North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of 'Julie'

EXECUTIVE SUMMARY

March 2018

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Contents

1/. The Review Process

1.1 This summary outlines the process undertaken by the North Yorkshire Community Safety Partnership Domestic Homicide Review panel in reviewing the homicide of Julie who was resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator, together with the wider family, to protect their identities:

- VICTIM: female aged 51 years- known as 'Julie.'
- PERPETRATOR: male aged 49 years and ex-husband of the victim – known as 'Marcus.'

1.3 Criminal proceedings were completed on 24th September 2018. The perpetrator appeared at Leeds Crown Court. He pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility. His plea was accepted by the prosecution following submission of a psychiatrist's report by the Defence. On 12th November 2018, Marcus was sentenced to life imprisonment with a minimum tariff of 10 years. He will be detained in a secure hospital until his treatment is completed and then serve the remainder of his sentence in HM prisons.

1.4 This process began with an initial meeting of the Community Safety Partnership on 26th March 2018 when the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with the victim and perpetrator prior to Julie's death were contacted and asked to confirm their involvement with them. Nine of the agencies confirmed their contact and were asked to secure their files.

1.5 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself."

1.6 The statutory guidance states the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

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

- To establish whether the events leading up to the homicide could have been predicted or prevented.

2/. Contributors to the review

2.1 The following agencies contributed to the review by provision of chronologies, Individual Management Reviews or summary reports:

- Leeds and York Partnership NHS Foundation Trust (LYPFT)

- York Teaching Hospital NHS Foundation Trust

- NHS Vale of York Clinical Commissioning Group (victim's GP)

- Yorkshire Ambulance Service

- North Yorkshire Police

- West Yorkshire Police

- Independent Domestic Abuse Service (IDAS)

- National Probation Service

- Leeds Clinical Commissioning Group (perpetrator's GP)

The IMR authors were completely independent and had no role in any of the decisions made or actions undertaken by their respective agencies prior to Julie's death.

3/. The Review Panel members

3.1 The Domestic Homicide Review panel was comprised of the following people:

- Steven Hume – Community Safety and Security Manager, Stockton-on-Tees Borough Council and appointed Independent Chair
- Odette Robson – Head of Safer Communities, North Yorkshire County Council
- Detective Superintendent Allan Harder –North Yorkshire Police
- Jacqui Hourigan – Nurse Consultant, Safeguarding Children and Vulnerable Adults, Primary Care, Scarborough & Ryedale CCG
- Christine Pearson- Designated Nurse, Safeguarding Adults Scarborough & Ryedale CCG and Vale of York CCG
- Claire Lindsay – Adult Safeguarding Manager, North Yorkshire County Council
- Sarah Hill – CEO IDAS (Independent Domestic Abuse Services) North Yorkshire and York
- Louise Johnson – Head of Area, National Probation Service
- Suzy Sweeting – Partnerships Manager, Selby District Council
- Gill Marchant – Head of Safeguarding and Designated Nurse, Leeds CCG
- Beverley Geary - Chief Nurse, York Teaching Hospitals NHS Trust
- Nikki Gibson - Head of Safeguarding, Yorkshire Ambulance Service NHS Trust
- John Needham - Deputy Head of Safeguarding, Leeds and York Partnership NHS Foundation Trust
- Mike Cane – Independent Author and Safeguarding Consultant

3.2 The group met three times as a panel and once for a briefing by the IMR authors. All panel members were independent of any decision-making or line management responsibilities of any staff involved in contact with the victim or perpetrator.

4/. Author of the overview report

4.1 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the North Yorkshire Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and tackling organised crime. He has extensive experience both as an author and panel member for Domestic Homicide Reviews and is a former member of Teesside's Safeguarding Vulnerable Adult Board, the Domestic Abuse Strategic Partnerships and the Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and

vulnerable adults. He chaired the MARAC meetings across Teesside for several years. He has previous experience of conducting Domestic Homicide Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

5/. Terms of Reference for the review

5.1 The following terms of reference were agreed by the Review panel with regards to the death of Julie:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for domestic abuse, stalking and harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of the victim and perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known or what should have been known at that time?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options / choices to make informed decisions? Were they signposted to other agencies?

- Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

- Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

- Was information recorded and shared where appropriate?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Were senior managers of the agencies and professionals involved at the appropriate points?

- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

- Are there ways of working effectively that could be passed on to other organisations or individuals?

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- Did any staff make use of available training?

- Did any restructuring during the period under review have any impact on the quality of service delivered?

- How accessible were services for the victim and perpetrator?

6/. Summary chronology

6.1 The victim, Julie, was born in 1966 and was 51 years old at the time of her death. Although she was divorced from Marcus, the couple continued to stay in touch with each other. Marcus lived only a short distance from Julie. She first met Marcus in 2010. Julie has an adult daughter from an earlier marriage.

6.2 The perpetrator, Marcus, was born in 1968 and was 49 years old at the time of the homicide. His first wife had died from cancer in 2008. He has two adult sons from his first marriage

6.3 J Julie reported domestic abuse to the police which she suffered at the hands of Marcus. The first occasion was on 21st August 2013 when she reported an assault that had occurred four days earlier while the couple were on holiday in Greece. Upon returning to the UK, Julie reported that Marcus and she had argued. During the argument he grabbed her by the throat with both hands and squeezed tightly shouting "I'm going to kill you." Julie pleaded for him to let her go. He threatened to throw her from the balcony. Eventually he calmed down and released his grip. Julie collected her belongings and flew back to the UK. Marcus remained in Greece. Julie reported the incident to the police and an investigation was carried out. She also consulted with her GP and the local hospital. However, Julie re contacted the police and decided to withdraw the allegation against Marcus. The criminal case was discontinued, and the relationship resumed.

6.4 The next incident of domestic abuse that Julie reported to police was on 28th June 2014. She telephoned '999' to report she had just been strangled by her husband, Marcus. He had left their home address but was traced by officers shortly afterwards and arrested. Julie again sought medical help. Marcus was charged with assault occasioning actual bodily harm and threats to kill and was subsequently remanded in custody awaiting trial. Following several suicide attempts Marcus was transferred to a secure hospital. In October 2014 he pleaded guilty at York Crown Court and was sentenced to be detained on a Hospital Order (section 37 Mental Health Act).

6.5 Julie and Marcus remained in contact with each other during his detention in the secure hospital. She visited him there. After a couple of months, Marcus was permitted temporary leave from the hospital and he lived with Julie during that time. On 10th March 2015 he was discharged from the secure hospital to the care of community health services.

6.6 Julie and Marcus met in 2010 and married on 12th May 2014. He assaulted her on their honeymoon in Thailand. They were divorced on 26th August 2015, but they did remain in close contact with each other.

6.7 Their case was listed at four separate MARAC meetings (Multi Agency Risk Assessment Conferences) which is the recognised national process to manage the highest risk cases of domestic abuse.

6.8 Professionals and Julie's family advised her to leave the relationship with this violent man. We know that Julie tried repeatedly to support Marcus and was controlled by him either by threats of violence or by his repeated suicide attempts.

6.8 On 5th March 2018, Marcus made a '999' call to police stating he had killed his ex-partner. He was arrested and charged the following day.

7/. Key issues arising from the review

7.1 There were many examples of good practice both within and between agencies aimed at protecting Julie.

7.2 There were some instances of poor communication. Agencies did not always have the same recorded version of events and information sharing could have been better.

7.3 The risk assessment process did not always match the circumstances as presented.

7.3 There is no doubt that Julie felt affection for Marcus. He used this to control and manipulate her. This was through serious physical violence, further threats of violence to Julie and her family and by his repeated suicide attempts.

7.4 There were several incidents where child protection procedures should have warranted further intervention.

7.5 All agencies struggled to plan and intervene due to the 'on / off' nature of the relationship.

7.6 Although Julie's family believe Marcus owed Julie several thousand pounds, Julie never made any allegation of financial abuse to any agency.

7.7 All grounds for discrimination or "protected characteristics" in the Equality Act 2010 i.e. age, disability, race, marriage, religion/belief have been considered. These had no bearing on any agency involvement.

8/. Conclusions and lessons learned

8.1 This is a tragic case. Julie was an intelligent and professional woman who was killed by her ex-husband. Her relatives describe her as the 'matriarch' of their family and her loss has been devastating. Julie suffered significant domestic abuse from Marcus. Although she attempted to end the relationship on several occasions, the pair repeatedly resumed their relationship.

8.2 We will never have the full answer why the relationship continued so long after the incidences of serious violence by strangulation and threats to kill. We know there were at least three previous episodes of strangulation perpetrated upon Julie by Marcus before he finally killed her by strangulation.

8.3 The review noted the control exercised by Marcus upon Julie ranging from extreme violence, to threats against her family to his own attempts at suicide. Julie was also aware Marcus had lost his previous wife to cancer. We can never be certain whether the reasons Julie stayed in the relationship were fear, affection, sympathy or a mixture of all three.

8.4 A crucial element within the terms of reference relates to Julie herself. **'When, and in what way, were the victim's wishes and feelings ascertained and considered?' Was the victim informed of options or choices to make informed decisions? How accessible were the services for the victim and perpetrator?'**

In response to this, there is a great deal of evidence to show that Julie was listened to. The police took positive action following the traumatic and serious violence episodes. Julie was interviewed and assessed by an experienced Independent Domestic Violence Advocate from IDAS.

There was an incident (when a threat and assault by Marcus was discontinued against Julie's wishes) when she did not receive the correct level of service required. The decision (evidentially) to discontinue the case was the right one. However, when Julie asked for the investigating officer to contact her about this decision, the officer did not do so. But this should be measured against many incidences of officers proactively getting in touch with Julie, including specialist Domestic Abuse Officers to outline the risks and her options.

When Marcus was detained under the hospital order, the staff at Leeds and York Partnership NHS Foundation Trust involved her in the planning around his eventual discharge.

On several occasions at the MARAC meeting, an action was for a specialist Domestic Abuse Officer to personally update Julie on agreed actions. The services available to Julie were visible and accessible.

8.5 Marcus was Julie's fourth husband. The three former husbands were contacted during the police investigation and the Domestic Homicide Review. They describe 'amicable' splits and at least one remained on good terms with Julie. There are no reports to police or other agencies of domestic abuse perpetrated towards Julie by any of her former husbands.

8.6 Marcus was violent to Julie and the reported incidents of domestic abuse were serious and life threatening. For a variety of reasons which have been explored and evaluated Julie remained in the relationship. She did tell family and professionals she intended to break away gently to not increase Marcus's paranoia. When considering the nature of the previous strangulations, the homicide may well have been predicted as this was ultimately how Marcus killed Julie. We cannot say with any certainty that the homicide could have been prevented. This review has identified some missed opportunities where a more effective intervention could have taken place. But these missed opportunities should be balanced against some of the

positive actions taken by agencies to protect Julie. These actions included advice to leave such a violent partner. Her family also pleaded with her to end the relationship as they had such concerns for her safety. For reasons which have been considered and documented within this review, Julie did not feel able to make a complete break from this destructive relationship.

9/. Recommendations

Recommendation 1:

All front-line professionals who may encounter domestic abuse situations should receive training in risk assessment using the recognised 'DASH' model.

Recommendation 2:

The Community Safety Partnership to ensure there are protocols in place between the police and Crown Prosecution Service to ensure any high-risk case of domestic abuse that meets the evidential threshold is not discontinued without good reason. That rationale of the decision together with a plan to protect the victim is in place should be recorded.

Recommendation 3:

All professionals should receive appropriate training to recognise Child Protection situations. The training should include (a) Putting the child at the centre of their thinking irrespective of the reason they are involved. (b) An appreciation of the different levels of child welfare concerns ('Child Protection' and 'Child in Need').

Recommendation 4:

All agencies review their processes for closure of incidents involving vulnerable people. This system to include checks and balances to ensure any necessary safeguarding referrals are submitted.

Recommendation 5:

In high risk cases of domestic abuse, professionals within a support role should consider the benefits of making direct face to face contact with the victim rather than on the telephone. This should not be discontinued simply because the victim does not consent. Ideally this would be a joint home visit with IDAS and a police DAO, ensuring the victim is aware of all services available while simultaneously ensuring safety of staff.

Recommendation 6:

The Community Safety Partnership should satisfy itself that adequate training programmes are delivered which highlight to professionals:

(a) The recognition of domestic abuse and its complexities, 'push-pull' factors and pressure on victims

(b) Local procedures in place such as DASH risk assessments, the MARAC process, DVPN and DVDS provisions.

(c) The ECHR competing articles that both protect the confidentiality of victims / patients but also recognise the duty on all professionals to 'protect life.' Specifically, this should include balancing the requirements of Article 2 ('the right to life.') and Article 8 ('the right to a private and family life.')

Recommendation 7:

The Community Safety Partnership should review its Information Sharing Protocol for information exchange between professionals who are working in the field of domestic abuse and other areas of safeguarding. The revised ISP to be clear on the need for balance between confidentiality and protecting vulnerable people from significant harm and thus give professionals confidence in making referrals in challenging circumstances.

Recommendation 8:

All agencies involved in protecting the vulnerable should have a 'flagging' system in place to ensure their systems alert attending professionals of previous domestic abuse linked to a victim, perpetrator or address.

Recommendation 9:

Agencies should cross reference their patients / clients with married names / change of name / other aliases to ensure opportunities for identification of vulnerable people are not missed.

Recommendation 10:

The Community Safety Partnership should encourage and measure the training of staff within both the 'Responsible Authorities' (RAs) and the 'Duty to Cooperate' (DTC) agencies on the new MAPPA E Learning package.

Recommendation 11:

The Community Safety Partnership should carry out a review of the MARAC operating procedures within North Yorkshire. Where practices are working well staff should be recognised. The frequency of MARAC meetings should be considered together with the administrative support available to support the Chair ensuring actions are completed in a timely manner and accurately recorded. The CSP should provide visible governance to encourage regular attendance by all agencies with reporting back to the CSP on annual attendance levels. Above all, the CSP should provide leadership to demonstrate to agencies that ALL organisations should be fully committed to this partnership process.

Recommendation 12:

All professionals working directly with victims should receive training in stalking and harassment and particularly around identification, risk assessment and safety planning.

Recommendation 13:

This Domestic Homicide Review has included information and participation across two Community Safety Partnerships -North Yorkshire as coordinators and Leeds (where the perpetrator resided during periods of the review). It is good practice to share all learning and recommendations with colleagues within the 'Safer Leeds's Partnership'.

Recommendations: Single Agency IMR authors:

Most single agency recommendations are incorporated into the Overview Report recommendations to be adopted by all agencies involved in the Domestic Homicide Review. There are some additional specific recommendations made by the IMR author relating to their own agency:

<u>Leeds and York Partnership NHS Foundation Trust</u>

No additional recommendations

<u>York Teaching Hospital</u>

No additional recommendations

<u>Julie's GP surgery</u>

- GP Practice staff should routinely record names of partners and link to clinical

- records to enable a clear understanding of who potentially poses a risk to the patient.

Yorkshire Ambulance Service

No additional recommendations

North Yorkshire Police

- The Force Control Room make Domestic Abuse Officers (DAOs) aware of all incidents involving high risk victims. This will afford the DAO the opportunity to review the incident and make a further risk assessment.

- Ensure that during 'Daily Management meetings', consideration is given for the serving of Domestic Violence Protection Notices / Domestic Violence Protection Orders (DVPNs / DVPOs) for offenders in custody when no further action is being proposed. A breach of a DVPO carries a power of arrest and consideration of a custodial sanction.

- North Yorkshire Police should review the decision to appoint only police staff to the role of DAO. The IMR author believes a more blended mix of experiences would give a more comprehensive service to victims.

West Yorkshire Police

No additional recommendations

IDAS

No additional recommendations

National Probation Service

No additional recommendations

Leeds CCG

- The CCG to provide GP practices across the city with a template safeguarding policy which encompasses the most up to date information and resources. This will

standardise practice and promote an understanding of safeguarding, including domestic abuse.

These sets of recommendations will be incorporated into 'SMART' action plan with leadership and scrutiny provided by the North Yorkshire Community Safety Partnership.