North Yorkshire
Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

MARY - AGED 30

DIED OCTOBER 2019

REVIEW PANEL CHAIR

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REVIEW PANEL REPORT AUTHOR

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1. INTRODUCTION

This Domestic Homicide Review (DHR) examines agency responses and support given to 'Mary'[1], a resident of Catterick Garrison, North Yorkshire, prior to her death in October 2019.

In addition to agency involvement this review will also examine the recent history of interactions with Mary, to identify any relevant background and/or trail of abuse before the death. It will also look at whether support was accessed within the community by Mary and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

The review will consider agency/third party sector, contact and involvement with Mary and her family from 1st January 2017 to the day of her death. Any relevant facts from Mary's and Peter's earlier life will be included in background information. It will also undertake an assessment of whether appropriate procedures were followed.

The key purpose for undertaking DHRs is to enable lessons to be learned from deaths where a person dies and there is a potential causal link to domestic violence and/or abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

This report will follow the 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' published by the Home Office in 2016[2]

One of the guiding principles for this review has been to be guided by humanity, compassion, and empathy, with Mary's 'voice' at the heart of the process. This was an appalling tragedy for the family, and through the Chair, the Panel offer heartfelt condolences for their loss.

In line with best practice principles the Panel meetings which were convened, and this report follow the Home Office guidance on both conducting and authoring for a Domestic Homicide Review. In following this best practice, a photograph of Mary was provided to the Panel by the police having been previously approved for use by Mary's father, and this was used to bring the Panels and the Review to life, placing Mary at the center of the process and all conversations.

Note

The victim's father was contacted by the Chair and chose the pseudonym for Mary used in this report. He did not choose the name for Mary's partner at the time of her death.

[1] Not her real name, all names used in relation to non-Panel members are Pseudonyms
[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

TIMESCALES

After the death of Mary, the Chair and Author were appointed to conduct a review into the circumstances of the case. The Chair of the North Yorkshire Community Safety Partnership (CSP) commissioned this review.

The CSP rightly waited until all Criminal and Judicial processes had been finalised before undertaking the constitution of the Review process.

Partners had previously been contacted immediately after Mary's death and a scoping exercise had been undertaken. A decision-making group met and agreement for commissioning a review took place 20th February 2020. From this exercise the Review Panel was selected, based on those agencies who held information, those agencies which did not hold information but may be able to assist, and those needed for legitimacy of the process. These agencies were then contacted to seek support for a DHR, and to ensure the securing of any records held.

The Chair was appointed in April 2021, and a Panel was immediately convened, sitting for the first occasion on 5th May 2021.

Prior to this meeting draft Terms of Reference (ToR) – Appendix 1 - along with a proposed agenda were circulated to potential Panel Members and the net was thrown wide, in terms of attendance, to ensure the capturing of all possible contact with the family prior to Mary's death.

Potential Panel members were also asked to forward the details of any other parties they felt should be present. This included consideration for the use of specialists/experts where appropriate.

At this first meeting the draft ToR was discussed fully by the Panel and agreed. Chronology reports were commissioned from all identifiable public and voluntary bodies that may have had contact with the family.

The scope of the review was finally set as 1st January 2017 to the tragic circumstance of Mary's death in October 2019, after being fully discussed by the Panel. As a result, it was decided to include any information in these reports which existed between those dates, giving an overall c. four-year period. The 1st January 2017 was chosen to ensure all recent agency communication was captured since Mary commenced her relationship with Peter, who was not her partner at the time of her death.

No immediate urgent interventions or actions were identified by Panel members and timescales were set for submission of Chronologies. Full minutes were recorded, and an Action Tracking system put in place to monitor actions to be completed – this process applied to all subsequent meetings.

It was agreed by the panel that should any issues of concern be identified by any person involved in the Domestic Homicide Review (DHR), which fell outside of the agreed timescales, then these could be brought to the panel for discussion relating to relevance. During this Review period no such issues were identified.

Once all Chronologies were received, a further Panel was convened and used the opportunity to discuss fully the information that had been identified. As a result of these discussions and subsequent observations made, Individual Management Reviews (IMR) from those agencies who had contact with either Mary or Peter during the Review framework were discussed.

A number of agencies then completed IMR's and submitted these to the Chair and Panel for discussion at the following meeting. These IMR's were compiled by the Author, analysed in relation to organisational practice and an initial draft of the overview report which set out the narrative was considered at the meeting on 26th January 2022.

The final draft of the overview report was circulated to the DHR Panel on the 16th September 2022, and was shared with Mary's father in a face to face meeting on the 23rd September 2022. A full exceptional meeting of North Yorkshire Community Safety Partnership took place, via Microsoft Teams, on the 4th October 2022. The full version of the review and findings were presented by the Independent Chair of the DHR Panel, Jasvinder Sanghera. The presentation included correlation with the 'Key findings from analysis of domestic homicide reviews' published 30th March 2022.

Point of Note;

Due to the Corona Virus 19 Pandemic, National Lockdown, and safeguarding procedures all Panel meetings were conducted virtually, via Internet enabled video conferencing.

The majority of Panel Members were working from home during this period and general working practices nationally were being customised to meet safe working guidelines.

The impact on certain Panel members was clear to see and it is important to acknowledge that the national vaccination programme increased the pressure on those working within the National Health Service in a way never before experienced. The Chair and Author is therefore grateful for all efforts made to meet timescales and attend panel meetings.

All submitted documentation was password protected from the outset and passwords were only issued to those directly involved in the Panel and where there was a necessity.

The chronologies and IMR's are confidential. Information was available only to participating officers/professionals and their respective line managers.

The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Secure networks were used to transmit documents and where this was not possible password protection added an appropriate level of security to the documents being shared.

For ease of reference, all terms suitable for acronym will appear once in full, and also in a glossary at the end of the report - Page 36.

The deceased will be referred to herein as Mary. Her partner will be referred to as Peter, in line with the notes section on page 4 of this report.

TERMS OF REFERENCE

Following discussion of a draft in the first Panel meeting, Terms of Reference (ToR) were issued the following week (Appendix 1) with chronology and IMR templates for completion being shared with partners to aid consistent reporting.

The ToR was reviewed at every subsequent Panel meeting and were finalised on 5th October 2021. This final version was signed off by Panel members.

METHODOLOGY

Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was initially commissioned by North Yorkshire Community Safety Partnership, and, in April 2021, the Chair and Author were appointed.

This review was commissioned under Home Office Guidance issued in December 2016. Close attention was paid to the cross-government definition of domestic violence and abuse and is included in the ToR (Appendix 1). The following websites, policies and initiatives have also been used as reference documents.

- HM Government strategy for Ending Violence against Women and Girls 2016-2020[3]
- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016[4]
- Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016[5]

[3] https://www.gov.uk/government/consultations/violence-against-women-and-girls-vawg-call-for-evidence/violence-against-women-and-girls-vawg-strategy-2021-2024-call-for-evidence

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

- North Yorkshire County Council web site[6]
- North Yorkshire Police website[7]

At the first panel meeting a discussion was had to identify any prior Domestic Homicide Review (DHR) reports within the CSP area which may contain lessons learnt pertinent to this review. CSP records were examined, and no repeat lessons or trends were identified which had an immediate bearing on this review. This agenda item remained throughout the panel meetings and was regularly reviewed.

This report has been written and formatted in line with previous Home Office Guidance, however due to the unique circumstances surrounding Mary's death a number of additional sections have been included which the Chair and Author felt necessary to provide a full and holistic view of events.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

Prior to the first Panel meeting in 2021, North Yorkshire Police (NYP) had deployed officers to the family of Mary in line with the College of Policing guidance documents[8]. This is good practice in all such incidents and allowed the panel to have an initial view into the family's thinking and feelings.

Once the Panel had initially sat the details of family members were passed to the Chair and a communication channel was opened with Mary's father. In this way Mary was heard at the Panel through the voice of her father who was willing to let his conversations with the Chair be fully shared.

Mary's father provided the conduit to the wider family as it was quickly established that Mary's mother and brother were still too distressed to take part.

The Chair and the Head of Safer Communities, NYCC and Mary's father have been in contact throughout the period of the review and have communicated via the telephone and face to face.

Mary's father has been communicated with and updated throughout this review and has provided information to the panel and the Chair/Author which aids this report considerably.

He has been thoroughly supportive of the Review process and the Panel would like to formally thank him for engaging so fully with them and being candid in his disclosures. In acting as a conduit into the wider family he has enabled a richer picture of Mary to be obtained. It is acknowledged how difficult this must have been for him and the Panel passes on their thanks for his engagement throughout the Review.

[6] https://www.North Yorkshire.gov.uk
[7] https://www.northyorkshire.police.uk
[8] https://www.college.police.uk

Advocacy information, counselling services in the local area and appropriate personal support has been shared with Mary's father throughout, and this included local support charity information.

Once the final version of this Review report is agreed, a copy will be shared with Mary's father, either in person or virtually depending upon his preferred method. He has been invited to Panel meetings but at time of writing this report has been content to await the report before deciding if he will attend the final meeting. (Mary's father met in person to consider the final version of the overview report, he was aware of the exceptional Community Safety Partnership, but did not wish to attend.)

In relation to Mary's partner Peter although interviewed by police at the time of the death being investigated, he has not been spoken to by the Chair or Author of this review. This is on advice from NYP in relation to his mental health and any impact this could have on his welfare. He has never shown any remorse for his actions.

CONTRIBUTORS TO THE REVIEW AND PANEL MEMBERS

This overview report is an anthology of information and facts from the organisations represented on the Panel, many of which were statutory and potential support agencies for Mary and potentially Peter.

Name	Role and Organisation
Anonymous	Father of Mary
Sarah Marshall	Business Support, North Yorkshire County Council
T/ Det Supt Fiona Wynne	North Yorkshire Police*, Head of Safeguarding
Insp Steve Menzies and Superintendent Alan Harder	North Yorkshire Police (Senior Investigating Officer)
Colin Dales	Corporate Director (Operations), Richmondshire District Council
Christine Pearson	Designated Nurse, Safeguarding Adults, NHS North Yorkshire Clinical Commissioning Group*
Karen Agar	Associate Director of Nursing (Safeguarding), Tees, Esk and Wear Valley* (TEWV) NHS Foundation Trust (Mental Health Trust)
Heather Brennan	Housing Manager, IDAS (Independent Domestic Abuse Services, local provider of DA services and advisor to the Panel)

Sarah Walker	TEWV NHS Foundation Trust - acting as Learning Disabilities Advisor
Jasvinder Sanghera	Independent Chair
Helen Collins	Independent Report Author
Odette Robson	Head of Safer Communities, North Yorkshire County Council

* Agencies providing IMR's

This Panel ensured coverage of not only the statutory agencies required but also drew from the non-Statutory/voluntary sector with expertise relevant to the Review at hand. This included the Independent Domestic Abuse Services[9] (IDAS).

Note

Overall, Panel contribution was robust and communication between attendees flowed easily, despite the challenge of running the panel in a time of Covid lockdown and unusual working circumstances. Members embraced the need to keep Mary central to the discussions which took place.

CHAIR OF THE PANEL

Jasvinder Sanghera is the Chair of this panel. She is the founder of Karma Nirvana[10]. She has extensive experience in Safeguarding and currently sits on the Independent Safeguarding Board for the Church of England. She has completed the Home Office DHR training and is experienced at giving expert witness testimony in Courts relating to Domestic Violence and Safeguarding.

Jasvinder also has a wealth of experience in undertaking risk assessments in cases of Domestic Abuse and sexual harm to women and children, providing reports to the judicial services and associated agencies.

Set out for reference in Appendix 2 are the full respective 'independence statements' for the Chair, Author and Support Officer.

AUTHOR OF THE OVERVIEW REPORT

Helen Collins is the author of this overview report. She is a former senior police officer who had previously worked within Surrey Police.

[9] www.idas.org.uk
[10] https://karmanirvana.org.uk

She was appointed as the independent author of this report having not been involved in policing since her retirement from service in 2019.

Set out for reference in Appendix 2 are the full respective backgrounds and 'independence statements' for Helen Collins. Helen has been involved in 16 DHR and Domestic Abuse Death Reviews in the last 24 months.

She has also undertaken the Home Office DHR online training and attended numerous Advocacy After Fatal Domestic Abuse (AAFDA) events, including the recent monthly update events.

PARALLEL REVIEWS

At the first Panel meeting the Chair asked for disclosure of all current, pending or completed Reviews in relation to the death of Mary.

No information of a similar case was found which had a bearing on this case.

There were no criminal or judicial processes to complete before the Chair was appointed.

There were also no misconduct investigations pending, in relation to any participating organisations.

There has been no need for a Coroner's Inquest in this case.

EQUALITY AND DIVERSITY

Consideration has been given to the nine protected characteristics under the Equality Act 2010 in evaluating the various services provided. These have been discussed fully within the Panel meetings.

Age –

Mary was 30 years old, and Peter was 45 at the time of the tragic death. Research suggests that age difference can be seen to create a further power imbalance[11] but this was not classed as significant in this case. It is felt that Mary's age may have made her more vulnerable and acted as a barrier to her seeking help. For example, an estimated 28.4% of women aged 16 to 59 years have experienced some form of domestic abuse since the age of 16 years[12] (Office of National Statistics, 2019).

Disability –

The Equality Act 2010 defines **disability** as: "A physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities."

[11] Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009). *Partner Exploitation and Violence in Teenage Intimate Relationships*. London: NSPCC
[12] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/myths

There is no evidence to suggest that Mary had been recorded as physically disabled in any way in her medical records. However, Mary is recorded as having 'mild learning difficulties' during her time at school, and this is further recorded in her medical records. A key area of the Equality Act is the duty it places on public bodies to make reasonable adjustments for people with a disability, a reasonable adjustment being a change that the body can make to ensure that people with disabilities are not treated unfairly. There is no evidence from the information gathered during this review to suggest that Mary was treated unfairly in anyway by any public body.

There is however evidence to suggest that Mary's vulnerabilities were not fully recorded and therefore not available to health professionals.

Both parties were known to Mental Health services.

Gender reassignment – neither party had been, nor were known to be considering, gender reassignment.

Marriage and civil partnership – There was no marriage or civil partnership between Mary and Peter.

Pregnancy and maternity – this was not a relevant factor.

Race – Both Mary and Peter were of white British descent.

Religion or belief – Peter's religious beliefs are unknown and are not believed to have a bearing on the events being reviewed in terms of his offending. However, Mary was a regular church goer and a section further on in the report will cover this aspect of her life.

Sex – Mary was female, and Peter is male. Research show that the majority (74%) of victims of domestic homicide were female and that 80% of that number were killed by a partner or ex-partner.[13] In relation to abusive relationships and the use of coercive controlling behaviour recent studies have shown that 74% of offenders are male and 97% of those prosecuted for such offences are male[14].

Sexual orientation – the sexual orientation for each is believed to have been heterosexual

Note

The Panel discussed whether there was evidence of differential service or 'conscious/unconscious bias[15]' from any public body for anyone subject of this report. None was identified and the intersectionality of the applicable protected characteristics will be explored in the context of the report.

Further contextual information

- On average victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help

[13] Office for National Statistics, Homicide in England and Wales - year ending March 2018, www.ons.gov.uk
[14] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control - 2019 study
[15] https://www.qualityinteractions.com/blog/unconscious-bias-in-healthcare

- 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse
- Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to a Multi-Agency Risk Assessment Conference (MARAC) or accessing an Independent Domestic Violence Advisor (IDVA) service are women[16]

COERCIVE CONTROL

Coercive control[17] is a strategic form of ongoing oppression used to instil fear and self-doubt. The abuser, in this case Peter, will use tactics, such as monitoring all communication and movements, as a controlling effort, to manipulate the relationship.

There are a number of indicators that are recognised by health professionals as indicators of coercive control, in the case of Mary and Peter the following applied.

- Monitoring activity – This is evidenced by Peter's monitoring of her routes to and from work. During their investigation North Yorkshire police took 10 Section 9 witness statements all of which describe aspects of stalking relating to the behaviour displayed by Peter towards Mary. These were used at the subsequent trial and describe Mary telling her Church colleagues that she was being followed.

- Communications/isolation – Peter is recorded as using text messages and pressure to try to alienate Mary from her family and pressure her into distancing herself from those close to her. In his statement to Police Mary's brother stated, Peter had told Mary that she, '*shouldn't let her family rule her life'*. Mary asked for advice from her family, and '*she subsequently told him that he should stop contacting her, otherwise she would contact police and get a restraining order'.* However, this did not stop Peter's inappropriate contact.

- Controlling behaviour – Peter appears to have used social media (including through his mother) to contact and comment on Mary. As will be seen further in the report he continued to text and harass Mary after their break-up, and this is corroborated by Mary's last text to him.

- Stalking – Peter in hindsight is clearly displaying stalking behaviour towards Mary post their relationship ending, including 'bumping into her unexpectedly', following her and repeatedly contacting her.

STALKING AND HARASSMENT

In relation to stalking offences the Crown Prosecution Service state,

> *Whilst there is no strict legal definition of 'stalking', section 2A (3) of the PHA 1997[18] sets out examples of acts or omissions which, in particular circumstances, are ones*

[16] SafeLives - https://safelives.org.uk/
[17] Legislation relating to CCB - www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship
[18] Protection from Harassment Act 1997

associated with stalking. For example, following a person, watching or spying on them or forcing contact with the victim through any means, including social media.

The effect of such behaviour is to curtail a victim's freedom, leaving them feeling that they constantly have to be careful. In many cases, the conduct might appear innocent (if it were to be taken in isolation), but when carried out repeatedly so as to amount to a course of conduct, it may then cause significant alarm, harassment or distress to the victim[19].

A list of behaviours/characteristics are used by Law Enforcement agencies to identify stalking behaviour, and these include, but are not exclusively the following,

- Jealousy
- Narcissistic
- Compulsive
- Falls "instantly" in love
- Manipulative
- Does not take responsibility for own feelings or actions
- Needs to have control over others
- Socially awkward or uncomfortable.

The Policing UK website[20] goes further and gives examples of what stalking may include, these being,

- Regularly following someone
- Repeatedly going uninvited to their home
- Checking someone's internet use, email or other electronic communication
- Hanging around somewhere they know the person often visits
- Interfering with their property
- Watching or spying on someone
- Identity theft (signing-up to services, buying things in someone's name).

The office for National Statistics records National data for England and Wales in relation to Stalking, for the year in which Mary tragically died the majority of stalking victims are women and most stalkers are men. Three out of four stalking victims are stalked by someone they know; of these, 45 percent of stalkers are acquaintances of the victim and 30 percent were/are intimate partners[21].

[19] https://www.cps.gov.uk/legal-guidance/stalking-and-harassment
[20] https://www.police.uk/advice/advice-and-information/sh/stalking-harassment/what-is-stalking-harassment/
[21]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/stalkingfindingsfromthecrimesurveyforenglandandwales

Further contextual information

- On average victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help
- 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse
- Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women[22].

ALCOHOL- IN THIS CASE

Within her medical records it is noted that Mary, on occasions, was self-reporting that she was drinking up to a bottle of wine per night.

In 2006 the World Health Organisation (WHO) published a paper on 'Intimate partner violence and alcohol'[23]

In this paper they state that frequent heavy drinking can create an unhappy, stressful partnership that increases the risk of conflict and violence. On page three of this report there is a clear assertion that,

> *Experiencing violence within a relationship can lead to alcohol consumption as a method of coping or self-medicating.*

In terms of the impact of alcohol in relation to intimate partner violence, including coercive controlling behaviour, these can be wide ranging, including,

> *for the victim, health effects include physical injury (which for some women may lead to pregnancy complications or miscarriage), emotional problems leading to suicide, suicidal ideation and depression, and alcohol or drug abuse as a method of coping.*

In terms of policy this report states that,

> *Both the harmful and hazardous use of alcohol and intimate partner violence have been recognized internationally as key public health issues requiring urgent attention.*

It is evident from all the documentation provided to the Author that Mary drank alcohol regularly, however it appears that this is seen as an end game in its own right for her and could be seen as a coping mechanism. However, it is impossible to draw any conclusions in relation to Mary's alcohol consumption in its own right due to a lack of contextual information.

In their paper, 'Roles of Alcohol in Intimate Partner Abuse'[24], Alcohol Change published a very important key finding,

> *There were clear indications of intertwined cultural, sub-cultural, familial and contextual influences on gender and alcohol use, such that when women were drinking, they were held more accountable for any relationship conflict (victim blaming), whilst if men were drinking they were held to be less accountable (accused excusing).*

[22] SafeLives - https://safelives.org.uk/
[23] https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf
[24] https://alcoholchange.org.uk/publication/roles-of-alcohol-in-intimate-partner-abuse

The Author would draw the attention of the reader to this finding whilst reading the information which is contained in the section of this report relating to what was known by agencies.

Also of note is the current guidance from the Chief Medical Officer (UK), which states,

- The recommended maximum alcohol intake in the UK is no more than 14 units a week for both men and women, with two or more drink-free days in the week
- This was the recommended guidance during the timescale of this DHR
- Problem drinking is defined as regular consumption of alcohol above recommended levels.

It can therefore be deduced from the information collated during this Review that Mary was potentially exceeding the current guidance at the time of her death but on the evidence gathered and information obtained it is impossible to say if Peter's alcohol consumption was a contributory factor at the time of her untimely death.

DISSEMINATION

Initial dissemination of documents was restricted to Panel Members. The draft report was circulated for factual accuracy and proofing to the Panel.

The intended recipients of copies of the final, agreed, report, once approved by the CSP and Home Office Quality Assurance Panel, are listed at the end of the Review on page 36.

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2. BACKGROUND INFORMATION (THE FACTS)

FAMILY INFORMATION

Mary lived with her mother, father and brother in a 'Richmondshire Housing' rented premises (secure tenancy) belonging to Richmondshire District Council. The family had been resident here since December 2004.

As a young girl Mary attended a school which catered for students with 'additional needs' which were described as 'mild learning difficulties'. The family unit was described by those contacted in relation to this review as 'very close'.

On leaving school Mary entered employment and at the time of her death was working as a cleaner at two separate locations. Her employment consisted of an early morning (5.00am start) cleaning role at a local Health Centre, followed by an afternoon role at a local college.

Mary did not drive and used a pedal cycle to attend work and as her only form of transport.

INFORMATION FROM MARY'S FATHER

Mary's father describes her relationship with Peter as 'going fine' in the beginning but that overall, the family did not really take to Peter. He was older than Mary and this caused (undefined) issues.

In describing Mary her father stated,

"She was born with gills, she never stopped for breath."

He went on to describe his daughter as 'cheery and bouncy'.

He confirmed that Peter did visit the family home but did not really engage with anyone, preferring to play on his phone when he was there.

As a family they socialised together at the local Club, and Peter joined them on New Year's Eve in 2018. He recalled that Mary bought a bottle of wine to share with Peter. When it came to buying a second bottle Peter stated he couldn't afford to buy a bottle, and that he didn't like it anyway, this was after he had drunk half of the bottle that Mary had bought. He felt this was not right.

He went on to say that Mary enjoyed holidays and booked a spa holiday in Saltburn. Peter stated that he couldn't afford to go, so Mary went alone. She enjoyed it so much that she booked another break, this time to the Christmas market at Harrogate, but sadly didn't make it.

Although not entirely happy with the relationship, Mary's father was not aware of any concerns being raised or any issues.

After Mary ended the relationship, she told her father that she was tired of the number of texts she was receiving from Peter. Her father told her to tell Peter that if he didn't stop contacting her, she would be getting an injunction.

He believed that Mary was also seeing negative comments on social media from Peter's mother, so she talked about blocking phone numbers. He is not certain if this happened.

When spoken to Mary's father stated he,

***'felt that there was no sense that 'anything bad' was going to happen'*.**

What wider support and advice could have been made available to Mary was discussed and he stated that Mary was dealing with the relationship in her own way. He confirmed the last text she sent to Peter was,

"Just leave me alone please".

INFORMATION FROM FRIENDS [25]

Friends and colleagues of Mary described her as a breath of fresh air, being happy and bubbly. She is described as being a person who would do anything for anyone, being very kind. Mary was a person who took her work, and pride in her work, very seriously.

When Mary broke up with Peter, she expressed concerns to both work colleagues and friends from her Church that she was followed by him. She describes him casually bumping into her and trying to engage her in conversation, using an excuse that he would just casually meet her in public places, all in an attempt to convince her to resume their relationship. Mary would not entertain this idea.

Work colleagues noted that Mary would take her pedal bicycle into the health centre where she worked rather than lock it up outside after she finished the relationship with Peter, they believe that she did this to try to avoid being spotted by him. Mary also asked a male colleague from the college to stop and intervene if he could see that she had been stopped by a male (Peter) whilst she was on her way home from work.

After breaking up with Peter friends commented on how well Mary was looking, she seemed more confident, and had started to take more care of her appearance. She even began to increase her social circle through her local church.

MARY AND PETER'S RELATIONSHIP

Mary and Peter had been in a relationship for around 18 months prior to her death. Mary had previously worked at Tesco as a cleaner where she met Peter, but a change in management caused her to leave. Peter had worked previously at the same Tesco and was 45 years of age some 15 years older than Mary, and on one occasion waited for her to finish her shift and asked to start a relationship with her.

Initially the relationship between Mary and Peter appeared to go well, although Peter suffered from anxiety and depression. However, things deteriorated as the relationship continued and Peter became controlling displaying controlling behaviour towards Mary and it appears that as a result Mary suffered from depression.

Peter left his employment with Tesco, prior to his relationship with Mary and became unemployed, this is described by friends and relatives as causing contention between Mary and Peter. Mary continually encouraged Peter to find work however Peter was unable to do so and told a police witness that he,

'***wouldn't be told what to do by anyone'***.

Mary's father stated the relationship was fine at first however overall, the family didn't really take well to Peter.

Mary finally broke off the relationship around late August or early September 2019.

[25] Information obtained from Police statements from work colleagues and friends along with information from Mary's father.

Police inquiries established that the last telephone conversation between Mary and Peter took place at 07.26 hours on the 8th of September 2019 when she wrote to him, '**just leave me alone please'**, in a text message.

MARY'S RELATIONSHIP CONCERNS

Although after ending the relationship with Peter, Mary clearly had concerns about his behaviour and the way that he tried to interact with her, these concerns were never reported to the police. What is known is that Mary did say to Peter that she would inform the police of his actions if he did not leave her alone, unfortunately this seemed to enrage Peter and his attitude changed towards her at this time, becoming more verbally aggressive both in person and whilst attacking her on social media.

Mary never did inform the Police of her concerns; this has been looked into by the Panel, but no specific reason can be found for why this was the case. There are several possible reasons, for example lack of trust or inability to define clearly personally what was occurring (coercive control and stalking), but it would be pure conjecture to attribute any firm reason for this lack of reporting.

INFORMATION FROM MARY'S THERAPIST

Mary had sessions with a Cognitive Behavioural Therapist and during her first session Mary opened up to her about Peter. The therapist recalls this as,

> *It was only during our first session that Mary mentioned her ex-partner. Mary said she was feeling anxious at her home when her family were out, in case the ex-partner turned up so she would close the curtains or blinds. I asked Mary when she last saw her ex-partner and she said not for at least 3 weeks. I asked Mary if she needed any support such as calling the police. Mary said no that she had already threatened him with the police, which his mum was not happy about, as she had contacted Mary and told her not to threaten her son with the police. I asked Mary what she would do if the situation worsened and replied she would feel safer with the support of her family if she needed to call police.*

INFORMATION ACCESSIBILITY

Having heard the history of Mary's relationship with Peter and referencing the ToR put in place for this report, the Author conducted open source searching to establish if, should the same situation occur, family and friends could easily access information on how to report suspected domestic abuse, including stalking and harassment/coercive and controlling behaviour.

Screenshots of this open-source searching can be found at Appendix 3 of this report and are shown in a sequence of logical searches which could be made by any member of the public.

The image captures were of course, taken after the death of Mary, and it is impossible for the author to research what was available at the time of her tragic death. However, they are included to evidence and show the current position. Clarity of message is key and although the links give information regarding the need to call 999 in an emergency one can see how this route could be overlooked.

In summary it is felt that there is a significant amount of information both locally and nationally in relation to the subject of domestic abuse/stalking which is easily accessible through search engine research. However, for those with access issues and disabilities the websites can prove challenging.

The difficulty is in finding a website which makes it very clear what an individual should do including friends or family, once suspicions are aroused. There is no single format for Council websites, which of course would be impossible, yet a single, simple pictorial pathway may be viewed as more appropriate to assist reporting along with simplicity of message. The website usability.gov[26] states,

> *When writing for the web, using plain language allows users to find what they need, understand what they have found, and then use it to meet their needs. It should also be actionable, findable, and shareable.*

Going on to quote a study[27] by Jakob Nielsen which showed,

> *on the average webpage, users have time to read at most 28% of the words during an average visit; 20% is more likely*

It should be stressed that this issue is found when searching generally and is not a specifically North Yorkshire based issue, however overall, it can be viewed as confusing for members of the public attempting to gain assistance and help, with the agency websites not necessarily aligning if search links are followed through**.**

This issue is further exacerbated if the searcher, has learning difficulties or is not confident in the use of search engines.

THE DAY OF THE FATAL INCIDENT

On the morning of Wednesday the 9th of October 2019 Mary set off from her home address at 04.30 hours on her pedal cycle after saying goodbye to her father. She was in possession of her work tabard and her personal identification card for the health centre, she was wearing pink waterproof jacket and black waterproof trousers as the weather was inclement, along with her glasses, which were never recovered by the police.

At 07.47 hours on that day, just before Mary's shift at the health centre was due to end the National Health Service facilities manager made a phone call to Mary via her mobile phone. Mary's phone appeared to be switched off at this point. This call was made as Mary had not turned up for work that morning and this was very unlike her, she was described as never failing to attend. A further call by this manager was made to Mary at 1530 hours but again no reply was received.

At 1333 hours on the same day Mary's father contacted North Yorkshire Police to report that his daughter Mary was missing. He indicated that she had set off that morning to go to work as normal and that she also had a scheduled medical appointment that morning with a cognitive behavioural therapist which she had failed to attend. It was established that nobody had seen Mary or was able to make contact with her via her mobile phone since she had left home that morning, and she had not attended her second job at the college.

[26] https://www.usability.gov/how-to-and-tools/methods/writing-for-the-web.html
[27] https://www.google.com/search?client=safari&rls=en&q=Jakob+Nielsen&ie=UTF-8&oe=UTF-8

At 1643 hours on the same day a call was received by North Yorkshire Police via the 999 system from the mother of Peter. She told police, without any first-hand knowledge, what her son had told her about the events of the day.

Peter's mother told the 999 operator that her son had been camping out with his girlfriend and that they had been going for a walk that morning when his girlfriend, Mary, had fallen into the river. She stated that her son had pulled Mary out of the river and given her CPR, but he thought that she was dead. Peter's mother explained to the operator that this incident happened around 04.30 hours that morning, so some 12 hours prior to the call that she made.

She went on to state that Mary was in a tent, which her son had been using for camping, she said her son had taken Mary to the tent because they were both cold. This phone call from Peter's mother was described by the police operator as incredibly confusing and as a result they asked for Peter to come to the phone. Peter appeared to be upset and crying and provided an initial account to police.

Police attended the location where the tent was pitched as described by Peter, crossing a shallow stream to find the tent containing the naked body of Mary. It was at this point the police arrested Peter on suspicion of Mary's murder.

Peter refused to answer all questions when interviewed by the police. However, it was established via digital forensics that Peter had sent a message to a friend in the United States of America which stated,

'***goodbye I've killed Mary, handing myself in'***.

Peter was charged with the kidnap and murder of Mary on the 16th of October 2019 and was remanded in custody until his trial in 2020.

The jury took less than three hours to find Peter guilty of the kidnap and murder of Mary and he was sentenced at Teesside Crown Court on the 21st of November 2020 by Judge HHJ Ashurst, receiving a life tariff with a minimum term of 25 years.

Peter has never shown any remorse in relation to his actions towards Mary.

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3. ANALYSIS

WHAT WAS KNOWN TO SERVICES AND AGENCIES (IMR)

In the below section where there is no record relating to either Mary or Peter held by the agency, or unrelated records with no bearing on this Review a statement has been made to clarify this as 'no records'. This has been included to show that full research was conducted by all agencies.

This includes decisions made, any actions taken, if judgements were made.

Agencies were specifically asked by the Chair about immediate learning opportunities and to identify information relating to practice improvements. These are listed in section four of this report.

2017

North Yorkshire Police[28] (NYP)

No records

Tees, Esk and Wear Valleys NHS Foundation Trust[29] (TEWV)

Peter

On 11th May 2017 Peter was assessed by the local mental health team and it was recorded that he would receive counselling to explore the impact of a lifetime of negative relationships. It is recorded that Peter felt he had been unfairly treated and treated badly by women he had had relationships within adulthood.

It was also agreed that mindfulness Cognitive behavioural therapy (CBT) could be explored at the end of this counselling.

Prior to his discharge from this process on 14th December an AQ10[30] form was completed with Peter which indicated that a specialist diagnostic assessment should be considered to rule out if any of his social difficulties could be related to Autistic traits. At point of discharge Peter was the subject of a referral to the Tuke Centre[31] in York for assessment but this had a **12-month minimum waiting list.** It is unclear what was to be achieved from this referral. Peter was also signposted to self-help guides and information on mindfulness.

On discharge no safeguarding concerns were highlighted, his notes reference relationship difficulties but nothing was identified to instigate the use of Domestic Abuse procedures. All information from these sessions was communicated to Peter's GP.

Mary

No records

North Yorkshire Clinical Commissioning Group (NYCCG) - GP Services

Mary

No records

[28] https://www.northyorkshire.police.uk
[29] https://www.tewv.nhs.uk
[30] https://www.nice.org.uk/guidance/cg142/resources/autism-spectrum-quotient-aq10-test-pdf-186582493 - link to questionnaire
[31] The Tuke Centre is part of Retreat, York and offers assessment for Autism and ADHD amongst other services https://theretreatclinics.org.uk/adults/autism-adhd/

Peter

There is only one record in relation to Peter having contact with primary care services in this year. This relates to a discharge letter from the primary mental health team which states Peter attended seven sessions with a senior counsellor and resulted in an assessment of potential autism. It is noted that a full assessment would need to be conducted but the waiting list at this time was in excess of 12 months. Peter's discharge and assessment related to low mood and depression which was felt to be moderate to severe, and his anxiety levels were scored as severe. There was no indication of suicidal ideations and Peter was offered telephone and Internet based helplines to assist him. Peter is recorded as saying he was engaging with a job coach at the job centre and that he had a yoga mentor.

2018

North Yorkshire Police (NYP)

No records

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

No records

North Yorkshire Clinical Commissioning Group[32] (NYCCG) - GP Services

Mary

On the 7th of November 2018 Mary had an appointment with her GP to discuss anxiety, work related stress and was provided with a fit for work certificate to be reviewed in two weeks' time.

On the 4th of December 2018 Mary attended an appointment with the advanced nurse practitioner and presented with low mood and reported not being able to sleep. Mary reported that she lived with her mum and dad and had a good relationship with her mum who she was able to talk to it was explored if she had any self-harm or suicidal ideations and this was recorded as not present. Mary was recorded as appearing well dressed fluent in speech but became agitated when talking about her workplace. There is no reference in the notes relating to Mary's current sexual partner, and there was an opportunity given her recent diagnosis of anxiety and depressive disorder, along with her mild learning disabilities, to ask about this relationship in more detail.

Mary had two more appointments in December 2018 with the same advanced nurse practitioner and on the 28th of December Mary states she is ready to go back to work it is at this point that Mary is referred to the psychological therapy services and is prescribed Citalopram, which is an antidepressant.

Peter

[32] https://northyorkshireccg.nhs.uk

In 2018 Peter is noted as having seven interactions with this service the majority of which relate to issues not pertinent to this review, for example assistance with completing a Universal Credit form.

On the 12th of April Peter attended his GP practice for a physical health assessment and reported that he had a sexual partner at that time, but no further information was recorded, it is assumed that this is Mary.

On the 25th of April Peter again is shown in his GP health records having a face-to-face appointment and stating that he was having counselling again, unfortunately it is not recorded who is providing this counselling or any other details regarding it. It is therefore impossible to assess this interaction.

Between May and July 2018 Peter was accepted into the North Yorkshire autism service and requested 3 separate fit notes all of which were issued and noted mood disorder as the reason. There is no record in the notes to give context to this or to explain what this actually means.

2019

North Yorkshire Police (NYP)

On 07/05/2019 an unrelated report by Mary of Criminal Damage at her place of work is recorded

On 09/10/2019 Mary's father, reports her missing at 13:37hrs. This report was recorded as a High Risk[33] missing persons enquiry within the hour.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

Peter – no records

Mary

In January of this year Mary was referred by her GP for 'Improving Access to Psychological Therapy' (health mind services) relating to stress, low mood, and sleep issues. She was seen within time scales and is recorded as '*in a relationship'* but this was not explored.

Whilst awaiting treatment Mary was again referred to her GP for review by Adult Improving Access to Psychological Therapies (IAPT)[34]. An Early Intervention Psychosis (EIP) consultation took place, and it was agreed that a referral would be required to assess Mary further.

This referral was made 18 days later this delay cannot be accounted for and it is unclear what impact this had on Mary's treatment or risk assessment.

Some **six months later** Mary was assessed by the 'Early Intervention in Psychosis team' (EIP) on 11th June 2019, and it was recorded that she did not meet the criteria for first episode psychosis. At this time Mary was also assessed using the AUDIT-C[35] questionnaire in relation to her consumption of alcohol and was given associated advice. A risk assessment was

[33] https://www.college.police.uk/app/major-investigation-and-public-protection/missing-persons
[34] https://www.england.nhs.uk/mental-health/adults/iapt
[35] https://www.gov.uk/government/publications/alcohol-use-screening-tests

completed, and it is recorded that Mary had '*fleeting thoughts "visions" of self-harm and suicide*". In relation to this Mary named Peter and her family as protecting factors. It is unclear what exploration actually took place in relation to this risk. This information was relayed to Mary's GP and the IAPT services. Mary was subsequently placed on a waiting list for CBT.

On 18th September Mary began the first of three CBT sessions and alluded to the fact that she used alcohol as a coping mechanism to stressful situations. What is not clear is how this use of alcohol manifested itself in Mary.

In the first session Mary disclosed that,

> '*she had recently split up with her partner (Peter) and that she sometimes becomes concerned that he might be following her but could be being a bit paranoid even though he was cycling at the same time she was cycling to work'.*

The record goes on to state that Mary had spoken to Peter and told him to stop and she had warned him she would go to the police if he continued to follow her. She confirmed he had desisted in the last three weeks. **This is the first official record of stalking behaviour by Peter.** The clinical notes record that Mary felt confident to go to the police with the help of her family and she is further recorded as having capacity to do this. There is no record of Mary being offered any specific advice about stalking/harassment and there is no record of any follow up in relation to checking she had taken action.

This new risk was not escalated within the domestic abuse process in place, nor fully recorded.

Mary then failed to attend her 4th session with the clinical team and several attempts were made to contact her including an opt in letter which was sent for her continuation of treatment. It is unclear how many attempts were actually made.

<u>North Yorkshire Clinical Commissioning Group (NYCCG) - GP Services</u>

<u>Mary</u>

In 2019 Mary is recorded as having 19 separate interactions relating to her GP services.

January 2019 saw seven interactions with Mary, the majority of which relate to her low mood, associated treatment and appropriate referrals.

However, on the 12th of January 2019 Mary was seen by the out of hours GP regarding an acute stress reaction, it is unclear from the notes how this manifested itself but from the recorded documentation relating to protective factors and a safety plan being put in place for the weekend it is fair to assume that this related to self-harm in some way. Mary's personal GP was informed, and Mary was asked to follow up with this through her own practice in two days' time.

On the 28th of January 2019 Mary presented at the South Tees NHS Foundation Trust Accident and Emergency Department with an ankle injury, this was found to be a closed fracture. It is unclear how this injury occurred. Mary was to have follow up treatment in the fracture clinic and again on this day so her advanced nurse practitioner where she disclosed, she had started a new job and was feeling better about herself.

29th of January there was a letter from the hospital to the GP stating that the ankle injury had been caused by a fall from a bicycle. It is not clear how this fall came about.

February 2019 record 3 interactions with Mary relating to prescriptions, sick notes relating to the ankle fracture and on the 19th of February Mary's GP receives a letter which refers to a partner in Mary's life. This letter is from IAPT and states that Mary is not at risk to or from others.

On the 17th of April 2019 Mary attended a GP appointment and it is recorded in the notes that she was seen with her partner, what is not recorded is who this partner was, the demeanour of the couple and any of the relating factors to their relationship. Mary reports that she is drinking one bottle of wine per night and her medication is reviewed it does not appear on this occasion that an alcohol assessment was conducted, and no reason was given for why this drinking was occurring it is also unclear if her partner was joining her in this alcohol consumption. Mary was offered referral to Horizons[36] regarding her alcohol usage but she declined this offer.

In May of this year there are six interactions with Mary recorded including GP appointments both in person and by telephone and on the 29th of May 2019 Mary failed to attend an appointment for the first time.

The appointment that Mary attended on the 8th of May in person with her GP was an opportunity for her to be questioned about her relationship with her partner, this opportunity was missed. Routine Enquiry[37] questions could have been put to Mary as she attended alone on this occasion and a clear lack of professional curiosity is noted.

It is in this month that Mary is recorded as having,

> ***'learning difficulty but is able to attend consultations by herself and understand the conversation fully'.***

In June Mary again reports drinking most evenings, but caveats this by saying it is a bottle of low alcohol sparkling wine that she drinks.

On the 10th of June Mary's reported as doing well at her review appointment and is happy with her current medication, she reports she has a meeting with the mental health team the following day and discusses contraception.

The last interaction with this service for Mary was on the 3rd of September 2019 when she attended a GP appointment reporting pain behind her right ear. Her ear was examined and found to be normal, there was no evidence of further anxiety symptoms, and a review of her medication was conducted.

<u>Peter</u>

Peter was next noted in his records on the 27th of August 2019 as having not met the diagnostic criteria for autistic spectrum disorder. The letter received by the GP reported no risks of harm to Peter or others but did state that he was currently feeling upset due to the

[36] https://www.nyhorizons.org.uk

[37] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

break-up of his relationship with a long-term partner, again no details are recorded in relation to this but it is assumed that this is Mary.

OTHER FACTORS

HOUSING

Enquiries were also made with the Corporate Director of Operations in relation to any information the local Council's housing department may have held in relation to the family which was pertinent to this case.

After a thorough review of the records no information was found which had any bearing on this review.

MARY'S FAITH AND RELATIONSHIP WITH THE CHURCH

During panel discussions it became apparent that Mary was a regular attender at her local church, and this was confirmed by her father. As a result it was agreed that an approach would be made to the church to gain an insight into Mary's attendance and to see if she ever disclosed any issues relating to Peter to members of either the congregation or the officiates.

A meeting took place on the 8th of March with the parish Safeguarding Officer and the Parish priest. The following is a precis of the information obtained and gives an insight into the woman Mary was,

- Mary's mother attends church at times, but often works Sunday mornings at the local Co-Op. Mary's father attends the Wellbeing Café run by the church.
- Prior to her death Mary had started the Alpha course[38] and had expressed an interest in volunteering for the church.
- She was described as a "kind, thoughtful young woman". During her time attending the church (approximately 6 months), she had started "to flourish" and was described as having grown in confidence.
- Mary loved clothes and in particular handbags.
- She was described as having an 'innocence' about her.
- Mary had been confirmed into the church in the June prior to her death.
- Mary had described sometimes feeling alone and anxious during her early morning cycles to work. On one morning she had felt the presence of God, 'she saw a light' and felt reassured.
- Both the safeguarding officer and priest stated they had no sense that Mary was in any type of danger and confirmed that they were aware she had separated from Peter.
- The bishop had conducted Mary's funeral and was extremely supportive to the family. A community fund raising event took place and a memorial bench and planters were installed in the grounds of the church.

This meeting was not able to offer any further insight into Mary's experiences shortly before her death. It was confirmed that safeguarding procedures and training were in place

[38] https://alpha.org.uk – The Alpha course is an evangelistic course which seeks to introduce the basics of the Christian faith through a series of talks and discussions. It is described by its organisers as "an opportunity to explore the meaning of life".

(including the displaying of information posters relating to domestic abuse) but there was no indication that Mary was at risk.

MARY'S DIAGNOSIS RELATING TO LEARNING DIFFICULTIES

The Panel wished to explore when Mary had been officially diagnosed with learning difficulties, what these were and what professional support she was receiving in relation to this diagnosis, if any.

On making the relevant enquiries it was established that the current GP Practice have not been able to ascertain when Mary was diagnosed with a learning disability, as that information is not held by her current GP Practice.

Mary registered with her current GP practice on 29 Dec 2004, and the information requested regarding date of diagnosis would be within her paper records prior to 2004 which the current GP Practice do not have access to. That specific piece of information was not contained within the summary received by the current GP Practice when Mary first registered.

Due to this information not being readily accessible a further request was made by the Panel to further research hospital records as Mary attended a 'special school' which would indicate a formal diagnosis. It is now confirmed that the paper records are not accessible and therefore there is no further information available to this Panel in relation to Mary's diagnosis.

From a definition perspective a 'Special School' was defined as,

> *a school catering for students who have special educational needs due to learning difficulties, physical disabilities, or behavioural problems.*

Local authorities now refer to such establishments as Special Educational Needs (SEN) schools.

The terms 'learning disability' and 'learning difficulty' will be explored further in briefing sessions and future learning events relating to this review. 'Learning disability' constitutes a condition which affects learning and intelligence across all areas of life. 'Learning difficulty' constitutes a condition which creates an obstacle to a specific form of learning but does not affect the overall IQ of an individual (Mencap).

GENERAL ANALYSIS OF INFORMATION GATHERED

From medical records it is clear that Peter had a long history of persistent low mood, depression, anxiety, and work-related stress going back over a significant time, and prior to 2017 he was referred for therapy and counselling on at least nine occasions which although outside of the review time frame give an indication of his mental status.

Post 2017 the treatment that Peter received concentrated on anxiety management, managing his negative thoughts and encouraging positive action. There are no disclosures recorded in relation to Peter to any agency relating to domestic abuse either as a victim or a perpetrator.

From the information gathered in this review, and the discussions held during Panel meetings there is no evidence to show that Mary disclosed abuse to medical staff in any capacity, but she clearly was the victim of domestic abuse, coercive controlling behaviour and stalking. For example, her disclosures of being followed on her bicycle.

Unfortunately, within Mary's medical records there are no records in the notes to indicate that she was ever asked about her relationship status, domestic abuse or stalking directly by any practitioner. The names of attendees with Mary at appointments were not recorded.

What is clear is that information sharing took place at an appropriate level between medical services and practitioners.

VULNERABILITY AND THE IMPLICATIONS IN RELATION TO COERCIVE CONTROL/ STALKING

As previously stated, it has been impossible to gain access to Mary's initial diagnosis in relation to vulnerability and her 'special needs'.

However, it is possible to draw some basic inferences into how Mary was viewed by Peter and the role her vulnerability played in terms of her susceptibility to be the victim of controlling behaviour and stalking.

Vulnerability is defined by the Department of Health as,

> *a person aged 18 or over who may need community care services because of a disability (mental or other), age, or illness.*
>
> *A person is also considered vulnerable if they are unable to look after themselves, protect themselves from harm or exploitation or are unable to report abuse.*

Mary's vulnerability was discussed by the Panel, and it was clear that although Mary was significantly self-sufficient, she was unable to protect herself from harm or exploitation and certainly was unable to report the abuse she was receiving from Peter. However, she was able to articulate unwanted behaviours clearly, for example to her therapist.

The medical reports show that Mary was deemed as 'having capacity' to make her own decisions but due to a lack of professional curiosity and the recording of a rationale for this, it is not possible to say if a more robust approach could have assisted Mary in reporting Peter's behaviour, and therefore leading to her being offered a significantly different level of protection.

SPECIFIC ANALYSIS OF INFORMATION OBTAINED BY THE REVIEW

Indicators of Domestic abuse and/or stalking

Research papers and the National Institute of Clinical Excellence (NICE) record a number of potential indicators of domestic abuse which practitioners may witness and should use as a basis for professional curiosity these include the following,

- Symptoms of Depression
- Anxiety
- Post-Traumatic Stress Disorder (PTSD)
- Sleep disorders
- Alcohol and or other substance usage.

Apart from PTSD all these factors can be found within Mary's medical records, within the timeframes of this review. When this is coupled with the fact that Mary had mild learning disabilities and therefore may not have been able to recognise the signs of abuse herself the Panel feel it would have been appropriate for practitioners to be more intrusive and more inquisitive in relation to Mary's relationships.

OVERALL THEMES

- Lack of professional curiosity – particularly in relation to learning disability and the context of stalking, harassment, and domestic abuse
- Lack of professionals understanding of the Mental Capacity Act
- Lack of comprehensive note taking and the recording of decisions/rationales
- Lack of follow up to action identified – no plan, do, review of case notes
- Lack of timeliness in terms of referrals
- Lack of accessible and relevant information on websites and communication strategies, disguised compliance and domestic abuse, role of employers and church community (both places Mary was involved in) raising awareness of domestic abuse.

In relation to waiting times for autism assessments the Panel requested further information to be able to understand the local picture. Research was undertaken and nationally it was found that it is not possible to accurately compare waiting times for autism assessment with other areas due to the poor reliability of the information that is available. NHS Digital[39] do provide a platform for data comparison, however it is clear from looking at the tables that not all areas provide their information on the platform.

4. CONCLUSIONS and RECOMMENDATIONS

NEW INITIATIVES

[39] Autism Waiting Time Statistics - NHS Digital

Post Mary's tragic death several new initiatives have already begun within the North Yorkshire area and the panel felt it was appropriate to record these within the report for completeness. These initiatives were discussed by the Panel.

1. **Stalking Clinic Pilot**

The Scarborough multi-agency stalking clinic was launched initially in May 2020 as a six-month pilot scheme to support victims, reduce risk and bridge the gap of interventions with perpetrators to prevent stalking behaviours. The clinic focuses on high-risk cases and are attended by representatives from North Yorkshire County Council Children & Family Services, Scarborough Borough Council and Ryedale District Council Housing & Homeless Support, North Yorkshire Police, IDAS, Foundation UK, North Yorkshire Horizons, and probation officers who are involved with each individual case. To date, the clinics have discussed over 25 different perpetrators. It is unclear at this time when this pilot is to be reviewed and what measures of success have been put in place.

2. **Specialist Stalking Team**

In 2021 North Yorkshire Police established a new dedicated Stalking Team to better identify and address all forms of stalking at the earliest opportunity. The Team is comprised of a Detective Constable with extensive experience of investigating stalking offences and two Stalking Victim Support Officers who offer bespoke personal safety planning and implement specialist safeguarding measures as necessary to reduce further risk of harm.

In addition to reviewing all related incidents to ensure stalking concerns are more effectively identified and managed, the Team offer 'Stalking Clinics' for officers leading on current stalking & harassment investigations can discuss any concerns. The Team ensures any lessons learnt are acted upon in a timely manner and an effective problem-solving approach is embedded across the force in respect of stalking.

The Team is also responsible for the supervision and monitoring of perpetrators who are subject of Stalking Prevention Orders, conducting intelligence checks as required to ensure positive action and effective responses within the wider criminal justice system are delivered.

In January 2022, the Team was strengthened by a specialist Stalking Perpetrator Support Worker employed by Foundation UK as part of the commissioned +Choices: Support Services for Adult Perpetrators to specifically engage with perpetrators of stalking and support them to complete a bespoke behavioural change programme.

3. **North Yorkshire – Local Picture in relation to Autism services**

NHS North Yorkshire CCG in partnership with NHS Vale of York CCG have recently undertaken a procurement for the adult Autism assessment and diagnosis service to improve quality, improve efficiency and improve the outcomes for patients. The newly procured service commenced on 1st April 2022.

In preparation and in parallel, additional funding was agreed to deliver a waiting list initiative as the long waiting times and list was recognised as an unacceptable position. The waiting list initiative should have reduced the waiting time from approximately 12 months to around 6 months.

However, over the last 12 months demand has significant increased and in some areas is double to what was being seen prior to the pandemic. Although the procurement was based on the level of demand at the start of the project there is now a gap between capacity and demand meaning that the waiting list is expected to continue to grow. The CCG continues to work hard with the provider to look at any further efficiencies and processes to make sure that those patients that have waited the longest and/or have the greatest need are seen first. The new service also offers support to patients who are on the waiting list.

IDENTIFIED GOOD PRACTICE/ FUTURE OPPORTUNITIES

Although not in itself an identified piece of good practice it should be recorded that this area in North Yorkshire is currently undergoing a process of Local Government Reorganisation which is believed to offer an opportunity for partnership agencies and associated support mechanisms to work more closely together. A local consultation exercise has already taken place and it may be appropriate for this review to feed into this reorganisation via the Community Safety Partnership. This reorganisation will encompass Craven District Council, Harrogate Borough Council Richmondshire District Council, Ryedale District Council, Scarborough Borough Council, Selby District Council and North Yorkshire County Council.

This is an opportunity to strengthen and ensure join up of services for the most vulnerable and at risk in the community.

LESSONS LEARNT

NHS England currently request that all deaths of individuals with a learning disability and/or autism are referred to the learning disability mortality review programme (LeDeR). The purpose of this review programme is to improve care, reduce health inequality and prevent people with a learning disability dying sooner than the general population by learning lessons and changing practice.

This programme is now in its fifth year. Established in 2017 and funded by NHS England and NHS Improvement, Learning from Lives and Deaths (LeDeR) is a service improvement programme working to: improve care, reduce health inequalities, and prevent early deaths for people with a learning disability and people with autism. People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes to identify good practice and what has worked well, as well as where improvements in the provision of care could be made. Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally. Every person with a learning disability whose death is notified to LeDeR will have an initial review of the health and social

care they received prior to their death. Reporting is not mandatory, but it is advised and encouraged.

None of the professionals who were made aware of Mary's death reported it to LeDeR but this was rectified when the Independent Management Review was completed. The local area contact for the programme is aware of the findings from the Domestic Homicide Review.

NHS North Yorkshire Clinical Commissioning Group (CCG) have delivered the programme for the North Yorkshire and York area since its inception. The responsibility for the programme will transfer to the Integrated Care Board (ICB)/Integrated Care System (ICS) from 1 July 2022. The first combined Annual Report for the six CCGs in Humber and North Yorkshire for 2021/22 will be published on the website from July 2022[40]

It is important that all opportunities for learning are exploited to the maximum.

SPECIFIC LEARNING AND ACTIONS REQUIRED

1. TEWV

What is stalking behaviour and identification?

On disclosing stalking behaviour by Peter, a further risk assessment should have been recorded within the safety summary of Mary's notes. This would have been in line with the harm minimisation policy but did not occur. These safeguarding concerns should also have been recorded inclusive of all evidence provided by Mary and a safety plan put in place with rationales for decisions made as per the domestic abuse procedure. This did not occur, and if it had taken place would have given further opportunity to explore and assess the risk to Mary and effectually managed the ongoing situation, provide relevant ongoing support, and inform future potential interventions. At this point there would also have been an opportunity to escalate to other agencies which was not taken.

This is clearly a learning point in relation to recordkeeping and risk assessments. There is no indication that had this taken place Mary would still be alive today.

a) All risks identified within a patient assessment should be fully documented within that patient safety summary and reviewed as per the harm minimization policy, at a supervisory level.

Staff should consider the safeguarding adults procedure and domestic abuse procedure when a risk is identified by either a professional or a victim and recorded appropriately. Records

[40] Humber & North Yorkshire Health & Care Partnership (humberandnorthyorkshire.org.uk)

should give comprehensive information regarding concerns, be clear in the decisions that are to be made and explain fully the rationale why action is taken or not taken.

RECOMMENDATIONS

1. Training

That primary care providers receive additional training to raise awareness of the potential indicators of domestic abuse, and this should encompass when they should ask routine inquiry questions of their patients, with reference to those individuals who may lack the capacity to identify or understand an abusive relationship for themselves.

2. Community Curiosity

To ensure that partners' public facing websites contain clear, accessible information on recognising domestic abuse, stalking behaviour and coercive control.
To target the promotion of an employer workforce Domestic Abuse Charter. This should include key partners of North Yorkshire Domestic Abuse Local Partnership Board and Community Safety Partnership. Opportunities should also be sought within the private sector, including Mary's employers.

3. North Yorkshire Domestic Abuse Local Partnership Board to develop a multi-agency communications plan

This plan should include the effective dissemination of any new initiatives (both local and national). The plan should also include an engagement strategy with local communities, to ensure local resources (posters, leaflets) are disseminated in community venues, including churches. The local area where Mary lived should be a 'pilot' area for this engagement focus. Within an agreed timeframe, a roll out of the strategy should be implemented across the county.
Further community initiatives should be explored with local providers e.g. IDAS. The barbers' initiative[41] should be reviewed and developed for hairdressers. Mary regularly went to her local hairdressers. Again, a 'pilot' in Mary's local area, with a wider roll out in due course.

4. Professional Curiosity

Previous domestic homicide reviews in North Yorkshire have identified the need for professionals to maintain accurate recording and action, with a 'plan, do and review' approach. The review for Mary identified this as an area for improvement. Members of North Yorkshire Domestic Abuse Local Partnership Board and Community Safety Partnership will be required to provide assurance statements on the standards and approaches within organisations.
A multi-agency training programme to be developed to enhance 'professional curiosity' in the context of domestic abuse.

5. Multi-agency Awareness of Police Stalking Team

North Yorkshire Police have established a new dedicated Stalking Team to better identify and address all forms of stalking at the earliest opportunity. The Team has extensive experience of investigating stalking offences and two Stalking Victim Support Officers who offer bespoke personal safety planning and implement specialist safeguarding measures as necessary to

[41] IDAS Barbershop Ambassadors

reduce further risk of harm. This review has identified stalking and harassment as a factor in Mary's experience, although she did not state this term.
The need for multi-agency partners to be aware of this team is important, therefore, this review recommends the police raise awareness amongst partners about this team, its role and what support can be offered to partners and/or victims.

6. All Partnerships Websites

Mary had a learning disability and the questions relating to accessibility and understanding of information (had she accessed) linked to domestic abuse and themes such as stalking, harassment, coercive and controlling behaviour were raised. This review recommends all partners review their websites to ensure all have accessible language **that includes everyone**. People can feel excluded when they don't understand words or phrases that results in language being used in ways that pose challenges for those with access challenges. All websites need to be updated with clear and easily accessible information and language to ensure access for all, especially those with learning difficulties and/or disabilities. This should include use of simple, descriptive section headings, use of images, videos, short paragraphs, and ordinary familiar words that does not include the use of acronyms and jargon, to explain domestic abuse themes highlighted within this review.

The performance group of North Yorkshire Community Safety Partnership will monitor the implementation of these recommendations.

****

6. GLOSSARY

AAFDA	Advocacy After Fatal Domestic Abuse
ASC	Adult Social Care

CJSM	Criminal Justice Secure Email
CCB	Coercive Controlling Behaviour
CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DA	Domestic Abuse
DHR	Domestic Homicide Review
DASH	Domestic Abuse Stalking and Honour Based Violence Safeguarding Risk Assessment
GPMS	Government Protective Marking Scheme
IMR	Individual Management Reviews
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference

7. DISTRIBUTION LIST

Name	Partnership/ Organisation
Via Odette Robson, Head of Safer Communities, NYCC Chair- Assistant Chief Constable North Yorkshire Community Safety Partnership	North Yorkshire Community Safety Partnership
Via Sheila Hall, Head of Engagement and Governance, NYCC Chair- Independent Chair	North Yorkshire Safeguarding Adults Board
Via Odette Robson Chair- Independent Chair	Domestic Abuse Local Partnership Board
Via Odette Robson Council Leader	Portfolio Lead Cllr Carl Les (North Yorkshire County Council Leader)
Via Odette Robson Chief Executive	Richard Flinton (North Yorkshire County Council)
Via Odette Robson Chief Executive	Tony Clark (Richmondshire District Council)
Sarah Arnott Commissioning and Partnership Manager	Office of the Police, Fire and Crime Commissioner for North Yorkshire
T/ Det Supt Fiona Wynne Head of Safeguarding	North Yorkshire Police (DHR Panel rep)
Colin Dales Corporate Director (Operations)	Richmondshire District Council (DHR Panel rep)
Karen Agar Associate Director of Nursing (Safeguarding)	Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust (Mental Health Trust) (DHR Panel rep)
Christine Pearson Designated Nurse, Safeguarding Adults	NHS North Yorkshire CCG (DHR Panel rep)
Via Odette Robson Domestic Abuse Commissioner- Nicole Jacobs	Office of the Domestic Abuse Commissioner

Appendix 1

TERMS OF REFERENCE

Terms of Reference for Review

Panel considerations

1. Could improvement in any of the following have led to a different outcome, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any relevant referrals. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency.

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

7. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

<u>Questions to be discussed</u>

1. What appears to be the most important issues to address in identifying the learning from this specific homicide? How can the relevant information be obtained and analysed?

2. Which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have come into contact with the victim or perpetrator but might have been expected to do so? For example, victims may come from communities who may find it difficult to engage in services e.g. refugees, the disabled etc., and consideration should be given on how lessons arising from the DHR can improve the engagement with these communities.

3. How will the DHR process dovetail with other investigations that are running in parallel, such as an NHS investigation, a criminal investigation or an inquest? For example, would running a DHR and Mental Health Investigation or Safeguarding Adults Review in parallel be more effective in addressing all the relevant questions that needs to be asked, ensuring staff are not interviewed twice and that there are individuals who sit on both panels to ensure good cross communication? Is the duty of candour principle relevant? How will the Review take account of a coroner's inquiry, and/ or criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process? It will be the responsibility of the review panel chair is made with the chair of any parallel process.

4. Should an expert be consulted to help understand crucial aspects of the homicide?

5. Over what time period should events in the victim's and perpetrator's life be reviewed taking into account the circumstance of the homicide i.e. how far back should enquiries cover and what is the cutoff point? What history/ background information will help to better understand the events leading to the death?

6. Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

7. Did the victim have any contact with a domestic violence and abuse organization, charity or helpline? How will they be involved and contribute to the process? Helplines, charities and local specialist domestic abuse services, including refuges, can be a source of information, although the disclosure of information about perpetrators may be subject to legal considerations.

8. How should family members, friends and other support networks (for example, co-workers and employees, neighbours etc.) and, where appropriate, the perpetrator contribute to the review (including influencing the terms of reference) and who would be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of the possible conflicting views within the family?

9. How should matters concerning family and friends, the public and media be managed before, during and after the review, and who takes responsibility for this?

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse.

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system.

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned.

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences.

e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010.

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level.

h. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations.

Definition of Domestic Abuse
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

APPENDIX 2

INDEPENDENCE STATEMENTS

Chair of Panel

Jasvinder Sanghera was appointed by North Yorkshire CSP as Independent Chair for this DHR Panel/Review.

She has extensive experience in Safeguarding and currently sits on the Independent Safeguarding Board for the Church of England. She has completed the Home Office DHR training and is experienced at giving expert witness testimony in Courts relating to Domestic Violence and Safeguarding.

She has no connections professionally with the North Yorkshire CSP area and is totally independent.

Author

Helen Collins was appointed by North Yorkshire CSP as Independent Author for this DHR Panel/Review and is the author of this report. She is a former police officer with 30 years operational service. She served mainly as a detective in both specialist (Public Protection and Major Crime) and generalist investigation roles and was head of Crime for Surrey Police.

As Head of Public Protection, she oversaw the introduction of both MARAC and MAPPA processes within Surrey

As Head of Crime, she was responsible for the deployment of some 1500 police and civilian staff on a daily basis dealing with all serious and specialist crime investigations and operations in Surrey including homicide, armed robbery, kidnap, fraud and abuse. She also has a background in counter terrorism operations from a Firearms Command perspective.

As Temporary Assistant Chief Constable in Surrey she was also responsible for all matters pertaining to Community Policing and customer service and sat on the Corporate Parenting Board for Surrey County Council.

Helen has since set up his own company to provide public service consultancy and investigative expertise in relation to complex and historic investigations within the public sector.

She has never worked within the North Yorkshire CSP area and is totally independent.

Administrative support to Panel

The administrative support for this review came from the Safer Communities Team, within North Yorkshire County Council. The team supports all functions of North Yorkshire Community Safety Partnership. Odette Robson, Head of Safer Communities has supported the processes for all the Domestic Homicide Reviews that have been commissioned, developed and implemented by North Yorkshire Community Safety Partnership.

APPENDIX 3

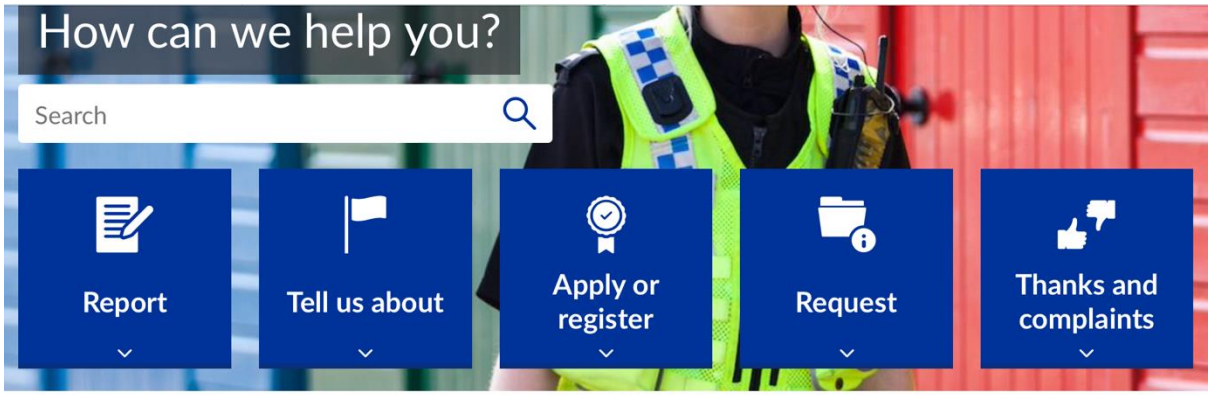
Screenshot 1

This shot shows the front page of the North Yorkshire Council site[42]. It is noted that there is no public safety information

[42] https://www.northyorks.gov.uk/

Screenshot 2

This screenshot is the front page of North Yorkshire Police.[43] Here it can be seen that there is a section on 'Violence against women and girls, when following this link one is directed to the page captured in screenshot 3.



From North Yorkshire Police

Report crime online

If you've witnessed or been the victim of crime please report it to us. Reports are dealt with by our control room in exactly the same way whether you report it online or call 101.

Online service

Latest news

What's happening in your area? We'll keep you updated about crime appeals, missing people, court results and more. Get the latest news, straight from us.

News

Safeguarding Week

An extensive programme of learning events, seminars and interactive sessions which all underpin this year's theme - 'Safeguarding is everybody's business'.

News

Report incidents on the roads

If you've been involved in a collision, or think you might have witnessed an offence on the roads, report it using our simple online tool.

Online service

Support for victims and witnesses

As a victim of crime or someone who has witnessed a crime, there are things you can expect from the police and criminal justice system. Find out how you can access support.

Advice

Violence against women and girls

Find out how we're helping women and girls to feel safe and be safe.

Campaigns

Jobs & volunteering

Join us! You'll be working alongside colleagues who are enthusiastic, professional and committed to the safety and well-being of the people of York and North Yorkshire.

Careers

[43] https://www.northyorkshire.police.uk

Screenshot 3

Helping women and girls to feel safe and be safe

In December 2021 the National Police Chiefs Council (NPCC) published Year 1 of a three-year national framework setting out their approach to policing violence against women and girls.

We welcomed and fully support the national framework.

Violence against women and girls continues to take place and the harm caused to all survivors, their families and society is significant.

North Yorkshire Police has already adopted 'violence against women and girls' as a strategic priority and recognised misogyny as a hate crime. We have a raft of initiatives, internal and external, which demonstrate our commitment to develop our staff and to investigate, bring offenders to justice and safeguard victims.

We know that we need to do more to eliminate violence against women and girls. To remove the harm that blights our society.

We have the power, responsibility and opportunity to prevent and to reduce harm. Through this strategy we set out our approach to ensuring every woman and girl in North Yorkshire feels safe and is safe. We are restating our commitment to delivering against he areas of focus set out by the NPCC and how we will go further to demonstrate that 'We care'.

Eliminating violence against women and girls will require a collaborative solution because it is a societal problem. We are committed to making the difference that the public, especially women and girls, and our partners, expect from us as their police service.

Our strategy

- We will demonstrate how we are meeting the overarching objectives of the NPCC framework
- We will be public facing, to ensure that:
  - the public are aware of the work that we are doing
  - women and girls are consulted on how we develop and deliver our services
  - we know that what we are doing is improving the safety of women and girls
  - those who are unwilling to report their fears or experience of crime to the police can still access our services through third party support
- We will continue to develop effective working relationships with our partners and relevant charities in this sector to better support women and girls to help them to feel safe and be safe
- We will develop our culture to provide an exemplary work environment that demonstrates the best of professional policing standards

Working with our **Police, Fire and Crime Commissioner** we will establish a systematic approach to surveying the public and tracking the level of public confidence and trust in North Yorkshire Police.

Definition of Violence against Women and Girls, July 2021, HM Government:

> *The term 'violence against women and girls' refers to acts of violence or abuse that we know disproportionately affect women and girls. Crimes and behaviour covered by this term include rape and other sexual offences, domestic abuse, stalking, 'honour'-based abuse (including female genital mutilation forced marriage, and 'honour' killings), as well as many others, including offences committed online. While we use the term 'violence against women and girls', throughout this Strategy, this refers to all victims of any of these offences.*

Our approach

- Build public trust and confidence in policing
- Relentlessly pursue perpetrators
- Create safer spaces

Downloads

PDF Helping women and girls to feel safe and be safe.pdf
110KB

More information

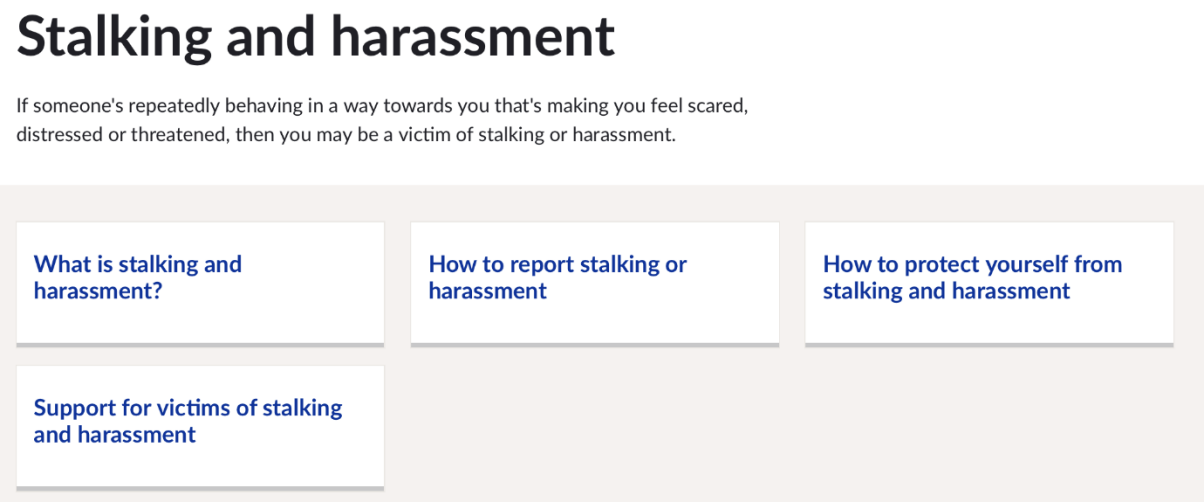
Violence Against Women and Girls: Our commitment as a new national framework is launched

Request information under Clare's Law: Make a Domestic Violence Disclosure Scheme (DVDS) application

StreetSafe

Screenshot 4

On following the link related to Stalking one is taken to the following site.



The advice on reporting is as per the below screenshot 5.

Screenshot 5

It is only at this point that the 999 and 101 call number are referenced. If one searches 'How to report stalking in North Yorkshire' this page is also displayed, however any victim would have to identify the conduct being experienced as stalking.

How to report stalking or harassment

If you, or someone you know, has been a victim of stalking or harassment there are a few different ways you can report it to the police. We understand it can be difficult. Our officers and partner organisations are here to listen and work together to support you in any way we can. Importantly, your information could help us bring the offender to justice and make sure you, and other people in a similar situation, are kept safe.

Is it an emergency?

Is someone in immediate danger? Is a crime taking place or has one just happened? If so, **call 999 now** and ask for the police. If you're deaf or hard of hearing, use our textphone service 18000 or text us on 999 if you've pre-registered with the emergencySMS service.

Report online

Call 101

If you'd like to talk to someone, our national non-emergency telephone number is staffed 24/7. Call us on 101 and report what happened or just get some advice.

Visit a police station

If you'd like to speak to an officer in person, we can provide a safe and comfortable environment at any of our police stations.

Police station finder

Find your nearest police station or contact point using the search box below.

Enter a postcode, street address or area.

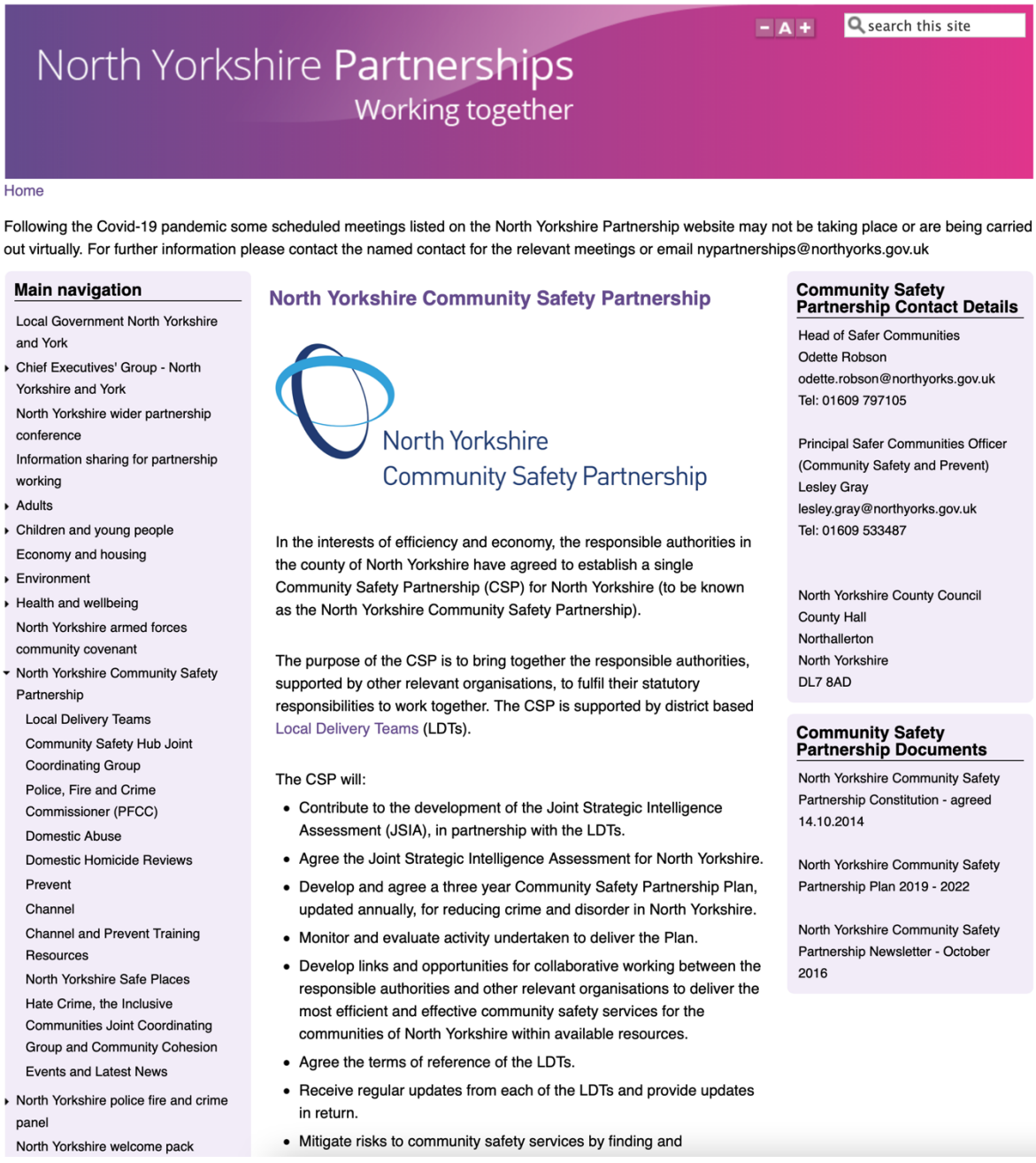
eg E14 1SE

or

Use current location

Screenshot 6

This is the information displayed when searching for the North Yorkshire Community Safety Partnership. As can be seen this is very 'word' heavy and Domestic Abuse assistance is not prominent.



North Yorkshire Partnerships
Working together

search this site

Home

Following the Covid-19 pandemic some scheduled meetings listed on the North Yorkshire Partnership website may not be taking place or are being carried out virtually. For further information please contact the named contact for the relevant meetings or email nypartnerships@northyorks.gov.uk

Main navigation

- Local Government North Yorkshire and York
- Chief Executives' Group - North Yorkshire and York
- North Yorkshire wider partnership conference
- Information sharing for partnership working
- Adults
- Children and young people
- Economy and housing
- Environment
- Health and wellbeing
- North Yorkshire armed forces community covenant
- North Yorkshire Community Safety Partnership
  - Local Delivery Teams
  - Community Safety Hub Joint Coordinating Group
  - Police, Fire and Crime Commissioner (PFCC)
  - Domestic Abuse
  - Domestic Homicide Reviews
  - Prevent
  - Channel
  - Channel and Prevent Training Resources
  - North Yorkshire Safe Places
  - Hate Crime, the Inclusive Communities Joint Coordinating Group and Community Cohesion
  - Events and Latest News
- North Yorkshire police fire and crime panel
- North Yorkshire welcome pack

North Yorkshire Community Safety Partnership

North Yorkshire
Community Safety Partnership

In the interests of efficiency and economy, the responsible authorities in the county of North Yorkshire have agreed to establish a single Community Safety Partnership (CSP) for North Yorkshire (to be known as the North Yorkshire Community Safety Partnership).

The purpose of the CSP is to bring together the responsible authorities, supported by other relevant organisations, to fulfil their statutory responsibilities to work together. The CSP is supported by district based Local Delivery Teams (LDTs).

The CSP will:

- Contribute to the development of the Joint Strategic Intelligence Assessment (JSIA), in partnership with the LDTs.
- Agree the Joint Strategic Intelligence Assessment for North Yorkshire.
- Develop and agree a three year Community Safety Partnership Plan, updated annually, for reducing crime and disorder in North Yorkshire.
- Monitor and evaluate activity undertaken to deliver the Plan.
- Develop links and opportunities for collaborative working between the responsible authorities and other relevant organisations to deliver the most efficient and effective community safety services for the communities of North Yorkshire within available resources.
- Agree the terms of reference of the LDTs.
- Receive regular updates from each of the LDTs and provide updates in return.
- Mitigate risks to community safety services by finding and

Community Safety Partnership Contact Details

Head of Safer Communities
Odette Robson
odette.robson@northyorks.gov.uk
Tel: 01609 797105

Principal Safer Communities Officer (Community Safety and Prevent)
Lesley Gray
lesley.gray@northyorks.gov.uk
Tel: 01609 533487

North Yorkshire County Council
County Hall
Northallerton
North Yorkshire
DL7 8AD

Community Safety Partnership Documents

North Yorkshire Community Safety Partnership Constitution - agreed 14.10.2014

North Yorkshire Community Safety Partnership Plan 2019 - 2022

North Yorkshire Community Safety Partnership Newsletter - October 2016

Appendix 4

North Yorkshire
Community Safety Partnership

Domestic Homicide Reviews commissioned by North Yorkshire Community Safety Partnership (Published reports are available via www.nypartnerships.org.uk/dhr) North Yorkshire Community Safety Partnership have amalgamated the action plans from previous domestic homicide reviews into one multi-agency action plan. This is routinely scrutinised by the performance group of the CSP, which then accordingly reports to the strategic partnership. The Partnership are seeking assurance that although each of the cases have had different circumstances, there is a constant review of the learning and partners remain accountable for emerging multi-agency themes. The specific actions relating to 'Emma' are highlighted.

Julie (March 2018) Julie was an intelligent and professional woman who was killed by her ex-husband. There were at least three previous episodes of strangulation perpetrated on Julie by Marcus before he finally killed her by strangulation. The review noted the control exercised by Marcus ranged from extreme violence, to threats against her family to his own attempts at suicide.

(Published)

What Difference this Review and Action Plan Makes to Local Arrangements?

- An effective multi-agency workforce training/ communications strategy. Including stalking and harassment, controlling and coercive behaviour.
- Detailed multi-agency training plan being developed that will include face to face training, webinars, podcasts etc. Differentiated according to different needs within the multi-agency workforce.
- Re-establishment and development of multi-agency Domestic Abuse Champions and Domestic Abuse Forums, across the county and City of York.
- Review of MARAC arrangements across North Yorkshire and York. Ensuring consistency across the geography and increased partners' accountability and ownership.

- Improved practice and multi-agency arrangements; safe and effective use of 'flagging systems', face to face contact with high risk victims.
- Develop better links with the Local Criminal Justice Board, MAPPA Strategic Management Board.
- Large scale multi-agency briefings are a useful opportunity to share current picture of domestic abuse and receive direct feedback from front-line practitioners on the arrangements.

Dianne (September 2018) Dianne was 70 years old at the time of her death. She had been in a relationship with her female friend for over 30 years. Although Dianne chose to disclose the true nature of her relationship to some organisations, she did not divulge the intimacy of their relationship to other organisations. This meant she was not identified as a victim of domestic abuse and this subsequently prevented her from accessing the most appropriate services. **(Published)**
What Difference this Review and Action Plan Makes to Local Arrangements?

- Further use of multi-agency workforce training/ communications strategies. This will include action focused on
  - Effective use of risk assessments
  - Enhanced understanding of domestic abuse, including within same-sex relationships and for older people
  - Enhanced identification of psychological and financial abuse, harassment and coercive control.
  - Improved understanding of potential 'impacts' e.g. use of alcohol, ACEs
- Detailed multi-agency training plans will be reviewed and developed further. Delivery will include face to face training, webinars, podcasts etc. Delivery will be differentiated according to different needs within the multi-agency workforce strategy.
- Strengthening established multi-agency arrangements, Namely, Domestic Abuse Champions and Domestic Abuse Forums across North Yorkshire and City of York.

Emma (September 2019) Emma was vulnerable in many ways. Her vulnerabilities included an adverse childhood experience, mental health problems, a learning difficulty and a physical disability. 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. **(Published)**
What Difference this Review and Action Plan Makes to Local Arrangements?

- Further use of multi-agency workforce training/ communications strategies. This will include action focused on

  - The importance of professional curiosity and avoiding unconscious bias. Exploring the nature of the relationships and any history
  - Use, provision and application of the Care Act 2014
  - Appreciation of the vulnerabilities around learning difficulties and mental health, and the impact on the recognition of domestic abuse. Ensuring practitioners understand the impact and where support can be sought
  - Raising awareness of the impact of economic abuse (featured in previous reviews and previous training has been provided
- Enhanced community safety hub model with effective performance managements around partners' attendance, engagement and accountability. Ensuring that domestic abuse is identified and appropriate action, signposting takes place at the earliest opportunity.

Single agency recommendation- TEWV (Tees, Esk and Wear Valley NHS Trust) **Identifying stalking behaviour** On disclosing stalking behaviour by Peter, a further risk assessment should have been recorded within the safety summary of Mary's notes. This would have been in line with the harm minimisation policy but did not occur. These safeguarding concerns should also have been recorded inclusive of all evidence provided by Mary and a safety plan put in place with rationales for decisions made as per the domestic abuse procedure. This did not occur, and if it had taken place would have given further opportunity to explore and assess the risk to Mary and effectually managed the ongoing situation, provide relevant ongoing support, and inform future potential interventions. At this point there would have also been an opportunity to escalate to other agencies which was not taken. This is clearly a learning point in relation to recordkeeping and risk assessments. There is no indication that had this taken place Mary would still be alive today.
TEWV has undertaken recent improvement work to ensure they have robust systems in place to comprehensively assess, mitigate, record and review patient risk • The functionality of PARIS has been improved • Improved the use of the safety summary • This is now the 'go-to' place to understand the patient's risk and how we work together to maintain safety. IAPT (Improving Access to Psychological Therapies programme) record a version of risk within this section • Reviewed the Harm Minimisation Policy in light of the safety summary and safety plan changes • E-learning training has been mandated across the Trust for all clinical staff with supplementary training videos

- Domestic abuse was, and is, incorporated into TEWV safeguarding training which is mandatory to all Trust staff at a level suitable to their role. Since Sept 2020 safeguarding training is now mandated every 3 years as part of new joint (Adult/ Child) safeguarding training packages
- TEWV also offer training in Basic Awareness of Domestic Abuse to all staff on a non-mandatory basis
- Both TEWV Safeguarding Adults procedures and the Domestic Abuse procedures have been reviewed in 2020 and are presented in a way which makes it operationally easier to follow the process
- A briefing with these learning points will be circulated across IAPT services

Single- agency recommendation 1. Training
That primary care providers provide additional training to raise awareness of the potential indicators of domestic abuse, and this should encompass when they should ask routine inquiry questions of their patients, with reference to those individuals who may lack the capacity to identify or understand an abusive relationship for themselves.

Scope of Rec	Action to take	Lead agency	Key milestones achieved in enacting recommendations	Target date	Completion date
Single Agency	**Hot Topics training 2019/20** – monthly delivery of session to primary care practitioners which covered Domestic Homicide Review and learning from 'Julie' – awareness of DASH risk assessment and referral to MARAC. = 744 attendees **Hot topics training 2020/21 -** monthly delivery of session to primary care practitioners which covered Domestic Abuse: stalking and harassment, inc. Alice Ruggles film, impact on victims, actions for primary care and advice for victims, SPOs & awareness of national stalking helpline. = 690 attendees **February 2022** – Domestic Abuse Policy written and shared for use by Primary Care/GP Practices This is a new document which details the standard guidance for General Practice in North Yorkshire and York and provides clear guidance for staff in dealing with cases of domestic abuse. Sent to all GP practices in North Yorkshire and York	ICB Primary Care and Designated Professionals Safeguarding Team	**Hot Topics training 2019/20** **Hot topics training 2020/21** **February 2022** – Domestic Abuse Policy written and shared for use by Primary Care/GP Practices. An audit of the uptake/ use by primary care of the DA policy launched Feb	**February 2022** **Audit report and action March 2023**	**March 2020** **March 2021** **February 2022**

	Head of Safer Communities, NYCC attended the Scarborough and Ryedale Practice Learning Time session and presented on DHR learning specifically for GPs on the 7th July 2022: 50 GP attendees Multi-agency offer re: DA training from IDAS sent to primary care on 10th November 2022. Foundation (+Choices) offer of DA training re: perpetrators was sent to primary care safeguarding leads 16th November 2022. **Hot topics training 2022/23 -** monthly delivery of session to primary care practitioners which covered key points of Domestic Abuse Act for primary care; coercive control; potential indicators; targeted clinical inquiry based on presentation; how to respond; DA services and resources. = 608 attendees so far (4 sessions still remaining) **Hot topics training 2023/24 –** will include learning from 'Mary' with reference to those individuals who may lack the capacity to identify or understand an abusive relationship for themselves and the accessibility of the information available for support. Presentation will be developed by March 31st 2023. Delivery of these sessions will be monthly starting in April 2023. Final session will be March 2024 **Safeguarding Assurance Tool**- has been sent to GP practices to self-assess their practice against expected safeguarding standards- sent November 2022. Completion date (report and feedback) March 2023. The tool stipulates a DA policy is required as follows: "3C The practice has a Domestic Abuse Policy which includes information on local Domestic Abuse services. All staff have an awareness of domestic abuse and clinical staff have an		22 is currently underway. **Multi-agency training** **Hot topics training 2022/23** **Hot topics training 2023/24** **Safeguarding Assurance Tool dissemination**	**Develop presentation materials March 2023**	**March 2023** **Complete delivery of 2023/24 sessions March 2024** **Completion of assurance report March 2023**

	understanding of the indicators of domestic abuse and use targeted/ clinical enquiry when safe to do so. Practice staff know where to signpost individuals for domestic abuse support and refer for safeguarding if appropriate.				
Multi- agency recommendation 2. Community Curiosity To ensure that partners' public facing websites contain clear, accessible information on recognising domestic abuse, stalking behaviour and coercive control					
Multi- agency recommendation 6. All partnership websites Mary had mild learning difficulties and questions relating to accessibility and understanding of information (had she accessed) on domestic abuse and themes such as stalking, harassment, coercive and controlling behaviour were raised. This review recommends all partners review their websites to ensure all have accessible language **that includes everyone**. People can feel excluded when they don't understand word or phrases that results in language being used in ways that pose challenges for those with access challenges. All websites need to be updated with clear and easily accessible information and language to ensure access for all, especially those with learning difficulties and/ or disabilities. This should include use of sample descriptive section headings, use of images, videos, short paragraphs, and ordinary familiar words that does not include the use of acronyms and jargon, to explain domestic abuse themes highlighted within this review					

Scope of Rec	Action to take	Lead agency	Key milestones achieved in enacting recommendations	Target date	RAG Status
Local	**Providers' Websites** To ensure that the websites of DA service providers reflect the principles for information accessibility (see below). Action- To request overview reports for the DA commissioning group from IDAS and Foundation, focusing on the action providers take to make sure their information is accessible and accurately reflects local DA arrangements	North Yorkshire and York Joint DA Commissioning Group Lead- DA Community Safety Officer, NYCC	Report- DA commissioning group Providers to develop an action plan for scrutiny via the Commissioning Group	Q3 group 06.02.23	
	Partners' Websites To ensure that all websites that reference DA have common, agreed information that reflects local arrangements and referral mechanisms. Action- Audit of info to be developed and suggested partnership 'wording' to be developed. Will include DA content and accessible information principles	North Yorkshire Domestic Abuse Local Partnership Board Lead- DA Community Safety Officer, NYCC	Include on agenda for Domestic Abuse Local Partnership Board (DALPB)	12.01.23	
	Accessible Information Accessible Information report - June 2022 | Healthwatch Northyorkshire Local work to reflect the principles developed by Healthwatch North Yorkshire. See appendix 1.	North Yorkshire Domestic Abuse Local Partnership Board Lead- DA Community Safety Officer, NYCC	Audit cycle to be developed with future reporting to DALPB Working group to be established and developed 'common wording'.	Aim for sign off 30.04.23	
	Local Government Reorganisation (LGR) Internet and intranet information is being developed for the new unitary authority that will cover North Yorkshire. Action- Ensure this content aligns with the learning and action from 'Mary'	Head of Safer Communities, NYCC LGR Community Safety sub group	'Vesting day' North Yorkshire Council	01.04.23	
Multi -agency recommendation 2. Community Curiosity To target the promotion of an employer workforce 'Domestic Abuse Charter'. This should include key partners of North Yorkshire Domestic Abuse Local Partnership Board and Community Safety Partnership. Opportunities should also be sought within the private sector, including Mary's employers					

Scope of Rec	Action to take	Lead agency	Key milestones achieved in enacting recommendations	Target date	RAG status
Local	North Yorkshire County Council in conjunction with Fiona Bowman Fiona Bowman - Oasis Community Housing and Unison have developed a Domestic Abuse Charter supporting employees impacted by domestic abuse. Employers have a duty of care and a legal responsibility to provide a safe and effective work environment. Preventing and tackling domestic abuse is integral to this. 'Charters/ toolkits' help organisations to support employees and contribute to tackling domestic abuse. Action 1- following publication of NYCC DA charter (it has been agreed that the Charter will continue to be used in the new authority from April 2023). The charter is to be shared across partners and organisations, via the Domestic Abuse Local Partnership Board and the Community Safety Partnership. Monitoring to be developed to assess status across organisations, which organisations have suitable arrangements in place, which organisations are developing arrangements and which organisations need support? Action 2- contact to be made with Mary's employers and explore opportunities to further develop their arrangements. Action 3- opportunities to be sought in linking in with the local 'private' sector via Local Enterprise Partnerships etc. to present and share charters. All of the actions to be monitored by CSP and performance group, but partners to identify appropriate contacts.	Via NYCC Organisation Development leads the DA charter to be launched and shared across NYCC North Yorkshire Community Safety Partnership (NYCSP) North Yorkshire Domestic Abuse Local Partnership Board (NYDALPB) Lead- DA Community Safety Officer, NYCC Lead- Head of Safer Communities, NYCC Lead- Head of Safer Communities, NYCC All partners to support in identifying contacts	Signed off by corporate leads, including Unison To include on NYCSP agenda To include on NYDALPB agenda To be included on future agendas for partners to update on progress Contact to be made with Mary's employers Contacts/ networks to be identified and appropriate links to be sought	Launch by 30.11.22 20.12.22 12.01.23 01.12.22 (post launch NYCC charter) 01.01.23	
Multi- agency recommendation 3. North Yorkshire Domestic Abuse Local Partnership Board to develop a multi-agency communications plan					

This plan should include the effective dissemination of any new initiatives (both local and national). The plan should also include an engagement strategy with local communities, to ensure local resources (posters, leaflets) are disseminated in community venues, including churches. The local area where Mary lived should be a 'pilot' area for this engagement focus. Within an agreed timeframe, a roll out of the strategy should be implemented across the county					
Multi- agency recommendation 3. North Yorkshire Domestic Abuse Local Partnership Board to develop a multi-agency communications plan Further community initiatives should be explored with local providers e.g. IDAS. The barbers' initiative should be reviewed and developed for hairdressers. Mary regularly went to her local hairdresser. Again, a 'pilot' in Mary's local area, with a wider roll out in due course					
Scope of Rec	**Action to take**	**Lead agency**	**Key milestones achieved in enacting recommendations**	**Target date**	**RAG status**
Local	Both North Yorkshire Domestic Abuse Local Partnership Board (DALPB) and York DALPB are developing and implementing local communication strategies and calendars. IDAS are commissioned to lead on local communication strategies. To support partners that sit across the local geography strong links between the 2 local boards exist, to avoid duplication, to ensure consistent, clear messages that accurately reflect local issues. Action 1- Strategies to be developed and implemented that recognise the learning from this review (accessible information). Action 2- Strategies to use local resources e.g. IDAS campaigns and others e.g. Community Safety Christmas campaign. Action 3- Strategies to reflect a range of audiences and venues e.g. night time economy and community venues. Action 4- For North Yorkshire a targeted communications and engagement strategy to be developed. To include local churches and hairdressers and other community 'opportunities' that have been identified in this review.	Lead- DA Community Safety Officer, NYCC Joint North Yorkshire and York DA Working Group North Yorkshire Domestic Abuse Local Partnership Board York Domestic Abuse Local Partnership Board Lead- Head of Safer Communities, NYCC	Communication strategies to be developed and signed off the respective DALPBs (North Yorkshire and York) Include on agenda for NY Domestic Abuse Local Partnership Board. Ongoing monitoring via the DALPB With support from the local church (already agreed) a local engagement event to take place, to include local organisations and	12.01.23 Planning to start 01.01.23	

			business, to explore opportunities to raise awareness of domestic abuse		

Multi- agency recommendation 4. Professional curiosity

Previous domestic homicide reviews in North Yorkshire have identified the need for professionals to maintain accurate recording and action, with a 'plan, do and review' approach. The review for Mary identified this as an area for improvement. Members of North Yorkshire Domestic Abuse Local Partnership Board and Community Safety Partnership will be required to provide assurance statements on the standards and approaches within organisations. A multi-agency training programme to be developed to enhance 'professional curiosity' in the context of domestic abuse

Scope of Rec	Action to take	Lead agency	Key milestones achieved in enacting recommendations	Target date	RAG status
Local	North Yorkshire and City of York have commissioned a large scale multi-agency training programme delivered by IDAS. Appendix 2. Overview of the current modules. Action 1- Review of current content, ensure professionals is a key theme in modules. Action 2- Similar to the quality assurance process introduced around MARAC engagement. A tool to be developed and shared with all partners of NYCSP and DALPB, for partners to submit an overview of practice measures to ensure professional curiosity is embedded e.g. via supervision, training, audit of cases	Lead- DA Community Safety Officer, NYCC Joint North Yorkshire and York DA Working Group Lead- DA Community Safety Officer, NYCC North Yorkshire Domestic Abuse Local Partnership Board	Training programme 'live' and being accessed. High demand for modules and opportunities and different approaches and future funning to ensure more access. Monitoring reports to be developed and presented at DALPB Quality assurance statements to be developed and shared across the partnerships. Findings to be scrutinised at future partnerships. Clear actions to be	12.01.23 Statement to be developed and shared 01.01.23 Findings to be initially scrutinised	

		North Yorkshire Community Safety Partnership	identified and implemented. Partnerships to maintain ongoing scrutiny	DALPB 16.03.23 NYCSP 21.03.23	
Multi- agency recommendation 5. Multi -agency awareness of police stalking team North Yorkshire Police have established a new dedicated stalking team to better identify and address all forms of stalking at the earliest opportunity. The team has extensive experience of investigating stalking offences and two Stalking Victim Support Officers, who offer bespoke personal safety planning and implement specialist safeguarding measures as necessary to reduce further risk of harm. This review has identified stalking and harassment as a factor in Mary's experience, although she did not state this term. The needs for multi-agency partners to be aware of this team is important, therefore, this review recommends the police raise awareness amongst partners about this team, its role and what support can be offered to partners and/ or victims					
Scope of Rec	**Action to take**	**Lead agency**	**Key milestones achieved in enacting recommendations**	**Target date**	**RAG status**
Local	Four Domestic Abuse Forums exist across the local geography. Forums and locality based and multi-agency and provide updates on local arrangements. During the last round of forum the stalking team presented. Wider awareness raising plans have been discussed, including using the voice of a victim, who wishes to be part of local campaigns. This has a strong dependency with the communications strategy. Action- A clear, sustained plan to be developed and implemented raising aware of stalking and the police dedicated team	Lead- DA Community Safety Officer, NYCC North Yorkshire and York Domestic Abuse Tactical Group (joint group of North Yorkshire Police and domestic abuse service commissioners. Currently meet on a fortnightly basis, focus on local need and demand across services)	Clear communications plan for the stalking team to be developed, using different modes and considering different audiences Present plan, including implementation to DALPB	12.01.23	

Appendix 1 'Accessible Information Report' (June 2022) Health Watch Proposed Principles

1. Ask what helps and do something about it. Put the user first

2. Make Accessible Information an organisational priority from the top down and ensure everyone knows why it is important. Have understanding, committed staff championing this at all levels
3. Ensure that you ask people about their preferred format. Record this and use that information to provide information in a person's preferred format. There is no point in having a flag on a record which is ignored
4. Once identified, share people's information needs across organisations. Information about people's needs should only have to be recorded once for people to get the right format from all parts of that organisation
5. Involve people with lived experience to help find pragmatic answers
6. Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone
7. Each organisation should have one contact or team who works across that organisation to find solutions to accessible information needs quickly and effectively
8. Seek and share good practice. Providing information in accessible formats isn't always easy, but lots of organisations are trying. Sahre progress and challenges so that things are constantly improving
9. Review what you're doing to make sure it is working and learn from what is and isn't working well.

Appendix 2 North Yorkshire and City of York Domestic Abuse Training Programme

IDAS (Independent Domestic Abuse Services) is a leading specialist charity supporting anyone subjected to domestic abuse or sexual violence. The following training courses have been jointly commissioned by North Yorkshire County Council and City of York Council, therefore are specific to professionals working within the North Yorkshire and City of York Councils.

Our training has been developed by experts, informed by over 40 years of practice, providing specialist support to thousands of victims and survivors of domestic abuse and sexual violence. Our team of experts have created innovative and interactive training courses to improve the response to and safeguarding of victims of domestic abuse and their children.

Domestic abuse signs, indicators, DASH and MARAC Join IDAS for this full day virtual training session. We will explore the signs and indicators of domestic abuse and the referral pathways in the morning, and the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) Risk Assessment, and the MARAC (Multi Agency Risk Assessment Conference) process in the afternoon.

Supporting older victims of domestic abuse Older people are often hidden victims of domestic abuse, with many having no contact with any services and experiencing additional barriers to accessing support. This half-day course will explore the complexities and challenges as well as the importance of adopting a tailored approach. We will also cover referral pathways and the range of support available.

Substance misuse and domestic abuse Substance misuse and domestic abuse often intersect. This half-day training course looks at the complexities around supporting and safeguarding people where there is substance misuse and ensuring the right support is available.
Trauma and how it affects domestic abuse victims This 2 hour course will provide you with increased knowledge around trauma and its link to the experiences of domestic abuse victims. Through an interactive programme you will begin to understand how victims can be affected by trauma and in turn how this affects their future experiences as well as their engagement and presentation with professionals.
Supporting young people and domestic abuse Join IDAS for a half-day, virtual training session looking at young people's experiences with, and the impacts of domestic abuse. You will explore some of the myths regarding young people and domestic abuse, and the risks of domestic abuse and so called 'toxic' relationships, and how to effectively support young people.
Coercive control workshop Gain an understanding of the dynamics and risks associated with coercive and controlling behaviour. You will look at the legal definition, case studies and signs and indicators, to be able to spot the warning signs and understand the impacts on victims and their children.
Supporting male victims of domestic abuse Join IDAS for a half-day, virtual training session focussing on the particular needs and experiences of male victims of domestic abuse. You will consider experiences of male victims of domestic abuse, the additional challenges faced by male victims of domestic abuse, how to effectively respond to male victims and signpost for support.
Safeguarding children and domestic abuse Join IDAS for a full day, virtual training to raise your awareness and understanding of safeguarding children in a d domestic abuse context. We will discuss the legal frameworks, including the provisions in the Domestic Abuse Act, research and evidence and effective safeguarding measures and procedures.
Supporting LGBTQ+ people impacted by domestic abuse LGBTQ+ people may experience additional barriers accessing support and face forms of domestic abuse that target their sexual orientation or gender identity. This practice informed training will help support you in your response to LGBTQ+ people impacted by domestic abuse.
Supporting people with mental health and domestic abuse Join IDAS for a half-day, virtual training session which provides an introduction to mental health and domestic abuse. We will look at the barriers our clients face and how we can overcome these challenges and effectively support them with their mental health difficulties. We will explore questioning techniques, the guidance and our responsibilities for recording.