Domestic Homicide Review

Name: Jane
Died: December 2016

Author: Ged McManus
Date: May 2018

1 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Jane, a resident of Middlesbrough prior to the point of her death in December 2016.

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

1.3 Jane was murdered in her own home. Her youngest son, Roger has now been convicted of her murder. Roger had assaulted Jane before and been sent to prison for it. Jane lived alone and often allowed Roger into her house and provided him with food, drink and shelter.

1.4. The DHR panel and Community Safety Partnership would like to extend their condolences to Jane's family.

1.5 The review will consider agencies contact/involvement with Jane and Roger from 28 April 2012, until her death in December 2016.This period was chosen because it encompasses the first time that Roger was convicted of assaulting Jane and a period in which he was subject to supervision by the National Probation Service. The panel's view was that this four and a half year period was sufficient to give proportionate depth to the review.

1.6 The intention of the review process is to ensure that 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 that they are understood and adhered to by their employees. Note: It is not the purpose of this DHR to enquire into how Jane died. That is a matter that has already been examined during Roger's trial.

2 Timescales

2.1 This review began on 22 September 2017. The start of the review was delayed by complicating factors within the police investigation. Initially there were a number of lines of enquiry into Jane's murder and until a suspect had been formally identified and charged it was not thought appropriate to make decisions on the progression of a DHR. Once that stage had been reached an independent chair and author was appointed and the DHR panel was constituted. The DHR panel met on five occasions, the last meeting being on 12 April 2018. The report was concluded on 10 May 2018, following consultation with Jane's family who requested minor changes to the report.

3 Confidentiality

3.1 A pseudonym agreed with the victim's family has been used to protect her identity. The panel allocated pseudonyms to Roger and Henry, Jane's partner who both did not take part in the review.

Victim: Jane, 44 years, white British female

Perpetrator: Roger 23 years, white British male

Jane's partner: Henry, white British male

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 28 April 2012 to the date of Jane's murder in December 2016.

4.3 **Case Specific Terms**

Subjects of the DHR

Victim: Jane, 44 Years

Perpetrator: Roger, 23 Years

Specific Terms

1. How did your agency identify and assess the domestic abuse risk indicators in this case; was the historical domestic abuse taken into account when setting the risk levels and were those levels appropriate?
2. What indicators of domestic abuse, including coercive and controlling behaviour,[1] did your agency identify?
3. What consideration did your agency give to any mental health or substance misuse when identifying, assessing and managing risks around domestic abuse?
4. How did your agency manage those risks?
5. What did your agency do to keep the levels of risk under review?

[1] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

6. What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

7. How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?

8. Were there any opportunities for professionals to routinely enquire regarding domestic abuse with the victim which might have been missed?

9. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?

10. What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?

11. Was there sufficient focus on reducing the impact of the perpetrators abusive behaviour towards the victim by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?

12. Were single and multi-agency policies and procedures, including the MARAC[2] and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

13. How effective was your agency's managerial oversight of this case?

14. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

15. What knowledge did family and friends have of the adults' relationship, that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?

16. The review must take full account of issues raised by the victims' family and represent the voice of the victim and her family, in its narrative.

5 Methodology

5.1 Following Jane's death, a scoping meeting of the Middlesbrough Community Safety Partnership took place on 24 January 2017. The meeting had available to it brief

[2] Multi-agency risk assessment conference. This is a process in which agencies meet to consider what action can be taken to protect the victims of domestic abuse. Generally only those victims that are considered to be at high risk of serious harm are referred to a MARAC.

chronologies from a number of agencies and received a briefing from the police senior investigating officer on the progress of the case. A decision was made to conduct a DHR and the Home Office was informed of that intention on 30 January 2017. However, at that time a decision was made not to progress a DHR until the police investigation was sufficiently advanced. Once Roger had been charged with the murder, arrangements were made to appoint an independent chair and author and begin the DHR.

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

6.1 The independent chair of the review wrote to Jane's mother and son inviting them to contribute to the review. The letters were delivered and explained by the police Family Liaison Officer. The chair also wrote to Jane's former partner – Roger's father, inviting him to contribute to the review. He did not reply. In addition, the chair wrote to Roger in prison, inviting him to contribute to the review. He indicated that he did not wish to be involved.

6.2 Jane's mother and her partner agreed to speak to the Independent Chair of the review on behalf of the family and shared information about Jane. They were offered support through Victim Support or AAFDA[3] but declined third party assistance.

6.3 Jane was brought up in Middlesbrough as one of five siblings. The family lived together in social housing on a local estate. Her father disappeared from her life suddenly when she was quite young, and her mother remarried. Jane attended local schools and left school aged sixteen. She had a number of jobs working in the kitchen of a restaurant and in a shop as a cleaner.

6.4 Jane became pregnant with her first child aged eighteen and moved into her own home. She had her second child, Roger, two years later. Both children had different fathers and it was with Roger's father that Jane formed an enduring relationship. Although the couple never lived together, Jane and Henry spent time together and both contributed to bringing Roger up. Henry visited almost every day and spent much of his time at Jane's house when he wasn't working.

6.5 Jane's mother described Roger as having an unremarkable childhood. His older brother spent much of his time at his own father's house and Roger was provided with everything he needed by Jane and his father. Problems began in Jane's mother's opinion when Roger, as an adolescent, began to use cannabis. He later

[3] Advocacy After Fatal Domestic Abuse. A charity which supports the families of victims of domestic homicide.

moved on to use other substances and misuse alcohol. This led to him pressuring Jane to give him money and when she didn't, he could be aggressive and sometimes violent. Jane pawned items, such as televisions so that she could give Roger money and when her mother bought them back for her she quickly pawned them again.

6.6 Although she was aware of some things that happened, Jane's mother described Jane as being a very private person who had held back many things. For example, she did not share details of the attacks on her by Roger for which he was sent to prison twice. On other occasions she sought to minimise and excuse Roger's behaviour.

6.7 Although she had always enjoyed drinking, her family thought that Jane began to seriously misuse alcohol following the death of her younger brother, to whom she was very close eleven years ago. Although she did seek help on occasions she continued to drink and her mother described Jane as an alcoholic. In her opinion this was a factor which made Jane especially vulnerable to being abused by Roger.

6.8 Jane told her mother that she loved Roger because he was her son, but that she didn't like him because of the way that he behaved. She later said to her mother of Roger "I'm frightened of him".

6.9 Jane's mother came to see Jane's relationship with Henry as being characterised by his controlling behaviour. She said that he was generous to Jane in many ways but also tried to control her. At one point in their relationship he told Jane "it's your mam or me". Her mother said that on one occasion when Jane had been in a rehabilitation centre for her alcohol misuse, Henry picked her up and gave her a bottle of Southern Comfort, she thought that this was another example of controlling behaviour. On other occasions Jane's mother said that Henry would persuade Jane to let Roger in the house and feed him even though there was a restraining order in place preventing him from being there.

6.10 The couple were aware of just one violent incident between Jane and Henry many years ago, in which Jane had told her mother the couple had fought but Jane had "given as good as she'd got". [The panel were aware that an incident similar to this was reported to the police in 2002]

6.11 Jane's mother and her partner thought that they would have been able to help Jane more if she had shared with them what was happening. For example, when she had difficulty with rent arrears because of the under-occupancy charge [so called 'bedroom tax'], her mother paid the money that was needed. The couple felt that they would have been able to exert some control over Roger by talking to him and influencing him if they had known how badly he was behaving.

6.12 Jane's family say that she was a kind and generous person who loved her family deeply and was badly affected by the death of her brother. They would like her to be remembered as 'a kind and generous person with a heart of gold'.

7 Contributors to the review/ Agencies submitting IMRs

Agency	Contribution
Cleveland Police	IMR
South Tees CCG	IMR
Tees Esk and Wear Valleys NHS Foundation Trust	IMR
South Tees Hospital NHS Foundation Trust	IMR
National Probation Service	IMR
My Sister's Place	IMR
Middlesbrough Recovering Together	IMR
Youth Offending Team	Short report
Middlesbrough Borough Council Adult Social Care	IMR
Thirteen Housing	Short report

7.1 As well as the IMRs, each agency provided a chronology of interaction with Jane including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, 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. All IMR authors were independent of the case having not previously been involved in the case or the line management of others who were.

7.2 The IMRs in this case were written sensitively and were very much centred on Jane. 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

Ged McManus	Independent Chair and author
Paul Cheeseman	Independent Support to Chair
Claire Moore	Domestic abuse coordinator, Middlesbrough Borough Council
Detective Inspector Darren Birkett	Cleveland Police
Barbara Potter	Head of quality and adult safeguarding, South Tees Clinical Commissioning Group
Karen Agar	Associate Director of Nursing [safeguarding] Tees Esk and Wear Valleys NHS Foundation Trust
Helen Smithies	Assistant Director of Nursing, Safeguarding, South Tees Hospital NHS Foundation Trust
John Bagley	Probation manager, National Probation Service – Cleveland
Kirsty Madden	Safeguarding manager, My Sisters Place
Gary Besterfield	Hospital Intervention Liaison Team manager [Middlesbrough Recovering Together]
Rachel Burns	Health improvement specialist, Middlesbrough Borough Council

Paul Harrison	Operations manager, South Tees Youth Offending Service
Danielle Chadwick	Service manager, Harbour
Erik Scollay	Director Middlesbrough Adult Social Care and health integration
Chris Joynes	Director of customer services, Thirteen group [housing]

9 Author of the overview report

9.1 Ged McManus was chosen as the DHR Independent Chair and Author. He is an independent practitioner who has chaired and written previous DHRs and was judged to have the skills and experience for the role. He is currently Independent Chair of a Safeguarding Adult Board in the north of England. He was assisted by Paul Cheeseman another independent practitioner who has experience of the Chair and author role. Neither of them has previously worked for any agency involved in this review.

10 Parallel Reviews

10.1 An inquest was opened on 31 December 2016. It was adjourned pending Roger's crown court trial. Following his plea of guilty to murder on 9 October 2017 the inquest was finalised without a hearing.

There are no other parallel reviews.

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 may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. [There has been nothing to suggest that a disciplinary inquiry or process is merited in respect of any agency involved in this review].

11 EQUALITY AND DIVERSITY

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

- age
- disability

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

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. They were living in an area which is predominantly of the same culture. 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 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provides that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.4 Domestic homicide and domestic abuse in particular, is predominantly a gender 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. Between March 2013 and March 2015 over three-quarters (77%) of female domestic homicide victims were killed by a partner/ex-partner, with the remaining 23% killed by a family member. For male homicides, there was a much more even split, with around a half (51%) of victims killed by a partner/ex-partner and the other half (49%) killed by a family member. [ons.gov.uk]. That Jane was killed by her son makes the circumstances of this case relatively unusual.

12 DISSEMINATION

12.1

- Middlesbrough Community Safety Partnership
- Cleveland Police
- South Tees CCG
- Tees Esk and Wear Valleys NHS Foundation Trust

- South Tees Hospital NHS Foundation Trust
- National Probation Service
- My Sisters Place
- Middlesbrough Recovering Together
- Harbour
- Thirteen housing group
- Middlesbrough Adult Social Care

13 **BACKGROUND INFORMATION (THE FACTS)**

13.1 Jane lived on her own in Middlesbrough, she was not married but her long term partner, Henry visited her most days. Their son Roger had his own home but also visited Jane on most days of the week. Both Jane and Roger misused alcohol and Roger also misused drugs.

13.2 On 21 December 2017 and 22 December 2016, Roger subjected his mother to a sustained assault over several hours. Henry found Jane injured. He later told the police that he did not realise how badly hurt she was and tried to care for her. He telephoned for an ambulance late in the evening of 22 December 2016, when he thought that Jane had stopped breathing. Paramedics were quickly on the scene but were unable to save Jane.

13.3 Roger was arrested and denied assaulting his mother saying that he had found her injured in the street and that she had been mugged by others. He pleaded guilty to Jane's murder on 9 October 2017 and was sentenced to life imprisonment with a minimum tariff of twenty years and two months.

13.4 Jane had forty one injuries, including twenty nine fractures, with severe head and chest injuries. The likelihood is that the injuries were caused by Roger stamping on her and beating her.

13.5 At Roger's sentencing the judge said;

"Only you know precisely what happened, but the widespread injuries suffered by your mother can only be explained by you delivering a relentless series of blows on her head and body.

The family as a whole simply cannot understand how you, [name redacted], could have killed your own mother. You knew your mother was weak, alone and vulnerable. You attacked her in her own home, a place where, despite her many problems, she was entitled to feel safe. The attack was unremitting.

You left your dying mother in the house, well knowing that she was in dire need of medical attention. You attempted to divert the blame. Self-induced intoxication is of course no excuse".

14 Chronology

14.1 Glossary of agencies involved in the case

My Sisters Place - an independent specialist 'One Stop Shop' for women aged 16 or over who have experienced or are experiencing domestic abuse.

Middlesbrough Recovering Together – An umbrella body that provides a range of drugs and alcohol services, including:

- HILT – Hospital Intervention Liaison Team, based at James Cook University Hospital. The team support the introduction of screening, brief psychological interventions, assessment and clinical management of unplanned alcohol withdrawal and provide specialist assessment for those referred.
  MRT [Change, Grow, Live] novated the HILT (Hospital Intervention and Liaison Team – based in James Cook Hospital) contract on the 01/06/2017 after the liquidation of Lifeline Project the previous provider. Lifeline Project were commissioned to deliver the HILT service from 01/04/2014 therefore there is information available from this date. Any contacts prior to 01/04/2014 are unavailable as the service was managed by The Albert Centre which no longer exists.
- Change Grow Live – Community drug and alcohol services

South Tees Hospitals NHS Foundation Trust

[STHFT] provides two acute hospital sites and a range of community services. The largest hospital site is James Cook University Hospital [JCUH]. The Trust employs approximately 8500 staff who provide a range of local and specialist regional services to 1.5 million people.

Tees Esk and Wear Valleys NHS Foundation Trust

This NHS Trust provides mental health services for the area. It also provided substance misuse services for part of the review.

Probation Service

Durham Tees Valley Probation Trust (DTVPT) supervised Roger until 1 June 2014, when the Probation Trust was reconfigured into the National Probation Service [NPS]. All references in this report will be to the Probation Service.

Thirteen Housing Group – Jane's landlord

Thirteen Housing Group was created in April 2014, being a merger between Fabrick Housing, consisting of Erimus Housing and Tees Valley Homes and Vela Group, consisting of Tristar Homes and Housing Hartlepool. At the outset each group continued working within its own policies and procedures until consolidated processes were agreed. Jane's house was originally owned by Erimus housing.

14.2 THE FACTS BY AGENCY

The agencies who submitted IMRs are dealt with without comment in a narrative which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 16.

14.3 Prior to 2012 Roger was known to the South Tees Youth Offending Service as a young person who was referred to them on five occasions between 2007 and 2010. This contact related to offences of criminal damage, theft, possession of cannabis and two assaults on Jane. Youth Offending Service assessments identified that Roger was at medium risk of offending and he was subject to an Enhanced level of supervision. This meant that the Youth Offending Service were required to make contact with the young person at least once per week for the first 3 months of his order and fortnightly thereafter.

During the course of his supervision, referrals were made to external agencies for:

- Family Mediation, which both Roger and Jane engaged with
- To a drug service to provide intervention to support Roger around his substance misuse

Roger successfully completed all his statutory orders and showed a good level of compliance.

14.4 Jane was a diabetic and had misused alcohol for many years. She had many health appointments. Only those thought to be of most relevance are documented in the chronology.

14.5 On 28 April 2012, Jane contacted the police to make a complaint that Roger had stolen £40 from her. A DASH[4] risk assessment was conducted which was graded as

[4] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March

medium risk. Following enquiries to trace him, Roger was arrested on 1 May 2012, charged with robbery and kept in police custody to attend court. A special measures request was made for either screens at court, evidence by live link or in private through Jane's fear of Roger.

14.6 On 23 May 2012, Jane was seen by the Tees Esk and Wear Valleys NHS Foundation Trust, Crisis Response Team following a referral from her GP. She told them that her use of alcohol was impacting on her mental health and she didn't know what was real. She agreed to an appointment for an alcohol assessment but did not attend and after attempts to engage her failed, she was referred back to her GP

14.7 On 3 July 2012, a Police Community Support officer on patrol passed Jane's home and saw that she was crying and upset. Jane indicated that she was considering self-harm. As a result, she was detained under section 136 of the mental health act and taken to Roseberry park psychiatric hospital. Medical staff were unable to assess Jane due to her state of intoxication and she stayed on the unit until the following day. When assessed it was found that there was no evidence to suggest depression, anxiety or psychotic symptoms. Her risks were summarised and a plan devised to sign post her to appropriate agencies to address issues around her alcohol use, mental health and domestic violence. She disclosed a number of issues including her son's behaviour, drug use, that she had been exploited by Roger and misuse of alcohol.

14.8 On 5 July 2012, Jane attended an appointment at a substance misuse service managed by Tees Esk and Wear Valleys NHS Foundation Trust. She remained engaged with the service until September 2013. Jane missed many appointments but kept others and attained periods of abstinence from alcohol but relapsed on several occasions. Alongside her treatment for alcohol dependence she was supported to improve her physical and mental health, promoting her independence by addressing housing, employment and financial difficulties and providing support to enhance her social support. Jane disclosed on a number of occasions that she continued to have contact with Roger. On every occasion she was advised to contact the police and stop contact with Roger.

14.9 On 19 July 2012, Jane contacted the police and was upset about receiving a letter asking her to attend court as a witness in the case against Roger. Jane said that she had drunk a bottle of vodka and indicated that she was considering self-harm. Police officers attended at her home whilst she was kept talking on the telephone. Having spoken to her they were satisfied that she was safe and she was left in the

2009, having been accredited by ACPO Council, now known as National Police Chief Council [NPCC] For more detail see Appendix A

company of a friend.

14.10 On 30 July 2012, Jane was served with a witness summons to attend court to give evidence in the case against Roger scheduled for 7 August 2012.

14.11 On 7 August 2012, Roger pleaded guilty at Teesside Crown Court to the robbery of property from Jane on 28 April 2012. He was released with bail conditions not to approach Jane whilst a pre-sentence report was prepared. However, Jane contacted the police later the same evening and reported that Roger had been to her house. Police attended that evening, took a statement from Jane and arrested Roger. He was charged with breach of bail conditions and appeared at Teesside Magistrates Court the following morning, 8 August 2012. Roger was remanded into custody until the case was heard on 27 September 2012, when he was sentenced. Jane did not appear as a witness in the case.

14.12 On 27 September 2012, Roger appeared at Teesside Crown court. He was made subject to a Suspended Sentence Order comprising nine months detention in a Young Offenders Institution suspended for two years. The Order contained requirements for two years Supervision and for Roger to complete 160 hours unpaid Work. A Restraining Order was also imposed indefinitely prohibiting him from

I) Either by himself or his agents directly or indirectly in any way whatsoever from contacting, harassing, alarming or distressing or molesting Jane.

II) Notwithstanding the generality of the aforesaid, he is prohibited either by himself or his agents by any means whatsoever from.

III) Telephoning, faxing, texting of communicating by letter, electronic mail or internet, or the sending or soliciting to send any item or correspondence whatsoever to the said Jane or attending her home address at **** or attending any address the said Jane may move to in the future.

14.13 Prior to his sentence a pre sentence report was carried out by the Probation Service using the nationally accredited offender assessment system [OASys] and all relevant factors were taken into account. The assessment was that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane, and a medium risk of causing serious harm to the public.

14.14 Roger's case was allocated to the same probation officer who had completed the pre sentence report. The expectation was that, jointly with the probation officer, the offender would complete the Citizenship Programme Induction Module, which was an eight week programme addressing offending behaviour. This was completed by 19 March 2013, with delays being caused by non attendance at appointments as

well as links being made with partner agencies to secure accommodation and to work on drug and alcohol problems.

14.15 On 24 October 2012, during an appointment with the Tees Esk and Wear Valleys NHS Foundation Trust, substance misuse service, Jane disclosed that Roger was attending at her home in breach of a court order. She was encouraged to contact the police to report this. She also told staff that she was worried about her housing situation due to the introduction of the under occupancy charge and was advised to contact the citizens advice bureau.

14.16 On 28 January 2013, Jane attended an appointment with the Tees Esk and Wear Valleys NHS Foundation Trust, substance misuse service. Roger was noted to be in the waiting room waiting for her, in breach of his restraining order.

14.17 On 19 February 2013, at an appointment with the Probation Service, Roger admitted that he had been in contact with Jane. Roger was assessed as posing a medium risk of causing serious harm to a known adult, his mother Jane, and a medium risk of causing serious harm to the public.

14.18 On 26 February 2013, Roger again admitted to his probation officer that he had been in contact with his mother. That information was not passed to the police and the Probation Service did not take any action in response to it.

14.19 On 30 March 2013, the police were contacted by a witness who stated that Roger and other men were fighting in her house [the witness was a parent of Roger's friend and this incident is unconnected to Jane] Roger was arrested, charged with affray and kept in police custody to attend court.

14.20 On 10 June 2013, Jane was admitted to James Cook University Hospital after she collapsed at a shopping centre. Whilst there she was seen by the [Tees Esk and Wear Valleys NHS Foundation Trust] Liaison Psychiatry team based at the hospital. Jane had said that she would jump in front of a car when told that she was fit to go home. It was assessed that Jane's low mood was due to drinking large amounts of alcohol and social stressors. The police were contacted with regard to threats that Jane said she had received from unnamed people to whom Roger owed money. The police, were satisfied that Jane was safe and took her home.

14.21 On 15 June 2013 Jane reported to the police that Roger had punched her. Police officers attended at her home address and arrested Roger. Jane was taken to hospital and admitted for treatment to a head injury caused by the assault. She disclosed drinking approximately 35 units of alcohol per week and was seen by the PADS [Primary alcohol and drug service]. At this time PADS was a commissioned service to carry out drug and alcohol assessments and follow up referrals and interventions. [As of 1 April 2014 the PADS service was recommissioned from

another provider and was renamed as HILT - Hospital Intervention Liaison Team]. She was discharged the next day.

14.22 Roger was charged with assaulting Jane and breach of a restraining order. He was kept in police custody to attend court where he was remanded to prison. A DASH risk assessment was completed and was initially classed as medium risk by the attending officer. This was then raised to high risk by the risk assessment officer in the vulnerability unit. A referral was made to My Sisters Place and the case was considered by the police for a referral to MARAC as it had been assessed as high risk. A decision was made not to refer to MARAC as there was already a restraining order in place, no children were involved and Jane had allowed Roger access to the house.

14.23 On 17 June 2013, following a referral from the police, My Sister's Place contacted Jane by telephone to offer support services. Jane said she would like support but not at that time as she didn't want to go out with injuries [2 black eyes]. Safety planning was discussed with Jane and a letter was sent outlining the support available.

14.24 On 18 June 2013, following a number of complaints from Jane about her neighbours, noise monitoring equipment was installed in Jane's house by her landlord Thirteen Housing Group. On 7 July 2013, the noise monitoring equipment was removed as no evidence of noise nuisance was found.

14.25 On 13 July 2013, Jane was taken to hospital by ambulance. She said that since the assault on her by Roger she had been having seizures and episodes of collapsing. Jane left the hospital during the night to buy alcohol and said that she had drunk a quarter of a bottle of vodka. She was referred to a liver harm reduction clinic but did not attend.

14.26 On 9 September 2013, Roger appeared at Teesside Crown Court for breach of the suspended sentence order, breach of restraining order and common assault, which took place on 15 June 2013. Roger was sentenced to six months Detention in a Young Offenders Institution.

14.27 A Pre Sentence Report completed by Roger's probation officer concluded that the common assault took place during a period in which Roger was frequently being invited to Jane's home. It recognised that there was an established pattern of abuse towards his mother. The assessment was that he continued to pose a medium risk of causing serious harm on the basis that there was a pattern of incidents rather that an escalation which would have crossed the threshold in to high risk.

14.28 On 9 September 2013, Jane was taken to hospital by ambulance following a fall whilst walking downstairs. She was treated for an incomplete dislocation of the jaw. Jane said that she was drinking seventy units of alcohol a week and was invited to attend a liver harm reduction clinic but did not do so.

14.29 On 25 October 2013, Roger was released from prison on licence until 26 April 2014. The expectation was that he completed the Citizenship Programme Induction Module at weekly appointments. There were interruptions to this process particularly relating to discussions about accommodation and misuse of drink and drugs but by 14 November 2013, session four had been completed. Roger then failed to attend appointments on 21 and 27 November 2013, which led to the issue of first and second warnings in keeping with enforcement procedures. He was issued with a verbal warning on 9 December 2013 when it came to light that he had not been residing as directed.

14.30 On 14 November 2013, Jane was taken to hospital by ambulance. She said that she had been assaulted by being struck over the head. She did not say who was responsible. She was intoxicated by alcohol and was agitated and hallucinating. Bystanders had told ambulance staff that Jane had fallen over.

14.31 On 10 December 2013, Jane reported to the police that Roger was at her house trying to force his way in. This was in breach of a restraining order. Following a further incident the following day, when Jane alleged that Roger made threats to her, the police located and arrested Roger. A DASH risk assessment was completed at the time and was initially graded as standard by the attending officer. This was raised to medium by the risk assessment officer who attempted to ring Jane twice, but the call went to voicemail, so a message was left to re-contact if she required any further support. In her statement, Jane described how she had allowed Roger to stay at her house a couple of times as he was freezing and hungry. Roger was remanded into custody until sentencing on 17 March 2014.

14.32 On 11 December 2013, Jane contacted the police before Roger had been arrested for the offence of 10 December 2013. She said that Roger had telephoned her making threats and had walked past her house. When the police attended later in the day the officer obtained a signed pocket book entry stating that Jane did not want to make a complaint. The entry indicated that Jane let Roger stay, fed him and gave him money but that she rang the police when she was fed up of him. On 12 December 2013, a fixed term recall was instigated by the Probation Service as Roger was in breach of licence conditions as a result of his offending. Fixed term recall is for a set period of twenty eight days before automatic re release. However, as he had been remanded in custody to appear at Teesside crown court Roger was not released in that timescale.

14.33 On 30 December 2013, My Sister's Place telephoned Jane to discuss Roger's court case. Jane said that she didn't think she could face Roger in court. Special measures and the support available were discussed but Jane declined any help.

14.34 On 13 January 2014, police contacted Adult Social Care and discussed a number of concerns in relation to Jane who had reported that a number of incidents had taken place with her neighbours. Concerns were expressed about her use of alcohol, mental health and general vulnerability. Adult Social care were unable to contact Jane by telephone but left several messages. On 22 January 2014, a letter was sent to Jane offering her advice and support.

14.35 On 18 February 2014, Jane contacted the police following a dispute with a neighbour. She was distressed and said she 'felt like doing herself in'. Officers liaised with a relative and were satisfied that Jane would not self-harm but was exhibiting what they thought might be paranoid behaviour.

14.36 On 17 March 2014, Roger appeared at Teesside Crown Court for Breach of his Restraining Order which took place on 10 December 2013. He was made subject to a Suspended Sentence Order comprising twelve months custody suspended for eighteen months. The Order contained requirements for eighteen months supervision and for Roger to complete 150 hours unpaid work. The Restraining Order was extended until March 2016.

14.37 Prior to the sentence, Roger's probation officer prepared a third pre sentence report. That report analysed the breach of his restraining order on 10 December 2013 in the context of Roger being regularly invited to Jane's home. It appeared that on this occasion he attended Jane's home uninvited before an argument ensued and the police were called. An OASys risk assessment maintained that he posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public. Roger's compliance with the order was initially good, he completed six sessions of the Citizenship Programme Induction Module and completed the unpaid work order by 24 May 2014.

14.38 On 24 March 2014, Jane contacted the police to report a dispute with a neighbour and an assault on her son [not Roger]. On attendance police officers judged that Jane was exhibiting symptoms of being mentally unwell and with her consent she was taken to Roseberry park psychiatric hospital.

14.39 Jane described to medical staff paranoia about her neighbours saying she was a paedophile and thoughts of wanting to attack her neighbours. She said her partner was being very controlling, but they did not live together. There were no signs of underlying mental health issues and Jane had full insight into her overall situation. She was referred to Middlesbrough Recovering Together, a separate organisation who by now had taken over responsibility for substance misuse services in

Middlesbrough.

14.40 On 7 April 2014, Jane attended hospital following a seizure. She was admitted for observations and discharged the following day. Jane said that she was stressed due to her son's impending release from prison and that she was drinking a litre of vodka a day together with wine. She was again seen by the [Tees Esk and Wear Valleys NHS Foundation Trust] Liaison Psychiatry Team based at the hospital. It was concluded that there was no role for the Liaison Psychiatry Team. The assessment summarised that the past self-harm was due to social stressors and there was risk of misadventure evident due to alcohol misuse and impulsivity. As a result, the Patient Alcohol & Drug Service [South Tees NHS Trust] was asked to assess her.

14.41 On 28 April 2014, Jane called the police and reported that she had experienced threats from neighbours. She displayed evidence of paranoid thoughts. Police sought advice from the [Tees Esk and Wear Valleys NHS Foundation Trust] Crisis Team and were advised to encourage Jane to see her GP. She did see her GP that morning who referred her to the [Tees Esk and Wear Valleys NHS Foundation Trust] Access Team. The referral was declined until Jane could achieve a reduction in her alcohol consumption as it was felt that there was no significant change since the assessments of 24 March and 7 April 2014.

14.42 On 7 May 2014, Jane was seen by the HILT team after an admission to James Cook University Hospital for seizures. The primary substance was defined as alcohol [vodka]. HILT team completed an AUDIT[5]. The score was 36 indicating possible alcohol dependency. Jane was offered Chlordiazepoxide, a drug used to treat alcohol withdrawal seizures but declined it. Jane stated she had been alcohol free for 3 months after a previous detox. She reported drinking 70cl of vodka over 4 times per week. Notes record that Jane had a community alcohol worker who the service tried to contact unsuccessfully and Jane had requested a home visit from the community team. There is no evidence to suggest this information was passed on to the community team. The risk assessment was not completed on the assessment form, therefore there seems to have been no opportunity taken to discuss risks, or risks from others. There is no evidence that other services were updated.

14.43 On 21 May 2014, Roger told his probation officer that he had visited Whitby with both his parents. This was in breach of the restraining order not to contact Jane.

[5] Alcohol Use Disorders Identification Tool. A ten item screening tool developed by the World Health Organisation to assess alcohol consumption, drinking behaviours and alcohol related problems.

14.44 On 28 May 2014, Roger again told his probation officer that he had been visiting Jane. Roger was advised that he should collect any belongings from Jane's home and stop visiting.

14.45 On 28 May 2014, following a referral from her GP the Tees Esk and Wear Valleys NHS Foundation Trust, Access Team wrote to Jane's GP, stating that as two recent assessments had recently found no psychotic or paranoid thoughts, it was felt another assessment would be unnecessary, although it was thought that engagement with substance misuse services could be helpful.

14.46 On 3 June 2014, Jane was seen by the HILT team after an admission to James Cook Hospital for seizures. The primary substance was defined as alcohol (Wine). HILT completed an AUDIT. The score was 28 indicating alcohol dependence. An alcohol detox was commenced in hospital. Jane reported that she had tried to cut down her alcohol intake by moving from drinking spirits to drinking wine and she thought that this was why she had a seizure. This change is consistent with the advice that would be given for alcohol reduction. Jane reported drinking 7 bottles of wine per week. This would mean she was consuming around 13-15 units daily. A bottle of vodka 70cl contains around 30 units. Therefore, an attempt at a reduction was evident. Jane said that she was working with a community alcohol team. There is no evidence that other services were updated. A risk assessment was not completed.

14.47 On 10 June 2014, Roger's probation officer visited the address he had given and found he was not living there. A warrant without bail was issued for his arrest on 24 July 2014, when Roger failed to appear at Teesside magistrates court for breach of the suspended sentence order imposed on 17 March 2014.

14.48 On 16 July 2014, following a concern about Jane's welfare expressed by a third party, police and the [Tees Esk and Wear Valleys NHS Foundation Trust] Street Triage Team attended at Jane's home. The street triage team could not carry a full assessment due to Jane's level of intoxication, but she did not appear to be psychotic or present with a thought disorder. Jane was referred to Stepping Forward at MIND, this was a project the intention of which was to reach out to hard to engage clients. Following a series of telephone calls, letters and failed appointments Jane was discharged from the project as they were unable to engage with her.

14.49 On 29 August 2014, Roger was arrested on a warrant which had been issued by Teesside magistrates court on 4 August 2014, for breach of his suspended sentence. He appeared at court on 1 September 2014. The Suspended Sentence Order was allowed to continue and Roger was ordered to complete an additional twenty hours unpaid work which he did successfully by 5 September 2014.

14.50 On 3 September 2014 and again on 10 September 2014, Roger told his probation officer that he had been visiting Jane. On 1 October 2014, at a further appointment he claimed that Jane had been contacting him. Roger was reminded of the terms of the restraining order.

14.51 On 11 October 2014, Jane contacted the police to report that she had been assaulted by Roger causing a head wound. Police attended immediately and arrested Roger. He was charged with assault, breach of a restraining order and threats to kill. He appeared at Teesside Magistrates court on 13 October 2014, when he was remanded in custody to appear at Teesside Crown court on 11 November 2014.

14.52 Jane was taken to hospital by ambulance and treated for a 3cm laceration to her scalp. She discharged herself soon after against medical advice. A mental capacity assessment[6] was completed which showed that Jane had the capacity to make her own decisions. A DASH risk assessment was completed by the police, which was graded as medium risk by the attending officer. This was raised to high risk by the reviewing officer. A MARAC referral was made together with a referral to My Sisters Place for IDVA support and the sanctuary scheme for improved security of the address.

14.53 On 13 October 2014, My Sister's Place contacted Jane by telephone to offer support. She agreed to attend an appointment on 27 October 2014 and for the sanctuary scheme [security assessment and installation of security measures] to visit her.

14.54 On 15 October 2014, after being unable to contact her by telephone Sanctuary scheme staff visited Jane at home. She said that she had just got up and didn't want to do an assessment then. Staff agreed to telephone her to make an appointment. Subsequent telephone calls and letters received no reply.

14.55 On 22 October 2014, Jane's case was heard at MARAC. Jane was due to attend an appointment at My Sister's Place on 27 October 2014 and the only action from

[6] Under the provisions set out in the Mental Capacity Act 2005, in order to decide whether an individual has the capacity to make a particular decision two questions must be answered. **Stage 1**. Is there an impairment of or disturbance in the functioning of a person's mind or brain? If so, **Stage 2**. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision? The Mental Capacity Act says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- understand information given to them
- retain that information long enough to be able to make the decision
- weigh up the information available to make the decision
- communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand

MARAC was a joint police and My Sister's Place visit to Jane at home if she did not keep her appointment with My Sister's Place. Erimus Housing [now Thirteen housing group], IDVA support and alcohol services all provided input to the meeting.

14.56 On 11 November 2014, Roger appeared at Teesside Crown Court for Breach of Suspended Sentence Order, Assault Occasioning Actual Bodily Harm which took place on 10 October 2014 and for two Breaches of Restraining Order which occurred on 9 and 10 October 2014. The suspended sentence order was activated and he was sentenced to 86 weeks imprisonment.

14.57 A pre sentence report was again carried out by Roger's probation officer. The OASys risk assessment stated that Roger posed a high risk of causing serious harm to a known adult, his mother Jane and a high risk of causing serious harm to the public. It was said that the offence took place when he was homeless and staying at his mother's home. Having drunk a number of cans of lager and taken some sleeping tablets, he was awakened by his mother and in the midst of an argument he placed his arms around her neck and strangled her to the point where she feigned loss of consciousness to get him to stop. He also threw a mobile telephone at her which caused an injury to her face and head which drew blood. The rationale for increasing the level of risk of causing serious harm was that there had been an escalation in the level of violence used.

14.58 On 26 November 2014, a joint visit to Jane at her home took place with an IDVA from My Sisters Place and a police officer attending. Jane was not seen and although records are unclear it is believed that a business card was left with Henry with a request for Jane to make contact. No further contact was received and no further action was taken.

14.59 On 21 February 2015 and 27 February 2015, Jane was admitted to hospital following a collapse or seizure. On both occasions she was seen by the [Tees Esk and Wear Valleys NHS Foundation Trust] Liaison Psychiatry Team after expressing thoughts of self harm. It was again concluded that there was no role for the Liaison Psychiatry Team. Jane was referred to My Sister's Place and Substance Misuse Services. Jane was seen by the HILT Team on the 21 February 2015 admission. She declined to fully complete an AUDIT stating that it was her mental health not her alcohol use that was the issue. Jane stated that she had been drinking for 6/7 days, brief advice was given highlighting the connection between alcohol, low mood and anxiety. Jane was signposted to MIND but she declined an onward referral to community alcohol services.

14.60 On 27 March 2015, Jane was seen by HILT after an admission to hospital for a seizure and a bang to the head after she had collapsed. HILT completed an AUDIT; the score was 29 indicating alcohol dependence. Jane stated that she was drinking

to forget problems that she had from drug dealers and had thoughts of harming other people.

14.61 On 5 May 2015, Jane disclosed to a witness liaison officer that she was feeling suicidal as a result of Roger's impending release from prison. Police visited Jane at home and with her consent she was taken to Roseberry Park. Following an assessment Jane was referred to the [Tees Esk and Wear Valleys NHS Foundation Trust] Crisis Response Team for a period of assessment for possible delusional thoughts.

14.62 On 6 May 2015, Jane was visited at home by the Crisis Response Team, but an assessment was not possible due to her level of intoxication.

14.63 On 7 May 2015, the Crisis Response team again visited Jane at home. Jane told them that she was worried that her son's drug dealer to whom he owed money would be visiting asking for money as she had received her benefit money that day. She also referred to an ongoing dispute with a neighbour. Following an assessment there was no evidence of psychosis or thought disorder and therefore there was no further role for the Crisis Response Team.

14.64 On 3 June 2015, Roger was released from prison on licence, supervised by the Probation Service, from 3 June 2015 to 30 March 2016. He was again expected to complete the citizenship programme induction module which he did by 15 July 2015.

14.65 On 7 July 2015, the police raised concerns about Jane's welfare with Adult Social Care. A number of telephone calls to Jane were unsuccessful in contacting her.

14.66 On 31 July 2015, two staff from Adult Social care visited Jane at home in an unannounced visit. Jane spoke to them about her difficulties with alcohol misuse and she told them that she had been drinking that day. She said that she had been through detox before and a referral to Middlesbrough Recovering Together was agreed. Jane spoke about issues that she was facing around the so called 'bedroom tax' and was given advice on how to deal with the issue. Jane said that her mood was 'all over' and she did not have any support with this, she was advised to see her GP. She talked about the problems that she had with Roger and the bedroom tax making her feel as if she should move house even though she didn't want to.

14.67 It was assessed that Jane was managing her home and personal care well and did not require support from Adult Social Care. A referral was made to Middlesbrough Recovering Together.

14.68 On 11 September 2015, Jane was admitted to hospital after being found collapsed in the street. She discharged herself against medical advice.

14.69 On 14 October 2015, Roger told his probation officer that he had been in contact with Jane.

14.70 On 5 November 2015, Roger again told his probation officer that he had been in contact with Jane. Over the previous months concerns had emerged around Roger's misuse of alcohol and drugs and it was confirmed on this date that he had engaged with Middlesbrough Recovering Together.

14.71 On 3 December 2015, Roger was served with a warning letter by the Probation Service regarding his contact with Jane. He was also told that the police would be making spot checks at Jane's house and a request was made to the police by email to do this. The checks were allocated to a neighbourhood officer who visited the house on two occasions in December 2015. The officer received no reply and no further action was taken. There is no record of the result of these checks being reported to the Probation Service.

14.72 On 15 January 2016, Jane attended at Roseberry Park psychiatric hospital and asked to be admitted because she said drug dealers were coming to her house as her son owed them money. She appeared to be intoxicated but was not displaying mental health issues. She was signposted to appropriate support services. Later the same day, Jane contacted the police and reported that Roger and his friends were in her home. This was in breach of his restraining order. Police attended and found that Jane was by that time alone, had been drinking and was heavily intoxicated. After liaising with other family members no action was taken and a DASH risk assessment was not completed.

14.73 On 27 April 2016, a final OASys assessment was completed marking the termination of Roger's licence period on 31 March 2016. This concluded that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public. That assessment was based on the fact he had complied with Licence conditions and reached the end of it without re-offending and there was no evidence from the Police that he was in contact with his mother.

14.74 On 17 June 2016, Roger was taken to hospital by ambulance following a fall from a bike when he received a facial injury. He said he had been drinking heavily and had taken six zopiclone tablets[7] for recreational purposes. On admission he gave Jane as his next of kin. Roger was discharged from hospital following treatment and did not attend a follow up appointment.

[7] Zopiclone (brand names Zimovane and Imovane) is a hypnotic agent used in the treatment of insomnia.

14.75 On 2 November 2016, Jane was assessed by the HILT team after an admission to hospital following a collapse at a local supermarket. An AUDIT was completed which scored 40 indicating alcohol dependence, Jane reported drinking half a litre of vodka daily. She said that her partner provided her with the alcohol but that she lived alone. Jane agreed to a referral to community substance misuse services and the Liver Harm Reduction Clinic.

14.76 On 17 November 2016, Jane did not attend an appointment with Change Grow Live, community alcohol service [Part of Middlesbrough Recovering Together].

14.77 On 30 November 2016, Jane had an appointment to attend a liver harm reduction clinic but did not attend.

14.78 On a day in late December 2016, following a call to the ambulance service by her partner Henry, Jane was found deceased in her home.

15 OVERVIEW

15.1 This overview has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs and supplementary reports from some agencies. Information from police statements has also been used. The findings of previous reviews and research into various aspects of domestic abuse has been considered.

15.2 In preparing the overview report the following documents were referred to:

- The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews 2016
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Key findings from analysis of Domestic Homicide Reviews. Home Office December 2016
- Evan Stark (2007) Coercive Control. How Men Entrap Women in Personal Life. Oxford University Press.
- Agency IMRs and Chronologies.

15.3 Jane had two children, Roger and an older son who had a different father. From an early age the older son spent much of his time with his father whilst Roger lived with Jane. Roger's father Henry, whilst not living with Jane visited almost every day.

15.4 Following the death of a sibling Jane began to misuse alcohol excessively. According to her family she had always enjoyed drinking alcohol from being a teenager, but

this seemed to be the catalyst for heavier alcohol use. This coincided with the time when Roger was a young teenager.

15.5 From as early as 2007 Roger came to the attention of the youth offending team and was supervised for five offences, two of them being assaults on Jane. Work that was done with Jane and Roger at that time was considered to be successful.

15.6 From 2012, Roger's offending against Jane increased in frequency. He was arrested on a number of occasions and went to prison twice for offences of assault against Jane. The court imposed a restraining order preventing Roger from contacting his mother but he breached this on many occasions, most of which did not come to the attention of any agency. Sometimes Jane allowed him in and fed him because he was cold and hungry despite the order being in place. On other occasions the review heard that Roger would beg her to let him in. It is difficult to know now what pressure she was under to do so, or if she was acting entirely of her own free will.

15.7 Jane's misuse of alcohol undoubtedly reduced her resilience to Roger's behaviour. She was admitted to hospital on many occasions when she had been drinking and had other health conditions. Although she was offered many different services, Jane would often disengage from them quickly and no service was ever successful in helping Jane over a meaningful period of time. Her mental health was often questioned and Jane herself believed that she had a mental health condition on some occasions. Despite a number of referrals to mental health services no mental health condition other than depression was ever diagnosed and Jane's symptoms were always found to be due to alcohol misuse.

15.8 Jane's mother told the chair of the review that Jane was often pressured by Roger to give him money. She pawned personal items and electrical goods in order to give him cash which it is thought was spent on drink and drugs. In effect Jane was subject to financial abuse but this was never reported. Despite Roger's poor behaviour towards her, Jane was unable to break off contact with him. In the last month of her life Jane was not in touch with any agency. Information from police statements indicates that during that month Roger spent much of his time at Jane's house and they both misused alcohol on a daily basis.

16 ANALYSIS

Each term appears in bold and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

16.1 **How did your agency identify and assess the domestic abuse risk indicators in this case; was the historical domestic abuse taken into account when setting the risk levels and were those levels appropriate?**

16.1.1 On four occasions during January and February 2012, police attended reports of domestic incidents where Jane had called them as a result of Roger's poor behaviour. The incidents were dealt with by removing Roger from the scene and taking him somewhere else. All of these incidents clearly fell within the Government definition of domestic violence [see appendix A] but did not result in a DASH risk assessment being conducted, despite Roger previously being in the criminal justice system on two occasions for assaults against Jane. It is possible that adolescent to parent violence was not recognised as domestic abuse by the officers involved. The panel noted that the term adolescent to parent violence was not commonly known or in use in 2012.

16.1.2 The Home Office information guide on Adolescent to Parent Violence and Abuse [APVA][8] states [para 1.4]

It is important to recognise that APVA is likely to involve a pattern of behaviour. This can include physical violence from an adolescent towards a parent and a number of different types of abusive behaviours, including damage to property, emotional abuse, and economic/financial abuse. Violence and abuse can occur together or separately. Abusive behaviours can encompass, but are not limited to, humiliating language and threats, belittling a parent, damage to property and stealing from a parent and heightened sexualised behaviours. Patterns of coercive control are often seen in cases of APVA, but some families might experience episodes of explosive physical violence from their adolescent with fewer controlling, abusive behaviours. Although practitioners may be required to respond to a single incident of APVA, it is important to gain an understanding of the pattern of behaviour behind an incident and the history of the relationship between the young person and the parent.

16.1.3 On 28 April 2012, Jane reported to police that Roger had stolen money from her. He was arrested within a few days and charged with robbery. A DASH risk assessment was conducted and graded as medium risk. This was an appropriate grading and did take into account the historic incidents and the escalation of incidents in the previous few months.

16.1.4 Prior to being sentenced on 27 September 2012, a pre sentence report was carried out by the Probation Service using the nationally accredited offender assessment system [OASys] and all relevant factors were taken into account. The assessment

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/420963/APVA.pdf

was that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane, and a medium risk of causing serious harm to the public.

16.1.5 As part of his sentence Roger was given a restraining order preventing him from contacting or approaching Jane. The crown court clearly recognised that Roger presented an ongoing risk to Jane and put in place a control measure to offer her some protection. The restraining order ended on 31 March 2016.

16.1.6 On 19 February 2013, following his admission to the Probation Service that he had been in contact with Jane, Roger was assessed as posing a medium risk of causing serious harm to a known adult, his mother Jane, and a medium risk of causing serious harm to the public. No action was taken against Roger and despite his admitted breaches of the restraining order the risk to Jane was perceived to remain the same. The panel concluded this was a missed opportunity.

16.1.7 On 15 June 2013, Jane reported to the police that Roger had punched her in the face. He was quickly arrested. A DASH risk assessment was conducted and graded as medium, this was regraded to high risk on review by the risk assessment officer in the police vulnerability unit. This was an appropriate grading which clearly took account of the current and historic risks.

16.1.8 On 9 September 2013, Roger appeared at court for the offence committed on 15 June 2013. A pre sentence report by the Probation Service assessed that Roger posed a medium risk of causing serious harm to Jane on the basis that there was a pattern of incidents rather that an escalation which would have crossed the threshold into high risk. This was an appropriate grading.

16.1.9 On 10 December 2013, Jane reported to the police that Roger was at her house trying to force his way in. This was in breach of the restraining order. The police attempted to find Roger that night but were unsuccessful. Following a further incident the following day, Roger was located and arrested. A DASH risk assessment was completed and was initially graded as standard by the attending officer. This was raised to medium by the risk assessment officer in the police vulnerability unit. The decision to regrade to medium risk was an appropriate one which took into account the historic context, some of which may not have been apparent to the attending officer.

16.1.10 On 17 March 2014, Roger appeared at court for sentencing in relation to the breach of the restraining order of 10 December 2013. A third pre sentence report was prepared which analysed the breach of restraining order on 10 December 2013, in the context of Roger regularly visiting Jane's home despite being prohibited from having any form of contact with her. On this occasion he attended his mother's home uninvited before an argument ensued and the police were called. The OASys

risk assessment maintained that he posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public. This was appropriate given that this was again a continued pattern of behaviour rather than an escalation.

16.1.11 On 11 October 2014, Jane contacted the police to report that she had been assaulted by Roger causing a head wound. Police attended immediately and arrested Roger. He was charged with assault, breach of a restraining order and threats to kill. A DASH risk assessment was completed which was graded as medium risk by the attending officer. This was raised to high risk by the reviewing officer. The regrading to high risk was an appropriate decision taking into account the historic context and escalation in seriousness of offending, all of which may not have been apparent to the attending officer.

16.1.12 On 11 November 2014, Roger appeared at court for sentencing in relation to the assault on Jane of 11 October 2014. A fourth pre sentence report was conducted by the Probation Service. The OASys risk assessment stated that Roger posed a high risk of causing serious harm to a known adult, his mother Jane and a high risk of causing serious harm to the public. This was an appropriate grading which recognised an escalation in the seriousness of Roger's conduct towards Jane.

16.1.13 On 3 June 2015, Roger was released from prison on licence, supervised by the Probation Service until 30 March 2016. On 27 April 2016, a final OASys assessment was completed at the termination of Roger's licence period. This concluded that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public. That assessment was based on the fact that he had complied with Licence conditions and reached the end of it without re-offending and there was no evidence from the police that he was in contact with his mother.

16.1.14 Roger had in fact admitted to breaching his restraining order a number of times and had been served with a warning letter on 3 December 2015, by the Probation Service in relation to this. The Probation Service emailed the police to ask that the police do spot checks at Jane's house to see if Roger was there. The checks were allocated to a neighbourhood officer who visited the house on two occasions in December 2015. No one was in and no further action was taken. The police did attend a report from Jane that Roger was at her home on 15 January 2016, but had not taken any action as Jane was very intoxicated, Roger was not there by the time they attended and there was no evidence to support the allegation. This was not reported to the Probation Service. Jane or other family members could have been contacted in order to confirm if Roger's apparent improvement in behaviour was real. The Probation Service asked the police to conduct "spot checks" for two

reasons. Firstly, to confirm to Roger that his case was being discussed with the police and if he was located at his mother's home then there was a distinct possibility that he would be recalled to prison for breaching the licence. The second reason was to provide a level of protection and safeguarding to Jane. There was little evidence from the Probation Service or the police that this strategy was followed through or that the two organisations communicated with each other over its implementation.

16.1.15 The regrading of risk from high to medium was based on Roger not breaching the restraining order from 3 December 2015, until the expiry of his licence period on 30 March 2016. This was perhaps an optimistic view of the risks given that Roger had continued to breach the restraining order until warned about it in December 2015. Between December 2015 and March 2016, there was a failure to take coordinated multi agency action between the police and Probation Service to effectively monitor Roger's conduct. However, there were no further reports of any incidents of Roger offending against Jane until her murder nine months later.

16.2 **What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify?**

16.2.1 The Serious Crime Act 2015, received royal assent on 3 March 2015. The Act created a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both. The new offence, which does not have retrospective effect, came into force on 29 December 2015. Consequently, there was a period of 12 months during which agencies had opportunities to consider using that legislation. The following paragraphs analyse those opportunities and the response of agencies.

16.2.2 Within the time frame of 29 December 2015, when the legislation came into force until the date of Jane's death, little information came to the attention of agencies. Apart from a single report that Roger was in breach of his restraining order [commented on at 16.1.11] the police were not involved with Jane in the last twelve months of her life. Having previously been involved regularly with health agencies, Jane had little contact with them in her last twelve months apart from in November 2016, when she was taken to hospital following a collapse at a supermarket. On this occasion she stated that her partner provided her with alcohol. This statement alone was not sufficient to raise concerns around coercive or controlling behaviour.

16.2.3 The Crown Prosecution Service policy guidance on coercive control states[9];

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
- 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

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

- 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.

16.2.4 Within the timeframe of the review it is clear that a number of the indicators were present. Roger assaulted Jane. Damaged her property, threatened her and according to her family regularly took money from her. It is highly likely that Roger put Jane under pressure to pawn goods in order to give him money. It is also clear that there were many times that Jane did not report domestic abuse or breaches of the restraining order. Her voice can no longer be heard and the Panel know there are many reasons why victims do not report abuse or answer questions.[10]

16.2.5 It is not now possible to know what pressure Jane was under to allow Roger into her house in breach of the restraining order. However, the potential impact of coercion and control was not recognised on a number of occasions, for example following an assault on Jane by Roger on 15 June 2013, one of the reasons stated for not referring the case to MARAC was that Jane had invited Roger into her home in breach of the order. The Probation Service pre sentence report for the offence referred to Roger being invited to Jane's home regularly. Health professionals were also aware of the pressures Jane felt, including from Roger's financial exploitation of her and encouraged her to report breaches of the order to the police. While the offence of coercion and control was not in place agencies could have done more in terms of using the powers then available to them. For example, by having a joined up multiagency plan to deal with Roger's regular breaches of his restraining order.

16.2.6 Jane's family also point to Henry as a potential controlling influence. They state that he would persuade Jane to let Roger into her house and would provide or withhold alcohol as a means of control. Henry was not generally visible to agencies and there were no reports to the police in relation to his conduct during the timeframe of the

[10] The reasons victims gave for not reporting the domestic abuse to the police were identified in a survey as: 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). Everyone's business: Improving the police response to domestic abuse; March 2014

review. It is thought however, that it was Henry who was spoken to on 26 November 2014 by the police and My Sister's Place representatives, when a visit took place to Jane's home. Jane was not seen and a business card was left with a man believed to be Henry. Roger was in prison at the time of the visit and there was nothing known to professionals at that time to suggest that anyone other than Roger was a risk to Jane. The panel considered however, that leaving a business card with an unknown third party was an inappropriate response to a high risk victim.

16.2.7 Analysis of some of the historic events in the context of coercion and control may provide some learning. It is also important to state that there were no incidents reported after the legislation came into force on 29 December 2015, that gave rise to suspicion of coercive and controlling behaviour. All agencies involved in the review report that their staff now have a better understanding of coercive control whilst acknowledging that there is more to do.

16.3 **What consideration did your agency give to any mental health or substance misuse when identifying, assessing and managing risks around domestic abuse?**

16.3.1

Date	Agency	Type of risk assessment	Person perceived to be at risk	Grade/outcome
28.4.12.	Cleveland Police	DASH	Jane	Medium
27.9.12.	Probation Service	OASys	Jane	Medium
19.2.13	Probation Service	OASys	Jane	Medium
15.6.13	Cleveland Police	DASH	Jane	High
9.9.13.	Probation Service	OASys	Jane	Medium
10.12.13.	Cleveland Police	DASH	Jane	Medium
17.3.14.	Probation Service	OASys	Jane	Medium
11.10.14.	Cleveland Police	DASH	Jane	High

11.11.14.	Probation Service	OASys	Jane	High
17.6.15.	Probation Service	OASys	Jane	High
27.4.16.	Probation Service	OASys	Jane	Medium
The above table shows risk assessments that were carried out in relation to the perceived risks to Jane from Roger. They are commented on in the following paragraphs.				

16.3.2 Jane was referred to mental health services by her GP on a number of occasions, but other than treatment for depression she was never diagnosed with a mental illness. Following her detention under section 136 of the Mental Health Act on 3 July 2012, Jane engaged with a substance misuse service until September 2013. Alongside her treatment for alcohol dependence she was supported to improve her physical and mental health and given help to address housing and financial difficulties. Whilst not directly addressing risks around domestic abuse this support was potentially significant in helping Jane to improve her personal resilience during that period.

16.3.3 Throughout their dealings with the case the Probation Service was aware of Jane's vulnerabilities and took them into account when assessing the risk that Roger posed. However, Roger admitted to his probation officer on a number of occasions that he had breached the restraining order by visiting Jane. Many of these breaches were not acted upon by warnings or other escalation. It is probable that one of the reasons for this was because Roger's assertions that the visits were with Jane's consent were taken on face value. This did not take into account that her ability to refuse him access to her house may have been reduced by her alcohol misuse.

16.3.4 Cleveland police conducted four DASH risk assessments. These took into account the risks known to the officer completing the assessment but also other information which may not have been known initially. For example, following the robbery of 28 April 2012, the DASH risk assessment was graded as medium. Following the assault on Jane by Roger on 15 June 2013 the attending officer graded the DASH risk assessment as medium. This was upgraded to high by a risk assessment officer in the vulnerability unit who was able to access information about a number of incidents indicating Jane's vulnerability through alcohol misuse or mental health which had occurred in the period between the two incidents. This is an example of good practice and a recognition by the police of the links between alcohol, mental illness and domestic abuse.

16.3.5 On 10 December 2013, when Jane reported a breach of restraining order and threats from Roger, the DASH risk assessment was initially graded as standard but was regraded to medium by a risk assessment officer, again reflecting appropriate use of all the information available.

16.3.6 On 11 October 2014, Jane reported that Roger had assaulted her causing a head wound. A DASH risk assessment was conducted and graded as medium risk. It was then raised to high risk by a risk assessment officer. All of the reassessments of DASH grades took into account information in relation to Jane's alcohol misuse and mental health which may not have been known to the officer initially completing the risk assessment and to that extent this was good practice.

16.3.7 All of the risk assessments conducted by the Probation Service using the OASys system took into account Jane's use of alcohol and Roger's use of alcohol and drugs. Throughout the course of the review period Roger was assessed as posing a medium risk of causing serious harm to Jane until the incident of 11 October 2014, after which he was assessed as posing a high risk of causing serious harm to her. This was based on the escalation in Roger's offending behaviour and does not appear to have been influenced by the level of Jane's alcohol use or vulnerability at that time. Similarly, at the end of Roger's period of supervision by the Probation Service, the assessment that he posed a medium risk of causing serious harm to Jane was based on the fact that there had been no reported incidents of non compliance with the restraining order for three months. There was no contact with Jane and the risk assessment was unsighted on the level of her personal vulnerabilities at the time of the assessment.

16.4 **How did your agency manage those risks?**

16.4.1 The risks to Jane were managed reactively by the police arresting Roger when Jane reported that he had committed offences. For much of the period of the review, Roger was in custody or under the supervision of the Probation Service. This is commented at in more detail at 16.11

16.4.2 Opportunities to bring the case within the view of multi-agency management were limited. The case was referred to MARAC but the single action from that meeting was ineffective. Notwithstanding that, Roger was in prison at the time of the MARAC meeting and to that extent the risk to Jane was mitigated at that time. No account however was taken of the fact that Roger would be released from prison in due course and the risk would be highly likely to recur. This is commented on in more detail at 16.12.

16.4.3 From a health point of view, domestic abuse was not seen to be the main risk. Jane was diabetic and had misused alcohol for many years. Her GP monitored Jane's

health conditions according to National Institute of Clinical Excellence [NICE] guidelines and referred her to appropriate services for her alcohol misuse when she was amendable to that.

16.5 **What did your agency do to keep the levels of risk under review?**

16.5.1 From his first sentence within the review period on 27 September 2012, the risk that Roger posed both to Jane and others was assessed using the nationally accredited offender assessment system (OASys). All relevant factors were taken into account. For most of the period the assessment was that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public.

16.5.2 On 11 November 2014, when Roger appeared at court for sentencing in relation to the assault on Jane of 11 October 2014, the OASys risk assessment completed by the Probation Service stated that Roger posed a high risk of causing serious harm to a known adult, his mother Jane and a high risk of causing serious harm to the public. This heightened assessment reflected an escalation in Roger's offending behaviour and is clear evidence that the risks were appropriately reviewed.

16.5.3 At the end of Roger's period of supervision by the Probation Service a further assessment was conducted which concluded that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public. This is again evidence that risks were kept under review in light of changing circumstances.

16.5.4 The termination of Roger's supervision by the Probation Service on 30 March 2016, coincided with the end of the restraining order preventing Roger from visiting or harassing Jane. There was no further risk assessment by any other agency. As there were no further reports of domestic abuse after that time the police were not in contact with Jane and Roger and nothing further was done by any agency to manage the potential risks.

16.6 **What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?**

16.6.1 **Substance Misuse Services**

On 5 July 2012, Jane attended an appointment at a substance misuse service [Middlesbrough SMS] managed by Tees Esk and Wear Valleys NHS Foundation Trust. She remained engaged with the service until September 2013. Jane missed many appointments but kept others and attained periods of abstinence from alcohol but relapsed on several occasions. Alongside her treatment for alcohol dependence

she was supported to improve her physical and mental health, promoting her independence by addressing housing, employment and financial difficulties and providing support to enhance her social support. Jane disclosed on a number of occasions that she continued to have contact with Roger. On every occasion she was advised to report this to the police and stop contact with Roger. On one occasion Roger attended an appointment with Jane in breach of the restraining order. Staff should have escalated the issue by taking advice from a supervisor or manager in relation to an appropriate course of action to address Roger's behaviour.

16.6.2 During her period of involvement with Middlesbrough SMS Jane had thirty four appointments of which she did not attend eighteen. This was Jane's most sustained period of engagement with any service during the period of the review.

16.6.3 Following this period of engagement with Middlesbrough SMS, a different organisation, Middlesbrough Recovering Together, took over responsibility for substance misuse services in Middlesbrough. Due to a number of changes in services it has not been possible for the review to obtain a comprehensive record of Jane's interaction with substance misuse services. Those records that have been accessed indicate a picture of several brief engagements following a referral, followed by discharge from the service when Jane did not keep appointments.

16.6.4 During the period of the review Jane was seen in the emergency department of James Cook University Hospital by the Hospital Intervention Liaison Team [HILT] on five occasions. HILT is a substance misuse service provided by Middlesbrough Recovering Together after 1 April 2014 which works in the emergency department. Records from the previous provider of this service are unavailable.

16.6.5 HILT saw Jane after she had attended at the hospital having suffered seizures or collapses in public five times. Jane was assessed as alcohol dependent on all five occasions. On 7 May 2014 and 3 June 2014 Jane told HILT that she was working with a community alcohol worker. On both occasions there is no evidence that liaison between the hospital and community substance misuse services took place. In later attendances Jane declined a referral to community alcohol services twice but then accepted a referral on 2 November 2016. She did not attend that appointment or a second related appointment for a liver harm reduction clinic.

16.6.6 Although there is evidence of a number of referrals between services, Jane did not engage consistently to the extent that the support offered could help her to make changes in her life.

16.6.7 **Tees Esk and Wear Valleys NHS Foundation Trust**

This NHS Trust provides mental health services for the area. It also provided substance misuse services for part of the review. This has already been commented on at 16.6.1

16.6.8 Jane had been known to the trust since 1991 and had been engaged with substance misuse services prior to the relevant dates of this review. Within the timeframe of the review Jane was seen by Trust staff on eleven occasions. A summary is shown below. Further details of each contact can be found in section 14 of the overview report

Date	Issue	Outcome
23.5.12.	Referral to crisis response team from GP	Referral to substance misuse services
2.7.12.	Detained Section 136 Mental Health Act	Referral to substance misuse services [engaged until Sept 2013]
10.6.13.	Assessment in A&E	Low mood due to alcohol
24.2.14.	Taken to crisis assessment suite by police	Had full insight into her situation
7.4.14	Assessment in A&E	No role for mental health services. Situation due to alcohol and social stressors
28.4.14.	Referral by GP	Referral declined until change in alcohol misuse
16.7.14.	Concern for welfare by third party	Referral to MIND
21.2.15	Assessment in A&E	No role for mental health services
27.2.15.	Assessment in A&E	No role for mental health services
6.5.15.	Assessment at home following concern for safety	No role for mental health services

15.1.16.	Attended at Roseberry park psychiatric hospital	No role for mental health services

16.6.9 On every occasion that Jane was assessed it was found that she was not displaying symptoms of psychosis, thought disorders or other mental illness. On some occasions Jane said that she was being prescribed antidepressant medication from her GP but that she was not taking it. On all but the last occasion that she was seen by TEVW, Jane had been referred by other professionals who were seeking help for her. In light of all of the assessments not revealing mental health issues TEVW appropriately referred her to other services. Apart from one period of engagement with the Middlesbrough Substance Misuse Service, which lasted for over a year, other services were unsuccessful in engaging with Jane on a consistent basis.

16.6.10 **Adult Social Care**

On 13 January 2014, Adult Social Care were contacted by the police who raised concerns about Jane's welfare. Having been unable to contact her by telephone a letter was sent to Jane offering advice and support from Adult Social Care. Jane did not respond. Given Jane's well established history of non engagement with services sending a letter to her was very unlikely to be successful. A discussion with her GP and mental health colleagues followed by a home visit may have been more appropriate.

16.6.11 On 31 July 2015, following further concerns about Jane's welfare being raised by the police, two staff from Adult Social Care visited Jane at home. Jane discussed with them the things that were troubling her, including financial and health issues as well as her problems with Roger. It was decided that Jane did not need support from Adult Social Care and she was advised to see her GP and housing officer. A referral to Middlesbrough Recovering Together was agreed but Jane did not engage with that service. The Adult Social Care visit resulted from police concerns about Jane's welfare which focussed on her alcohol misuse and general welfare. Domestic abuse was not a focus of the visit and was not explored.

16.6.12 The preoccupation with her non engagement, alcohol and mental health difficulties overshadowed the domestic abuse issue and there is no recorded evidence that this was considered. There is no recorded evidence of an assessment under the Care Act 2014 taking place that would have provided greater in-depth information on Jane's needs. Overall this was a missed opportunity to get to know Jane and understand her needs. Liaison with other professionals for example, GP, housing,

mental health and domestic abuse, may have provided the basis for a coherent plan to support Jane.

16.6.13 **General Practitioner**

Jane's GP treated her various health needs and monitored how much damage was being caused due to alcohol and diabetes. She attended the GP practice in crisis and was referred to TEWVW crisis team appropriately. Her GP always referred to any agency that was thought to be able to assist when Jane was willing to engage. There is however no evidence of an overall plan to manage and coordinate Jane's health care needs.

16.6.14 **South Tees Hospitals NHS Foundation Trust**

The trust manages James Cook University hospital where Jane attended on twelve occasions during the review period.

16.6.15 During the four and half year period of the review Jane attended the Accident and Emergency department on twelve occasions, each time arriving by ambulance. Five of these attendances resulted in an overnight admission to a ward. On four other occasions Jane self-discharged from A&E prior to admission and against medical advice. In the remaining three attendances Jane was seen, treated and discharged from the department.

16.6.16 Jane also had two out-patient's appointments during the period of the review, the first in October 2013 and the second in November 2016. Both of these were to the liver harm reduction clinic and neither were attended. On both occasions a letter was written to Jane's GP advising of the non-attendance and asking that Jane be re-referred to the service if required.

16.6.17 Whilst at the hospital Jane was seen by HILT [substance misuse service] and the Liaison Psychiatry Team as appropriate. On two occasions, 15 June 2013 and 11 October 2014, Jane attended the hospital as a result of being assaulted by Roger. Details of the offender were not obtained and a referral to domestic abuse services was not considered. Although not formally documented, it is highly likely that this was because hospital staff knew that Jane had reported the assaults to the police and that Roger was already in custody.

16.6.18 **Thirteen Housing Group**

Jane had lived in the same house for many years. Thirteen Housing Group was created in April 2014, being a merger between Fabrick Housing, consisting of Erimus Housing and Tees Valley Homes and Vela Group, consisting of Tristar Homes and Housing Hartlepool. At the outset each group continued working within its own

policies and procedures until consolidated processes were agreed. Jane's house was originally owned by Erimus housing.

16.6.19 On 18 June 2013, following a number of complaints from Jane about her neighbours, noise monitoring equipment was installed in Jane's house. This was removed on 7 July 2013 after no evidence of noise nuisance was found.

16.6.20 Jane told other professionals that she was worried about the under occupancy charge. Jane did fall into rent arrears as a result of the under occupancy charge and her mother has told the chair of the review that she contributed money to help Jane. Jane was visited at home by Thirteen Housing Group staff who advised her on how best to deal with the issues. Her tenancy was not at risk.

16.6.21 For the latter part of the review period Roger lived independently in Thirteen Housing group accommodation. There were no significant issues raised with his tenancy. Housing staff were not aware of domestic abuse issues affecting Jane and this was not explored as she was living alone.

16.6.22 **My Sister's Place**

My Sister's Place is an independent specialist 'One Stop Shop' for women aged 16 or over who have experienced or are experiencing domestic abuse. This service received four referrals from other services relating to Jane during the review period.

16.6.23 Although normal processes were followed by My Sister's Place, Jane chose not to engage. On one occasion on 17 June 2013, during a telephone call Jane said that she would like to access the service but did not do so. At that time no outreach service was available within My Sister's Place and when Jane did not follow up on the contact that had been made her case was closed. Outreach was available through another service. It is known that there was a waiting list for the service but there is no evidence as to whether or not Jane was offered this service.

16.6.24 In October 2014, following a referral from the police My Sister's Place again contacted Jane and she agreed to an appointment and for the Sanctuary Scheme [security assessment and installation of security measures] to visit her. When sanctuary staff visited her, Jane declined help at that time and subsequent telephone calls and letters went unanswered. Jane did not attend her appointment with My Sister's Place, as a result of which an unsuccessful joint visit to her home with the police took place.

16.6.25 Although Jane spoke to My Sister's Place on the telephone on two occasions immediately after she had been assaulted by Roger she did not go on to engage with their services. It is not now possible to know why she made this choice.

However, on both occasions Roger was in custody and Jane may then have felt that she was safe from him and did not need help.

16.6.26 The Association of Directors of Adult Services publication, 'Adult safeguarding and domestic abuse a guide for practitioners and managers', lists a number of barriers to working with victims of domestic abuse.

- fear of the abuser and/or what they will do (these may be realistic fears based on past experience and threats that have been made)
- lack of experience or knowledge of other victims who have dealt with abuse successfully
- lack of experience of positive action from statutory agencies, including the courts
- lack of knowledge/access to support services
- lack of resources, financial or otherwise
- previous experiences and/or a fear of being judged or not being believed
- love, loyalty or emotional attachment towards the abuser and the hope that their partner/ family member/abuser will change
- feelings of shame or failure
- pressure from family/children/community/ friends
- religious or cultural expectations
- previous experience and/or fear that the issues and concerns of people from their
- community (e.g. LGBT, BME, Traveller) will be poorly understood or ignored
- fear of agency pressure to pursue a criminal case
- the long-term effects of abuse such as prolonged trauma, disability resulting from abuse, self-neglect, mental health problems
- numbness or depression arising from their circumstances
- low self-esteem/self-worth
- drug and/or alcohol addiction (and fear that this will be used against them)
- anticipated impact on children and dependent adults
- fear of single parent stigma
- fear of losing contact with children, dependent adults and other relatives and friends.

The panel recognised that Jane may have been affected by a number of the barriers listed.

16.7 **How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?**

16.7.1 The inability of services to consistently engage with Jane meant that it was difficult for most services contributing to the review to ascertain her wishes. The police responded to her reports of assault and arrested Roger in order to protect her. However, it is clear that she was at least apprehensive about giving evidence against him and on one occasion an application for special measures e.g. a screen in court was made. In the event she did not give evidence.

16.7.2 During her period of engagement with Middlesbrough SMS Jane initially told them that she was worried about Roger and what would happen when he came out of prison. Later she disclosed that she had had contact with Roger on many occasions even though it meant he was in breach of the restraining order. Staff advised her that she should stop contact with him and report any contact to the police. While not recognised by agencies at the time, the panel believe that Jane's actions may well have been because Roger was exercising coercion and control over her.

16.7.3 Roger's feelings about his offending were to some extent disclosed to the Probation Service. He alluded to a troubled relationship with his mother. Jane struggled to discipline Roger and he resented her attempts to control him. No other agency contributing to the review had sufficient information to form a view.

16.8 **Were there any opportunities for professionals to routinely enquire regarding domestic abuse with the victim which might have been missed?**

16.8.1 Although Jane had many medical appointments, the review has not seen evidence of routine enquiry although there were many occasions when Jane could have been asked about domestic abuse, for example hospital and GP attendances. When asked, Jane said that she lived alone and this may have distracted professionals from routine enquiry about domestic abuse. Although Jane did discuss concerns about Roger with a number of professionals, it is possible they did not recognise Roger's behaviour as domestic abuse as it did not follow the more commonly recognised situations e.g. male to female intimate partner violence.

16.9 **How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?**

16.9.1 The review has seen significant evidence of information sharing and referrals between agencies in relation to Jane. No agency was unable to access the information it needed. This however did not on the whole result in effective interventions to support or protect Jane. Agencies acted in isolation, passing on referrals and information as necessary. Whilst she was clearly a challenging client to engage, there is limited evidence of multi agency working or coordination.

16.9.2 There were some opportunities for agencies to share information in relation to Roger. The Probation Service did get in touch with Cleveland police on 10 December 2013, when Roger was suspected of breaching the Restraining Order. On 27 October 2014 they requested information about the offence committed on 10 October 2014, and again on 3 December 2015 requested spot checks at Jane's home. However, there were many other possible breaches of Licence conditions and the terms of the Restraining Order which were not referred to the police. This may have been because the probation officer was aware that Roger was sometimes invited to be in contact by Jane and because she may have been reluctant to give witness evidence against him. Nevertheless, on each occasion when the probation officer had information which suggested a possible breach of the restraining order an email ought to have been sent to Cleveland Police intelligence hub so that an investigation could be carried out and to build up a more complete intelligence picture surrounding the relationship and contact between Jane and Roger.

16.10 **What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?**

16.10.1 Jane disclosed in police statements that Roger regularly demanded money from her and assaulted her when she did not comply. She acknowledged that there had been a number of times this had happened that she had not reported. The police arrested Roger and charged him when evidence was available. This had the short term effect of protecting Jane from Roger's behaviour for the time that he was in custody. The police also made a referral to MARAC which brought the case under multi agency scrutiny. However, the single MARAC action was ineffective.

16.10.2 The Probation Service obtained an account from Roger of his background and relationship with Jane, which was used to inform work with him during the various periods that he was under Probation Service supervision during the review period. No other agency contributing to the review had sufficient contact with Roger in order to understand his behaviour.

16.11 **Was there sufficient focus on reducing the impact of the perpetrators abusive behaviour towards the victim by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?**

16.11.1 Roger was arrested on four occasions when the police had a clear power of arrest. These arrests lead to court appearances and sanctions being imposed by the courts.

16.11.2 The Probation Service allocated Roger's case to the same probation officer throughout his period of involvement with the service. This allowed the probation officer to develop a relationship with Roger which should have enhanced the way that he was managed by the service. On some occasions when he failed to attend

appointments he was issued with warnings in keeping with enforcement procedures, on other occasions the procedures were not followed.

16.11.3 Throughout the several periods of his supervision by the Probation Service, Roger's compliance with them was mixed. He completed the citizenship programme induction module at the outset of all of his periods of supervision and his compliance with the requirement for unpaid work was generally good. There were many other occasions when he did not attend appointments, which could have been dealt with by a sanction and were not. Some action was taken against Roger for non compliance, for example a fixed term recall to prison was instigated on 12 December 2013 and on 10 June 2014 the probation officer ascertained that Roger was not living where he was supposed to be. The probation officer ought to have discussed the case with a manager and applied to Teesside Magistrates court for breach proceedings to be listed within two working days.

16.11.4 On five occasions between May and October 2014, Roger admitted to his probation officer that he had breached the restraining order by visiting Jane. There is no evidence that the probation officer discussed this with a manager or contacted the police.

16.11.5 Following admissions from Roger in October and November 2015 that he had visited Jane, Roger was issued with a licence warning and was told that police would be carrying out checks of Jane's address to make sure he wasn't there. This may have worked as there were no incidents reported in the following months until the end of his licence period. It may also have been that Roger became less candid with the probation officer when he realised that he would face sanctions for further breaches.

16.12 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?**

16.12.1 Following the assault on Jane by Roger of 15 June 2013, a DASH risk assessment was conducted which after initially being graded as medium risk was regraded to high risk. This level of risk would usually result in a referral to MARAC. Cleveland police considered a referral to MARAC but decided not to do so. The rationale was that the referral was not necessary as there was already a restraining order in place, no children were involved and Jane had allowed Roger access to the house. This decision did not take into account the possibility that Jane's resilience to deny Roger access may have been reduced by her alcohol misuse or the potential for her being subject to coercion and control by Roger, reducing her ability to protect herself.

16.12.2 Although the case was not referred to MARAC at this point, an appropriate referral was made to My Sister's Place for domestic abuse support. Jane was contacted but she did not engage with the service.

16.12.3 Following the assault on Jane by Roger of 11 October 2014, a DASH risk assessment was initially graded as medium risk but later upgraded to high risk. The case was referred to MARAC and a referral was made to My Sister's Place who made an appointment for Jane on 27 October 2014. The case was discussed at MARAC on 22 October 2014. The only action was that a joint visit to Jane by My Sister's Place and the police would take place if her appointment of 27 October 2014 was unsuccessful.

16.12.4 Jane did not attend the appointment with My Sister's Place on 27 October 2014. A joint visit involving police and My Sister's Place was therefore arranged, which took place on 26 November 2014. Records of the visit are unclear, but it is believed that a business card was left with Henry. There is no way of knowing whether Jane ever saw the business card or understood its significance. No account was taken of the fact that Roger would be released from prison in due course and the risk would be highly likely to recur and the case was not kept under review. The MARAC process was ineffective and did not contribute to keeping Jane safe.

16.12.5 The case was not referred to MAPPA. The following is an extract from current MAPPA guidance in relation to the risk of harm.

11.7 For the purpose of this Guidance, serious harm is defined as: "An event, which is life-threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible."

11.8 The level of risk of serious harm is the likelihood of this event happening. The levels are:

- Low: current evidence does not indicate a likelihood of causing serious harm.

- Medium: there are identifiable indicators of serious harm. The offender has the potential to cause such 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.

- High: there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

- Very High: 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.

16.12.6 The OASys assessment of 11 October 2014, which assessed Roger as posing a high risk of causing serious harm to Jane made him potentially eligible for consideration of referral to MAPPA.

MAPPA guidance states:

Category 3 – Other dangerous offenders: a person who has been cautioned, reprimanded, warned or convicted of an offence which indicates that he or she is capable of causing serious harm and requires multi-agency management at MAPPA level 2 or 3. The offence might not be one specified in Sch.15 of the CJA 2003.

16.12.7 Roger was not referred to MAPPA level 2 or 3 as it was judged that the requirement for multi agency management was not met. The panel discussed this decision and concluded that the number and seriousness of other cases referred to MAPPA would have meant that even if referred to MAPPA it is highly likely that the case would have been screened out. Even if accepted into the MAPPA process, the panel thought it likely that the case would have quickly been finalised given that there was no further offending until Jane's death in December 2016.

16.13 **How effective was your agency's managerial oversight of this case?**

16.13.1 The Probation Service system of supervision relied on the offender manager bringing any change in the circumstances of a case to the attention of a supervisor. There are a number of instances when Roger's probation officer became aware that he had breached the restraining order and no action was taken including the issue being escalated to management. When on 14 October 2015, Roger admitted to again being in contact with Jane, his probation officer discussed the case with a manager. At that point on 5 November 2015, senior managerial oversight led to the decision to issue Roger with a first licence warning which was served on him on 18 November 2015. Roger's compliance with Licence conditions then improved until the Licence period ended on 30 March 2016.

16.13.2 There is some evidence of other managerial oversight of Jane's case. For example, DASH risk assessments were reviewed and upgraded by the police when necessary. Other evidence is limited, for example Jane's brief involvement with Adult Social Care appears to have been concluded without management input. This may have been appropriate in the context of Jane's brief contact with the service, but it did not fully take into account Jane's history of contact with mental health services, alcohol misuse and abuse by Roger.

16.13.3 Managerial oversight that took place did so in a single agency context. Whilst each agency provided some level of oversight in isolation and information was shared

between professionals, no one professional or agency had lead responsibility for helping Jane to manage the issues she was facing. MARAC was the multi agency forum which could have provided oversight of the case, but it was ineffective.

16.14 **Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?**

16.14.1 Many referrals to services were made for Jane and services were ready to provide help. They were simply unable to engage her. My Sister's Place commented that, had an outreach service been available within My Sisters Place at the relevant time, then they may have had a better chance of engaging with Jane. This service is now in place within My Sister's Place. Nothwithstanding that, an outreach service was available through a different organisation at the time Jane needed support. It is known that there was a waiting list for it but there is no evidence as to whether Jane was offered this service.

16.14.2 Throughout the time frame of the review Roger's probation officer was carrying a workload of significantly more than 100 percent when measured on the workload management tool used by both Durham and Tees Valley Probation trust and the National Probation Service. It is probable that this high workload impacted on decision making on the occasions that Roger's breach of licence conditions and the restraining order were not sanctioned. This has to be balanced against the legitimate attempts to build on his positive engagement and compliance. The probation officer ought though, to have sought approval from a manager not to follow enforcement procedures. Had the case been discussed with a manager it would have been reasonable for breach proceedings to have been averted. This opinion takes into account that there is a drive in the Probation Service to promote compliance and make informed decisions, with oversight from a manager. The intention is to avoid offenders being returned to Court for breach proceedings or having Prison Licences revoked and being recalled to prison.

16.15 **What knowledge did family and friends have of the adults' relationship, that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?**

16.15.1 Jane's mother has told the chair of the review that although she was aware that Jane had difficulties with Roger, the family did not know the details of his attacks on Jane despite him going to prison. The family were aware of Roger's alcohol and drug misuse and the fact that he pressurised Jane to give him money.

16.15.2 Although her mother was aware of some of Jane's difficulties and tried to help her, for example by helping to pay rent arrears, she perhaps did not appreciate how serious Roger's behaviour could be. In the last year of her life Jane did not report anything negative about Roger's behaviour to the police and her mother is not aware of any physical assault taking place. She was aware that Roger continued to pressure Jane for money. Jane's family were not aware of the coercive and controlling behaviour legislation and did not recognise Roger's behaviour [other than the assaults] as domestic abuse.

16.16 **The review must take full account of issues raised by the victims' family and represent the voice of the victim and her family, in its narrative.**

16.16.1 Jane's voice can no longer be heard. Her mother describes her as a very private person and speculates that this is why Jane did not engage with the services that were available to her. Jane's mother told the chair of the review that people need to know where they can get help when they need it from people they can trust. She felt that Jane had never formed a trusting relationship with professionals from any agency.

16.6.2 Jane's family have been consulted on the final version of the report. They were offered but declined support. Having read the report, they asked for some minor changes as a result of factual errors. They agreed with the recommendations of the report and hope that local services will change for the better.

17 CONCLUSIONS

17.1 Jane suffered from violence at the hands of her son Roger for at least nine years. The first record of an assault by Roger on his mother was in 2007. Over the following years Jane reported four assaults on her by Roger as well as a robbery, breach of bail conditions and breach of restraining order. She disclosed in police statements that there had been other assaults, but she had not reported them.

17.2 Despite Roger's assaults on her and his other poor behaviour Jane was unable to break off contact with him. A restraining order was in place preventing Roger from contacting Jane for much of the review period, but it is known that this was breached regularly. It is difficult to know whether this was because of an unbreakable bond that she felt to her son or whether her resilience to his behaviour had simply been eroded over the years and she was unable to say "no". Jane told her mother that she loved Roger but didn't like him because of his behaviour.

17.3 Jane's life was severely affected by her alcohol misuse. She sometimes engaged with substance misuse services and disengaged with them as was her right. In the last two years of her life Jane did not accept help for her alcohol misuse and was not engaged consistently with any support. The panel discussed whether Jane had

used alcohol as a coping mechanism given the coercive and controlling behaviour she had experienced. Whilst the panel felt this was likely it was not possible to be conclusive given the information that Jane had started to misuse alcohol following the death of her brother.

17.4 Individual agencies provided services to Jane according to their own policies and procedures. When Jane did not keep appointments, standard processes were followed and she was offered further appointments and reminders before being discharged from services.

17.5 The review identified that the referral to MARAC, when it was made, offered the only opportunity within established protective procedures for a multi-agency overview of the case. The result was ineffective and the case was closed to MARAC without anything having been achieved. The Probation Service asked the police in December 2015 to conduct spot checks at Jane's home to see if Roger was there. This was never followed up and there was no further communication between the two agencies on the matter.

17.6 For much of his time under the supervision of the Probation Service, Roger admitted to having continued contact with Jane despite this being in breach of the restraining order. On many occasions he said that Jane had invited him into her home and on others they had gone on family days out. From 3 December 2015, when he received a formal warning from the Probation Service about his contact with Jane, nothing further was reported and by the end of his licence period on 31 March 2016, the risk of him causing serious harm to Jane was said to be reduced to medium risk. This was in part influenced by the fact that the police had not reported any breach of Roger's licence conditions following the Probation Service request for them to do spot checks at Jane's home. However there had been no further communication between the two agencies on the issue and the Probation Service were unaware that that the scale of the checks had been two unanswered visits in December 2015.

17.7 The end of Roger's licence period coincided with the end of the restraining order. From 31 March 2016, there was no legal barrier to any contact between Roger and Jane. Despite the fact that Jane had previously been seen as a high risk victim of domestic abuse at MARAC and by the Probation Service, there was now no monitoring of risk by any agency.

17.8 In the nine months that followed, up until her murder in late 2016, Jane's contact with agencies almost ceased. She was taken to hospital in November 2016 following a collapse and was assessed as alcohol dependent. She was offered and accepted follow up appointments but did not keep them. Despite her previous difficulties and ongoing alcohol misuse she had become almost invisible to services.

17.9 In the days before her murder, police statements show that Jane was drinking large amounts of vodka, at least one bottle per day and perhaps more. Roger was spending time with her and was also drinking large amounts of alcohol. Why Roger beat and murdered his mother may never be known. He declined to reply to any questions that the police asked in interview and has declined the opportunity to take part in the review.

18 Lessons to be learned

The DHR panel identified the following lessons. The panel did not repeat the lessons identified by agencies. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to a recommendation a cross reference is included in bold.

18.1 Narrative

Jane's illnesses brought her into contact with many services. She engaged and sometimes disengaged with them. The panel recognised that there are many reasons victims feel unable to engage with services. This made it challenging for any one service to have a holistic view of the issues affecting her. It is not now possible to know whether this was an active choice that Jane made, or whether she was simply unable to engage with services on a consistent basis due to her alcohol misuse.

Lesson

People with multiple needs may find it particularly difficult to engage with services. A coordinated case management approach may help to support service users who for whatever reason engage in risky behaviours.

Recommendation 1

18.2 Narrative

Jane declined support in relation to domestic abuse when it was offered. Following an appropriate referral to MARAC the single action taken was ineffective and engagement with Jane was not achieved.

Lesson

Victims of long term domestic abuse do not find it easy to seek help for a number of reasons including lack of self-confidence, fear, intimidation, financial dependence and guilt. Some of these indicators were apparent in Jane's relationship with Roger

and a more assertive approach to supporting victims who do not easily engage is required.

Recommendation 2

18.3 **Narrative**

Jane had chronic alcohol misuse issues. She last had significant engagement with alcohol misuse services in 2013 and despite a number of referrals did not consistently engage with services after that. Professionals followed the established attendance policies of their organisations and accepted that it was Jane's right not to engage with services. Some of the features in Jane's case camouflaged her vulnerabilities and may have prevented services from regarding her as a victim of domestic abuse. It would appear that professionals did not see beyond the social norms and assumptions about addiction.

Lesson

People with long term substance misuse issues are vulnerable to a range of different abuses and may be unable to effectively protect themselves. Alcohol Concern[11] say that the perception that if a problem drinker does not want to change, nothing can be done is untrue. Their Blue Light Project[12], supported by Public Health England challenges the traditional approach and radically changes the working agenda by showing that there are positive strategies that can be used with this client group.

Recommendation 3

18.4 **Narrative**

Roger had abused Jane for at least nine years. For much of the review period he was subject to some control measure whether that be prison, bail conditions, restraining order, suspended sentence orders or prison licence. It was known that despite those measures he had continued to offend, breach the restraining order and assault Jane. From 31 March 2016 there were no control measures in effect. Jane did not report any further issues and she was in effect invisible to services until her murder in December 2016.

Lesson

[11] A national charity working to help reduce the problems that can be caused by alcohol.

[12] https://www.alcoholconcern.org.uk/blue-light-project

The risks to Jane did not abate simply because Roger came to the end of his licence period and supervision by the Probation Service. Services had last tried to engage with Jane in July 2015 and attempts could have been made to engage her in safety planning towards the end of Roger's sentence in 2016.

Recommendation 2

18.5 **Narrative**

Changes in the provision of substance misuse services over the several years of the period of this review have meant that available records of Jane's engagement with substance misuse services are incomplete.

Lesson

Commissioners should ensure that access to records is considered within the continuity arrangements when the provider of a service changes.

Recommendation 5

18.6 **Narrative**

Roger had abused Jane for many years. Some agencies had worked with him to address his behaviour. Other agencies did not recognise that Roger's behaviour towards his mother was domestic abuse and had little or no awareness of Adolescent to Parent Violence and Abuse. It is also likely that Jane and her family did not recognise Roger's behaviour as domestic abuse.

Lesson

It is important that all professionals recognise patterns of behaviour in a young person that may indicate APVA and the risk that young person presents to others. Agencies need to have pathways in place so that professionals can recognise and respond appropriately to APVA.

Recommendation 4

19 **DHR Panel Recommendations**

19.1 Middlesbrough Community Safety Partnership should consider the feasibility of developing a coordinated case management approach to the care of vulnerable service users, who engage in risky behaviours, with full consideration of MARAC and other safeguarding processes.

19.2 The Middlesbrough Community Safety Partnership should put in place processes by

which it can gain assurance that:

1. MARAC actions are meaningful and contribute to the safety of the victim.
2. Agencies are held to account for the delivery of agreed actions.
3. Safety planning for victims of domestic abuse when offenders come towards the end of a sentence imposed by the criminal justice system can be made an integral part of the domestic abuse community response, for example by being incorporated into MARAC.

19.3 The Middlesbrough Community Safety Partnership should consider adopting an appropriate evidence based model for supporting victims of domestic abuse with complex needs [mental health/substance misuse], such as the Alcohol Concern Blue Light Project methodology and training materials.

19.4 Middlesbrough Community Safety Partnership should circulate the Home Office Information booklet on Adolescent to Parent Violence and Abuse [APVA] to partner agencies and seek assurances they have pathways in place that ensure the appropriate response is delivered when APVA is recognised. Partner agencies should circulate the information to their staff and ensure it is included on new and refresher training.

19.5 The Middlesbrough Community Safety Partnership should seek assurance from commissioners that access to historic records is considered as part of the continuity arrangements when commissioning new services.

Single agency recommendations

19.6 **Cleveland Police**

PC *******is spoken to and debriefed around actions when attending the incident on 11th December 2013

19.7 **National Probation Service**

The Probation Service Individual Management Review should be shared with the probation officer and the three managers responsible for supervision during the period of Roger's contact with the Probation Service so that its findings can influence and improve future practice relating to risk assessment, enforcement and seeking guidance from a manager.

19.8 The probation officer's present manager to conduct a "deep dive" assessment of ten of the cases which the probation officer managed at Middlesbrough Probation Office to seek assurance about enforcement and risk assessment practice and the

extent of case referral to a manager for advice.

19.9 All staff of NPS Cleveland to be issued with a reminder from the Head of Area that all contacts and telephone calls must be recorded on Delius within 24 hours.

19.10 All staff of NPS Cleveland to be issued with a reminder of enforcement processes from the Head of Area in respect of Court Orders and Prison Licences and the need to seek approval from a manager if they wish to depart from the process in an attempt to achieve improved compliance.

19.11 All staff of NPS Cleveland to be notified by the Head of Area that they must bring cases assessed as posing a medium risk of causing serious harm in the context of domestic violence to a manager for discussion when new information is received and/or when they are to re-assess the level of risk of causing serious harm.

19.12 All staff of NPS Cleveland to be issued with guidance from the Head of Area about the need to pass information about possible new offences and breaches of Court Orders and Prison Licences to Cleveland Police Intelligence Hub.

19.13 All staff of NPS Cleveland to be re-issued with guidance from the Head of Area as to when referrals to MARAC, MAPPA and Adult Safeguarding should be made.

19.14 **South Tees Hospital NHS Foundation Trust**

The development of a management of domestic abuse policy

19.15 To audit A&E staff response to disclosures of domestic abuse

19.16 **South Tees Clinical Commissioning Group**

GPs to input into the frequent attenders at Emergency Departments.

19.17 GPs to input into case management of patients with severe chronic dependence on alcohol.

19.18 **Middlesbrough Recovering Together [Hospital Intervention Liaison Team and community Teams]**

Provide staff training around DASH Risk Identification Checklist and MARAC process

19.19 Ensure quality standards for case note recording and assessments are being met.

19.20 Provide risk identification and management training for all members of staff in HILT team.

19.21 Ensure community teams are following up none attendance via the Did not Attend policy.

19.22 **Tees Esk and Wear Valleys NHS Foundation Trust**

To raise the profile of Domestic Abuse in TEWV services through training to equip practitioners with information and tools on best practice when addressing concerns related to domestic abuse. This should cover topics such as the Toxic Trio and the Safe Lives DASH (Domestic Abuse, Stalking and Harassment and Honour Based violence) 2009) risk assessment.

19.23 To provide information and guidance for information sharing with other agencies when it is vital in the best interests of people who are experiencing domestic abuse. This should include when confidentiality and consent issues arise to reduce the impact of further risk of abuse or harm.

19.24 To have a clear escalation process when risks of domestic abuse are identified which identifies where support can be accessed that is inclusive of the MARAC arrangements.

19.25 The Trust to adopt a more effective approach for practitioners to readily access information required for their assessments where MARAC alerts have been placed on the system.

19.26 To have a recognised tool in the Trust electronic notes that capture safeguarding concerns, the consideration given to the risk and the justifications for decision making. This should take into account a person's capacity to understand and serve a purpose for formulating a decision for safeguarding.

19.27 **Adult Social Care**

Staff should attend domestic abuse refresher training to ensure they have up to date knowledge and understanding of the issues relating to domestic violence.

19.28 All staff should attend Care Act 2014 refresher training to ensure they are fully up to date with their duties and responsibilities under this legislation.

19.29 Staff should attend refresher training on safeguarding and the referral criteria to ensure they are up to date with current practice and procedures.

19.30 Female victims of domestic abuse should be given the opportunity to be interviewed/assessed by a female social worker.

19.31 When individuals are signposted to other agencies there should be effective systems in place to ensure timely feedback/follow up on outcomes.

19.32 Social work staff require in house comprehensive initial and refresher training on recording skills to ensure a full recording of events is completed for every contact.

19.33 In house training on information sharing should be provided to all staff.

19.34 Cases that involve repeat contacts in respect of vulnerable/at risk individuals but currently do not progress from the Adult Access point require an agreed threshold point where the case requires allocation to a relevant social work team for a more in-depth assessment of the situation.

Appendix A

Terms

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) was: "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional. Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to

harm, punish, or frighten their victim.”

3. Therefore, experiences in Jane and Roger’s relationship fell within the various descriptions of domestic violence and abuse.

DASH risk assessment model

4. Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH) is the risk assessment model currently by Middlesbrough Community Safety Partnership

5. DASH is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference [MARAC].

6. There are three parts to the DASH risk assessment model:

i. Risk identification by first response police staff

ii. The full risk assessment review by specialist domestic abuse staff

iii.Risk management and intervention plan by specialist domestic abuse staff

7. The definitions of risk used by the Middlesbrough Community Safety Partnership are:

Standard: Current evidence does NOT indicate likelihood of causing serious harm

Medium: Identifiable indicators of risk of serious harm. Offender has potential to cause serious harm but unlikely unless change in circumstances

High: Identifiable indicators of risk of imminent serious harm. Could happen at any time and impact would be serious. All High risk cases go to MARAC.

Appendix B

Demographics of Middlesbrough

In the 2011 census the population of Middlesbrough was 138,412 and is made up of approximately 51% females and 49% males.

The average age of people in Middlesbrough is 38, while the median age is lower at 37.

90.2% of people living in Middlesbrough were born in England. Other top answers for country of birth were 1.8% Pakistan, 1.0% Scotland, 0.7% India, 0.4% China, 0.3% North Africa, 0.3% Ireland, 0.3% Northern Ireland, 0.3% Wales, 0.2% Nigeria.

94.6% of people living in Middlesbrough speak English. The other top languages spoken are 0.7% Panjabi, 0.7% Urdu, 0.6% Arabic, 0.4% Polish, 0.4% All other Chinese, 0.3% Kurdish, 0.2% Czech, 0.2% Persian/Farsi, 0.1% Tamil.

The religious make up of Middlesbrough is 63.2% Christian, 21.9% No religion, 7.0% Muslim, 0.4% Hindu, 0.4% Sikh, 0.3% Buddhist.

8,531 people did not state a religion.

A summary of domestic abuse services available in Middlesbrough can be seen at https://www.middlesbrough.gov.uk/social-care-and-wellbeing/domestic-abuse

Appendix C

No	Recommendation	Scope	Action to take	Lead agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
Community Safety Partnership							
1	Middlesbrough Community Safety Partnership should consider the feasibility of developing a coordinated case management approach to the care of vulnerable service users, who engage in risky behaviours, with full consideration of MARAC and other safeguarding processes.	Local	Review process, systems and forums already established and consider how they interrelate. Consider system change needed in order to embed a case coordinated approach as part of new commissioning model across homelessness, substance misuse, domestic abuse and homelessness. Written into specifications and tender Process mapping workshop to take place between CSP and Adult SC re complex needs – internal review progressed Adult social care	CSP CSP CSP Adult SC	Shared Case load Management System implemented Policy and procedure & multi agency information sharing protocol developed defining case coordinated approach for vulnerable service users Services commissioned and developed to meet needs of vulnerable service users. Thresholds and Pathways agreed and shared widely	October 2019 June 2019 October 2019 March 2019	**Ongoing** **Ongoing** **Ongoing** **Ongoing**

2	The Middlesbrough Community Safety Partnership should put in place processes by which it can gain assurance that: 1. MARAC actions are meaningful and contribute to the safety of the victim. 2. Agencies are held to account for the delivery of agreed actions. 3. Safety planning for victims of domestic abuse when offenders come towards the end of a sentence imposed by the criminal justice system can be made an integral part of the domestic abuse community response, for example by being incorporated into MARAC.	Local	MBC Representatives identified on strategic meeting and SPOC attending MARAC meetings consistently	OPCC CSP Cleveland Police	MCB representation strategic and operational level	April 2018.	**Completed** Governance
			MARAC meeting. Information sharing Protocol shared with service leads	OPCC CSP Cleveland Police	Procedure and policy developed re MARAC across Tees	April 2018	**Completed** Policy launched
			Full review of MARAC process completed	OPCC	Review completed	January 2018	**Completed** Review published
			Independent MARAC chair recruited – funded collaboratively across agencies	OPCC CSP Cleveland Police	Post filled – funding agreed	April 2018	**Completed** Independent chair appointed
			Letter prepared to CJMB requesting review across NPS, Prison Service and D&T CRC ensuring clear lines of responsibility agreed re how agencies are notified to ensure a victim in informed and safety planning is implemented with a victim if offender due for release from a custodial sentence	CSP CJMB	Tabled on CJMB and next steps agreed to ensure this recommendation is addressed	January 2019	**Ongoing**

3	The Middlesbrough Community Safety Partnership should consider adopting an appropriate evidence based model for supporting victims of domestic abuse with complex needs [mental health/substance misuse], such as the Alcohol Concern Blue Light Project methodology and training materials.		MBC to develop new commissioning approach to be developed across substance misuse, homelessness, domestic abuse and sexual violence & abuse The approach will incorporate triage, case coordination and assertive outreach and will embed evidence based models such as person centred & trauma informed practice. This will also link with Navigator Partnership which is a Regional Project for victims with complex need funded by Ministry of housing & the aligned Ministry of Justice Bid for female offenders experiencing DA	CSP DA Lead MBC	Collaborative working across services Improved information sharing & monitoring Improved engagement and oversight for DA victims with complex need Project Management Board for Navigator overseeing work carried out and feeding this into Local Domestic Abuse Strategic Partnerships	October 2019 October 2018	**Ongoing** **Completed** Funding secured until March 2020
			Develop vulnerable women's case conference This will provide governance and case coordination for all female victims of DA / sexual violence and abuse with high vulnerability/ high risk issues	DA Lead MBC	Terms of reference agreed and ensure this is promoted across agencies.	April 2019	**Ongoing**

4	Middlesbrough Community Safety Partnership should circulate the Home Office Information booklet on Adolescent to Parent Violence and Abuse [APVA] to partner agencies and seek assurances they have pathways in place that ensure the appropriate response is delivered when APVA is recognised. Partner agencies should circulate the information to their staff and ensure it is included on new and refresher training.	Local	Booklet circulated to Middlesbrough Domestic Abuse Strategic Partnership, Middlesbrough Children Safeguarding Board & Teeswide Adult Safeguarding Board.	DA Lead MBC	Guidance shared via network	July 2018	**Completed** Information shared across DASP network and children / adult safeguarding
			Information, Briefing & link for booklet added to Middlesbrough Council website and LSCB site re APV	DA Lead MBC/ LSCB	Updated website and materials re APV	July 2018	**Completed** Information readily available
			LSCB level 1 and 2 training adapted to include APV and learning from DHR	DA Lead MBC	DA training incorporates APV for refresher / Induction training across multi agency professionals	August 2018	**Completed** Revised training materials
			DA Coordinator attended LSCB to update on theme identified in DHR re APV	DA Lead MBC			
			7 minute Briefing Paper re DHR overview and learning shared with directorate & included on MBC website	DA lead MBC	Strategic Briefing completed	November 2018	**Completed** Increased awareness
			APV pathways presentation developed for YP Risk Roadshow for multi- agency professionals	DA lead MBC	Increased awareness across partnership	October 2018	**Completed** Presentation to be rolled out

5	Middlesbrough Community Safety Partnership should seek assurance from commissioners that access to historic records is considered as part of the continuity arrangements when commissioning new services.	Local	Appointment of commissioning officer to support commissioning activity within public health Guidance has been developed regarding the decommissioning of service provision which includes the transfer of records	Commissio-ning & public health Team MBC	Commissioning process and procedures reviewed	June 2018	**Completed** Jan 2019
Cleveland Police							
6	PC *******is spoken to and debriefed around actions when attending the incident on 11th December 2013	Local	Officer concerned spoken to in person by D.I Birkett around his sequel of event - that T.M did not want to provide a statement against A.M when the day before she had provided a statement. As this event was 5 years ago, officer could not recall this event although he knew he had dealt with T.M at some point. He could not account for why she would not provide a statement on this occasion.	Cleveland Police	This was a specific incident with no long term learning from it.	July 2018	**Completed** July 2018
National Probation Service							
7	The Probation Service Individual Management Review should be shared with the probation officer and the three managers responsible for supervision	Local	IMR to be disclosed to LN and 3 managers involved -Learning points to be shared with all managers	Head of Area	Meeting has taken place	Meeting with those involved in IMR – June 2018. Meeting with	**Completed** Meeting has taken place. Lessons learned discussed and

	during the period of Roger's contact with the Probation Service so that its findings can influence and improve future practice relating to risk assessment, enforcement and seeking guidance from a manager		-Focus on false optimism and information sharing			all managers – July 2018	plan made for implementing lessons in future practice
8	The probation officer's present manager to conduct a "deep dive" assessment of ten of the cases which the probation officer managed at Middlesbrough Probation Office to seek assurance about enforcement and risk assessment practice and the extent of case referral to a manager for advice.	Local	Deep dive into 10 cases	Head of Area	Audit successfully completed and report submitted	September 2018	**Completed** No Further concerns
9	All staff of NPS Cleveland to be issued with a reminder from the Head of Area that all contacts and telephone calls must be recorded on Delius within 24 hours.	Regional	Email guidance Feedback DHR learning points to all staff	Head of Area	Learning points to be shared with all team managers July LMM	July 2018	**Completed** Learning points shared July 2018
10	All staff of NPS Cleveland to be issued with a reminder of enforcement processes from the Head of Area in respect of Court Orders and Prison Licences and the need to seek approval from a manager if they wish to depart	Regional	Email about enforcement processes Feedback DHR learning points to all staff	Head of Area	Since this offence was committed all Cleveland staff have had briefings and Guidance about 'achieving better compliance" – including guidance on enforcement steps and a	August 2018	**Completed.** New guidance has been implemented across the area

	from the process in an attempt to achieve improved compliance.				framework for applying professional judgement to enforcement and compliance decisions		
11	All staff of NPS Cleveland to be notified by the Head of Area that they must bring cases assessed as posing a medium risk of causing serious harm in the context of domestic violence to a manager for discussion when new information is received and/or when they are to re-assess the level of risk of causing serious harm.	Regional	Re-issue current guidance. Feedback DHR learning points to all staff	Head of Area	DHR learning points to be shared with all team managers in July LMM Head of area has met with police and agreed to be part of the new MATAC process – which aims to pick up on offenders not discussed ad MARAC / MAPPA	July 2018	**Completed** There is now lead SPO for MATAC to ensure appropriate attendance at meetings across the area
12	All staff of NPS Cleveland to be issued with guidance from the Head of Area about the need to pass information about possible new offences and breaches of Court Orders and Prison Licences to Cleveland Police Intelligence Hub.	Regional	Re-Issuing of guidance. Feedback DHR learning points to all staff	Head of Area	DHR learning points to be shared with all team managers in July LMM	July 2018	**Completed**
13	All staff of NPS Cleveland to be re-issued with guidance from the Head of Area as to when referrals to MARAC, MAPPA and Adult Safeguarding should be made.	Regional	Reminder to be sent to all staff regarding current processes which are all mapped on EQUIP Feedback DHR learning points to all staff		In addition to managing domestic abuse offenders via MAPPA and victims via MARAC Head of Area is also signed up to working with police on MATAC system for managing repeat	August 2018	**Completed** attending MARAC and MATAC

					Domestic Abuse situations where MAPPA and MARAC are not involved		
South Tees Hospitals NHS Foundation Trust							
14	The development of a management of domestic abuse policy	Local	Develop policy Ratify and launch policy	STHFT	Policy in draft for consultation Ratify policy	December 2018	**Completed** Policy Launched Dec 2018
15	To audit A&E staff response to disclosures of domestic abuse	Local	Audit to be undertaken			May 2018	**Completed** Significant improvement demonstrated.
South Tees Clinical Commissioning Group							
16	GPs to input into the frequent attenders at Emergency Departments.	Local	The CCG is exploring with the Trust ways of sharing information to the frequent attenders meeting and out to the GPs	CCG	The ED has a frequent attenders process that the CCG had a lot of input into and GPs are now asked to participate	June 2018	**Ongoing** An audit of all frequent attenders will be carried out to see if the GPs had input 1.3.19
17	GPS to input into case management of patients with severe chronic dependence on alcohol.	Local	GPS are carrying out MDTs in relation to this group of patients	CCG	GP's have been carrying this out independently the CCG is looking at a way of formalising this process	June 2018	**Ongoing** Work has been ongoing since DHR to find a way of case managing pts

Middlesbrough Recovering Together							
18	Provide staff training around DASH Risk Identification Checklist and MARAC process	Local	Training was delivered to the HILT team by a specialist DA provider My Sisters Place, which included DASH Risk Identification training. Internal DASH training has been delivered to the CGL team within MRT, around recognising signs and using the tool, in November 18.	MRT	Training sourced and provided to all Substance Misuse Teams in MRT. There is a MARAC lead for the partnership who represents MRT at MARAC meeting and feeds back to the partnership. There are also 2 dedicated Safeguarding Leads within the partnership to lead on staff/service development and risk management. Current briefings on MARAC, the DASH risk assessment and Claire's Laws are being delivered to all teams in March 2018.	November 2018 November 2018	**Ongoing** Further training to be delivered in 2019 – dates to be agreed
19	Ensure quality standards for case note recording and assessments are being met	Local	A national quality review process is in place, and additional local processes have been agreed to support quality and staff development, including Quality Improvement Framework audits, shadowing and	MRT	A quality review process has been implemented and embedded. Systems are in place to action learning needs identified within the review process on an individual, service and partnership level. There is a Quality Lead in	June 2018	**Ongoing**

			observation which feeds into supervision, protected professional development time, reflective practice sessions, etc.		post to focus on quality and performance.		
20	Provide risk identification and management training for all members of staff in HILT team.	Local	Risk identification and management training was delivered to the HILT team in June 2017, in addition to any previous training the team had received. All new staff were trained in risk identification and management as part of their induction process. Safeguarding and risk management is discussed within monthly supervisions and team meetings, to support ongoing learning and development and to ensure risk management is effective.	HILT	Training has been completed with all members of the team, and processes are in place to ensure new staff are trained and that training needs are reviewed regularly.	March 2019	**Completed**

21	Ensure community teams are following up none attendance via the Did not Attend policy.	Local	The DNA policy (Missed Appointment Checklist) is in place with an auditing process through management to support. This process takes individual risk level into account when responding to missed appointments	MRT	The process is in place with regular auditing to feed into quality assurance and development.	October 2017	Ongoing
Tees Esk and Wear Valleys NHS Foundation Trust							
22	To raise the profile of Domestic Abuse in TEWV services through training to equip practitioners with information and tools on best practice when addressing concerns related to domestic abuse. This should cover topics such as the Toxic Trio and the Safe Lives DASH (Domestic Abuse, Stalking and Harassment and Honour Based violence) 2009) risk assessment.	Local	Delivery of Domestic Abuse Basic Awareness. Training priority to be given to the teams involved in the review Safeguarding training to incorporate Domestic Abuse within it.	TEWV	Training has already been made available to Trust staff. 8 bespoke training sessions were delivered for the identified areas. Safeguarding Adults training has already included Domestic Abuse Basic Awareness. Domestic Abuse Basis Awareness has been incorporated as part of the Safeguarding Children's Level 3 update programme to be	Already in place prior to review. December 2018. Already in place prior to review.	**Completed.** Training has been available since August 2016. **Completed** **Completed.** Training has been available since August 2016. Completed.

					delivered until October 2019.		
23	To provide information and guidance for information sharing with other agencies when it is vital in the best interests of people who are experiencing domestic abuse. This should include when confidentiality and consent issues arise to reduce the impact of further risk of abuse or harm.	Local	Domestic Abuse Procedure.	TEWV	Domestic Abuse Procedure to be readily available to Trust staff. Communication to the workforce of the Domestic Abuse Procedure via e-bulletin. Circulate a SBARD (Situation, Background, Assessment, Recommendation, and Decision) to Trust staff highlighting the lessons to be learned from this review.	Already in place prior to review. March 2018. March 2018.	**Completed.** Procedure available on Trust intranet site since 02/04/2017. **Completed.** Email sent to communication team to include on next e-bulletin 09/05/18. **Completed.** Email sent to patient safety to distribute 09/05/18.
24	To have a clear escalation process when risks of domestic abuse are identified which identifies where support can be accessed that is inclusive of the MARAC arrangements.	Local	Domestic Abuse Procedure	TEWV	Domestic Abuse Procedure to be readily available to Trust staff. Communication to the workforce of the Domestic Abuse Procedure via e-bulletin. Circulate a SBARD (Situation, Background,	Already in place prior to review.	**Completed.** Procedure available on Trust intranet site since 02/04/2017. **Completed.** Email sent to

					Assessment, Recommendation, and Decision) to Trust staff highlighting the lessons to be learned from this review.	March 2018.	communication team to include on next e-bulletin 09/05/18.
25	The Trust to adopt a more effective approach for practitioners to readily access information required for their assessments where MARAC alerts have been placed on the system.	Local	Review of recording of MARAC on the Trust PARIS electronic records.	TEWV	MARAC information made accessible 24/7.	Already in place prior to review.	**Completed.** PARIS has already been reviewed and information has been made available since December 2016.
26	To have a recognised tool in the Trust electronic notes that capture safeguarding concerns, the consideration given to the risk and the justifications for decision making. This should take into account a person's capacity to understand and serve a purpose for formulating a decision for safeguarding.	Local	Review of Safeguarding documentation on the Trust PARIS electronic records.	TEWV	Recognised tool in place.	Already in place prior to review.	**Completed** PARIS has already been reviewed and information has been made available since December 2016.

Adult Social Care							
27	Staff should attend domestic abuse refresher training to ensure they have up to date knowledge and understanding of the issues relating to domestic violence.	Local	Provide domestic abuse refresher training for fieldwork staff in Adult Social Care	ASC&HI	Level 3 Domestic Abuse Safeguarding Training provided for fieldwork staff	May 2018	**Completed**
28	All staff should attend Care Act 2014 refresher training to ensure they are fully up to date with their duties and responsibilities under this legislation	Local	Provide Care Act 2014 refresher training for fieldwork staff in Adult Social Care	ASC&HI	Care Act 2014 training provided to all Adult Social Care fieldwork staff via CC Inform training platform	August 2018	**Completed**
29	Staff should attend refresher training on safeguarding and the referral criteria to ensure they are up to date with current practice and procedures.	Local	Provide adult safeguarding refresher training for all fieldwork staff in Adult Social Care	ASC&HI	Adult safeguarding refresher training provided to all Adult Social Care fieldwork staff via CC Inform training platform	August 2018	**Completed**
30	Female victims of domestic abuse should be given the opportunity to be interviewed/assessed by a female social worker.	Local	Develop practice guidance to ensure female victims of abuse have the opportunity to be interviewed / assessed by a female member of staff	ASC&HI	Gender mix of Social Work staff within Adult Social Care's Access and Safeguarding teams now provides the opportunity for this.	October 2018	**Completed**
31	When individuals are signposted to other agencies there should be effective systems in place to	Local	Establish practice guidance and process around which elements of	ASC&HI	Appointment of Adult Safeguarding Lead Officer to lead review anticipated by Jan 2019	January 2019	**Ongoing**

	ensure timely feedback/follow up on outcomes.		signposting require formal follow-up arrangements				
32	Social work staff require in house comprehensive initial and refresher training on recording skills to ensure a full recording of events is completed for every contact.	Local	Provide information on recording standards as part of Adult Social Care induction and provide updated practice guidance on recording standards for all existing fieldwork staff	ASC&HI	Recording standards included as part of induction for field workers in Adult Social Care; updated practice guidance issued and case audits in place as part of approval panel process	October 2018	**Completed**
33	In house training on information sharing should be provided to all staff.	Local	Provide information sharing training to Adult Social Care staff	ASC&HI	Information sharing, data protection and information security training provided to all staff within Adult Social Care	December 2017	**Completed**
34	Cases that involve repeat contacts in respect of vulnerable/at risk individuals but currently do not progress from the Adult Access point require an agreed threshold point where the case requires allocation to a relevant social work team for a more in-depth assessment of the situation.	Local	Establish threshold and process around allocation to Social Worker	ASC&HI	Appointment of Adult Safeguarding Lead Officer to lead review anticipated by Jan 2019	January 2019	**Completed**

Appendix D

Home Office

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Councillor Mick Thompson

Chair of the Middlesbrough Community Safety Partnership Member's Office

Middlesbrough
Town Hall PO
Box 503

9 January 2019

Dear Councillor Thompson,

Thank you for submitting the Domestic Homicide Review (DHR) report for Middlesbrough ('Jane') to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24 October. I am very sorry for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded that this is a good, thorough review in which there has been consistent and meaningful family engagement. The lessons identified by the review have been clearly articulated and evidence based.

There were, however, some aspects of the report which the Panel felt may benefit from additional comment, further analysis, or be revised, which you will wish to consider:

- The Panel felt the review could have explored in more detail alcohol being used as a coping mechanism by the victim given the coercive and

controlling behaviour she was subjected to by both the perpetrator and her partner;

- A narrow view has been taken in relation to equality and diversity which only appears to consider whether there was any bias by agencies in the delivery of services. The Panel felt sex and age were particularly relevant in this case and merited further exploration;

- You may wish to consider including a message of condolence in the report to help personalise the review;

- Please note there is a typing error in paragraph 13.2 in relation to the dates which you will wish to correct before publication.

The Panel does not need to review another version of the report, but I would be grateful if you could email us at DHREnquiries@homeoffice.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Krisztina Katona
Chair of the Home Office DHR Quality Assurance Panel