks identified.

16.6.3 No other agency identified a resourcing issues; nor did the panel.

Term 7

16.7 What learning has emerged for your agency?

16.7.1 Agency learning is set out within section 18.1 of this report.

16.7.2 This case has identified the complexities of managing the compliance of drug users who live a chaotic lifestyle, and the challenges this presents to agencies to motivate and encourage those individuals to reduce their drug usage and offending behaviour.

16.7.3 The Diocese was not providing Martha with a service or working with her for the purposes of this review; however, the case has highlighted the vulnerabilities that can be placed on the Diocese when they are engaging with individuals who are living a chaotic lifestyle.

16.7.4 The Vicar and his wife, placed unconditional trust in Martha, believing that she had the potential for change, and that she was actively making progress towards a drug free lifestyle and developing her Christian faith. Due to this trust and belief in change the Vicar and his wife did not understand nor were they able to assess the risks that were posed both by, and towards Martha from external influences. This friendship moved outside of the Diocese's policies and allowed a situation where they replaced their safeguarding roles and responsibilities, to become personally involved in a case based on Martha's alleged honesty and commitment to change.

16.7.5 The Vicar and his wife had compelling evidence that Martha was dishonest during her time in their home. Their overall lack of understanding of Martha's full needs and circumstances, together with their genuine hand of friendship, allowed them to passively accept the situation and not consider the wider implications of her situation and behaviour.

Term 8

16.8 Are there any examples of outstanding or innovative practice arising from this case?

16.8.1 There were no examples of outstanding or innovative practice arising from this case identified the by the DHR panel. Nevertheless, the panel acknowledged that the practitioners who worked with Martha did so with professionalism and care in challenging circumstances.

Term 9

16.9 Does the learning in this review appear in other domestic homicide reviews commissioned by Doncaster?

16.9.1 The DHR panel were content that the learning from this review does not appear in other domestic homicide reviews commissioned by Doncaster.

17. CONCLUSIONS

17.1 Martha killed Fred in his home in late December 2017. Martha was arrested and charged with Fred's death. In mid-June 2018, following a four day trial, Martha was convicted of Fred's murder and sentenced to life imprisonment, to serve a minimum of 13 years.

17.2 Martha had a long history of offending including previous convictions for committing acts of violence. She was a long-term drug user who lived a chaotic lifestyle, failed to keep appointments or engage with those agencies who were trying to work with her to address her offending and drug misuse. When people did extend sympathy and kindness towards her Martha took advantage of this situation and manipulated them for her own gain. For example, during Martha's stay at the Vicarage in 2017 the Vicar and his wife would regularly give Martha small amounts of money. However shortly afterwards they began to notice other money and personal items, including jewellery within the Vicarage going missing. They established that Martha was responsible for these incidents. This was not reported to the Police.

17.3 During her contact with agencies Martha said that she had been a victim of sexual abuse as a child. Martha also said that her Grandfather had asked her for sex in exchange for money whilst an adult. These allegations were not progressed or explored to identify any ongoing abuse or begin a process to have them formally investigated by the police.

17.4 Agencies records were not always clear as to whom Martha was referring to when she made these allegations, with records describing the perpetrator as 'Grandfather' of 'Step-Grandfather'; therefore, it was not certain that the allegations that were made appertained to Fred. Martha said during her interview for the DHR that the reference referred to Fred. The lack of an inquisitive nature by agencies did not enable any risk or domestic abuse within the relationship to be identified. No agency had a true understanding of the relationship between Fred and Martha. The complex link or dependency between a victim who provides drugs, or money for drugs, in exchange for sex with the perpetrator of a homicide, has been seen in a contempory DHR in another area and it may be a facet of relationships that requires a national perspective.

17.5 A professional assessment may have identified controlling and coercive behaviour within the relationship. It would also have looked at whether Fred was a person within the meaning of Section 42 Care Act 2014 who may have been in need of care and support.

17.6 When Martha was seen in prison, she was asked why she had not told the police about the abuse. Martha never provided an explanation. During the same interview Martha said she told two family members but was not believed. It is known that Martha made the same disclosures to several professionals and was referred to support services but continued not to engage. Martha stated that at the time of referral she was not ready to disclose the abuse. While Martha's disclosures have some variances in them, they do contain the consistent thread that she was abused over a lengthy period by her Grandfather. The disclosures of abuse were not effectively dealt with by agencies. They did not fully recognise or pursue what they were being told.

17.7 Fred was a well brought up and hardworking man of previous good character with no previous criminal convictions. The sexual allegations, made by Martha, remained 'untested' having never been reported to the Police. Fred was not afforded the opportunity to defend these allegations, nor the allegations of sexual abuse reported to DMBC and South Yorkshire Police in 2012. This fact is strongly felt by Fred's family who stated during a meeting with the independent chair and author that had they known about the allegations they would have insisted that Fred go to the Police Station to have the allegations investigated, regardless of the potential outcome.

17.8 Fred did not report any concerns to agencies in relation to the financial situation with Martha. The DHR panel felt that Fred may not have known that the financial abuse was a form of domestic abuse which could have been reported to agencies. The DHR panel identified that Fred may also not have reported the financial abuse because of fear in respect of the allegations that Martha had made to agencies of sexual abuse and any subsequent consequences that may have occurred surrounding the allegations.

17.9 During the trial into Fred's death Martha maintained these untested allegations of past sexual abuse as part of her defence. The Judge, in his sentencing stated that the allegations of sexual abuse as a child were a 'significant mitigating factor', including Martha's allegations that she was sexually abused by Fred in the two years that she lived with him prior to his death, which included an attempt to sexually assault her on Christmas Day.

17.10 Fred's family were aware that he was regularly giving Martha his own money in order for her to fund her drug abuse, to the extent that they claim he spent all his life savings on Martha and in their own words Martha had ended up 'fleecing Fred' of all his money. The family were not aware that this behaviour might be a form of domestic abuse and that the concerns they had

surrounding Fred's financial situation could have been reported to safeguarding agencies for investigation.

17.11 Towards the end of his life his family stated that Fred had resorted to lying to his family in order to obtain money from them under the guise it was for basic essentials for himself, when in fact, they knew Fred would be giving the money to Martha fund her drug use. During the meeting with the panel chair and independent author Fred's sister stated that it was a relief to her when Fred visited her five days before his death and told her that he had informed Martha that he would not be giving her any more money for her drug use.

17.12 Fred's decision to end the funding created a change in Fred and Martha's relationship, and meant that she could no longer be reliant on him for financial gain. This change in their dynamics, and increase in his vulnerability, may have contributed to her actions on the day she killed him.

17.13 The panel fully understood that Fred was the victim of the homicide. The Judge accepted that Martha had been the victim of long term sexual abuse by Fred, a fact taken into consideration when setting the minimum tariff. The standard starting point of 15 years,[24] was reduced to 13 years because of the circumstances.

17.14 Martha had other options open to her for dealing with the abuse and taking Fred's life was wrong and unlawful.

[24] www.sentencingcouncil.org.uk/about-sentencing/types-of-sentence/life-sentences/ http://www.legislation.gov.uk/ukpga/2003/44/schedule/21

18. LEARNING IDENTIFIED

18.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

Learning 1 (Panel recommendation 1 and 2)
Narrative
Fred's family knew about the financial relationship between Fred and Martha. Fred's family believed he was being financially exploited by Martha. Fred's family did not recognise at the time that Martha's behaviour amounted to domestic abuse which could have been reported to agencies to safeguard Fred in line with policies and procedures.
Learning
It is not unusual for family not to recognise when the actions of a perpetrator may amount to domestic abuse. This is particularly so when the perpetrator engages in the financial abuse of an individual. There is a need to change the public perception about domestic abuse and particularly to increase knowledge about the factors of financial abuse and how members of the public can report their concerns to agencies for advice, guidance and intervention.
Learning 2 (Panel recommendation 3 and 4)
Narrative
Martha alleged to several agencies that she had suffered past sexual abuse as a child, and that she was currently living with the alleged perpetrator. In addition to these allegations Martha also alleged that she was having a sexual relationship with the perpetrator in exchange for money. Agencies did not undertake an inquisitive approach to these allegations which meant they did not understand the dynamics of the relationship or financial abuse that was occurring. This resulted in the domestic abuse within the relationship not being recognised, and therefore safeguarding policies not being implemented.
Learning
It is known that individuals who live a chaotic lifestyle can present as challenging when engaging with agencies. However, in order to ensure that child and adult safeguarding policies are implemented and persons who are potentially at risk are identified, agencies need to adopt an inquisitive approach to gathering all available information to inform their decision making and risk assessment.
Learning 3 (Panel recommendation 5)
Narrative

The review identified that no agency recognised that the relationship between Fred and Martha could have been a form of domestic abuse and therefore policies and procedures that were in place were not implemented. Martha provided limited information, on several occasions to agencies of her relationship with Fred, in respect of ongoing allegations of sexual and financial abuse; however, these allegations were not explored further with Martha. Martha may have been reluctant to provide further clarity or information to agencies, but this reluctance should not have been a barrier to agencies making those enquiries. Agencies had in place policies and procedures for responding to Domestic Abuse, but the review identified that there was no overarching policy across all agencies that would have ensured that agencies were working with a consistent approach in responding to domestic abuse.
Learning
Professionals need to adopt a pro-active approach when responding to allegations of sexual and domestic abuse to inform risk assessment and decision making. This includes a need for a consistent approach across all front-line practitioners in response to domestic abuse
Learning 4 (Panel recommendation 6)
Narrative
Martha disclosed to several agencies that Fred sexually abused her as a child and adult. The agencies receiving the disclosures did not share them with any agency, including the police. The retention of the disclosures denied the police the opportunity to assess the information and determine whether to begin a criminal investigation. Such an investigation may have identified other victims or people at risk. Retention also denied the police the opportunity to implement safeguarding policies and procedures. The DHR panel, have not identified any information which would clarify that Fred was aware, at the time agencies knew, that these allegations had been made and therefore he was not afforded the opportunity to engage with professionals to provide them with further information.
Learning
It is known that when agencies share information amongst professionals it allows for those agencies to work together to identify any further potential victims, establish any patterns of offending behaviour, gather evidence to inform a criminal investigation, and ensure that safeguarding measures are put in place for those individuals believed to be at risk.
Learning 5 (Panel Recommendation 7 and 8)
Narrative
In May 2016 Fred and Martha attended their GP practice within several days of each other and were both prescribed anti-depressants. These appointments may have been a coincidence; however, this fact will not be

known as there was limited information recorded in respect of Martha's appointment and no information recorded for Fred's appointment. Martha continued to be prescribed anti-depressants until December 2016.
Learning
People who are experiencing domestic abuse can present with differing symptoms including varying forms of mental health. Careful exploration and questioning with people can assist in the identification of domestic abuse which can then be responded to in respect of safeguarding and referrals in accordance with policies and procedures.
Learning 6 (Panel Recommendation 9)
Narrative
This is the second DHR known to the chair/author where the relationship between the male victim and the female perpetrator was dominated by the victim providing money and/or drugs in exchange for sex with the offender. These relationships are complex and both cases would have benefitted from a better understanding of where power and control lay and whether it varied with time and circumstance.
Learning
Without a thorough understanding of the dynamics of money and/or drugs for sex relationships, and reliable risk assessment processes, applying effective interventions is imprecise and success left to chance.
Learning 7 (Panel Recommendation 10)
Narrative
Risk to victims increases when the power dynamics changed in favour of the victim. Separation, when instigated by the victim, is an example of a shift in power and Fred's stated intention of stopping the flow of money to Martha was such a shift and analogous to separation.
Learning
This case reinforces the knowledge that the risk to victims of domestic abuse increases when the power dynamics changed in favour of the victim.
Learning 8 (Panel Recommendation 11)
Narrative
Martha had been referred to DRASACS but for reasons covered within the report Martha did not maintain this contact. When seen Martha stated that she found the referral process difficult and was not ready to discuss the sexual abuse at the point of referral, even though she acknowledged the opportunity for contact with support services.
Learning

Disclosure of sexual abuse can be a difficult and emotional time for victims who often need time and assurances before they are ready to disclose. Access to support services needs to have a flexible approach to ensure that opportunities are available in a timely manner when victims are ready to speak to Professionals.

18.2 Agencies Learning

Riverside Homes

Narrative

18.2.1 Martha alleged past sexual abuse to Riverside Homes and that she was still in contact with the perpetrator. Based on the allegations Martha made, Riverside Homes identified that she was vulnerable to sexual abuse. The information provided by Martha did not enable Professionals to fully understand the relationship between Martha and the perpetrator and inform their decision making around any safeguarding interventions that could have been instigated.

Learning

18.2.2 It is recognised that Professionals need to balance the wishes and feelings of their clients, whilst ensuring that when allegations are made these are fully documented and relevant information is gathered to ensure that safeguarding policies and procedures are adhered, and relevant referrals are made where appropriate.

N.B Staff at Riverside Homes are now aware of the need to contact Doncaster Metropolitan Borough Council Safeguarding Team when allegations of sexual abuse are made. In addition, staff have also been notified when any form of abuse is disclosed the Police are to be notified even if the client does not wish for this to happen.

RDASH

Narrative

18.2.3 People who live a chaotic lifestyle which involves criminality and drug use are often reluctant to share personal information surrounding their current as well as historical information in relation to their life and family history. It is known that this information can often provide a wealth of knowledge to agencies that will assist them to obtain a greater understanding of the people who they are working with.

Learning

18.2.4 In order to understand an individual's family circumstances and any potential external influences then agencies need to ensure that when working with clients they undertake formal analysis of an individual's background, including family dynamics.

Sheffield Diocese

Narrative

18.2.5 The Vicar and his wife gave unconditional trust and friendship to Martha despite knowing about her chaotic lifestyle involving criminality and drug use. This included allowing Martha to reside within their home. Over a period of time they believed that Martha was making a positive change towards her withdrawal from drug use and therefore any risks that she may have posed where reduced. This could be seen as a 'Christian' approach; however, these risks were not taken into consideration given the vulnerable people that Martha may have come into contact with at the Community Café or through the Vicar's family members.

Learning

18.2.6 Members of the Church will often come into contact with vulnerable people and will as part of their faith want to help and assist those individuals where appropriate. In doing so cognizance needs to be taken of any potential safeguarding risks and where these are identified policies and procedures adhered to, or where there is any doubt advice should be sought from the Diocesan Safeguarding Advisor.

19. RECOMMENDATIONS

19.1 Panel Recommendations

Number	Recommendation
1	That the Safer Stronger Doncaster Partnership conducts a domestic abuse campaign highlighting the different aspects of domestic abuse – including financial abuse, and referral pathways.
2	That the Safer Stronger Doncaster Partnership updates domestic abuse website with more information about how family/friends and colleagues can support victims and perpetrators of domestic abuse.
3	That the Safer Stronger Doncaster Partnership ensures that agencies policies and procedures identify all aspects of domestic abuse and that all staff are aware of their roles and responsibilities in respect of implementing these policies.
4	That the Safer Stronger Doncaster Partnership share the Domestic Homicide Review report with its substance misuse group to ensure that the learning is incorporated into practice, and the importance of professional curiosity highlighted.
5	That the Safer Stronger Doncaster Partnership incorporates the learning from this Domestic Homicide Review to into the new sexual abuse training currently being developed.
6	That the Safer Stronger Doncaster Partnership produces a Joint Domestic Abuse protocol with the Doncaster Safeguarding Boards highlighting the importance of professional curiosity and risk assessment and how to deal with disclosures of sexual abuse.
7	That Doncaster Clinical Commissioning Group disseminate the learning from this review to all GP's in respect of the requirement to fully explore and document within patient records where anti-depressants are prescribed, including where there is a diagnosis of depression.
8	That Doncaster Clinical Commissioning Group ensures that the learning from this review is incorporated into the domestic and sexual abuse training delivered to GP's.
9	That the Safer Stronger Doncaster Partnership determines whether its risk assessment tools, and agencies use of them, are effective when dealing with relationships where money and or drugs are exchanged for sex, and whether new interventions are needed.
10	That the Safer Stronger Doncaster Partnership continues to promote the message that the risk to victims of domestic abuse increases when the power dynamics changed in favour of the victim.

11	That the Safer Stronger Doncaster Partnership ensures that agencies referral pathway for victims of sexual abuse is accessible for all victims.

19.2 Agencies Recommendations

RDaSH

19.2.1 To educate drug and alcohol staff and raise awareness on identifying and signposting when trauma /domestic violence is disclosed during clinical contact with patients.

South Yorkshire Community Rehabilitation Company

19.2.2 Provide practitioner refresher briefings for working with a range of familial abuse, including broader typologies, relating to adult safeguarding and including financial abuse.

19.2.3 Provide practitioner refresher briefings for working with substance misusers - to reinforce the need to address and not lose sight of broader risk management issues due to the continuous focus on substance abuse for example other relationships, associates and accommodation.

19.2.4 The learning from this review to be disseminated to all staff involved in this case, including in their Supervision, to ensure that the lessons identified are embedded into practice.'

Sheffield Diocese

19.2.5 Learning to be disseminated to all those involved in this review within the Sheffield Diocese, ensuring any welfare needs are taken into consideration.

19.2.6 The National Safeguarding Team to be made aware of learning from this review in relation to male victims of domestic abuse and for a review to be undertaken of their policy in relation to male victims of domestic abuse.

19.2.7 Appointment of an Independent role within parishes, for cases when it is identified that the Safeguarding Officer is also the clergy's spouse and there is a potential conflict of interest.

19.2.8 Additional 'Responding well to domestic abuse' training programmes to be delivered.

19.2.9 Parish Safeguarding Audit to review parish's policy statements in relation to domestic abuse.

19.2.10 Embedding of structured links between parishes and local agencies who respond to domestic abuse.

19.2.11 Review of procedures regarding the residents within Dioceses properties.

Appendix A – Events Table

Date	Events – Pre TOR
28.12.12	DMBC open case file following allegations received against Fred. Records stated that Martha had contact with Fred in relation to her drug use and providing a place to stay. Initial assessment undertaken by DMBC – Martha signed written agreement for children to have no contact with Fred.
Jan 2013	South Yorkshire Police speak to victim of sexual abuse. Fred named as suspect. No formal complaints were made to Police. Fred was not seen, and no criminal action was undertaken. Martha was not the victim.
06.03.14	Martha was seen by ASPIRE[25]. During the consultation Martha spoke about past abuse as a child and that she felt she would benefit from counselling.
08.01.15	Martha seen by RDaSH. During consultation Martha spoke about past abuse as a child by her Grandfather. Martha stated she had been receiving counselling.
Date	**Event**
Early 2015	Martha started to attend a Community Café at a local Church. During the coming months she became friends with the Vicar and his wife. Over a period of time Martha alleged to the Vicar and his wife that she lived with Fred and engaged in sexual intercourse with him to fund her drug dependency.
13.02.15	Martha issued with a 12 month suspended custodial sentence under the supervision of South Yorkshire Community Rehabilitation Community (CRC).
20.02.15	Martha had initial appointment with New Beginnings.
25.02.15 – 18.03.15	Martha missed four appointments with New Beginnings.
March 2015	Entry in GP records that Martha lived with Grandfather.
26.03.15 – 19.05.15	Martha missed eight appointments with Drug & Alcohol services.
31.03.15	Martha seen by New Beginnings – records stated she was living with Fred.

[25] Doncaster Drug and Alcohol Services were provided by RDaSH who subsequently joined with ASPIRE – which is a partnership organisation set up by RDaSH and the Registered Charity – 'The Alcohol & Drug Service' (ADS).

17.04.15	During RDaSH substance misuse consultation Martha stated she would not disrespect Fred by using drugs in his home.
10.06.15	RDaSH records state Martha was having a slow start to Drug Rehabilitation Requirement (DRR).
30.06.15 – 01.09.15	RDaSH Substance Misuse Consultation with Martha on 3 occasions.
28.07.15	RDaSH – Martha recorded as illicit drug free.
22.09.15	RDaSH – Martha recorded as opiate free.
29.09.15	RDaSH provide Martha with paperwork to apply for rehabilitation placement.
24.11.15	RDaSH – Martha reported to be using illicit drugs.
10.12.15	RDaSH – Martha recorded as low mood and tearful.
19.01.16	RDaSH – Martha recorded as being illicit drug free and that she was finding life more manageable.
Feb 2016	Supervision order of Martha expired with South Yorkshire CRC who had no further contact with Martha during time period of this review.
02.02.16 – 23.02.16	RDaSH – Martha failed to attend three appointments.
08.03.16	RDaSH Substance Misuse Consultation with Martha – Martha stated she did not realise she had to attend appointments now DRR finished.
22.03.16 & 07.04.16	Martha failed on two occasions to attend RDaSH Substance Misuse Consultation.
15.04.16 – 26.05.16	Martha attended on seven occasions for RDaSH Substance Misuse Consultations.
06.05.16	Entry in GP records that Martha of low mood and tearful. Prescribed anti-depressants. Last time prescribed 22.12.16.
09.05.16	Fred was prescribed anti-depressants. No further information held in GP records.
10.05.16	Martha arrested and tested positive for illicit drugs.
12.05.16	During RDaSH medical review Martha stated she had been volunteering at a local church, undertaken a computer course and moved address.
09.06.16	Martha failed to attend RDaSH Substance Misuse Consultation.
16.06.16	Martha attended RDaSH Substance Misuse Consultation Surgery. Martha placed on Structured Day Programme. Martha stated she had been volunteering at church, had

	undertaken a computer course and self-referred to New Beginnings.
22.06.16	Martha attended RDaSH Substance Misuse Consultation and assessed for the Structured Day programme. Martha invited to attend the open day on the 23.6.16.
23.06.16	Referral received for Martha for counselling by Changing Lives. Martha placed on waiting list. No further records held by Changing Lives.
23.06.16	Martha attended New Beginnings open day.
27.06.16	Martha attended RDaSH Substance Misuse Consultation – New Beginnings. Martha stated she had had a rough weekend due to drug abuse. Provided with some written work and invited back to programme on 29.06.16. Martha was told that if the written work is completed and that she has not used heroin she can start on the programme.
27.06.16	Entry in GP records – Telephone consultation with Martha – records state in 'better mood'.
30.06.16	Martha attended RDaSH Substance Misuse Consultation – New Beginnings. Referral for move to Garnham House[26] to be undertaken.
04.07.16	Martha attended RDaSH Substance Misuse Consultation – New Beginnings. Records stated Martha currently residing with Fred which was recorded as not ideal as other family members use drugs in house. Referral made to Garnham House. Contact to be made with sexual abuse services.
05.07.16	Referral received at Riverside Homes for Martha in relation to place at Garnham House. Duty staff arranged for Martha to attend Garnham House for eligibility assessment.
11.07.16	Martha attended RDaSH Substance Misuse Consultation – New Beginnings. Counselling form filled out and sent back to DRASACS and awaiting appointment. Martha reported to be attending church which she finds helpful and encouraging.
15.07.16	Martha attended RDaSH Substance Misuse Consultation and Relapse Prevention Workshop on Cycle of Change and linking it to Outcomes Star in order to create SMART goals and improve well-being.
15.07.16	Martha attended eligibility assessment at Riverside

[26] Garnham House (Riverside Homes) offers a safe, supportive, enabling environment for those with a history of drug or alcohol misuse who are now committed to exploring positive, substance-free lifestyles.

	Homes. Martha accepted on to service and offered accommodation at Garnham House. During assessment Martha alleged past sexual abuse with her Grandad. Martha stated she was currently living with Grandad. Martha alleged that there had been an incident two months ago when 'he tried again' and had offered her money for sex.
18.07.16	Martha attended RDaSH Substance Misuse Consultation and Honesty Group. During group Martha stated she had feelings of uncertainty and had attended church where she found support from the Vicar and his wife.
20.07.16	Martha referred to DRASACS by key worker. DRASACS contact Martha by phone but male answered so no message left.
25.07.16	Martha contacted by DRASACS – appointment arranged for 01.08.16.
25.07.16	Martha booked into Garnham House.
26.07.16	Riverside Homes undertake initial assessment and support plan with Martha. Further review to be undertaken in 12 weeks in line with procedures. Vulnerability to sexual abuse (historic) identified as an area of risk. Noted that Martha seeking support through DRASACS. Assessment notes that Martha not having contact with Grandfather at that point.
During 2016	The vicar and his wife believed Martha to be addressing her drug use as she had moved to Garnham House and had engaged with ASPIRE and New Beginnings.
02.08.16	RDaSH – consultation with Martha. Martha stated she wished to reduce her medication.
Aug 16	Online housing application received by St. Leger from Martha. Martha was registered in gold banding reflecting her housing need which was 'leaving supported people accommodation'.
01.09.16	Martha self-referred to DRASAC. Stated felt pressured to attend last time but states now feels ready.
07.09.16	RDaSH – consultation with Martha following her request to stop her reduction of methadone immediately. Record provided a positive reflection of Martha's progress.
14.09.16	RDaSH – care plan review of Martha. Record stated Martha was feeling positive about her recovery, she wished to contact her Mum to try and build a relationship with her children. Martha stated she was no longer interested in a rehabilitation placement.
19.09.16	Martha contacted by DRASACS – appointment arranged for 21.09.16.

21.09.16	Martha attended appointment at DRASACS. Martha provided information in relation to sexual abuse as a child, and that she had witnessed domestic violence as a child. Martha was signposted to DRASACS ISVA service.
Oct 2016	RDaSH – New Beginnings noted that Martha had been looking 'under the influence' in meetings. Garnham House also reported concerns. Martha became aggressive when this was addressed. Martha was invited back to New Beginnings and when seen she stated she had placed emotional stress upon herself.
16.10.16	Riverside Homes undertake 12 week review with Martha. Vulnerability to sexual abuse identified as area of risk.
24.10.16	Martha contacted by DRASACS and appointment arranged for 28.10.16.
26.10.16	Martha issued with first strike by Riverside Homes due to testing positive for Heroin and Cocaine.
28.10.16	Martha failed to attend appointment with DRASACS – case closed.
09.11.16 & 14.11.16	Martha attended RDaSH Substance Misuse Consultations. During care plan review on 14.11.16 the focus was on family - Martha stated it was difficult to discuss, Martha stated she wished to build a relationship with her Mother and was encouraged to write her a letter.
Late 2016	Martha started to help at the Community Café by cleaning and washing up. Vicar and his wife noticed a positive difference in Martha which they believed was due to her coming off drugs. Martha turned to the Church for moral and practical support when she was in crisis.
15.11.16	Martha contacted DRASACS – stated she missed appointment due to illness.
16.11.16	Martha issued with second strike by Riverside Homes due to testing positive for Heroin and Cocaine.
16.11.16	RDaSH records stated Martha had plans to see her Mother.
17.11.16	RDaSH records stated Martha had relapsed in her drug use due to seeing her Mother. Martha was invited to New Beginnings on 18.11.16 but she failed to attend but attended on 21.11.16 instead.
30.11.16 & 02.12.16	Martha was disruptive during group work at New Beginnings.
Dec 16	Martha missed four appointments with New Beginnings.
14.12.16	Martha attended RDaSH Surgery appointment. Records noted that Martha remained illicit drug free, she was volunteering at her local church as well as being on a

	mentor programme with M25.[27] Martha expressed that she was keen to come off her methadone. Martha placed on a waiting list for methadone detoxification. Records state that Martha presented as focused and determined.
23.12.16	Martha contacted by DRASACS – appointment arranged for 03.01.17.
03.01.17	Martha discharged from New Beginnings Structured Day Programme.
03.01.17	Martha failed to attend appointment with DRASACS. Martha contacted DRASACS later in day apologising for missing appointment. Further appointment made for 10.01.17.
07.01.17	Riverside Homes undertake 12 week review with Martha. Vulnerability to sexual abuse no longer identified as area of risk as Martha had stated she had not had contact with Grandfather for six months.
08.01.17	Martha issued with third strike by Riverside Homes due to testing positive for Heroin and Cocaine. Notice to determine issued to Martha due to testing positive for heroin and cocaine (28 DAYS NOTICE).
10.01.17	Martha failed to attend appointment at DRASACS – case closed.
16.01.17	Martha contacted DRASACS – stated she was on a 12 week course and could not make Tuesdays. Martha provided further availability and was added to waiting list.
19.01.17	Martha found Great Grandmother deceased. Attended address with her Grandfather. See genogram at 1.2. This incident is disputed by Fred's sister.
19.01.17	Martha seen at New Beginnings. Martha presented as very focused and positive about her recovery. Martha informed staff that she was moving into supported accommodation and was due for admission for treatment on 23.01.17.
23.01.17	Martha transferred from the intense accommodation service to the dispersed service. During the following week some concerns were expressed that Martha may have been using illicit drugs.
24.01.17	Riverside Homes undertake initial assessment of risk and support with Martha. No vulnerability to sexual abuse was identified.

[27] A charity providing advice and specialist help in community care, housing and welfare benefits for people who are homeless or threatened with homelessness.

06.02.17 & 08.02.17	Martha attended group sessions at New Beginnings during which she presented as volatile and agitated at times.
09.02.17	Martha attended RDaSH – New Beginnings Consultation during which she was asked to leave due to her behaviour to staff and peers.
10.02.17	Welfare contact undertaken by New Beginnings with Vicar in relation to Martha and incident on 09.02.17.
Feb 17	Martha moved to live at the Vicarage.
Feb 17	Entry in GP records that Martha had been removed from New Beginnings due to alleged disruptive behaviour.
20.02.17	RDaSH held Multi-Disciplinary Team meeting in relation to Martha.
08.03.17	Martha contacted by DRASACS and appointment arranged for 13.03.17.
March – November 17	During these 9 months there are repeated incidents of Martha not collecting her prescription from her designated pharmacy. This is discussed with Martha when seen by her case worker or Doctor and Martha stated this was due to the distance she had to travel from the Vicarage to collect her prescription.
13.03.17	Martha attended appointment at DRASACS. Notes provided separately. Signposted to ISVA. Further appointment arranged for 20.03.17.
16.03.17	Telephone contact with Martha by RDaSH. Martha confirmed that she was still staying at the Vicarage.
20.03.17	Martha failed to attend appointment at DRASACS – case closed. There was no further contact between Martha and DRASACS.
06.04.17	Martha cancelled her appointment with her caseworker.
07.04.17	Martha moved to Address 1. (Address at time of incident).
19.04.17	Riverside Homes undertake 12 week review with Martha. No vulnerability to sexual abuse was identified.
02.05.17	RDaSH – entry in records that given the number of missed pick-ups of prescriptions by Martha over the last few months this would be discussed with her at her appointment on 04.05.17.
04.05.17	Medical review. Martha stated she would test positive for Opiates. Missed prescriptions discussed with Martha and she stated as she lived at Vicarage she had a long way to walk. Martha requested if she could pick up less frequently. This was agreed if she tested negative at next appointment.
10.05.17	Garnham House contact Police to report Martha as a missing person. Martha had not been seen for two days. Contact made with Vicarage and message left.

	Martha later returned to Garnham House and stated she had been staying with Fred due to the paint fumes as she was decorating the property.
17.05.17	Martha seen by Dr ****. Missed pick up of prescriptions was noted. Martha was provided with a further prescription with instruction that if she did not attend her next medical appointment she would not be provided with a further prescription.
22.05.17	Riverside Homes transferred Martha to the floating support service. Initial risk assessment undertaken. No details of any identified risks recorded.
July 17	Fred reported to landlord being locked out of flat by Granddaughter. Locks changed, and single key issued.
14.08.17	Riverside Homes undertake 12 week review with Martha. "Risk from others" was increased following Martha alleging a recent incident involving an historical male.
12.09.17	Riverside Homes withdraw Floating support service with Martha due to none engagement.
02.11.17	Martha tested clear for illicit drug use when seen by RDASH. Martha's prescribed medication was reduced to a weekly pick-up.
Nov 17	Martha involved in incident at the Community Café when she is reported to have gone 'ballistic' when asked about her Grandad (Fred) stating that she was going to kill him and look on the Internet.
23.11.17	Letter sent to Martha from GP due to missed appointment.
16.12.17	Fred informed landlord Martha had moved into his flat. Landlord also reported having seen a female at flat in early December.
Dec 17	Martha helped at the Church during Carol Service.
Dec 17 (approx. 5 days before death)	Fred's sister stated Fred had visited her and told her he had told Martha he would not be giving her any more money.
25.12.17	Martha contacted Vicar's wife via text message for details of convenience store being open.
Late Dec	Fred found deceased at home. Murder investigation undertaken by South Yorkshire Police. Martha subsequently arrested and charged with the death of Fred.

Appendix B - Action Plan

The DHR Panel							
No	**Recommendation**	**Scope local or national**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Status**
1	That the Safer Stronger Doncaster Partnership conducts a domestic abuse campaign highlighting the different aspects of domestic abuse – including financial abuse, and referral pathways.	Local	Domestic Abuse communications strategy produced, agreed by the Domestic and Sexual Abuse Partnership and then implemented	Doncaster Council	Capacity issues resolved to ensure support is available when campaign is launched Communications Strategy Produced DSA Theme Group Approval of strategy Communications Strategy implemented	September 2019	New referral pathway implemented making in much easier to access support. New posters and leaflets designed and launched in November 2019, including financial abuse. DA training also includes financial abuse.
2	That the Safer Stronger Doncaster	Local	New website produced and	Doncaster	Website designed	January 2019	January 2019.

	Partnership updates domestic abuse website with more information about how family/friends and colleagues can support victims and perpetrators of domestic abuse.		promoted in relation to helping friends/family/colleagues to support victims and perpetrators of DA	Council	and tested Website launched as part of Domestic Abuse Communications Strategy		Action completed
3	That the Safer Stronger Doncaster Partnership ensures that agencies policies and procedures identify all aspects of domestic abuse and that all staff are aware of their roles and responsibilities in respect of implementing these policies.	Local	SSDP to direct all partner agencies to review their domestic and sexual abuse policies and procedures to ensure that they include all aspects of domestic abuse and roles and responsibilities – and that they are in compliance with the overarching Multi Agency Domestic Abuse Protocol	Doncaster Council	Domestic Abuse Protocol produced and agreed by SSDP SSDP to conduct an audit of which agencies have completed the directive	June 2019	Draft protocol produced and launched. Protocol, new leaflets and posters reflect all aspects of domestic abuse.

4	That Safer Stronger Doncaster Partnership share the Domestic Homicide Review report with its substance misuse group to ensure that the learning is incorporated into practice, and the importance of professional curiosity highlighted.	Local	DHR report taken to Substance misuse group following approval from the SSDP	Doncaster Council	DHR Overview report sign off by SSDP DHR Report taken to substance misuse group	February 2019	Action Complete – February 2019
5	That the Safer Stronger Doncaster Partnership incorporates the learning from this Domestic Homicide Review to into the new sexual abuse training currently being developed.	Local	Learning from this DHR incorporated into the new sexual abuse training	Doncaster Council	Training package developed Training package agreed by partnership Training package advertised and delivered	January 2019 January 2019 March 2019	Sexual Abuse training developed and delivered and includes learning from this review.
6	That the Domestic and Sexual Abuse Manager at Doncaster	Local	Domestic Abuse Protocol produced and	Doncaster Council	Draft DA Protocol produced and circulated to the Domestic and	June 2019	Draft protocol produced and launched.

	Metropolitan Borough Council produces a Joint Domestic Abuse protocol with the Doncaster Safeguarding Boards highlighting the importance of professional curiosity and risk assessment and how to deal with disclosures of sexual abuse.		agreed by SSDP. Domestic Abuse Protocol launched to Doncaster Practitioners		Sexual Abuse Theme Group and safeguarding boards for consultation. Second draft produced and circulated to SSDP for consultation Final protocol agreed by SSDP and the Safeguarding Boards Protocol launch event		Awaiting sign off from safeguarding boards
9	That the Safer Stronger Doncaster Partnership determines whether its risk assessment tools, and agencies use of them, are effective when dealing with relationships where money and or drugs	Local	Discussion at DSA Theme Group	Doncaster Council	Time spent at DSA Theme Group to discuss	May 2019	Discussed at Substance Misuse Theme Group and Domestic and Sexual Abuse Theme Group. There was reassurance from all agencies that the DASH is being used and that there are no

	are exchanged for sex, and whether new interventions are needed.						other risk assessments needed. There has been more awareness raised however in relation to the risks where money, drugs, sex is involved and learning has been incorporated into domestic and sexual abuse training.
10	That the Safer Stronger Doncaster Partnership continues to promote the message that the risk to victims of domestic abuse increases when the power dynamics changed in favour of the victim.	Local	Domestic Abuse Training reviewed and refreshed	Doncaster Council	Training reviewed and refreshed	November 2018	Training refreshed November 2018. Action Completed.
11	That the Safer Stronger Doncaster Partnership ensures that agencies referral pathway for						New Sexual Abuse Referral Pathway is being developed

No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Status
	victims of sexual abuse is accessible for all victims.						
Doncaster Clinical Commissioning Group							
No	**Recommendation**	**Scope local or national**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Status**
1	That NHS Doncaster Clinical Commissioning Group disseminate the learning from this review to all GP's in respect of the requirement to fully explore and document within patient records where anti-depressants are prescribed, including where there is a diagnosis of depression.	Local	Named GP to share NICE guidance and Safe lives guidance for responding to Domestic Abuse. Named GP to share with GP practices learning identified from this review.	NHS Doncaster Clinical Commissioning Group	Named GP has shared information with GP practice Safeguarding Leads regarding learning from this review including remaining professionally curious when managing depression and considering other aspects of abuse that might cause low mood. Named GP has shared information regarding National Institute for Health and Care Excellence guidance for Domestic Abuse	August 2019	Information sent to GP Safeguarding Leads and other practice safeguarding contacts 02/08/2019. Information sent to GP Safeguarding Leads and other practice safeguarding contacts 02/08/2019.

					and SafeLives guidance for domestic abuse with GP practice Safeguarding Leads.		
2	That NHS Doncaster Clinical Commissioning Group ensures that the learning from this review is incorporated into the domestic and sexual abuse training delivered to GP's.	Local	Doncaster CCG Deputy Designated Nurse Safeguarding Children and Named GP Safeguarding to meet with the Domestic and Sexual Abuse Theme Manager and Workforce Development Officer to discuss improving the offer for GP practices in relation to understanding domestic abuse and responding to concerns.	NHS Doncaster Clinical Commissioning Group	Meeting to take place to discuss training offer for GP practices.	October 2019.	Meetings have taken place with Named GP, Deputy Designated nurse and the Domestic Abuse Theme Manager to discuss referral pathways. Further training dates for GPs have been provisionally booked for March 2020.
RDaSH							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**

1	To educate drug and alcohol staff and raise awareness on identifying and signposting when trauma /domestic violence is disclosed during clinical contact with patients	Local	A standalone master class on Trauma /Domestic Violence to be undertaken	RDaSH / Aspire	Masterclass takes place	June 2019	Completed on 11-12-19.
South Yorkshire Community Rehabilitation Company							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Provide practitioner refresher briefings for working with a range of familial abuse, including broader typologies, relating to adult safeguarding and including financial	Local	Group supervision session a month after the PDF- to note if learning has been retained	South Yorkshire CRC	Staff more confident	December 2018	To be populated

	abuse.						
2	Provide practitioner refresher briefings for working with substance misusers - to reinforce the need to address and not lose sight of broader risk management issues due to the continuous focus on substance abuse for example other relationships, associates and accommodation.	Local	Group supervision session a month after the PDF- to note if learning has been retained	South Yorkshire CRC	Staff more confident	December 2018	To be populated
3	The learning from this review to be disseminated to all staff involved in this case, including in their Supervision, to ensure that the lessons identified are embedded into practice.'	To be populated	To be populated	South Yorkshire CRC	To be populated	To be populated	To be populated
No	**Recommendation Domestic**	**Scope local or**	**Action to take**	**Lead Agency**	**Key milestones achieved in**	**Target Date Completion**	**Completion Date and Outcome**

	Homicide Review Panel	regional			enacting recommendation		
Sheffield Diocese							
1	Learning to be disseminated to all those involved in this review within the Sheffield Diocese, ensuring any welfare needs are taken into consideration.	Local – across the Diocese	Learning from this review to be addressed directly with those involved and to be reflected in the training module 'Responding well to Domestic Abuse'	Diocesan Safeguarding Team – led by Linda Langthorne	Meeting held with those directly involved in this case to consider the learning and to address any welfare needs Domestic Abuse training programme amended to reflect the learning from this review	End of January 2019 End of January 2019	Completed Completed
2	The National Safeguarding Team to be made aware of learning from this review in relation to male victims of domestic abuse and for a review to be undertaken of their policy in relation to male victims of	National	Discuss the learning from this review with the national safeguarding team and advise that the national guidance be amended to take into account the	Diocesan Safeguarding Management Group – led by Linda Langthorne	Report to be sent to the National Safeguarding Team detailing the learning from the review Discussion to be held with the National Policy Writer in relation	End January 2019 End March 2019	Completed Person responsible for policy in the national team has been advised but the

	domestic abuse.		learning from this review		to amending the guidance		policy has not been reviewed owing to long term sickness on long term sick
3	Appointment of an Independent role within parishes, for cases when it is identified that the Safeguarding Officer is also the clergy's spouse and there is a potential conflict of interest.	Local – across the Diocese	Advise the incumbent in each parish that neither the clergy person nor their spouse should be the Parish Safeguarding Officer in line with House of Bishop's guidance and support in identifying an independent person	Each Parochial Parish Council (PCC) across the Diocese	Diocesan Safeguarding Adviser contacts all clergy and PCC's to identify parishes where an independent person needs appointing PCC's supported in identifying and appointing an appropriate, independent Safeguarding Officer	End September 2019	Process is underway to identify parishes where an independent person needs appointing
4	Additional 'Responding well to domestic abuse' training programmes to be delivered.	Local – across the Diocese	Dates set to deliver 'Responding well to Domestic Abuse'	Safeguarding Trainer	Individuals required to attend the training are invited to book on to a training session	End January 2019 6 sessions delivered January to	4 session already delivered in 2019 and further sessions arranged

					Sessions delivered	December 2019	
5	Parish Safeguarding Audit to review parishes policy statements in relation to domestic abuse.	Local – across the Diocese	The requirement for each parish to produce and publicise a statement on Domestic Abuse to be monitored via the Parish Safeguarding Audit in 2019	Diocesan Safeguarding Management Group, led by the Diocesan Safeguarding Adviser	Information regarding the requirement to be circulated to parishes along with a template Parishes to evidence that they have a statement via the parish safeguarding audit	End Jan 2019 End July 2019	Completed Safeguarding Audit is circulated to all parishes end April with a deadline for submission of 31.07.19
6	The embedding of structured links between parishes and local agencies who respond to domestic abuse.	Local – across the Diocese	Circulate guidance to parishes to advise them on making links with local agencies supporting victims of domestic abuse	Diocesan Safeguarding Team	Local agencies identified across all local authorities in the Diocese (6) Information relayed to parishes Parishes to evidence in the Safeguarding Audit that links have been made	End February 2019 March 2019 July 2019	Completed Completed Safeguarding Audit is circulated to all parishes end April with a deadline for submission of

							31.07.19
7	A review to be undertaken of the procedures in relation to residents within Dioceses properties.	Local – across the Diocese	Advise the Diocesan Board of Finance to consider a review of its process for obtaining information in relation to those housed in diocesan premises	Diocesan Safeguarding Adviser	Written advice to be presented to the Chair of the Diocesan Board of Finance in relation to what information the Diocese requires about visitors/guests staying in diocesan properties	End January 2019	Completed – letter sent to advise the Diocesan Board of Finance of the learning from this review in relation to visitors/guests staying in diocesan properties

End V0.8 Fred DHR