DHR Overview Report into the Death of Karen
September 2016
Carlisle and Eden Community Safety Partnership
Report author: Lesley Storey
Report completed: September 2018

Table of contents

1. Introduction

This domestic homicide review examines agency responses and support given to Karen, a resident of Cumbria, prior to being killed by her partner, Peter, in September 2016.

In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse prior to 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.

The review considers agencies' contact with Karen and Peter from 2009 up to her murder in September 2016. During the period from 2009 up until the arrival of the family in Cumbria in 2015 there was very little agency contact apart from police reports. There were no formal disclosures of domestic abuse to any agency. The period from 2015 to July 2016 was characterised by intense agency contact and the review is therefore focused on this period.

2. Background

2.1 Karen, a resident in Carlisle, was killed at her home address. Her partner, Peter, was arrested for her murder. At the time of the homicide, the family's two children, Child A, and Child B, were in foster care.

2.2 Peter had been released from prison some 48 hours before the homicide. He had been detained for a period of 100 days for assaulting Karen in early July 2016. During his imprisonment, Karen had been referred to LetGo, the Independent Domestic Abuse Advisory Service in Cumbria. Whilst Peter was in prison, she disclosed rape and physical abuse of herself, and the physical abuse of Child B, by Peter. Peter was arrested on his release from prison, he was subsequently interviewed, and he denied all the allegations put to him.

2.3 Peter was released from police custody as Cumbria Constabulary (CC) felt they had insufficient evidence to charge him. Licence conditions were attached, which were not to contact Karen or go to her address. An answerphone message was left for Karen. This advised her of Peter's release from police custody, with no charges to answer due to insufficient evidence.

2.4 In the early hours of the morning (15 September 2016), a neighbour of Karen's rang CC stating a male had broken into Karen's home. She could hear screaming. CC arrived some 5 minutes later, and Karen was found with injuries that were incompatible with life.

2.5 Peter was arrested at the scene of the homicide and was subsequently put before Carlisle Magistrates Court for trial on the charges of rape and murder. The Crown Prosecution Service (CPS) view being that the decision by CC to take no further action on the previous alleged rapes, and to release Peter, had been:

2.6 **"premature and did not fully consider all lines of enquiry. In particular there were no statements taken from the neighbours who made reference to charges of rape when spoken to by the police. Medical records and social services records were not obtained – presumably on the basis the deceased stated she had not made any disclosures. Whilst this may be the case, they may have assisted in providing background to the relationship and details of domestic abuse, which, in turn, could assist in relation to issues around consent."**

2.7 In September 2016, Peter appeared before Carlisle Crown Court and entered a not guilty plea to all charges. During the investigation, the CPS wrote to the Hungarian authorities to collate evidence in relation to the backgrounds of both Karen and Peter. As a result of this request, officers were allowed to enter Hungary to carry out further investigations. These enquiries revealed that Peter had a significant history of violence. In 2003, he had damaged property and had possession of a knife. He had threatened to kill himself, was taken to hospital, escaped, and then sent threatening messages to a female described as **"a love interest"**. He was sentenced to two years licence period for affray.

2.8 In 2006, he was subject to a court finding. He forced a female at knifepoint to a remote area where he made threats to rape and kill her. Previous checks made in relation to foreign convictions had not revealed this information as the findings were not stored on the Hungarian Register of Convictions.

2.9 In March 2017, Peter was found guilty of murder and three counts of rape, by a jury, following a trial at Carlisle Crown Court. During sentencing, the judge made the following remark: **"The defendant was released from custody on 13th September, not two days before the murder. He was subject to licence conditions that he should not go to Karen's home, or contact his partner. He was arrested as soon as he arrived back into Carlisle to be interviewed in relation to the rapes, which he denied. He said what she had alleged was entirely untrue, an attempt by her dishonesty to manipulate the care proceedings in which to regain custody of her children. There was, therefore, a stark issue between her allegations and his denials, which it seems to me, is a matter that should have been resolved by a jury, but for some reasons, which I do not begin to understand, he was released without charge, still subject to the terms of his condition. That decision is now under review by the Independent Police Complaints Commission."**

2.10 Peter was given a sentence of life imprisonment with a minimum of 28 years for murder and 10 years for rape, to run concurrently on each of the three counts of rape.

3. Purpose of a Domestic Homicide Review

3.1 The key purpose for undertaking a Domestic Homicide Review (DHR), is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. 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, what needs to change to reduce the risk of such tragedies happening in the future.

4. Timescales

4.1 The review began on 27 October 2016 and concluded in September 2018. The decision for Carlisle and Eden Community Safety Partnership (CSP) to undertake a Domestic Homicide Review (DHR), was taken by the chair of the Community Safety Partnership on 27 September 2016, and the Home Office were informed on the same day. Following notification to establish a DHR, Cumbria Constabulary and the CPS wrote to Safer Cumbria Partnership and requested that the DHR process was suspended to allow the conclusion of criminal proceedings. The first panel meeting was held in October 2016 chaired by the CSP Chair .Agencies were asked to secure records and complete chronologies.

4.2 The CSP then appointed an independent chair and report author, Lesley Storey, not directly linked to any of the agencies in contact with the victim, perpetrator or children.

4.3 The family were contacted to inform them of the purpose of the review and to ask for their contributions and comments, specifically, were there any issues or questions they wished to explore through the DHR processes. The family did not add any further lines of enquiry to the terms of reference (TOR).

4.4 This DHR has not been concluded within the recognised timescales set out in statutory guidance. For multiple and complex reasons, it was not possible to achieve completion within the timescale and the Home Office have been informed of the background. Any immediate lessons identified have been implemented within a single-agency context, and reference to these lessons will be highlighted within the report.

5. Methodology

5.1 On notification of the domestic homicide, all relevant local agencies were contacted. Agencies were asked to secure their files if contact was confirmed. A scoping meeting was held on 1 November 2016, chaired by Lesley Storey. As a result of this meeting, the following agencies were identified as possibly having information on the family: North Cumbria University Hospitals Trust (NCUHT); Clinical Commissioning Group (CCG); Ambulance Service; Carlisle City Council; Children's Social Care and Education Directorate; Victim

Support; Cumbria Constabulary; LetGo; Riverside; Cumbria and Lancashire Community Rehabilitation Company; The Crown Prosecution Service.

5.2 All agencies who had contact with individual family members have submitted a chronology. Those agencies with direct contact have also supplied an Individual Management Review (IMR).

5.3 The panel is grateful to the Crown Prosecution Service who provided an IMR and advice to the panel on matters relating to the investigation of serious sexual assaults.

5.4 In addition, this review draws upon the report written in August 2017, entitled: Operation Zaatar, by the Independent Police Complaints Commission.

5.5 The panel were able to interview friends and neighbours as part of the review and received a letter from Karen's mother.

5.6 Previous Domestic Homicide Reviews were also examined. This ensured lessons identified in those reviews had been implemented, and learning disseminated across the partnership. This area has had 3 previous DHRs.

5.7 The overview report is an anthology of this information.

6. Confidentiality

6.1 The findings of each review are confidential. Information is available only to participating officers and professionals and their line managers, until the review has been approved for publication by the Home Office Quality Assurance Panel. To protect the identities of the victim, perpetrator, and their family, pseudonyms (approved by the victim's family) have been used throughout the review.

7. Persons involved in the review

7.1 The victim will be known as Karen. She was 33 years of age at the time of her death. The perpetrator will be known as Peter. He was 29 years of age at the time of the offence. Karen and Peter were both from Hungary. The eldest child in the family, Child A. The youngest child, Child B. Both children were born in the UK, however, they were, in foster care at the time of the homicide.

8. Terms of reference

8.1 The terms of reference are listed below. The main questions are the key lines of enquiry identified in this review. The subset questions are addressed where there is information or evidence.

8.2 **Were practitioners 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?

Were practitioner's sensitive to the needs of the victim and perpetrator?

8.2.1 **Did the agency have policies and procedures for (DASH) risk assessment and risk management for victims or perpetrators, and were those assessments correctly used in the case of Karen and Peter?**

Were these assessment tools, procedures and policies professionally accepted as being effective?

Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse?

Was the victim subject to a MARAC?

8.2.2 **Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?**

8.2.3 **What were the key points or opportunities for assessment and decision making in this case?**

Do assessments and decisions appear to have been reached in an informed and professional way?

Did actions or risk management plans fit with the assessment and decisions made?

Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known, or should have been known at the time?

Were senior managers or other agencies and professionals involved at the appropriate points?

8.2.4 **Had Karen disclosed to anyone and, if so, was the response appropriate?**

Was this information recorded and shared, where appropriate?

When, and in what way, were her wishes and feelings ascertained and considered?

Is it reasonable to assume that her wishes should have been known?

Was Karen informed of her options/choices to make informed decisions? Was she signposted to other agencies?

8.2.5 **Was anything known about Peter? For example, was he being managed under MAPPA?**

8.2.6 **Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of Karen, Peter and their children?**

Was consideration for vulnerability and disability necessary?

How accessible were services for the victim and perpetrator?

8.2.7 **Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one committed in this area for a number of years?**

8.2.8 **Are there ways of working effectively that could be passed on to other organisations or individuals?**

Are there lessons to be learned from this case to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?

Where can practice be improved?

Are there implications for ways of working, training, management and supervision, in partnership with other agencies and resources?

9. Involvement of family, friends, neighbours and the wider community

9.1 Following the core principles in the guidance, particularly those emphasised in the revised guidance of December 2016, this report seeks to draw out key learning enhanced by the contribution of family, friends, and issues affecting the wider community. In addition to agency contact, family and friends have provided a deeper context and history that has been invaluable in providing an understanding of the couple's relationship, and key events before and after they arrived in the UK.

9.2 Karen's mother provided a letter to the panel, which described deep sadness at the loss of her daughter when she moved to the UK to have a better life. She described Karen as an intelligent woman, educated to a high level, whom she had sadly lost touch with following the beginning of her relationship with Peter.

9.3 Karen's friend, Cara, and Cara's mother also gave generously to the panel, despite the utter devastation they experienced, and the ongoing trauma that followed, witnessing the murder. They brought alive a woman they described as gentle, caring, funny and intelligent, but entirely dominated by Peter.

9.4 Family members were written to at the onset of the review to explain the process and invite their participation. A copy of the terms of reference was translated and supplied. The family members contacted were: Karen's mother,

resident in the US; her father, resident in Hungary; and her sister, also resident in Hungary.

9.5 Further contact with Karen's mother and sister has taken place via letter.

9.6 The contribution from friends has helped the panel understand the coercive control Karen experienced; the levels of poverty and financial abuse she struggled with, alongside the ongoing sexual abuse. The panel is grateful to family members and friends who have given information in the hope this helps others. Understanding the barriers to accessing services, within a wider community/social context, is crucial to help introduce better ways of engaging with hidden victims. Above all, Karen's friends helped the panel understand how badly Karen had wanted her children to be with her, to be the mother she knew they needed, but was prevented from doing so by the struggle to survive and the abuse she experienced daily.

10. Contact with employers

10.1 The panel identified that Karen, during the timescales identified within the TOR, had three separate, consecutive employers. All her places of employment were written to and asked if they could contribute to the review. This did not prove to be a productive line of enquiry. The panel believe this was, in part, due to the nature of Karen's contracts. Karen worked part-time, in temporary positions with zero-hours contracts. Due to the transient and precarious nature of her contracts, Karen was not well-connected in her workplaces and it was not possible to locate collegial networks, or indeed management, who had worked alongside or managed her. We do know that at one of her places of employment – her last before the homicide – she had at least one friend. However, they had moved on and could not be located.

10.2 Further senior managers within the organisations were not aware of Karen's personal issues and could not contribute to the review.

11. Contact with the perpetrator

11.1 The chair of the DHR, Lesley Storey, wrote to Peter, both through his solicitor, and by contacting the prison service post-conviction. Peter despite many re-peated attempts declined to respond.

12. Review panel members

The panel has met a total of five times. The panel, including IMR authors, has not directly line managed any members of staff that had contact with the victim, the perpetrator, or their children.

List of panel members:

Lesley Storey	Independent chair and author
Louise Kelly	Domestic and sexual abuse coordinator – CCC
Clare Stratford	Community safety coordinator – CSP
Sarah Gaskell	Prevent lead – CPFT/NHS
Lisa Handley	Service manager SG HUB – CCC Children's services
Gemma Hannah	Detective Inspector – Cumbria police
Joanne Cunliffe	Unit head (Rasso) – CPS
Jonathon Lear	Sodexo (CLCRC)
Julia Carver	Service lead – Safety Net (UK)
Louise Kitcher	Service manager district – CCC Children's Services
Lee Evans	Operations manager – Victim Support
Lee Sherriff	CSP chair – Carlisle City Council
Louise Gaskell	Coordinator (temp) – CSP
Rebecca Metcalf	Hub manager – HMPS
Louise Mason Lodge	Designated nurse children – CCG North Cumbria
Nicola Byrne	Service manager – LetGo
Simon Parker	Dep designated nurse SG – CCG
Tammie Rhodes	Homeless, prevention and accommodation services manager – Carlisle City Council
Vikki Pattinson	Housing services manager – Riverside Housing

Overview managers who did not attend panel but received minutes:

Anne Cooke	Safeguarding business manager – Cumbria CCG
Melanie Baxendale	Named nurse SG children – NCUH/NHS
Tony Walker	Named nurse SG – NCUHT

Lynn Berryman	Senior service manager – Children's Services CCC
Mark Harris	Head of offender management – HMPS
Donna Cardell	Service manager – The Bridgeway SARC

13. Author of the overview report and panel chair

13.1 The chair and author of this overview report has 25 years' experience working in the field of violence against women and girls, and has completed the accredited Home Office training for chairs and independent report writers.

13.2 The author has extensive experience working in the field of domestic abuse, coercive control, and stalking, both operationally and strategically. She has been the domestic violence/violence against women and girls (VAWG) strategic lead in Newcastle for 14 years. As domestic abuse/VAWG lead, she has devised multi-agency training programmes, commissioned specialist services, set up and managed complex partnership initiatives such as specialist domestic violence courts (SDVC), and perpetrator programmes. Prior to this she worked for Newcastle Women's Aid for 12 years. The author has not worked for any of the agencies involved in this review and has complete independence from both the agencies involved and the individuals.

14. Parallel reviews

The IPCC (IOPC) were notified of the murder and conducted an independent investigation, which ran parallel to this DHR.

The terms of reference for their investigation addressed the following points:

- To investigate the nature and extent of police contact with Karen prior to her death, and in particular the measures put in place to safeguard Karen's welfare.
- The decisions made by Cumbria Constabulary to take no further action in respect of the rape and assault allegations, and whether these were appropriate in the circumstance.
- Contact was made with the IPCC lead investigator throughout the IPCC investigation and terms of reference were mutually shared.

14.1 Following the investigation, the IPCC concluded that, whilst there was no indication that any person under investigation had committed a criminal offence, there were grounds that the conduct of the officers under investigation fell far enough below the standards of behaviour expected of them, in a manner that would justify the bringing of disciplinary proceedings. The IPCC did not share a copy of the report with the panel prior to publication despite early agreement that the reviews would run in parallel. A redacted copy, out in the public domain was used to inform the panel of the findings.

Where relevant this report has inserted additional points that were learned from the IPCC report.

15. Dissemination

The report will be sent to a designated senior manager in the following agencies:

Independent chair and members of Carlisle and Eden Community Safety Partnership

Police and Crime Commissioner for Cumbria

Chief constable – Cumbria Constabulary

Chief officer – Clinical Commissioning Group (North)

Chief officer – NHS Foundation Trust, Mental Health and Disability Trusts

Chief executive –NHS Foundation Trust

Director – Children's Services, Cumbria County Council

Chief officer – Cumbria County Council

Ambulance Service Trust

Chief officer – Carlisle City Council:

Chief officer – Impact Housing on behalf of LetGo

Chief officer – NPS Cumbria

Chief officer – Sodexo (CLCRC)

Chief officer – Crown Prosecution Service

16. Key events

16.1 Karen and Peter were born in Hungary and moved to the UK in 2009. They had two children together, both were born in London in the UK. The children are now living in Hungary with Karen's sister.

16.2 Karen had a degree in English and had taught English in her home country prior to moving to the UK. The couple decided to come to the UK in search of what friends and family describe as "a better life".

16.3 The family lived in Waltham Forest initially and, despite having two children born in this area, they did not come to the attention of services. Little is known about the family during this period, although, during the review, neighbours of Karen were able to fill in some of the gaps as reported to them by Karen. This will be covered in more detail in the section of information from family and friends.

16.4 We know they were registered with a GP practice. On the new patient registration form, there was some discrepancy about when Karen had arrived in UK: she had put 2005 as her year of arrival rather than 2009. There is no further comment on this in the health record. The registration form at the time did not include any questions relating to safeguarding vulnerabilities.

16.5 Between pregnancies, in 2014, Karen had contact with GP services for a miscarriage, a few months prior to her second successful pregnancy. There is very little written about this episode and no documented concerns about safeguarding at that time.

16.6 The first significant account provided to the panel of the family coming into contact with services, was 30 September 2015. The family had moved from London and were living in a hotel in Gretna Green. Records from Police Scotland show the hotel had contacted police with concerns about two adults leaving their small children alone in their hotel room for periods of time whilst they were smoking.

16.7 This information was shared with Children's Social Care in Dumfries and Galloway. No direct contact was made with the family because they left the hotel within days of the referral as they could no longer afford to pay the rent. They had resided in the hotel for a few weeks.

16.8 The family then moved to Cumbria, in early October 2015, and presented as homeless to Carlisle City Council. They were accepted as homeless, and the records examined highlighted that the family had left London to come to Cumbria to work and this was confirmed by the employment agency.

16.9 The initial assessment by the homeless accommodation scheme focused on need, risk, and support requirements. Translation services were offered but declined. The family were advised of their responsibilities in relation to rent, and a housing benefit application was completed. It was noted that the family had no income other than Child Tax Credit and Child Benefit.

16.10 During this first contact with statutory services, the children's welfare was recorded as being "concerning". They were both poorly dressed for the weather conditions. The baby's bottle looked worn and they had no toys. Basic items were provided for them, i.e. milk, food, clothing and toiletries. The family were advised where they could access further support and were taken to their temporary accommodation, based within a community.

16.11 On 7 October 2015, the family attended their first formal support session. They said they were settling in well. They stated conditions in London had been squalid and overcrowded and they were glad to be moving on with their lives positively.

16.12 The following day, the Carlisle health visiting team were contacted by the Leytonstone Multi-Agency Health Hub, and were advised that a family from the area was now residing in Carlisle and living in a hostel. Karen was contacted by health visitor services and a transfer-in visit was arranged for five days later.

16.13 The transfer-in visit took place on 13 October 2015 and the whole family were present. It was immediately apparent that the children had what appeared to be developmental delays, and a subsequent visit was arranged to explore this further. It was also noted by the health visitor that the children had no toys and the family had a general lack of clothes and belongings.

16.14 During this visit, the health visitor noted Peter **"standing over the member of staff in a manner that appeared intimidating"**, but not **"of sufficient concern to warrant taking any action".**

16.15 On 14 October 2015 a further support meeting between the family and the homeless service was held, and the family were required to bring proof of income to support their application for housing benefit. It was noted that Karen had an organised, comprehensive file of documentation. Both adults stated they had job interviews with local factories the following day. They asked for assistance with nappies and milk and stated they did not receive benefits until the following day. They were advised that they needed to manage their money better, but were provided with the items they had requested.

16.16 The family were also reminded at this visit to register the children with a GP and health visitor, as they said they had not done so yet. However, records do show that the family had already seen a health visitor. The support worker discussed making a referral into Children's Social Care (CSC), due to concerns, and she stated the family did not appear to be concerned by this.

16.17 The Support Worker contacted the Safeguarding Hub and asked the duty social worker if the family had an allocated social worker, and would they pass on, what records of the homeless service noted as **"escalating concerns"**. They recorded these as follows: **"regular presentation for donations of essential items, lack of appropriate clothing for the children, and a lack of urgency in registering for medical /health visiting support."**

16.18 The case then became managed through the Cumbria Safeguarding Hub, the front door for children's services in Cumbria. A social worker contacted the hostel to advise the staff there that they needed to advise the family to register with a GP as soon as possible. They also phoned the family and spoke to Karen directly. She gave a summary of why the family had moved to Carlisle: she said they had had a rent crisis and wanted to move to a nicer area for the children. Karen was due to start her new job and as a family they were stretched financially and had needed to use foodbanks.

16.19 Through contact with the London Safeguarding Hub, Cumbria Safeguarding Hub established that the family were known, but had never been allocated a social worker as they had not reached the threshold for social care involvement. The decision was made that on this occasion, based on the information available and the number of agencies involved, the case would be managed by health visiting, who would meet the family and undertake an Early Help Assessment.

16.20 The family were seen again, for a planned support session, by staff at the homeless accommodation project on 17 October 2015. Karen informed staff that she now had a job with a local factory, on a zero-hour contract. They also said they had been visited by a health visitor and had had a session at a Barnardo's family centre. A further appointment with welfare advice was scheduled for 20 October 2015. The purpose of this was to look at all benefits, and the family were reminded to bring along all paperwork in terms of payslips, proof of income and identification. Additionally, a change in circumstances form was completed for housing benefit as Karen was now in work. The family were also reminded to register the children with a GP: Karen stated she had been too tired to do so.

16.21 The family came to the benefit maximisation interview on 20 October 2015. Further information was gathered on the family's previous circumstances. Peter said that a recent claim for job seekers in London had been refused because he had not passed the "genuine prospect of employment" test, and they had not appealed this decision; instead they had come north looking for work. They stated they had both come to the UK in December 2009. Karen had a job from March 2010 to June 2011, but had not worked since; Peter had worked from December 2009 till 2012, and had then claimed job seekers allowance. He had a brief spell of employment from May 2015 to July 2015. Peter was advised that he may have a "permanent right to remain" due to his status as a retained worker, but further information would be needed to assess this more fully. It was noted that the children seemed well and happy, Karen was noted as being warm and caring.

16.22 On 21 October 2015, health visiting contacted the homeless accommodation unit and advised that they had been assigned to the family and were going to undertake an Early Help Assessment. The health visitor then visited the family and during this routine visit, the health visitor noticed Child B had bruising on their eyelid, and she made a referral into the Cumbria Safeguarding Hub, as per the policy in place regarding bruising in immobile babies. The referral was sent out to the area social work team, who held a telephone S47 meeting with the police. This triggered a request by CSC to have a medical assessment for the baby, and Child B was taken to hospital by their mother and the allocated social worker.

16.23 Child B was seen by a consultant paediatrician at a children's ward, due to the unexplained bruising on their eyelid. Child B was also found to have a further bruise on their thigh. The consultant paediatrician noted several bruises on the lower face, and around the mouth and eyelid. A detailed medical report was submitted. In summary, no evidence was found of deliberate injury; the bruises may have been caused by their sibling, during what was described by the family as **"rough play".** It was also noted that Child B had been in damp clothing and there was no appropriate infant formula in the home. Child B was admitted to the ward for an overnight stay, as it was late in the day, and still required a full skeletal X-ray and ophthalmic assessment, which would need to take place the following day.

16.24 Karen then left the ward to return home to sleep, she explained she had just started a new job and needed to be in work the following morning, she could not take time off as she feared she would lose her job. Staff also noted they were concerned that Child A was in the care of their parents; they questioned CSC about this, but were informed that CSC had assessed the risk for Child A to remain in the care of the parents.

16.25 Child B was discharged from hospital into the care of the parents, on the evening of 22 October 2015. All assessments had been completed by medical staff and no abnormality had been found.

16.26 On 22 October 2015, support staff from the homeless unit attended the family property to undertake daily welfare checks, in-line with standard health and safety procedures. Peter let the staff in and two social workers were already at the house. A discussion took place outside the house and the homeless staff were informed that the children were at risk due to neglect. Additional visits by the hostel support staff were requested over the weekend. Karen was also advised of this, and that she needed to keep in touch and let staff know if she needed additional support.

16.27 On 26 October 2015, Riverside Housing Association rang the homeless unit to advise that they had a 3-bedroom property ready to be let immediately, and did they want to nominate a family. The property was deemed suitable for the family and a visit was arranged for that same afternoon. The family took up the offer and confirmed, following a visit, that they were happy to accept the house. Riverside agreed to leave the carpets and other items of furniture in the house, so the new home would be habitable for the family.

16.28 On 27 October 2015, the health visitor rang the homeless unit; she said she had been contacted by the social worker as the family had been asking again for support with bottles, toys and clothes for the children. The homeless section had provided the items requested. When Peter was questioned as to what they were spending their money on, he said he had bought a new belt and they were spending £30.00 per week on cigarettes as **"they felt angry if they didn't smoke"**.

16.29 On 28 October 2015, a joint visit took place with both the health visitor and the social worker visiting the family. The visit took place at 9.30am. The health visitor took toys for the children. Present in the home were both children and Peter; Karen was at work. The house was found to be in darkness, both children were still in nightwear. The health visitor noted that the situation was not ideal, and it appeared that neither child had been washed or fed; Child B was in a full, damp nappy.

16.30 The following day, Karen rang the health visitor to cancel her appointment, stating she needed to sort out her housing arrangements at the Civic Centre, the appointment was rescheduled for the next day.

16.31 On 30 October 2015, a full developmental and health review of both children was conducted by the health visitor, Karen was working. Both children were found to have significant developmental delays: Child B was observed to be unable to sit, and could not hold up their head. The heath visitor made a referral for paediatric services and physiotherapy. The IMR noted: **"Peter may not have understood some of the questions asked of him, and he appeared to have an optimistic opinion towards the development of his children."**

16.32 On the same day, the whole family – Karen included – attended a support session with staff from the homeless unit, in preparation for their move to their permanent home. The family were keen to be moving in as soon as possible. The practicalities of what needed to happen first; for example, uncapping the gas supply and setting up utilities were discussed, alongside grant funding and financial support. The family were noted to be happy and looking forward to moving into the new home.

16.33 On 02 November 2015, the family signed up to their new tenancy and were given the keys; the start date was confirmed as 06 November 2015. They accepted help to have utilities signed up to and were signposted to services such as the Salvation Army, in relation to assistance with essential furniture, they also completed a change in circumstances form for housing benefit. The family refused the offer of a travel cot and direct assistance with moving in. Karen stated they would buy a cooker, fridge and a washing machine at a later stage when she was paid. The offer of a grant application for these items was refused, as was the offer of post-tenancy support. The social worker and health visitor were advised the family had taken this stance.

16.34 There was an eligibility and affordability check carried out before they were accepted for housing: they passed both. No information was disclosed at this point about any issues relating to violence in the relationship. References were also received for both the victim and the perpetrator from previous landlords.

16.35 They became joint tenants of the address and were given a starter tenancy, as is Riverside's policy for new tenants. As part of the starter tenancy process,

the housing officer will visit the address three times during the first year; the review noted housing officer did not get access to the property on any of the planned starter tenancy visits.

16.36 On 09 November 2015, the health visitor visited the family and, on this occasion, all of the household were present. The house was found to be in darkness – the parents explained they had no light bulbs at all in the property. The children's developmental delays were discussed, and they were informed that health visiting would be recommending that the children were both placed on a child protection plan.

16.37 The initial child protection conference (ICPC) was held on 11 November 2015, at which both children were made subject to a child protection plan under the category of neglect. The information shared at the conference focused on the injuries Child B had sustained, and the developmental delays. Both parents agreed they were open to support, and stated that they had become confused because of the move, as an explanation for why they had not registered the children with a GP. An interpreter was present to ensure there was no confusion in the parents understanding of both the process and what would be expected of them.

16.38 In advance of this conference, a child and family assessment had been undertaken. This was based on eight visits to the home by the social worker and information sharing with other agencies. The assessment did not explore domestic abuse or coercive control in detail; a social worker is noted within the IMR by CSC as asking both parties about their relationship, no disclosure of abuse was made. Peter did state he became aggressive if he does not have tobacco, but this was not explored further, or used as a prompt for further exploration.

16.39 Following the child protection conference, CSC began what they describe as a short but intensive period of support with the family. The support package between 21 October 2015 and 02 December 2015 was characterised by multiple visits, up to five per week, with fourteen visits in total from a multi-disciplinary team of health visiting, child and family workers, and a social worker. Peter was the family member seen most often, and most of the home visits were observations of his childcare.

16.40 During this period, Karen was the sole breadwinner for the family and was often at work during professionals' visits. In fact, the only time professionals had been able to see Karen on her own, was during the hospital assessment for the baby on 21 October 2015.

16.41 On 22 November 2015, Karen attended a GP practice to register her children. The registration was on a temporary resident form. She included information on the forms that her children were on a child protection plan and had a social worker. Karen did not register herself, and Peter was not registered at this

point either. It was noted that Child B was bilingual; Child A spoke in Hungarian.

16.42 On 27 November 2015, the health visitor made an unplanned visit to the family's home and again found the house in darkness, with the curtains drawn; this was around 11.30 a.m. There was a significant delay before the door was opened, and Karen answered the door with two full nappies to dispose of in the bin. The rest of the family were all upstairs. The health visitor advised the family that Child B immunisations were still outstanding, and the general concerns of the children's most basic needs not being met were again raised.

16.43 On 30 November 2015, a Core Group was held, both parents were present and they were advised that progress was not being made. Little change had been observed by all professionals involved and neglect remained a significant concern. Karen and Peter were advised that the Local Authority (LA) would be seeking legal advice and intended to apply for an interim Care order in respect of both children. The allocated social worker later reflected, as part of the IMR interview, she could not **"understand why the family were not meeting the children's needs, as they both seemed able to".** There were no clear indications at this point that would account for this, such as drug misuse or poor mental health, the social worker reflected; she kept an open mind as to the range of possible underlying factors, one of which was domestic abuse.

16.44 In fact, all three factors were present but were unknown to professionals at the time of the conference. Given the known existence of what can be described as the toxic trio and neglect, the panel were curious as to why the social worker did not explicitly ask direct questions during the course of her assessments. Peter had been observed by the health visitor to be intimidating, and that he did become angry if he didn't have tobacco. This information could have been used as a prompt to start a conversation with Karen, and to explore what may have been going on in the relationship. It is acknowledged it was difficult, given Karen's long hours, to see her alone. However, given the seriousness of the situation, and the implications of an assessment at this threshold, time alone with Karen should have been considered. These issues, i.e. that of information sharing and exploration of abuse with a non-disclosing victim will be revisited in the analysis section.

16.45 During the meeting Peter became very angry, and he said he would not allow anyone to access his house to see the children.

16.46 On 02 December 2015, social workers attended the home and both adults were advised that interim care orders were applied for and the children would be removed from their care. Again, Peter became very upset and said both he and his wife were **"suicidal"**, and that social workers would **"never see them or the children again".**

16.47 This escalated concerns to a higher level and, on the basis that the parents were a flight risk or a suicide risk, an emergency protection order was sought, early evening, from a Judge, and CC supported CSC to take the children to foster carers.

16.48 The following day (3 December 2015) an interim care order was granted, and as part of this a parenting assessment and paediatric assessments of the children were ordered. The parents were asked to name any relative who could be assessed to care for the children; they did not do so.

16.49 As part of the assessment, the Hungarian authorities were also contacted but nothing came back regarding either Karen or Peter. An independent social work assessment was also requested, and the court ordered a psychological assessment of both parents.

16.50 By early February 2016, the psychological assessment of both parents had been completed and written up in a report for court. Both parties were interviewed as part of this process. Karen was seen for 2.5 hours on her own, and she was asked about her childhood experiences and her relationship with Peter.

16.51 It is recorded that Karen had been asked explicitly to describe her relationship with Peter, and she responded that it was an equal relationship. Karen also went on to say she had clear opinions of her own and could voice them, and that her partner understood and valued this.

16.52 Karen was asked to describe Peter; she said he was very strong-minded, could be stubborn, but that he was also very affectionate to her. She said that although he was stubborn she could change his mind, and she was one of the few people who was able to do so.

16.53 Based on the information provided by both Karen and Peter, the psychologist court report summarised the relationship as being mutually supportive and that both partners felt valued and cared for. The psychologist highlighted that both parties had reported difficulties in past experiences, and they found comfort in each other, no specific concerns were noted. There was no mention of domestic abuse, coercive control or sexual abuse /violence within the report. The assessment concluded there was no psychological reason either parent could not care for the children.

16.54 The independent social worker (ISW), prescribed by the court to establish the ability of the couple to safely care for their children, was another source of information and assessment provided to CSC. The ISW visited the couple in their home and also had a number of sessions with Karen on her own. The panel were not provided with a full account of the report provided to CSC, or a summary account of all the visits. What we do know, however, is that on at least one occasion, Peter was directly observed to be aggressive with both Karen and the ISW.

16.55 In April 2016, the family were visited by an officer from Riverside Housing; Peter was at home. The couple were now in significant arrears with the rent. Peter assured the officer that the rent arrears would be cleared. Peter spoke to the officer about his health problems, and disclosed that he had visited his GP and had been signed off work with depression. This was the first of several attempts by Riverside Housing to contact the couple to discuss the rent arrears.

16.56 On 31 May 2016, Peter was observed to be visibly angry after Karen woke him to be part of the meeting. He stormed out of the room and refused to be a part of the assessment. Karen was described as distressed, but wanted to continue with the assessment. Peter did re-join them but continued to be angry and asked the ISW to leave. Karen was questioned about this and she maintained that she was able to talk him down and that he was the better parent.

16.57 On 02 June 2016, concerns were raised by their child and family worker, who was supervising the contact visit, that she felt intimidated by Peter. It was decided that all further visits should now take place at the Family Centre. It was noted by the panel that this did not elicit concerns that Karen might be subject to Peter's intimidation, and there were now at least three occasions of intimidation or outbursts by Peter held within a single agency context.

16.58 The ISW did continue to assess the family and both parents were seen together, and on at least one occasion alone. Peter presented as aggressive and intimidating to the independent social worker. The assessment also raised some concerns about Karen's attachment to her children as she deferred to Peter, maintaining he was the better parent and the children should be returned to his care.

16.59 On 06 June 2016, Karen came to the contact visit on her own and said she would be attending alone from now on as she had ended the relationship. Again, no professional, either from the contact centre or a social worker, is recorded as having asked Karen why the relationship was over.

16.60 The following day, the social worker rang to speak to the couple and Peter again became aggressive, and was heard shouting to the social worker: **"you should watch your back"**. Karen was spoken to on the phone and seemed upset but said she was OK. The case records showed the social worker was concerned about Karen and the instability in the relationship, but does not record that any further questioning resulted from this, or that consideration was given as to how Karen could be spoken to on her own, in a safe environment.

16.61 In response to concerns raised from this phone call, a home visit was arranged for the following day. Peter, however, refused entry to the house and said it was because they had not tidied up. The interview therefore took place outside the home, and both Karen and Peter confirmed they were back in a

relationship, and had just had a row. Peter's behaviour was discussed, he said his medication made him tense and depressed, but this wears off. Both parties said they felt suicidal and they were given the telephone number for the crisis team and CMHT. The social worker noted she could smell cannabis coming from the house. The panel did not receive information that supported either Karen or Peter had accessed the services they were signposted to.

16.62 On 17 June 2016, Karen rang the social worker. Initially this was to say she was running late for the contact visit, but during the course of the conversation she became very distressed. Karen said she felt like **"throwing herself under a train"**. She said she thought she might go back to Hungary and did not know what Peter would do. Later that day Karen rang again, asking for the number of the crisis team.

16.63 On 27 June 2016, during a planned contact visit, Peter was abusive to the social worker. The children were present, and he said in relation to the social worker that he **"hated her".**

16.64 On 20 July 2016, Karen called CC to report that Peter had assaulted her. He had smashed the baby's cot, beaten her with a wooden stick from the cot, and tried to push her down the stairs. The crime was recorded as a domestic abuse incident and Peter was arrested by Police Constable PC1. He was charged with common assault and was denied police bail. He was then remanded in custody to be put before the magistrates' court the following day. Karen was graded a standard risk, in response to six questions on the DASH risk assessment form being identified by the OIC (PC1).

16.65 On 21 July 2016, Peter was released on bail from the court with the following conditions attached:

- Not to contact his partner
- Not to enter the road where Karen lived
- To report to a police station each Monday

16.66 Peter left the court and was seen shortly after in a distressed state at a petrol station, by PC2 of CC. Peter explained to the officer that he had been released from court, but all his belongings were at his former address. The officer then rang Karen and asked if she would mind if he brought Peter to the property to collect his personal items; the officer would be there to prevent any "trouble".

16.67 On the same day, the family proceedings court hearing took place, and Karen requested that she be assessed as the sole carer for the children as her relationship was now over. The ISW was requested to update the assessment in respect of this and focus on Karen being the carer. Karen was advised at the court visit by the social worker, to go and see her GP as she was visibly

shaken and upset. She was also encouraged to work with LetGo and to seek a house move.

16.68 On 22 July 2016, a detective sergeant (DS1) from the Protecting Vulnerable People (PVP) referral unit quality assured the case, and upgraded the assessment from standard. This increase was based on professional judgement and in recognition that a weapon had been used against Karen. There was, however, confusion as to the upgraded risk level and this will be explored in the analysis section of the report.

16.69 The case, however, did not get referred into MARAC.

16.70 The IDVA service tried to contact Karen, between the dates of 22 July 2016 and 14 August 2016, on several occasions, but were unable to reach her.

16.71 Children's Social Care rang Peter on 22 July 2016, and he said he had slept rough; he stated he was still in a relationship with Karen. He was advised about mental health support and homelessness.

16.72 On 24 July 2016 Victim Support received a referral for Karen via the automatic data transfer from CC. The case was tagged as domestic abuse. There was no contact number for the victim; however, there was a record that the victim had given consent to be contacted. Attempts to contact the OIC to get a safe contact number are recorded as unsuccessful.

16.73 On 26 July 2016, Karen was visited by the family social worker; the home was found to be in much better condition and Karen said she had been cleaning because of stress. Karen was found to be very tearful and said Peter had been to the house for his ID and, because he was so upset, she had let him in. She also said that she still loved Peter and wanted to be in a relationship with him, but she knew at this point in time he was not right and needed to sort himself out. There is no record of this information, i.e. a breach of bail conditions, being shared with CC.

16.74 However, on 26 July 2016, CC did attend Karen's home to conduct a welfare check to ensure Peter was not in breach of his bail conditions. Peter was at the house and he was arrested by two police constables (PC3 and PC4), as he was found to be in breach of his bail conditions. He was detained overnight and put before the courts the following day. Children's Social Care were advised of the arrest.

16.75 The following day, Peter pleaded guilty to the assault and was sentenced to 100 days imprisonment, to be held at Durham Prison. His release date was to be 13 September 2016. It was noted in the IMR, provided by CLCRC, that the National Probation Service would normally be expected to provide the court with a pre-sentence report; in this case, no information was provided detailing the circumstances of the offence, possible causes or risk of further offences, or the level of harm posed by the perpetrator. He was sentenced without any

information being provided by the National Probation Service. It remains unclear why this happened.

16.76 On the same day, CC reallocated Karen's case management from Detective Sergeant DS2 to a Detective Constable DC1, and the records from CC at this point noted that a referral into MARAC **"should be considered".** This referral was not made.

16.77 Three days later, on 30 July 2016, DC1, now managing the case, tried to call Karen but received no reply. There is no further record of CC attempting to contact Karen or pursue the referral into MARAC until 17 August 2016. At this point, new information came to light from IDVA services and a further referral came in to MARAC. This will be explored in analysis.

16.78 On 8 August 2016, Victim Support received a safe contact number for Karen from the OIC; the service made attempts to call her but were unsuccessful.

16.79 On 10 August 2016, Victim Support made contact with Karen and she requested that they call her back the following day.

16.80 On 11 August 2016, Victim Support made telephone contact with Karen. She informed the caller she was not feeling good at that moment, but that she had supportive neighbours and work colleagues. Karen said LetGo were a service she had been trying to contact but had not been able to get them. Victim Support agreed to make contact with LetGo. Contact was then made with LetGo who confirmed they had been trying to get in touch with Karen but had been unable to. On 15 August 2016, LetGo IDVA services made contact with Karen and a support session was planned for the following day.

16.81 Karen attended the support session, as planned, on 16 August 2016, at LetGo offices. Karen was described by the IDVA as a very polite, petite, woman, who was warm and open to the support being offered to her. She said she had never told anyone before of the abuse she had endured. The IDVA completed a DASH assessment with Karen and asked the questions relating to sexual abuse. Karen was described as taking a deep breath, pausing, and saying, **"I have never told anyone about this before"**, and went on to disclose and describe multiple rapes and sexual assaults.

16.82 Karen was very clear that she did not want to report the rape/sexual offences to the police, stating that she wanted to move on with her life. When asked if she was afraid of Peter, Karen replied that she was not afraid whilst he was in prison, but she would be if she saw him in the community. She also said Peter had made several threats to kill her.

16.83 Karen also stated that Peter did nothing to care for their youngest child; he would leave Child B crying for hours, would not change the nappies, and had put his hands around Child B's throat when crying. Karen said he referred to Child B as, **"a piece of shit, and a slut like her mother".**

16.84 The risk assessment also identified that, whilst Karen stated the assault on 21 July 2016 was the first time she felt Peter had physically assaulted her, there were many other occasions, in which she describes being assaulted and slapped and having her hair pulled, but she did not see these as assaults. She explained this by saying it was common behaviour in her culture. It was only when Peter used a weapon to assault her that she viewed this as a physical assault.

16.85 The risk assessment, when completed, identified Karen as high-risk, with 17 out of a possible 24 questions being positive. The IDVA then explained that it was policy for her case to be referred into the MARAC process, due to the high level of risk. Karen agreed to the referral but stressed she did not want the police to be involved. The IDVA explained that it was possible the police may make contact with her.

16.86 A support plan was put in place for Karen; this included a MARAC referral and referrals into services for her health and well-being, children's services, and a referral into CC community safety team.

16.87 The IDVA's MARAC referral was received by CC and was reviewed by the PVP unit. As further offences had been identified, a crime report was recorded in the case management system for the offence of rape. The case was allocated to the PPU and Detective Sergeant DS2 was allocated this new referral. DS2 then allocated the case to Police Constable PC5, to update Karen following the MARAC meeting.

16.88 DS2 contacted the IDVA service on 17 August 2016 to discuss the victim's wishes and how best to progress the case, as it was known that Karen did not want to report the rape to the police. A joint visit was put forward as a potential way forward, only if Karen agreed to it. The IDVA service agreed to facilitate this when the IDVA returned from leave. The possibility of a joint visit with CC was then suggested to discuss the rape of Karen and the physical abuse of Child B. Karen agreed to this taking place; a date of 1 September 2016 was agreed on.

16.89 On 18 August 2016, a community safety officer from CC attended Karen's home for an impromptu visit to assess the safety of the home. Karen was present, and she identified that the lighting on the side of the house was poor, and that Peter always used this side to access the property, and the spyhole in the front door was damaged. CC arranged to have security lighting fitted and the spyhole repaired.

16.90 On 18 August 2016, Victim Support received a further referral for Karen via the automatic data transfer system. This time it was in relation to the rape. It would not be usual practice to contact the victim of any sensitive crime without gaining consent for information passed on through the automatic transfer. However, Victim Support also held the contract for the Independent Sexual Violence Advisers service. There is no record of any action being taken by

Victim Support in relation to Karen's support needs and no record of an ISVA being allocated to Karen's care at this time. The IMR noted there was "limited capacity" within the service and contact was not established for the next twelve days. This will be explored in further detail in the later sections of the report on analysis.

16.91 Karen spoke to the IDVA service by telephone on 19 August 2016. Karen confirmed she had spoken to her GP, had an appointment with First Steps counselling service, and had spoken to her housing provider about the prospect of Peter's name being removed from the tenancy. She had been advised this was not possible due to the level of rent arrears and the type of tenancy she held.

16.92 On 22 August 2016, CSC visited Karen at her home in response to the new information that had been shared through the MARAC referral. Karen opened up at this visit and said Peter had a significant gambling problem and most of the money they had was gambled away; one night he had spent £600. Karen said he would take all the money from their joint account. The social worker then informed Karen of the LA plans to have both children adopted. Karen was very distressed but said she understood.

16.93 On 30 August 2016, Karen was contacted by an ISVA from Victim Support. Karen informed the ISVA that she would like counselling, but had been told – by whom, it is not clear – that she was "too high risk". Karen was advised to discuss a restraining order with LetGo. Karen informed the ISVA she felt safe and had a personal alarm. She did not see the point in reporting sexual violence, and she didn't want to give a statement as the offender was in prison. She didn't know which area the offender would be released into and had not been contacted by a victim liaison officer (VLO). The ISVA said she would make contact with the VLO to get the information Karen needed.

16.94 On 01 September 2016, the IDVA visited Karen's home with Detective Constable DC2. It was noted by both DC2 and the IDVA that Karen was very reluctant to speak about the rapes she had suffered, or the abuse of Child B. Karen did describe an incident where Peter had put his hands around the baby's neck when they were crying. DC2 explained that this was a very serious matter and she would therefore need to complete a crime report.

16.95 What is clear from the IMR of LetGo, is that Karen was vocal in her views of reporting the rape and of having this investigated; she expressly said she did **"not want to press charges".** The IMR also highlights that DC2 from CC said to Karen, **"In certain circumstances the police can take action regardless of what the victim wants".** Karen said she understood this.

Karen also informed DC2 that Peter had contacted her from prison, and she had told him that she had let the police and other people know he had raped her and had abused Child B. She stated that Peter believed, on his release from prison, he would return to the family home; she had told him she did not

want him to and that the relationship was over. It was clear, however, that Karen was concerned about Peter and said she knew he had nowhere else to go or to live.

16.96 Karen also said that, whilst she did not want him to return home, she did want to see him and she wanted to say goodbye. She did not, therefore, want any conditions on him that would prevent him from coming to the house. At this point she then agreed to give a first account of the rape, but remained clear she did not want to press charges.

16.97 On 3 September 2016, an ISVA from Victim Support spoke to Karen to update her, regarding the fact she had still not managed to speak to the VLO.

16.98 On 3 September 2016, Detective Constable DC2 visited Karen at home to complete an initial contact booklet (ICB). This booklet contains a brief account, verbatim, from Karen on what had been spoken about to date regarding the rapes. Karen also gave her consent for her medical records to be obtained. DC2 also discussed the process of video interviews and asked Karen to provide this. The IDVA was not present at this meeting and it is not clear why Karen was not accompanied by her support worker at this appointment.

16.99 On 4 September 2016 CC reviewed Karen's case; Detective Sergeant DS2 completed this task. The case review was felt necessary as the situation was developing quickly. A request was noted for a STORM alert to be placed on Karen's address. This is an alert for specific addresses, placed so emergency service is provided to that address. The alert advises officers of information relating to the house, the occupants and any other relevant information that might assist officers in their response. This alert was not added to the system by DC2, the OIC, or the officer (DS2) reviewing the case, believing this had been completed.

16.100 On 5 September 2016, the ISVA spoke to LetGo and received an update on the offender's release, the ISVA confirmed that Karen had told them she did not want to press charges.

16.101 On 5 September 2016, the IDVA service received an email from DC2 of CC, informing them that Karen had agreed to provide an achieving best evidence (ABE) interview, and they wanted the IDVA to accompany her to provide support. The LetGo IDVA spoke to Karen on the phone to make arrangements to support her giving her first account of rape. What is unclear, from both the IMR of CC and LetGo, is what had happened to lead to Karen agreeing to take part in an ABE interview. The IDVA service expressed surprise that this had happened, as they had not taken part in this discussion. This theme will be explored in greater detail in the analysis section.

16.102 A safety plan was discussed in preparation for Peter's release from prison. It was clear at this point that Karen was very afraid of Peter; she knew he wanted to return to the family home and she was nervous about telling him he could not do this, that it was prohibited, and she did not want him there. She expressed concerns that he might be violent to her, or emotionally harm her. Karen stated again that she did want to see him, but felt a public place would be better.

16.103 The IDVA asked permission to contact Peter's probation officer. Peter's release from prison was viewed as a high-risk time, and the IDVA wanted to establish his housing situation and prohibitions preventing him from returning to Karen's home.

16.104 A phone call to the probation service was conducted and the IDVA requested that Peter was housed on release in approved premises. The probation officer explained that these premises were for "high-risk" offenders only, and Peter did not meet this category of risk. He would be advised to present to homeless services on his release.

16.105 During the afternoon of 5 September 2016, Karen rang the IDVA service and informed them that Peter had called her from prison. Peter had said he believed they would get back together; he would be returning to her home on release from prison. When she said she didn't want this, he became very abusive: he told her he had nothing to live for, he would be on the streets and die, and this was her fault. Peter would not accept the relationship was over.

16.106 On 6 September 2016, the IDVA attended a police station and provided her witness statement to Karen's disclosure.

16.107 On 9 September 2016, Karen was accompanied by the IDVA to complete her ABE interview. The interview took place at a police station and was conducted by DC2. Karen gave a detailed account of her experiences. She stated that the rapes began following the birth of her first child. Peter would force himself on her; he used blackmail to coerce her, saying he would sleep with other women if she did not have sex with him, and he said it was her duty. He would also pull her hair, slap her, and force her down on the bed. Karen could not recall how many times this had happened, but rather it was a regular occurrence, sometimes more than once a week for an enduring period of time. The last time she said had been the week before 20 July 2016. Karen recalled that he had at this time anally raped her as she was menstruating.

16.108 Karen was clear that she had asked him to stop so many times over the years, she had now given up. Peter had told her it was his right as a man to do whatever he wanted. Karen said this was the view in Hungary, and this was how Peter was raised. Karen also said she had not told anyone other than the IDVA about the rapes.

16.109 Following the interview, Karen again said she wanted to meet with Peter; she wanted to tell him what he had done to her and to discuss the children. Karen requested assistance to facilitate this discussion, she was afraid of him but needed to see him and be safe whilst she spoke to him. She also said again that he had been contacting her from prison, and had requested that she meet him at the train station on his release. Karen was asked not to meet him, and she should contact the police if he contacted her. It should be noted this was the third occasion Karen had informed agencies that Peter was contacting her from prison. There is no record of any action being taken by CC, despite the ongoing harassment and intimidation of Karen.

16.110 During this time period, it became apparent to CC that they had not made a MARAC referral for Karen. They now had the referral in from LetGo, but due to timescales the case would not be able to go into the August 2016 meeting and would go on the scheduled list for September 2016.

16.111 On 9 September 2016, the IDVA service received an email from the MARAC coordinator at CC, informing them that Karen's case would not be heard at the September MARAC; it was felt that all safeguarding measures were in place and Peter was due to be arrested on release from prison. The MARAC coordinator provided the IDVA service with a definition of domestic abuse, and stated the case would be marked as "not processed", as it did not meet the threshold/is not domestic abuse related. On receipt of the email the IDVA contacted the MARAC coordinator to challenge this decision.

16.112 CC information in relation to the MARAC was also gained from the IPCC report; from this we know that a decision was taken internally not to put Karen into the MARAC scheduled for 21 September 2016. The temporary DI responsible for MARAC decided that sufficient safeguarding was in place to protect the victim, and that due to pressures on the case list Karen would be removed. At this point in time Peter was in prison, and it was also noted by the temporary DI that Peter would be arrested on his release. This will be explored in greater detail in the analysis section.

16.113 Following the ABE interview and the concerns raised by Karen, DC2 from CC did contact the probation service to request and ensure licence conditions were in place to protect Karen. It was agreed that conditions would be added. It was also agreed that probation would facilitate the arrest of Peter from prison for the allegations of rape.

16.114 On 12 September 2016, Detective Constable DC2 visited Karen's home address. Karen was not in, but the officer did speak to her neighbours. They said Karen had told them about the rapes she had reported. The neighbours were asked to call the police if Peter did show up. Karen came home whilst DC2 was still at the address, and she was spoken to and given information about what would happen on the day of Peter's release, i.e. he would be arrested. She was advised to call 999 if he came to her home and to have no contact with him.

16.115 On 13 September 2016, Peter was released from prison. He attended his probation meeting at 3pm in the city centre. The probation officer went through Peter's licence conditions with him, and he was informed he could have no contact with Karen. The probation officer said, **"He started crying and asked if he could ring her."** The probation officer said, **"No, he posed a risk to her and, if he did, he would be recalled to prison."** During the visit, Peter's phone rang a number of times and he said it was Karen; he was again informed that he could not contact her. When questioned about where he would sleep that night, Peter said he could stay at a friend's house but was unable to provide an address. This was accepted, as he'd said he did not know the address, and he would supply this at his next meeting. Peter was at the probation office for an hour, and during this time CC were contacted to facilitate Peter's arrest post interview.

16.116 Peter was arrested immediately post interview and taken to police custody. He was interviewed regarding the rape and child neglect allegations. He did not have an interpreter. Peter denied all allegations put to him, stating he had a loving relationship and all sex had been consensual. He said he wanted to take the children back to Hungary, but Karen did not, and she was saying this to prevent him. He also said Karen suffered from depression and had been abused as a child.

16.117 DC2 interviewed Peter; advice was sought post interview from the reviewing officer, Detective Sergeant DS2. However, DS2 had left for the day so another DS was sought. The temporary DI was informed, and he recommended no further action to be taken at that time, as Peter had denied all allegations and no further lines of enquiry had come out. In his view, the investigation did not meet the thresholds for referral to the CPS. At this point, Karen's medical records and information from CSC were not sought, and the decision to NFA was therefore based on Peter's rebuttal of the questions put to him.

16.118 Peter was released and his licence conditions were reiterated to him. He had £70 on his person and he was advised to book into a hotel for the night, to go and see his probation officer the following morning, and to get an appointment with homelessness.

16.119 Following Peter's release from custody, Karen was contacted by telephone to advise her of the decision to "no further action" Peter. Karen did not answer her mobile phone and a voicemail was left for her. The IDVA service and probation were also contacted. DC2 stated, when questioned by IPCC investigation, that she had planned to go and visit Karen on 15 September 2016.

16.120 On the same day, in the Family Proceedings Court, Karen disputed LA plans to have her children permanently removed from her and adopted. She requested more time to be assessed as the sole carer. This would have

been an extremely stressful day for Karen, having to face both the family court and a rape investigation, and having to face them alone.

16.121 On 14 September 2016, the IDVA service had contact with Karen, to check that she knew Peter had been released. Karen confirmed she had listened to the voicemail. Karen was firm that she had not, and would not, contact Peter. She was angry that Peter had said to the probation officer she was calling him, she strongly denied this, and said she wanted to talk to Detective Constable DC2 to let her know this. Karen said she was going to a solicitor to get a letter sent to Peter informing him not to come to her house, she also said she intended to give up her job as she was so stressed. The IDVA service emailed DC2 immediately following this call, to request that she contact Karen as soon as possible.

16.122 On 14 September 2016, Police Constable PC6 from CC attended Karen's home to complete a welfare check and to explain Peter's licence conditions to Karen. Karen was described as safe and well. The welfare check involved a search of Karen's home to see if Peter was there. That day, at 4.46 p.m., DC2 received an answerphone message from Karen saying she wanted to talk to her about Peter and could she call her back. At 5.27 p.m. DC2 had a missed call from Karen. The calls were not picked up until 15 September 2016.

16.123 On 15 September 2016, CC received a 999 call from the neighbour of Karen, stating a male had broken into Karen's home and Karen could be heard screaming. Police then attended, and Peter was arrested at the scene. Karen was found to have injuries that proved incompatible with life.

17. Interview with Karen's neighbours

17.1 The DHR process gained significant insight into Karen's life from her neighbour and her neighbour's mother, with whom, following Peter's imprisonment, she formed a very close friendship. The following is an extract from the meeting that was held with both women.

> We were good friends, more so after the arrest as I opened up to her about my own experiences and had been in a very similar situation. She knew she could trust me, and she didn't have anyone else. She was very isolated and lonely. We'd known her since she moved in; we used to talk over the garden fence. She spoke really good English, we didn't know how well-educated she was at the time, but she could beat us all hands down education wise.
>
> She was a beautiful person, extremely well-mannered and caring. She used to cook Hungarian food for me and the kids. She'd spend the last money she had on food to cook meals for her kids or me. She used to take food to the contact meetings for her kids. She'd wait until she'd been paid and then go out to buy ingredients to cook with. He used to take her to get the money. You know benefits money is paid in after midnight, so they used to wait up and

then you'd see them both walking out the house to the cash point, she couldn't go without him.

On life before the family came to Carlisle

Nobody knew about her. She had a health visitor and the health visitor knew the kids had no toys. They lived in a one-bed flat and they had to hide stuff under the bed when the health visitor came, but they said they were prioritising their needs over the kids. He had a lot of friends and used to take drugs and party, but she wasn't allowed any friends. She told me I was the first friend she ever had, he kept her isolated.

We know they arrived with nothing, no bags, just what they stood up in.

She'd go out to work but he'd accuse her of cheating, but she was devoted to him. She knew he'd kill her. I said she'd be protected but she wasn't. You could tell he was horrible, very dark, and created an atmosphere. He wouldn't let the kids mix with other kids, he kept Child A contained and wasn't bothered about Child B.

On the issue of domestic abuse and coercive control and poverty

The friend's insight into the nature of the abuse, and the extent to which Karen was controlled, provided a picture that had been largely hidden to agencies – with the exception of the IDVA services. What was notable was, whilst her friends were working-class women with low incomes, they were deeply shocked by the level of poverty Karen lived in.

I didn't know about the domestic violence until after the arrest. We used to hear arguing, banging and her crying. She used to sit under the window ledge in the garden, crying. But following the arrest she told me what had been happening to her.

The abuse got ten times worse after the children got taken away. She loved her kids, she said they'd been taken away until she could get stuff for the house; she needed furniture and to get work. I gave her stuff for the kids as they didn't have any toys.

She was embarrassed by the house when he was there. After he left, she started decorating the house. They had to keep food in the back bedroom as they didn't have a fridge. They went to a well-known national shop to try to get furniture, they were refused the first time as they weren't working but were able to get equipment the second time. She was living in poverty; I hadn't ever seen anything like this before.

She was ashamed of her appearance, she felt she was a bit tatty; she didn't have a bath as often as she liked because they couldn't afford the gas and she had to hand wash all the clothes as they didn't have a washing machine. I did her washing for her, but she didn't like to ask for help. She said she liked to hand wash her clothes as it kept her mind occupied.

Immediately after the arrest we didn't see her for a few days.

We then saw her, and she said she hadn't eaten for five days. I gave her tea and toast because she was starving and didn't have any money. He used to spend all the money on energy drinks and drugs.

He would take speed, cannabis, anything. After the arrest, she'd decorated the bedrooms and was meant to be going to court on the nineteenth of September to find out if she'd get the kids back; she'd done everything she needed to do to get them back. She didn't want him, but he told her she wouldn't get the kids back without him. Once she hadn't been with him, she seemed more positive. She went to the Cathy Queen Centre, who help people who've experienced domestic violence, and families in need. I told her to go and visit them and they were great. She started buying clothes and shoes. She only had one pair of shoes but, once he wasn't there, she wanted to take care of herself. She wanted to buy hair dye, she used to tell me.

She got a voluntary job in Oxfam and was making friends. He controlled her life completely before this, especially in London where she didn't have any contact with anyone.

She came here because she loved the countryside; she wanted to go on walks with her kids. She wanted her kids to get a good education and she wanted her family to have a good life. She didn't want her kids educated in Hungary, she said that men can do what they want to women in Hungary and she didn't want that for her kids. She'd never ask for help, it was a struggle to convince her to let me wash her clothes.

He used to rape and beat her. He controlled her. If she spoke when she wasn't supposed to, he talked over her. At first, we thought they were as bad as each other, but you realised that you didn't feel safe around him, he used to undress you with his eyes. He didn't like me because I was strong. He wanted to use my son to get him drugs; he used to invite boys from the estate round to the house and used them to get him drugs. He gave them drugs and money, so they'd do it. I complained that he had boys taking drugs in his house whilst she was at work and stood up to him, he didn't like it.

She told the police about the rape, she told the council, she told Riverside. She begged Riverside to move her, but they told her they couldn't move her until she sorted out the rent arrears. She had over £800 in arrears and if she could get it to £300, they said they'd move her. She didn't want him to come back, she wanted to be safe. She loved that house, but it wasn't a safe home. She wanted and needed to move. None of us wanted to be there, there were lots of problems with drugs and antisocial behaviour. We'd only been there since July and she moved in in October, my mum used to visit every day as she was a neighbour, but we'd both asked Riverside to move us.

After she told the police about the rape, she thought he'd be remanded, so when she found out he wasn't, she just locked herself in the house for 24 hours, and she missed work. She told us he'd phoned her and told her he'd leave her alone and then demanded money from her. My son saw him and said he was in a field at the back of our house, he'd asked my son where my eldest was.

He told her he needed £50 to go and stay at another house but she said no and wouldn't give him any money. He was there on the estate the same day, (after being arrested for rape) it was like she wasn't believed. Rent arrears shouldn't have come into this, she was willing to pay every penny of the arrears, and she just wanted to move. I didn't get to speak to her after she reported the rape because she just locked herself away 24/7, I knew she was in a bad situation.

On children's services involvement

Social services made it really hard for her to see her kids. Once it snowed, and she couldn't make the visit because the trains weren't running, they basically did not believe her. She felt she was bullied by social services as they kept checking her cupboards and bins, even after the kids were gone. He never wanted to go and see the kids when they were in care because he was always on drugs, she had to push it and make sure they both went.

She had a very cheeky personality, she loved cooking and she had high hopes for the future. She wanted her kids to understand their Hungarian culture, which is why she cooked Hungarian food for them, but it was hard when they were taken into care. She kept trying to keep him motivated. The contact was in Workington, but she was in Carlisle, forty miles away, when there's one just around the corner, they knew they didn't have a car but still made her travel forty miles. They needed to get the train, so they needed to leave the house at 7-7:30 a.m. to make it to Workington for a 10 a.m. appointment. She had to get up at 5:30 a.m., having finished work at 11 p.m. and then cooked a meal when she got home because he'd never cook. She only had two to three hours' sleep and then back up at 5:30 a.m. to get him up and out the door at 7 a.m. to make the appointment. It was crazy.

Despite the strong views on children services, and the perceived lack of support, the friends did acknowledge the children were not safe in the home, they said:

"The kids weren't safe with him there, he wasn't a safe man. It was a godsend that the kids weren't there when it happened. He didn't want Child B; he said it wasn't his, even though they were. He wasn't normal with Child A, he didn't want Child A talking to other kids or getting their hair cut, he would just pull Child A back and not let Child A talk to them."

Day of the homicide

The day Karen was killed was also covered in the meeting, and the following information was given to the panel:

It was early in the morning and I heard banging in the back garden, it was 5:40 a.m., I know because I'm a light sleeper. I opened the window and he was banging the window with something. He got in so fast. I shouted at my sister, who was living with me, and told her to ring the police. The way he looked at me, I knew he was going to kill her. My sister tried to kick the door in and I kept the police on the phone. We heard banging and we looked through the letterbox. We heard everything; it was just one scream and then nothing. The police turned up in about three or four minutes.

My kids heard everything. My three-year-old is a nervous wreck and my twelve-year-old has anxiety and doesn't sleep, he has to go around and check all the doors and windows are locked before he goes to bed because he's scared.

She thought he'd be rearrested so, when she found out he wasn't, she just locked herself in the house for twenty-four hours, and she missed work. She told us he'd phoned her and told her he'd leave her alone, and then demanded money from her. My son saw him and said he was in a field at the back of our house, he'd asked my son where my eldest was.

I'm grateful I met her; I was the only person she had. Speaking to us showed her that there could be a way out. She could see her way to an independent life. She was scared of being alone but she was getting stronger, reporting the rape was critical to that.

I spoke to her about a week before reporting the rape. She'd told people about the rape and we told her to report it to the police. She was scared Child A would end up like his dad. He was trying to use my eldest son to buy drugs, but I wouldn't let him at him. My son told her he wouldn't tolerate anyone who hit women, she looked at me when he said this, and smiled, I think that gave her some comfort. She knew it wasn't going to be kept a secret any more. He never wanted to go and see the kids when they were in care because he was always on drugs, she had to push it and make sure they both went.

When asked: is there anything you think could have been done to prevent this event from happening?

They just could have listened and believed her. She didn't tell social services about the domestic violence, she was too scared to. You just hold so much back; if you do tell, you're scared in case they'll take the kids away. They just needed to listen, but how can you open up when you're in fear? They should be trained to spot situations like this, but they took the kids and blamed her for it. You can't open up because of repercussions; anyone reporting domestic violence should always feel like they're being believed, but social services

didn't believe her. Women shouldn't be living in fear; they shouldn't ever feel like they're on their own.

18. Letter from Karen's mother

The panel received a letter from Karen's mother. This informed the panel of a bright, clever woman whose life changed dramatically when she began her relationship with Peter. Shortly after meeting him she became distant from her family, secretive, and tensions and arguments started to occur with frequency. It was her mother's view that Peter was not right for her daughter. Eventually, Karen became estranged from her family and all contact was lost with her mother. Her mother described her great sadness at the loss of her talented daughter, and the loss of her grandchildren and a life that might have been very different had she not met Peter.

19. Analysis

19.1 The chronology and individual IMRs, including the notes from the interview with Karen's neighbours, have been carefully considered to ascertain if the agencies' contacts were appropriate, and whether they acted in accordance with their set procedures and guidelines. Where they have acted accordingly, the panel has also attempted to go beyond 'evaluating if procedure was followed, to checking it was sound', as stated in the revised Home Office guidance. Simply put, are agencies' policies and procedures fit for purpose? Are they good enough to safeguard victims?

19.2 In doing so, several themes or narratives have emerged that require some examination to fully understand the circumstances of this case, so that all professionals may learn from the lessons identified.

19.3 **i) Were practitioners knowledgeable about potential indicators of domestic violence and abuse, and aware of what to do if they had concerns?**

Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Were practitioners sensitive to the needs of the victim and perpetrator?

19.4 Prior to Karen's death, all agencies had access to some form of domestic abuse training, linked to their respective organisational policies and procedures. Cumbria County Council, working with the LSCB, has a well-established multi-agency training programme that is free for all professionals to attend. Evidence was provided to the chair of the multi-agency take-up of training in the last three years.

19.5 CPFT identified that none of the staff involved in supporting the family had had face-to-face training, and this is reflected in their recommendations as an area for improvement.

19.6 An HMIC inspection of CC in 2015 found that the force required improvement in its understanding of vulnerable victim's needs and risks, and outlined domestic and sexual abuse as an area for further training. Subsequently, CC have had in-house training for officers and have a rolling programme that ran throughout 2016/17.

19.7 Despite the existence of training programmes, the panel found evidence that knowledge of the impact and dynamics of domestic abuse was limited in several agencies, and indeed there were wide variations across service areas.

19.8 CC was found to have good front-line officer awareness of domestic abuse: officers were proactive and arrested Peter for the first reported offence. A good level of awareness was also evidenced, for example, when Peter was released by magistrates and found at a petrol station by an officer. This officer demonstrated an understanding of domestic abuse situations, and was proactive seeking to prevent Peter from breaching his bail conditions by taking him to Karen's home to collect his belongings. It is evident that front-line officers view domestic abuse as very much core business, and take active measures.

19.9 The OIC in this case was also proactive, following up on bail checks after Peter's release from magistrates' court. Due to this, Peter was found to be in breach of bail and was subsequently rearrested and put before the courts again.

19.10 The impact of coercive control and use of this new power was not utilised to protect Karen. This was a line of enquiry taken within the IPCC investigation and the officers questioned demonstrated the belief that focus on rape and violence should be prioritised. When asked by the IPCC investigator as to whether any consideration had been given to controlling or coercive behaviour, especially in light of comments about blackmail, and it being Peter's right to have sex with her, the investigative officer replied, **"Potentially, yes, but not at that particular time as she didn't give me enough,**" then added, **"I was more concerned about the rape and getting her account."**

19.11 The investigative officer, DC2, did not pick up on the cues given by Karen to explore the rape within a wider context of abuse and coercive control, and further lines of enquiry to support the rape prosecution were lost. Stalking and harassment were also not a focus of criminal justice interventions, despite the force being made aware that Peter was continuing to contact Karen from prison and had issued threats.

19.12 Critically, CSC, despite repeated cues, did not pick up on domestic abuse. An experienced social worker is required to look beyond the presenting factors and reflect on what is taking place; indeed, we know the social worker did discuss this case in supervision, and stated she could see no reason why the

couple could not care for the children, that she was keeping an open mind to all other factors, and this included DA. Domestic abuse did not, however, feature in the assessment process until an actual disclosure was made by Karen to an IDVA. No evidence was provided to the panel that Karen was asked specifically about domestic abuse.

19.13 Health visiting services did not suspect domestic abuse was taking place either. On the occasion Peter was observed to be intimidating, and standing over a member of staff, this was assumed to be as a result of his fear of judgement by professionals over the neglect concerns. The IMR reflected on routine enquiry and the possibilities of safely asking Karen direct questions in relation to abuse. Karen was rarely seen alone and the IMR author could not identify a time it would have been safe to ask her direct questions. This was viewed at the time, with the information available to this service, to be a result of Karen working long hours, rather than of control. This was a reasonable assumption, given how reliant the family were on Karen's income.

19.14 The GP had had recent domestic abuse training and was knowledgeable about support services available in the area. He was also aware of the need to have safety plans in place where domestic abuse is a feature and was able to describe what this could look like. The GP practice does not formally use any domestic abuse risk assessment tools, or use routine or selective enquiry with patients.

19.15 At Karen's first appointment, records show she discussed the stress she was under and how depressed she felt as her children were not with her. Karen was given medication – anti-depressants – and at a further appointment a referral was made into the community mental health team. Karen did not make any direct disclosure of abuse from her partner, and nor was any form of direct questioning used in relation to this.

19.16 At a subsequent visit in August 2016, Karen is recorded in the IMR as having identified herself as a victim of domestic abuse. The GP who cared for Karen is noted as **"focusing on establishing what support she needed for her mental health needs"**. At this point Peter was in prison, and a space had opened up to enable Karen to articulate her experiences. The GP could have facilitated further discussion, and made linkages between the control and abuse and her mental health, instead of viewing the issues as distinct and unrelated.

19.17 Karen came into the practice in September 2016 and asked for a note to say she was not fit for work; Peter was due out of prison and Karen said she was feeling very stressed about this. The medical form was provided but issues relating to the fear she was experiencing, and the impact of the abuse, were not discussed.

19.18 In relation to Peter, the records showed he had a new patient consultation in April, he is recorded as having a diagnosis of anxiety and depression. His medication was reviewed in June 2016. In July, whilst on remand, Peter was seen by a doctor within the prison on a number of occasions. At the first appointment, he was seen for self-harming. A referral into the mental health team was made and he was seen by a psychiatric nurse two days later.

19.19 In August, Peter was seen for a routine health screening by a GP attending the prison; it is noted that Peter asked at this appointment to have his ribs checked, as he stated they were tender following his wife pushing him down the stairs. There is then little contact with health professionals and the last note, within the scope of this DHR, records a discharge note back to his GP in Carlisle, following his release from prison.

19.20 The GP IMR has the following to say, on missed opportunities to both recognise and respond to domestic abuse:

"The focus of each of the clinical consultations was on the mental and emotional well-being of the parents in this difficult time. It is not documented whether wider safeguarding issues were discussed at this time, or whether the issue of domestic abuse was considered and addressed. However, it has been recognised by the practice involved that there should have been recognition of these risks for Karen, and that she should have been flagged as vulnerable on the record system and discussed further as a vulnerable adult. This is particularly so, when the issue around the imprisonment and subsequent release of Peter for domestic abuse occurs. Discussion of these issues could have led to better coordination and responses from multi-agency partners to better protect Karen."

19.21 The IMR fully recognised, specifically in the final consultation when Karen raised her concerns about what would happen when Peter was released from prison, there was an opportunity for primary care to discuss this issue and respond with a safeguarding concern, alongside a mental health concern.

19.22 As described above, this has already been identified by the practice as a missed opportunity, and identified as being a situation that should have initiated flagging on the primary care system and discussion of the risks Karen faced at that time. The IMR also examined contact with both children in the family and found very few contacts between primary care and the children. Child A was seen by the GP as part of a routine new infant visit in 2012, although this did not occur until Child A was eight weeks old. There is a comment in the records that the baby, at six weeks of age, was in need of some medication but had not been registered, and the practice was not able to contact the mother on the contact number provided by her.

19.23 No social or medical concerns were identified when the baby was seen.

19.24 On a further occasion, in 2013, Peter was seen by the out-of-hours GP because of a long-standing rash, and was diagnosed with a common skin condition.

19.25 Prior to the delivery of Child B, Child A attended the emergency department with an injury to his mouth, reported to be from jumping off a bed. This is noted as "information received" by the practice and no further action was undertaken by them.

19.26 After Child B was born, there were a number of attempts to contact the parents about both post-natal checks for Karen, and routine checks and immunisation appointments for Child B. When Child B was four months old, the baby was seen urgently for failure to thrive. A few days later, the family changed their registration to a new GP practice in the same locality. There is no reason recorded for this change and again the new patient registration information does not highlight any safeguarding concerns. Further information about Child B's weight loss was received and there was a further missed appointment for immunisations. With a history of failure to thrive, and three missed appointments for immunisations, this could have been an opportunity to consider safeguarding issues further – both with respect to the children and the wider family.

The IMR author noted:

"In summary, there were a number of opportunities for Primary Care to have considered the safeguarding risk to Karen – either when consulting with her, or when reviewing the care of the children – and the author would recommend that practices consider this fact, and ensure that all clinical contacts with a family consider whether there is a risk of domestic abuse, as well as safeguarding issues for the children".

ii) Did the agency have policies and procedures for (DASH) risk assessment and risk management, and were those assessments correctly used?

Were these assessment tools, procedures and policies professionally accepted as being effective?

Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse?

Was the victim subject to a MARAC?

Both the police and LetGo have indicated that they used the DASH in their contact with Peter and Karen. CC uses the Police DASH Model: the first response staff complete the risk identification, using the DASH questions; they will assess the risk then the specialist officer will quality-assure it and conduct the full risk assessment, leading to development of a bespoke risk management plan.

19.27 LetGo also use the DASH model, for non-police services, and this is consistent and complementary and usual in most areas nationally.

19.28 In relation to the MARAC process, the panel identified this as a key area to explore in detail through the lens of the DHR. The following section leads us through the MARAC process in some detail.

19.29 On the first recorded incident of domestic abuse known to the police, Karen was assessed as "standard" risk, giving six "yes" answers on the DASH to the OIC. A domestic abuse report was correctly completed and submitted to the protecting vulnerable people referral unit (PVP).

19.30 Karen was reassessed by the PVP unit, and the information provided within the police IMR records this as follows: **"DS1 from the PVP unit reviewed the DA report and raised the risk grading from medium (6 yes answers on the DASH risk assessment taken by the OIC) to high, based on professional judgement. This was due to a weapon being used; a referral into the IDVA service had already been made."** No referral into MARAC was recorded as an action from this reassessment of risk.

19.31 The information provided in CC IMR LetGo IMR contradicted this account, and this caused considerable debate at panel meetings. LetGo were able to provide written evidence, in the form of an email from CC to the IDVA service, that Karen was viewed as standard risk and this risk was not upgraded as outlined in CC IMR. LetGo did, however, receive a referral, which would not be usual practice in relation to standard risk.

19.32 What seems most likely is that, whilst there was some recognition from CC that the risk level needed to be upgraded, this was not recorded accurately, and subsequently a referral into MARAC was not made.

19.33 The MARAC meeting in Cumbria is held on a monthly basis. The cut-off date for the case to make the next available MARAC meeting, which was due to be held on 24 August 2016, was 5pm on 12 August 2016. The case could have been heard at this MARAC.

19.34 The IDVA service made several attempts to contact Karen before they finally succeeded. When they did manage to meet with Karen, the DASH assessment was used and Karen was found to be of high risk. A risk mitigation plan was put in place and an action on this plan was to make a referral into MARAC, this was completed on the same day.

19.35 The referral made by LetGo (16 August 2016), missed the cut-off deadline for the August meeting, as outlined in para 19.33. Usual practice, in a situation of this kind in Cumbria, would have been to include the case on the following month's schedule. LetGo made the referral, but Karen's case did not get included on the list for the MARAC the following month.

19.36 Despite the case now being both formally recognised and accurately recorded as high risk, by both LetGo and CC, a decision was made to take the case off the list. A screening process was implemented by a temporary DI. The officer decided to review all cases listed on the MARAC schedule for the September meeting, and decided that Karen's would not be heard at this meeting. The rationale provided by the temporary DI was recorded in the IPCC report as follows:

"I was of the opinion, at that particular time, that there was no necessity for the referral to the MARAC to be discussed on the 21/09/2016, as the following agencies were involved with the family: Children's Services Department, in respect of the children who were in the care of the local authority after concerns in relation to neglect from Peter and Karen; the IDVA involved with the victim; investigating officer regarding the rape and child neglect complaints; Community Safety visit regarding security at the victim's home address."

19.37 LetGo challenged CC on this matter; they requested the case was heard within the MARAC meeting. A phone call with the officer who made the decision, was requested by the IDVA; due to availability and capacity this did not take place. The feedback they received was as follows, and came from the MARAC coordinator:

19.38 **"Advice has been sought from a detective inspector as to whether the MARAC is an appropriate forum for this referral, or if indeed it meets the MARAC threshold.**

I have now spoken to the temp DI, who works within the public protection unit at HQ, who has read through the information you have provided and has stated that: 'in respect of Karen, I am satisfied that safeguarding measures are in place, as we, the police, are working closely with LetGo, who has provided an ABE interview today, which will result in the arrest of her partner following his release from prison on the 13.09.16.'

Please see the definition for domestic abuse as follows: any incident or pattern of incidents 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**
***emotional**

Many thanks for your time, and following this email your referral will be marked up not processed as it does not meet the MARAC threshold/is not domestic related."

This represented a breach in the accepted MARAC protocol in place and was outside the agreed policies and procedures of CC and its partners.

Whilst an undoubtedly significant number of measures appeared to be in place, these measures were applied in a single-agency context.

19.39 The panel agreed there had been one clear opportunity to hear Karen's case within the multi-agency framework, during the timeframe examined in this DHR. If CC had referred the case on 22 July 2016, it could have been heard on 24 August 2016.

19.40 CC MARAC protocol has the following to say as to why a meeting that considers risk from a multi-agency perspective is crucial to safeguarding:

"At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA (Independent Domestic Violence Advisor) who speaks on their behalf."

The very point, and the absolute strength of MARAC, is that all partner agencies come to a table and share their collective information, and then their collective experience, to action plan. There is no doubt CC and LetGo had safety plans in place and measures to protect Karen were evident. However, these were single-agency plans, which lacked the robust measures gained from multi-agency action planning.

19.41 Despite being clearly identified as a high-risk victim, by both agencies who completed a DASH, Karen did not have the opportunity to be safeguarded through the MARAC process; on the first occasion, as a result of a combination of human error and system failure; on the second occasion, as the result of a flawed decision made outside the existing agreed protocols for MARAC.

19.42 Whilst it is very clear this MARAC would not have afforded any opportunities to safeguard Karen, the point of DHRs is to identify lessons to prevent future homicides. It is therefore appropriate and within the scope of this DHR to explore this issue further.

19.43 A combination of factors and issues were used by the temporary DI to explain why the referral was turned down. The email forwarded to LetGo stated safeguarding measures were in place and seemed to indicate the case did not meet the definition of domestic abuse, or did not meet the threshold. The threshold test had certainly been met, so this leaves the issue of the case not being domestic abuse – possibly due to the fact that a serious sexual offence

had now been reported. The investigation of the rape should have been fully considered within the complex dynamics of domestic abuse.

19.44 Karen's disclosure of rape and sexual abuse placed her at great risk, she had never spoken about it before and this matter required sensitive handling. A MARAC meeting with health, sexual abuse specialists and her GP may have provided further information to assist in the investigation and offer support services to Karen.

19.45 It would appear that the rape investigation was not considered within the lived experience of Karen's life. Rather, the rapes were considered separate and not fully located within a context of abuse and coercive control.

20. Recommendations

20.1 A multi-agency review of the MARAC protocol did take place immediately following the homicide of Karen, and emerging lessons identified were considered. Focus should now be given to the specific areas identified through this review, and a full multi-agency review of policy, procedure and protocol is recommended. Referrals from IDVA/ISVA and other specialised services should be accepted where the threshold is met either from the DASH or from professional judgement.

20.2 In addition, it is recommended that the existing protocol should be revised to ensure victims whose partners are in prison are still given multi-agency protection through MARAC. In this case, Karen continued to be controlled from prison.

20.3 Consideration should also be given to the existing schedule of the monthly MARAC. It is recommended partners consider moving to a weekly or fortnightly meeting in order to ensure high-risk cases are heard in a timelier manner. Consideration should also be given to holding an emergency MARAC should the risk level and situation arise.

20.4 CC have identified on a number of occasions that there was confusion as to which officer had taken action. The MARAC referral is the first example of this with two officers believing the other had made a referral. The next is the storm alert, which again did not get made as two separate officers felt this had been completed by the other, and neither had taken the action. Precise, contemporary record keeping, and action logs are essential.

20.5 **iii) Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?**

The panel found that CC did not follow the agreed multi-agency protocols and procedures in relation to MARAC.

Children's Services acted accordingly to their protocols and response thresholds with the information given in relation to neglect, they did not, however, "Think Family". No DASH was completed, and there were no interventions tailored to Karen's needs in response to the abuse when this became known. There were opportunities to share information with other agencies, specifically CC, and these were missed.

20.6 **iv) What were the key points or opportunities for assessment and decision making?**

Do assessments and designs appear to have been reached in an informed and professional way?

Did actions or risk management plans fit with the assessment and decisions made?

Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known or what should have been known at the time?

Were senior managers or other agencies and professionals involved at the appropriate points?

Did any concerns relating to Karen or Peter lead to a wider referral/assessment of either family? If not, are there indications that they should have done so?

20.7 The panel identified several critical points wherein key opportunities for assessment of the family's circumstances were lost. Children's Services had significant contact with the family and undertook assessments on the parents' ability to care for their children, and the court commissioned psychological assessments to support child protection proceedings. These assessments failed to get to the underpinning dynamics and issues that Karen and Peter were struggling with. This was, in part, due to neither parent disclosing issues that were relevant for them: for Peter, neither mental health nor addiction issues relating to gambling and cannabis; for Karen, domestic and sexual abuse.

20.8 Karen never got to the point where she felt she was able to trust professionals from either children's social care and health visiting, or the psychologist tasked by the court with undertaking assessment to inform the care proceedings. The panel felt this was as a direct result of the coercive control she experienced. The multi-agency response to children living with domestic abuse, September 2017, has the following comments to make on the impact of coercive control:

"Coercive control can have such a significant impact on victims that it is difficult to gain accuracy and clarity as to what is occurring with a relationship. Victims can appear to be secretive or contradictory. It takes skill and insight to

identify that untruths or attempts to distract or mislead may be a coping strategy. Effective management of victims relies on skill, insight and experience of professionals and their ability to move beyond a victim blaming approach."

Karen often pointed out that Peter's child caring skills were greater than hers; he was the better parent. This was viewed by the panel as examples of control, and trauma bonding.

20.9 However, the panel felt neither parent had been explicitly asked about control or domestic abuse in any of the contacts they'd had, with the exception of Karen being asked during the psychological assessment about her relationship. At this point, due to the pressure on Karen and the consequences of disclosing, she was unlikely to be in a position to disclose.

20.10 We know domestic abuse compromises a parent's ability to parent effectively to such an extent that children may become neglected. The demands of parenting can be overwhelming to a mother suffering from trauma and damaged self-confidence, and other emotional and physical effects of the experience of long-term abuse take their toll.

20.11 CSC focused on neglect and the children's needs during the assessment process. The impact of neglect during a child's very early years can have profound and life-lasting effects on brain development, which can lead to lifelong problems. Indeed, neglect in the first five years of life can damage all aspects of a child's development, and health visiting had taken cognisance of this, and the children were displaying physical signs of neglect. This was evidenced in Child B having little control of their head, and delayed development globally.

20.12 Neglect can also cause fatalities due to poor supervision, leading to accidents occurring, or poor hygiene; again, both children had to some degree experienced both of these factors. We know that neglect is a factor in 60 per cent of serious case reviews and, as such, CSC were correct in taking swift action and proceeding to child protection measures. Good practice was evidenced in the response to swift identification of neglect, and a robust plan was put in place with enhanced supervision and clearly set-out timescales to monitor improvements. The plan was multi-agency and CSC and health visiting worked together to support the children. Health visiting services specifically demonstrated a huge commitment to ensuring the children had toys and clothes, and were provided with basic essential items in the way of food, milk and nappies.

20.13 Neglect, however, frequently occurs in a context in which parents are dealing with a range of other issues, commonly: domestic abuse, substance misuse, poor mental health, poor housing, and poverty. All these factors were present within the family and yet were invisible within the assessment process.

20.14 What is concerning in this case, is CSC being cognisant of these co-occurrence factors and not seeking opportunities to explore what was going on in the home in more depth. Any interventions, therefore, were likely to be unsuccessful, as they were not targeted on specific issues such as the domestic abuse, substance misuse or mental health. Karen was not asked directly about the abuse, right up to the point where her children were removed from her care. The panel did acknowledge that the circumstances in which the family lived, i.e. Karen working long hours and often being at work during home visits, presented specific challenges to services. The barriers to access Karen on her own were complex. She had both a controlling partner and a job that had uncertain hours and working patterns.

20.15 The panel also felt more support would have benefited Karen when the children were in foster care. The neighbour described how difficult it was for Karen to keep in contact with her children due to her working hours and a long journey to the contact centre. Karen was also struggling to keep Peter motivated to attend contact sessions and this often caused arguments. Post Peter leaving the family home, a stepped-up approach to ensure contact was easily accessible, and at appropriate times, could have been considered.

20.16 v) **Had Karen disclosed to anyone and, if so, was the response appropriate?**

Was this information recorded and shared where appropriate?

When, and in what way, were Karen's wishes and feelings ascertained and considered?

Is it reasonable to assume that her wishes should have been known?

Was Karen informed of options/choices to make informed decisions? Was she signposted to other agencies?

20.17 Karen did not disclose the abuse she had endured for many years until Peter physically assaulted her in June 2016 and she rang the police. It is unclear why Karen felt able on that occasion to call the police and what the tipping point was for her. We know from detailed information provided through the IDVA and her neighbours, that this was not the first time he had physically attacked her. It was the first record of any disclosure to anyone as far as the panel were aware. In terms of a victim's help-seeking processes this is unusual, as victims will often turn to friends or family first, then health services.

20.18 The view of IDVA services was that this was a result of Karen having very few people in her life she could turn to, and the fact that the assault featured a weapon. This was a change in the dynamics of the abuse and may have been the reason she finally reached out for help.

20.19 The first response to this call for help was appropriate; the criminal justice response was swift and positive and she received a direct referral into IDVA services. The IDVA services proactively contacted her on several occasions before they were successful. The service kept trying and did not give up on the victim.

20.20 Once contact had been made, a risk assessment was completed and safety planning implemented. This approach facilitated further disclosures of rape. The victim was believed, taken seriously, and supported at her pace and in the manner in which she requested it.

20.21 **vi) Was anything known about Peter?**

20.22 Peter was not managed at MAPPA level and little was known about him. Through the DHR process the panel uncovered a picture of a man who had addiction issues to cigarettes, cannabis and gambling, and mental health issues that were chronic but low-level. A pattern of offending emerged of a man adept at coercive control and manipulation, who used emotional and economic abuse to control his partner. From family and neighbours, the panel learned that Peter had a disturbing attitude to women and girls; the neighbour described feeling uncomfortable around him and stated he had called Child B a slut. It was also apparent that Peter had used intimidating behaviour toward social workers and health visitors, which had been tolerated to some extent as it was viewed at a level that was unsettling, rather than explicitly threatening. Adjustments were made when Peter crossed boundaries and was menacing towards a social worker. This information was not used, however, to reflect on Karen's safety and assess her risk levels.

20.23 In fact, Peter did have previous convictions for serious sexual offences in Hungary, but this was unknown to services until after the homicide.

20.24 The police IMR states that, whilst he had a previous conviction in Hungary for offences against women, this information was not shared with them when checks were made. This information was only retrieved after the homicide. Further work is needed at a national level to support police forces in obtaining the information they need to manage risk. In this case, the information available was only uncovered post-homicide, when investigative officers travelled to the area in Hungary where the offences were committed. Hungary does not have a national database of convictions.

20.25 An assessment of Peter's risks and supervision provision post-sentence (to the assault in July 2016), was completed by the National Probation Service. Peter was assessed to be medium risk of harm and low risk of reconviction. As a result, he was deemed to be suitable for supervision by CLCRC. No information was provided regarding Peter's housing needs post-release from prison.

20.26 Furthermore, whilst Peter was in prison, the prison authority was responsible for undertaking risk assessment and post-sentence planning. These assessments should identify pertinent issues for the effective supervision of an offender whilst in custody, and the issues that need action for a safe release back into the community. Whilst the assessment was taken, information was not provided on the difficulties in relation to Peter's accommodation needs. Contact was made between the supervising probation officer and the prison, on 1 September 2016, and on a further occasion on 5 September 2016 to gain access to Peter's release paperwork.

20.27 The relevant documents were provided on 7 September 2016, and whilst these included a specific condition that Peter must not contact Karen, his housing needs were not communicated to any of the partner agencies, and specifically the local authority (LA) homeless section, clearly. The neglect of any agency to consider his housing, was a significant gap identified during this review. The CLCRC IMR clearly identified areas for improvement in relation to this, and highlighted the lack of constructive pre-release planning between CLCRC and the prison service, including the critical issue of the delay in release papers being provided, alongside housing provision generally.

20.28 The Through the Gate (pre-release service provision) contract provider was not from Cumbria, and lacked relevant local knowledge. CLCRC developed a robust action plan to implement lessons identified through this review. This included:

- Practice development unit (PDU) to develop and deliver a development session to responsible officers, to improve the quality of risk assessment sections within OASys.
- The PDU to undertake dip sampling of responsible officers Offender Assessment System (OASys) assessments.
- PDU to undertake development sessions with the responsible officer to reemphasise the importance of raising risk of harm concerns in the Through the Gate process with the prison resettlement team.
- PDU to include, in discussion with responsible officers, the importance of fully investigating potential risks of harm to children.

It should be noted that all these actions have now taken place, without exception.

20.29 vii) Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of Karen, Peter, and their families?

Was consideration for vulnerability and disability necessary?

How accessible were the services for the victim and perpetrator?

Did any concerns relating to Karen or Peter lead to a wider referral/assessment of either family? If not, are there indications that they should have done so?

21. Equality and diversity

21.1 The Equality Act came into force on 1 October 2010. The Equality Act brings together over 116 separate pieces of legislation into one single Act. Combined, they make up a new Act that provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act aims to simplify and strengthen current legislation that protects individuals from unfair treatment and promotes a fair and more equal society. There are nine protected characteristics, and those felt by the panel to be most relevant to this review link to race, gender and disability.

Disability

21.2 Neither Karen nor Peter were assessed as an "adult at risk" under Section 42 of the Care Act 2014. The panel identified a number of occasions when referrals into safeguarding adults framework could have been considered in relation to concerns expressed by both Peter and Karen relating to mental health. Peter and Karen both described on occasions that they felt suicidal. Karen gave a very specific example to the social worker, of feeling like she wanted to **"jump under a train"**. Both adults were signposted to their GP.

21.3 The GP did make referrals for both adults into First Steps, in relation to mental health concerns, but again a referral into SA was not considered.

21.4 The panel believes these were lost opportunities to share information across health economies and work in multi-agency partnerships.

Gender

21.5 Gender roles in Hungary were believed by Karen to be rigidly defined. Karen described to her friends on many occasions that she felt, in Hungary, the abuse she experienced was normal behaviour. A desktop review of domestic abuse services, policies, procedures and legislation revealed very little information that proved useful in providing a deeper understanding of either Karen or Peter's cultural context. What we do know about how Karen viewed gender roles has come from reports from her friends and family. The panel were also able to gain some understanding of Peter's beliefs and this is explored in the section on friends and family.

21.6 In addition to language barriers, professionals do need to consider wider social and cultural influences that create barriers for anyone attempting to seek help for problems relating to mental health, domestic abuse and substance misuse.

21.7 There are additional and specific issues to the Hungarian community regarding institutional distrust with the police, health, mental health and Children's Services. There appears to be very limited understanding of the impact of the family's cultures, other than the language barrier. No agency has identified this as a potential risk indicator or vulnerability factor, which may have greatly inhibited Karen's contact with agencies and access to services. Karen had a clear view that services in Hungary did not view rape and domestic abuse of intimate partners as a serious issue, stating to her friend: **"In Hungary a man can do what he likes."** Whilst it is not expected that agencies could have known this was Karen's view, there does not appear to have been professional curiosity shown as to what her views were on this, or what life was like in Hungary in respect of intimate relationships and family matters.

21.8 Karen was very isolated, both from her family back in Hungary and the US, and from her new community in Cumbria.

21.9 **viii Are there other questions that may be appropriate and could add to the content of the case?**

The panel agreed two key thematic areas for examination in detail, those were: Housing and the rape investigation.

The next section of the report will therefore consider these themes.

22. Housing issues and rape investigation

Housing issues for Karen

22.1 The panel debated rigorously as to whether the intervention of a house move, or, indeed, access to emergency accommodation, would have prevented this homicide. The panel was presented with somewhat contradictory information from the available sources and it was difficult to fully establish Karen's needs in relation to housing.

22.2 The housing provider, Riverside, had a significant amount of contact with the family.

22.3 The first contact they had with the family was regarding the suspension of their housing benefit. A visit was made to the address by the income officer. He met with the perpetrator, who advised that the victim was still in employment and he was no longer employed due to health issues; the perpetrator advised they would ensure the arrears balance was cleared.

22.4 Despite repeated attempts, the arrears were not cleared. Riverside's affordable warmth officer (AWO) made a targeted visit to the property following a notice of seeking possession being served for rent arrears. Victim and perpetrator were both present at the visit. They discussed some financial issues and made the AWO aware that they were struggling financially due to the victim's fluctuating hours at work. The AWO made a referral to the

Citizens Advice Bureau to help them with their debts; they were contacting them with an appointment.

22.5 The income officer then made a number of attempts to contact the tenants; this was eventually successful on 13 July 2016. Karen was present at the visit, income and rent arrears were discussed. Karen disclosed debts to an online betting company and some other debts. The income officer viewed the couple's bank statements and observed a large number of online transactions to a betting company. A referral was made to StepChange (Debt Management Charity), with the victim's consent, to address the debts. Karen agreed to a referral to Riverside's floating support team to provide support to enable them to sustain their tenancy.

22.6 Riverside's floating support officer visited the property; Karen and Peter were both present. The change in their income was discussed at this visit and they advised they were able to manage on what they were receiving. They were advised that Peter could make a claim for Employment & Support Allowance, due to the fact he was stating he was unfit for work, and he agreed to consider this.

22.7 Following this, a further visit was carried out to the victim on 26 July 2016. At this visit she advised the floating support officer that she had been assaulted and this was a one-off incident. The IMR noted: **"Karen asked about transfer as she felt the area wasn't very nice, she stated that she was applying for sole custody of the children and wanted to live somewhere nicer, at no point did she ask about a transfer due to domestic abuse. She advised that police had told her the perpetrator was unlikely to be released."**

22.8 She was advised that, due to still being in a starter tenancy period and having rent arrears, Riverside would not approve a transfer. This advice was confirmed by the housing officer; the victim was made aware of the procedure and she was also made aware of how to look for accommodation with an alternative provider.

22.9 Following the visit, the floating support worker followed up with another visit; the victim had made further payments to her rent account and had completed an initial appointment with StepChange to look at the debts. Karen asked at this point for support to be ended as she did not feel she required any additional assistance.

22.10 It would appear from Riverside's IMR that Karen had requested a house move and Riverside were aware of the domestic abuse. She was, however, refused a housing move on the grounds she had not said specifically that it was due to domestic abuse, and she had considerable rent arrears.

22.11 LetGo also covered the issue of rehousing – in detail – within their IMR, and concluded that Karen was adamant she wanted to remain in the home she was now starting to build. Karen believed that staying in this house would increase the likelihood of her children being returned to her.

22.12 Staying in the house placed her in greater financial hardship, she was subject to the bedroom tax as her children were in care. The under-occupancy penalty, imposed on Karen when the children became accommodated, had a significant impact on her ability to manage her finances. LetGo provided advocacy and support to her, making her aware of this issue. Karen remained resolute that she would not move as this was to be a home for her children.

22.13 LetGo contacted Riverside in early August and asked if Peter's name could be removed from the tenancy. Peter was due to be released from prison imminently and LetGo were concerned that, as his name was still on the tenancy, he would view Karen's house as his and would be likely to try and return. Riverside confirmed, due to housing policy and legislation, this would not be possible.

22.14 Karen's financial situation was known to be extremely difficult and it is likely that the tension she experienced, between the need to have a home to bring her children to and the need to balance her fluctuating finances in order to make ends meet, was very difficult to manage. This may somewhat explain why two seemingly opposing viewpoints emerge. It could also be that the housing provider had informed her she could not move to a new house and she was therefore making the best of the situation she was in and could not change. The interview conducted with Karen's neighbour brings further evidence that Karen did in fact want to move, and had asked Riverside if she could be rehoused. Due to high levels of rent arrears she was informed a house move would not be possible.

22.15 The housing sector has a critical role to play in keeping victims of domestic abuse safe, but agencies can sometimes lack the skills, knowledge, or procedures to tackle domestic abuse with confidence. Riverside Housing could have considered Karen's request for a house move, responding to her needs as a victim of domestic abuse rather than merely a tenant in arrears. The rent arrears effectively blocked her route to safety from the house she had shared with her partner, of which he knew the address, the entrances and exits, and the locality.

22.16 The consequence of the case not being discussed at MARAC was that Riverside did not have the full picture of the level of risk the victim was subject to. They did not have the opportunity to discuss the possible transfer of the victim, or make an assessment on the risk level of the case in a multi-agency context.

Emergency accommodation/refuge provision

22.17 LetGo reflected within their IMR, having undertaken a full review of the case, whether the IDVA could have been more proactive in encouraging Karen to seek refuge accommodation. This was not explored as Karen had been adamant to the IDVA that she did not want to move and wanted to remain in her home, as she believed it would increase the likelihood of her children being returned to her. Whilst we can never know if this option would have been taken, the panel's view was that all services should ensure keeping immediate safety at the heart of interventions is a core principle. Asking victims what they want and need and giving them options as risk levels change is vital. The IMR from LetGo reflected this option could have been explored with greater urgency.

22.18 We know from neighbours that in the days following the rape investigation Karen did not leave her home and she was very afraid. At this point, offer of emergency accommodation to Karen could have been utilised as part of her risk management plan.

Housing issues for Peter

22.19 The panel were united in the view that Peter's release from prison, and his effective homelessness at this point, increased risk to Karen. From Peter's perspective, he had a house – his name was on the tenancy – where else would he go? CLCRC identified that working with the prison service to ensure a post-release intervention was in place, through the gateway, could have decreased the risk to Karen.

Rape investigation

22.20 The rape disclosures were made to LetGo and came as a result of direct questioning as part of the DASH assessment. Karen wanted to let her support worker know this had happened to her and was part of the abuse she had experienced, but she was very clear she did not want to report the rapes to police personnel; she did not want to support a prosecution. The panel also notes it has never been clearly understood as to why Karen agreed to an ABE interview. LetGo have expressed within their IMR that it was never discussed with them, or made clear why Karen had agreed to give the ABE interview; this took place outside any meeting they supported and seems to have come about as a direct request from CC to Karen.

22.21 The prosecution of sexual offences is complex. This is even more so within the context of rape within an intimate relationship, as was the case here. It often amounts to the issue of consent and one party's word against the other's. In this case, Karen was an unwilling party to supporting a prosecution.

22.22 The strategy to gain best evidence and take this case forward, in the short period of time from CC becoming aware of the rapes to the arrest of Peter, was challenged rigorously at a panel meeting. The panel had the benefit of a CPS panel member, who provided expert knowledge in matters relating to the investigation. The author has also used evidence from the IPCC investigation, which examined the rape investigation and its failure in some detail.

22.23 We know CC did not seek advice from the CPS prior to deciding not to pursue a prosecution. The ACPO guidance on Investigation and Prosecuting Rape 2010, provides guidance on early consultation between the police and CPS. It states:

"Officers investigating rape should liaise between the CPS at the earliest opportunity. The involvement of a CPS lawyer during the investigation phase (whilst not compulsory) is likely to assist the investigating officer in identifying key evidential issues which can be dealt with prior to charging a suspect. It may also minimise the need for a further arrested suspect to be released on police bail while investigators need further evidence."

The guidance further states that this guidance should be sought, **"Where the allegations have not been or are not being admitted, or where it seems likely that the allegations will be denied."**

The CPS Director's Guidance on Charging sets out protocols for working with the police and prosecutors in relation to rape, and also provides early investigative advice and sets out: **"Prosecutors may provide guidance and advise in serious, sensitive and complex cases and in any case where the police supervisor considers it would be of assistance in helping to determine the evidence that will be required to support a prosecution or to decide if a case could proceed to court. Specific case involving a death, rape or other serious sexual offence should always be referred to the Area prosecutor as early as possible and in any case once a suspect had been identified and it appears that a continuing investigation will provide evidence on which a charging decision has been made."**

22.24 In this case, we know from the IPCC report that no advice was sought from the CPS. When questioned in relation to this, the supervising officer, temporary DI, stated, **"If somebody is in custody we can go for early advice in complex cases, this wasn't a complex case."**

22.25 A CPS prosecutor for rape and sexual offences was interviewed as part of the IPCC investigation, and her view on this matter is as follows: **"It did appear when looking at all the evidence available at the time that it appears to be one word against another's, and the investigation may not have been ready for a charging decision at the time of Peter's interview; however, the CPS do prosecute cases that are one word against another, and in**

my view a case could have been built by looking at other enquiries and considering its background in respect of a controlling relationship."

22.26 The panel does not accept CC's view; clearly, domestic abuse and coercive control are sensitive matters, and could be viewed in the category of complex – the CPS guidance supports this view. The panel also rejects the viewpoint that the case amounted to one person's word against another, as being a reason to not take a case forward. In the majority of rape cases it amounts to precisely that: one word against another, with little supportive evidence being seen initially. This need not be a reason to No Further Action a case.

22.27 The temporary DI was interviewed in the course of the IPCC investigation and gave a detailed account of the rationale to No Further Action the case. He explained that his decision was based on the strengths and weaknesses of the case, which he details as follows:

Strengths

- Victim has no previous convictions for dishonesty.
- The suspect was charged with common assault following a domestic incident on 20 July 2018, was subsequently convicted, and received a term of imprisonment.

Weaknesses

- The victim's ABE interview was not specific as to when the incidents occurred, and gave a generic answer that he ripped her clothes off and raped her on numerous occasions, but not a detailed account. She also complained that following the act of rape she was sore, but states that she did not seek medical attention as there were no injuries.
- The defendant was interviewed under caution, denying that he raped his partner or assaulted his child.
- There is no forensic evidence to support the complaint of rape, due to the victim not reporting the incident sooner.
- The victim did not report the continued abuse to the police or third parties, except for LetGo.
- In December 2015, both children were removed from the family home, due to neglect, and are the subject of a care order.

22.28 The panel's position is that early evidential advice would have been hugely beneficial in this case. Whilst it is impossible to predict the outcome of advice being sought, it was felt the investigation strategy could have been strengthened by expert advice. It was also the position taken by the IPCC investigator, who concluded that the decisions taken by both the investigating

officer and the supervising officer were not in line with either ACPO or CPS guidance.

22.29 Furthermore, from the IPCC report we know that Karen was questioned during the ABE interview about the specific times she had been raped. Karen was unable to give precise dates and times but did say it had happened on a number of occasions, and gave the statement that about 50 per cent of the times she'd had sex, she had not wanted to. She described how Peter would slap her or pull her hair. Karen also clearly stated that Peter subjected her to emotional abuse and would blackmail her, threatening to sleep with other women if she would not sleep with him. During the course of the interview Karen said it had been happening for so long, so often, she had given up; she just thought, **"What's the point of saying it (no) anymore?"** Karen was very clearly starting to open up about the extent to which she was controlled. Again, whilst it is not possible to say outcomes would have been different, the possibilities of exploring the use of the new offence of coercive control, were not utilised.

22.30 The panel also felt that the rationale applied by the temporary DI, regarding the weakness of the case, was questionable. Karen said she did not seek medical assistance when she had experienced the rapes, and there were no injuries, this is common and should not necessarily be viewed as an evidential weakness.

22.31 The temporary DI's statement that the children were not living with Karen should have no bearing on the evidential strengths of the case, and the panel were unsure why this was included in his assessment.

22.32 The comments relating to Karen not previously telling anyone about the rapes, except LetGo, were also questioned. Karen was starting to open up; she was at the beginning of a potentially long journey to safety. The disclosures were initially to a service that Karen trusted; she was not ready to support a prosecution.

22.33 It should be noted that during this timeframe Peter was in prison, so Karen had space to make disclosures and decisions about her life – she needed to do this in her own time. It is the panel's view that Karen was not at a point where she was able to fully support the criminal justice process, and an enhanced victim-led strategy might have wielded both better evidence and a better outcome in this case.

ISVA support

22.34 Victim Support's (providers of the ISVA service) involvement with Karen came about through the automatic transfer of data from CC to the service. Though data is shared as stated – automatically – victims of sensitive crimes such as domestic abuse and rape/sexual assault would only be contacted if the victim had expressly given consent. Karen gave her consent to be contacted when she was a victim of the first assault, reported to the police in July. A contact

number wasn't available for her and, as a result, it was two weeks before any contact was made. A further data transfer was made on 18 August 2016, and again, it was almost two weeks before Karen was contacted.

22.35 Two weeks is a significant time gap between referral and contact. Victim Support highlighted two distinct explanations for this. In the first instance, no telephone number was supplied, and the service had difficulties contacting the OIC. In the second instance, Victim Support highlight low staffing numbers and limited capacity within the team.

22.36 Victim Support at this time was experiencing significant staffing issues: two members of the team were on long-term sick. This meant a team of four was down to one ISVA, with additional support from agency staffing. In order to manage this situation, contingency measures were implemented to manage the volume of cases. A temporary procedure was implemented and cases were allocated for support based on factors such as the nature of the incident and whether the incident was contemporary or historic.

22.37 Karen was not assessed as a high priority due to, **"The historic nature of the offences, ongoing support from LetGo and, at the time of the referral, the offender was in prison, reducing the immediate risk to her safety."**

22.38 In fact, the rapes were not historic and had been occurring up until the date the offender was arrested. Victim Support, however, did not have the most recent information relating to the sexual offences, and based their decision on the information from CC's initial referral, which had placed the date of the rape as1 December 2009. As no contact was made with Karen for two weeks, with either CC or Karen herself, Victim Support were unknowingly basing allocation of service on incomplete and inaccurate information.

22.39 It is correct that the IDVA was in place to support Karen; however, ISVAs have very specialised training and skills. There is evidence of ongoing interaction between the two services and, whilst it is clear there was ongoing communication, it may have been unclear to Karen who was doing what and why. Victim Support recognised this within the IMR, and noted: **"The best interests of the client are not always served by multiple agencies duplicating work. To this end, as part of Safer Cumbria's 'Sexual Abuse and Assault Needs Assessment', it has been agreed, in domestic abuse cases where there is a sexual violence element, liaison will take place to determine the most appropriate action in accordance with the victim's needs."**

23. Conclusions: lessons identified

This review considered whether there are ways of working effectively that could be passed on to other organisations or individuals. In particular, we have considered what lessons are to be learned that may benefit other women in Karen's situation.

23.1 This review found several services needed to do further work to establish safer and more victim-focused ways of working. Underpinning these findings was a fundamental lack of understanding of both the nature of coercive control, and its impact on a victim's life. It was also found services did not fully appreciate the nature of financial abuse and how this can both manifest and impact on a victim's life.

23.2 Further work is needed to ensure victims of rape and sexual abuse receive the support they need, and that no victim of any sexual offence is taken beyond the remit of their wishes in relation to prosecution of the offence. The principle of prioritising safeguarding, before securing a prosecution, should be considered.

23.3 The panel were concerned that the provision of ISVA services was limited to a series of telephone calls, and the victim at no point received face-to-face contact or support. Clear timescales for contacting victims, based on risk and need, should be in place for all victims of rape and sexual assault.

23.4 Clearer referral pathways need to be in place for victims of rape and sexual assault, to ensure they are given the highest possible standard of service as early as possible.

23.5 The review uncovered a lack of professional curiosity in service areas, notably children's social care and health services. Children's social care undertook multiple assessments on the family, yet at no time, including in preparation to accommodate the children, did any member of staff ask questions in relation to domestic abuse. There was evidence that a "Think Family" approach was not present, reliance was instead placed on Karen and Peter to self-refer and find services for themselves.

23.6 Critically, despite the interventions of many different professionals in the family's life, the extent of the domestic and sexual abuse did not become visible until specialist services became involved. This highlights the importance of ensuring families get specialist support as early as possible.

23.7 There were also significant gaps uncovered in the implementation of existing policies and procedures; the starkest example of this is the MARAC procedure. It was simply not utilised, with key individuals either not making referrals due to error, or overriding the process based on their individual viewpoint that the process was not required. Safeguards were not robust within the system to adjust for human error. As a result, no multi-agency safeguarding or information sharing took place. If Karen had been referred into the MARAC, issues such as her housing situation and the impact of the arrears, could have been discussed. The MARAC could have provided a more coordinated response. The panel noted that in a relatively short period of time multiple contacts were made with the family from multiple agencies. This may have been deeply confusing for both Karen and Peter, and the MARAC could have provided the coordination of services needed.

23.8 The review also uncovered recording of actions and record keeping as an area for improvement. CC have identified on a number of occasions there was confusion as to which officer had taken which actions. This caused considerable issue for the DHR panel, and we are aware some specifics were never fully uncovered.

23.9 Poverty, economic abuse, and the linkages to the neglect of the children were themes noted throughout the review. Karen's neighbours stated they had never seen poverty at this level before. Karen was in receipt of "poverty wages" on a zero-hours contract. She had little control of what her money was spent on and was denied access to basic resources, such as food, clothing, heating and lighting, and so, by proxy, were her children. The panel were in no doubt that the presentation of neglect was underpinned by coercive control and economic abuse. The panel therefore welcomes focus on the concept of "economic abuse" as an aspect of "coercive control", which government has recently highlighted.

23.10 This review presented a challenge to the panel, in that Karen, due to her long working hours, was difficult to reach. Her employment was a significant barrier and the panel debated at length how those barriers could have been overcome. The panel's view was that the Cumbria Domestic Abuse Champions' network was well placed to begin identifying champions in the private sector. Targeting the largest employers, specifically those who have large numbers of female employees on zero-hours contracts, was seen as a step towards overcoming this barrier.

23.11 This review uncovered the difficulties police forces have in accessing information that is vital to managing the risk posed from foreign nationals. Further work is needed at a national level to enable police forces to have the information they need to manage risk and safeguard victims.

23.12 Robust referral pathways need to be developed and implemented to ensure adults with needs in their own right are referred directly into services rather than signposted. Both adults in this review had mental health needs, which they clearly articulated on a number of occasions, yet no referral was made by agencies into adult safeguarding.

23.13 A critical issue uncovered through the lens of this DHR, was the lack of support and supervision post-release from prison for Peter. A robust post-release plan could, and should have been implemented to ensure Peter had suitable housing. Peter was released from prison and the only home he had was the home he had shared with Karen. He gravitated back to this home after a short period of time sleeping rough. This dramatically increased the risks to Karen, and both CC and CLCRC were aware of this, yet neither agency made a referral or shared this information with Carlisle homeless section, who could have assisted.

24. Good practice

24.1 Front-line police officers were found to have a proactive approach to domestic abuse and the review panel commends this. Action was taken by officers that ensured Peter was put before the courts, and again, when he breached his bail conditions, measures were taken to ensure he was arrested and imprisoned. This undoubtedly gave Karen the space and confidence to speak out about what she had been enduring for many years.

24.2 LetGo provided support and advocacy to Karen and professionally challenged CC on their decision not to put the case into MARAC. They are to be commended on the delivery of care they provided. LetGo are a leading-light project and, as would be expected of a service of this level, were open, transparent and self-critical in embracing the principles of a DHR.

24.3 Health visiting were noted by the panel to have gone over and above the duty of care they are bound to provide. Toys, food, clothes and other essential items were provided on multiple occasions. The health visitor was persistent in her approach, and we know from Karen's neighbours that the kindness demonstrated was greatly appreciated.

24.4 Carlisle City Council's homeless unit provided a high standard of care and were proactive in identifying early on that the children were subject to neglect. Appropriate services were also put in place to ensure income maximisation.

25. Lessons identified from single agencies

IMR authors identified the following learning points:

Recommendations from LetGo

To establish a course of action that will be taken following disclosures of historic abuse so victims can receive the information they need to make decisions.

Recommendations from Crown Prosecution Service

A reminder should be given to CPS North West prosecutors about the use of ancillary orders and toolkits, to ensure consideration is given to appropriate applications for restraining orders and other appropriate orders, and that such considerations are appropriately recorded.

Rape toolkits should be used in all appropriate cases to assist in identifying evidential issues and further areas of investigation.

Early investigative advice (EIA) should be considered in all appropriate cases, in accordance with the Director of Public Prosecutions Charging Guidance, fifth edition.

Further training to raise the awareness of police supervisors in relation to consent toolkits; EIA may be of assistance, together with an evaluation of such training.

Recommendations from CCG IMR

Primary Care should ensure that information relevant to the immediate family is recorded in records for each individual within that family, and cross-referenced to other members. This will allow the identification of any safeguarding issues, and thus prompt a consideration of the need for a discussion with other health colleagues or with other relevant agencies. Assurance that if this is the case it will be provided through completion of section 11 audits, by practices and safeguarding assurance visits by NHS North Cumbria CCG.

Safeguarding concerns, including domestic abuse, should be considered and recorded at key contacts with primary care. In particular these would include any referrals for maternity, any episodes of mental health or emotional well-being concerns, and consideration of issues relating to the children in the family for failure to thrive, non-attendance at appointments, and injuries. The author would recommend that this is included in a wider, multi-agency audit, reviewing domestic abuse across the locality.

Recommendation from Cumbria Constabulary

Community Safety officers to attend MARAC.

Community Safety officers to be made aware of all high-risk victims.

An additional MARAC date should be considered if all MARAC referrals cannot be heard on the day.

Criteria should be made for enhanced, foreign national conviction checks.

Recommendations from CLCRC

CLCRC developed a robust action plan to implement lessons identified through this review. This included:

Practice development unit (PDU) to develop and deliver a development session to responsible officers, to improve the quality of risk assessment sections within OASys.

The PDU to undertake dip sampling of responsible officers' OASys assessments.

PDU to undertake development sessions with responsible officers to re-emphasise the importance of raising risk of harm concerns in the Through the Gate process, with the prison resettlement team.

PDU to include, in discussion with responsible officers, the importance of fully investigating potential risks of harm to children.

It should be noted that all of these actions have now taken place, without exception.

Recommendations from Cumbria Partnership NHS Trust

To review and develop initial assessment documentation throughout CPFT to incorporate routine enquiry questions regarding domestic abuse. This should include all patients (aged 16 plus), regardless of gender, sexual orientation or cultural background. A further prompt for staff to consider any cultural differences may be added after further consultation has taken place.

To promote staff attendance at LSCB training whilst in-house training is being developed.

Lessons identified, and implemented, by the trust, were to update the domestic abuse policy to include flow charts to support staff when domestic abuse is either suspected or disclosed, and to promote information relating to domestic abuse through the existing Domestic Abuse Champions' network, so team leads can cascade this throughout teams.

26. Multi-agency recommendations

Strategic and operational:

Training that reinforces "front-line" risk identification, and risk management strategies for domestic violence and abuse, including **coercive control and the links between domestic abuse and sexual violence,** across all agencies. This training should encourage routine enquiry in practitioners and managers undertaking assessments, and those managing responses.

Review the MARAC **protocol** within multi-agency context.

Explore ways of enhancing GP responses to domestic abuse and coercive control that enhance outcomes for victims, perpetrators and children. This should emphasise the importance of GP representation with the MARAC process.

Explore methods of reaching out to employers – developing workplace domestic abuse policies through the existing champions' network.

Establish clear victim-focused referral pathways for victims of rape and sexual assault. **Consider integrating IDVA/ISVA services** so victims receive a joined up, cohesive offer from a single point of referral.

Implement the Domestic Abuse Housing Alliance (DAHA) scheme to ensure victims of domestic abuse, at whatever risk level, get the support they need.

Refresh local community engagement strategies; aim to build confidence in communities of statutory responses to violence and abuse, and ensure those statutory responses are increasing the opportunities for marginalised groups to feel, and be safer, because of those interventions.

Domestic Homicide Review Action Plan

Recommendation	Scope of recommendation ie local, regional or national	Action	Lead agency	Key milestones achieved in enacting the recommendation	Target date	Date of completion, outcome, and where evidenced
Training that reinforces "front-line" risk identification, and risk management strategies for domestic violence and abuse, including coercive control and the links between domestic abuse and sexual violence, across all agencies.	Regional.	Deliver advanced domestic and sexual abuse training package to front-line professionals who work with children and families. This training should encourage routine enquiry in practitioners and managers undertaking assessments, and those managing responses.	LSCB	Training has been reviewed and courses are available from September 2018.	Sept 18	

Recommendation	Scope of recommendation ie local, regional or national	Action	Lead agency	Key milestones achieved in enacting the recommendation	Target date	Date of completion, outcome, and where evidenced
Review MARAC Protocol within multi-agency context.	Regional.	Safer Cumbria Domestic and Sexual Abuse Strategic Board have undertaken a review and the new Protocol is out for consultation.	Cumbria Constabulary	Protocol out for consultation with expected sign-off at next meeting. Self-assessments booked for October and November 2018.	Dec 18 Oct/Nov 18	
Enhance GP responses to domestic abuse and coercive control.	Regional.	Ensure adequate training is offered and provided to GPs. Engage with the CCGs in north and south Cumbria to ensure GP surgeries share information and are represented at each quarterly MARAC.	CCGs		Dec 18	

Recommendation	**Scope of recommendation ie local, regional or national**	**Action**	**Lead agency**	**Key milestones achieved in enacting the recommendation**	**Target date**	**Date of completion, outcome, and where evidenced**
Develop and expand the Champions' Network.	Regional.	Champions' Network relaunch planned for Oct 18.	Women's Community Matters	Relaunched 8 Oct	Oct 18	
Develop workplace domestic abuse policies.	Regional.	Local authorities develop and update policies. Support private businesses to develop policies for their workforce.	Chief exec. Allerdale BC on behalf of Chief Exec. Group. Vicki Ellis, Cumbria Constabulary.	First meeting taken place. Existing policies have shared and meet again to discuss in Dec 2018. Requested an invite to join the existing chief officers business meetings. Made inroads with Sellafield, Nestle, and Iggesund Paper board. Business champions will be launched in Nov 18.	Dec 18 Nov 18	

Recommendation	Scope of recommendation ie local, regional or national	Action	Lead agency	Key milestones achieved in enacting the recommendation	Target date	Date of completion, outcome, and where evidenced
Establish clear victim-focussed referral pathways for victims of domestic abuse and sexual assault/rape. Need to consider early help and intervention, medium/high and very high-risk victims.	Regional.	Integrate the IDVA/ISVA services. Tender has been advertised for April 2019 in Oct 2018. Referral pathways to be clear, up to date, and available/promoted.	Safer Cumbria police and crime commissioner office lead.	High-risk service has been merged as of 1 May 2018. Medium/high-risk cases are being accepted by the service but is managed through the regular VS service provision. In developmental stage in preparation for new contracts due to be tendered on the 1 April 2019.	May 18 May 18 April 19	

Recommendation	Scope of recommendation ie local, regional or national	Action	Lead agency	Key milestones achieved in enacting the recommendation	Target date	Date of completion, outcome, and where evidenced
Implement the Domestic Abuse Housing Alliance Scheme (DAHA).	Regional.		Housing Providers / Authorities			
Refresh local community-engagement strategies.	Regional.	Develop a community engagement strategy. Develop awareness campaigns to increase opportunities for marginalised groups to access services and feel/be safer.	Safer Cumbria DA Strategic Group.	Will be discussed at the next meeting in December 2018.		
Information police forces hold on foreign nationals.	National.	Make a recommendation to the Home Office to consider requesting they update the PNC system with foreign nationals' crimes.	CSP chair.			

28. Appendix one: risk assessment tools

The DASH risk assessment is a structured, professional judgement risk assessment tool, which, like other SPJs, is designed to inform levels of risk, aid risk-management plans, and do so by using a common language because other practitioners from other disciplines use the same tool. The risk factors included are evidence-based, drawn from extensive research by leading academics in the field of domestic homicides, “near misses”, and lower-level incidents. The research base for each factor can be found in the practice guidance www.dashriskchecklist.co.uk.

The DASH guidance states that risk in domestic abuse situations is dynamic and can change very quickly. As and when things change, the risk assessment must be revisited and reviewed. The police use the police DASH model. First response staff complete the risk identification using the DASH questions. They will categorise the risk then the specialist officer will quality assure it and conduct the full risk assessment.

29. Appendix two: glossary of terms

ABE	Achieving Best Evidence
ACPO	Association of Chief Police Officers
ASC	Adult Social Care
AWO	Affordable Warmth Officer
CC	Cumbria Constabulary
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPFT	Cumbria Partnership NHS Foundation Trust
CPS	Crown Prosecution Service
CLCRC	Cumbria & Lancashire Community Rehabilitation Company
CSC	Children's Social Care
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist.
DHR	Domestic Homicide Review
DV or DA	Domestic Violence or Domestic Abuse
DI and DS	Detective Inspector and Detective Sergeant
EIA	Early Identification Advice
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabularies
HMPS	Her Majesty's Prison Service
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Report

IOPC (IPCC)	Independent Office Police Conduct
ISVA	Independent Sexual Violence Adviser
ISW	Independent Social Worker
LA	Local Authority
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conference
OIC	Officer in Charge
PC	Police Constable
Peter	Perpetrator
PVP	Protecting Vulnerable People
SARC	Sexual Assault Referral Centre
SW	Social Worker
TOR	Terms of Reference
VLO	Victim Liaison Officer

30. References

Director of Public Prosecutions Charging Guidance fifth edition.