MIDDLESBROUGH COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Jessica

Died May 2018

EXECUTIVE SUMMARY

Home Office QA

March 2020

Chair Ged McManus
Author Paul Cheeseman

CONTENTS

1. THE REVIEW PROCESS

1.1 This executive summary outlines the process taken by Middlesbrough Community Safety Partnership following the homicide of Jessica. It includes Jessica's story, the views of her family and work colleagues and ends with learning and recommendations.

1.2 Jessica is known in the report by her real name at the express wish of her family. The following pseudonyms agreed with Jessica's family are used within the report.

Name	Relationship	Age	Ethnicity
Jessica	Victim and wife of Mayur	34	British Asian
Mayur	Perpetrator and husband of Jessica	36	British Asian
Abir	A male who Mayur indicated he wanted to be his partner	36	British Asian British Asian

1.3 Jessica's family provided the following words about her.

"Heaven has gained an angel but the world is at a loss for it."

Jessica was a rarity; she was beautiful on the outside, and even more so on the inside. She had a truly selfless soul and afforded everyone she met with a kindness and generosity that was second to none.

As the first born in our family, she brought an immense amount of joy as a loving daughter, granddaughter, niece, elder sister and aunt. She had this lovable smile which encapsulated her gentle nature and innocence, and would make our house feel like a home.

She was ambitious, and despite some challenging times, through her own determination and hard work she achieved her dream to be a pharmacist. As a highly commended medical professional, she understood the true impact of her role, which was to help people and make a difference, something she did every day. A truly inspiring example to us all of what you can achieve with courage and perseverance.

She had her whole life ahead of her, a life in which she simply wished for true love, a family of her own and to live happily ever after. Above all, her greatest wish was to be a mother, to share the love she had in her heart and feel the same happiness she afforded to our family as a child. She

deserved to have a wonderful life, but these wishes will now remain unfulfilled.

To know that she is here no more, a day that has come decades too early, brings an indescribable pain. However, the outpouring of love and prayers for her has shown the huge loss felt not only by our family, but by the entire community. The world is a dimmer place to have lost a soul like hers.

We are extremely blessed to have had Jessica in our lives. Even in her own hardships she would still offer you her warm smile, a testament to the wonderful person she was and should be remembered for. We will forever reminisce of our memories together with her and hope one day, somehow, somewhere, we will see her again.

Jessica, rest peacefully and know that we miss you and will love you always and forever.

2. CONTRIBUTORS TO THE REVIEW

2.1 The following agencies provided information to the review.

Agency	IMR[1]	Chronology	Report
Health (on behalf of South Tees CCG, Tees Esk and Wear Valley NHS Foundation Trust and South Tees NHS Hospitals NHS Foundation Trust, Alliance Psychological Services & James Cook University Hospital)	No	No	Yes
Cleveland Police	No	No	Relevant witness statements
HART Gables (LGBT support services)	No	No	Not known to service
Substance misuse services	No	No	Not known to services
London Women's Clinic (Darlington)	No	Yes	Yes
HALO[2]	No	No	Not known to services

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

[2] The Halo Project Charity is a national project that will support victims of honour-based violence, forced marriages and FGM by providing appropriate advice and support to victims. We will also work with key partners to provide required interventions and advice necessary for the protection and safety of victims. https://www.haloproject.org.uk/

2.2 Some of Jessica's family and work colleagues knew some aspects of her relationship with Mayur. Their contribution is incorporated within section 6 of the Overview report. Mayur and his family did not contribute to the review.

3. THE REVIEW PANEL MEMBERS

Name	Job Title	Organisation
Paul Cheeseman	Author and support to panel chair	Independent
Yasmin Khan	Director	HALO
Lisa McGovern	Team Leader	My Sister's Place
Ged McManus	Panel Chair	Independent
Jen Milsom	Detective Inspector	Cleveland Police
Claire Moore	DA Ops. Coordinator	Middlesbrough Community Safety Partnership
Barbara Potter	Head of Quality & Adult Safeguarding	South Tees CCG
Ann Powell	Head of Cleveland National Probation Service	National Probation Service
Erik Scollay	Director of Adult Social Care and Health Integration	Middlesbrough Council
Marion Walker	Head of Stronger Communities [lead for Community Safety Partnership]	Middlesbrough Council

3.1 The Chair of Middlesbrough Community Safety Partnership was satisfied the Panel Chair was independent. The Panel Chair believed there was sufficient independence and expertise on the Panel to prepare an unbiased report.

3.2 The panel met four times and the review chair was satisfied that the members were objective and did not have any operational or management involvement with the events under scrutiny. There were no reported conflicts of interest.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 On 12 June 2018 the Chair of Middlesbrough Community Safety Partnership informed the Home Office by letter that a DHR was taking place. Ged McManus was appointed as the independent chair and on 6 September 2018 the first DHR meeting took place.

4.2 The chair completed over thirty years in public service [the British police service] retiring, from full time work in 2016. He is currently Independent Chair of a Safeguarding Adult Board in the north of England. Paul Cheeseman supported the Chair and was the Author of the report. He completed thirty-five years in public service [British policing and associated roles] retiring from full time work in 2014. Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews.

4.3 Neither the Chair or Author has worked for any agency providing information to this review. The Chair and Author previously undertook a DHR in Middlesbrough during 2017.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 **The purpose of a Domestic Homicide Review 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 policies and procedures as appropriate;

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

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7] The Guidance was update in December 2016.

5.2 **Timeframe under Review**

The review covers the period from 1 April 2016 to the date of Jessica's death in Spring 2018. This period was selected because it started with the date the couple bought their house in Middlesbrough.

5.3 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Jessica as a victim of domestic abuse and what was your response?
2. What risk assessments did your agency undertake for Jessica; what was the outcome and if you provided services were they fit for purpose?
3. What was your agency's knowledge of any barriers faced by Jessica that might have prevented her reporting domestic abuse and what did it do to overcome them?
4. What knowledge did your agency have of Jessica and Mayur's physical and mental health needs and what services did you provide?

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

6. What knowledge did your agency have that indicated Mayur might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC]?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Jessica and Mayur?

8. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

9. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Jessica and Mayur, or on your agency's ability to work effectively with other agencies?

10. What learning has emerged for your agency?

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

12. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Middlesbrough Community Safety Partnership?

13. Was there any indication or evidence that the homicide of Jessica was a so called 'honour killing'?

6. SUMMARY CHRONOLOGY

6.1 Jessica

6.1.1 Jessica was born and brought up in the Leeds area. Jessica and her family are Hindu. She was the eldest of three daughters. She studied at a university in Leicester and lived there for three years, graduating in 2005. Jessica then studied pharmacy and graduated from a university in Manchester in 2010.

6.2 Mayur

6.2.1 He was brought up in the Halifax area with his father, mother, grandmother and brother. He also attended the same universities as Jessica and graduated in pharmacy in 2009.

6.3 The Relationship

6.3.1 Jessica's family, friends and work colleagues were able to provide information on aspects of the couple's relationship. Jessica had known Mayur when she was a child and the two families were acquainted. They met again when at university and married in 2009. They lived at first with Mayur's parents in West Yorkshire where they both worked as locums in pharmacies.

6.3.2 The couple moved to Middlesbrough in 2013/14. After initially working there as locums, they then established their own pharmaceutical practice in 2015. Although they did not know their significance at the time, since Jessica's death, her family have identified a number of events [see below] which they now believe are examples of domestic abuse, including in particular controlling and coercive behaviour by Mayur.

- Jessica being told by Mayur's family that she had married into their family and should only care for their side; that she belonged to them;
- When Jessica's grandfather was dying Mayur would not allow her to come home to see him or to stay. She could only visit when he was in hospital;
- Jessica disclosed to her younger sister that Mayur hit her whilst they were in the car because of the issue of her grandfather dying as Jessica wanted to stay;
- Jessica stopped speaking up about things and appeared scared to commit to attending family events and often wouldn't come. When she did visit her younger sister says she always seemed to 'clock watch' and needed to get back home pretty much as soon as she had arrived;

- Jessica told her younger sister that Mayur's mother was verbally abusive to her and she drove a wedge between her and Mayur. Jessica's mother in law would always complain to Mayur about Jessica and he would take his mother's side. Jessica's sister described him as a 'mummy's boy'. Jessica had to do what Mayur's mother wanted her to do;
- Mayur always put Jessica down a lot and when Mayur conversed with her and her younger sister he would always talk negatively about Jessica. This became repetitive and destroyed Jessica's confidence;
- Jessica's family say Mayur was a compulsive liar. For example when working as locums in West Yorkshire, Mayur told a member of staff that Jessica was pregnant with twins. This was untrue and Jessica was upset when she then had to tell the member of staff the truth. Mayur thought it was funny and Jessica's family believe he was using her desire, to conceive and bear a child, against her as a way of exercising control;
- Because of Mayur's behaviour, particularly following an occasion when he suggested Jessica's family interfered and were a hinderance in his marriage, the family say if Jessica did or said something Mayur did not agree with, he would 'give her an ear full';
- Jessica's family believe Mayur deliberately arranged the move to Middlesbrough as an attempt to isolate her from her family after she discovered an incriminating text message [see paragraph 16.3.4 below];
- Shortly before he killed Jessica, Mayur told her father that he was the dominating one, that he could do what he wanted, that he didn't want a wife like that and that Jessica never questioned him.

6.3.3 Jessica disclosed to her family that Mayur would come home from work and go into another room to talk to a male[3]. She said this happened every night and he would spend hours talking to him. Jessica also disclosed to an uncle that she had not had sex with Mayur for ten months and said she would make the relationship work.

6.3.4 During 2012 Jessica's youngest sister found a record of a conversation on Mayur's telephone between him and Abir in which they both spoke about loving each other. Jessica saw a picture of the text of the conversation. She was upset when she saw it, although it is not known whether she disclosed this information to Mayur.

[3] At this time it did not appear Jessica knew the identity of this male. However, the family say the male was Abir, who lived in the Leeds area. He subsequently moved to Australia where the family understand he continues to live.

6.3.5 However, Jessica did tell Mayur's brother in confidence about this information and it appears he then told Mayur. This led to a family meeting attended by Mayur's family and Jessica's father. Jessica's family say Mayur's sexuality was never discussed or disclosed at this meeting and instead, it was made to look as though Jessica was at fault. Despite this, Jessica told her father she would make her marriage work as she had chosen Mayur.

6.3.6 Her family says that Jessica's greatest wish was to be a mother and after several years of marriage she had not conceived. In 2015 Jessica therefore started a course of privately provided IVF treatment. During the homicide enquiry it was established that Mayur was secretly taking a drug that was made to supress sperm count hence it was unlikely Jessica would conceive naturally. Since Jessica's death her father has found out Mayur made threats to leave her if she did not continue with IVF treatment.

6.3.7 In February 2018, during a facetime conversation with her younger sister, Mayur entered the room and said that if that he and Jessica argued, they may go for days without talking to one another. Jessica then said that 'sometimes you [meaning Mayur] put your hands around my neck and it hurts'. Mayur made a joke of this. Unbeknown to Jessica's sister, such behaviour is very often an indication of escalating domestic abuse and an increase in the risk a victim faces from a perpetrator.

6.3.8 Colleagues who worked with Jessica in pharmacies in West Yorkshire and Middlesbrough also provided important information about the couple's relationship. In 201-11 Jessica told a colleague that Mayur was not interested in her in a sexual way and she suspected he was gay.

6.3.9 Several employees working in the pharmacy in Middlesbrough commented upon the relationship between the couple and about the abusive behaviour of Mayur towards Jessica. They say Mayur had a very quick temper in the shop, he often shouted at Jessica in front of staff and customers. Mayur often reduced Jessica to tears, slammed doors, threw things and kicked the plinth of the island in the dispensary. Staff also noticed Jessica limping and she told them she had a bruise and that Mayur had thrown his mobile phone towards her which had hit her leg.

6.3.10 A colleague in the pharmacy says Mayur used the app 'Grindr' and was constantly chatting on it. He also had a reputation for telling lies to the point colleagues no longer believed what he said. He was also seen on the pharmacy CCTV to have been in an intimate embrace with another male. Colleagues in the pharmacy also discovered from Mayur's patient record that he was taking a tablet that reduced his sperm count [see paragraph 6.3.6]. None of this information was reported the police or any other agency and only came to light during the homicide enquiry.

6.4 Information known to Statutory Agencies

6.4.1 The DHR found that no statutory agency held any information that related to the abuse Mayur perpetrated on Jessica nor of the matters described in section 6.3.

6.4.2 As part of the DHR process agencies were asked to review the information they held concerning Mayur and Jessica. Jessica and Mayur were both registered at the same GP practice in Middlesbrough[4]. Mayur only made one visit during the period under review. They were both well-known to the GP practice as their pharmacy was closely linked and it had daily contact with the practice.

6.4.3 Jessica visited her GP in connection with IVF treatment and the GP made a referral to the London Women's Clinic [henceforth referred to as the Clinic]. Her GP also referred Jessica to Alliance Psychological Service for low intensity cognitive therapy as she was anxious about not conceiving. She was also prescribed medication on two occasions by her GP. Once was when she was struggling with anxiety as she was worried about the impact on her health from some of the medication she was given in connection with her IVF treatment. The second occasion followed a period of anxiety and sleeplessness after two long haul flights to India and back.

6.4.4 There is no information within any of the GP records neither the Alliance Psychological Service records that indicate Jessica disclosed domestic abuse or any of the indicators of domestic abuse. There is nothing within these records to indicate whether or not she was asked any direct questions about domestic abuse.

6.4.5 When Jessica attended for IVF treatment she indicated to the Clinic that she and Mayur had a normal intimate relationship. During the assessment process Jessica completed a number of documents relating to the 'Welfare of the Child'. Information was also sought by the Clinic from Jessica's GP. There was nothing in any of this information to indicate any welfare concerns. After a period of IVF treatment within the NHS, Jessica returned to the Clinic and in March 2018 eggs were successfully collected and fertilized and three embryos were frozen. These embryos were not transferred to Jessica before her homicide.

[4] Jessica and Mayur left this GP practice and registered elsewhere shortly before the homicide. There is no record they had any contact with the second GP practice.

6.4.6 Cleveland Police had no contact or information concerning Jessica and Mayur's relationship until 20.22hrs on a date in spring 2018 when Mayur made a 999-telephone saying Jessica had been attacked and the house ransacked. Police officers and ambulance staff found Jessica had been bound with tape and she was deceased. A post-mortem examination was conducted which found she had died from pressure to the neck. Suspicion soon fell on Mayur. The police found a significant amount of evidence that indicated Mayur's explanation for the death of Jessica was untrue and that he had planned to kill her for some time. In summary the police found the following;

- Mayur frequently visited a geo-social networking site geared towards gay and bi-sexual men [Grindr];

- Mayur had intimate relationships with a number of men during the time he was married to Jessica. It seems he formed a particular affection for a man called Abir;

- Messages were found from 2012 onwards that showed Mayur wanted to spend the rest of his life living with Abir in Australia. There was evidence that Jessica knew or strongly suspected that Mayur was gay;

- Using internet searches going back to 2013, Mayur had investigated strangulation, how long it took for a victim to die, hiring a hit man, how much methadone overdose kills a person and insulin overdoses;

- Had he not been convicted, Mayur would have received around £2m from various life insurance policies taken out in respect of Jessica;

- A CCTV hard drive from the house had been hidden in a suitcase by Mayur. It showed no evidence of anyone entering the house during the period Jessica was killed and no evidence of a forced entry;

- A roll of duct tape identical to be that used to bind Jessica was found hidden in the back of a store-room at the pharmacy. The end of that roll physically fitted the end of the piece of tape used to bind Jessica;

- The police found four syringes in Mayur's lap top bag. Two contained insulin and the other two a fast-acting sedative. Mayur had been researching for information on-line about this drug. The prosecution case was that Mayur had an alternative method with him with which to kill Jessica.

6.4.7 Mayur was charged with Jessica's murder and convicted after a trial before a Crown Court which ended in 2018. He was sentenced to life imprisonment for murder with a minimum tariff of 30 years. That means he will not be considered for release from prison by the Parole Board until he has served that period of time.

7. FINDINGS

7.1 In contrast to Jessica, who was a warm and kind person, Mayur was a cruel and manipulative individual. He wanted the world to see him as a young and successful businessman. Yet in reality he was someone who perpetrated domestic abuse upon Jessica and tried to coerce and control her for most of the nine years they were married. The DHR panel found the abuse he perpetrated started early in the relationship.

7.2 For example, Mayur told Jessica lies and said her family would not accept him. Soon after they married he told Jessica she was not part of her own family anymore. Cruelly, Mayur would not allow her to stay with her family when her grandfather was dying.

7.3 As well as coercive and controlling behaviour the DHR also found evidence that Mayur used physical force upon Jessica on at least three occasions. He struck her once while they were travelling in the car; he threw a mobile telephone at her bruising her leg and also placed his hands around her neck. The DHR felt the last act was a sign of the increasing risk that Jessica was at from Mayur.

7.4 The DHR found ample evidence from colleagues who worked alongside the couple that Mayur was a bully and treated Jessica in an appalling and humiliating way in front of them and customers. Mayur was also an accomplished liar and the panel saw many examples of this behaviour.

7.5 Mayur is gay. The panel saw evidence that Mayur had little if any intimate contact with Jessica. He spent long periods of time using the Grindr app and on the telephone engaging with other men and evidence from his trial showed he had relationships with other men. The discovery of messages between Mayur and Abir was significant, and disclosed Mayur wanted to spend his life with this man and not with Jessica.

7.6 Despite the emergence of information that raised suspicions about Mayur's sexuality, it was Jessica who Mayur's family insinuated was responsible for the marital difficulties. There were opportunities for Jessica to leave the marriage and her father said he would have supported her in doing so if she chose this path. The panel do not know why she remained with Mayur, although they recognise there are many reasons that victims choose to remain in abusive relationships. It may have been that Jessica felt under pressure to make the marriage work as it was she that persuaded her father to let her marry Mayur. The family say that it maybe Jessica felt she had to back down with Mayur being so persuasive.

7.7 Although Jessica wanted to have a child, given the lack of intimate contact with Mayur it was unlikely she would conceive naturally. The DHR felt that

Jessica was probably under very significant pressure from Mayur to undergo IVF treatment. Jessica's family say they have found out since her death that Mayur made threats to leave her if she did not continue with IVF treatment. The discovery during the homicide investigation that Mayur was taking a drug to reduce his sperm count was significant. The panel felt it was a clear example of how Mayur circumvented the IVF process and used coercive and controlling behaviour to ensure Jessica had to undergo what can be a painful and distressing process for a woman.

7.8 The panel looked carefully at whether the homicide of Jessica could be classed as an example of a so called 'honour killing'. They concluded it was and that because of cultural beliefs about sexuality, divorce on the grounds that Mayur was gay could never have been for him or his family a reason to end the marriage. Consequently, the only way that Mayur might be able to leave the marriage with honour was by killing Jessica.

7.9 The criminal trial of Mayur revealed a catalogue of evidence that overwhelmingly linked him to the homicide of Jessica. The panel looked very carefully and could not find any information that agencies knew of this evidence prior to the homicide or of anything else which might have indicated Jessica was the victim of domestic abuse. However, the panel did conclude there was a missed opportunity for Jessica's GP to ask direct questions when she consulted them over her anxiety and stress.

7.10 Jessica's family and work colleagues held some pieces of information about Mayur's behaviour towards Jessica which only had significance after Jessica's homicide. Some pieces of information [particularly the information about Mayur placing his hands around Jessica's neck] might have been recognised as significant by a professional with training in domestic abuse. However, there was never the opportunity for that to happen before Jessica was killed.

8. LEARNING

8.1 Agencies Lessons

8.1.1 None of the agencies involved in this review identified any single agency learning.

8.2 The Domestic Homicide Review Panel's Lessons

8.2.1 The DHR panel identified the following lessons. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson 1 [Panel recommendation 1]
Narrative
Jessica's family and work colleagues held pieces of information about the abuse that Jessica suffered at the hands of Mayur. Much of that information, if considered in isolation, may not have seemed significant or alerted them of concerns. Some of the information indicated that the risk Jessica faced was increasing significantly [for example Mayur placing his hands around her throat]. That information would have been recognised as significant to domestic abuse trained professionals.
Lesson
Friends, family and work colleagues often hold important pieces of information. Agencies need to continue their efforts to publicise information about the indicators of domestic abuse that allows friends, family and work colleagues to recognise what they know and how to report those concerns to agencies. There needs to be more focus on the types of domestic abuse such as psychological and emotional abuse as these often go unnoticed and are harder to see.

Lesson 2 [Panel recommendation 2]
Narrative
Jessica presented at her GP and disclosed that she was suffering anxiety and was under pressure because she could not conceive. The GP referred her for low intensity cognitive therapy. There is no evidence that anyone in this pathway, either GP or IAPT services, asked Jessica if she had or was experiencing domestic abuse.
Lesson
There is a well-researched link between domestic abuse and mental health problems. Research suggests that women experiencing domestic abuse are more likely to experience a mental health problem, while women with mental health problems are more likely to be domestically

abused. In cases of mental health problems, health professionals should always consider asking a direct question of the patient. Middlesbrough Borough Council commission a domestic abuse counselling service which is trauma informed. Had Jessica disclosed domestic abuse that would have been a more appropriate pathway for her than IAPT.

Lesson 3 [panel recommendation 3]
Narrative
As in the previous DHR case in the Middlesbrough area [Jane], Jessica was a long-term victim of domestic abuse. While she told members of her family and work colleagues some instances of Mayur's behaviour she never disclosed the full extent of her suffering at his hands and did not leave him when she suspected he was gay and he was engaging in intimate conversations with another gay man.
Lesson
Research suggests there are many reasons that women like Jane and Jessica do not report the abuse they suffer. This may include lack of self-confidence, fear, intimidation, financial dependence and guilt. In Jessica's case this was compounded because of the way Mayur manipulated her to believe that if they separated her family would disown her and she would be on her own. Jessica was also professionally vulnerable as she was one of the two partners in the business [the other being Mayur]. Therefore she had no manager to turn to for support and this was also a barrier.

Lesson 4 [panel recommendation 4]
Narrative
Mayur was gay and engaged in relationships with other men, some of whom he met through Grindr. Because of cultural beliefs about sexuality, divorce on the grounds that Mayur was gay could never have been a reason for him to end his marriage. Consequently, the only way that Mayur may have felt able to leave the marriage with honour was by killing Jessica.
Lesson
Jessica did nothing that was, or might be perceived, as dishonourable. However her death at the hands of Mayur should be considered an honour killing because Mayur killed her to try and protect his own honour.

9. RECOMMENDATIONS

9.1 The panel and single agency recommendations appear in tables within Appendix A.

Appendix A Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Outcome**
1	The Middlesbrough Community Safety Partnership should review the effectiveness and if necessary strengthen the information provided to family, friends, work colleagues and diverse communities about recognising the signs of domestic abuse and where they can go, if necessary anonymously, with such information. In particular there should be a focus on smaller businesses that do not have the infrastructure in place to support victims of abuse.	Local Local	Chair of Community Safety Partnership to meet Cleveland Police and Crime Commissioner and Chair of Adult Safeguarding Board to raise awareness of Jessica Patel DHR. Community Safety Partnership alongside Domestic Abuse Strategic Partnership and Communications team will review information currently provided to friends, family,	Middlesbrough CSP Middlesbrough CSP Middlesbrough Communications Team DASP	Meeting completed -Communication meeting planned -Understand needs of target audience -Identify key messages -Review media and communication materials	Meeting take place no later than 1 month from DHR publication Campaign to be launched within three months of DHR publication	Better awareness and understanding of learning and recommendations in the review Increased awareness of domestic abuse amongst friends family and work colleagues, local businesses and diverse communities

			work colleagues and small business via Middlesbrough council website and leaflets.		-Engage with survivors and service user groups to ensure communications are effective		
		Local	Community Safety Partnership will support the Tees wide VAWG Communications Strategy, which ensures minority groups included in communication plans across Cleveland	Community Safety Partnership Tees wide VAWG Communication strategy steering group	-Strategy approved -Steering group meetings arranged on quarterly basis	Ongoing – developed Nov 2018	Key stakeholders aware of, and participate in, awareness raising activity. Key messages and communication channels agreed and used by all agencies,
		Local	Middlesbrough community safety partnership to work along the Middlesbrough domestic Abuse partnership to develop a campaign in relation to increasing understanding HBV	Task and Finish group FM and HBV group (HALO, MBC reps, BME Network)	-Task and finish group for July HBV / FM Awareness campaign established - Communication plan agreed - Conference *Transforming public sector response to tackling Illegal cultural harms* takes place - Radio Interview community radio	8 - 12 July 2019 May 2019 July 11 2019	Stronger multi-agency response Increased Referrals for BME victims Improved understanding of services available Better understanding of HBV, the risks and where to get help

		Local Local	Community Safety Partnership will use media to best effect including social media ensuring it is both age appropriate and culturally appropriate to Promote learning and recommendations from DHR through delivery at team meetings, partnership boards	Middlesbrough CSP Middlesbrough Communications Team DASP Middlesbrough Community Safety Partnership DA lead	Social media campaign with student ambassadors -7 minute briefing developed and shared with key partners and on website. -Presentation developed for agencies with key learning points	Within 1 month of DHR publication Within 3 months of publication of DHR	Greater knowledge of specifics of the DHR concerning Jessica and the key learning points Better understanding and awareness of DHR and key learning points
2	The Middlesbrough Community Safety Partnership should seek assurances from health agencies and commissioners within the partnership that professionals are trained in recognising abuse, being alert to indicators and understanding the links between mental health and domestic abuse. Professionals should have	Local	Chair of Community Safety Partnership in partnership with health representatives involves in review re CCG will develop a briefing paper re pathways and routine enquiry CCG and Health Representatives will consider if	Chair of Community Safety Partnership Clinical Commissioning Group Health Reps Clinical Commissioning Group	Briefing paper produced and circulated to front line professionals Training materials reviewed and developed to include learning points	Briefing paper in place Training plan in place	Improved understanding with front line staff and practitioners Better awareness of pathways and effective response when using routine enquiry

	clear understandings of pathways and when appropriate use routine enquiry to ask and understand if a patient is a victim of domestic abuse.		training offered provides information re pathways and routine enquiry and learning from DHR 2 is incorporated into training or briefings.	Health Reps			
3.	Middlesbrough Community Safety Partnership should seek assurance from agencies that their policies and training in relation to domestic abuse recognise the barriers that victims of domestic abuse may face and that measures are in place to help victims overcome their fears about making a disclosure of domestic abuse. Where gaps are identified agencies should provide assurance that plans are in place to deal with them.	Local Local Local	Chair of Community safety Partnership to request a review or audit of effectiveness of the training offered by MBC and LSCB and Adult safeguarding board in relation to Domestic Abuse Chair of Community Safety Partnership to write to agencies to request they review DA policies in light of DHR recommendations	Chair of Community Safety Partnership Community Safety Partnership OPCC	Range of Training, including online and classroom based training courses is available and accessible Agencies have DA policies in place - with clear process for overcoming barriers and facilitating disclosure	Audit completed and shared with CSP members Within one month of DHR publication	Improved understanding with front line staff and practitioners Victims are aware of, and able to access services in an easy and timely way Increased understanding

			Chair of Community Safety Partnership to agree with Police and Crime Commissioner how Domestic abuse Champion training and scheme will be delivered and embedded in Middlesbrough and ensure learning from local DHR is shared with champions		Network of trained and supported DA Champions identified	Within one month of DHR publication	across broader sections of community
4	Middlesbrough Community Safety Partnership should seek assurance from agencies that they have policies and training in place to recognise and respond to 'so called' honour based violence. Where gaps are identified agencies should provide assurance that plans are in place to deal with them.	Local	Chair of Community safety Partnership to write to partner agencies represented on the board to seek assurances that training is available and that are appropriately accessing resources	Middlesbrough Community Safety Partnership Children Trust Health and Well Being Board	Letter produced and agreed by Middlesbrough community safety partnership Response received from partner agencies and board Implement / carry out audit and	Letter to be sent within three months of DHR publication – and audits to be carried out 6- 12 month time periods Audit to be carried out	Improved access to training and resources Increased front line practitioner awareness and understanding of HBV Training available and accessible for

			Review existing domestic abuse training from external providers, re courses specifically in relation to honour based violence and ensure they include details of this DHR case	Middlesbrough Community Safety Partnership	identify area for improvement	within 3 months of DHR publication	a range of specialisms.
5.	The Human Fertility and Embryo Authority [HFEA] ensure that health professionals working in this sector have policies, systems and training in place that ensure staff proactively look for risk indicators of domestic abuse and ask direct questions when appropriate opportunities are available.	National	Contact Home Office for update	Home Office	Response received from Home Office	Email to be sent within three months of DHR Publication and followed up every 3 months for progress updates	HFEA health professionals aware of process and more effective response
6.	NHS England considers issuing guidance to GP practices to ensure patient care is not impacted upon by other relationships that may exist, for example, were there is also a business or commercial relationship.	National	Contact Home Office for Update re NHS England response	Home Office	Guidance Issued	Email sent within three months of DHR publication to enquire if guidance issued	Good practice in relation to patient care

7.	Home Office work with the Employers Initiative to create best practice policy for small family owned and run businesses [such as pharmacies] that provides guidance on how staff and employers deal with disclosures, suspicions or indicators of domestic abuse.	National	Contact Home Office for update and share policy via Health Reps / employee engagement groups	Home Office	Policy shared and promoted across small businesses	Email sent within three months of DHR publication to enquire if policy developed. Policy shared within six months	Improved confidence in the process and pathways for responding to domestic abuse in small businesses

End Exec Summ Middlesbrough