FINAL EXECUTIVE SUMMARY

SAFER
NORTH TYNESIDE

DOMESTIC HOMICIDE REVIEW

INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF
'Josephine'

EXECUTIVE SUMMARY

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1) THE DOMESTIC HOMICIDE REVIEW PROCESS

1.1 Who the report is about:

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to **'Josephine'**[1], (the 'Victim') a resident of North Tyneside prior to her death in 2013. She was in her mid-forties when she died.

The review considers agencies' contacts and involvement with Josephine and her estranged husband Harold (the 'Perpetrator') also in his mid-forties.

In January 2014 Harold pleaded guilty to a charge of murder. He was sentenced to life imprisonment, with a minimum term of 24 years

1.2 The homicide incident

On a Sunday in the autumn of 2013, Josephine's body was found by her employer, in the retail premises which was her place of work. She had suffered multiple stab wounds. On the same day, Harold was arrested and charged with her murder, to which he subsequently pleaded guilty. The police investigation and evidence presented in court suggest the following sequence of events:

- Harold went to the retail premises, as Josephine was preparing to close for the night. She was the only member of staff present. At this time the couple had been married for around 15 months, but had been separated for several months. Harold was living in close proximity to Josephine's place of work.
- Harold asked Josephine to go with him for a drink, but she refused. An argument ensued and Harold attacked her with a knife, stabbing her 27 times.

1.3 Purpose of the review:

[1] Pseudonyms of Josephine and Harold are used, to protect the confidentiality of the victim, perpetrator and family members.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

An anonymised version of the executive summary will be published, after clearance has been received from the Home Office Quality Assurance Group.

1.4 Terms of Reference

The terms of reference included a requirement for the Individual Management Reports (IMR) and this overview report to specifically address the following questions:

- If there was a low level of contact with your agency why was this so? Were there any barriers (particularly ethnic origin, culture or language) to either the victim or the accused accessing your services and seeking support?
- Was there indication of the victim being isolated by the accused and could this have prevented them from contacting services?
- Were there any other issues relating to this case such as drug or alcohol abuse and if so what support was provided (victim and accused)?
- Whether the accused had a history of any violent behaviour and if any referrals were made to services in light of this?
- Whether any risk assessments had been undertaken previously on the victim or accused and whether these had judged risk appropriately?
- Whether the victim was experiencing coercive control on the part of the accused?

- Was there any indication of domestic violence or coercive control occurring before the incident and if so did the victim consider this to be control or domestic abuse?
- Do you hold any information offered by informal networks? The victim or accused may have made a disclosure to a friend, family member or community member.
- To what extent did contact and involvement with the victim and/or accused result in a formal or informal assessment of the wider family including any children or young people?
- Did the victims, origin, culture or language impact on access to services or service delivery?
- Involvement role and function of the MARAC (Multi Agency Risk Assessment Conference)?

The Terms of Reference (ToR) specify that the DHR should consider in detail the period November 2011 to September 2013 in order to allow for an analysis of issues immediately relevant to the homicide. Additionally, the ToR required consideration of the history of violence relating to the accused (1999 onwards) and the record of victimisation of the deceased.

1.5 DHR Contributors:

The following individuals and organisations have contributed to this DHR:

Name	Organisation	Contribution to DHR
Tom Wood	Independent Consultant	Chair of DHR Panel
Richard Corkhill	Independent Consultant	Panel Member Independent Overview Report Author
Lynne Crowe	Safer North Tyneside	DHR Coordinator
Janine Charlton	Safer North Tyneside	DHR Administrator
Stephen Blades	GP Lead for Adult Safeguarding	IMR author
Sharon Thompson	Professional Lead for Mental Capacity and Mental Health Acts, Northumbria Healthcare NHS Trust	Panel Member
Jane Abbott	Named Nurse Safeguarding Children, Northumbria Healthcare NHS Trust	IMR Author
Jan Grey	Northumberland Tyne & Wear NHS Foundation Trust	Panel Member IMR Author
Joan Robson	Northumbria Police	IMR Author
DCI Steve Barron	Northumbria Police	Panel Member
Catherine Lawson	Manager Acorns North Tyneside Domestic Violence Advocacy Service	IMR Author
Angela Glenn	Fieldwork Manager North Tyneside Council Preventative & Safeguarding Service (Children's Services)	IMR Author
Margaret Turner	Director of Offender Management (North Tyneside) Northumbria Probation Trust	IMR Author
Sheila Moore	Designated Safeguarding Nurse North Tyneside CCG	Panel Member

1.6 Contact with victim's family:

The victim's family has been kept advised and informed about the DHR process.

They had a meeting with the Independent Chair, enabling them to contribute

directly to the DHR process. Present at this meeting were Josephine's parents, her sister and her adult daughter.

The DHR Panel is very grateful to the family for their cooperation, during a period of such immeasurable distress. Their involvement has contributed greatly to the learning outcomes.

2) BACKGROUND SUMMARY

Josephine was the eldest of three children. Her mother describes as having been

"*a captivating child when she was young, popular and attractive. She had a bubbly personality and was always full of life. As a young girl she was well behaved and good at school – she was particularly keen on art and she was good at athletics"*

Josephine had a son and a daughter, to previous relationships. At the time of her death they were both young adults. Her daughter was pregnant. Josephine had been the victim of domestic violence abuse in previous relationships.

Harold has a history of violent behaviour, including convictions for offences committed against previous partners. These offences include threatening behaviour, assault and affray. In 1996 he was charged with murdering a foreign sailor in a street attack. He was found not guilty of this offence. Harold had two children to previous relationships, each of whom remained resident with their mothers when those relationships ended. In each case there was Children's Services involvement, as a result of child safeguarding concerns arising from reported incidents of domestic violence perpetrated by Harold.

Josephine and Harold started their relationship between November 2011 and March 2012. They married in 2012, but had subsequently separated, following which their relationship was intermittent. Following the latest separation, Josephine was living with her daughter, while Harold was living in a flat in close proximity to the shop where Josephine worked and where the homicide took place. This was Harold's long term place of residence, so the fact of him living so close to her place of work was coincidental, rather than evidence of stalking behaviour.

3) PREVIOUS REPORTED INCIDENTS INVOLVING JOSEPHINE and HAROLD: SUMMARY OF POLICE AND MULTI-AGENCY RESPONSES

November 2012: Josephine reported that Harold had assaulted her daughter, who was then in her late teens. Her daughter denied an assault stating that there had been a verbal argument and no offences were disclosed. A police domestic violence risk assessment concluded that Josephine's daughter was at standard risk.

The DHR has established that her daughter attended a hospital accident and emergency department immediately following this incident, and told medical staff on duty that head and neck injuries resulted from an assault by her mother's boyfriend.

January 2013 Josephine reported that Harold had attended her workplace when Josephine was not present and had made threats to kill her. He returned to the shop 20 minutes later and apologised. She wanted this recorded for information only and did not wish for Harold to be spoken to, or for officers to attend her workplace. A risk assessment was completed by the police and concluded that

Josephine was at standard risk. This was based on there being three concerns identified, with no previous incidents of domestic violence between Josephine and Harold.

January 2013: On the following day, Josephine reported that Harold had been sending harassing text messages, he had also grabbed her hand and removed a ring. Harold was issued with a Police Information Notice (PIN) regarding harassment. The PIN process and its implications were explained to Josephine. The officer believes that the possible option of Josephine taking civil action against Harold was discussed, but does not specifically recall the detail of the discussion. A risk assessment was completed and identified 13 concerns, of which three were identified as significant. This resulted in her being assessed as being at medium risk, and a referral for support from the Neighbourhood Policing Team. This was standard Northumbria Police procedure for this risk level.

March 2013 Josephine reported that Harold had made threats to set fire to her daughter's house and was still in contact, despite the PIN. She also stated that he had damaged her son's vehicle and assaulted her. Harold was arrested and bailed, with conditions not to approach Josephine or her place of work; not go within 100 yards of her daughter's house, but subsequently the decision was to take no further action.

Following a number of attempts at follow up contact, the police spoke to Josephine on 15 May 2013, when she retracted her complaint. The case was reviewed by the officer's supervisor and a shift inspector. It was concluded that there was insufficient evidence to proceed with a victimless prosecution. A further risk assessment at this stage concluded that Josephine was at high risk, resulting in a referral to the MARAC.

26 March 2013, first MARAC meeting: As a result of the incident on 10 March 2013 and the assessment of a high domestic violence risk, a MARAC referral was generated by the police. MARAC records reviewed by the DHR record that Josephine had been assessed at *"Risk level 4 – significant concerns".* Subsequent clarification by Northumbria Police is that the system in use (Coordinated Action Against Domestic Abuse/CAADA) only had three risk levels, which were high, medium or standard. It appears that the reference to "risk level 4" was incorrect and should have referred to there having been four significant areas of risk, which would have resulted in the risk level being gauged at "high".

The initial MARAC notification from the police also makes reference to Harold's history: *"Warnings/PIN (re. harassment of victim) Pubwatch Exclusion, Conceals, Drugs, Weapon (Stanley knife 2005) Violent."*

Notes from the MARAC on 26 March 2013 record that risks were reduced, due to the bail conditions in place. There were a number of Children's Services actions identified in relation to Harold's daughter from his last relationship, with the following actions in relation to risks to Josephine:

- Domestic Violence Officer (DVO) to visit her at home to complete a safety plan
- Discuss a restraining order with the her
- Pass contact details of the Independent Domestic Violence Advisor (IDVA) to her
- Encourage her to engage with the IDVA/Update her on the MARAC.

A MARAC progress update document (reproduced below) was circulated (received by Children's Services on 8 April 2013), showing that attempts at engaging with Josephine were proving unsuccessful:

Agency	Action	Result
DVO	Establish Josephine's safety at her workplace	Negative attempts to speak with Josephine on 30 March 2013; 3 April 2013; 5 April, 2013
Fire Service	Conduct a fire safety check at the Josephine's home	Many attempts made to contact her but no reply to messages left.
IDVA	Update the Josephine	I have been unable to get through to Josephine but have left voicemail asking her to contact me. I will keep you informed.

5 May 2013: Harold was arrested for threats to kill and common assault after Josephine reported that the previous evening she had been at his address. When she attempted to leave, she said he had prevented this. She reported that Harold then made a noose out of a belt and threatened to kill her before killing himself. The police IMR reports that the Crown Prosecution Service (CPS) would not agree to a charge of threats to kill. On 20 June 2013 Josephine made a retraction statement, outlining her wish to withdraw support for the prosecution. On 5 July 2013 the police issued a witness summons, requiring her attendance at the court hearing on 25 July 2013.

The case was dismissed by the Magistrates Court on 25 July 2013, after Josephine attended court, but made it clear that she remained unwilling to give evidence, before leaving the court building. The police chronology also records that she disclosed that she did not want to pursue a restraining order, as they had reconciled.

Second MARAC meeting 21 May 2013: Following the incident on 5 May 2013, Josephine was discussed again at MARAC. At this meeting, the risk level was confirmed as high, as there were 18 risk factors identified as being present. This was using a revised CAADA assessment format which uses a checklist of 26 questions, where affirmative answers to 14 or more results in an assessment of high risk.

MARAC records do not show any new actions agreed at this meeting. An update on outstanding actions was circulated. This refers to the actions originally agreed at the first MARAC on 26 March 2013. The information from the MARAC records, IMRs and chronologies for the Police and the IDVA service confirm that attempts at effectively engaging Josephine with the agreed actions and safety planning strategies were continuing to be unsuccessful. The police IMR observes that, following the second MARAC meeting:

*"*Josephine *again failed to engage through visits or phone calls. This lack of engagement limited any measures that could have been taken to assist in the safeguarding process"*

4) SUMMARY OF KEY FINDINGS AND LEARNING POINTS

This summary addresses the key questions and topic areas, as set out in the Terms of Reference:

If there was a low level of contact with your agency why was this so? Were there any barriers (particularly ethnic origin, culture or language) to either the victim or the accused accessing your services and seeking support?

There was a low level of contact between Josephine and specialist domestic violence services, including notably the police DVO and the IDVA service. The

most obvious reason for this was that she chose not to engage with these services, despite receiving relevant information and a number of attempts by these services to engage her with safety planning strategies. It is not clear whether or not police DVOs continued to make proactive attempts at contact after the second MARAC on 21 May 2013. As this was a key element of safety planning, attempts at contact should have continued and have been clearly recorded.

It is not possible to be sure of the reasons for Josephine's apparent reluctance to engage with police DVO and IDVA services but information from her parents indicates that, although frightened of Harold, she also had a belief in her ability to manage the relationship and to appease him when necessary.

Had she engaged with the IDVA service, it is possible that they would have increased her awareness of risk factors and achieved engagement with an effective safety plan. One important factor is that the IDVA service is under resourced, which limited the amount of IDVA worker time which could be allocated to attempts at making contact and building a relationship. The police DVO did manage to achieve some limited contact.

As the IMR for the IDVA service points out, an early joint visit with the police immediately following incidents may well have presented a better opportunity to engage effectively with the victim. That this did not happen is also largely a resource issue, bearing in mind the volume of visits that police DVOs will be making, following domestic abuse incidents.

The DHR has seen no evidence to indicate that either the victim or perpetrator experienced barriers to services as result of issues of ethnic origin, culture or language, or any other form of unfair / unlawful discrimination.

Was there indication of the victim being isolated by the accused and could this have prevented them from contacting services?

From the victim's parents' perspective, they lost regular contact with Josephine, as a result of the relationship with Harold. Her parents also observed that Josephine's friends were frightened of him, as a result of his reputation for violence. The DHR has not seen evidence that Josephine was directly prevented from contacting services as it is clear that she did contact the police on six occasions following incidents involving Harold.

Josephine continued to go to work during the period she was with Harold and following the 'end' of their relationship. In summary, there is no evidence that Harold deliberately attempted to isolate Josephine but her relationship with him did result in her parents being unable to provide support.

Were there any other issues relating to this case such as drug or alcohol abuse and if so what support was provided (victim and accused)?

Alcohol was a factor in a number of incidents which resulted in police involvement. The evidence seen by the DHR indicates that both Josephine and Harold sometimes drank to excess and that these were points at which conflict and violence were most likely to occur. There is no evidence that either the victim or perpetrator have ever sought, or been offered, any specialist help with alcohol related problems.

Whether the accused had a history of any violent behaviour and if any referrals were made to services in light of this?

Harold had a significant history of violent behaviour, including incidents of domestic violence against previous partners. The only known referral which

attempted to directly address this behaviour was the CDVP requirement attached to a Community Order in 2001. Unfortunately he did not engage with the CDVP.

Whether any risk assessments had been undertaken previously on the victim or accused and whether these had judged risk appropriately?

The Police IMR and follow up enquiries by the DHR Panel show that the police carried out domestic violence risk assessments following each reported incident of violence (or threats of violence) by Harold against Josephine and her daughter. The view of the DHR is that the earlier assessments which found 'standard risk' did not judge risk appropriately. If these assessments had properly taken account of the known history of violent behaviour by Harold and applied professional judgment based on that knowledge, this would have resulted in earlier recognition of high risks of domestic violence. **The key learning here is that risk assessment checklists are an important tool but should never be allowed to take precedence over professional judgment.**

An earlier assessment of high risk would have resulted in earlier referral into the MARAC process, meaning that there would have been more opportunity for the IDVA and other services to try and engage Josephine in safety planning strategies. It is of course entirely possible that earlier MARAC and IDVA involvement would not have resulted in any different outcomes in this case. However, it is reasonable to observe that it would at least have increased the opportunities for services to build working relationships with Josephine and attempt to establish her engagement in safety planning strategies.

The IMR for NHCFT has highlighted a significant gap in MARAC risk assessment processes, meaning that the MARAC was completely unaware that Josephine's pregnant 18 year old daughter, who had previously informed accident and

emergency services of an assault by Harold, was potentially at serious risk of violence.

A specific element of risk in this case was Josephine's safety at her place of work. Key factors were that Harold was known to live close to her work place and to have attended there and made verbal threats to kill her. If it had been possible to secure her cooperation with the MARAC safety planning processes, it may then have been possible to implement safety measures, such as the installation of a panic alarm and adjustments to work rotas so that she would not be alone on the premises. As attempts at engagement by the police and IDVA services were unsuccessful, the possibility of such measures was not discussed with her, or her employer.

Whether the victim was experiencing coercive control on the part of the accused?

The available evidence does not indicate that the perpetrator successfully applied ongoing or systematic coercive control. However, the individual reported incidents, including alleged threats to set fire to Josephine's daughter's house and the alleged threat to kill Josephine whilst showing her a noose, could certainly be described as extreme attempts at coercive control. The fact that Josephine was able to report these incidents to the police suggests that these attempts at control were unsuccessful.

There is no evidence to indicate that Josephine's decisions to withdraw support for criminal prosecutions resulted from threats or coercive control by Harold. Whilst this possibility cannot be entirely ruled out, it seems more probable that these were decisions based on her belief that she could manage this relationship without the intervention of outside agencies. This highlights the importance of

raising public awareness of domestic violence and the protection and support packages available to people known to be high risk.

Was there any indication of domestic violence or coercive control occurring before the incident and if so did the victim consider this to be control or domestic abuse?

There was very clear evidence of domestic violence and other forms of abuse by Harold on Josephine and her daughter, between November 2011 and May 2012. Josephine did recognise that this was domestic abuse, as evidenced by the occasions on which she involved the police. Unfortunately, her wish for criminal justice interventions was not consistent and she apparently was prepared for reconciliation with Harold, as late as July 2012. This led her to withdraw support for the criminal process following the last reported incident of abuse.

Do you hold any information offered by informal networks? The victim or accused may have made a disclosure to a friend, family member or community member.

The DHR has established that Harold's abusive behaviour and his history of violent offences was known to informal networks, including Josephine's parents, her friends and work colleagues. Her parents made concerted efforts to dissuade her from continuing the relationship, but unfortunately these were not successful. There is no evidence to indicate that informal networks made referrals to local services. However, Josephine did have good information about services and was offered specialist support, which she did not engage with. Her individual reasons for not engaging are unclear. But it is clear that many people at high risk from domestic violence make similar choices. This highlights an urgent need for domestic violence services to better understand and address factors which lead high risk victims to make such choices. Factors to be addressed may include:

- Lack of confidence that engaging with services will reduce risks.

- Fear that engaging with services may provoke the perpetrator and increase levels of violence.
- Lack of understanding and awareness of the levels of risks posed by the perpetrator.
- Victim's belief (often based on experience to date) that they are best able to manage risks by themselves, employing a range of techniques to pacify the abuser and reduce the level and frequency of violent incidents.

To what extent did contact and involvement with the victim and/or accused result in a formal or informal assessment of the wider family including any children or young people?

There was formal assessment and involvement of Children's Services, in relation to Harold's child from his previous relationship. That this information was shared within the MARAC is an example of good practice. The Children's Services IMR has identified some important learning points arising from their involvement, though these points are not directly relevant to how services worked with Josephine.

The aspect of wider family assessment and involvement which did not take place was in relation to Josephine's pregnant daughter. This is a key point of learning, which has already been outlined in response to the above question about risk assessments.

Did the victims, origin, culture or language impact on access to services or service delivery?

The DHR has seen no evidence to suggest **that Josephine's** origin, culture or language had any impacts on services or service delivery.

Involvement role and function of the MARAC.

As already outlined, the MARAC played a very significant role in assessing risks and agreeing actions to manage risk, in the months preceding Josephine's murder. In many respects, the operation of the MARAC can be recognised as good practice, even though the outcome for Josephine was very obviously and tragically unsuccessful. This was very largely because Josephine did not engage with the safety planning actions which had been agreed by MARAC partners. It is not possible to be certain of the reasons for non-engagement but a probable factor was that she was unaware of the gravity and level of risk evidenced by escalating threats from an individual with a known history violence against women.

Whatever reasons she had for not engaging**, it is essential to challenge any assumption that failures to engage with safety plans are solely the responsibility of the victim.** On the contrary, MARAC partners should make every attempt to understand why Josephine did not engage and to ask whether any different multi-agency approaches could have led to effective engagement. As already noted domestic abuse victims who do not engage with specialist services are often those who are at the greatest risk.

5) RECOMMENDATIONS

5.1 Recommendations from IMRS

Only two IMRs include recommendations:

Northumbria Healthcare NHS Foundation Trust (NHCFT)

1) Where a young adult resides with a victim of domestic abuse they are included in the MARAC research. All agencies should generate an alert for the vulnerable young adult as they would for any other child**.**
2) Midwives will routinely access Patient Administration System (PAS) following a booking appointment to see if there are any safeguarding alerts attached to the woman's medical record which would inform their risk assessments of families**.**
3) Maternity services will conduct an audit of women only appointments, to ensure this occurs routinely in practice.
4) NHCFT to introduce MARAC champions in to key areas of the Trust this will enhance knowledge and confidence of the MARAC process of staff.
5) There needs to be a review of information sharing processes involving NHCFT and GPs. The process needs to be simplified so that research information goes directly to GP surgeries for their return to MARAC.

Acorns Project

1) Acorns IDVA service worked to the agreed protocols for victim contact in this case however improved capacity in line with CAADA recommendations could improve the service to victims.
2) Improved communication and partnership working with the DVOs allocated to victims of Domestic Violence may improve the service to victims – this would require a review of the current protocol.

5.2 Overview recommendations:

Police

1) There should be a review of the initial risk assessment processes and documentation which found Josephine and her daughter to be at standard risk. This should seek to establish whether or not risk was appropriately assessed, based on the information available to officers at that time. The result of the review and any planned actions resulting from it should be fed back to the Community Safety Partnership.
2) There should be a review of procedure and guidance and training around the use of PINs, to ensure that alleged harassment victims are, as standard practice, advised on the option of taking action through civil court processes.
3) Drawing on learning from this case, there should be a review of policy, procedure, practice and training relating to risk assessment and safeguarding strategies when domestic abuse victims may be at risk at their place of work.

MARAC

1) There should be a review of procedure and practice for DVOs, IDVAs and other partners when following up actions agreed at MARACs. This should include a process to ensure that all follow up contacts/attempted contacts with victims are recorded, with times/dates/nature of contact/response.