North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of Emma

September 2019

EXECUTIVE SUMMARY

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Dated: 11th December 2020

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 Emma who was resident in their area.

1.2 'Emma' is a pseudonym. It will be used throughout the review in order to protect the victim's identity. This pseudonym has been agreed with her family. The perpetrator in this case is referred to by the pseudonym, 'Thomas.'

Subjects of the Review:

The victim; Emma, a female aged 51 years at the time of her death.

The perpetrator; Thomas, a male aged 38 years at the time of the murder.

1.3 Criminal proceedings were completed on 10th December 2020. The perpetrator appeared at Leeds Crown Court. He pleaded not guilty to murder but was convicted by the jury. Thomas was sentenced to life imprisonment with a recommendation he serves at least 16 years in prison.

1.4 This process began with a notification by West Yorkshire Police. The circumstances of Emma's death were then discussed at the North Yorkshire DHR decision-making group. The decision to convene a Domestic Homicide Review was taken by the Independent Chair of the North Yorkshire Community Safety Partnership on 25th October 2019. All agencies that potentially had contact with the victim and perpetrator prior to Emma's death were contacted and asked to confirm their involvement with them. Further enquiries during the initial scoping led to contacts with a number of organisations around the UK. Eventually, twenty-one agencies confirmed their involvement 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.

1.7 There were delays to the completion of this Domestic Homicide Review due to the onset of the Covid-19 pandemic. The first panel took place as planned in January 2020 but subsequent meetings were held 'remotely'. The criminal trial was also adjourned for eight months which meant significant delays to the process.

2/. Contributors to the review

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

- NHS North Yorkshire Clinical Commissioning Group (on behalf of GP Practice for victim)

- Harrogate and District NHS Foundation Trust

- Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company

- West Yorkshire Police

- Tees, Esk & Wear Valleys NHS Foundation Trust

- Yorkshire Ambulance Service

- North Yorkshire County Council Health & Adult Services
- City of York Council
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- NHS Bradford City, Bradford District and Airedale Wharfedale & Craven CCGs (on behalf GP Practice for perpetrator)
- North Yorkshire Police
- Harrogate Borough Council
- West Midlands Police
- Leicestershire Police
- National Probation Service
- Community Rehabilitation Company (CRC) Staffordshire and West Midlands
- Nottinghamshire Police
- West Mercia Police
- Office of Police Fire and Crime Commissioner North Yorkshire
- DISC (now renamed Humankind)

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 Emma's death.

3/. The Review Panel members

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

- Graham Strange - Independent Chair
- Odette Robson, Head of Safer Communities, North Yorkshire County Council
- Christine Pearson, Designated Nurse for Safeguarding Adults, North Yorkshire CCG
- Louise Johnson, Head of Area, North Yorkshire, National Probation Service
- Sandra Chatters, Community Director (North Yorkshire), The Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company Ltd
- Detective Chief Inspector Vanessa Rolfe, Senior Investigating Officer, West Yorkshire Police
- Chris Davis, Head of Client Services, Independent Domestic Abuse Service (IDAS)
- Karen Agar, Associate Director (Safeguarding), Tees, Esk & Wear Valleys NHS Foundation Trust
- Jill Foster, Chief Nurse, Harrogate District NHS Foundation Trust
- Detective Superintendent Allan Harder, Head of Safeguarding for North Yorkshire Police
- Amanda Robinson, Acting Deputy Designated Nurse (Safeguarding Children), Domestic Abuse Manager, NHS Bradford City, Bradford District, Airedale, Wharfedale & Craven CCGs
- Ruth Davison, Domestic Abuse and Sexual Violence Manager, Bradford Metropolitan District Council
- Rachel Robertshaw, Development Worker, DHR Co-ordinator, Domestic and Sexual Abuse Team, Bradford Metropolitan District Council (observer)
- Cara Nimmo, Head of Practice, Health and Adult Services (HAS), North Yorkshire County Council
- Rachel Braithwaite, Principal Regulatory Solicitor, Harrogate District Council
- Dennis Southall, Housing Services Manager, City of York Council
- Nikki Gibson, Head of Safeguarding, Bradford District Care NHS Foundation Trust
- Sarah Turner, Assistant Chief Nurse, Vulnerable Adults, Bradford Teaching Hospitals NHS Foundation Trust
- Mike Cane, Independent Author for the review

3.2 The group met three times as a panel and once for a briefing to 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 a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and 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 murder of Emma:

- The date parameters under consideration would be from 1st January 2016 to September 2019. This incorporated the earliest known date of the start of the relationship through to the possible date of the death of the victim. However, the panel agreed that if other pertinent information was discovered during their enquiries, then these details would also be referenced within the IMRs.

- Were practitioners sensitive to the needs of the victim and the perpetrator? Were they 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? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in the case of this victim and perpetrator? Were these assessment tools, policies and procedures professionally accepted as being effective?

- Was the victim subject to a MARAC or other multi-agency fora?

MARAC is the Multi-Agency Risk Assessment Conference; where local professionals meet to exchange information and plan actions to protect the identified highest risk victims of domestic abuse.

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

- What were the missed opportunities for intervention? 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? Were they subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or previously had been in place?

  MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

  MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse.

- 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?

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

- How accessible were the services for the victim or perpetrator?

6/. Summary chronology

6.1 The victim, Emma, was 51 years old at the time of her death. She had many difficulties during her life and this was evident by her vulnerabilities.

6.2 The perpetrator, Thomas, was 38 years old at the time of the murder. He moved around frequently and lived in many areas of the UK. It is believed Emma and Thomas met online. There were no children in the relationship.

6.3 Emma disclosed an Adverse Childhood Experience but full details are not known as historic records are no longer available from that time. She had some mental health problems, a possible learning difficulty and a physical disability. She had very little physical contact with her family; though she did contact he mother by telephone most weeks.

6.3 Thomas is known to have perpetrated violence towards several previous partners. He has an extensive criminal record with convictions for violence, harassment, theft and criminal damage. He suffered from anxiety and depression but did not have a diagnosed mental health illness.

6.4 Domestic abuse perpetrated by Thomas towards Emma was reported to police and other agencies in the West Midlands, West Yorkshire and North Yorkshire. This included verbal arguments, economic abuse, harassment, sexual abuse and physical violence. North Yorkshire Police alone recorded over 100 occurrences of contacts or follow-up actions with Emma or Thomas. Many of these calls were connected to Emma's vulnerabilities, but 21 related to allegations of domestic abuse. The first incident reported to North Yorkshire Police was in January 2016 and was an allegation of harassment.

6.5 Thomas resided for several years in Bradford. (This is within the West Yorkshire Police area). Emma resided in Harrogate (within the North Yorkshire Police area). This meant there were many calls to police which transcended police boundaries. Many of the calls included counter-allegations. Likewise, there were reports made to separate Local Authorities or NHS Trusts.

6.6 In April 2014, Emma was assaulted (not related to domestic abuse). She suffered a fractured neck of the femur to her left leg and she was admitted to hospital. She declined surgery, despite input from the Community Learning Disabilities team, the Mental Health team, the Independent Mental Capacity Advocacy (IMCA) service and the Hospital Trust Safeguarding Lead. A 'best interests' decision was made on Emma's behalf. The decision was not to proceed with the operation as Emma was adamant this was not what she wanted to happen. This lack of surgery meant that Emma then had a physical disability (difficulty in walking unaided).

6.7 In January 2019, Emma reported to North Yorkshire Police that she had been sexually abused by Thomas at his home over the Christmas/New Year period. Thomas was apparently still at his home in West Yorkshire. There were delays in police taking appropriate action. This is subject to a separate enquiry by the Independent Office for Police Conduct (IOPC).

6.8 Emma was recorded as a missing person by North Yorkshire Police in August 2019. This led to extensive enquiries taking place. Including liaison with colleagues in west Yorkshire Police. In September 2019 Thomas was arrested by West Yorkshire officers on suspicion of the murder of Emma. Emma's remains were found in the Doncaster area in October 2019.

6.9 Thomas was subsequently charged with Emma's murder and appeared at Leeds Crown Court in March 2020. The criminal trial was adjourned due to the onset of the Covid-19 crisis and reconvened in November 2020. Thomas pleaded not guilty to the murder of Emma but was found guilty by the jury. He was sentenced to life imprisonment with a minimum term of 16 years. Thomas pleaded guilty to preventing the lawful burial of a body for which he was ordered to serve 2 years concurrently.

7/. Key issues arising from the review

7.1 There was uncertainty for professionals supporting both the victim and the perpetrator regarding the status of the relationship. Emma stated to several (though not all) professionals that she was or had been in an intimate relationship with Thomas. Thomas always maintained that they were simply friends.

7.2 Emma was a vulnerable person. Her vulnerabilities included an 'Adverse Childhood Experience', a physical disability, a possible learning difficulty, poor personal hygiene and a chaotic lifestyle. Although Emma did receive support from Adult Social Care she would not consent to a full assessment of her needs. This prevented a holistic approach to providing her with support.

7.3 Both Thomas and Emma had regular contact with a variety of services.

7.4 Thomas was a violent individual who had abused several former partners. He targeted vulnerable women.

7.5 The risk assessment process did not always match the circumstances as presented. Agencies did not take account of previous incidents or case history. On too many occasions the practitioner simply assessed that particular incident or call they were dealing with. They did not look at the 'bigger picture'.

7.6 Although a 'best interests' decision was made on Emma's behalf in April 2014 (regarding her lack of capacity to consent to an operation on a fractured femur), the result of this decision (for the operation not to go ahead) meant she then suffered a permanent physical disability in addition to her other problems.

7.7 Both Emma and Thomas moved around the UK. This meant there were frequent and repeated exchanges of information between service providers in different localities. This prevented any one agency 'gripping' the issues.

8/. Conclusions and lessons learned

8.1 Emma and Thomas were ex-partners. This was disclosed and noted by agencies but there was a repeated failure of front line staff to recognise the domestic abuse that was taking place. This meant domestic abuse risk assessments were not carried out, there were no reviews by specialist staff and subsequently there were no referrals to domestic abuse support agencies.

8.2 The victim of the homicide was vulnerable in many ways. She was entitled to an assessment of her needs. Her vulnerabilities included an adverse childhood experience, mental health problems, a learning difficulty and a physical disability. These issues led to further problems of poor hygiene and self-care. She had very little support from family or from any circle of friends.

8.3 Under the Care Act 2014, local authorities must carry out an assessment of anyone who appears to require care and support. This was attempted regularly but Emma would not consent to a needs assessment. Emma's behaviour could also be particularly challenging. She was frequently rude to staff or would hang up the telephone and then call back repeatedly. Practitioners found it difficult to engage with Emma as she would often leave home after making a call or if she were at home would only speak to professionals on her doorstep.

8.4 The 'best interests' decision taken on Emma's behalf in April 2014 resulted in her suffering a permanent physical disability. A capacity test was conducted under the Mental Capacity Act 2005 which determined Emma did not have the capacity to make a decision regarding the required surgery. Protocols

were correctly followed and an IMCA was contacted. However this ‘best interest’ decision added to Emma’s existing vulnerabilities.

8.5 There is evidence of unconscious bias being displayed during a minority of interactions between Emma and front line professionals. Comments on incident logs such as ‘Both parties suffer from mental health issues’ or ‘Emma is well known for making hoax calls’ suggest that in some situations staff had some preconceived ideas of what they were facing. This is not to say that the mental health issues or hoax calls were not a reality. But the danger is that professionals could allow the circumstances of an incident to fit within these parameters. This would prevent a more investigative mindset to what was actually taking place. It should be stressed this was a minority of incidents. In a large number of cases, staff noted the presenting conditions and dealt with them as effectively as they could in the circumstances.

8.6 The perpetrator was a known violent offender. He had many criminal convictions including several for violence. He had assaulted and harassed former partners in the same way as he did with Emma. He had breached restraining orders which had been issued to protect his former partners. All of this information was available to both police and probation services yet was not acted upon. National records were accessible via the Police National Computer (PNC) or the Police National Database (PND). There is absolutely no doubt that his previous convictions and arrests should have been disclosed to Emma within the guidance of the ‘Domestic Violence Disclosure Scheme’ (Claire’s Law). This was a missed opportunity to warn Emma about Thomas’ past. A common description was given by different organisations when describing Thomas’ victims. From his wife in Nottinghamshire in 2008, to his next partner in Shropshire in 2014, to his alleged victim of a sexual assault in Leicester in 2015; all are described as ‘vulnerable’ women. There is no doubt that Thomas is a manipulative individual who targets and preys on vulnerable women. The allegation of a sexual assault made by a woman in Leicester in 2015 was very similar to the circumstances of the sexual assault alleged by Emma in January 2019. Thomas’ taking of a mobile phone and preventing his ex-wife from leaving their house in 2008 was also very similar to what was later alleged by Emma. The information about his past was readily available to the police and it is extraordinary that this was missed.

8.7 The lack of submission of domestic abuse risk assessments meant there was never a full picture established on the level of domestic abuse taking place in the relationship. Even the incidents that were correctly recorded did not result in any coordinated action to protect Emma from domestic abuse. The incidents were dealt with in isolation. All incidents that were risk assessed were graded as ‘standard’ or ‘medium’ risk. Such assessments are victim led and staff must take care to use professional judgement, especially if a victim is being challenging or not willing to engage. At no time did any manager intervene to review all the incidents that were taking place. There was no consideration of how Emma’s vulnerabilities placed her at greater risk from a

manipulative individual. These vulnerabilities, together with the perpetrator's propensity for using violence towards his partners suggest that, taken together, these became high risk incidents and should have been referred to the MARAC to consider how best to protect the victim. This never took place.

8.8 The behaviour of the perpetrator also included coercive control and financial abuse. Police dismissed Emma's allegations of Thomas taking or failing to return her property or money. There were some occasions when clearly Emma had not told the truth but on the balance of probability he did prey on her vulnerability. Some staff to their credit even record on incident logs that they do not think Emma's allegations are a hoax, but there was still no effort to interview Thomas about the matter. It was very difficult for officers to investigate, given Emma's withdrawal of allegations or when she left home and did not return officer's calls. But there was clearly a lack of recognition of financial abuse taking place and it was too easy to dismiss the incident as a 'civil dispute'. The national definition of domestic abuse (see paragraph 1.3.2) is explicit that it includes both coercive control and financial abuse. Even if a criminal charge was unlikely, officers should have focused on how to protect Emma from this control or financial abuse.

8.9 The chaotic lifestyle of the victim and perpetrator meant that records were held by agencies that spanned many geographical locations. They frequently accessed services across Police Force areas, across different Health Trusts, across probation services and across Local Authorities.

8.10 Several agencies submitted referrals for additional support for Emma. They had recognised her vulnerabilities and acted upon their concerns. This is positive. However, there are examples throughout the review of referrals requesting mental health support when the issue was social care. During other incidences, a learning difficulty was confused with mental health. This is understandable and staff across different organisations cannot be expected to become an expert in another professional's field. Nevertheless, with circumstances quickly moving on (i.e. Emma moving back to Thomas, or another emergency episode such as homelessness or threat of self-harm), the right service could be accessed more promptly if staff have a greater understanding of learning difficulties and mental health.

9/. Recommendations

Recommendation 1:

The Community Safety Partnership reviews its Information Sharing Protocols. There are many examples in this review when professionals have dealt with an isolated incident but not researched any other relevant incidents that had taken place. A case history would have given staff much more clarity of the risks they were dealing with. A good ISP gives front line professionals the confidence to ask probing questions.

Recommendation 2:

The Community Safety Partnership reviews the local training programmes being accessed and develops future training to fill in gaps identified during this review. The training should focus on:

(i) *Training* in the identification of domestic abuse. Both parties may not give the same account of their 'relationship'. Staff should be professionally curious about the nature of a relationship and research previous incidents.

(ii) *Training* in the recognition of 'unconscious bias'. Repeat callers can involve a significant use of an agency's time and resources. Despite the best intentions of staff, unconscious bias can develop into an individual's mindset, especially if they are faced with abusive language. A vulnerable person may exhibit abuse and may make hoax calls but this does not mean they are not at risk of abuse or exploitation from others. Training is a good way to guard against the onset of unconscious bias.

(iii) *Training* in the use, provisions and application of the Care Act 2014. This should include the entitlement of a person to a needs assessment under the provisions of the Act. Such training would enhance all practitioner's ability to recognise vulnerability, to take a 'person centred' approach and consider their options.

(iv) *Training* in appreciation of learning difficulties and of mental health. During this review there were many instances of staff not recognising what they were dealing with and where to access support. Any training programme should include mental illness, crisis episodes, how learning difficulties can present and capacity to make decisions under the Mental Capacity Act 2005.

(v) *Training* in the recognition of economic or financial abuse and coercive control. There were too many incidents in this case when a vulnerable person's concerns were dealt with as a 'civil dispute'. Financial abuse is clearly defined within the national definition of domestic abuse. When a

victim is particularly vulnerable, professionals should be mindful of financial abuse and coercive control taking place.

Recommendation 3:

The Community Safety Partnership should seek assurance that all agencies have domestic abuse policies in place. Many agencies taking part in this review have comprehensive safeguarding policies in place. However, several do not have a stand-alone domestic abuse policy. Given the prevalence of domestic abuse in society and the impact on services, the drafting of specific policies linked to domestic abuse would provide a focus and clarity in relation to identification and initial actions required when dealing with a victim or perpetrator of domestic abuse. Any domestic abuse or safeguarding policy should be reviewed regularly to incorporate updates in national legislation or local procedures.

Recommendation 4:

West Yorkshire Police and North Yorkshire Police should agree protocols for cross-border requests for assistance. When an incident has taken place in one Force area, but the victim has returned home to another Force area there should be absolute clarity in what action is being requested and which organisation is conducting the risk assessment.

Recommendation 5:

West Yorkshire and North Yorkshire Police develop or revise their protocols for effective use of the Police National Database (PND). If there is any suggestion a victim or a perpetrator of domestic abuse has lived elsewhere in the UK, then the default position should be that PND is checked to review any incidents that have taken place elsewhere.

Recommendation 6:

The Community Safety Partnership ensures there is a review of multi-agency procedures for the application of the Domestic Violence Disclosure Scheme (DVDS or ‘Claire’s Law’). There were too many missed opportunities in this case when the victim could have been warned about the previous behaviour and offending of the perpetrator.

Recommendation 7:

The Community Safety Partnership undertakes a review of the MATAC pilot in North Yorkshire which has been set up to manage the behaviour of repeat and serial perpetrators of domestic abuse.

Recommendation 8:

The relevant partner agencies review the role, remit and structures of the Harrogate Community Safety Hub. Such forums can be valuable in developing effective multi-agency working to reduce crime and disorder. However, the group requires protocols confirming the roles of attendees both before and after the meeting of the group (i.e.

including researching information held on internal databases before the meeting and updating any actions post meeting). There should be formal reporting mechanisms to the MARAC if domestic abuse concerns are highlighted.

Recommendation 9:

All agencies should be encouraged to make comprehensive records of disclosures made by clients. The notes should include their considerations of risks identified, any ongoing safeguarding concerns, any multi-agency conversations that took place and the wishes of their client.

Recommendation 10:

The findings and recommendations of this Domestic Homicide Review are shared with colleagues from the North Yorkshire Safeguarding Adults Board, City of York Safeguarding Adults Board and Bradford Safeguarding Adults Board.

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