Middlesbrough Community Safety Partnership

Domestic Homicide Review

Executive Summary

'Jean'

Died October 2018

Chair David Hunter

Author Ged McManus

Date December 2020

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1. THE REVIEW PROCESS

1.1 This executive summary outlines the process taken by Middlesbrough Community Safety Partnership following the homicide of Jean. It details Jean's life from information provided by her family, agencies and the criminal investigation. It ends with learning and recommendations.

1.2 The following pseudonyms have been agreed by Jean's family. They did not want to dignify the offender with a pseudonym and requested he be called 'the perpetrator'.

Name	Who	Age in years	Ethnicity
Jean	Victim	33	White British
the perpetrator	Offender and partner	24	White British

1.3 Jean and the perpetrator had known each other since the spring of 2018. In October 2018 the perpetrator strangled Jean in her home. He was found guilty of murder and sentenced to life imprisonment with a minimum tariff of 21 years in jail.

1.4 He had a long history of violence against female partners. Jean had also been the victim of long term domestic abuse from previous partners.

1.5 Following Jean's death notification of the homicide was sent to Middlesbrough Community Safety Partnership by Cleveland Police on 10 October 2018. A Scoping Meeting took place on 30 October 2018, where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed on 31 October 2018.

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

2. CONTRIBUTORS TO THE REVIEW

2.1 The following agencies provided information to the review.

Tees Esk and Wear Valleys NHS Foundation Trust	Middlesbrough Recovering Together [1]	Cleveland Police
Durham and Tees Valley Community Rehabilitation Company (DTV CRC)	Middlesbrough Council Children's Social Care	National Probation Service (NPS)
South Tees Clinical Commissioning Group	My Sisters Place [2](MSP)	Harbour [3]

[1] This organisation offers support to people who are experiencing difficulties through the misuse of drugs and/or alcohol.

[2] My Sisters Place is an independent specialist 'One Stop Shop' for women aged 16 or over and have experienced or are experiencing domestic violence.www.mysistersplace.org.uk

[3] Harbour works with families and individuals who are affected by abuse from a partner, former partner or other family member.

3. THE REVIEW PANEL MEMBERS

Name	Job Title	Organisation
Karen Agar	Associate Director (Safeguarding)	Tees Esk and Wear Valleys NHS Foundation Trust
Gordon Bentley	Senior Adult Safeguarding Officer	South Tees Clinical Commissioning Group
Rachel Burns	Health Improvement Specialist	Public Health, Middlesbrough Council
Danielle Chadwick	Service Manager	Harbour
Vicky Franks	Manager	Change Grow Live [4]
David Hunter	Chair	Independent
Suzy Kitching	Principal Social Worker	Children's Social Care, Middlesbrough Council
Kirsty Madden	Service Manager	My Sisters Place
Ged McManus	Author	Independent
Claire Moore	Domestic Abuse Operational Coordinator	Middlesbrough Council
Chris Motson	Detective Chief Inspector	Cleveland Police
Kay Nicholson	Deputy Director of Operations	Durham and Tees Valley Community Rehabilitation Company
Anne Powell	Head of Service	National Probation Service, Cleveland
Erik Scollay	Director Adult Social Care	Middlesbrough Council
Helen Smithies	Assistant Director of Nursing (Safeguarding)	South Tees Hospitals NHS Foundation Trust
Marion Walker	Head of Stronger Communities	Middlesbrough Community Safety Partnership

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

[4] A treatment and Care Service providing confidential drug and alcohol service for adults and young people in Middlesbrough.

3.2 The panel met five times and its Chair was satisfied that the members did not have any operational or management involvement with the events under scrutiny. There were no reported conflicts of interest nor were any detected.

4. CHAIR, AUTHOR OF THE OVERVIEW REPORT

4.1 David Hunter was appointed as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He was judged to have the skills and experience for the role. Ged McManus wrote the report. He is currently the Independent Chair of a Safeguarding Adult Board in the north of England (not in Cleveland or an adjoining authority) and has chaired and written previous DHRs and Safeguarding Adult Reviews. Both practitioners served for over thirty years in different police service (not Cleveland or Durham) in England. Neither of them has previously worked for any agency involved in this review. Ged McManus has chaired two previous DHRs in Middlesbrough and was also the author of one of them. The DHR commissioners did not identify any conflict of interest in the appointments.

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 Subjects of the DHR

Victim: Jean

Perpetrator: the perpetrator

5.3 Timeframe under Review

The DHR covers the period 1 May 2018 which is believed to be the date they met, to the homicide of Jean in October 2018. Substantial background information preceding 1 May 2018 is included for context.

5.4 Specific Terms

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

2. Were the MARAC[5] procedures effective in protecting Jean from domestic abuse?

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

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

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

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

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

8. What learning has emerged for your agency?

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

10. Does the learning in this review appear in other domestic homicide reviews commissioned by Middlesbrough?

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

6. HISTORY OF JEAN AND THE PERPETRATOR

6.1 Jean

6.1.1 Jean was born in Middlesbrough and brought up with her sibling by their parents. She attended local schools until she was thirteen but following a number of difficulties she stopped attending. Jean is known to have used alcohol and drugs.

6.1.2 At thirteen years of age Jean formed a relationship with Abuser 1 and remained in the relationship for eleven years. During 2002-2011 police recorded 60 reports of domestic abuse involving them. Jean had three children with Abuser 1. They were formally placed with Jean's parents who brought them up. Jean's parents told the chair and author that, where needed, they accessed services to support all the family.

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

6.1.4 In 2017, Cleveland Police began receiving reports of domestic abuse involving Jean and Abuser 2. There were nine reports up to June 2018 including assaults, criminal damage and theft. The couple's deteriorating relationship and evidence of drug and alcohol misuse led to Children's Social Care intervention and eventually both children were permanently removed from Jean's care.

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

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

6.2 The perpetrator

6.2.1 Between 2012 and 2013 the perpetrator subjected Victim 1 to eight known incidents of domestic abuse following which she obtained a Non-molestation Order against him.

6.2.2 In 2014, the perpetrator was sentenced to six years imprisonment for violent offences including robbery. Victim 2 obtained a Restraining Order against the perpetrator in relation to an allegation of sexual assault. He was released on licence under National Probation Service supervision in August 2017.

6.2.3 Between leaving prison in August 2017 and forming a relationship with Jean in June 2018, the perpetrator is known to have had relationships with two other women (Victims 3 and 4) both of whom complained to the police of domestic abuse. Jean was his fifth known victim.

6.3 The Relationship

6.3.1 Very soon after meeting Jean the perpetrator moved into her rented home and his abuse of her began. The first recorded instance of domestic abuse was reported in July 2018.

6.3.2 Over the following months there were six reports of domestic abuse involving them. Additionally Jean reported an assault on her and the perpetrator by Abuser 1.

6.3.3 Jean reached out to agencies for help with her victimisation. On occasions some agencies did not action her disclosures and overall agencies were unable to sustain effective engagement with her.

6.4 The Homicide

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

6.4.2 The perpetrator was arrested and declined to answer questions. In a prepared statement he claimed that Jean had been alive when he had gone to sleep and that someone must have come into the house and attacked her. He maintained this defence during his trial. The court heard that Jean had suffered 85 blows but that the cause of her death was strangulation.

7. NOTABLE EVENTS

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

7.2 During the course of her relationship with Abuser 1, Jean reported many incidents of domestic abuse and he was arrested and sent to prison. Jean found herself unable to look after their three children consistently and they were formally placed in the care her parents.

7.3 Jean met Abuser 2. For a number of years they appeared to have been in a stable relationship and they had two children together. However, after the birth of the second child reports of domestic abuse began. Jean and Abuser 2 were unable to maintain consistent parenting and the children were permanently removed by Children's Social Care.

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

7.5 Within a very short time the relationship became abusive and the police attended several times. The perpetrator was only arrested once when a witness reported that he had assaulted Jean in the street. Jean did not make a statement. The police officers dealing with the matter did not obtain available evidence in the form of witness statements and the interviewing officer had not viewed the available CCTV evidence. A poor investigation led to the perpetrator being quickly released without charge. When Jean did contact the police to make another complaint on 31 July 2018, she was not seen until 4 August 2018 and by then she had changed her mind. This was ineffective engagement by the police and did not support Jean as a victim.

7.6 Jean's case was referred to MARAC and from there to MATAC.[6] However, MATAC was new and rejected the referral. No consideration was given to referring the perpetrator to MAPPA.[7] No professional thought to refer Jean to Adult Social Care as a vulnerable person.

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[6] Multi-Agency Tasking and Coordination protocol. The core objective of MATAC is to ensure that agencies work in partnership to engage serial domestic abuse perpetrators in support, take enforcement action where required, and protect vulnerable and intimidated victims.

[7] Multi Agency Risk Assessment Conference. Assess and manage the risks posed by sexual and violent offenders:

7.7 Two reports of shouting from Jean's house were dealt with under anti-social behaviour protocols and not recognised as domestic abuse.

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

7.9 During the timeframe of the review Jean was being supervised by DTV CRC. She did not attend the initial appointment and no action was taken for 40 days. The Responsible Officer did not see her at any time in person. Jean did not keep any appointment and was not at home when visited. The Responsible Officer was aware that domestic abuse was taking place because information had been appropriately shared by Cleveland Police. Had DTV CRC been able to achieve any engagement with Jean the Responsible Officer may have been able to offer support and guidance to improve Jean's safety. The panel felt DTV CRC's failure to support Jean as a victim of domestic abuse was an individual's poor practice and not a systemic problem.

7.10 NPS were responsible for supervising the perpetrator following his release on licence in 2017. At the time he met Jean, he was on licence and had already abused Victims 3 and 4 in Durham. NPS were not aware of this as the information was not shared with them by Durham Constabulary. In addition, legal orders were in place preventing him from contacting Victims 1 and 2 due to abuse. At the age of twenty four the perpetrator was a serial abuser of four women and had been sentenced to six years in prison for other violent offences. It is highly likely that he sought out Jean as his fifth victim.

7.11 NPS did not apply appropriate standards of supervision to the perpetrator. As a person who presented a high risk of serious harm to the public, he should have been seen at least once a week but often went for long periods without supervision. His Offender Manager failed to recognise or deal with the risks that the perpetrator presented. For example he inexplicably told the police that he had no concerns about domestic abuse. Opportunities to sanction the perpetrator for missed appointments and poor behaviour were not taken. The potential to initiate a recall to prison or require the perpetrator to reside in Approved Premises[8] when risks escalated were not considered. Overall NPS supervision of the perpetrator was inadequate and was again an individual's responsibility rather than an organisational issue.

[8] Approved Premises (APs) are premises approved under Section 13 of the Offender Management Act 2007. They provide intensive supervision for those who present a high or very high risk of serious harm.

7.12 Jean's friends knew she was the victim of domestic abuse and one told the police after her death, 'I wasn't shocked. Everyone knew he would kill her. People would regularly say he will kill her one day. I witnessed so many arguments and fights between them when they were walking past my house that it became normal to see'.

7.13 There were many direct indicators that Jean was subjected to coercive and controlling behaviour by the perpetrator and Abusers 1 and 2. The perpetrator financially exploited Jean and took away her mobile telephone to prevent her contacting the police.

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

8. LEARNING

8.1 Agencies

8.1.1 The agencies' learning is reflected in the recommendations below and the Action Plan at Appendix A.

8.2 Domestic Homicide Review Panel

8.2.1 The DHR Panel identified the following learning.

1. The interface between MARAC, MATAC, MAPPA and Adult Social Care needs to be fully understood by professionals engaged in protecting victims from domestic abuse, otherwise the approach will be uncoordinated and victims left more vulnerable. Recommendation 1 applies.

2. There is a need for professionals in all agencies to understand that reported incidents/complaints of noise nuisance, damage to property and other anti-social behaviour, could mask domestic violence. Recommendation 2 applies.

3. The supervision of the perpetrator by NPS and of Jean by DTV CSC was inadequate and did not protect Jean from domestic abuse. Recommendations 3 and 4 apply.

4. Agencies did not deploy the full range of tools available to them. By not considering DVPN and DVPO Jean was not supported as well as she should have been and the opportunity to use the breathing space provided by these tools was missed. Recommendation 5 applies.

5. Responding rapidly to victims of domestic abuse when they ask for help is important for effective engagement. This may particularly be the case when a victim such as Jean has suffered extensive previous trauma. Agencies need to consider training for professionals to work in a trauma informed way.[9] Recommendation 6 applies.

[9] A generally accepted definition of trauma *is* 'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.(1)' Domestic abuse is clearly a form of trauma, made all the more complex due to the fact that it is planned yet unpredictable and takes place in the context of a relationship. http://www.safelives.org.uk/practice_blog/trauma-informed-work-key-supporting-women

6. Failing to share critical information in relation to offenders who are assessed as presenting a high risk of serious harm to the public reduces agencies ability to manage the risks and increases the risk to victims. Recommendation 7 applies.

7. Without clear guidance on what members of the public can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring and/or placing the victim in greater danger. Recommendation 8 applies.

8. Not referring vulnerable people to Adult Social Care prevents the opportunity to have their care needs assessed (Care Act 2014). Recommendation 9 applies.

9. RECOMMENDATIONS

9.1 Agency Recommendations

Cleveland Police

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

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

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

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

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

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

Review of control room management and tasking of domestic incidents.

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

National Probation Service

Details of domestic abuse history obtained from Police systems are routinely recorded in the Non-Disclosure Section of OASys, as well as in the Case Management System in order to ensure that this

information is flagged to any member of staff who may need to access the case record.

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

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

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

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

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

Durham and Tees Valley Community Rehabilitation Company

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

Improved response to safeguarding of adults.

Consistent response across DTV CRC team areas to MARAC.

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

Improved effective management oversight of practice

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

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

9.2 The DHR Panel's Recommendations

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

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

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

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

5. That each constituent agency of Middlesbrough CSP provide it with written assurance that staff in their agencies dealing with victims of

domestic violence, understand what DVPNs and DVPOs are and how they can be obtained.

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

7. That Middlesbrough CSP and Durham CSP should seek written assurance from, Durham Constabulary and NPS that the failure to share information in this case has been resolved by new processes and that the issue is brought to the attention of the Home Office (for the police) and The Ministry of Justice (for Her Majesty's Prison and Probation Service.)

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

9. That the learning from this review should be shared with Teeswide Safeguarding Adult Board so it can consider whether to respond to learning point 8.

End of Executive Summary