Middlesbrough Community Safety Partnership

Domestic Homicide Review

Overview Report

'Jean'

Died October 2018

Chair David Hunter

Author Ged McManus

Date December 2020

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1 Introduction

1.1 In October 2018 following a call to the ambulance service, Jean was found to have passed away in her house. She had suffered multiple blows and strangulation. The perpetrator was arrested and subsequently found guilty of her murder, hereinafter referred to as her death. He was sentenced to life imprisonment with a minimum tariff of twenty-one years. Further details are contained at paragraph 13.3.4

1.2 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Jean[1], a resident of Middlesbrough prior to her death. The panel would like to offer their condolences to Jean's family on their tragic loss.

Jean's family said, 'She was their baby. She was a fun loving girl with a kind heart. When she was young she was a little ray of sunshine and no parent should have to bury their child, it haunts us. The family will never recover from her violent death. We just want to give her a big hug and tell her we love her. Jean's memory will live on in her children'.

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

1.4 Jean had been a victim of domestic abuse since the age of thirteen. She was in two long-term relationships with abusive men during the course of her life, and gave birth to five children. At the time of her death none of her children lived with her.

1.5 Jean's third known abusive relationship was with the perpetrator[2], who went on to murder her. It is believed that the couple first met in June 2018. The perpetrator moved into Jean's home within a few days of them meeting. The first report of domestic abuse was on 7 July 2018. Background information, collected during the review showed he was a violent abuser of women and other people. At the time he met Jean, two court orders were in place preventing him from contact with two separate women as a result of his abuse. He had also abused women in other relationships and had convictions for violent offences.

[1] A pseudonym chosen by the victim's family.
[2] See paragraph 3.2

1.6 The review will consider agencies' contact and involvement with Jean and the perpetrator from 1 May 2018, until Jean's death in October 2018. This time period was chosen because the start date was several weeks before Jean and the perpetrator met and formed a relationship. The panel thought that this was an appropriate period. Background information prior to 1 May 2018 is used in the report to provide context.

1.7 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and if they are understood and adhered to by their employees.

1.8 **Note:**
It is not the purpose of this DHR to enquire into how Jean died. That is a matter that has already been examined during the perpetrator's trial.

2 Timescales

2.1 Middlesbrough Community Safety Partnership were alerted of Jean's murder in October 2018. A decision taken quickly to hold a Domestic Homicide Review. The commissioning of the independent chair and author, and their availability, meant the DHR began on 8 February 2019 and was concluded on 18 October 2019. The DHR was suspended until post trial in May 2019 and to enable the family to be an integral part of the work.

3 Confidentiality

3.1 The findings of DHRs are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 A pseudonym chosen by Jean's family has been used to protect her identity. The family asked that the perpetrator should be known as that and not given a name. It is written using a lower case p to reflect the family's wishes.

4 Terms of Reference

4.1 The purpose of a DHR is to:

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

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

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

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

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe under Review

The DHR covers the period 1 May 2018 to the homicide of Jean in October 2018.

4.3 Case Specific Terms

Subjects of the DHR

Victim Jean aged 33 years

Perpetrator the perpetrator aged 24 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Jean as a victim of domestic abuse and what was the response?

2. Were the MARAC[3] procedures effective in protecting Jean from domestic abuse?

3. What knowledge did your agency have that indicated the perpetrator might be a perpetrator of domestic abuse and what was the response?

4. What services if any, or signposting, did your agency offer Jean and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Jean from seeking help for the domestic abuse?

5. What knowledge or concerns did the victim's family, friends and employers have about Jean's victimisation and did they know what to do with it?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Jean and/or the perpetrator?

7. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Jean and/or the perpetrator, or on your agency's ability to work effectively with other agencies?

8. What learning has emerged for your agency?

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

10. Does the learning in this review appear in other domestic homicide reviews commissioned by Middlesbrough? This term is for the DHR panel to respond to.

[3] A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. An Independent Domestic Violence Advocate (IDVA), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential. http://www.safelives.org.uk

5 Methodology

5.1 Following Jean's death, formal notification of the homicide was sent to Middlesbrough Community Safety Partnership by Cleveland Police on 10 October 2018. A Scoping Meeting took place on 30 October 2018, where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed on 31 October 2018. A trial date was set for the perpetrator in April 2019. In the meantime, work commenced on gathering the information needed for the review. The DHR review panel met five times.

6 Involvement of family, friends, work colleagues and wider community

6.1 The DHR chair wrote to Jean's family inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[4] leaflet.

6.2 Jean's parents and brother wanted to be integral to the review and met the panel chair and author. The family were supported by a worker from AAFDA. They provided useful background information about Jean's life, which is included at section 14 of this report.

6.3 Prior to her death Jean had not been employed for some time, although she had previously worked in a shop and as a waitress. Her family were not aware of any close friends. Neighbours living near to Jean made statements for the purposes of the police investigation but made clear that they did not really know her. The police also obtained statements from witnesses who knew Jean as a friend. These statements were made available to the chair and author by Cleveland Police and were considered when drawing up the picture of Jean's life. The DHR did not ask the statement makers for a verbal contribution.

6.4 Jean's family asked the review to consider what address was recorded on licence, what the perpetrator's licence conditions were on his release from prison and why he had not been recalled to prison when the domestic abuse was reported. They were unsure how she met the perpetrator.

6.5 Jean's family accepted an invitation to attend a panel meeting. The chair of the panel expressed the panel's condolences to the family at the start of the meeting. They provided a moving account of Jean's life and their experience of helping her, which assisted the panel to understand more about Jean. The panel were grateful to the family for their input and the chair agreed to write a letter thanking them for their attendance and input. The family received a copy of the report via their advocate and the family and advocate's feedback informed the drafting of the final version.

6.6 The perpetrator's offender manager delivered a letter to him from the independent chair of the review offering the perpetrator the opportunity to contribute to the review. A discussion took place highlighting the benefits of his involvement in the review. The perpetrator indicated that he did not wish to contribute to the review and that he was considering an appeal against his

[4] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

conviction. At the time of publishing this DHR, there has not been an appeal and in the DHR chair's experience it is extremely unlikely there will be one.

7 Contributors to the review/ Agencies submitting IMRs[5]

7.1	Agency	Contribution
	Cleveland Police	IMR
	South Tees Clinical Commissioning Group	Chronology
	Tees Esk and Wear Valleys NHS Foundation Trust	Short report
	National Probation Service (NPS)	IMR
	Durham and Tees Valley Community Rehabilitation Company (DTV CRC)	IMR
	Middlesbrough Recovering Together (MRT)	Short report
	My Sisters Place (MSP)[6]	IMR
	Harbour [6]	Short report
	Middlesbrough Children's Social Care	Short report

7.2 In addition, South Tees NHS Foundation Trust were asked to provide an IMR. The Trust provided maternity services to Jean during her five pregnancies and the panel thought that the Trust would be able to provide helpful background information to the review. However, the Trust was mindful that the episode of care for the last pregnancy ended in February 2016 some 26 months prior to the beginning of the review period. In addition, the Trust noted that the father of this child was not the perpetrator. Mindful of its obligations under the NHS Confidentiality Code of Practice (Department of Health 2003) they sought legal advice. On the basis of this advice the Trust's Caldicott Guardian[7] declined the request on the grounds that:

'…the information you have requested is excessive and does not fit the categories of being "relevant" or "proportionate" as detailed within the Home Office guidance that you have provided'.

[5] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Jean and/or the perpetrator.
[6] Organisations that support victims and families of domestic abuse.
[7] A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

7.3 The panel accepted this response and the Trust's offer of providing relevant and proportionate assurance as to the Trust's practice in a way that did not disclose personal sensitive information. This was through a comprehensive Management of Domestic Abuse Policy, which they has ratified in January 2019. The Trust advised that this was its first stand-alone domestic abuse policy. Previously, domestic abuse was an element of its adult and children's safeguarding policies for many years.

7.4 In addition, the Trust told the panel that all women who present for midwifery care are asked about domestic abuse. At their initial booking appointment, and at 16 and 28 weeks gestation as a minimum. This is part of the Trust's standard documentation. Additionally, if a woman presented with any concerning behaviours or injuries additional questioning would occur. This is in line with the NICE[8] pathway for pregnant women with complex social factors. If a disclosure was forthcoming the Trust's domestic abuse policy would support staff on their subsequent actions. This has been in place for many years and at least since 2005.

7.5 As well as the IMRs, each agency provided a chronology of interaction with Jean and the perpetrator including any decisions made and any actions taken. The IMRs considered the Terms of Reference (TOR) and considered if internal procedures were followed and if, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Jean or the perpetrator, nor had any involvement in the provision of services to them.

7.6 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator, over the time-period, set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to Jean and the perpetrator and any other action taken.

7.7 It should also provide an analysis of events that occurred, the decisions made, and the actions taken or not taken. If judgements were made or actions taken that indicate that practice or management could be improved, the review considered not only what happened but why.

[8] The National Institute for Health and Care Excellence

7.8 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.9 The IMRs in this case were of good quality and focussed on the issues facing Jean. They were quality assured by the original author, the respective agency and by the Panel chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

8 The review panel members

David Hunter	Independent Chair
Ged McManus	Author and support to Chair
Gordon Bentley	Senior Adult Safeguarding Officer, South Tees Clinical Commissioning Group
Karen Agar	Associate Director (Safeguarding), Tees Esk and Wear Valleys NHS Foundation Trust
Chris Motson	Detective Chief Inspector Cleveland Police
Anne Powell	Head of National Probation Service, Cleveland
Marion Walker	Head of Stronger Communities (lead for Middlesbrough Community safety Partnership)
Claire Moore	Domestic Abuse Operational Coordinator Middlesbrough Council
Erik Scollay	Director Adult Social Care, Middlesbrough Council
Kay Nicholson	Deputy Director of Operations, Durham and Tees Valley Community Rehabilitation Company (DTV CRC)
Vicky Franks	Change Grow Live[9]
Kirsty Madden	Service Manager, My Sisters Place

[9] A voluntary sector organisation specialising in substance misuse and criminal justice intervention projects in England and Wales

Suzy Kitching	Children's Social Care, Middlesbrough Council
Danielle Chadwick	Service Manager, Harbour
Rachel Burns	Health Improvement Specialist, Public Health, Middlesbrough Council
Helen Smithies	Assistant Director of Nursing (safeguarding) South Tees Hospitals NHS Foundation Trust

8.1 The panel was a representative review panel drawn from statutory and voluntary services with local knowledge and relevant expertise in relation to circumstances of the case.

9 Author and Chair of the overview report

9.1 David Hunter was chosen as the DHR independent chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. It was determined he had the skills and experience for the role. Ged McManus wrote the report. He is currently the independent chair of a Safeguarding Adult Board in the north of England (not in Cleveland or an adjoining authority) and has chaired and written previous DHRs and Safeguarding Adult Reviews. Both practitioners served for over thirty years in different police service (not Cleveland or Durham) in England. Neither of them has previously worked for any agency involved in this review. Ged McManus has chaired two previous DHRs in Middlesbrough. He was the DHR author for one of those.

The DHR commissioners did not identify any conflict of interest in the appointments.

10 Parallel Reviews

10.1 An inquest was opened and adjourned immediately following Jean's death. It was finalised without a hearing after the perpetrator's trial.

10.2 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action could be initiated by a partnership agency, the agency's own disciplinary procedures should be utilised; and remain separate to the DHR process.

11 Equality and diversity

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

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

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
  (a) P has a physical or mental impairment, and
  (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 All subjects of the review are white British. At the time of the review they were living in an area which is predominantly of the same demographic and culture.[10] There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.3 Domestic homicide and domestic abuse in particular is predominantly a gendered crime with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. For example in 2018 the Office of National Statistics homicide report stated;

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

[10] Middlesbrough is the most ethnically diverse local authority area in the Tees Valley, with a British Minority Ethnic population of 11.7% identified at Census 2011, an increase of 86% since 2001 and which is projected to grow further. www.middlesbrough.gov.uk/open-data-foi-and-have-your-say/about-middlesbrough-and-local-statistics/local-population-diversity

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

11.4 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed. Neither Jean nor the perpetrator ever came to the attention of Adult Social Care and therefore there was no opportunity to consider whether a care and support assessment was appropriate. The panel discussed in the light of information now available whether Jean would have had a level of need requiring a care and support assessment and concluded that she would on the basis that she was suffering abuse and was unable to protect herself. There is no evidence that a referral to Adult Social Care was made or considered in this case.

11.6 Financial exploitation, also referred to as economic abuse, is an ingredient of domestic abuse. Jean had not worked for several years and her income came from benefit entitlements and support from her family. Jean's convictions for theft and fraud probably illustrate the financial pressure she was under and when combined with her use of drugs and alcohol, it can fairly be said that she would have been vulnerable to financial exploitation by those who associated with her, including abusers 1 and 2.

11.7 The perpetrator did not work and his income seems to have derived from criminal activity as indicated by his convictions for robbery. His use of drugs and alcohol required financing and it is not unreasonable to say that he was likely to have obtained money from Jean and those around him.

11.8 The panel considered the relevance of age, marital status, pregnancy and maternity, religion and sexual orientation as factors in the review.

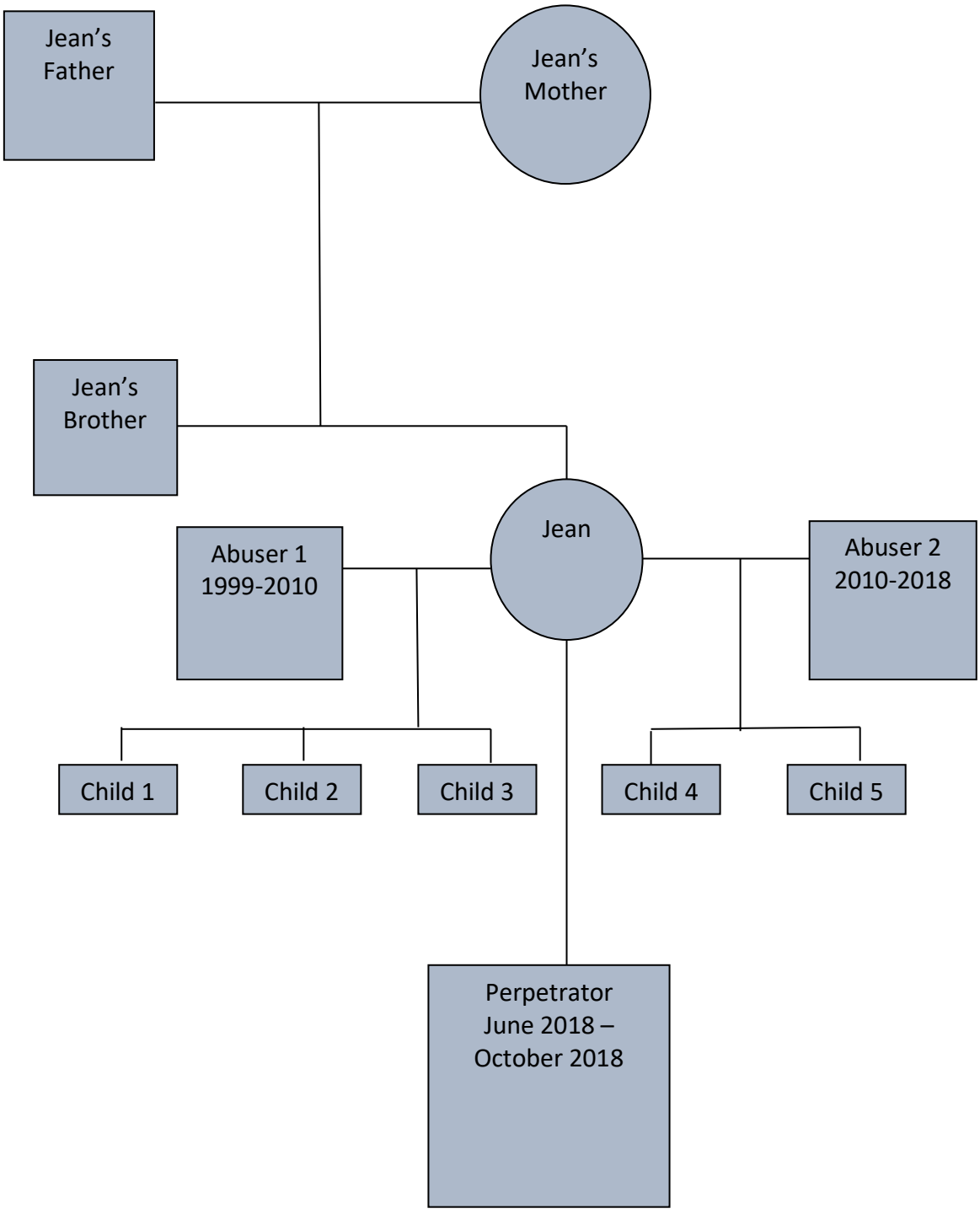
- The panel did not consider that the age of the victim or perpetrator was relevant and their age did not affect any services that they received.
- The couple were not married but their relationship was known to services.
- Jean had a number of pregnancies all of which were before the timescale of the review and before she met the perpetrator.
- Neither of the couple followed a particular religion and faith was not a significant part of their lives.
- The couple were hetrosexual.

The panel did not see any evidence that there had been either a negative or positive bias in the delivery of services in relation to the protected characteristics.

12 **DISSEMINATION**

Jean's family
Home Office
Middlesbrough CSP
South Tees Clinical Commissioning Group
Tees Esk and Wear Valleys NHS Foundation Trust
Cleveland Police
National Probation Service
DTV CRC
My Sisters Place
Harbour
Change Grow Live
Cleveland Police and Crime Commissioner
Advocacy After Fatal Domestic Abuse
The Middlesbrough Domestic Abuse Strategic Partnership
South Tees Children Safeguarding Partnership

Genogram depicting Jean's family and relationship's



13 Background, Overview and Chronology

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was structured in this way to avoid duplication of information. The information is drawn from documents provided by agencies, input from Jean's family and material gathered by the police during the homicide investigation.

13.1 Jean

13.1.1 Jean was born in Middlesbrough and brought up by both parents together with a sibling. She attended local schools until she was thirteen but following a number of difficulties that Jean experienced she stopped attending school. Jean experienced a number of problems in her life and it was known that used alcohol and drugs.

13.1.2 At thirteen years of age, Jean formed a relationship with Abuser 1 and experienced domestic abuse by him for 11 years. (Offences committed against her between the ages of thirteen and eighteen were not recognised as domestic abuse. The definition excluded anyone under eighteen). Police records show that between 2002 and 2011 there were sixty reports of domestic abuse. During this period, Jean had three children with Abuser 1. Following intervention from Children's Social Care and legal processes, all three children were placed with Jean's parents who have since brought them up. Jean's parents told the chair and author that when needed, they accessed services to support all the family.

13.1.3 From 2012 to 2016, there were no reports of domestic abuse involving Jean. During this time Jean had met and formed a relationship with Abuser 2 and the couple had two children.

13.1.4 In 2017, Cleveland Police began receiving reports of domestic abuse involving Jean as a victim of Abuser 2. There were nine reports up to June 2018 including assaults, criminal damage and theft. The couples deteriorating relationship and increasing evidence of drug and alcohol misuse led to Children's Social Care intervention. Eventually both children were permanently removed from Jean's care and placed outside the family.

13.1.5 In the year before her death Jean had been convicted of fraud and theft. The report prepared by National Probation Service for the court recorded that Jean felt pressured into the offence by Abuser 2.

13.1.6 Throughout Jean's experience of victimisation her family continually offered her support and refuge in the hope that she could be free from domestic abuse and return to a more stable lifestyle.

13.2. The perpetrator

13.2.1 Between 2012 and 2013, the perpetrator was in an abusive relationship with victim 1. The police recorded eight incidents of domestic abuse, including assault, where the perpetrator was noted to be the aggressor. Victim 1 obtained a non-molestation order against the perpetrator.

13.2.2 In 2014, the perpetrator was sentenced to six years imprisonment for a range of violent offences including robbery. Whilst he was in prison, victim 2 obtained a restraining order against the perpetrator in relation to an allegation of sexual assault. The perpetrator was released on licence under National Probation Service supervision in August 2017. The licence was due to expire on 24 August 2020.

13.2.3 Between leaving prison in August 2017 and forming a relationship with Jean in June 2018, the perpetrator is known to have had relationships with two other women, both women complained to the police about domestic abuse. Jean was to be his fifth known victim.

13.3 Jean and the perpetrator's relationship

13.3.1 It is thought that the couple met and formed a relationship in June 2018, soon after Jean's relationship with Abuser 2 broke down. It seems that the perpetrator moved into Jean's home within days and the relationship became abusive within the first few weeks. The first recorded instance of domestic abuse in the relationship was on 7 July 2018, when a third party, concerned for Jean's safety rang the police.

13.3.2 Over the following months, there were six reports of domestic abuse involving Jean and the perpetrator. In addition, Jean reported an assault on her and the perpetrator by Abuser 1.

13.3.3 One evening in October 2018, the couple went out together and the perpetrator bought alcohol, cannabis and diazepam. They returned home and spent the rest of the evening in the house. The following morning the perpetrator telephoned the ambulance service and claimed that he had found Jean injured. Paramedics

attended and found that Jean had died. It was clear to them that Jean had suffered severe injuries. They notified the police who attended.

13.3.4 The perpetrator was arrested and declined to answer questions. In a prepared statement he claimed that Jean had been alive when he had gone to sleep and that someone must have come into the house and attacked her. He maintained this defence during his trial. The court heard that Jean had suffered 85 blows but that the cause of her death was strangulation. The jury who heard all the evidence took two hours to return a unanimous verdict of guilty. The perpetrator was sentenced to life imprisonment with a minimum tariff of twenty-one years.

13.3.5 One friend said in a police statement after Jean's death.

'I wasn't shocked. Everyone knew he would kill her. People would regularly say he will kill her one day. I witnessed so many arguments and fights between them when they were walking past my house that it became normal to see'.

Chronology	**Events selected to represent important points in Jean's life.**
Date	**Event**
1999/2000	Jean contacted the young people's drug and alcohol service (alcohol consumption). Records showed history of abusive relationships from a very young age.
2002	Jean, 16 years was in a relationship with Abuser 1. Jean reported experiencing violence and abuse by abuser 1 every year from 2002 until 2007. In 2007 her case was heard at MARAC.
Before 2011	Three children born to Jean and Abuser 1.
2011	Jean began a relationship with Abuser 2.
2012/13	The perpetrator was in a relationship with victim 1. Eight reports of domestic abuse; he was the aggressor.
December 2014	The perpetrator sentenced to six years imprisonment for robbery, arson and having an article with a blade or point.
Before 2017	Two children born to Jean and Abuser 2.
2017/ 2018	Nine reports of domestic abuse involving Jean and Abuser 2
24 August 2017	The perpetrator released on licence under NPS supervision.
Late 2017	The perpetrator in relationship with victim 3. One report of domestic abuse; he was the aggressor.
November 2017	Jean did not attend the Freedom Programme.[11]
Early 2018	The perpetrator in relationship with victim 4. One report of domestic abuse; he was the aggressor.
21 June 2018	Police told NPS that Jean had new boyfriend (the perpetrator).

[11] Freedom Programme is a domestic violence programme primarily designed for women as victims of domestic violence.

22 June 2018	The perpetrator asked NPS for permission to reside with Jean. NPS needed to check with Jean and the police for any domestic violence incidents.
22 June 2018	Jean sentenced to a 12 month Community Order with a Rehabilitation Activity Requirement of 15 days for fraud offences. DTV CRC to supervise the order.
9 July 2018	Cleveland Police told DTV CRC about domestic abuse incidents involving Jean and the perpetrator
27 June 2018	Middlesbrough Council Neighbourhood Safety Team received a report of anti-social behaviour about the occupants of Address 1 (Jean and the perpetrator)
7 July 2018	Police attended Jean's house following a third party report of domestic abuse, including threats to kill, between her and the perpetrator. They spoke with the perpetrator and Jean who insisted nothing had happened. A DASH[12] risk assessment was completed and scored as medium risk.
9 July 2018	The perpetrator arrested for assaulting Jean in the street and released no further action. A DASH risk assessment showed medium risk.
22 July 2018	Police attended Jean's address and spoke to Jean and the perpetrator about a third party report of domestic abuse. Both were heavily intoxicated. No offences were disclosed. The perpetrator was removed from the premises by the police. A DASH risk assessment scored medium risk.
23 July 2017	NPS undertook a supervisory visit with the perpetrator at Jean's house. It is unknown whether Jean was present.
26 July 2018	Neighbours complained to the Council of anti-social behaviour from Address 1.
26 July 2018	Police attended Address 1 after a third party report of domestic abuse. They saw the perpetrator who appeared to be alone. No offences disclosed and no DASH risk assessment done.

[12] Domestic Abuse Stalking and Harassment (risk assessment) www.savelives.org.uk

31 July 2018	Jean telephoned the police and said the perpetrator had threatened to put her in hospital. An officer attended the following day but did not receive a reply.
3 August 2018	The police tried unsuccessfully to re-contact Jean.
4 August 2018	The police telephoned Jean; the perpetrator answered and said that she was not there. Later that day a police supervisor expedited the matter and an officer spoke with Jean. She denied calling the police and had no visible injury. DASH medium risk. next
5 August 2018	PVP support hub reassessed the DASH risk assessment and referred the now marked as high-risk case to MARAC and notified MSP, NPS and DTV CRC. Jean was contacted by a police domestic abuse support worker and declined support.
5 August 2018	MSP was unsuccessful in contacting Jean.
6 August 2018	DTV CRC made an unannounced home visit to Jean's address; there was no reply from the boarded up property.
6 August 2018	NPS PO1 (Probation Officer) visited Address 1 and spoke with Jean and the perpetrator. They denied any domestic abuse or being in a relationship.
10 August 2018	Jean told DTV CRC that she was the victim of an abusive relationship.
14 August 2018	DTV CRC visited Jean's address but did not make contact on this or two subsequent occasions.
15 August 2018	The perpetrator failed to attend NPS; no enforcement action taken.
24 August 2018	Police attended Address 1 to arrest Jean on warrant; the perpetrator denied she was present. Following additional information the police returned and arrested Jean on the warrant. A DASH risk assessment scored medium risk. The police informed NPS and DTV CRC about the incident.
24 August 2018	Court fined Jean £60 for theft.
24 August 2018	DTV CRC had their letter to Jean returned and marked, 'no letter box – address inaccessible'.

28 August 2018	DTV CRC telephoned Jean at her request. An unknown male answered. He had allowed her to use his telephone but she was not with him. Appointment arranged for next day.
29 August 2018	Jean did not attend her DTV CRC appointment.
30 August 2018	MARAC held for Jean and the perpetrator; five actions set.
3 September 2018	DTV CRC made appointment to see Jean on 12 September.
5 September 2018	Planned joint visit to Jean by both MSP and the police was cancelled due to police work pressures.
11 September 2018	MSP and police joint visit to Jean was unsuccessful in making contact with her.
11 September 2018	The perpetrator attended an appointment with NPS. He stated he was now residing with his uncle in Middlesbrough.
12 September 2018	Jean did not keep appointment with DTV CRC; breach proceedings started; court date 7 November 2020.
17 September 2018	NPS referred the perpetrator to alcohol misuse service.
19 September 2018	The Perpetrator failed to keep his appointment with the alcohol service.
19 September 2018	MSP and police completed a joint visit to Jean. Clare's Law disclosure not ready. A police officer indicated there was something to tell.
24 September 2018	Jean contacted MSP requesting support with housing. Appointment given for 28 September 2018. Jean did not attend.
2 October 2018	Jean told the police that she and the perpetrator had been assaulted by her ex-partner, Abuser 1. Photographs taken, safety advice given and a referral made to MSP. A DASH determined medium risk. No further investigative activity before Jean's death.
5 October 2018	Jean attended appointment with MSP following the referral. Safety planning done and a further legal appointment booked for 11 October 2018 to discuss a Non-Molestation Order (Abuser 1).

14 ANALYSIS

14.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Jean as a victim of domestic abuse and what was your response?

14.1.1 Jean was known by Cleveland Police and other agencies to have been a victim of domestic abuse at the hands of two abusers, over a period of nineteen years from 1999 to 2018. Previous incidents and relationships are not analysed here but provide context to Jean's experiences in her relationship with the perpetrator and the response of agencies.

14.1.2 Jean and the perpetrator's relationship first became known to agencies when police officers attended Jean's home to arrest her for an outstanding warrant on 21 June 2018. The perpetrator was present and the couple said that they had been together for about two weeks.

14.1.3 On 27 June 2018, the Middlesbrough Council Neighbourhood Team received an indirect report of anti-social behaviour coming from Jean's address. Whilst there was no other information about this, the chair and author identified that from experience in other reviews, that domestic abuse, in the way of loud arguments, crashing and banging is sometimes reported by third parties as anti-social behaviour. The links between reports of anti-social behaviour and reports of domestic abuse were not made in this case.

14.1.4 On 7 July 2018, police were called to Jean's house by a concerned member of the public, who said

'I can hear him like really shouting at her and threatening her and saying he's gonna kill her and batter her'.

Police attended and found that the couple had both been drinking and were arguing about their address being targeted by police looking for an ex-partner of Jean's (Abuser 2). Owing to previous police attendance the doors to the premises had been forced and were boarded up. The couple insisted that nothing had occurred and Jean did not want[13] to be spoken to alone. A DASH risk assessment was completed, Jean did not provide consent for the dissemination of the form and the risk assessment scored as medium.

14.1.5 The incident was reviewed by the PVP (Protecting Vulnerable People) support hub on 9 July 2018. As a result of the review it was apparent that Jean was being supervised by DTV CRC and an email was sent to DTV CRC on 9 July 2018, informing them of the incident. A police domestic abuse support worker

[13] The panel recognised that Jean's refusal may have been her way of staying safe.

was tasked to make contact with Jean. The assessment determined that the perpetrator was a serial domestic abuse perpetrator and a Clare's Law[14] request was submitted.

14.1.6 The purpose of Clare's Law is to provide members of the public with a way to make enquiries about an individual who they are in a relationship with, or who is in a relationship with someone they know if they suspect that the individual may be abusive toward their partner.
Anyone can make a request for disclosure if there is concern that an individual may harm their partner, not just the potential victim. However, just because a third party has made the application it does not always necessarily mean a disclosure is made to them; it may be more appropriate for someone else to receive the information.

14.1.7 The Right to Ask gives the victim (actual or potential), third parties (neighbours, friends and relatives) and agencies the ability to make an application to the scheme.

14.1.8 The Right to Know is when the police make a proactive decision to disclose details when they receive information to suggest a person may be at risk. This is the decision that Cleveland Police applied when making decision if they should disclose information about the perpetrator to Jean, but as described later (14.1.10) the actual disclosure was not made.

14.1.9 The referral for a Clare's Law disclosure was submitted by the PVP support hub on 9 July 2018. The Home Office guidance on processing Clare's Law disclosures (Domestic Violence Disclosure Scheme [DVDS]) outlines three steps which should be completed prior to deciding whether to make a disclosure. The guidance recommends that these steps and the referral to a multi-agency decision making meeting is completed within 20 days.

14.1.10 Following the initial application on 9 July 2018, the request took thirteen weeks to progress to stage one. During this time, several domestic abuse incidents were reported by Jean and the disclosure was never made. Cleveland Police state this was due to the pressure of work in terms of the volume of disclosures which had to be progressed at that time. The panel were assured by Cleveland Police that this issue had been addressed with further resources being applied and the process reorganised. Cleveland Police single agency recommendation 1 in the action plan at Appendix A refers to this issue.

[14] Clare's Law is the Domestic Violence Disclosure Scheme. It's named after Clare Wood, who was murdered in 2009 by her ex-boyfriend who had a history of violence against women.

14.1.11 Jean did not attend an initial appointment with DTV CRC on 27 June 2018. DTV CRC was notified by Cleveland Police of the domestic abuse incident of 7 July, but action was not taken until 6 August 2018 when an unsuccessful visit was made to her home and a calling card was left. The police notification should have raised concerns regarding the risk of harm to Jean and to the fact that no action had been taken in terms of the absence of 27 June 2018. Multi-agency liaison did not take place between DTV CRC and the National Probation Service to ascertain the current supervision status of the perpetrator, share risk information and contribute towards risk management planning in the light of new information pertinent to risk. There are no recorded attempts to obtain information from any other agencies. As an OASys[15] (Offender Assessment System) assessment had not been completed because Jean had not physically attending an appointment and therefore information gathering to inform the assessment was not commenced. Expected practice would be for information gathering by the Responsible Officer (RO) to commence at the point of case allocation and also occur when new information is received, such as information regarding domestic abuse risk of harm.

14.1.12 On 9 July 2018, a third party called police to a male screaming at a female in the street and pinning her against the wall. When police officers attended it was established that there had been a physical altercation between Jean and the perpetrator. Officers were approached by witnesses and it was established the incident was partially captured by CCTV. The perpetrator was arrested and detained until he was fit for interview as he appeared to be intoxicated by alcohol. He was later interviewed whilst still in custody and made no reply. Jean did not make a complaint in relation to the incident and the perpetrator was released without charge.

14.1.13 A DASH risk assessment was completed in relation to the incident. Jean did not answer any of the questions and the form was graded as medium risk. Later the same day the DASH risk assessment was reviewed by the PVP support hub. An email was sent to NPS informing them of the perpetrator's arrest and an email was sent to DTV CRC in respect of Jean. The information did not tell each probation agency that the other was also involved. A Clare's Law application was made (combined with previous incident).

[15] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the Probation service nationally from 2002 to measure the risks and needs of criminal offenders under their supervision.

14.1.14 The incident of 9 July was reviewed as part of the subsequent murder investigation and witnesses were spoken to.

One witness described: 'I noticed the male was pushing the female with both hands violently and shouting in her face. I could not hear what was being said but could clearly see what was happening. I was worried for the female as I felt that the female was not in a safe situation'.

CCTV of the incident was also viewed and whilst it is partially obscured, in the opinion of the reviewing officer it shows that the perpetrator pushed Jean. Statements were not obtained from witnesses at the time of the incident or subsequently, and the officer interviewing the perpetrator had not viewed the available CCTV. The investigation into this incident was poor and has resulted in a single agency recommendation for Cleveland Police. (Recommendation no 12)

14.1.15 On 22 July 2018, a concerned witness reported to the police what sounded like a domestic assault taking place at Jean's house. Police attended the address and spoke to Jean and the perpetrator. The couple were both heavily intoxicated and said that this had been a verbal argument in the street over money. No offences had been committed and the perpetrator was removed from the premises to prevent any offences taking place. A DASH risk assessment was conducted with the risk assessed as medium. PVP support hub reviewed the form on 5 August 2018 and shared information with DTV CRC and NPS. The support hub confirmed that a Clare's Law application had been submitted. This incident was dealt with appropriately within the information available to officers at the time.

14.1.16 On Thursday 26 July 2018, a witness called police with a concern that Jean and the perpetrator were constantly arguing and had been arguing for the past two to three days. An officer attended and found that only the perpetrator, who was asleep, was present at the address. Jean was not spoken to and nothing was done to check on her safety. Cleveland Police are to update their domestic abuse policy as a result and this forms a single agency recommendation. (Recommendation no 15)

14.1.17 On 31 July 2018, Jean contacted the police. She reported that she had been with the perpetrator for about six weeks and he had threatened to put her in hospital. She stated that she did not wish to be with him and that he had previously assaulted her. She now wished to make a complaint of assault and had visible injuries to show. She claimed that the perpetrator had previously

broken into her address to assault her and had taken her phone from her so that she could not contact Police. An officer attended the following day but did not receive a reply. The mobile phone number that Jean called police on was rung but there was no answer. Control room staff made a further attempt to call her at 2200 hrs on the same day and reported that the phone number did not ring and cut off straight away. On 3 August 2018 the police control room tried to re-contact Jean. The telephone did not connect.

14.1.18 On 4 August 2018, the police control room tried again to contact Jean. This time the perpetrator answered the telephone. He said that Jean was not there and that he would pass the message on. Given the information in the previous call that the perpetrator had previously taken Jean's phone this should have raised immediate concern for her safety. Later on 4 August 2018, the incident was reviewed by a supervisor. Having reviewed the history between the perpetrator and Jean and the content of the control rooms recent conversation with the perpetrator, they directed that a police officer attend the incident as a priority. An officer did then visit and speak with Jean. The perpetrator was not believed to be in the house. She denied calling the police and had no visible injury. Based on the details on the initial call a crime report for assault was recorded. The DASH risk assessment documented that Jean would not go through the questions, but the assessment was completed to the best of the officer's ability and the risk was recorded as medium.

14.1.19 The case was reviewed by the PVP support hub who reassessed the risk to be high and referred the case to the MARAC due to the volume of domestic incidents in a short relationship. As this was a high risk case a referral was sent to My Sisters Place. DTV CRC and NPS were notified in relation to both Jean and the perpetrator. Jean was contacted by a police domestic abuse support worker, she declined any support and stated that she was fine. The reassessment of the risk to high and the referral to MARAC were appropriate. This provides good evidence that the PVP support hub was effective in assessing the holistic risks of the case, as opposed to the risk seen in a single incident by the attending officer.

14.1.20 The five days between the initial report and the 'high' risk DASH are accounted due to two reasons. Firstly, the call was initially given a non-priority response and was not recognised as requiring a more urgent response until a supervisor realised some days later that it required one. Thereafter the police were unable to contact Jean immediately. The officer who made contact was unable to engage effectively with Jean and completed the DASH using limited information. The officer submitted the DASH to the PVP support hub so that a person more experienced in domestic abuse could assess the risk level using

information on the DASH and from other police databases. This is standard practice. The PVP support hub process identified the risk as high. All 'high' DASH assessments are referred within 24 hours to the next MARAC by the PVP support hub. Additionally, 'high' DASH cases are referred to My Sisters Place the same day and immediate support offered to the victim. This incident followed that process. Referrals to support agencies in high risk cases and those where the victim consents are now conducted by the immediate supervisor of the attending officer. This process involves the supervisor emailing the details of the DASH assessment/PPN form to the support agency allowing for a timelier referral.

14.1.21 On 6 August 2018, an NPS probation officer conducted a home visit to see the perpetrator. The probation officer saw both Jean and the perpetrator who denied that the reports of domestic abuse were true. The perpetrator denied that he was in a relationship with Jean despite previously telling NPS that he was. The DHR panel noted that it was inappropriate for the probation officer to see Jean and the perpetrator together to discuss domestic abuse.

The National Offender Management Service (NOMS) Domestic Abuse guidance states: 'While it is of vital importance for staff to be curious and inquisitive to help identify domestic abuse, it is equally important that victims are not put at risk as a result. Staff should always be mindful of the potential risks to a victim when gathering information, making referrals, and recording and storing information. Systems and procedures must be put in place to ensure that risk to victims is minimised.' The NPS IMR author noted, 'Offender Managers are required to use their professional judgement. It is unclear from records whether Jean was spoken to in the presence of the perpetrator, although it is acknowledged they were both present at the property. There is an expectation that conversations would be bi-lateral if it was considered risk of serious harm would be increased otherwise but also to provide an environment where the victim felt safe to disclose'.

The NPS has made a wide-ranging recommendation on domestic abuse. It is: 'Home Visit Guidance is reviewed and re-issued to all staff in order to reiterate the importance of home visits and the purpose of them in identifying and addressing risk factors, particularly where there is a history of domestic abuse'.

14.1.22 On 10 August 2018, Jean did not attend a pre-arranged appointment with DTV CRC. However, she contacted the Responsible Officer by telephone and stated that she barely left the house and was the victim of an abusive relationship. A home visit was arranged for 14 August 2018. When the Responsible Officer

attended on 14 August there was no reply to knocking. The DTV CRC Responsible Officer in this case demonstrated an inadequate response to the escalating concerns in relation to the domestic abuse and increasing risks Jean was experiencing. This was highlighted by information shared by Cleveland Police, disclosures by Jean herself and information given by neighbours during the home visit. This should have prompted a discussion with the line manager, where next steps and risk management strategies could have been explored. This did not happen.

14.1.23 On 24 August 2018, police attended at Jean's house intending to arrest her on an outstanding arrest warrant. Upon initially searching the premises police were told by the perpetrator that Jean was not present and left. Within ten minutes of leaving the police were called back to the address by a concerned witness. The witness reported that police had been to the address and there was now a domestic incident occurring and shouting could be heard from the address. Police re-attended the address which was quiet on arrival. Following a search of the premises they arrested Jean who had been hiding in the loft. The domestic abuse was reported as a verbal argument with no offences being disclosed. There were no signs of a disturbance.

14.1.24 A DASH risk assessment was completed but Jean did not answer questions, it was graded as medium risk. The case was reviewed in the PVP support hub on the following day and information in respect of the incident emailed to both Jean and the perpetrator's probation workers. A further follow up call was made to Jean, which she did not answer.

14.1.25 On 30 August 2018, a MARAC meeting was conducted which discussed Jean and the perpetrator's case. Present at MARAC were: My Sisters Place, Sanctuary, Harbour, NPS, MRT, HMP (Her Majesty's Prison) Holme House, Thirteen Group (housing), Middlesbrough Council Children Services, Safeguarding Nurses, Middlesbrough Council Adult Services and Cleveland Police. Durham Tees Valley CRC and South Tees NHS Foundation Trust and Tees Esk and Wear Valleys NHS Foundation Trust did not attend but did provide information for the meeting. The number of agencies represented or providing information to the meeting meant that there was significant information sharing and that the risks in the relationship between Jean and the perpetrator were then well known to agencies. Further consideration of this meeting is at paragraphs 14.2 et al.

14.1.26 On 19 September 2018, as a result of the MARAC meeting, the police and MSP undertook a joint visit to Jean. She was spoken to through the window of her

house as both doors were boarded up. (Jean and the perpetrator were accessing the house by climbing through windows). Jean declined support and said that calls to the police had been her ex-partner causing trouble. MSP were aware that there was an urgent Clare's Law disclosure outstanding in relation to the perpetrator and asked the police if this could be completed. They were advised this was not possible, as there was a backlog of disclosures and the officer did not have the appropriate information. The disclosure was not completed at that time. The officer did indicate to Jean that there would be a Clare's Law disclosure.
The officer who attended knew the case had been to MARAC and did not judge that the circumstances observed required any immediate intervention. The doors had been boarded up for at least three weeks. The DHR panel thought that the boarding up of the doors had been done to secure the property as opposed to a means of 'imprisoning' Jean. The DHR panel recognised that in an emergency Jean's egress through a window would have disadvantaged her.

The DHR panel thought either the police or MSP could have considered whether the sanctuary scheme[16], or a police crime prevention officer, had a role to play in assessing the property to determine what the victim needed to help her feel safer in the house. This could have involved contact with the landlord. The sanctuary coordinator can, in some circumstances, fund repairs and/or approve the installation of a new door.

14.1.27 On 2 October 2018, Jean contacted the police reporting that both she and the perpetrator been assaulted by her ex-partner, Abuser 1. She reported that the perpetrator had been knocked unconscious and Abuser 1 had assaulted Jean by punching and kicking her. Abuser 1 had left the scene and so advice was given to Jean for her and the perpetrator to return home and await police attendance.

14.1.28 Later the same day the police control room contacted Jean who confirmed that she had a few bruises and that there had been no further issues with Abuser 1. The investigation was assigned to an officer on 3 October 2018. The following day they made contact with Jean and completed a DASH risk assessment graded as medium risk. Arrangements were made to speak with Jean on 10 October in order to obtain a statement. Jean indicated that the door

[16] To prevent homelessness due to domestic abuse and to help you feel safer by adding additional security measures to your own property which can include a safe room, window locks, new door locks and other security measures. https://www.middlesbrough.gov.uk/community-support-and-safety/sanctuary-scheme

to her property was broken and the officer contacted the landlord of the property to advise them of this problem. The DASH risk assessment was reviewed by the PVP support hub and the respective probation workers for Jean and the perpetrator were notified. A referral was made to My Sisters Place. Although there was an outstanding suspect for a domestic abuse assault there was little urgency shown in the investigation and no progress was made before Jean's death.

14.1.29 On 5 October 2018, MSP contacted Jean following a police referral. She told them that she was on her way to the MSP office. Jean was seen by a MSP worker and said that she had been assaulted on 1 October by an ex-partner. (Abuser 1). She was staying with a friend and asked for support with housing. A police photographer attended MSP to take pictures of Jean's injuries. A legal appointment was arranged and she was signposted to debt advice. Jean did not discuss her relationship with the perpetrator during this appointment and this was a potential missed opportunity given the recent history of domestic abuse from the perpetrator. However, the worker who saw her was responding to Jean's immediate needs following the assault by Abuser 1. The panel heard that Jean's request for help with housing would have been further addressed the following week had it not been for her murder.

14.1.30 The panel considered whether there was evidence that the perpetrator had subjected Jean to coercion and control and in doing so referred to the Crown Prosecution Service's policy guidance.

14.1.31 The Crown Prosecution Service's policy guidance on coercive control states:[17]

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services

[17] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.1.32 The panel saw that Jean has been subject to a significant volume of domestic abuse incidents in a short space of time. The perpetrator had twice threatened to kill her, pinned her against a wall on another occasion, engineered for himself to receive one of her calls by insisting she used his telephone and financially exploited her by taking her money. Additionally the perpetrator took away her telephone so she could not contact the police. The panel thought

that, together, these examples provided strong evidence of coercive control which was very likely to have intensified during the relationship.

14.2 **Were the MARAC procedures effective in protecting Jean from domestic abuse?**

14.2.1 Cleveland Police Domestic Abuse Policy October 2019[18] states:

3.6 Multi Agency Risk Assessment Conference (MARAC)

3.6.1 MARACs are recognised nationally as best practice for addressing cases of domestic abuse that are categorised as high risk.

3.6.2 …All cases reaching a 'high' risk under the Domestic Abuse Stalking and Harassment (DASH) model will be considered by the independent MARAC chair and MARAC coordinator. All MARAC referrals are screened and accepted or declined from the process by a panel within Safeguarding, once accepted, they are presented to the chair. This gate keeping system is essential as the MARAC can only function effectively with a limited number of referrals and so these must be prioritised. Any high risk cases not proceeding to MARAC will be notified to the referrer. This will often be because the chair feels that sufficient safeguarding has already been done.

3.6.12 Cases can be referred to MARAC by any agency signed up to the Information Sharing Protocol (ISP). Once a victim has been identified as high risk a referral should be made to the lead agency usually the police. Additionally, it is appropriate to refer cases into MARAC for which the risk of harm has been identified as a significant concern by the Domestic Violence Disclosure Scheme Panel.

The policy does not include a referral criteria based on number of incidents in a set time. The policy does allow for referrals using professional judgement. The PVP support hub will review all DASH risk assessments that are graded as high and medium. They will also review standard cases where there have been three incidents within the last three months. Part of this review conducted by the PVP support hub will be to consider MARAC referral as per the above.

[18] https://www.cleveland.police.uk/SysSiteAssets/foi-media/cleveland/publication-scheme/our-policies-and-procedures/9-domestic-abuse-policy-v1.10_redacted.pdf

The panel thought that Middlesbrough Community Safety Partnership should review whether to introduce a MARAC referral criteria based on repeat referral as supported by SafeLives[19].

14.2.2 Jean's case was heard at a meeting on 30 August 2018 and the following actions set.

Action	Update
MATAC [20] referral	closed as no longer a MARAC case
Clare's Law referral	completed
Complete joint visit (see below) between MSP and police	completed
Update social worker	open
Probation to update on licence for the perpetrator and housing situation	completed

There are no further MARAC notes in relation to Jean or the perpetrator. The update shows that the MATAC referral was closed as the case was no longer in MARAC. In fact the MATAC referral was rejected rather than opened and closed.

A joint visit is a local tactic tried where domestic abuse agencies have been unable to engage with victims. It has had local success in that engagement sometimes take place after a joint visit. The visits are used regularly in an attempt to engage victims in a safe way. The police offer legitimacy if a perpetrator is present. Services turning up unannounced does not promote a trusting relationship. Planned joint visits can break down barriers and help to support engagement with police in future.

14.2.3 The MATAC process was established in Middlesbrough on 27 June 2018 and was therefore within the first few weeks of implementation at the time of the events discussed. The objective of the core process for MATAC is to ensure that agencies work in partnership to engage serial domestic abuse perpetrators, take enforcement action where required and to protect vulnerable and intimidated victims and their families.

[19] https://safelives.org.uk/definition-repeat marac#:~:text=SafeLives%20defines%20a%20'repeat'%20as,of%20coercive%20and%20controlling%20behaviour.

[20] Multi-Agency Tasking and Coordination protocol. See paragraph 14.2.3

14.2.4 There was confusion over the referral to MATAC. The MARAC chair clearly expected that, by making the referral, MATAC would take action in relation to the perpetrator.

Conversely the MATAC co-ordinator provided information to the panel that: 'The remit of MATAC is that we look at serial perpetrators, but excludes those who are being managed by any other process. As MARAC is a multi-agency process and have similar agencies involved they can task perpetrator actions, in the same way the MATAC will deal with safeguarding of victims as part of our process in dealing with the perpetrator. Whilst that action was created at MARAC we will simply have referred it back to them and no further record or actions were taken'.

It was generally agreed during this review that there were misconceptions as to the nature and remit of MARAC. In effect, MARAC is a risk management and safeguarding multi-agency process and panel which gathers, assesses and evaluates up to date information surrounding post incident risk (the incident that leads to the referral to MARAC). Agencies should not under any circumstances delay any immediate safety measures or information sharing amongst key agencies until it is heard at MARAC. A risk analysis and action plan are formulated for each MARAC case. MARAC does not continue managing or coordinating each MARAC case. It is heard initially and then discharged with an action plan. It will only be heard again in MARAC as a repeat MARAC case, if MARAC receives a referral and it is accepted within the 12 months of the case initially been heard. Outside of the 12-month period a new MARAC referral would need to be submitted and accepted.

14.2.5 Section 14 of the Cleveland MATAC protocol states:

14. LINKS TO EXISTING MULTI AGENCY GROUPS

There are a range of policies, services and groups intended to address perpetrator behaviour and safeguard victims of domestic abuse and their families. Partners will work to complement these existing multi-agency groups by understanding their remit and practices and not seek to encroach on any existing interventions where they are identified. Cleveland Police will be responsible in the first instance to identify where intervention already exists.

14.2.6 The effect of that confusion was that nothing was done in order to attempt to manage or change the perpetrator's behaviour.

14.2.7 The panel heard from the MATAC project manager that the issues identified by the panel had been identified and addressed since the events identified in the report. MATAC was introduced in June 2018 and at the time of the referral in this case, it was still being established and the processes were not completely clear. This has now been addressed and a clear process has been established in relation to the primacy of MARAC/MATAC.

14.2.8 The action to complete a Clare's Law referral was superfluous as the referral had already been made several weeks earlier. The panel was told that the independent MARAC chair had been concerned about the time taken to complete MARAC referrals and as a result a new process has been put in place which means that where necessary and proportionate a disclosure can be made directly and quickly following a decision at MARAC without going through the Clare's Law process.

14.2.9 The action for a joint visit to Jean by MSP and the police did result in a visit taking place on 19 September 2018. The detail of the visit has already been discussed at paragraph 14.2.2.

14.2.10 It is unclear what the action 'update social worker' means. It is thought to refer to updating the children's social worker with responsibility for Jean's children regarding the current situation. It does not appear that this was done.

14.2.11 The action 'Probation to update on licence for the perpetrator and housing situation' is shown as being completed. NPS were aware that the perpetrator was living with Jean although he had at one point denied that they were in a relationship. The NPS information provided to the meeting did not fully disclose up to date information in relation to the risk issues around previous domestic abuse nor that a Restraining Order was in place in respect of another victim.

14.2.12 The incident which gave rise to the MARAC referral took place on Tuesday 31 July 2018. The referral was made four days later on Saturday 4 August 2018 after Jean had been seen by an officer on Friday 3 August 2018. This missed the cut off date of 3 August 2018 for the next MARAC meeting which was to take place on 16 August 2018 and was therefore delayed until 30 August 2018, eighteen working days later. The panel thought that this took too long given the nature of the risks in Jean's case. However safety planning and other practical steps to support victims should not wait for the next MARAC; such actions should be taken in real time.

On 6 August 2018 MSP received the police referral regarding the domestic abuse incident reported to police on 31.07.2018. MSP telephone Jean on 6 and 7 August 2020 but did not make contact. On 7 August 2018 MSP e-mailed the police to review if a MARAC referral had been made as detailed on the referral as the case was not listed for next meeting (15.08.2018) and also to review if further police safety planning was required. This demonstrated that MSP was monitoring MARAC case progression.

14.2.13 Following the MARAC meeting it took until 19 September 2018, a further fourteen working days, for the joint police and MSP visit to Jean to take place. This was following an arrangement to visit on 5 September 2018 that was cancelled by the police due to other work pressures and an unsuccessful visit on 11 September 2019. The panel thought that this took too long given the nature of the risks in Jean's case and other opportunities to complete the visit should have been sought. The visit was an opportunity to carry out the Clare's Law disclosure which had been authorised but not processed at that time due to the volume of other work. This was a missed opportunity. Jean was given information on how to contact MSP and offered support with regard to her housing situation. She did in fact contact MSP a few days later on 24 September 2019, to ask for help and to that extent the visit had a positive impact. At the relevant time Cleveland Police had a substantial backlog of disclosures. The panel was assured that additional resources have now been provided and the backlog has been eliminated.

14.2.14 Overall the panel felt that the MARAC did have some impact by arranging the joint visit by police and MSP which was in part successful because Jean accessed help from MSP a few days later. As stated previously, this is the aim of 'joint visits'.

14.2.15 The panel considered what else MARAC could reasonably have done in the circumstances. One option would have been a referral to Multi Agency Public Protection Arrangements (MAPPA) in order to bring a multi-agency perspective to bear on the management of the perpetrator. The perpetrator was already being managed at MAPPA level 1 and a further referral would have ensured that consideration was given to him being managed at MAPPA level 2, which would have brought more intrusive risk management and partnership oversight to bear.

14.2.16 At the time of this referral to MARAC, actions were not reviewed. This meant that the chair of MARAC was unaware that MATAC had declined the referral

and that nothing would be done. The panel thought that a process of reviewing MARAC actions would in general be likely to improve outcomes.

14.3 **What knowledge did your agency have that indicated the perpetrator might be a perpetrator of domestic abuse and what was the response?**

14.3.1 Cleveland Police were aware that the perpetrator was a domestic abuse perpetrator and had records of his abusive behaviour towards four previous partners. Cleveland Police first became aware of the relationship between Jean and the perpetrator on 21 June 2018, when officers attended at Jean's house in order to arrest her and saw the couple tidying the garden. An officer correctly submitted an intelligence report which was appropriately shared with NPS the same day.

14.3.2 The perpetrator was released from prison on licence under National Probation Service supervision on 24 August 2017 and remained on licence and under NPS supervision until he was arrested for Jean's murder. He was assessed by NPS as presenting a high risk of serious harm to the public, low risk of harm to known adults, children and staff using OASys.

The definitions of Risk of Serious Harm levels, as defined by the National Offender Management Service are as follows:

Very High Risk of Serious Harm *(there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious);*

High Risk of Serious Harm *(there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious);*

Medium Risk of Serious Harm *(there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse);*

Low Risk of Serious Harm *(current evidence does not indicate likelihood of serious harm).*

14.3.3 The perpetrator was subject to the following standard licence conditions.

a) be of good behaviour and not behave in a way which undermines the purpose of the licence period;

b) not commit any offence;

c) keep in touch with the supervising officer in accordance with instructions given by the supervising officer;

d) receive visits from the supervising officer in accordance with instructions given by the supervising officer;

e) reside permanently at an address approved by the supervising officer and obtain the prior permission of the supervising officer for any stay of one or more nights at a different address;

f) not undertake work, or a particular type of work, unless it is approved by the supervising officer and notify the supervising officer in advance of any proposal to undertake work or a particular type of work;

g) not travel outside the United Kingdom, the Channel Islands or the Isle of Man except with the prior permission of your supervising officer or for the purposes of immigration deportation or removal.

In addition, the following specific conditions applied;

- Attend Probation appointments, as reasonably required by your supervisor, to give a sample of oral fluid/urine in order to test whether you have any specified Class A or specified Class B drugs in your body, for the purpose of ensuring that you are complying with the condition of your licence requiring you to be of good behaviour.
- To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your substance misuse problems.

14.3.4 The perpetrator was managed at MAPPA level 1. On 28 May 2018 a MAPPA level 1 review was completed by PO1 however there was no indication of whether level 1 management was appropriate at that time. (This was before the perpetrator's relationship with Jean). A senior probation officer reviewed all MAPPA level 1 cases (28 in all) with PO1 in supervision sessions, including the perpetrator's and PO1 did not raise any concerns in relation to his case. High risk of harm cases should be reviewed every six months unless there is an escalation in behaviour that warrants a review being done sooner. The next review for the perpetrator was scheduled in November 2018. It is expected practice that MAPPA levels are reviewed when there is evidence of escalating behaviour, had PO1 taken concerns around the issues emerging to a Senior Probation Officer, expected practice is that a referral to MAPPA Level 2 would

be considered when addressing risk management plans. The panel noted that the perpetrator was assessed as presenting a low risk of serious harm to children. Nowhere in the papers seen by the panel was the risk to children from exposure to domestic abuse considered. There is undisputed evidence that children living in a home where domestic violence happens are at risk. The panel felt that the danger to children may have been overlooked. The panel acknowledged that no children were in fact exposed to domestic abuse in this case. The panel heard that the assessment that the perpetrator presented a low risk of harm to children was based on the fact that at the point of release from prison he did not have access to children and that the risk assessment should have been revisited dynamically if that had changed. The panel felt that the perpetrators conduct after 28 May 2018, represented an escalation in behaviour, evidenced by a referral to MARAC, and merited a further review of his MAPPA status.

14.3.5 On 22 June 2018, a PO1 visited the perpetrator at the relative's house where he was living according to his licence conditions. The perpetrator asked if he could move to live with Jean at her home. PO1 said that Jean would need to be spoken to and checks completed before that would be possible.

14.3.6 On 27 June 2018 an email was sent by PO1 to Cleveland Police requesting information regarding any convictions or domestic abuse information in relation to Jean. PO1 confirmed the perpetrator had been on licence since August 2017 and that he had no risk concerns in relation to substance misuse or potential domestic abuse. The perpetrator had a history of domestic abuse in relation to previous partners and it was therefore wrong for PO1 to state there were no risk concerns in relation to potential domestic abuse. PO1 did not ensure the police were fully appraised of the history of domestic abuse and the Restraining Order that was in place in relation to a previous partner. This is not in line with expected practice. Cleveland Police provided information to PO1 from the Police National Computer in relation to Jean. The email sent also outlined that there was a long history of Jean being abused by her previous partner.

14.3.7 As there was evidence of the perpetrator being in a new relationship an OASys review should have been completed to update the risk management plan and inform sentence planning including reviewing the Spousal Assault Risk Assessment (SARA) however this was not undertaken. SARA's assists criminal justice professionals to predict the likelihood of domestic abuse. The tool is a quality-control checklist that determines the extent to which a professional has assessed risk factors of crucial predictive importance according to clinical and empirical literature. The manual for SARA defines spousal assault as:

'Any actual, attempted or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or has had, an intimate, sexual relationship'.

The SARA tool is intended for use with all offenders as it is not limited to gender, or victim or perpetrator ethnicity, or physical injury alone. The tool should be seen as a systematic method of collecting, assessing and combining information into risk assessments - which is defined as 'structured professional management judgement'.

Had a SARA been completed, relevant risk areas from this would have informed risk planning. Areas that are flagged within a SARA should then be addressed within sentence planning and risk management plans. This could have been a protective factor for Jean.

14.3.8 On 4 July 2018, PO1 sent an email to a Senior Probation Officer (SPO1) with details of the perpetrator's proposed new address at Jean's house. This was in an adjoining NPS area and PO1 was instructed to send the details to SPO2 who was responsible for that area. PO1 stated in the email that he had spoken to Jean who denied being in a relationship with the perpetrator but said that it would be okay for him to live at her house. PO1 again stated that he had no concern in relation to domestic abuse or substance misuse. PO1's assertion was inexplicable given the evidence. The NPS IMR author and DHR panel have been unable to obtain an explanation due to ongoing internal NPS procedures and PO1 leaving NPS.

14.3.9 On 23 July 2018, PO1 visited the perpetrator at Jean's house, this was the first time PO1 had seen the perpetrator since 22 June 2018. (The perpetrator was assessed as posing a high risk of harm and should have been seen every week.) By this time, three instances of domestic abuse had been reported. There is no record of Jean being spoken to at this visit.

14.3.10 On 6 August 2018, PO1 again visited the perpetrator at Jean's house. PO1 was by now aware that there had been reports of domestic abuse between the couple and spoke to both of them. They both denied that any abuse had taken place or that they were in a relationship. The perpetrator said that he was looking to move to another address.

14.3.11 The communication with a Senior Probation Officer in the adjoining area that PO1 had been instructed to make did not happen until 8 August 2018. By that

time the perpetrator had moved into Jean's house and five instances of domestic abuse had been reported.

14.3.12 From 8 August 2018, PO1 was on leave for two weeks and temporary management arrangements were put in place for the perpetrator. He did not attend appointments as instructed but no action was taken.

14.3.13 On 11 September 2018, the perpetrator attended an appointment with PO1 and said that he was now living at a relative's house. Expected practice would have been for PO1 to conduct a home visit to check on suitability. This did not happen and there is no record of a check being made with Jean to see if the perpetrator had moved out of her house. During the following days a number of referrals were made to other agencies including: alcohol treatment; accommodation; education; training and employment. There is no evidence within NPS records that the perpetrator was given permission to reside at the new address in accordance with his licence conditions.

14.3.14 During the period covered by the review, case records indicate the perpetrator was seen for supervision by his Offender Manager, PO1, five times. The expected practice in managing a high risk of harm offender is weekly supervision and this can be more when the risk is deemed to require it. In addition, this poor management meant that the perpetrator's risks were not adequately reassessed once the relationship with Jean became known. The panel concluded that NPS expected practice around the supervision of the perpetrator was not undertaken. Appropriate supervision could have been a protective factor for Jean.

14.3.15 The panel discussed, given that the perpetrator was on licence whether there would have been the potential to recall him to prison once the escalating risks in his relationship with Jean became known. The panel were aware that the perpetrator had been involved in domestic abuse incidents with two other women since his release from prison and thought that this showed a clear pattern of behaviour which taken together should have prompted a more assertive response.

However, the domestic abuse incidents relating to two previous victims took place in the Durham Constabulary area and details of them were not shared by Durham Constabulary with NPS. The panel heard that there is no policy regarding proactively sharing this type of information with NPS.

The panel heard that the perpetrator had been released from prison to an address in the Cleveland NPS area and that this had been appropriately notified to Cleveland Police. However, he quickly moved to the Durham area. This move

was not notified to Durham Constabulary and the panel was told that there is no NPS guidance or process to indicate that this should happen in routine cases.

Notification would have been made had the perpetrator been a sex offender or a domestic abuse offender moving in with an intimate partner, but that was not the case.

The panel thought that taken together this showed that there was a significant deficit in information sharing between the two organisations in this case. The DHR panel thought it would be useful to escalate the actions regarding NPS and Durham Constabulary to the Home Office as these could be relevant nationally.

14.3.16 Jean's family believe that the perpetrator should have been recalled to prison as a result of his behaviour, which they feel breached his licence conditions. The panel heard from NPS that a number of factors are taken into consideration in relation to a recall to prison. For example, whether or not there are any charges brought, whether whereabouts are unknown, engagement to date and if the person's behaviour has become unmanageable in the community.

In this case expected practice would have been for PO1 to have discussions with a Senior Probation Officer. In light of no charges being brought, the denial by the victim and the perpetrator that they were in a relationship or that any incident had occurred, a lack of NPS knowledge about other domestic incidents since release and his whereabouts being known - it would have been unlikely that the perpetrator would have been recalled at that time. However, other risk management plans could have been put in place such as, a direction to reside at an approved premise.[21] The perpetrator could also have received a verbal or written warning about his breaches of licence.

14.3.17 The panel asked what the NPS response should have been if the domestic abuse incidents involving two previous victims in the Durham Constabulary area had been known to them. The panel was told that had NPS known about the previous domestic abuse incidents reported to Durham Constabulary, then expected practice would have been for PO1 to have had risk discussions with a Senior Probation Officer at the time of the information coming to light.

[21] Probation hostels (approved premises), are located in the community and occupied by some of the riskiest individuals as they are released from prison. They act as a half-way house between prison and home, and have two main roles: to help rehabilitate and resettle some of our most serious offenders, and to make sure that the public are protected in the offenders' early months in the community.

It would have been expected that risk management plans were put in place at that point and a potential move to approved premises considered. Enforcement action and recall discussions should have taken place and a decision made on the facts available at that time. The perpetrators MAPPA management level should have also been reviewed.

14.3.18 As described in paragraphs 14.1 et al Cleveland Police responded to seven incidents of domestic abuse involving Jean during the time-period of the review. On most occasions Jean did not tell officers what had happened. However, when the perpetrator was arrested for assaulting Jean on 9 July 2018, as a result of third party information, a poor investigation led to him being released without charge. When Jean wanted to make a complaint on 31 July 2018, it took five days for Cleveland Police to see her about the matter and by then she did not want to make a complaint.

14.3.19 The police could, on a number of occasions have considered an application for a Domestic Violence Protection Notice (DVPN) [22] and subsequent Domestic Violence Protection Order (DVPO). There is no evidence that this protective measure, which would have removed the perpetrator from Jean's house and prevented him from contacting her, was considered. Had a DVPO been granted there would have been a window of opportunity for professionals to support Jean without the perpetrator's influence. The panel noted that the perpetrator was subject to court orders not to contact two other women he had abused. There is no evidence that he breached those orders and therefore the panel concluded that a DVPO would have had a reasonable chance of success. It seems that applying for DVPN and DVPO was not mainstream practice for Cleveland Police.

Cleveland Police Domestic Abuse Policy October 2019 deals with DVPN and DVPO. See: https://www.cleveland.police.uk/SysSiteAssets/foi-media/cleveland/publication-scheme/our-policies-and-procedures/9-domestic-abuse-policy-v1.10_redacted.pdf

14.3.20 Opportunities to intervene and manage the perpetrator's behaviour were not maximised by any agency. Greater coordination e.g. a referral to MAPPA for multi-agency management would have helped.

14.4 **What services if any, or signposting, did your agency offer Jean and were they accessible, appropriate and sympathetic to her needs and**

[22] Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) Guidance Sections 24-33 Crime and Security Act 2010

were there any barriers in your agency that might have stopped Jean from seeking help for the domestic abuse?

14.4.1 Jean had contact with MSP during her relationship with Abuser 2 and so she was at least to some extent aware of its services. She had previously been scheduled to attend the Freedom Programme [23] but did not attend.

14.4.2 On 6 August 2018, following a referral from the police MSP attempted to contact Jean but were unable to do so and communicated that to the police.

14.4.3 Following the MARAC meeting of 30 August 2018, MSP and the police jointly visited Jean on 19 September 2018. Jean did not take up the offer of support but was given information about MSP and how to contact the service. Jean did make contact with them and subsequently attended MSP without an appointment on 5 October 2018. She was seen straight away. The panel recognised this immediate access as good practice. The chair and author have seen in many other reviews that delays in providing immediate access to services for a victim who is willing to engage often results in non-engagement with the service. MSP discussed safety planning with Jean, including her immediate accommodation needs. Jean indicated she was staying with a friend and would remain there until she could be re-housed. Safety planning was completed with Jean, a legal appointment booked for 11 October 2018 to discuss a Non-Molestation Order (Abuser 1). Jean requested housing support and was advised of support available from the Homeless Team (Jean was aware of how to access Homeless Team) and an internal referral was agreed to the Support Team for housing and debt advice. A police photographer attended MSP to take evidential photographs of Jean's injuries. Jean did not discuss her relationship with the perpetrator during the appointment and this was a potential missed opportunity given the recent history of domestic abuse from the perpetrator; however the practitioner who saw Jean was responding to Jean's immediate needs following the assault by Abuser 1

14.4.4 Jean had previously reported abuse in other relationships, so it is clear that she knew how to report abuse. She had experience of the criminal justice system as a witness and a defendant. The panel thought that her previous experiences of the criminal justice system, for example being arrested, may have reduced the likelihood of her reporting incidents. During the period under review, Jean was arrested by the police after the perpetrator had lied to officers that she was not at home. She was hiding in the loft. No thought was given to arresting the perpetrator for obstructing the police in the execution of their duty; it

[23] The Freedom Programme is a domestic violence programme (for victims) which was created by Pat Craven who holds the copyright (all rights reserved) and evolved from her work with perpetrators of domestic violence.

should have been. Additionally, by obstructing the police, the perpetrator probably breached his licence conditions a and b. See paragraph 14.3.3. That breach could then have been considered by NPS to determine whether a sanction was merited.

14.4.5 There were seven known reports of domestic abuse involving Jean during the time-period under review. Jean herself reported the fifth incident; whereas prior to this incidents had always been reported by third parties. The sixth incident came to light after police had attended her house to arrest her, and a loud argument between her and the perpetrator was reported by a third party after the police left (this was when Jean was found hiding in the loft when the police went back). The seventh incident was reported by Jean and was in relation to the assault on her and the perpetrator by Abuser 1.

14.4.6 The panel saw that after initially denying incidents had taken place in the early part of her relationship with the perpetrator, she had started to make reports as the relationship progressed. The panel recognised that many victims of domestic abuse suffer for some time before reporting anything. SafeLives [24] say "On average victims experience 50 incidents of abuse before getting effective help".

14.4.7 In light of the information now available, the panel felt identified that there may have been barriers to Jean reporting abuse. Independent domestic abuse professionals on the panel identified that there were a number of social and statutory barriers for Jean which professionals could have identified e.g. the barrier of the perpetrator living with Jean and his constant daily presence. The information she shared with a professional that she was unable to leave the house was also a barrier. Jean would also have been aware that breach action may have been taken by DTV CRC for her non-attendance and that may have presented a barrier to accessing services. There are a number of pieces of research and publications that identify barriers common to victims of domestic abuse which could prevent them reporting their experiences. Here are two of them:

14.4.8 Research conducted by Her Majesty's Inspector of Constabulary (HMIC)[25] found the following reasons for not reporting domestic abuse to the police;

[24] SafeLives.org.uk A charity supporting domestic abuse victims and professionals

[25] Everyone's business: Improving the police response to domestic abuse; March 2014 Her Majesty's Inspectorate of Constabulary (now Her Majesty's Inspector of Constabulary and Fire and Rescue Services (HMICFRS))

Fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent).

14.4.9 The Victim Support report 'Surviving Justice' 2017 report contains the following information:

Barriers to reporting as cited by Victim Support caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.4.10 Refuge[26] list the following as barriers to leaving an abusive relationship.

It takes a great deal of courage to leave someone who controls and intimidates you. Women often attempt to leave several times before making the final break.
Remember, leaving an abusive partner can be very dangerous. Women are at the greatest risk of homicide at the point of separation or after leaving a violent partner.
It is important that you plan your departure safely. If you are planning to leave an abusive partner, read our planning to leave page.
'Why doesn't she just leave?'
The truth is that there are many practical and psychological barriers to ending a relationship with a violent partner. Here are just some:

[26] https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/barriers-to-leaving/

Safety: the woman may be fearful of what the abuser will do to her and the children if they leave or attempt to leave
Lack of self-confidence: the woman may believe that it is her fault and that she deserves the abuse, and may fear she would never find anyone else if she left
Denial: she convinces herself that "it's not that bad"
Shame: she is embarrassed about people finding out
Guilt: the abuser makes her believe that she is to blame for his actions
Financial dependence: the woman may not be able to support herself and her children independently. See our page about financial abuse here
Loyalty: she may be loyal to the abuser regardless of his actions
Hope: she believes that things will improve with time. She believes she can make him change
Lack of support: she doesn't know to whom to turn
Pressure: family and friends pressurise her to stay and 'make it work'
Religious/community beliefs: she is under pressure not to break up the family
Love: despite the abuse, she still loves him
Jekyll and Hyde: the abuser switches between charm and rage; the woman thinks, 'He's not always like this'
Intimidation: the abuser threatens to take the children or pets away
Gender roles: she might normalise his behaviour because he's a man – 'that's how men are'. She may believe it's the woman's role to put the needs of others first
Immigration: if the woman has insecure immigration status, she may fear being deported

The DHR panel thought that Jean experienced barriers which prevented her being able to leave abusive relationships. Her family explained that she had been in domestic abuse relationships since she was teenager and had lost her children as a result of the domestic abuse she experienced. This inevitably caused trauma. Domestic abuse for Jean had longstanding effects to her mental and physical health, her relationships with friends and family, children, career and economic well-being. Jean was distrustful of police, courts, probation and therefore did not always reveal the abuse. When Jean did reveal abuse the DHR panel identified the support was not always forthcoming at the time she needed it most. She was distanced from family and friends who might have previously tried to help or support her to access help and was isolated due to her confidence, low mood and drug and alcohol use. Domestic abuse relationships involve an imbalance of power and control and a pattern of abusive and violence behaviours. The abuse is cyclical. There are periods of time when things maybe calmer, followed by a build-up of tensions and abuse which results in the perpetrator peaking to intensified violence. Although Jean had experienced domestic abuse in the past, the tactics perpetrators use to instil fear and maintain control can differ. This relationship was relatively new

one, and the perpetrator had moved into her house very quickly. Jean contacted the police early on in the relationship. This evidences she had concerns and that she had recognised some of those tactics and behaviours. Although, as it was new she was probably disempowered by the perpetrator from being able to take any action against him.

14.5 **What knowledge or concerns did the victim's family, friends and employers have about Jean's victimisation and did they know what to do with it?**

14.5.1 Jean was only in contact with her family by telephone during the relationship with the perpetrator. Sadly they were unaware of the abuse she was suffering. Neighbours reported domestic abuse incidents to the police on a number of occasions, but it is clear from evidence presented during the trial that there were other incidents of abuse that were not reported by third parties.

14.5.2 Jean's family were not aware of the abuse she was subjected to at the hands of the perpetrator. They did know about abuse she had received from Abuser 1 and Abuser 2 and continually supported Jean.

14.5.3 Jean's friends and neighbours were aware of the abuse that she suffered from the perpetrator. They had seen the perpetrator assault and abuse Jean in public. She had showed them bruises and told them what had happened. Neighbours called the police on some occasions but not others. Jean's friends told her to get away from the perpetrator or go to a refuge, but she said that she was too scared to do so as she was concerned the perpetrator would find her.

14.5.4 The DHR chair and author have completed many reviews where third parties had knowledge of abuse in a relationship that was unknown to any agency. Victims often swear third parties to secrecy when making disclosures of domestic abuse and which places those parties in an invidious position. Sometimes victims tell their friends that it will make things worse if the perpetrator becomes aware a disclosure has been made. The DHR chair searched the internet using the question, 'My friend in Middlesbrough is being abuse what can I do?'

The first page of returns shows several direct links to an answer, two of the links are:

I'm worried a friend or relative is suffering domestic abuse is found at:

https://www.middlesbrough.gov.uk/community-support-and-safety/domestic-abuse

and

Whether you suspect that a friend or family member is being abused or you witnessed someone being abused, you can take steps to help is found at:

https://www.womenshealth.gov/relationships-and-safety/get-help/how-help-friend

The DHR Panel made a recommendation (17.8) on this point.

Cleveland Police's response to third party queries is:

'If a call was received by a third party into the force control room in relation to concern there will be an assessment made by the control room around the immediacy of the response required. The new step is that the Force's Vulnerability Desk will also review any incident flagged as a domestic abuse incident to ensure that it has been appropriately resourced which would include submission of support referrals and obtaining details of any children in the address etc. It is worthy of noting that the practices that we have at present (2020) are different to those we had two years ago (2018)'.

14.5.5 The panel thought that Jean's response may have been an example of traumatic bonding. The term traumatic bonding was developed by Patrick Carnes.[27] It is said to occur as a result of ongoing cycles of abuse in which the intermittent reinforcement of reward and punishment creates powerful emotional bonds that are resistant to change. A simpler definition is that traumatic bonding is a strong emotional attachment between an abused person and her abuser, formed as a result of the cycle of violence.

14.6 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Jean and or the perpetrator?**

14.6.1 The DHR did not uncover any bias or other forms of discrimination in agencies dealings with Jean or the perpetrator in relation to protected characteristics or other diversity issues. The poor management of the perpetrator by the Probation Service did not provide any restraint on his abuse of Jean. Better supervision of him by NPS would have at least ensured some constraints on his activities. Whether that would have reduced his abuse of Jean cannot be known

[27] https://healingtreenonprofit.org/wp-content/uploads/2016/01/Trauma-Bonds-by-Patrick-Carnes-1.pdf

for a fact. As a female, Jean, was at far greater risk of being a victim of domestic abuse than a male in similar circumstances. This is a societal issue recognised by HM Government who have plans and strategies in place to combat violence against women and girls.
https://www.gov.uk/government/news/government-sets-out-key-measures-to-tackle-violence-against-women-and-girls

14.7 **Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Jean and/or the perpetrator, or on your agency's ability to work effectively with other agencies?**

14.7.1 The panel recognised that all agencies have to work within the resources allocated to them and that such resources have competing demands. This means that agencies prioritise the demand for their services, while looking for ways of increasing efficiency and maximising effectiveness. Without detailed post-event analysis it is not possible to say whether limited resources had a direct negative impact on the support given to Jean. The panel discussed at length whether examples of poor professional practice were as a result of a lack of resources. Panel members were very clear that they felt the examples of poor practice were more fundamental and not related to the availability of resources; for example the lack of a feedback loop from MARAC actions.

14.7.2 Cleveland Police recognised that there was a resource issue which impacted on how quickly they processed Clare's Law applications. (Para 14.1.10). Action has now been taken to resolve the issue. (Cleveland Police single agency recommendation 1 applies) Also see paragraph 15.8.

14.8 **What learning has emerged for your agency?**

The agencies learning is taken directly from their IMRs.

14.8.1 **DTV CRC**

Action taken in respect of the enforcement of Jean's order was not effective at the beginning of sentence. Closer monitoring of engagement and enforcement practice has been introduced and is the responsibility of Operations Manager, overseen by Deputy Director. This has demonstrated positive results and is reducing the likelihood of offenders not being instructed for inappropriate periods of time. In order to monitor Responsible Officers' compliance with local operational standards more closely, DTV CRC in March 2019, introduced a series of local standards compliance reports, which are reviewed by Managers.

Non-compliance is raised within Responsible Officer monthly supervision and this to be confirmed via assurance reporting to Deputy Directors monthly.

14.8.2 DTV CRC are in the process of completing a domestic abuse strategy that will include organisational training and development in order to enhance practitioners' ability to recognise and respond to domestic abuse. Within the strategy a review of the MARAC and MATAC processes will also take place in order to set basic standards of engagement with the process, regardless of the model. DTV CRC have produced an aid memoir to assist practitioners understand the benchmark regarding the actions to take when dealing with domestic abuse from both a perpetrator and victim perspective. This will followed up with training on assessment and case management that specifically focuses on multi-agency working and communication to understand risk.

14.8.3 DTV CRC have also introduced a quality assurance framework that reviews 75 cases per quarter from across the organisation. Within this framework the decision has been taken to focus on domestic abuse as a thematic and 25 cases per quarter will specifically scrutinise the work of responsible officers in relation to this area of work. This approach will evaluate an officer's actions in relation to recognition and response, when dealing with either a victim or perpetrator of domestic abuse.

14.8.4 **NPS**

PO1 did not effectively manage the perpetrator within existing NPS policies and processes. NPS supervision processes were ineffective in picking up the multiple failures that took place. PO1 was seen monthly for supervision by a senior probation officer where cases were discussed. The NPS system of supervision relies on the professional responsibility of probation officers raising issues of concern in their supervision sessions. This did not happen in this case and therefore the senior probation officer was unaware of the developing issues and poor decision making in the perpetrator's case. Supervision in National Probation Service should be in line with the National Supervisory and Line Management Framework, and supervision processes have been strengthened since this time in line with that framework.

14.8.5 **Cleveland Police**

Following a third party report of an argument at Jean's house the police attended, but only the perpetrator was spoken to. There was no consideration to check if Jean was safe and well, to see if she wished to report any incidents or to provide her with access to support. This was surprising given the perpetrator's history of committing domestic abuse. Additionally failing to follow

through on third party reports undermines the wider desire of agencies that such third party reporting should be encouraged. Efforts should be made to speak to all parties prior to the incident being closed. Since the above events the police have introduced clearer pathways for people who disengage from their domestic abuse services.

14.8.6 Paragraph 14.1.20 explored why it took five days for the police to see Jean after she reported domestic abuse by which time she downplayed the incident. Five days is an unacceptable period and does nothing to support victims or instill confidence in them. Victims may be more willing to make a complaint if they are seen promptly.

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

14.9.1 The panel did not identify outstanding or innovative practice. However, the panel recognised the work of My Sisters Place in facilitating a walk-in appointment and the attendance of a police photographer to record Jean's injuries as good practice.

14.10 **Does the learning in this review appear in other domestic homicide reviews commissioned by Middlesbrough?**

14.10.1 Middlesbrough CSP has previously published one DHR. It contained five panel recommendations and a further 28 single agency recommendations. A DHR awaiting review by the Home Office quality panel has a similar recommendation to recommendation 8. This will be taken account of in the ongoing action plan from both relevant DHRs.

15 CONCLUSIONS

15.1 Jean had been a victim at the hands of abusers since the age of thirteen. From that age she had a difficult relationship with her family and despite their support, she followed a life which was dominated by people who did not work and misused alcohol and drugs.

15.2 During the course of her relationship with Abuser 1, Jean reported many incidents of domestic abuse and he was arrested and sent to prison. Jean found herself unable to consistently look after the three children that she had with Abuser 1 and they were looked after by her parents.

15.3 Subsequently Jean met Abuser 2. For a number of years that appears on the face of it to have been a stable relationship and the couple had two children. However, after the birth of the second child reports of domestic abuse began. Jean and Abuser 2 were unable to maintain consistent parenting and the children were removed by Children's Social Care.

15.4 Jean and Abuser 2 separated in early June 2018 and soon after Jean met the perpetrator and began a relationship with him. On some occasions, the couple denied that they were in a relationship.

15.5 Within a short time the relationship with the perpetrator became abusive and seven matters relating to domestic abuse came to the attention of the police.

15.6 Cleveland Police had a significant back-log of cases waiting disclosure under the Domestic Violence Disclosure Scheme; among them Jean's. Additionally no one in Cleveland Police considered protecting Jean through a Domestic Violence Protection Notice and Domestic Violence Protection Order.

15.7 The perpetrator was only arrested once when a witness reported that the perpetrator had assaulted Jean in the street. Jean did not make a statement. The police officers dealing with the matter did not obtain available evidence in the form of witness statements and the interviewing officer did not view the available CCTV evidence. A poor investigation led to the perpetrator being released quickly without charge. A Domestic Violence Protection Notice and subsequent Domestic Violence Protection Order could have been applied for on this and other occasions, but it appears that this was not considered. When Jean did contact the police to make a complaint on 31 July 2018, she was not seen until 4 August 2018 and by then she had changed her mind.

15.8 Her Majesty's Inspector of Constabulary and Fire and Rescue Services (HMICFRS) in its 2018/19 inspection of Cleveland Police found the force

'inadequate' in the three PEEL categories of: police effectiveness, efficiency and legitimacy.[28] Here is a relevant extract from the report.
'I have serious concerns that the force is not adequately protecting vulnerable people. Disappointingly, the force has not made progress against areas we have previously identified as requiring improvement. Where it has tried to improve, through changing its processes, it has created risks in victims not being identified or responded to in a timely way'.

Cleveland Police has an action plan to deal with the inspection findings and the Force's recommendations from this DHR will be audited by the future inspections.

15.9 During the timeframe of the review Jean was supervised by DTV CRC. She did not attend the initial appointment that she had been given on 27 June 2018, but no action was taken until 6 August 2018. The Responsible Officer did not see her at any time in person. Jean did not keep any appointment that she was given and was not at home when visited. The Responsible Officer was aware that domestic abuse was taking place because information had been appropriately shared by Cleveland Police. Had they been able to achieve any engagement with Jean the Responsible Officer may have been able to offer support, guidance and signposting to improve Jean's safety. The panel felt DTV CRC's failure to support Jean as a victim of domestic abuse was poor practice.

15.10 NPS were responsible for supervising the perpetrator following his release on licence in 2017. At the time he met Jean he had already been involved in domestic abuse with two other women whilst he was on licence since his release from prison (NPS were not aware of this as the information was not shared with them by Durham Constabulary). In addition, legal orders were in place preventing him from contacting two other women due to abuse. At the age of 24 the perpetrator was a serial abuser of four women and had been sentenced to six years in prison for other violent offences. It is highly likely that he sought out Jean as his fifth victim.

15.11 NPS did not apply appropriate standards of supervision to the perpetrator. As a person who presented a high risk of serious harm to the public, he should have been seen at least weekly but often went for long periods without supervision. His Offender Manager failed to recognise or deal with the risks that the perpetrator presented, for example inexplicably telling the police that he had no concerns about domestic abuse. Opportunities to sanction the perpetrator, for example for missed appointments and poor behaviour were not

[28] https://www.justiceinspectorates.gov.uk/hmicfrs/peel-assessments/peel-2018/cleveland/

taken. The potential to initiate a recall to prison or require the perpetrator to reside in approved premises when risks escalated was not even considered. Overall NPS supervision of the perpetrator was inadequate.

15.12 The collective response of agencies in Middlesbrough to the escalating risks faced by Jean from the perpetrator in Summer 2018 lacked urgency, coordination and in some cases agencies did not recognise changing risk factors, share information or follow their own procedures. Actions which may have reduced the risks were not taken. The identification and management of the risk the perpetrator presented to Jean was inadequate and in this context, Jean did not receive effective protection from a serial perpetrator of domestic abuse that she should have done.

16 LEARNING

This learning arises following debate within the DHR panel.

16.1 **Narrative** Recommendation 1 applies

The perpetrator had a long history of committing domestic abuse, including coercive and controlling behaviour of multiple victims; he was also a violent man in other situations. He was assessed as presenting a high risk of serious harm to the public and managed through MAPPA at level 1 by NPS. Jean's victimisation by him went to MARAC and a referral from there to MATAC was rejected. There was no effective coordination between the processes. SafeLives offers ten points for an effective MARAC. Given that MARAC is a forum requiring strong leadership, the tenth point is particularly important. It is:

10 Governance

There is effective strategic support and leadership of the MARAC and IDVA response, and agencies work together effectively

https://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf

Learning

The interface between different processes needs to be fully understood by professionals engaged in protecting victims from domestic abuse, otherwise the approach will be uncoordinated and victims left more vulnerable

16.2 **Narrative** Recommendation 2 applies

Two reports of anti-social behaviour were received which related to loud arguments emanating from Jean's house. The resulted in an anti-social behaviour response and were not recognised as potential domestic abuse. Reports of anti-social behaviour provide the opportunity to explore whether domestic abuse is a factor.

Learning

There is a need, for professionals in all agencies, to be alert to the fact that reported incidents/complaints, for example of noise nuisance, damage to property and other potential anti-social behaviour, could inadvertently mask domestic violence as a contributory factor and or risk.

16.3 **Narrative** Recommendations 3 and 4 apply

Narrative

An offender manager from NPS failed to meet its standards in supervising the perpetrator, including inadequate risk formulation and management. A Responsible Officer from DTV CRC failed to meet it standards in supervising Jean. The managerial process in both agencies failed to identify that the standards were not being met.

An inspection of DTV CRC by Her Majesty's Inspector of Probation (April 2020) noted: 'I am pleased to see that, in response to our recommendations, the CRC has now improved the quality of case supervision'.

https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2020/04/Durham-Tees-Valley-CRC-Report.pdf

A June 2019 inspection of probation services in the North East (under which Durham and Cleveland sit) had the following as its second recommendation.

'Introduce clear direction supported by effective quality assurance to make sure that risk management plans are reviewed and updated to address changes to the risk of harm to others'.

https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2019/06/NE-NPS-Inspection-report.pdf

The lack of effective quality assurance was a failing in this case. Since then every offender manager in Cleveland NPS had had their work audited against the HMIP standard to improve its internal Quality Assurance.

Learning

Staff who do not comply with service standards, and a system that did not recognise that non-compliance, placed Jean at ongoing risk of domestic abuse from the perpetrator.

16.4 **Narrative** Recommendation 5 applies

DVPN and DVPO are valuable tools in protecting victims of domestic abuse and have been available to the police and courts since the enactment of Sections 23 and 24 Crime and Security Act 2010. Some eight years later neither Cleveland Police nor its partner agencies thought about whether they should have been used in Jean's case. That suggests DVPN and DVPO are not embedded in agencies responses to domestic abuse. Additionally, no

organisation working in Middlesbrough has written a process for what needs to be done once a DVPN/DVPO has been granted.

In May 2019 Victim Support published a report titled, 'Learnings from the London Domestic Violence Protection Order Caseworker Project'. A key finding was:

'DVPNs and DVPOs were seen as an effective tool. However, six themes arose from the interviews with practitioners as areas requiring improvement in the process and effectiveness of this intervention. These were: 1. A failure to use DVPNs and DVPOs as an early and preventative intervention. 2. A lack of understanding of the DVPN and DVPO process within the police and magistrates' courts. 3. The time consuming and labour-intensive nature of the process. 4. Concerns about the cost of DVPOs and whether they represent value for money. 5. Prevalence and lack of reporting of breaches. 6. The need for a collaborative approach'.

https://www.victimsupport.org.uk/sites/default/files/VS%20-%20London%20DVPO%20Report.pdf

Learning

Agencies need to deploy the full range of tools available to them. By not considering DVPN and DVPO Jean was not supported as well as she should have been and the opportunity to use the breathing space provided by these tools was missed.

16.5 **Narrative** Recommendation 6 applies

This case graphically illustrates the challenges face by professionals in achieving effective engagement with victims of domestic abuse. As stated earlier in the report there are multiple reasons why victims feel unable to engage. On one occasion when Jean reached out for help, it was not forthcoming and she was denied an opportunity to engage.

Learning

Responding rapidly to victims of domestic abuse when they ask for help is important for effective engagement. This may particularly be the case when a victim such as Jean has suffered extensive previous trauma. Agencies need to consider training for professionals to work in a trauma informed way.[29]

[29] A generally accepted definition of trauma *is* 'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has

16.6 **Narrative** Recommendation 7 applies

Durham Constabulary were unaware that the perpetrator who was on licence had moved to reside in their area. NPS were unaware of critical information that the perpetrator had been named as an abuser by two domestic abuse victims whilst he was on licence prior to him meeting Jean.

Learning

Failing to share critical information in relation to offenders who are assessed as presenting a high risk of serious harm to the public reduces agencies ability to manage the risks and increases the risk to victims.

16.7 **Narrative** Recommendation 8 applies

The homicide investigation identified that many people outside of the family knew that Jean was being abused by the perpetrator and largely did nothing. This finding is consistent with many other DHRs. The panel felt that additional publicity is required so that people who know or suspect someone is a victim of domestic abuse, know what they can do and should not do.

Learning

The absence of clear guidance on what members of the public can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring and/or placing the victim in greater danger.

16.8 **Narrative** Recommendation 9 applies

In light of the information now available the panel discussed whether Jean would have had a level of need requiring a care and support assessment. They concluded that she would, on the basis that she had care and support needs, was suffering abuse and was unable to protect herself. There is no evidence that a referral to Adult Social Care was made or considered in this case.

Learning

A failure to make an appropriate referral to Adult Social Care means that people do not have the opportunity to have their care needs assessed (Care act 2014) and Adult Social Care do not have the opportunity to provide appropriate services, advice and assistance.

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lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.(1)' Domestic abuse is clearly a form of trauma, made all the more complex due to the fact that it is planned yet unpredictable and takes place in the context of a relationship. http://www.safelives.org.uk/practice_blog/trauma-informed-work-key-supporting-women

17 RECOMMENDATIONS

DHR Panel

The panel's recommendations have been developed in partnership with the panel.

17.1 That Middlesbrough CSP should seek written assurance from all relevant agencies that the interface between MARAC, MATAC and MAPPA is understood and which process to apply in individual cases and to review whether it needs a 'repeat incident' MARAC referral criteria.

17.2 That each constituent agency of Middlesbrough CSP provides it with written assurance that staff in their agencies dealing with reports of anti-social behaviour understand that it can mask domestic abuse and/or that the underlying cause maybe domestic abuse.

17.3 That NPS and DTV CRC provide written assurance to Middlesbrough CSP that staff in their agencies have a good understanding of domestic abuse, including the ability to identify and respond appropriately when supervising offenders who are, or maybe, victims or perpetrators of domestic abuse.

17.4 That NPS and DTV CRC provide written assurances to Middlesbrough CSP that staff are provided with the training, tools and skills to meet their agencies standards when supervising victims and perpetrators of domestic abuse and that managers are supported by the processes, tools and skills to readily identify when the standards are not being met and take remedial action when they are aware this is the case.

17.5 That each constituent agency of Middlesbrough CSP provide it with written assurance that staff in their agencies dealing with victims of domestic violence, understand what DVPNs and DVPOs are and how they can be obtained.

17.6 That each constituent agency of Middlesbrough CSP provide it with a written report that sets out how their agency engage with hard to reach victims of domestic abuse and those who have suffered previous trauma. This will identify learning needs as well as any good practice so that it can be disseminated locally and nationally.

17.7 Middlesbrough CSP and Durham CSP should seek written assurance from Durham Constabulary and NPS that the failure to share information in this case has been resolved by new processes.

17.8 Middlesbrough CSP should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and diverse communities about recognising the signs of domestic abuse and where they can go, if necessary anonymously, with such information.

17.9 The learning from this review should be shared with Teeswide Safeguarding Adult Board.

Single agency recommendations

Cleveland Police

17.10 The process in which Clare's Law disclosure is made should be reviewed to ensure that requests are being processed in line with Home Office Guidance.

17.11 Message around the investigation golden hour to be disseminated. This is an action that is being replicated in the Crime Allocation and Improvement Rapid Response plan.

17.12 Training to be disseminated to all operational officers around evidence-led prosecutions.

17.13 All domestic abuse crimes should be reviewed by a supervisor prior to closure.

17.14 Training and guidance around the quality of supervisory reviews to be cascaded to all supervisors as part of the Crime allocation and Improvement Rapid Response plan

17.15 Domestic abuse policy to be updated in respect to the handling of "no reply" domestic abuse incident, or those where only one party has been spoken with.

17.16 Review of control room management and tasking of domestic incidents.

17.17 Clear guidance to be created and circulated around the ongoing management of DA investigations where there is a suspect who still needs to be traced. Where a suspect has not been arrested for a DA incident the requirement to arrest/trace them should be handed over to the Investigation Team.

National Probation Service

17.18 Details of domestic abuse history obtained from Police systems are routinely recorded in the Non-Disclosure Section of OASys, as well as in the Case Management System in order to ensure that this information is flagged to any member of staff who may need to access the case record.

17.19 Home Visit Guidance is reviewed and re-issued to all staff in order to reiterate the importance of home visits and the purpose of them in identifying and addressing risk factors, particularly where there is a history of domestic abuse. Staff should always be mindful of the potential risks to a victim when gathering information, making referrals, and recording and storing information. Systems and procedures must be put in place to ensure that risk to victims is minimised – which would include taking a cautious approach to discussing abuse directly with the victim and offender together in the same meeting.

17.20 Information to be provided to staff in relation to the importance of clear and accurate recording on the case record of all offenders in order to ensure that all contacts and work undertaken are evident to any authorised individual accessing that record.

17.21 Guidance to be re-issued to staff in relation to caretaking cases and the importance of good communication between staff and the expectations around enforcement when caseholders are unavailable/on leave. In addition to the timeliness of requesting caretaking. (Caretaking means someone else has to look after the case in the absence of the allocated member of staff.)

17.22 National Standards guidance to be recirculated to staff in order to reiterate the level of contact expected and guidance around practice and expectations.

17.23 Guidance to be reissued to staff in relation to information sharing with other agencies in particular the police and MARAC to ensure appropriate information is shared in order to manage risk effectively.

DTV CRC

17.24 To improve DTV CRC's response and safeguarding of victims of domestic abuse

17.25 Improved response to safeguarding of adults.

17.26 Consistent response across DTV CRC team areas to MARAC

17.27 Improved enforcement practice of Court Orders and defensible approach to absences.

17.28 Improved effective management oversight of practice

17.29 Improved Responsible Officer practice in regards to domestic abuse-related information and the overall context of risk and case management.

17.30 To enhance the skills of practitioners to recognise escalating and dynamic risk factors and respond to these effectively.

Appendix A Action Plan Jean DHR Middlesbrough Community Safety Partnership

		DHR-4 Panel Recommendations Jan 2021						
No	**Recommendation** **Middlesbrough Community Safety Partnership**	**Scope**	**Action to take**	**Lead Individual**	**Key milestones achieved in enacting recommendation**	**Start Date**	**Target Date**	**Outcome**
1.	That Middlesbrough CSP should seek written assurance from all relevant agencies that the interface between MARAC, MATAC and MAPPA is understood and which process to apply in individual cases.	Cleveland	Community Safety Partnerships requests a review or audit of the arrangements effectiveness and governance of MARAC, MATAC and MAPPA	Claire Moore DA lead Single Point of Contact for Review	Safe lives commissioned by OPCC and four LA's to undertake an in-depth strategic review. The purpose is to ensure a standardised level of quality across the region	Jan 2021	April 2021	Ongoing The review will measure • To what extent does MARAC model in Cleveland adhere to Safe Lives Principles • If screening processes enable the principles of effective MARAC to be reached • Define what are the longer term outcomes and impact of MARAC model – does it make victims and

								their families safer & how can Cleveland monitor performance • Consider how does MARAC link to wider safeguarding arrangements
2.	That each constituent agency of Middlesbrough CSP provide it with written assurance that staff in their agencies dealing with reports of anti-social behaviour, understand that it can mask domestic abuse and/or that the underlying cause maybe domestic abuse.	Local	Chair of Community Safety Partnership writes letter to Social Housing Landlords and Neighbourhood Teams to update on learning and requesting information regarding staff understanding and policy / protocols. Training provided to MBC Neighbourhood team in relation learning from DHRs and correlation between anti -social behaviour and Domestic Abuse	Marion Walker CSP Lead Claire Moore DA Lead Jane Hill Strategic Community Safety Manager Claire Moore DA lead	Letter sent and responses reviewed and updated in CSP Training materials reviewed and developed to include learning points	April 2021 April 2021	June 2021 May 2022	Improved identification of indicators of abuse to increase safety of victims / pursue and deter perpetrators Early Identification of DA / Increase in referrals from Neighbourhood Teams to DA services or Safeguarding

3.	That NPS and DTV CRC provide written assurance to Middlesbrough CSP that staff in their agencies have a good understanding of domestic abuse, including the ability to identify and respond appropriately when supervising offenders who are, or maybe, victims or perpetrators of domestic abuse.	Local	Chair of CSP to request NPS and DTV CRC attend DHR Steering Group meeting to update re progress in relation to addressing actions 3 & 4 and how changes will improve outcomes and update provided to CSP	Jane Hill Strategic Community Safety Manager	Invitation to attend DHR steering Group	April 2021	June 2021	Improved identification Increase in referrals
4.	NPS and DTV CRC provide written assurances to Middlesbrough CSP Staff are provided with the training, tools and skills to meet their agencies standards when	Local	NPS to provide written assurance in relation to work undertaken in response to DHR.	Marion Walker Community Safety Lead Ann Powell National Probation Service	Written report provided and shared with CSP members	April 2021	June 2021	Staff working in NPS and DTV CRC have skills, training and experience to recognise and respond effectively to domestic abuse

	supervising victims and perpetrators of domestic abuse and Managers are supported by the processes, tools and have the skills to readily identify when the standards are not being met and take remedial action when they are aware this is the case.		DTVCRC provided update. Work undertaken in relation to -Policy and guidance – Training and development -Quality Assurance activity -Operational standards and benchmarking -Supervision and escalation processes.	Kay Nicolson DTV CRC Operations Manager	CRC review of domestic abuse policy and guidance to be undertaken CRC issue of guide to working with domestic abuse cases Monthly supervision for all practitioners Countersigning of all PSO grade practitioners assessment work Operational Minimum Standards for practitioners implemented	June 2018 May 2019 May 2019 Nov 2018	June 2019 July 2019 July 2019 Jan 2019 Jan 2020	

						October 2019		
5.	That each constituent agency of Middlesbrough CSP provide it with written assurance that staff in their agencies dealing with victims of domestic violence, understand what DVPNs and DVPOs are and how they can be obtained.	Local	One minute Guide re DVPN and DVPOs updated on Middlesbrough council website as part of glossary of DA one minute guides Chair of Community Safety Partnership and Domestic Abuse Strategic Partnership to seek assurance from agencies that staff are aware of information regarding DVPN's and DVPO's	Claire Moore DA lead Marion Walker Community Safety Partnership Erik Scollay DASP Chair Claire Moore DA lead	One minute guide uploaded onto website Agenda item on meeting to remind agencies information available	April 2021 April 2021	May 2021 Sept 2021	Review police data to understand if use of DVPN/ DVPO has increased/ how success measured and if breaches are being reported.
6.	That each constituent agency of Middlesbrough CSP provide it with a written report that sets out how their		Community safety Partnership requests update from relevant lead in Middlesbrough Council responsible for implementing Integrated model and	Marion Walker Community Safety Partnership	Integrated service model (homelessness/ substance misuse and domestic abuse services) will launch from April 2021. This is	April 2021	April 2022	A trauma informed framework and clinical governance developed by integrated model to

	agency engage with hard to reach victims of domestic abuse and those who have suffered previous trauma. This will identify learning needs and any good practice so that it can be disseminated locally and nationally.		MEAM in relation to progress re embedding trauma informed approaches. Navigator Partnership across 6 LAs has been awarded funding via MHCLG to with DA victims who are hard to reach and experiencing Complex need since 2016. MBC to consider how successful elements of this project can continue from April 2021 when funding no longer available	Erik Scollay Chair of DASP Claire Moore DA Lead	focused on adopting and embedding Trauma informed approach and is aligned with work going on in Adult and Children Services New Burden Funding awarded to MBC Paper presented re LMT re financial envelope and consideration if funding should be used to sustain/ increase provision for complex need DA victims	March 2021	August 2021	ensure agreed principles and understanding across partnership Service users who experience barriers to accessing accommodation due to high harm / high vulnerability are supported via dedicated role within DA service and needs re accommodation are identified in DA needs Assessment

7.	Middlesbrough CSP and Durham CSP should seek written assurance from Durham Constabulary and NPS that the failure to share information in this case has been resolved by new processes.	Regional	Chair of Community Safety Partnership to write to Durham Constabulary and NPS to request they review information sharing processes with other areas in light of DHR learning and recommendations. Copy of Email sent to Durham and Cleveland OPCC	Jane Hill Strategic Community Safety Manager	Written update provided to CSP in relation to process introduced in response to DHR learning	April 2021	August 2021	
8.	Middlesbrough CSP should review the effectiveness and if necessary strengthen the information provided to family, friends, neighbours and diverse communities about recognising the signs of domestic abuse and where they can go, if necessary	Local	Chair of Community Safety Partnership to write to agencies to request they review DA policies in relation to disclosure and routine enquiry in light of DHR recommendations Community Safety Partnership will direct Domestic Abuse	Jane Hill Strategic Community Manager Claire Moore DA lead	Agencies have DA policies in place - with understanding of how third party can disclose information Information on website for friends and families updated and press release sent	March 2020	Nov 2021	Victims are aware of, and able to access services in an easy and timely way Increased awareness of domestic abuse amongst friends family neighbours and diverse communities Partners aware of, and participate in,

	anonymously, with such information.		Strategic Partnership and Communications team to review how information is currently provided to friends, family, neighbours and diverse communities via Middlesbrough council website and leaflets Middlesbrough Domestic Abuse Strategic Partnership to inform information sharing arrangements with partners developed as part of and develop agreed protocol in relation to information sharing, including how and if anonymous information should be acted upon	Claire Moore Domestic Abuse Lead	Agencies have and are adhering to information sharing protocol in place - with clear process for overcoming barriers and facilitating disclosure	Jan 2021	April 2021	awareness raising activity. Key messages and communication channels agreed and used by all agencies, Agencies access to and understanding of Information sharing protocol

9.	The learning from this review should be shared with Teeswide Adult Safeguarding Board.	Local	Email will be sent to TSAB to notify report published and offer to attend meeting to provide update if required. 7 min briefing prepared	Claire Moore DA lead	TSAB members aware of review and process for implementing learning and recommendations	March 2021	April 2021	TSAB aware of DHR and oversee across Cleveland identifying themes and opportunities for shared learning across Tees
	Cleveland Police							
1.	The process in which Clare's law disclosure is made should be reviewed to ensure that requests are being processed in line with Home Office Guidance.	Local	The internal administrative process conducted by the support hub will be streamlined. A new dedicated problem solving team will commence working in the PVP support hub	Cleveland Police	Review completed and changes implemented	Oct 2020	Jan 2020	Timely intervention and problem solving support. Claire's Law applications processed in a timely manner

			A new process for the completion of emergency Claire's law applications is being introduced. This significantly reduces the administrative backlog in some of the higher risk cases.					Improved response rate re Emergency Claire's Law applications.
2.	Message around the investigation golden hour to be disseminated. This is an action that is being replicated in the Crime allocation and Improvement Rapid Response plan	Local	To feature on newly promoted Sgt's and Inspectors course. Aide-memoire and guidance document provided for dissemination which is available on investigation standards sharepoint page.	Cleveland Police	All newly promoted Sgt and Inspectors have received an input on initial crime investigation. The need to secure early evidence in investigations has been reiterated in a message to all staff. Guidance document in relation to "golden hour" and initial investigation standards produced in a draft form	Jan 2019 Dec 2019	May 2019 Jan 2020	Training provided to newly promoted sergeants Ongoing standards event arranged across force

3.	Training to be disseminated to all operational officers around evidence led prosecutions.	**Local**	1. Briefings to be provided to all operational teams in respect of evidence led prosecutions. 2. All Sgts and Inspectors to receive input on evidence led prosecutions as part of newly promoted Sgt/Insp course.	**Cleveland Police**	Newly promoted Sgt/Inspectors briefing completed in May 2019 Operational officers receive briefings on evidence led prosecution Briefings conducted by domestic abuse Detective Inspector	Jan 2019	May 2019	All response teams have received a briefing on Evidence led prosecutions. 2. Newly promoted Sgt/Inspectors have received an input in relation evidence led prosecutions on their promotion course. Outcomes Measure Data re number of evidence led prosecutions increase.
4.	ALL domestic abuse crimes should be reviewed by a supervisor prior to closure.	Regional	Agreement to be reached by heads of command in relation to enhanced supervision of DA cases. Agreement to be implemented within Crime Management Support Bureau (CMSB)	Cleveland Police	Agreed by heads of command and implemented	Oct 2019	Nov 2019	Approved by Local Policing commanders.

5.	Training and guidance around the quality of supervisory reviews to be cascaded to all supervisors as part of the Crime allocation and Improvement Rapid Response plan	Local	All Sgts and Inspectors to receive input on investigation standards as part of newly promoted Inspectors/ Sgts course	Cleveland Police	Newly promoted briefing completed Policy and Guidance document available for reference "Crime Supervision Guidance	Jan 2019	May 2019	Audits conducted to assess quality of supervisory reviews
6.	Domestic abuse policy to be updated in respect to the handling of "no reply" domestic abuse incident, or those where only one party has been spoken with.	Local	Policy holder to review and amend policy. Amendment to be disseminated to all operational teams and control room.	Cleveland Police	Domestic Abuse Policy updated and approved. Disseminated to wider partners	Oct 2019	Jan 2020	Domestic abuse policy revised and refreshed
7.	Review of control room management and tasking of domestic incidents.	Local	Significant review ongoing of Force Control Room, including the manner in which police respond to domestic abuse incidents	Cleveland Police	Review completed and if required change to policy and practise implemented	Oct 2019	April 2020	Cleveland Police have update deployment guidance in relation to domestic abuse incidents and as a result all domestic incidents result in the deployment of a police officer to see the complainant.

8.	Clear guidance to be created and circulated around the ongoing management of DA investigations where there is a suspect that still needs to be traced. Where a suspect has not been arrested for a DA incident the requirement to arrest/trace them should be handed over to the over team.	**Local**	Definitive guidance on the use of "rolling arrest packages" for outstanding arrests.	**Cleveland Police**	Rolling arrest packages are used in all high risk DA cases. Rolling arrests are formulated for medium risks cases based on professional judgement	Dec 2019	April 2021	Monitor high risk cases effectiveness of rolling arrest packages
	National Probation Service							

1.	Details of DA history obtained from Police systems are routinely recorded in the Non-Disclosure Section of OASys, as well as in the Case Management System	Local	Development day organised for staff in each LDU Cluster concentrating on domestic abuse issues. Policies and guidance re-issued at event which included "aide memoir to assessing and managing risk in domestic abuse cases", "observations during and recording following home visits" and National Standards as found on Equip, the process mapping service for the NPS. Partnership agencies invited to attend including a representative from MARAC and safeguarding within the police.	NPS NPS NPS	Attendance for Offender Management staff will be mandatory. All staff have access to policies and guidance Broad representation attending development day across agencies	Sept 2019 Sept 2019 Sept 2019	Oct 2019 Nov 2019 Oct 2019	Information is flagged to any member of staff who may need to access the case record. Improvement in multiagency working understanding of roles and responsibilities

			Meetings held in Durham to look at better ways of working with MARAC which will potentially involve Offender Managers attending conferences to provide updates and information. Durham LDU are in the process of having access to Police computer systems in each office in order to check for domestic abuse information in relation to cases.	NPS NPS	Actions agreed at meeting and implemented Offender managers attending MARAC Access approved designated contacts responsible for this	Jan 2010 Jan 2010	Jan 2021 April 2021	MARAC minutes and action plan evidence benefit of offender manager input Access approved – named contacts identified
2.	Home Visit Guidance is reviewed and re-issued to all staff in order to reiterate the importance of home visits and the purpose of them in identifying and addressing risk factors, particularly where there is a	Local	Briefing issued to staff	NPS	National Good practice guide for home visits issued Briefing in Durham Audit booked in Cleveland Workshop for staff and managers delivered	Sept 2019	Nov 2019	All staff have access to home visit guidance and applying this in day to day practice

	history of domestic abuse.							
3.	Information to be provided to staff in relation to the importance of clear and accurate recording on the case record of all offenders in order to ensure that all contacts, and work undertaken are evident to any authorised individual accessing that record.	Durham and Darlington NPS	Briefing issued to staff	NPS	Briefing shared OSAG audits and HMIP preparation audits and HMIP audits to confirm that instruction being followed	Oct 2019 April 2020	Oct 2019 April 2021	Briefing shared with staff Audit took place in 2020 outcomes need to be recorded
4.	Guidance to be re-issued to staff in relation to caretaking cases and the importance of good communication between staff and the expectations around enforcement when caseholders are unavailable/on	North East Division	Reinforce the national guidance and add additional NE best practice notes	NPS	Issue briefing and undertake review to check that it is being followed	March 2019	Nov 2019	Guidance issued Review undertaken General compliance some issues so guidance re-issued

	leave. In addition to the timeliness of requesting caretaking							
5.	National Standards guidance to be recirculated to staff in order to reiterate the level of contact expected and guidance around practice and expectations	Regional	Re-issue guidance	NPS	Issue guidance and then HMIP audit will check for learning	Nov 2019	April 2020	HIMP Audit report measured outcomes
6.	Guidance to be reissued to staff in relation to information sharing with other agencies in particular the police and MARAC to ensure appropriate information is shared in order to manage risk effectively.	Regional	Ensure we have an up to date information sharing agreement Ensure that there are systems in place to resolve disputes and blockages to information sharing	NPS	Durham and Darlington LDU and Cleveland LDU, Durham Police and Cleveland Police Review and sign updated information sharing agreement Put in place meetings with police to ensure that information sharing agreement is working in practice	Nov 2019	April 2021	Information sharing protocol in place and all staff across services familiar with this
	Durham and Tees Valley Community Rehabilitation Company (DTVCRC)							

1.	To improve DTV CRC's response and safeguarding of victims of domestic abuse Improved response to safeguarding of adults.	Local	Additional training recommended from victim perspective rather than current perpetrator led approach. DTV CRC Domestic Abuse Strategy and Practice Guidance to be developed and introduced.	DTVCRC	Training plan updated Guidance written Publicised on intranet Delivered via team meeting initiatives.	Sept 2019	Jan 2020	Updated and refreshed practice – victim and perpetrator initiatives
2.	Improved response to safeguarding of adults.	Local	Review of the DTV CRC Safeguarding Adults Policy and Guidance, launch of these via the DTV CRC Lets Connect staff intranet and discussion led by Operations Managers at Team Meetings	DTVCRC	Policies reviewed Publicised on intranet and delivered via team meeting initiatives	Dec 2018	Dec 2019	Policy and Guidance documents embedded into Responsible Officer practice with Operations Manager oversight.
3.	Consistent response across DTV CRC team areas to MARAC	Local	Current MARAC processes across DTV CRC to be reviewed and standardised approach to be introduced	DTVCRC	MARAC review undertaken Publicised on intranet Delivered via team meeting initiatives	July 2019 Aug 2019	Aug 2019 Sept 2019	Standardised practice with consistent administrative support

4.	Improved enforcement practice of Court Orders and defensible approach to absences.	Local	Standard supervision agenda set and introduced Standard supervision agenda set and introduced OMS MIS reporting introduced Enforcement project to review absences and Court work in relation to delivering the sentence of the Court	DTVCRC	Document written and publicised Used by managers in staff supervision. Used by Deputy Directors & Managers Review OMS team compliance and manager oversight. Operational report created to monitor compliance with minimum standards implemented with teams. Analysis of data Quality assurance processes reviewed and further developed Monitoring report and Management Information Review of structure to facilitate enforcement process.	Feb 2019 March 2019 March 2019 Sept 2019	March 2019 April 2019 April 2019 Dec 2019	Improved manager awareness of case-loads within team and prompt response to non-compliance. Improved enforcement outcomes Greater accountability and defensible practice outcomes Quality assurance Improved sentence confidence

5.	Improved effective management oversight of practice	**Local**	Creation of Internal Management Minimum Standards (OMMS), overseen by DTV CRC Deputy Directors	**DTVCRC**	Standards created Published Implemented via Operations Managers meeting Report created to monitor management oversights	Jan 2019	April 2019	Standards implemented and monitored monthly reports to Deputy Directors and discussed in supervision with Operations Managers.
6.	Improved Responsible Officer practice in regards to domestic abuse related information and the overall context of risk and case management.	Local	Standardised approach to MARAC Monthly Responsible Officer supervision by Operations Manager following OMMS, reviewing individual cases and risks of harm	DTVCRC	MARAC review undertaken Standardised administrative processes Published on intranet Flow chart produced OMMS created and implemented Standardised supervision agenda	Jun 2019 Jan 2019	Sept 2019 April 2019	Standardised process and greater administrative support for practitioners Oversight and scrutiny reporting to senior leadership team

			Operations Manager countersigning of OASys assessments, including risk of harm Risk Management Plan template use Domestic abuse strategy and guidance to be developed and introduced as standard working practice.		Countersigning switched on for all PSO grade staff Countersigning for PO grade staff within 12 month timeframe Template developed Training devised Training implemented Published on intranet Disseminated in team / hub meetings Monitored via quality assurance framework Updated policy and guidance Strategy plan on a page to be created Domestic abuse training to be delivered Strategy to be launched Publicised on intranet Disseminated via team / hub meetings Domestic Abuse 121 programme of intervention reviewed and updated	Feb 2019 Jan 2019 April 2019	March 2019 Feb 2019 April 2020	Oversight and scrutiny Quality Assurance reporting to senior leadership team Training and Strategy pending Organisational approach to domestic abuse. Interventions to appropriately address risk Consistent approach to risk management and multi-agency engagement

					DA 121 training devised and delivered			
7.	To enhance the skills of practitioners to recognise escalating and dynamic risk factors and respond to these effectively.	Local	Risk of Harm training for all practitioners and Operation Managers, with follow up training to review effectiveness, facilitated by HMIP Inspector.	**DTVCRC**	Training devised Delivery in conjunction with HMIP Inspector All operational staff to complete Review training Consolidate training with further training events	Feb 2019	Sept 2019	Enhanced practitioner skills and awareness raising

Glossary of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
CJS	Criminal Justice System
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Harassment
DHR	Domestic Homicide Review
DTV CRC	Durham and Tees Valley Community Rehabilitation Company
DVDS	Domestic Violence Disclosure Scheme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
HMICFRS	Her Majesty's Inspector of Constabulary and Fire and Rescue Services
HMP	Her Majesty's Prison
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
ISP	Information Sharing Protocol
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tasking and Coordination
MRT	Middlesbrough Recovering Together
MSP	My Sisters Place
NHS	National Healy Service
NOMS	National Offender Management Service
NPS	National Probation Service
OASys	Offender Assessment System
PO	Probation Officer
PVP	Protecting Vulnerable People
RO	Responsible Officer
SARA	Spousal Assault Risk Assessment
SPO	Senior Probation Officer
TOR	Terms of Reference

End of overview report 'Jean'