**FINAL REPORT**

SAFER
NORTH TYNESIDE

# DOMESTIC HOMICIDE REVIEW:

## INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF "JOSEPHINE"

**PREPARED BY RICHARD CORKHILL**

***Updated anonymised version, Oct 2015***

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## 1) THE DOMESTIC HOMICIDE REVIEW PROCESS

### 1.1 Who the report is about:

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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 Purpose of the review:**

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.

**1.3 The decision to carry out a review:**

A DHR Core Group meeting on 18 September 2013 considered the presenting circumstances of the homicide. The decision of this meeting was to make a formal recommendation to the Chair of Safer North Tyneside Partnership that a DHR should be carried out. This recommendation was accepted and the Home Office were formally notified of this decision.

**1.4 Review timescales:**

Following the decision to carry out a review, a DHR Panel was convened and met for the first time, on 12 November 2013. The review process concluded at the final DHR Panel meeting on 18 March 2014. This final report was presented

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

to Safer North Tyneside Partnership Board, on 16 April 2014. The time taken to complete the DHR process has slightly exceeded the target of six months suggested by Home Office guidance. This has been due to a number of factors, including the need for follow up enquiries and clarifications in relation to the police Individual Management Review.

**1.5 Confidentiality:**

Home Office guidance makes it clear that this report **must be treated as strictly confidential and should not be circulated, other than to members of the DHR Panel and their line managers.** Once the Community Safety Partnership has signed off the overview report and executive summary, these will be forwarded to the Home Office Quality Assurance Group, together with supporting documents.

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

**1.6 Individual Management Reviews, Terms of Reference and time periods examined by the review:**

Each of the agencies which had been identified as having significant and relevant involvement with the victim and/or perpetrator carried out an Individual Management Review (IMR) of that agency's involvement. The Terms of Reference (ToR) included a requirement for the IMRs and this overview report to specifically address the following questions: Note: The perpetrator is referred to as the accused as these were drawn up before his guilty plea.

- 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?

The 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.

**1.7 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<br>Independent Overview Report Author |
| Lynne Crowe | Safer North Tyneside, North Tyneside Council | DHR Coordinator |
| Janine Charlton | Safer North Tyneside, North Tyneside Council | 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<br>IMR Author |
| Joan Robson | Northumbria Police | IMR Author |
| DCI Steve Barron | Northumbria Police | Panel Member |
| Catherine Lawson | Manager<br>Acorns North Tyneside Domestic Violence Advocacy Service | IMR Author |
| Angela Glenn | Fieldwork Manager<br>North Tyneside Council Preventative & Safeguarding Service (Childrens 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 |

Each of the Panel members has received a copy of the report, in advance of signing off by the Community Safety Partnership and forwarding to the Home Office Quality Assurance Group. **(See section 1.5 above re confidentiality)**

**1.8 Independent Chair:**

**Tom Wood** is currently Independent Chair of both Adult and Child Protection Committees in two Scottish Local Authority Areas. He was Deputy Chief Constable and Director of Operations of a large police force in Scotland and subsequently served as a Special Adviser on Alcohol and Drug Policy in Scotland**.**

**1.9 Independent Overview Report Author:**

**Richard Corkhill** has a professional background in statutory and voluntary sector social care, including senior management of services for vulnerable young people and adults. As an independent consultant since 2004, his work with public sector organisations has included research into safeguarding adults policy and practice and production of independent reports for safeguarding adults Serious Case Reviews and DHRs.

**1.10 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.**

The Chair has ensured that the Overview Report Author has been fully informed of the family's views about the circumstances leading to the homicide, including the involvement of services which were involved with the family over the period specified in the ToR. The family has also had the opportunity to see the final report and comment on key findings and recommendations.

**1.11 Methodology:**

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There have been three meetings of DHR Panel. The meetings took place between 12 November 2013 (initial meeting) and 18 March 2014 (final meeting). There have also been meetings (group and individual), discussions and correspondence between the Overview Report Writer and the authors of IMRs.

The IMR author has reviewed MARAC minutes from 26 March 2013 and 21 May 2013, relating to previous concerns about risks to Josephine from Harold.

Having agreed ToR and report formats, chronologies and IMRs were completed by each organisation which held relevant information about the victim and/or the perpetrator. IMRs were prepared on the basis of reviews of paper and/or computer based records held by those organisations. Where possible and appropriate, IMR authors have also interviewed staff members who had direct responsibility for managing or delivering services which worked with the victim and/or perpetrator.

The IMRs were presented and discussed at an initial meeting with IMR authors. A first draft Overview Report was prepared, based on the contents of the IMRs and points raised at the IMR authors' meeting. This draft Overview Report was circulated to IMR authors and Panel members and reviewed at a further meeting on 14 February 2014. Agreed clarifications and amendments were made before the final report was presented to the Panel on 18 March 2014. It was then presented to Community Safety Partnership for final approval, on 16 April 2014.

**1.12 Chronology:**

As part of the review process, individual agencies produced detailed chronologies of their contact with both the victim and perpetrator. These chronologies where combined to produce a comprehensive chronology of all contacts and have been used to inform this DHR.

## 2) THE HOMICIDE INCIDENT

On a Sunday in the autumn of 2013, the victim'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:

- On the evening of the homicide, 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 a flat close by.
- 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.

## 3) FAMILY BACKGROUND AND VIEWS OF VICTIM'S PARENTS

### 3.1 The Victim's family history

This section of the report is closely informed by the victim's parents and her daughter.

Josephine was the eldest of three children. She had a son and a daughter (who were young adults at the time of the homicide) to previous relationships. The following outline history is based on information provided by her mother:

Josephine was *"….. 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"*

However, when she started secondary education her parents noticed a change in her behaviour, and they recall that she was always in trouble. Her mother recalls being told by teachers that Josephine had a strong personality, was amusing and could always make people laugh, and sometimes would use her personality to disrupt the class. She left school at 16 without qualifications. Following periods working in a shop and a café, she trained as a hairdresser.

Her mother observes that, from around 14 years of age and throughout her adult life, Josephine always seemed to be attracted to "bad boys". She was apparently attracted by the danger and excitement of such relationships.

Josephine met her first partner when she was in her early 20's, but the relationship ended before the birth of her son. She and her son moved into her parents' home around 1990.

In 1990 Josephine married a new partner, but this ended in divorce after about four years.
In 1996 she started a new relationship. Her parents report that this man was violent, tried to borrow money from them and once threatened Josephine's mother in street.

Josephine married again, in 2004. Her parents describe both partners in this relationship as "fiery", recalling that things could "kick off" when they had both had a drink. When Josephine ended this relationship in 2008, there were incidents when her estranged husband was reported to have vandalised her home and her car. (There is no record of any police involvement resulting from these incidents.). Her mother recalls that this became so bad that Josephine and her daughter had to move to two different women's refuges in other parts of the country.

There is some conflicting information about precisely when Josephine and Harold met, but it is understood to have been between November 2011 and March 2012. Her parents were extremely unhappy about this relationship, because they were aware of Harold's reputation for violence and found him to be a frightening and intimidating personality. When they married, her parents chose not to attend the wedding, because they could not bear witnessing what they were sure was a big mistake.

For the last two years of her life, Josephine's parents lost regular contact with her, but were still in touch with their granddaughter. They believe Josephine was frightened of Harold, but Josephine always thought she could control things and tried to placate him. They describe Harold as a controlling man who scared all of Josephine's friends and family away.

**3.4 Family's views on agency involvement and any possible lessons to be learned:**

Josephine's mother has agreed the following statement, based on the discussion which took place between her and the Independent Chair of the DHR:

*"We have been asked if we can think of anything that could have prevented my daughter's death. We did everything we could and if we could not help her we doubt if anything else could. We can think of only two opportunities to intervene that may have helped:*

*1) If* Harold *had been convicted of assaulting my daughter on the occasion he was arrested he may have been imprisoned and therefore unable to kill her. We recognise that she did not help matters by withdrawing her complaint.*

*2) Her biggest problem was her attraction to bad men. She spent lengthy periods in women's hostels but at no time was this issue recognised or tackled. We*

*doubt if she would have listened to advice but there may have been a slim chance and we wonder whether, with professional help she may have acted differently. We will never know.*

*She was a much loved member of our family. The past two years, since she met* Harold*, have been a living nightmare made worse by her terrible death and our inability to help our daughter"*

## 4) PERPETRATOR

Police records confirm that 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. Section 6.2 below includes a more detailed history of police incidents involving criminal charges and convictions.

When Harold met Josephine, his most recent ex-partner was 'Mary'[2]. They had a daughter Tina, born in 2010. North Tyneside Councils Children's Services have had involvement with the family, as a result of potential concerns for Tina's safety and welfare. These concerns initially arose from allegations that Mary had been assaulted by Harold, whilst pregnant with Tina.

The information available to the DHR suggests that Josephine and her family had no significant contacts or relationships with Harold's ex-partner and daughter.

[2] Pseudonyms are used for all family members' names, to protect confidentiality.

Harold also had a son to a previous relationship, born in 1989. The son was resident in another locality in the North East region and there was child protection involvement from Children's Services in that area.

## 5) RELATIONSHIP BETWEEN JOSEPHINE AND HAROLD

The relationship started between November 2011 and March 2012. They married in spring 2012, but had subsequently separated, following which their relationship was intermittent. Following the separation, Josephine was living with her daughter at their address in North Shields, while Harold was living in a flat close to 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 following the separation.

There were four reported incidents of domestic abuse inflicted on Josephine by Harold in the months preceding the homicide. There was also one reported allegation that he assaulted Josephine's (now adult) daughter. None of these alleged incidents resulted in criminal convictions. (See section 6.2 on police involvement for further detail).

## 6) ANALYSES OF AGENCY INVOLVEMENT

### 6.1 Introduction

This section considers the involvement of each of the agencies:

| Agency | Significant roles in relation to victim/alleged perpetrator |
|---|---|
| Northumbria Police & MARAC* | Police responses to and prosecutions following offences/alleged offences committed by perpetrator, including incidents involving the victim. |
| Acorns Project | Independent Domestic Violence Advocacy Service offered to victim |
| Northumbria Healthcare NHS Foundation Trust. | Hospital treatment of the victims daughter, following allegation of assault by perpetrator |
| North Tyneside Councils Children's Services | Social work involvement in relation to concerns for the perpetrators daughter, qq. |
| Northumberland Tyne and Wear NHS Foundation Trust | Mental Health assessment and support services to perpetrator |
| NHS North Tyneside Clinical Commissioning Group | GP services |
| Northumbria Probation Trust | Supervision of Community Orders |

**MARAC is a multi-agency responsibility, but has been included within the analysis of police interventions, as it was the police service which referred* Josephine *into the MARAC process.*

Each of the above agencies is considered in turn, with reference to the respective IMR. In each case, a summary of key elements of the agency's involvement is followed by separate commentary and analysis.

### 6.2 Northumbria Police and MARAC

The Police IMR summarises a substantial history of offending behaviour and criminal justice interventions with Harold. In 1996 he was charged with an offence of murder. The murdered man was a foreign sailor who died after an attack in the street. Following a period of remand in custody, Harold was found not guilty of this offence.

**Police records of incidents involving Harold and previous partners**

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Police records for the period July 2002 - June 2011, show that they were involved in 13 separate incidents where there were allegations of aggressive behaviour, verbal threats or physical assaults carried out by Harold against previous partners, although only two of these resulted in criminal convictions:

| | | |
|---|---|---|
| July 02 | Arrested for false imprisonment and assault of his partner | Assault conviction, 160 hrs Community Payback Order (CPO) (False imprisonment charge to lie on file) |
| March 05 | Arrested for Breach of Bail, Threats to Kill and Posses Offensive Weapon after entering his ex-partner's home. | Affray conviction 160 hrs CPO |

The remaining 11 alleged incidents with previous partners, which did not result in criminal convictions, are summarised as follows:

| | |
|---|---|
| July 02 | Arrested for breach of bail after his partner received a number of aggressive messages |
| July 04 | Arrested after being seen arguing with a female in the street and she stated that he had previously assaulted her. This was dismissed in court. |
| December 07 | Officers attended after Harold's partner reported he was being verbally abusive. No offences disclosed |
| December 07 | Officers attended after Harold's partner reported he was kicking at her front door. No offences disclosed |
| December 07 | Officers attended after Harold's partner reported he was drunk and verbally abusive. He was warned regarding his behaviour. No offences disclosed. |
| January 08 | Report received that Harold had threatened to burn his partner's house down. It is not recorded if he was spoken to regarding this. |
| April 10 | Arrested for Breach of the Peace after a verbal argument with his partner and later common law released. |
| June 10 | Police called after a report of a disturbance. All parties concerned stated it was a verbal argument only. No offences disclosed. |
| October 10 | Arrested for Breach of the Peace and Resist Arrest after his partner's daughter reported that he had assaulted her. The partner denied that she had been assaulted. He was bound over for six |

| | |
|---|---|
| | months. |
| January 11 | Arrested for assault after his partner reported that he had punched her during an argument. The case was dismissed at court. |
| June 11 | Police attended after Harold's partner reported a disturbance. This was a verbal argument and no offences were disclosed. |

**Police records of incidents involving Josephine and previous partners**

During May and June 2004, Josephine called the police on five separate occasions as a result of incidents involving a male who was at that time an ex-partner. The incidents included breaches of bail conditions to stay away from the house, verbal abuse and damage to property. They did not include any allegations of physical violence or assault.

There was one further incident involving a different partner in April 2011, when a neighbour reported a disturbance at Josephine's address. When the police attended, she said her partner was drunk, but this was a verbal argument only. The partner was removed from the house, to prevent a breach of the peace.

**Police and MARAC records of incidents involving Josephine and Harold**

**26/11/2012:** Josephine reported that Harold had assaulted her daughter, who was then 18 years old. 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. (See section 6.4)

**08/01/2013** Josephine reported that Harold had attended her workplace but she was not present and he 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 them.

**09/01/2013** 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 her 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.

**10/03/2013** 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 she was at high risk, resulting in a referral to the MARAC.

**26/03/2013, 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 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 on Josephine | I have been unable to get through to Josephine but have left voicemail asking her to contact me. I will keep you informed. |

**05/05/2013:** 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 (see section 6.3) 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"*

**Police IMR conclusions:** The IMR concludes that police and MARAC procedures were followed correctly and that Josephine was appropriately assessed as at high risk of domestic abuse and violence. The major obstacle to implementing an effective safety plan which could have prevented this homicide is identified as her choosing not to engage effectively with such a plan. Largely on this basis, the IMR concludes that the homicide could not have been accurately predicted and prevented.

**Analysis**

Police records confirm that Harold had a long term history of violent behaviour towards previous partners. Similarly, Josephine had a history as a victim of domestic abuse, by previous partners. This is not an uncommon pattern, as perpetrators may target women who are vulnerable to abusive relationships.

Police records show that, prior to the homicide, there were five reported incidents involving Josephine and Harold, during the six month period between November 2012 and May 2013. They also show an escalation of seriousness, culminating in the incident in May, when she reported a direct threat on her life, involving the presence of a lethal weapon, in the form of a noose fashioned from a belt. This pattern of escalation raises two key questions about responses to these incidents:

- ***Following the incidents reported to the police, were risk assessments carried out and were findings about levels of risk properly informed by all of the available evidence?***
- ***Was there any realistic possibility that any of the earlier incidents could have resulted in a successful prosecution of* Harold*?***

To address these questions, the following analysis considers the five episodes of police involvement with both parties:

***26/11/2012:* Josephine *reports an assault on her 18 year old daughter:***

The Police IMR describes this incident as follows:

*"On police attendance* Josephine*, her* daughter *and another male present all gave the same account, that all parties were in drink and there had been a drunken argument instigated by the daughter. She had, in their words "got in his face" and* Harold *had pushed her away. She had then fallen and banged her head. She refused to make any complaint. He left on police request and an ambulance was called as a precaution. As there was no complainant and this was a third party report no further action was taken."*

The above account differs from that given by Josephine's daughter to hospital staff (See section 6.4). Most significantly, she told hospital staff that she had intervened to prevent Harold from physically assaulting her mother and it was

then that he grabbed her by the hair and neck, swung her round, causing her head to hit a wall. However, it is recognised that police decisions at the scene would have been based largely on the evidence of accounts given by the parties present. It is not uncommon for assault victims to freely disclose information to health services, which they would not reveal to the police.

The police carried out a risk assessment which found Josephine's daughter to be at standard risk of domestic violence. If the assessment viewed this as an isolated incident (as reported by those present when the police attended) in which the alleged victim was making no formal complaint against Harold, then the conclusion of 'standard risk' may have been reasonable. However, the assessment should also have considered that the initial report from Josephine suggested that there had been an assault by Harold on her daughter. Most importantly, it should also have taken account of what was already known to the police about Harold's history of violent behaviour, including incidents of domestic violence. Had it taken these factors into account, this may well have resulted in Josephine's daughter being assessed at a higher level of risk. The following observation provided to the DHR by the police is of particular relevance to this issue:

*"The Domestic Abuse Check List is a tool designed to assist in the objective assessment of risk based on the prevailing circumstances as recounted through questioning of the victim (of the abuse). Whilst there is the opportunity, through the exercise of professional judgment, to override an outcome based exclusively on collation of the concerns contained in the list, it should be acknowledged that the system is liable to frustration if there is a lack of engagement in this process on the part of the victim. The most important factor influencing professional judgment in this case is* Harold's *history of violence. There are obvious precautions which must be exercised in completing the Domestic Abuse Check List based on information known to the police but which has not been confirmed*

*by the victim (e.g., The question - Does offender have a criminal record for violence or drugs? The police may well know of the offender's history and can independently answer in the affirmative to this question. However any subsequent involvement with the victim may assume she /he is aware of the offender's history and this may factor in the risk."*

The above observation represents an important learning point. This is that the CAADA assessment check list should be seen as a tool to *assist* professional judgment, but should *never replace or over-ride* professional judgment. Where there is a clear record of a history of domestic violence towards previous partners, whether known or unknown to the current partner, professional judgment would indicate that this is a highly significant risk factor.

***08/01/2013* Josephine *reports that* Harold *had attended her workplace and made threats to kill her.***

A risk assessment following this concluded that Josephine was at standard risk, on the basis that three significant concerns had been identified and there had been no previous incidents reported between her and Harold. Again there is no indication that the risk assessment took account of Harold's previous history of violence, or of the recent incident involving Josephine's daughter, even though both Josephine and her daughter were present at that incident. If these factors were given due consideration, a higher level of risk could have been identified.

The IMR states that Josephine did not wish for Harold to be spoken to. It is accepted that her stated wishes would have been an important consideration, particularly because going against her wishes may have increased risks.

***09/01/2013* Josephine *reported that* Harold *had been sending harassing text messages; he had also grabbed her hand and removed a ring***.

Josephine was assessed at this stage as being at medium risk. This was based on a total of 13 concerns in the previous 6 to 12 month period, of which three were categorised as "significant".

Harold was issued with a Police Information Notice. ACPO (Association of Chief Police Officers) guidance[3] on the use of PINs makes it clear that these are not formal police cautions or warnings, but are intended to inform the recipient that the reported behaviour could amount to an offence under the Prevention of Harassment Act. The same guidance explains that, even if further harassment is not prevented by the issuing of a PIN, the fact of the notice having been delivered could be relevant evidence in any future criminal or civil proceedings. The guidance also states that the PIN should be discussed with/explained to the victim, to include the fact that it is not a court order and the only way a court order could be granted at this stage would be through a civil case brought by the victim.

In response to DHR Panel enquiries, the IMR author has ascertained that the PIN was discussed with Josephine, but the officer cannot recall with certainty whether or not the option of civil proceedings was discussed. The ACPO guidance suggests that this should have been standard procedure. As Josephine was seemingly confident in her ability to manage any threats from Harold, such a discussion probably would not have prompted her to take civil court action. However, this is still an important learning point for future police practice.

The allegation that he grabbed her hand and removed a ring would appear to be an allegation of assault and possibly robbery. These would not be allegations for which issuing of a PIN would not be an appropriate intervention, but no other action appears to have been taken in response to these allegations. Follow up clarifications provided by Northumbria Police to the DHR Panel has established that, when interviewed, Josephine did not regard this incident as an assault and

[3] Practice Advice on Investigating Stalking and Harassment, ACPO 2009

would not support any criminal prosecution, so Harold was not arrested or charged in relation to this alleged incident.

***10/03/2013* Josephine *reports threats by* Harold *to set fire to her daughter's house, that he had damaged her vehicle, had assaulted her and that he was still in contact, despite the PIN.***

Following this reported incident, Josephine was assessed as being at high risk of domestic violence, resulting in automatic referral into the MARAC process where she was discussed for the first time on 26 March 2013. (See below for commentary on MARACs)

The police response to this incident included seizure of Josephine's phone to investigate the harassment allegation, whilst Harold was arrested and placed on police bail until 20 May 2013.

The DHR Panel have been advised by Northumbria Police that the possibility of victimless prosecution was given due consideration, but it was concluded by the CPS that there would be insufficient evidence to proceed on this basis.

Follow up enquiries by the DHR Panel with Northumbria Police have resulted in a more detailed account of the rationale for the CPS decision not to proceed with a prosecution:

"*In interview the suspect (*Harold*) had said the victim (*Josephine*) had accidentally hurt her back, he gave a credible account of this and denied assault. No witnesses who had actually seen the assault were willing to go to court and give evidence. An independent witness (pub landlord) said there was no assault. There was no recent complaint or visible injuries. The victim initially told her daughter she had fallen and only when her daughter pressured her did she say she was assaulted.*

*As for the threats to cause criminal damage the CPS concluded there was no immediate complaint (the victim stated the threats took place at 20:00hrs on 9 March 2013 but did not call the police until 18:09hrs 10 March 2013. This was some two hours after the victim arrived at the belief that the suspect had scratched her son's van, although there were no witnesses to this).*

*The suspect denied the words used but said he had said he would "go back and warm his flat up". This explanation was considered credible because the victim had told him she was staying at her daughters flat because his was too cold. The CPS was of the view the wording did not suggest the suspect had any intention of setting fire to the flat. On this basis the lawyer was not satisfied there was sufficient evidence to provide a realistic prospect of a conviction and advised no further action to be taken.*

*The CPS acknowledged the victim had been assessed by the police at high risk of domestic violence and applied CPS policy for prosecuting DV cases."*

**05/05/2013 Harold *is arrested for assault after* Josephine *reported that the previous evening she had been at his address. When she attempted to leave he prevented her. He then took a homemade noose and threatened to kill her.*** The domestic abuse risk assessment following this assessment confirmed that Josephine was at high risk, resulting in referral to the second MARAC on 21 May 2013.

Harold was charged with common assault, at the direction of the CPS. The rationale for not charging with threats to kill has been clarified by the following report from a senior officer who has reviewed police records:

*The police sought charging advice for threats to kill and assault by beating from the CPS. In relation to the threats to kill allegation the CPS lawyer (having*

*applied the full code test and CPS policy regarding domestic violence) concluded there was insufficient evidence to charge threats to kill on the basis of the seriousness and difficulties associated with proving this offence. (The prosecution must show that the suspect had a specific intent in that he intended to make the person he made the threat towards believe that the threat would be carried out). In this case the evidence was based on* the victim*'s (*Josephine*) word against the suspect (*Harold*), who denied the offence. Following a search by the police, three belts were recovered from* Harold's *flat but no information could be provided that these were tied together to form a noose. Abandoning threats to kill as a realistic charge the CPS chose instead to have the facts of the threat form part of the assault allegation. Some of the strengths of the assault case were considered to be the fact that* Josephine *had made a statement, had a visible injury consistent with her account, was prepared to attend court and give evidence, text messages had been recovered and demonstrated* Harold's *aggression. A bad character application was suggested given that a PIN had been issued by the police.*

*Some weaknesses in the case were the difficulty in proving any harassment claim given the victim had continued to see the suspect, the testimony of staff at a local pub who confirmed having seen the couple and had said the victim did not appear distressed. The suspect denied the offence, claiming the two were still in a relationship. The CPS decision acknowledged the domestic history and the victims risk level.*

*The police remanded* Harold *in custody to appear before court the following day. On 9 May 2013 he was remanded on conditional court bail and released from custody. The conditions imposed prohibited* Harold *from contacting prosecution witnesses (*Josephine*) by any means whatsoever or approaching the witness. This was to prevent interference with witnesses or obstruction of the course of*

*justice. An urgent result was required on the basis of the case being flagged as a domestic violence case.*

*On 20 June 2013* Josephine *prepared a statement in which she outlined her wish to withdraw her support for the prosecution. She pointed out in her statement that the police officer had explained the use of special measure to give her evidence (e.g. screens, TV video links etc…) and had also explained the use of restraining orders. She also acknowledged that she could realistically be made to attend court to give evidence by way of a summons but made it clear she did not want to attend or pursue the prosecution. In the event on 5 July 2013 the police did serve a witness summons on her which required her to attend court. On 25 July 2013 (the date of the trial) she attended magistrates court, advised witness care she would not give evidence and left the building. A CPS lawyer was later tasked with reviewing the case and noted the evidential position and the stance of the witness remained unchanged. The case was discontinued".*

On the basis of the above information from the police, it appears that the decision not to continue with this prosecution was based on a careful consideration of a range of factors, including a relatively low chance of successful prosecution without Josephine's cooperation as a prosecution witness.

Another factor for consideration is that this was a general Magistrates Court session, even though there are weekly specialist sessions for cases of domestic violence. The IMR author advises that the Police have no input on deciding where cases are heard and that this may be a matter for consideration by the CPS. It is clear that this was a case which ideally should have been considered by a specialist domestic violence court session, which would have helped to ensure that all involved (including magistrates and CPS solicitors) had a strong awareness of domestic violence issues. It may also have meant that advice and support workers would have been available to speak to Josephine about her

decision to withdraw support. It is by no means clear that this would have resulted in any different outcomes in this case, but the possibility cannot be ruled out.

**MARAC meetings**

The first MARAC meeting on 26 March 2013 followed Harold's reported threat to set fire to Josephine's daughter's house. Referral into the MARAC process was an appropriate response by the police. However an earlier referral into MARAC might have been considered, bearing in mind the historical evidence of risks presented by Harold.

The first MARAC agreed and recorded on a set of planned actions to try and minimise risks. This is noted as an example of good practice. The notes from this meeting observe that risks were reduced, due to the police bail conditions.

The second MARAC meeting on 21 May 2013 followed a significant increase in assessed risk levels, after Harold allegedly made a direct threat to kill Josephine. At this stage it was clear that Josephine had not engaged with the safety plan, but it was agreed that agencies (i.e. Police DVO and the IDVA service) would continue to make attempts at contact, in line with the original plan which had been agreed at the first meeting. It is now known that all such attempts were unsuccessful and no meaningful engagement with the MARAC devised plan was ever achieved.

**Unsuccessful attempts by Police DVOs to contact Josephine, in line with actions agreed at MARACs:** The MARAC records confirm that three attempts were made by Police DVOs to contact Josephine, following the first MARAC meeting. What attempts were made following the second MARAC is less clear, as the Police IMR and chronology do not provide a detailed record of attempted contacts. The IMR reports that, following the second MARAC on 21 May:

*"Again* Josephine *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."*

Subsequent queries raised by the DHR Panel confirm that police records show that attempts at contact were made on three dates: 6, 14, and 19 May. The IMR author advises that the DVO cannot be specific about any other dates or attempted contacts. This means that that there is no confirmed record of proactive contact attempts by the police following the second MARAC meeting on 21 May. It has been clarified that there was one recorded contact on 20th June, when she made her retraction statement in relation the incident on 5 May.

On this basis, it does not seem reasonable to assume that the *'failure to engage'* after the second MARAC was Josephine's choice, because it is not clear what proactive attempts (if any) were made by DVOs to contact her following the second MARAC.

There are major challenges and difficulties for all MARAC partners, where an individual who is identified as being at high risk of domestic violence does not engage with attempts at establishing an effective safety plan. Ultimately, the success of any safety plan for an adult with mental capacity (the DHR has seen no reason to doubt that Josephine had capacity to make decisions related to domestic violence risks) will depend to a very large extent on the voluntary engagement of that individual in drawing up and implementing the plan.

**However, 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.

**Safety planning at Josephine's place of work:** As Josephine was murdered at her workplace, which was located very close to Harold's home address, this is an important area for consideration by the DHR. The Police IMR and chronology confirm that Josephine's employer was not directly approached as part of the safety planning processes, following the MARAC meetings. Any direct contact with her employer would have required her consent, but it appears that such consent was not requested. Whether or not she would have given consent is unknown.

There was a discussion between Josephine and a DVO, after the first MARAC meeting. The Police chronology records that she informed the DVO that her

colleagues and boss were aware of the domestic violence issues. She was advised to tell them to call the police if Harold attended. There appears not to have been any discussion about other workplace safety measures, which could possibly have included installation of a panic alarm and arranging work rotas to ensure that Josephine would not be working alone. It is, of course, entirely possible that she would have rejected safety measures of this nature. However, as they were not raised as a possibility, this has to be identified as a potential missed opportunity which might have prevented the subsequent homicide.

**Summary conclusions and key learning points arising from police and MARAC involvement:**

- There is evidence that initial risk assessments did not take sufficient account of factors around Harold's history of violence, but subsequent assessments correctly identified Josephine as being at high risk.
- Earlier identification of high risk may have resulted in earlier referral into MARAC, which would have provided more time for services to try and achieve effective engagement with Josephine.
- That the police considered a prosecution without the active support and cooperation of the victim following the incident on 10 March 2013 is recognised as good practice.
- When the PIN was issued, this was discussed with Josephine, which was in line with recognised good practice and ACPO guidance. It has not been established whether the discussion included the possibility of civil court action by her. This should be standard practice.
- When Josephine withdrew her support for the prosecution regarding the incident with the noose on 5 May 2013, this created a major challenge for the prosecution case. It is noted that Josephine was summoned to appear as a witness, indicating that the police and CPS recognised the seriousness of these allegations and the continuing high level of risk presented by Harold. Arrangements had been made for special measures to support Josephine in

the court process and this is recognised as an example of good practice. It is very unfortunate that, even with these measures in place, she was still unwilling to cooperate as a prosecution witness when she attended court on 25 July 2013.

- It seems probable that there was no realistic prospect of a successful prosecution, without her cooperation. However, an adjournment at this point would have allowed time for careful consideration of prosecution options. Had the case been heard in a specialist domestic violence court, it is possible that the matter would have been handled differently. These are clearly issues not only for the police, but also the CPS and court system itself. Had Harold been successfully prosecuted on this occasion, he may have been serving a prison sentence which would have removed any threat to Josephine, at least until his release date.
- Josephine did not actively respond when police DVOs tried to contact her to discuss safety planning issues after the first MARAC. However, police records and IMR author discussions with officers have not confirmed what further proactive contact attempts (if any) were made after the second MARAC meeting. This highlights the importance of having a clear plan to achieve contact, including recording of all contact attempts and responses.
- This case also highlights that people at the highest risk from domestic violence will often be those who are most difficult to contact and engage in safety planning measures. On the other hand, there is an entirely understandable tendency to direct resources towards people who are more willing and able to engage.
- There was clear evidence that Josephine was at specific risk at her place of work, but there were no measures in place which could have reduced this aspect of risk. This was very largely due to the issues of non-engagement between her and the DVOs, as outlined above.

### 6.3 Acorns Project

# FINAL REPORT 20 JUNE 2014

Acorns are funded by the Witness and Victim Fund, to deliver an IDVA service. The following is a summary of the involvement with Josephine, based on their IMR and the combined chronology:

11/3/2013 Acorns received a referral for Northumbria Police, following the incident on 10 March 2013, when Harold had threatened to set fire to Josephine's daughter's house, had damaged a vehicle and assaulted her.

13/3/2013 Telephone contact was made with Josephine**,** but she was unable to talk and it was agreed they would phone back the following day at 13.30.

**14/3/2013** Acorns phoned back at the agreed time, but there was no reply.

**18/3/2013** Acorns successfully phoned Josephine and were able to explain their role and the MARAC process. She declined support, saying that she thought Harold had listened to the police after being warned by them. She did request telephone contact after the MARAC meeting which was scheduled for 26 March 2013

**26/03/2013** Acorns attended MARAC meeting.

**27 and 28/03/2013** Acorns attempted phone contact following the MARAC, but no reply. On the second attempt on 28 March 2013, a voicemail message was left, with a request for Josephine to phone back.

8/04/2013 A further attempt was made to telephone her but there was no reply.

7/05/2013 Acorns received another high risk referral from Northumbria Police. This followed the police incident on 5 May 13, when Josephine had reported that

on the previous evening Harold had prevented her from leaving the house, had made a noose and threatened to kill her, before killing himself.

13,14,15/05/2013 Attempts were made to contact Josephine by telephone on each of these days. All of these calls resulted in no reply. On the last occasion, it was noted that there was no voicemail service available and the phone cut off.

21/05/2013 Acorns attended MARAC meeting, where they advised that they had not been able to contact Josephine. This MARAC did not identify any further actions for Acorns.

Acorn's IMR reports that, after each of the police referrals and the resulting unsuccessful attempts at contact, Josephine's file was closed due to non-engagement/ no contact.

**Analysis**

Acorns had only two successful telephone contacts with Josephine and no face to face meetings. At the first telephone contact, Josephine was unable to speak. On the second occasion the IDVA worker explained the role of the IDVA service and the MARAC process. That this explanation was given is recognised as good practice, though it is not possible to know the extent to which this explanation was understood and retained.

Although she declined any ongoing IDVA support at that time, there was an agreement that Acorns would make further contact, to advise of outcomes from the forthcoming MARAC meeting. This was a partially positive outcome, as it could potentially have maintained a line of communication and opened the possibility of a service being accepted at a later date. Unfortunately, all subsequent attempts to contact Josephine by telephone were unsuccessful.

It is very regrettable that the IDVA service was unable to engage positively with Josephine but it is acknowledged that repeated efforts were made by the service to make contact by telephone, with a view to encouraging her to engage with the service.

It is not known whether she deliberately failed to answer calls, or to respond on the occasion when a voice mail message was left. Similarly, it is not known whether or not Harold was applying any form of pressure or coercion, which might have prevented her from engaging with the IDVA service. Whether or not he was aware of contacts with her from IDVA service is also unknown, though the DHR has seen no evidence to indicate that he was.

Bearing in mind the victim's parents' observations about her belief in her ability to control things and placate Harold, it is entirely possible that Josephine did not believe she needed help or support from the IDVA service and this was the primary reason for her non-engagement.

Acorn's IMR explains that all contact attempts were by telephone, rather than through visits to her home, because home visits can only be undertaken after a risk assessment has confirmed that a home visit is safe, both for staff members and the client. It points out that, unless the exact and current status of the relationship is known, an IDVA home visit which has not been appropriately planned and agreed in advance can substantially increase risks to the client. On this basis, it is accepted that restricting their initial contact attempts to telephone calls was appropriate, based on the information available to Acorns at that time.

Acorn's IMR highlights two important learning points, which are fully endorsed by The DHR:

**Learning point 1**

*"The efforts to contact and the contact made with* Josephine *were undertaken in line with the North Tyneside Domestic Violence Protocol which has been agreed by those agencies involved in the MARAC process. Whilst in many cases this practice is effective the addition of a joint visit with the DVO following the repeat incident on the 5 May 2013 may have encouraged* Josephine *to engage with the service."*

**Learning point 2**

*"On both occasions* Josephine's *file was closed by the team leader due to non-engagement/no contact. Acorns IDVA service strives to adhere to CAADA guidelines in respect of victims.*[4] *CAADA recommend that on current referral numbers Acorns IDVA service should have 4.5 IDVAs to support and accommodate the requirements of the victims. However due to restrictions in the availability of funding there are 1.6 IDVAS in the service. An increase in the capacity of the service may have allowed for further attempts to contact* Josephine*."*

It is acknowledged that the fact of Josephine being offered IDVA support was an example of good practice, not only by the IDVA service itself, but also by the police and other MARAC partners which ensured this type of support was offered.

However, it is also essential to recognise that establishing and building a relationship of trust with a domestic abuse victim requires significant skill, resources and time. If the IDVA service has around one third of the recommended staffing levels, it is understandable that work with victims who are more willing and able to engage will take priority over attempts at engaging

[4] Caada recommend there should be 4 IDVAs and 1 MARAC Coordinator for every 100,000 of the adult female population, with multi-agency funding from the local authority (including public health) Clinical Commissioning Groups and the Police and Crime Commissioner - *A Place of Greater Safety, November 2012*. www.caada.org.uk

people who do not readily engage with the service. Unfortunately, domestic abuse victims in the latter group may be those who are at the greatest risk. Tragically, this proved to be the case for Josephine.

**6.4 Northumbria Healthcare NHS Foundation Trust**.

**26/11/2012** Josephine's daughter (then 18 years old) attended NHCFT's Accident and Emergency department in North Tyneside, accompanied by Josephine. They reported that she had been assaulted by Harold, after she had intervened to try and prevent him from hitting Josephine. The IMR summarises description of events as follows:

*"Patient alleges that mum's husband was about to hit her mum, he was intoxicated. Patient intervened and he grabbed her by the hair and neck, swung her and she had hit her head against a wall. Patient states she managed to get to living room and collapsed in to couch where she thinks she momentarily lost consciousness and then vomited. The patient reported that the pain she was feeling was like whiplash in her head and neck."*

Following medical investigations which ruled out ligamentous injuries, a neck collar was applied.

Safeguarding issues were discussed with Josephine's daughter but she declined to undertake a risk assessment for MARAC. An IDVA referral form was completed, but was not sent to the IDVA service, as she did not consent. She did accept contact numbers for domestic violence support services.

**11/03/2013** Josephine's daughter presented for a pregnancy booking appointment with the Community Midwife, who completed a standard "level 1" assessment. The IMR observes that the Midwife appears not to have asked about any issues of domestic violence:

*"There was no disclosure of the previous domestic abuse incident to the midwife and it does not appear from the records that the midwife asked her about domestic abuse which is a mandatory field on the level 1 assessment form"*

If both parents are present at this first appointment, it would not be good practice to ask the mother about any concerns around domestic abuse, in the presence of the father. For this reason NHCFT have introduced a requirement for a "woman only" appointment during a booking, to ask specifically about domestic abuse. On this occasion, it appears that no woman only appointment was arranged, though the reason for this has not been ascertained.

The midwife has been interviewed but cannot recall events in detail. It is possible that the question about domestic abuse was asked, but the midwife omitted to record Josephine's daughter response on the standard form. The IMR author has also noted that the question would have been around any domestic abuse issues with her partner. As such it may well not have elicited information about incidents involving Harold.

It would not have been standard practice for the midwife to access Josephine's daughter's medical records, meaning that she would not have been aware of the Accident and Emergency involvement on 26 November 2012.

On the basis of the assessment completed by the Midwife, no risk factors for domestic violence were identified. The IMR notes that the assessment identified Josephine's daughter as a pregnant teenager, living with her mother. It goes on to point out that this could have been viewed as a protective factor, as the Midwife would assume (in the absence of any information about a history domestic abuse in the home) that the pregnant teenager would be likely to benefit from the family support provided by her mother.

**26/03/2013 – MARAC** NHCFT were asked to carry out research on Josephine and Harold, in advance of this MARAC meeting. MARAC was advised that NHCFT had no relevant records, relating to either. The research carried out did not highlight the A&E involvement with Josephine's daughter. The IMR explains that the case had been classified by MARAC as a case without children (the daughter was 18 years old) meaning that the research would not have picked up the A&E attendance on 26 November 2012.

As a result of the MARAC NHCFT placed Alert Codes on the medical records applying to both the Josephine and Harold. At the MARAC on 21 March 2013 it was disclosed by another agency that the Harold had a child (from his previous relationship) and an Alert Code was then attached to that child's medical records.

**21/05 2013 – MARAC** There was a further request for NHCFT Safeguarding Team to carry out research, following another reported incident of domestic abuse by Harold, on Josephine. Further research was carried out on parties previously given an Alert Code. NHCFT advised they had no record of attendances. Again, the research did not pick up the A&E attendance by Josephine's daughter, for the same reasons.

**Analysis**

NHCFT's IMR highlights some critical areas of learning. In particular it highlights that the MARAC was missing some key information about risks in Josephine's household:

- The most significant concern is that the MARAC had no knowledge of Josephine's daughter's admission to A&E, having reportedly been physically assaulted by Harold. However, as this incident had resulted in police involvement, the police should have shared their knowledge of the incident at the MARAC. This would have highlighted the presence of another potential domestic violence victim in the household.

- The MARAC were also unaware that Josephine's daughter had subsequently attended a pregnancy booking appointment on 11 March 2013. This appointment was two weeks before the first time that Josephine was discussed by the MARAC, on 26 March 13.
- At the subsequent MARAC on 21 May 2013, the information that Josephine had a pregnant teenage daughter living with her and that this daughter had recently (November 2012) reported a violent attack by Harold, was still not available to the agencies involved in the MARAC process.

The fact that the MARAC did not have this potentially critical information was not the result of failures by NHCFT staff or operational managers, who followed agreed procedures.

The issue, as clearly identified by the IMR author, is that MARAC procedures for collecting and sharing information do not include consideration of young (and / or pregnant) adults who may be at risk as a result of domestic violence between other adults in the household.

The IMR highlights a number of other important areas of learning, including:

- It was a mandatory requirement of Trust procedure that the Midwife should have asked Josephine's daughter about domestic abuse, as part of the level 1 assessment. That this (at least according to the midwife's records) did not happen was a missed opportunity. It is unknown whether she would have disclosed issues with Harold, but had she done so this could have resulted in a fuller assessment of risks in the household.
- The medical records at the time of the assault on 26 November 2012 make no reference to the identity of the assault perpetrator, or family circumstances. Further enquiry by staff could have revealed that the perpetrator had a small child, which would have resulted in a referral to Children's Services. (In fact Children's Services were already involved at this

point and aware of possible concerns for the child's safety and welfare, but this was not known to hospital staff)

- Currently, it is not standard practice for midwives to routinely access the Patient Administration System (PAS) to see if there are any safeguarding alerts on patient records. The IMR has identified that this means there is potential to miss pregnant women who may previously have been identified as victims of domestic abuse.

The IMR also notes examples of good practice, including excellent care provided to Josephine's daughter by Accident and Emergency staff, following the reported assault by Harold. Not only did they deliver the appropriate medical interventions, but they also discussed her social needs, offered the option of referral into MARAC (which was declined) gave her contact numbers for support services and referred her for support from the IDVA service.

At the time of this incident, the A&E service was engaged with a pilot project with the IDVA service, which involved training for staff on enquiring about domestic abuse and making referrals into MARAC and for IDVA services.

It is probable that the pilot project contributed to this element of good practice. This highlights the value of initiatives which promote cooperation and collaboration between non-specialist services (including not only health but also statutory social care and criminal justice services) and specialist domestic abuse services.

**Conclusions**

The DHR has identified some important lessons, arising from NHCFT's contacts with Josephine's daughter and their subsequent involvement in the MARAC meetings where domestic abuse risks involving her mother and Harold were discussed.

These lessons involve issues of both individual practice and of procedures which appear to be in need of revision, to ensure that MARACs have full information about **all** household members who may be at risk from domestic abuse. The IMR author has made some valuable recommendations (see section 8) which aim to ensure that these lessons are translated into improvements in practice and in outcomes for future patients affected by domestic abuse.

### 6.5 North Tyneside Council Children's Services

**Incidents involving Josephine and previous partners**

Children's services have some brief records about contacts from the police following incidents involving Josephine and previous partners, though they appear not have had any direct involvement following these contacts:

**2003 – 2004:** Children's Services received Child Concern Notifications (CCNs) from the police following incidents involving a previous partner of Josephine, in June 2003 and March 2004. There is no record of actions taken by Children's Services as a result of these notifications and it appears that they had no contacts with Josephine, following these CCNs

**2011:** On 11 April 2011, they received a further notification from the police, following an incident with another previous partner of Josephine. This was recorded by police as having been a verbal argument only. At this time

Josephine's daughter was 16 years old. No action was taken by Children's Services.

**Incidents involving Harold, his previous partner and their child, born July 2010**

In April 2010, a Police CNN referral following was received by Children's Services, following an incident when Harold was reported to have been verbally abusive and to have turned over tables. His partner was pregnant at this time.

In July 2010 another CNN was received. His previous partner was eight months pregnant and reported by her 16 year old daughter to be terrified of Harold, due to ongoing domestic violence. Following discussions with the police and the health safeguarding service, it was agreed that the situation would be monitored by community based health services.

In October 2010 Children's services carried out a core assessment which identified the child as a Child in Need (CIN)

In June 2011 there was another CNN notification from the police, following an argument between the child's parents. The police reported that there was evidence of alcohol consumption, with the ex-partner reported to have consumed half a bottle of vodka. Following this incident a Child Protection investigation was completed. The investigation outcome was that the child would continue to be identified as a CIN.

In September 2011, it was reported that Harold had moved back into the family home, resulting in the CIN review being moved forward.

Attempts were made to engage with the ex-partner but supervision notes recorded on 18 November 2011 indicate that she was not engaging, despite numerous visits and letters from the social worker, in addition to a letter from the

Council's legal department to the family's solicitor. She was reported to have low level engagement with health visiting services and some support from family members. There had been no further reports of domestic abuse at this stage.

In February 2012 it was recorded that the ex-partner was still not engaging with Children's Services. Legal advice had been taken, which was that there was not enough evidence to pursue the lack of engagement through legal proceedings. Checks with the police confirmed there had been no more reports of domestic abuse. On this basis, it was decided to close the case, due to lack of engagement.

In March 2012 there was a CNN from the police, following an incident when Harold had tried to take the child from another adult who was caring for her at the time. The situation was resolved, with police involvement. On the following day, Children's services attempted to contact Harold's ex-partner by telephone and text messages but received no response. It was noted that she continued to engage with the health visitor and the case remained closed to Children's services.

In May 2013 Children's Services had a discussion with Harold's ex-partner who advised that the child's contact with the father was for two, two hour sessions a week, at times when his partner (Josephine) was at work, in order to avoid the child becoming involved in any altercation between Josephine and Harold. She also advised that she was seeking legal advice about making sure that any contact between Harold and the child was safe.

In May and June 2013, Children's Services were party to the MARAC meetings where concerns about the safety of Josephine were discussed. However, this involvement was limited to sharing information in relation to the child, as they had no involvement with Josephine or Harold.

**Analysis**

The records of incidents in 2003/04 provide further evidence that Josephine experienced domestic abuse in previous relationships. At the time of these incidents, her daughter would have been around nine or ten years old, but it appears that Children's Services did not actively respond to CNNs received from the police. The IMR for this period is based on computer records only and there is no record of the rationale for taking no action. The IMR analysis points out that, since 2003/4, there have been changes in responses to incidents of Domestic Violence. This includes a domestic violence tool introduced in 2008, which aims to ensure appropriate thresholds for intervention. In December 2013 the Domestic Violence Medium Risk group was formed, to review all cases that meet the medium risk threshold in the CAADA DASH assessment model. The objective is to offer earlier intervention to support victims and their children and reduce the escalation of domestic violence. As the IMR author observes:

*"If this group had been in existence in 2003/4,* Josephine *may have received support/advice which may have given her a better insight into her relationship with* Harold*."*

As the incident in 2011 was reported as being a verbal argument only, was the first recorded incident involving this previous partner of Josephine's and her daughter was 16 years old at the time, it seems reasonable that this did not result in further action from Children's Services.

The IMR author's analysis raises a question about the assessment and decision making in relation to concerns about Harold's child and whether it was appropriate – bearing in mind the lack of engagement by both parents - to continue managing the case as a "Child in Need", rather than within Children's Safeguarding policies and procedures:

*"This, in my opinion, was naive of the social worker and her manager. Both parents were evasive and did not engage meaningfully. These indicators should have raised the threshold and on 12 September 2011 when* Harold *returned to the family home consideration should have been given to a Child Protection Conference."*

The DHR accepts the IMR author's analysis, whilst acknowledging that Children's Services decision making in relation to the welfare and safety of the child would have been of limited significance, in relation to Josephine's safety and wellbeing.

Children's Services involvement with the two MARACs was appropriately focused on Harold's contacts with his child. On this basis, they needed to be aware of his violent behaviour towards Josephine, as this was relevant to their assessment and management of risks affecting the child. They had no information to indicate any role for Children's Services with Josephine and her daughter.

However, the DHR has identified that, at the time of these MARACs there was an 18 year old pregnant woman in the household (Josephine's daughter) and that this young woman had already been assaulted by Harold a few months previously. Had this information been available to the MARAC meetings, Children's Services confirm that they would then have seriously considered the need for direct intervention, to protect the unborn child.

This may also have provided an opportunity for closer assessment of Josephine and her pregnant daughter's needs as a family unit. It is not possible to know what the outcomes may have been, if Children's Services had become involved at that time. However, this may have provided an additional opportunity to increase Josephine's awareness of the risks (to herself, her daughter and unborn grandchild) thus encouraging her to engage with services to reduce and manage those risks.

### 6.6 Northumberland Tyne and Wear NHS Foundation Trust

The Trust (NTW) has no record of contacts with Josephine.

They had two episodes of minimal contact with Harold, in 1991 and 1999/2000, respectively.

The latter of these was a GP referral for psychiatric assessment for suspected depression. The assessment found no evidence of low mood or mental health problems and he was discharged.

The initial contact was a request for a psychological assessment from Northumberland Children's Services. This was to assist with an assessment of his suitability to care for a child (born in November 1989 to an earlier relationship). The IMR summarises this contact, as follows: (Harold is referred to as 'the accused')

*The Psychologist offered four appointments, the accused attended one appointment only that of being 50 minutes late. Due to the limited assessment gathered on one short appointment the Psychologist gave an incomplete report to Children's Services with a brief explanation given that accused showed lack of willingness to engage. He denied the need for support from services, significantly minimised his actions and blamed the police and social care for his child being removed and placed in local authority care.*

The DHR has requested some background information about the circumstances surrounding their involvement with this child of Harold's but they have so far not been able respond.

The next contacts with Harold were not until 2013. Again, these were minimal:

**11/03/2013:** Offered appointment to see Criminal Justice Liaison Nurse, whilst in police custody as result of reported threats to set fire to Josephine's daughter's home, damage to a car, assault on Josephine. Appointment refused.

**07/05/2013:** Again offered mental health input / support whilst in police custody, following the incident when he was reported to have threatened Josephine with a noose. Support refused.

The only other involvement of NTW was attendance at the MARAC in May 2013, for the purposes of information sharing. Following this his electronic records were flagged, in line with NTW safeguarding policies.

**Analysis**

The involvement of mental health services with Harold was minimal, though it is noted as good practice that he was given the option of mental health assessment and support, following his arrests in 2013. This is an example of good joint working between the police and mental health services.

The evidence available to the DHR does not indicate that Harold had an enduring mental illness. It is understood that the criminal proceedings after the murder did not highlight any history of mental health problems and DHR has not seen any evidence to indicate that any form of compulsory detention or treatment under the Mental Health Act would have been lawful or clinically appropriate, at any point in the period covered by the terms of reference.

GP records do indicate some past history of self-reported anxiety and depression, but as he was unwilling to engage with mental health services on a voluntary basis, there were no apparent opportunities for mental health services to have worked with Harold to reduce the risks he presented to Josephine and others.

### 6.7 NHS North Tyneside Clinical Commissioning Group

The IMR prepared for the Clinical Commissioning Group (CCG) shows that there was very limited GP involvement with either Josephine or Harold:

**GP contacts with Josephine:**

She registered with practice **A** in July 2011. She was never seen by a GP or nurse at the practice. She was invited for a health check on three occasions but did not attend.

On 10 September 2003 she was seen by a previous GP. She reported that she had been assaulted two months previously by her husband. Since then she had been subjected to threats and was not sleeping. She was due to appear in court in relation to the incident but felt unable to do so. She asked for a letter from the GP to excuse her from appearing in court and this was provided to her on the grounds of her anxiety. She was also prescribed Diazepam to reduce anxiety and Zopiclone to help her sleep. She was asked to come back in two weeks but did not attend. She saw the GP again on 2 February 2004 and 2 June 2004 and on both occasions was complaining of threats and problems with her ex-husband. She was prescribed further Zopiclone and Diazepam.

The GP added “Actual bodily harm” to the summary card within her records and in 2006 “victim of domestic violence” was added to her computer summary.

**GP contacts with Harold**

He registered at practice **B** in September 2010 but was never seen by a GP or nurse at the practice. He had a past history of complaining of anxiety and depression which appears to often be related to his involvement with the police and criminal justice system. He was assessed by a Psychiatrist in 2000 who did not think he had a clinical depression. At that time he was noted to be drinking alcohol heavily but had no motivation to change.

On 19 March 2013 practice **B** received a request for MARAC information regarding Harold. Josephine was noted on the request as the victim and it was made clear that she was not a patient at practice **B**. The form was completed by **Dr C** who was aware of Harold from looking after his former partner. Although there was nothing of note other than the past history of anxiety and alcohol abuse on Harold's records, Dr C's report to MARAC also included mention of a domestic violence incident involving Harold and his previous partner, in April 2010.

There was no corresponding MARAC request form in Josephine's records at practice **A**.

**Analysis**

The GP records confirm that Josephine had a history of being abused by a previous partner and was treated for anxiety symptoms directly related to this.

She had no contact with her GP during the period she was in a relationship with Harold. This is of note, in that she may have been expected to have presented with similar anxiety symptoms as those reported in 2003/04. The DHR has seen no direct evidence that Harold was preventing Josephine from accessing GP services (for example through threats or other coercive pressure) but this possibility cannot be ruled out. It is at least equally possible that Josephine had developed different coping mechanisms and simply did not need or want primary health care intervention.

One point of concern highlighted in the IMR is that Josephine's GP practice apparently received no request for information, in relation to the two MARAC meetings held in 2013, when risks to Josephine were being assessed.

In Josephine's case, the records held by the practice would not have provided the MARAC with any additional information, so this apparent system failure had no impact. However, it is important to note that, in different circumstances (for example if the subject of the MARAC had recently presented to the GP with unexplained injuries) this could have resulted in a flawed risk assessment, based on incomplete information.

Similarly, the non-involvement of the GP service in the MARAC could also have resulted in the GP practice not being aware of current risk factors for domestic abuse and therefore not flagging medical records accordingly.

This issue requires further investigation by the MARAC Coordinator, followed by any necessary remedial actions.

The GP **Dr C** is commended for using their individual knowledge of Harold's previous relationship to provide relevant information to the MARAC in March 2013. However, the IMR notes that, had a different GP in the practice completed the MARAC response, this information would not have been picked up and shared, because the Harold's file had not been flagged with this information.

Advice from the IMR author is that a flagging system which could link notes between an individual's previous and current partners is unlikely to be a practicable option within existing primary healthcare recording systems. It would be even less realistic where more than one GP practice is involved.

### 6.8 Northumbria Probation Trust

Probation's recent involvement was following an offence of taking a vehicle without consent and drink driving. In September 2012, Harold was given a 12 month Community Order with 100 hour unpaid work. Probation records show that he breached this order, having failed to carry out any unpaid work. In December 2012 the Breach was proved and a new four month order imposed, with a four week curfew. The IMR notes that this order was made without pre-sentence reports and the Probation Service is therefore unable to comment on the suitability of the curfew address. As this new order did not require Probation involvement, the outcomes of this are not included in their IMR.

The IMR refers to one previous conviction and sentencing outcome of particular relevance to the DHR. On 22 November 2001 Newcastle Crown Court imposed an 18 month Community Order with a requirement to complete the Community Domestic Violence Programme (CDVP). Unfortunately Probation do not hold detailed case records going back this far, so there is no detailed information about his response to the order. However, it is known that the order was terminated in breach proceedings on 5 April 2004, so he clearly did not engage positively or effectively with the CDVP.

The IMR advises that this order would only have been imposed in the following circumstances:

- There is evidence of a pattern of domestic abuse,
- Some level of acknowledgement of responsibility on the part of the perpetrator,
- An expression of willingness to comply and attend the group work programme.

**Analysis**

The IMR observes that the Community Order with a CDVP requirement would have required a pre-sentence report and included a full assessment of risk of

serious harm and re-offending. Unfortunately this report has been destroyed, due to national Probation policy and procedure, which requires nearly all case records over six years old to be destroyed.

The CDVP requirement attached to the Community Order in 2001 confirms that Harold was seen to present with a pattern of behaviour of domestic abuse. The attempt to break this pattern through the CDVP was appropriate. Sadly, the evidence is that it was entirely unsuccessful in this case.

The more recent Probation involvement was not related to offences of domestic violence, although it is noted that alcohol is a common factor between this offence and many of the reported incidents of abuse.

## 7) SUMARY 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.

## 8) RECOMMENDATIONS

### 8.1 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 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**

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.

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.

### 8.2 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**

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.

Appendix 1

## DOMESTIC HOMICIDE REVIEW – (DHR2)13

# Action Plan

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| Northumbria Health Care Foundation Trust | | | | | | |
| 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. | Regional and Local | The recommendation of this review needs to be considered outside of the Northumbria Health Care Foundation Trust by CAADA/MARAC so all vulnerable young people living with high risk victims of domestic abuse are considered in safety planning | Northumbria Health Care Foundation Trust (NHCFT) | MARAC / Designated Nurse to progress this action | | Date of completion |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| Midwifes will routinely access the Patient Administration System (PAS) following booking an appointment to see if there were safeguarding alerts attached to the medical records, which would inform the risk assessments of the families | Local | Named Nurse to inform maternity Services of the findings of this DHR.<br><br>This action will be included in the Maternity guideline for Safeguarding | Northumbria Health Care Foundation Trust | Maternity Services consulted by author<br><br>Safeguarding guideline currently being written. | October 2014<br><br>To be launched August, 2014 | Complete<br><br>All midwives to routinely access GP systems to establish if pregnant women have safeguarding concerns attached to their records |
| Maternity services will conduct an audit of women only appointments to ensure that this occurs routinely in practice. | Local | Named Nurse to inform maternity Services of the findings of this DHR | Northumbria Health Care Foundation Trust | Maternity Services consulted by author | April, 2014 | Complete.<br>To give assurance that all Midwives are conducting women only appointments in practice ensure direct Enquiry of Domestic abuse in 100% of cases |
| NHCFT to | Local | Named Nurse | Northumbria | Northumbria | March, | Complete. |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| introduce MARAC champions into key areas of the Trust this will enhance knowledge and confidence of the MARAC process of staff. | | and Domestic Violence Coordinator in area have identified MARAC champions in key areas of Northumbria Health Care Foundation Trust | Health Care Foundation Trust | Health Care Foundation Trust has given commitment that MARAC Champions will be released from duty to attend MARAC training and associated meetings. | 2014 | Northumbria Health Care Foundation Trust MARAC champions will be available in key areas. They will be confident with the MARAC process and will impart this knowledge to their colleagues. |
| 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. | Local | Named Nurse will inform A&E of the findings of this DHR | Northumbria Health Care Foundation Trust and North Tyneside Clinical Commissioning Group | A&E consulted by author | February 2014 | Referral to North Tyneside Councils Children's Services of violent individuals who have access to children. |
| Northumbria Police | | | | | | |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| There should be an independent review of the initial risk assessment process and documentation that found the victim 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 the time. The result of the review and any planned actions resulting from it should be fed back to the Community Safety Partnership (CSP). | Agreed that this should be an internal review by Northumbria Police. | Review and report to Community Safety Partnership | Northumbria Police | Brief to CSP outlining basis for risk classification of standard which is considered to be essentially sound and founded on an objective assessment applying the Nationally adopted CAADA checklist. The exercise of professional judgement is subject to qualification in circumstances where the officer/ other partner agency consider the victim to be at **high** risk of death or further serious injury. Current Northumbria police policy expects an | December 2014 | Complete. |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| | | | | officer to communicate any concerns regarding the perpetrators previous domestic history (irrespective of the partner this has been recorded against) to a supervisor whereupon disclosure of the history to the current partner will be considered. Furthermore it is now policy within Northumbria Police to proactively monitor and safety plan "standard" risk victims of domestic abuse (i.e. safety planning extends | | |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| | | | | beyond signposting to support in these cases). | | |
| There should be a review of procedure and guidance and training around the use of Police Information Notices (PINS), to ensure that alleged harassment victims are as standard advised on the option of taking action through civil court proceedings. | Local | The relevant section of the Police Instructional Information System (IIS- The Police Guidance Reference) relating to domestic abuse, will be amended to reflect as standard practice an obligation to explain civil court remedies at the same time as issuing a PIN i.e. to make it explicit that there are | Northumbria Police | The IIS document explains the roles of various officers during stages of the investigation of domestic abuse. There are also links to National Documents within the guidance which explain civil procedures. The section of the DASH risk identification check list (left with the victim of domestic abuse) provides a good deal of information concerning safety planning and specifically refers | December 2014 | December 2014/January 2015. Updated DASH forms (containing message on civil remedies) already in circulation as is DVPN/O process. Incorporation into training is an on-going process. |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| | | additional civil processes which may operate alongside the PIN as a protective measure. Domestic Violence Investigation Training (whilst already incorporating an input on civil remedies) will specifically iterate the requirement when issuing a PIN. A force wide broadcast will reinforce the message. | | to the significance of none molestation orders. The issue of Domestic Violence Protection Notices /Orders (DVPN/O) has since become common practice and can protect the victim both in the household and place of work. | | |
| Draw on learning from the case, there should be a | Local | IIS (see above) to specifically reflect links to | Northumbria Police | The Violence Against Women and Girls Strategy | December 2014 following | December 2014/January 2015. |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| 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 | | the workplace regarding options for safeguarding. Additionally, on-going training will incorporate reference to safeguarding in the workplace. Force wide broadcast. | | has developed the concept of Domestic Violence Champions (Champions for support of colleagues in the workplace). | agreed amend of sec's of over view report. | Updated IIS, broad cast, incorporation into training programmes as an on-going process. |
| Acorns Project (IDVA Service) | | | | | | |
| Acorns IDVA service worked to agreed protocols for victim contact in this case, however improved capacity in line with CAADA recommendations could improve the service to victims. | Local | Liaise with relevant North Tyneside Council, Northumbria Police, Police and Crime Commissioner and Northumbria Health Care Foundation Trust to identify possible funding | Acorns | Information presented to appropriate boards<br><br>Decision to prioritise IDVA funding<br><br>Mainstream IDVA funding<br><br>Funding application to trusts and grant | December 2014 | |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| | | opportunities in light of the DHR recommendations<br><br>Explore grant funding to increase IDVA capacity - (short term) | | making bodies<br><br>Successful application | | |
| Improved communication and partnership working with the DVO's allocated to victims of domestic violence may improve the service to victims – this would require a review of the current protocol. | Local | Meet with Northumbria Police to review protocol | | Protocol reviewed and agreed<br><br>Protocol implemented | August, 2014<br><br>August, 2014 | Complete.<br><br>Review quarterly |
| MARAC | | | | | | |
| There should be a review of procedure and practice for DVOs | Local | Communication of the requirement to those engaged | Northumbria Police in the capacity of MARAC | Action complete | December 2014 | Complete. Records will reflect the nature of contact or the |

| Recommendation | Scope of Recommendation | Action to Take | Lead Agency | Key Milestones achieved in enacting the recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|
| and IDVAs and other partners when following up actions agreed at MARAC. This should include a process to ensure that all follow up contacts/attempted contacts with victims are recorded with time/dates/nature of contact and response. | | specifically in domestic abuse safeguarding related contact following actions generated from MARAC. (i.e: IDVA, ISVA, MARAC coordinators. Mechanism: Via MARAC steering group | chair. | | | reasons this was not done. (e.g. no reply will not necessarily assume lack of engagement) |

**Appendix 2**

## List of Abbreviations

| | |
|---|---|
| A&E | Accident and Emergency |
| ACPO | Association of Chief Police Officers |
| CAADA | Coordinated Action Against Domestic Abuse |
| CAADA DASH | Domestic Abuse and Honour-based violence risk identification checklist |
| CCN | Child Concern Notification |
| CIN | Child in Need |
| CCG | Clinical Commissioning Group |
| CDVP | Community Domestic Violence Programme |
| CPO | Community Payback Order |
| CPS | Crown Prosecution Service |
| DHR | Domestic Homicide Review |
| DV | Domestic Violence |
| DVO | Domestic Violence Officer |
| IDVA | Independent Domestic Violence Advisor |
| IMR | Individual Management Review |
| GP | General Practitioner |
| MARAC | Multi Agency Risk Assessment Conference |
| NHCFT | Northumbria Healthcare NHS Foundation Trust |
| PAS | Patient Administration System |
| PIN | Police Information Notice |
| ToR | Terms of Reference |
| NHS | National Health Service |