North Yorkshire
Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

MARY

EXECUTIVE SUMMARY

October 2019

REVIEW PANEL CHAIR

JASVINDER SANGHERA CBE

REVIEW PANEL REPORT AUTHOR

HELEN COLLINS BA (Hons) PGCE PCET

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1. THE REVIEW PROCESS

This summary outlines the process undertaken by North Yorkshire Community Safety Partnership's Domestic Homicide Review Panel, in reviewing the homicide of Mary who was resident in the area.

The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of family members.

Mary (victim) was 30 years old and Peter (perpetrator) was 45 years old at the time of the fatal incident. Both Mary and Peter were of white British descent.

Peter was charged with the kidnap and murder of Mary on the 16th October 2019 and was remanded in custody until his trial in 2020. The jury took less than 3 hours to find Peter guilty of the kidnap and murder of Mary and he was sentenced at Teesside Crown Court on the 21st November 2020, receiving a life tariff with a minimum term of 25 years.

The process began with an initial meeting of the Decision-Making Group of North Yorkshire Community Safety Partnership on 20th February 2020 when the decision to commission a domestic homicide review was agreed. All agencies that potentially had contact with Mary and Peter prior to her death were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW AND REVIEW PANEL MEMBERS

Partners had previously been contacted immediately after Mary's death and a scoping exercise had been undertaken. 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 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[1] (IDAS).

The group met three times as a panel. All panel members were independent of any decision-making or line management responsibilities of any staff involved in contact with the victim or perpetrator.

3. DOMESTIC HOMICIDE REVIEW PANEL CHAIR AND AUTHOR

Jasvinder Sanghera is the Chair of this panel. She is the founder of Karma Nirvana[2]. 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.

[1] www.idas.org.uk
[2] https://karmanirvana.org.uk

Helen Collins is the author of this overview report. She is a former senior police officer who had previously worked within Surrey Police. She was appointed as the independent author of this report having not been involved in policing since her retirement from service in 2019. 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.

4. TERMS OF REFERENCE FOR THE REVIEW

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.

Questions to be discussed

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.

5. SUMMARY CHRONOLOGY

5.1 Mary lived with her mother, father and brother and had resided in the same property since December 2004. The family unit was described by those contacted in relation to this review as 'very close'.

5.2 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 start, cleaning 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 as her only form of transport.

5.3 Mary and Peter had been in a relationship for around 18 months prior to her death. Mary had previously worked at a supermarket where she met Peter, who had previously worked at the same location. 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 displayed controlling behaviour towards Mary

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

5.5 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 Mary did say to Peter that he 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.

5.6 On the morning of Wednesday 9th October 2019 Mary set off from her home address on her pedal cycle after saying goodbye to her father. Contact to Mary's phone was attempted by her line manager, as she did not arrive at work, this was very unlike Mary. Later Mary's father reported his daughter missing. It was established that nobody had seen Mary or was able to make contact with her, she has not attended her second job at the college.

5.7 Later that afternoon Peter's mother contacted North Yorkshire Police via 999 and informed them of what her son had told her about the events of the day. Peter then gave an initial account to the Police over the phone.

5.8 Police attended the location and subsequently arrested Peter on suspicion of Mary's murder. Peter was charged with the kidnap and murder of Mary on 16th 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 21st November 2020, receiving a life tariff with a minimum term of 25 years.

6. KEY ISSUES ARISING FROM THE REVIEW

- 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.

7. CONCLUSIONS AND LESSONS TO BE LEARNED

Post Mary's tragic death several new initiatives have already begun within the North Yorkshire area.

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.

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.

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[3]

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

8. RECOMMENDATIONS FROM THE REVIEW

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

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

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[4] 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 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

[4] IDAS Barbershop Ambassadors

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.