North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of 'Emma'

September 2019

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Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This Domestic Homicide Review has been commissioned by the North Yorkshire Community Safety Partnership following the murder of 'Emma' which occurred between 17th February and 28th September 2019. Emma is a pseudonym which will be used throughout this overview report in order to protect the victim's identity.

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

1.1.3 This overview report will examine life 'through the eyes of the victim.' The purpose of the review is not to judge 'Emma' but to better understand her circumstances, so we may appreciate how or why she made certain decisions. It is also important to understand the involvement of several agencies in this case, to examine the professional's perspective within that context and to avoid hindsight bias. This will ensure that any learning is captured and acted upon.

1.1.4 The death of any person in these circumstances is a tragedy and the family are still coming to terms with their loss. Emma's family have been consulted during the review process and their views are reflected in this document. The overview report author is grateful for their contribution. The family are of course still grieving, and we extend our deepest condolences to them for their tragic loss.

1.1.5 Twenty-one agencies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) were requested and provided. Each of the appointed IMR authors had no direct involvement in the case and were therefore independent of any of the decisions or actions previously taken. The review chair and panel

agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author. The following organisations were required to produce an Individual Management Review:

1.1.6

- NHS North Yorkshire Clinical Commissioning Group (on behalf of GP Practice for victim)
- Harrogate and District NHS Foundation Trust
- Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company
- West Yorkshire Police
- Tees, Esk & Wear Valleys NHS Foundation Trust
- Yorkshire Ambulance Service
- North Yorkshire County Council Health & Adult Services
- City of York Council
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- NHS Bradford City, Bradford District and Airedale Wharfedale & Craven CCGs (on behalf GP Practice for perpetrator)
- North Yorkshire Police
- Harrogate Borough Council

Additional chronologies or summary reports were also provided from:

- West Midlands Police
- Leicestershire Police
- National Probation Service
- Community Rehabilitation Company (CRC) Staffs and West Midlands
- Nottinghamshire Police
- West Mercia Police
- Office of Police Fire and Crime Commissioner North Yorkshire
- DISC (now renamed Humankind)

1.2 The Review Panel

1.2.1 The Chair of the Review Panel is Mr Graham Strange. He is completely independent and has no connection to any of the agencies taking part in this review.

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

1.2.2 None of the DHR panel members had any involvement in the case prior to Emma's tragic death. All were therefore independent in reviewing the actions of their organisations.

1.3 Reason for conducting the review

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

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

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself."

1.3.2 For this review, the term domestic abuse is in accordance with the agreed cross-government 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*
- *Coercive control*

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 pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim."

1.3.3 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

1.4 Purpose of the review

1.4.1 The North Yorkshire Community Safety Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

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

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

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

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

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

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

1.5 Confidentiality

1.5.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

1.5.2 The victim, Emma, was 51 years old at the time of her death. The perpetrator, Thomas, was 38 years old at that time. They were both British citizens residing permanently in the UK. Their ethnicity is white / British.

1.6 Terms of Reference

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

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

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

- Did the agency have policies and procedures for domestic abuse, stalking and harassment? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in the case of this victim and perpetrator? Were these assessment tools, policies and procedures professionally accepted as being effective?

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

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

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

- What were the missed opportunities for intervention? Do assessments and decisions appear to have been reached in an informed and professional way?

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

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of

options/choices to make informed decisions? Were they signposted to other agencies?

- Was anything known about the perpetrator? Were they subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or previously had been in place?

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

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

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

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

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

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

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

1.7 The subjects of the review

1.7.1 The subject of this review is the victim; 'Emma'. This is a pseudonym and will be used throughout the review to protect her identity. At the time of her death she was 51 years old.

1.7.2 The perpetrator is identified by the pseudonym 'Thomas'. He is the ex-partner of Emma and was 38 years old at the time of the murder.

1.7.3 Any relevant addresses will only be referred to in general terms to protect the identity of those involved. The locations considered as part of this review span across the United Kingdom and include incidents which took place in Harrogate, Bradford, York, Birmingham, Leicester, Shropshire, Nottinghamshire, Northamptonshire and Doncaster.

1.8 Parallel Reviews and timescales

1.8.1 The decision to undertake a Domestic Homicide Review was taken by the Independent Chair of the North Yorkshire Community Safety Partnership on 25th October 2019. This decision followed a detailed notification of the circumstances of the death provided by West Yorkshire Police and discussions at the North Yorkshire DHR decision-making group. At that time, the criminal investigation and trial were still progressing but have since been concluded. Although the murder occurred in Bradford (West Yorkshire) and the victim's body was found in Doncaster (South Yorkshire), the agreement was for the North Yorkshire Community Safety Partnership to convene the Domestic Homicide Review. The victim and perpetrator had both lived at locations throughout the UK but the main residence of the victim was in North Yorkshire. This was Emma's home at the time of her tragic death.

1.8.2 The aim of the DHR panel was to deliver the review as soon as practicable but also recognising the delay in the criminal trial which pushed back some of the initial deadlines. This was unavoidable after the jury was discharged in the early stages of the Covid 19 pandemic. Nevertheless, the DHR panel Chair is confident the review maintained focus and the final report was completed in good time.

1.8.3 The inquest into Emma's death was opened and adjourned pending the conclusion of the criminal court process.

1.8.4 Section 42 of the Care Act 2014 provides a definition of an adult at risk: 'Someone who has needs for care and support, who is experiencing, or is at risk of abuse or neglect and as a result of their care needs is unable to protect themselves.' Emma was therefore considered a 'vulnerable adult' at the time of her death. Discussions took place between the Chair of the Domestic Homicide Review Panel and the Independent Chair of the Safeguarding Adults Board. It was agreed the Domestic Homicide Review would progress. There was no requirement for a separate Safeguarding Adult Review (SAR), though any learning identified through the DHR process would be shared in full with the North Yorkshire Safeguarding Adults Board (NYSAB) and the relevant Safeguarding Adults Board in West Yorkshire. In addition to several members of the DHR panel sitting on the

NYSAB, the business manager of the NYSAB was also invited to attend the DHR panels.

1.8.5 There are other parallel reviews progressing. These are convened by the Independent Office for Police Conduct (IOPC) and are scrutinising the actions of West Yorkshire and North Yorkshire Police.

1.8.6 The DHR was already in progress at the start of the Covid 19 pandemic (the first panel had convened in January 2020). The subsequent 'lockdown' did affect progress. Extra time was allocated to professionals who had additional responsibilities and pressures due to the crisis. Panels were conducted 'remotely' but still gave the opportunity for valuable and constructive dialogue and challenge. The final presentation to the Community Safety Partnership was conducted remotely for the same reasons.

1.9 The Prevalence of Domestic Abuse

1.9.1 The Crime Survey of England and Wales gives data on the levels of domestic abuse within society. For the year to March 2019 there were 2.4 million adults who experienced domestic abuse (1.6 million women and 0.8 million men). Nationally, the police recorded 746,219 offences linked to domestic abuse. This is a 24% increase on the previous year. However, all independent experts acknowledge this significant increase is due to much improved police recording practices. Nevertheless, these figures demonstrate just how widely domestic abuse affects society.

1.9.2 The Home Office homicide index also provides further data. For the year to March 2019, 38% of all female victims of homicide (a total of 79 women) were killed by their current or former partner. This figure of domestic homicide is the lowest for forty years. The downward trend began after the introduction of statutory Domestic Homicide Reviews. However, we should also be mindful that this is still 79 victims and 79 grieving families.

1.9.3 North Yorkshire Police recorded the following level of domestic abuse incidents in recent years:

Year	2016	2017	2018	2019
Number of domestic abuse incidents	11245	12866	11424	20562

For recorded domestic abuse related crimes the data is:

Year	2016	2017	2018	2019
Domestic abuse related crimes	3593	4217	5712	7789

The sharp rise in recorded crimes between 2018 and 2019 is due to a change in recording criteria. This is matched in the national data and should be viewed as a positive step to ensure the right vulnerable victims are identified.

1.9.4 The murder of Emma is the fourth Domestic Homicide Review in North Yorkshire since the introduction of legislation mandating Domestic Homicide Reviews in 2011. The three previous homicides occurred in February 2013 (Scarborough), March 2018 (Selby) and September 2018 (Filey). The learning from both DHRs in 2018 is subject to an action plan which is being progressed.

Section 2: Background Information (The Facts)

2.1 Case specific background

2.1.1 The victim, Emma, was born in Shropshire. She was 51 years old at the time of her death. She suffered an Adverse Childhood Experience but very little is known about this. Records from that time are no longer available. She had some difficulties during her childhood, including disruptive behaviour, which eventually meant she was placed in a 'special' school which was residential from Monday to Friday. She returned home at weekends. Emma was vulnerable. She had some mental health problems, a possible learning difficulty and a physical disability. She had very little physical contact with her family. Emma served a term of imprisonment in 2017.

2.1.2 The perpetrator, Thomas, was born in 1980 and was 38 years old at the time of the homicide. He moved around fairly frequently and lived at many different locations across the UK. He suffered from anxiety and depression but did not have a diagnosed mental illness. He had met Emma online and they began a relationship. He has always denied they were in an intimate relationship. Thomas has a history of violence to his previous partners and has an extensive criminal record with convictions for violence, theft and criminal damage.

2.1.3 Having met via an internet 'chat' site, Emma and Thomas then shared a flat in Birmingham. The first call to North Yorkshire Police relating to both of them was in January 2016 when Emma reported Thomas had followed her there from Birmingham. Around 20% of relationships in the UK begin online.[1] This can create additional risks and groups such as the Paladin National Stalking Advocacy Service have called for greater awareness in this area.

2.1.4 They were both frequent users of a variety of services. These ranged from policing, probation and housing through to health (physical and mental health), social care and other specialist services.

2.1.5 Emma was recorded as a missing person by North Yorkshire Police in August 2019. Tragically, the missing person enquiry had started after a local police officer realised Emma had not been seen for some time. She was well known to many agencies and had such regular contact with professionals that it was unusual for no one to have seen her. Extensive enquiries then began to find her. This included liaison with colleagues in West Yorkshire Police.

2.1.6 West Yorkshire detectives established Thomas (and a third party) has been collecting Emma's benefits. On 28th September 2019, Thomas was arrested by West Yorkshire officers on suspicion of the murder of Emma, alleged to have taken place between February and September 2019. The third party

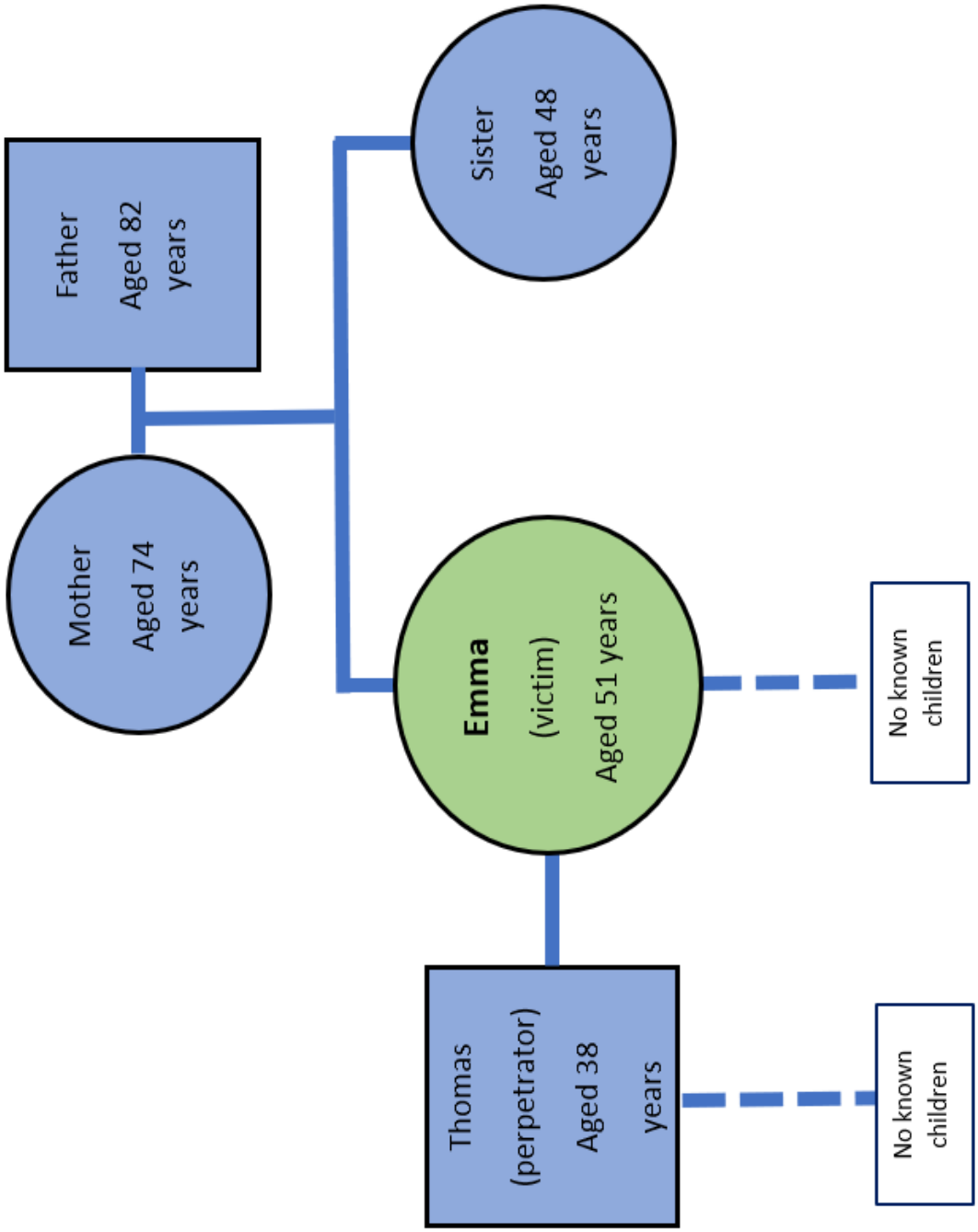
[1] Source: Paladin website 2021

was also arrested and it was this person that took police to the location where Emma's body had been buried.

2.1.7 Emma's remains were found in the Doncaster area in October 2019.

2.1.8 Thomas appeared at Leeds Crown Court in March 2020. The case was then adjourned and the jury discharged due to the Covid 19 crisis. The trial reconvened in November 2020. Thomas pleaded not guilty but was convicted by the jury of the murder of Emma. On 10th December 2020 he was sentenced to life imprisonment with a minimum term of 16 years. He pleaded guilty to preventing the lawful burial of a body, for which he was ordered to serve 2 years concurrently.

2.2 Genogram


Father
Aged 82
years
Sister
Aged 48
years
Mother
Aged 74
years
Emma
(victim)
Aged 51 years
No known
children
Thomas
(perpetrator)
Aged 38
years
No known
children

2.3 Chronology

2.3.1 As part of this Domestic Homicide Review, reports were compiled and submitted by 21 agencies. These comprised of chronologies of the organisation's involvement with Emma and Thomas. In the majority of cases, the agency also drafted an Individual Management Review (IMR) which examined their organisation's actions and decision-making.

2.3.2 To manage the huge amount of information, the Independent Author for the Domestic Homicide Review decided on providing a summary of each agency's involvement with the victim and perpetrator. Although this did mean some duplication and cross-over, it provided a valuable platform to consider each agency's recollection and interpretation of events and gave an understanding of each agency's perspective:

<u>NHS North Yorkshire Clinical Commissioning Group (on behalf of victim's GP).</u>

2.3.3 Emma was registered with a GP Practice in Harrogate from 8th October 2001 to 10th May 2018. She registered with a different GP Practice in Harrogate from 12th November 2018 until her death. She was not a frequent user of GP surgeries and only attended for 9 appointments over a period of 18 years. Of note, there are no next of kin details for Emma recorded on the electronic GP records. This is unusual.

2.3.4 In April 2014, the GP Practice was made aware that Emma had been admitted to Harrogate District Hospital with a fracture to the neck of her femur. This had occurred during an assault. This injury left Emma with a permanent physical disability which affected her mobility and caused her pain and discomfort thus affecting her well-being.

2.3.5 No entries in the GP records relate to any form of domestic abuse. There is a reference to Emma suffering an Adverse Childhood Experience.

2.3.6 Emma registered with a new GP in November 2018. On 12th November, the GP made a home visit. They liaised with both adult mental health services and the Crisis team to gather more information about Emma as she was a new patient to the practice. During the home visit, the GP witnessed a telephone conversation between Emma and a male. The male shouted at Emma and was abrupt with the GP when they spoke on the telephone. The identity of the male, or their relationship with Emma was not confirmed. This visit was the last direct contact with Emma by the GP Practice.

<u>Harrogate and District NHS Foundation Trust.</u>

2.3.7 Emma attended the Emergency Department at Harrogate District Hospital on 29th April 2014 following an assault (not related to domestic abuse). She disclosed she had been kicked in the left hip and left elbow by a male friend

while they were out in the town centre together. This man was a neighbour who was a tenant in the same building as Emma. While in the department, she refused various assessments and treatments. The diagnosis was a fractured neck of the femur to her left leg and she was admitted to the hospital. She declined surgery despite input from the Community Learning Disabilities Team, Mental Health Team, Independent Mental Capacity Advocacy service and the Trust's safeguarding lead. A capacity assessment was carried out which concluded that Emma lacked capacity to make decisions regarding the surgery. Emma was subject to restrictions under the guidance within the 'Deprivation of Liberty Safeguards.' A 'best interests' decision (Mental Capacity Act 2005) was made on Emma's behalf. She did not access the surgery for her broken femur. Further comment on this decision will be made within the conclusions and learning section of this report.

2.3.8 During her discharge planning, Emma disclosed that she did not want to return to her home address as she was afraid of being assaulted. One of the tenants had allegedly been linked to the original assault which led to her admission. On 5th June 2014, Emma was discharged to her home address.

2.3.9 During the time frame set for this review (2016-2019), Emma attended the Emergency Department on 15 occasions. Seven of these attendances related to limb pain (stemming from the assault in April 2014). Two attendances were due to chest pain. Two related to the victim's mental health (these were in January and October 2018 and both related to Emma threatening to self-harm). The mental health liaison team were involved on both occasions and carried out an assessment. They documented they would be making a referral to Community Mental Health Services. Of note, during one of these attendances Emma stated a 'friend' had stolen both of her phones. No subsequent action is recorded in relation to this. Four of her attendances were for 'social circumstances'. These were from 2016 through to 2018. On one of these visits, Emma was very abusive and left the Emergency Department without being assessed. One attendance was for poor hygiene and two related to Emma being homeless.

2.3.10 Harrogate District NHS Foundation Trust had no contact with the perpetrator.

<u>Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company (HLNYCRC)</u>

2.3.11 The Humberside, Lincolnshire & North Yorkshire CRC (supported by the National Probation Service) had direct contacts over an extended period with the victim. Although the perpetrator is referenced within the agency notes, HLNYCRC did not have any direct dealings with Thomas.

2.3.12 Emma was convicted of a theft at Leeds Crown Court on 7th November 2016. She had several previous convictions. The circumstances of the

offence are referred to as a ‘grave breach of trust’ as she had stolen from an elderly man whom she had befriended. She was sentenced to 16 months in custody. She was managed from November 2016 through to July 2018 by case managers from the Humber, Lincolnshire, and North Yorkshire CRC. The notes on her file indicate Emma had physical and mental health issues and that she was known to a number of services including a women’s support worker from ‘DISC.’ This is a charity (now called ‘Humankind’) who are commissioned to:

‘*Create services and support to meet people’s complex health and social needs, helping to build healthier lives.’*

All female offenders are referred and assessed by Humankind to identify any support they can deliver to assist in their rehabilitation. Emma was referred to DISC on 30th August 2017 and allocated a worker who supported her until 7th July 2018. The support worker does remember Emma telephoning in August 2017 to say that she could not attend their meeting and was staying with a ‘friend’ in Bradford. A male who identified himself as Thomas came on the phone and stated Emma was safe and well staying with him and that they had been friends for years. Over the following months Emma was recorded as visiting ‘friends’ several times, but the DISC worker remembers Bradford was a recurring theme.

2.3.13 When the theft charge progressed through the criminal justice system, the Crown Court commissioned a psychiatrist’s report. This was completed in April 2016. They concluded there was *‘no psychiatric reason why she cannot enter a plea. She is fit to plead in an unmodified trial (except for requiring disabled access).’* Of note, the psychiatrist’s report also states that Emma was accompanied by a ‘male friend’ for part of the interview. She was probably in a relationship with Thomas at this point though informed the psychiatrist she was ‘single.’

2.3.14 Emma was initially released from custody on 8th May 2017. However, her allocated premises were not suitable for her physical needs (poor mobility). No alternatives were available and so she was returned to secure custody 12 days later. She was finally released on 7th July 2017. Emma was subject to licence conditions until 6th March 2018 and then to Post Sentence Supervision until 7th July 2018.

2.3.15 There are several references in the CRC records that show Emma talks about Thomas as her partner or ex-partner. In particular, there are nine separate entries that indicate Emma was travelling to Bradford to visit Thomas between August and December 2017. The nature of the information suggests domestic abuse but this was not followed up by Emma’s case manager. It is unclear if this information was shared with the DISC support worker. DISC acknowledge they knew Emma was visiting Thomas but did not explore the nature of the relationship.

Nottinghamshire Police

2.3.16 The Nottinghamshire Police involvement with the perpetrator was historic (11 years before Emma's death) but is included as a summary due to the relevance of Thomas' offending behaviours. Thomas had met another female when she had visited the prison where he was detained at that time. They subsequently married. In December 2008, a friend of Thomas' wife had visited their home. Thomas had punched his wife on the arm, kicked her in the face and grabbed her by the throat squeezing with both hands. He had refused to let her leave the house and had confiscated her mobile phone. Her friend arrived and saw her bloodied face. As the friend was leaving, Thomas' wife silently mouthed "Phone the police." She did so and Thomas was arrested for assault and harassment. His wife would not provide a statement but did confirm the details with the attending officers including that he had strangled her. Nottinghamshire Police approached the Crown Prosecution Service with a case file but the CPS would not authorise a charge without the wife's statement. By this time, Thomas had been recalled to prison on other matters.

2.3.17 In November 2012, the same woman (by now Thomas' ex-wife) called police to report harassment as Thomas was repeatedly telephoning her. The DASH risk assessment was carried out and assessed the incident as 'high risk' (i.e. his ex-wife was at risk of significant harm). The woman provided a statement including details of the assault back in 2008. Police examined her telephone and found 7 calls from Thomas. Again, the CPS were approached but would not authorise a charge as the assault was several years earlier and the telephone calls were not deemed 'malicious'. When Thomas was due to be released from prison, his ex-wife was so afraid, she called police for help. The case was again assessed as high risk and proceeded to the MARAC in March 2014. A number of actions were agreed as part of a safety plan. There were no further problems reported by the victim.

West Mercia Police

2.3.18 On 3rd April 2014 a domestic abuse incident occurred in Shropshire involving Thomas and his new partner. They had been in a relationship for 11 weeks and had met online. Thomas had moved into the woman's flat. There had been an argument over money and the woman told police on the telephone Thomas had hit her. However, when police officers attended the address she stated he had not assaulted her and no further action was taken.

2.3.19 Six months later, in October 2014 another domestic abuse incident took place involving Thomas and the same woman. The attending police officers noted the victim's vulnerability and that she had suffered 'several unreported assaults.' Her injuries were noted by the officers. The woman told the police officers that Thomas had previously placed her in headlocks but she had never reported it. He was charged and appeared at Telford and South

Shropshire Magistrates Court where he received 12 weeks imprisonment for battery and 12 weeks concurrent for assaulting a police officer. A restraining order was made against Thomas in relation to this female victim. On 22nd January 2015, he breached the restraining order by telephoning the victim.

Staffordshire and West Midlands Community Rehabilitation Company

2.3.20 The perpetrator had a lengthy criminal record. He had 15 convictions for a total of 34 offences prior to Emma's murder. The offences included violence against partners, ex-partners, professionals (police officers) and the public.

2.3.21 His most recent period of supervision by a probation officer was in 2015. This followed his conviction at Birmingham Magistrates Court on 17th February 2015 for an assault. The victim was a male and it was not a domestic abuse related attack. He was supervised by Staffordshire and West Midlands CRC from February 2015 to April 2016. Breach procedures were initiated against Thomas on 26th February 2015 as he failed to keep his probation appointments and failed to notify a change of address.

2.3.22 On 26th March 2015, a domestic abuse 'risk flag' was uploaded onto his probation records. A 'Spousal Assault Risk Assessment' (SARA) was completed in March 2015. It assessed him as a 'medium risk of violence' towards partners and 'medium risk of serious harm' towards his ex-wife. It also assessed him as a 'medium risk of serious harm' towards the public. These domestic abuse concerns are highlighted on Thomas' electronic probation records.

2.3.23 On 8th April 2015 he again appeared at court for a breach of a restraining order. This appearance related to an offence which had originally occurred in January 2015 when Thomas contacted an ex-partner (not Emma). This was in breach of a restraining order imposed by Telford Magistrates Court on 13th October 2014. He was sentenced to 16 weeks in custody, suspended for 12 months and with two requirements: (a) To complete the 'Resolve' programme (later renamed the 'Thinking Skills Programme') and (b) Complete his supervision sessions with a probation officer. It does not appear on the records that Thomas completed the Thinking Skills Programme. Other entries on his records suggest Thomas was on medication for depression and that he had attended a session with 'Alcoholics Anonymous'.

2.3.24 On 12th August 2015, he disclosed to his probation officer that he had been arrested by Leicestershire Police for an indecent assault. He told his supervising officer he was on police bail until October and that he "has nothing to hide."

Leicestershire Police.

2.3.25 On 29th July 2015 a female with learning difficulties made an allegation of rape by digital penetration against Thomas. Thomas had met the woman and her partner at a train station in Leicester the previous week. He stated he had nowhere to stay and so the couple told Thomas he could stay with them. It is believed that Emma also stayed at the couple's address a few times. The female alleged Thomas had carried out the offence while her partner was out. Thomas denied the allegation. During his police interview he stated his girlfriend (Emma) was also staying there and that he was with her at the time of the alleged incident. No further action was taken by Leicestershire Police. The rationale for this decision is recorded as there was no supporting forensic evidence, there were inconsistencies in the victim's account and that Thomas' girlfriend provided a statement stating that Thomas was with her at the time of the alleged offence.

2.3.26 Leicestershire Police share a crime recording system with neighbouring Forces in Nottinghamshire and Northamptonshire. Those two counties show Thomas is linked to several domestic abuse related crimes in their areas. Leicestershire Police report that these offences occurred prior to 2015 and that the entries have been 'back record converted.' These crimes would not have been shown on the system at the time of Thomas' interview for the rape.

West Yorkshire Police.

2.3.27 West Yorkshire Police had extensive contact with the victim and perpetrator over many years. The first recorded contact with Emma was in January 1998 when she was arrested on suspicion of theft on behalf of a neighbouring Force; North Yorkshire Police.

2.3.28 Between 2002 and 2006 Thomas was dealt with for seven separate common assaults, an assault on a Police Constable, criminal damage and aggravated burglary. These incidents occurred outside the West Yorkshire area. During one of the common assaults listed, Thomas pushed a 68 year old male victim to the floor and kicked him twice in the face. He was wearing steel toe capped boots at the time. During the aggravated burglary he forced his way into a private dwelling. He then seized knives from the kitchen drawer and took these upstairs with him – placing them on the bannister before waking the female occupant of the house. He subsequently left the premises with stolen items.

2.3.29 Between 2017 and 2019, Thomas made a large number of calls to West Yorkshire Police. Several of these related to his contact with Emma. However, the majority of the calls (around 40 incidents in total) were either from Thomas or about Thomas, and related to disputes with neighbours, arguments with taxi drivers or mental health concerns.

2.3.30 On 4th May 2017, West Yorkshire Police received information that Emma was to be released from HM Prison Low Newton to an address in Bradford. During that month, Emma made 13 calls to West Yorkshire Police. Two of the calls related to Thomas. The other 11 calls were for a variety of reasons ranging from asking police to collect her flat keys, to feeling suicidal, to her neighbours smoking cannabis, to assistance in helping her out of her house, to her leg being injured, to having no food and to her electricity running out. Some of the calls were cross referenced with similar calls to the ambulance service. Emma was abusive to call takers on several occasions.

2.3.31 The two calls relating to Thomas were both made on 13th May. The first was at 8.10am when she reported she believed Thomas had been in the grounds of her property but had not seen him. She wanted the police to 'break up' with Thomas on her behalf. Police spoke to a neighbour who stated Emma was a nuisance and will call police just to help her out of her flat. (Emma called again at 12.46pm stating her leg was injured – an ambulance was called but the ambulance service confirmed they had already assessed Emma two days earlier). The second call relating to Thomas was made at 10.45pm. She reported a domestic abuse incident involving Thomas. She required help with 'someone who was annoying her.' She stated she was being harassed as she had been called all day by her ex-partner. She also stated he was very possessive and that she had recently come out of prison. A 'Domestic Abuse Stalking and Harassment' (DASH) form was completed and police officers spoke with Thomas. He denied ever being in any intimate relationship with Emma. He said he had only ever been a 'friend' and had tried to help her out with her disability. He stated he had only contacted Emma as she said she had fallen. Police advised Thomas not to contact Emma in the future. The DASH risk assessment recorded this was a 'standard' risk incident. The police officer noted on the DASH assessment that Emma's accommodation was unsuitable for her physical disabilities. There is no entry on the West Yorkshire Police records of any referral to social care.

2.3.32 On 20th August 2017, West Yorkshire Police received three '999' calls relating to Emma and Thomas. At 5.30pm, staff in a bakery shop reported that a female (Emma) had walked into the shop saying, "hide me, hide me." It was established Emma had been staying at Thomas' address and she alleged he had assaulted her and prevented her from leaving his property. The second call was 20 minutes later. Emma requested police assistance to recover her property from the house where she had been assaulted. While the police call-taker was explaining procedures, Emma swore at the member of staff and terminated the call. Two minutes later, Emma called back and reported that her ex-partner's girlfriend had assaulted her. She went on to say her ex-partner and his girlfriend had kidnapped her and kept her in the house for two days. She told police that she lived in Harrogate and that her ex-partner had keys to her house. She requested her belongings back from her ex-partner. She also told police that she had a 'gash' on her arm, that

she used a ‘walker’ and that she was bipolar. The police call-taker recorded that Emma was difficult to understand and that they were unsure which parts of the call were genuine. Emma became irate on the telephone to police.

2.3.33 Police attended and spoke with Emma and with Thomas and his new partner. The officers recorded there were ‘no signs that anyone had been held against their will.’ They noted Emma had been sleeping on a sofa in the living room and ‘the keys had always been in the back door next to where she was sleeping.’ The officers believed Emma could have left the property at any time. They noted Emma’s account was inconsistent and changed several times while they were speaking with her. The officers also recorded that the occupants of the address ‘were seemingly of good character’ and were concerned for Emma’s welfare and mental health. West Yorkshire Police contacted the First Response Service (part of the Bradford District Care Foundation Trust). They provided information that Emma was ‘known to have made similar allegations to this before which had proven to be false.’ The police officers consulted with their supervising officer who ratified the rationale that there was nothing to substantiate the offences being alleged. No DASH risk assessment form was completed. Further comment on these actions by police will be made in the analysis section of this report.

2.3.34 On 26th August 2017 , Thomas rang West Yorkshire Police stating Emma had been contacting him and that he had told police he did not want any contact from her. He also said he had lent Emma £1000.00 and that she had not paid him back. He was asked by the call-taker if he had spoken with his mobile phone provider to block Emma’s number. He replied he was not aware he could do this. A crime of harassment was recorded with Emma shown as the suspect. The officer assigned to investigate visited Thomas who told them he used to live in Harrogate and had offered Emma a place to stay and something to eat when required. He said that although they lived together for a period, they were never in any form of relationship. During the course of their friendship, he alleged he had lent her money which now added up to about £1000.00. Thomas went on to say that he had since moved to Bradford and ‘was living with his stepmother’. He stated Emma would visit him at his new address and used the money she owed as an excuse. She would bring him £20.00 each time. After letting her into his address, she would refuse to leave and threaten to call police – making up false allegations against him. However, Thomas said he has since changed his telephone number and there had been no contact for three weeks. He said he therefore did not want any further police investigation and was not bothered about the money he was owed. West Yorkshire Police then finalised the investigation. Emma was never spoken to by police and so would have been unaware of the allegations Thomas had been making against her.

2.3.35 On 22nd September 2017, Emma reported Thomas was harassing her by repeatedly texting and telephoning. Emma did not give any details of the texts or calls but shouted at the police call taker that they were ‘wasting her

minutes and she didn't need this hassle.' She also said she did not want Thomas informing she had called the police. A police supervising officer recorded that the risk to Emma was low as she lived in Harrogate, he lived in Bradford and there were no threats of harm. A crime of harassment was created and an officer assigned to investigate. As Emma lived in a different police area (Harrogate is in the North Yorkshire Police area) the supervisor noted the investigating officer could arrange with a North Yorkshire officer to obtain a DASH risk assessment if necessary. Emma was visited in person by North Yorkshire officers the same day but she told them she did not wish to discuss the matter until she returned from her holiday on 16th October (in nearly a month's time). This was followed up by another call from Emma to West Yorkshire Police on 23rd September to tell them she would not be available until 16th October. The call log describes her manner as 'irate.' The harassment allegation was graded as 'medium' risk. No 'DASH' risk assessment was ever completed but West Yorkshire Police did pass the information to North Yorkshire Police control room for the attention of their Safeguarding Team (as Emma lived in their area).

2.3.36 On 7th October 2017, West Yorkshire officers attended Thomas' address and spoke to him about the allegations. He was adamant he had never been in any form of relationship with Emma. He repeated what he had told police on earlier visits; that he had allowed Emma to stay at his former address in Harrogate as a friend, as she was having a hard time. When asked about contacting Emma, he stated he had changed his number but that Emma had contacted a mutual (female) friend who was staying with him. Thomas said that because of this he had 'messaged' her once, telling Emma he no longer wanted any contact with her. He was also adamant there would be no evidence recorded on their telephones of any other communication. He was advised not to contact Emma and the report was then filed on the basis of 'victim non-engagement.' On 16th October, Emma contacted North Yorkshire Police to say she had sorted the matter out and did not want to progress anything any further. She had apparently spoken to Thomas and his partner and things were now amicable. She stated she did not want any further involvement from the police. North Yorkshire Police passed this information on to West Yorkshire Police.

2.3.37 Eleven days after the call she made to North Yorkshire Police to say matters had been sorted amicably, Emma rang West Yorkshire Police via the '999' system to report she was frightened and being terrorised by a male (Thomas) with whom she had previously been in a relationship. Emma went on to say she had come out of prison and he was demanding money from her. He was at his own home and she was too frightened to tell police where he was. Emma said she had gone into a travel agents to ring the police. She stated she had come to Bradford from Harrogate by taxi and that Thomas had taken her money and she could not get back home. West Yorkshire Police liaised directly with Emma's social worker on the 'First Response' team. (This team is part of 'Acute Care Services' provided by BDCFT). The

social worker stated Emma had already rang them and confirmed she was stuck in Bradford with no money for a taxi. The social worker had no concerns for Emma. When officers attended, Emma signed their pocket notebooks to confirm that no domestic incident had occurred and that her call was purely to get a lift back to Harrogate.

2.3.38 A few hours after Emma had called West Yorkshire Police, Thomas rang them. He made a counter allegation and reported that Emma was harassing him by sending text messages and making repeated threatening phone calls. He described Emma as an 'old friend.' Thomas wanted a 'harassment warning' to be given to Emma to prevent her from contacting him. This crime report was finalised as 'not in the public interest' with the rationale being that it was one word against the other, there were ongoing issues between the two parties, the previous incident (completed on 16th October) resulted in victim non-engagement and there was no immediate harm as the two parties do not live near each other. It was also recorded that both of them had been advised to block the other's phone but it would appear that this advice had not been taken. No DASH risk assessment was completed.

2.3.39 It was nearly three months later, on 6th January 2018 that Emma next contacted West Yorkshire Police. She reported that Thomas was contacting her, pestering her to go to his house, asking for money and making threats to report her for harassment to the police. This was causing her distress. As Emma was living in Harrogate, West Yorkshire Police contacted colleagues in North Yorkshire. They responded that Emma was a persistent hoax caller and was seen by North Yorkshire Police on an almost daily basis. They advised that Emma had mental health issues, learning disabilities and a vulnerable adult marker and that she had a restraining order in relation to an unconnected male. The enquiry was passed to North Yorkshire Police to progress. On 8th January, North Yorkshire Police advised they had spoken with Emma to only use one 'SIM' card and not to give her number to Thomas. They concluded this was not a domestic issue but that Thomas was being persistent in his request, yet he was not being threatening or demanding. Further comment will be made on this in the analysis section of this report. No DASH risk assessment was completed despite previous entries on police systems recording Emma and Thomas as 'ex-partners.'

2.3.40 On 17th January 2018, the Tribunal Service in Leicester contacted West Yorkshire Police. They reported they had received a 'silent 999' call from a landline in West Yorkshire. On the call, a male could be heard shouting at a female. The woman was heard shouting to leave her alone or she will call the police. The male demanded an apology and made threats to smash something up (it was unclear if this related to the phone or the female). The phone number was provided and West Yorkshire called this number which was answered by Thomas. A female also identified herself (it was not Emma but Thomas' new partner). Thomas stated they had a disagreement but this was now sorted out. The female gave a similar account over the telephone. The log was then finalised. No police officer ever attended, the incident was

not recorded as a domestic abuse incident and so subsequently no risk assessment was carried out.

2.3.41 This call to the Tribunal Service would not have been known to Emma. But the day after it was received by West Yorkshire Police, Emma rang them to report Thomas had stolen £60.00 and a mobile phone from her. Police officers attended and recorded that Emma had stayed with Thomas – mainly to see their dog – and that she had given him £60.00 for staying there. They also recorded Thomas was not the ex-partner of Emma; it was only a friendship and there had never been any intimate contact. The mobile phone which Emma had alleged Thomas had stolen was found on her person. The officers noted Emma had some mental health issues and that Emma had previously rang police in order to get a lift home from Bradford to Harrogate. The officers gave Emma a lift to the Bradford Interchange, to make her own way from there to Harrogate. No DASH risk assessment was completed as the police officers deemed there was no intimate relationship nor had there been previously. Older existing police records would dispute this.

2.3.42 There were no incidents involving Emma and Thomas reported to West Yorkshire Police during February, March and the first half of April 2018. However, Thomas continued to be a regular caller to the police and on at least six occasions during that period he was named as a perpetrator relating to harassment against his neighbours or he in turn was complaining about various neighbours or taxi drivers.

2.3.43 On 24th April 2018, at 7.20pm a member of staff at a supermarket reported an argument between customers at their store. On police arrival, Thomas and his new partner had already left. Emma was still present and told police she lived in Harrogate but had come over to Bradford to see Thomas and his girlfriend. She alleged the two had tried to force her to buy them a bottle of alcohol and asked her for £110.00 which they had apparently said she owed them. Emma stated she did not want police involved. The supermarket employee told police Thomas had been abusive to him. The police log records there were no offences and that all parties had now left.

2.3.44 Half an hour later, Thomas telephoned West Yorkshire Police. He reported he had severe anxiety and was feeling stressed. He reported Emma had been staying at his address and that after she had left he discovered £50.00 missing from his wallet. The next day an officer visited Thomas' address. Thomas said that because of his mental state he was no longer certain if the money had been taken or whether he had spent it himself. The attending police officer emailed the Police Adult Safeguarding Unit requesting advice and support for Thomas as it appeared Emma was taking advantage of Thomas. Emma was not spoken to by the police about the initial allegation.

2.3.45 Over the next five months, there were 16 calls to West Yorkshire Police made by Thomas or made by Thomas' neighbours alleging harassment. The types of behaviour alleged against him were assault and verbal abuse. During one incident, Thomas was interviewed and received a conditional

caution. One condition attached was for Thomas to engage with mental health services and to write a letter of apology to his victim.

2.3.46 On 26th October 2018 at 7.00am, Emma rang West Yorkshire Police from the Bradford Hospital. She reported she had been staying with her friend Thomas at his address. Whilst there, she stated he had taken her phone and damaged the memory card slot. She also alleged he had previously stolen other phones from her. Emma was extremely distressed and threatened to walk in front of a car unless an officer attended immediately. Emma was in a taxi outside the hospital and refusing to go into the building. She subsequently got out of the taxi and sought treatment in the Accident & Emergency Department. Police confirmed with hospital staff that Emma was being seen there by mental health staff. Later that day, Emma was dropped by a taxi outside a police station in Bradford. An officer spoke with her and she again stated that a friend had stolen her mobile phone. The police officer describes Emma as 'being quite strange in manner'. The officer asked for assistance from the Hub mental health liaison team but it was then established she had already had a mental health assessment earlier in the day as she was having suicidal thoughts in relation to social issues. The police log was finalised as no offences disclosed.

2.3.47 On 3rd January 2019, Emma rang North Yorkshire Police to report she had been sexually assaulted by Thomas at his home in Bradford. The information was forwarded to West Yorkshire Police as police protocols are that the Force in whose area the crime was committed will investigate. Emma had apparently stayed with Thomas and his partner from Christmas Day until 2nd January. The allegation was that Thomas had sexually assaulted her and filmed the incident on his mobile phone. She stated they were friends and that he had forced her into sex which had hurt. She also stated that she had been hit over the head by Thomas' girlfriend. The attack had happened on 27th December (seven days earlier) but she was too afraid to report it until then. Emma went on to say that Thomas had made her go to the Post Office and take out £100.00 cash and give it to him, otherwise he would hurt her. She alleged he had told her that if she told the police it was the 'worst thing she could do'. She also said Thomas had stolen her new mobile phone and that he had thrown away her underwear and clothing she had worn on the night of the sexual assault.

2.3.48 It was not until 7th January that a crime of rape was recorded on West Yorkshire Police systems. North Yorkshire Police Officers had visited Emma and recorded she was uncooperative. On the 8th January, the crime was allocated to a detective who tried to contact Emma but without success. The officer also sent a letter to Emma but again did not receive a response. It was a full month later (6th February) when the West Yorkshire detective sent an e-mail to North Yorkshire Police colleagues. They requested an officer to attend Emma's home and ascertain her wishes in relation to the investigation.

2.3.49 On 10th February, North Yorkshire Police responded to the e-mail stating they had been unable to speak with Emma and had left cards with contact numbers. The message states "A male has once answered her phone and she has refused to speak to officers. Emma does not appear to be willing to provide an account in relation to this matter."

2.3.50 Three more weeks elapsed before a supervising officer at West Yorkshire Police made an entry on the investigation log. They noted Emma was not engaging with the police investigation and directed that Thomas should be interviewed by voluntary attendance. The officer in the case then left a message for Thomas to attend the police station and so Thomas had ample warning of what was to happen. He attended the police station on 8th March 2019 and was interviewed regarding the rape allegation. He denied the allegation. His mobile phone was not seized. The day after the interview, the officer requested the investigation be finalised citing that Emma was unwilling to provide an account, the details of the offence are unknown, there were no witnesses, no forensics, no CCTV and no digital media. There was no risk assessment carried out regarding Emma's whereabouts nor to address any of her vulnerabilities as a vulnerable victim in a rape investigation. Further comment will be made about this investigation in the analysis section of this review.

2.3.51 Emma was not seen again by West Yorkshire Police. Six months after the finalising of the rape investigation, Thomas was arrested on suspicion of the murder of Emma.

Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV).

2.3.52 Emma's first recorded contact with TEWV was in April 2014 (though she had contact with alternative mental health service providers dating back to the 1990s). The first contact followed Emma's attendance at the acute hospital in Harrogate in April 2014. She had suffered a broken hip following an assault and was refusing treatment to aid her mobility. This meant she needed a mental capacity assessment in relation to any consent to treatment. Hospital staff determined she lacked capacity to make a decision on her treatment and so a 'best interests' decision was made under the 'deprivation of liberty safeguards (DoLS) (Mental Capacity Act 2005).

2.3.53 The next TEWV involvement with Emma was in November 2015. A referral had been made by the Accident and Emergency Department regarding issues with a carer. The assessment was that Emma was not appropriate for crisis support and her social worker was informed of the contact.

2.3.54 Thomas was referred by his GP to the Improving Access to Psychological Therapies (IAPT) service on 14th May 2016. The referral acknowledged his history of chronic anxiety and long term problems with depression, and how this had a significant impact on his day to day functioning. Thomas reported a history of alcohol misuse and violence towards others which had resulted

in several periods of imprisonment between 2000 and 2015. He had a difficult relationship with his parents and was not happy in the shared accommodation he had been allocated in Harrogate. He stated he had increased anxiety. The risk assessment recorded Thomas had no current thoughts to harm himself or others and that he had no responsibility for any vulnerable person or child. He agreed to be added to the 'self-guided help list.' An appointment for the IAPT self-guided help was offered to Thomas for 27th June 2016 but he failed to keep the appointment.

2.3.55 On 20th July 2016, police contacted the York Force Street Control Triage team. Emma was in a public house causing a disturbance. She had reported a domestic related assault to police which had apparently taken place a few days earlier. The suspect was Thomas but no charges had been brought. Although Emma had retracted her statement she was still fearful of Thomas and refused to go back to their home address. A brief history was taken; Emma had previous involvement with social services and a learning disability service in Harrogate but had no current involvement with social care or mental health services. She reported to the mental health professionals she had moved to York with Thomas on 9th July 2016, having previously lived with him at Birmingham and Harrogate. It was identified Emma did have accommodation available at the pub where she had caused the disturbance and had stayed there for the last two nights. Emma was not happy with the response from police or TEWV staff and became verbally threatening. She stated she would call an ambulance to source a bed for her but was advised this was not an appropriate use of NHS resources. The assessment was that Emma did not have a mental health illness. However, she was given the Crisis team telephone number should she need further advice. The TEWV professional also telephoned Adult Social Care to request a social care needs assessment.

2.3.56 Emma presented herself at York Accident & Emergency Department a few hours later (in the early hours of 21st July). She spoke with the A & E Liaison and Psychiatry team. She initially requested a women's refuge but prevented staff from exploring this option further. Emma was eventually removed from the department by police due to her aggressive manner.

2.3.57 Ten days later, police again contacted TEWV to report Emma had telephoned threatening to kill herself if she could not speak to her probation officer. The Harrogate Crisis team were asked to follow this up. TEWV informed police that Emma was not currently in receipt of any mental health service but advised the police conduct a welfare check and if there were any mental health concerns then the situation could be reassessed.

2.3.58 On 19th January 2018, Emma attended the Accident & Emergency Department at Harrogate Hospital. This followed an earlier incident with the police when she had apparently reported a 'friend' taking her mobile phone. Emma had threatened to harm herself with a knife so police had arranged an ambulance to take her to hospital. During her mental health assessment,

Emma stated her 'friend' befriends vulnerable people in order to take their benefits. She said he had taken her mobile phone and also her television. She told the mental health professional that she had reported this to the police. She no longer had any thoughts of self-harm. The assessment concluded there was no evidence of any mental illness present. On 25th January, a member of staff from the mental health liaison team telephoned Adult Social Care informing them of the team's recent involvement. However, Adult Social Care had no current involvement with Emma. Enquiries since then suggest Emma may have meant her probation officer rather than a social worker, and so inadvertently gave the wrong details to the mental health team.

2.3.59 On 26th October 2018 a practitioner from the Bradford Royal Infirmary contacted the Harrogate Crisis Resolution & Intensive Home Treatment team. Emma had presented at the hospital in Bradford and reported she had been visiting a male friend in Bradford who had taken money from her. Emma was distressed. The Harrogate team advised Emma had no current involvement with TEWV. The practitioner in Bradford shared information that they would not be referring to the Intensive Home Treatment Team (IHTT) in Bradford but would want a follow up appointment for Emma when she returned to Harrogate. The practitioner was advised to seek support from Emma's GP.

2.3.60 The next day, (27th October), Emma was brought by ambulance to Harrogate Accident & Emergency Department having reported she had 'slit' her wrists. There was no physical attempt but Emma had threatened to do so if she was not taken to see mental health services. Staff recorded that during the appointment, Emma was short tempered and refused to answer direct questions. She described historic life trauma events and that she had never had the opportunity to talk about them.

2.3.61 Although there were further requests for information from other agencies (GP or police) TEWV practitioners had no further direct contact with Emma.

<u>West Midlands Police.</u>

2.3.62 West Midlands Police had three contacts with Emma and Thomas. The first time (January 2016) was on behalf of colleagues in North Yorkshire who were requiring a welfare check for Emma.

2.3.63 There were two incidents reported to police while Emma and Thomas lived together in Birmingham in 2016. The first (March 2016) is noted as an argument over money. No offences were disclosed and following police contact Emma returned to Yorkshire. The second was another argument between Emma and Thomas regarding his intoxication. Police took Emma to the train station and she returned to Yorkshire.

2.3.64 For both incidents, the attending officers determined that Emma and Thomas were in a relationship and completed a Domestic Abuse Stalking and Harassment (DASH) risk assessment. Both incidents were assessed as 'standard' risk.

Yorkshire Ambulance Service

2.3.65 The Yorkshire Ambulance Service had extensive involvement with the victim and perpetrator over many years. A review of their records indicates there were 120 telephone contacts relating to 75 different episodes of care during the timeframe of this review (2016-2019). With such a huge volume of calls, it is useful to summarise some of the encounters:

2.3.66 During March and April 2016, Emma called the ambulance service three times. These related to chest, hip and leg pain. There were three more calls from Emma in August 2016. The first two involved Emma being agitated. She was shouting at the call-taker and then terminated the calls. On the third she reported pain in her hip and was referred to the 'out of hours' GP service.

2.3.67 During 2017, there were 14 calls either directly from Emma or made on her behalf by the police. They related to falls, mental health and social care concerns. Emma was often recorded as being distressed; on at least three occasions Emma became agitated and terminated the calls. The responses to the calls ranged from an ambulance being provided, to referrals to the out of hours GP service through to being given direct home care advice from paramedics.

2.3.68 Thomas had contact with the ambulance service twice; once in December 2017 when he enquired if his partner had called the ambulance service on his behalf and then in January 2018 when 'NHS 111' reported he was 'severely housebound'. This was referred on to his GP for further attention.

2.3.69 Emma made at least 40 calls to the ambulance service during 2018. Most of these were directly from her and on occasion calls were made by the police on her behalf. The reasons varied and included chest pain, welfare needs, dental pain, assistance in registering with a GP, knee pain, hip pain, mental health and mobility problems. On many occasions an ambulance was provided, on others advice was given. Ambulance crews made referrals when necessary (e.g. to social care in relation to home conditions or lack of food, to the pharmacy service for medication or to the out of hours GP service in relation to long term pain problems). Emma made three calls on 9th December which related to long term hip pain. The initial call was at 4.50am. Emma rang back at 6.27am and at 6.49 am to state she now had an appointment at Harrogate Hospital and no longer required an ambulance. This was her last direct contact with the Yorkshire Ambulance Service.

2.3.70 The last recorded contact with Thomas was on 27th December 2018 and was a report of an unconscious male at Thomas' address. The records show the patient had taken sleeping tablets and refused to go to hospital.

2.3.71 None of the calls to the Yorkshire Ambulance Service related to domestic abuse. There was never any disclosure or partial disclosures that may have suggested domestic abuse to the attending crews.

North Yorkshire County Council Health & Adult Services (HAS)

2.3.72 North Yorkshire Health and Adult Services (HAS) provided social care and support to Emma throughout the timeframe set by the Domestic Homicide Review panel. Each period of involvement is summarised:

2.3.73 During February 2016 there were 12 case recordings. A safeguarding referral had been received from North Yorkshire Police in relation to Emma. The reasons listed were self-neglect, mental health and the pressure of a court appearance. The request was for Adult Social Care input to explore supported living and assistance to care for herself. The outcome was the case was closed as Emma did not want Health and Adult Services (HAS) involvement.

2.3.74 From June 2016 to January 2017 there were 6 case recordings on the HAS records. There was a telephone call from Emma relating to her landlord selling her house. Another telephone call was from HM Prison service requesting to speak to an allocated worker. Emma was given advice to remain where she was staying over the weekend and to present to the Housing department if required on the Monday.

2.3.75 From May 2017 to January 2018 there were 51 case recordings on the HAS files. Emma had made contact requesting food parcels. Attempts to carry out an assessment were made but Emma declined support from HAS.

2.3.76 From 22nd January to 29th January 2018 there were 8 case recordings. Two new referrals had been made to HAS; one from the Yorkshire Ambulance Service and one from North Yorkshire Police. These were transferred to the Planned Care team within HAS. There was also a telephone call from mental health services. Emma had attended Accident & Emergency on 19th January due to concerns of self-harm reported by the police. A 'friend' had apparently stolen Emma's mobile phone. This case was allocated for contact and assessment.

2.3.77 During February 2018 there were 9 case recordings. There were attempts to make contact, but Emma did not want an assessment from HAS. She did request support for food. The case was closed to the Planned Care team and information on food banks provided.

2.3.78 On 6th May 2018 there was a call directly from Emma to the Emergency Department team. She requested to be rehoused in Birmingham as she was

afraid of her ex-partner. No name of the partner is shown on the notes. Emma did not want police involved or contacted. The outcome of this enquiry was that the 24 hour Helpline number for the Independent Domestic Abuse Services (IDAS) was provided to give support.

2.3.79 From May to September 2018 there were 21 case recordings. There was frequent contact from Emma requesting food. There were attempts to make an assessment by the Independence team. Food parcels were delivered. Professionals observed that Emma was unkempt. However, when asked she said she did not want further support.

2.3.80 On 26th October 2018, HAS received a call from the Bradford Royal Infirmary to check if Emma was known to social care in North Yorkshire. Emma had attended the Bradford Hospital and was refusing to leave. Emma stated a 'friend' in Bradford was tampering with her phone and had been taking money from her. HAS gave a summary of their involvement to the practitioner at the Bradford Royal Infirmary.

2.3.81 On 5th November 2018, HAS received a safeguarding referral from North Yorkshire Police. Officers were concerned that Emma was being taken advantage of by Thomas. Emma had apparently informed police she had given Thomas money and wanted it back. The contact notes at HAS state: 'Does the person continue to be at risk of harm? Unknown as Emma states will cease contact with him but there is previous history of 'domvio' between them.' The outcome was recorded as a request for care and support for Emma in relation to nutrition, clothing, hygiene, cleanliness of the house and financial matters. The safeguarding adults referral was attached to the electronic recording system.

2.3.82 From 5th November to 13th December 2018 there were 91 case recordings. There were further safeguarding referrals from the GP, police and Yorkshire Ambulance Service. These were in relation to concerns about nutrition, clothing, hygiene, cleanliness of the house and financial matters. A social worker was allocated who carried out two home visits. There were frequent calls from Emma requesting food. The reablement service was put in place to support Emma to get out of bed and washed and dressed in the evening. Emma did not want ongoing support from HAS. She did agree to a referral to the 'Living Well' agency, which was to support her becoming independent with food.

2.3.83 There were 23 case recordings from 13th to 28th December 2018. There were frequent calls from Emma requesting food. Food was obtained and delivered. There was a joint visit with HAS and a practitioner from the Integrated Mental Health team. Emma was given the details of a local convenience store which carried out home deliveries. There were no concerns regarding Emma's mental health and so she was discharged from the Integrated Mental Health team.

2.3.84 On 4th January 2019, a Safeguarding Adults Referral and a 'request for support' form were received from North Yorkshire Police. The requests were in response to allegations of rape and sexual assault which Emma had made against Thomas. There were also concerns about Emma's living conditions. Specifically, the referral stated that Emma did not continue to be at risk of harm at that point. In the following days, several attempts were made to contact the police representative but without success. A home visit was made by a HAS professional to Emma's home but there was no reply.

2.3.85 On 8th January 2019, Emma called HAS requesting support to make a police statement. A home visit was arranged with Emma for 14th January. A team manager within HAS made further attempts to contact the police to establish what exact support was required. Again, there was no response from the police to this query. On 9th January HAS received a call from Emma stating she needed to move house as Thomas had been ringing and threatening her. Emma wanted to move to Shropshire to be near her family and then wanted to come back to Harrogate at a later date. The outcome was that HAS would assist Emma in her housing application to move.

2.3.86 On 10th January 2019, the HAS team manager made contact with the police officer supervising the rape investigation. Support needs were discussed. The outcome on HAS records was that the police agreed for the allegations to be discussed with Emma in order to attempt to obtain further information and to confirm if Emma wished to pursue the allegations. However, it does not appear that police were specifically informed by HAS that Emma had alleged Thomas had threatened her. The same day a joint home visit was made by professionals from the Social Care team and the Integrated Mental Health team. They discussed the issues with Emma who confirmed she did want to pursue the allegations. Emma was no longer sure if she wanted to move house but she was informed she could still receive support from the 'Living Well' team who could assist with any housing need. Emma also agreed to receive support from specialist services who support victims of sexual crimes. Subsequent referrals were considered to 'Rape Support' and the Community Mental Health team. The social care coordinator agreed to support Emma in any police interviews and the police were then informed of the outcome of the joint home visit.

2.3.87 Emma cancelled the home visit planned for 14th January. She texted HAS to say she would like to move to Shrewsbury. The home visit was rearranged for 22nd January. This visit was in turn cancelled by Emma. The HAS professional made several attempts to speak with Emma. On 19th January Emma responded and said she had been very busy. She stated she no longer required support from the 'Living Well' team.

2.3.88 There was no further contact from the police and so the referral was closed. The HAS notes record that a new referral was to be made if input was required with the police interviews. There was no further contact from Health

and Adult Services with Emma. As there was no further contact from police, HAS did not action any referral to specialist rape support services.

City of York Housing Options

2.3.89 The involvement of Housing Options in York with Emma was over a limited period of two months between 25th July and 20th September 2016.

2.3.90 On 25th July 2016, Emma visited the Housing Options office in York to make a homeless application. She stated she had left her home in the city as she was in fear of her former partner (Thomas). She stated she wanted to go to a refuge outside of York so that she would feel safe. Emma was placed in temporary Bed & Breakfast accommodation until a place in a refuge could be found. A referral was made to a refuge facility in Staffordshire. The notes in the housing records indicate Emma presented as 'chaotic, confused and unkempt.' The Housing Officer contacted the Independent Domestic Abuse Service (IDAS), but North Yorkshire Police had already made a referral. IDAS in turn had made a referral to Adult Services.

2.3.91 Conversations took place between York Housing Options and their colleagues in Harrogate as it appeared Emma had been investigated for a fraudulent housing benefit claim – making a claim in Harrogate at the same time as claiming such a benefit for a property in Birmingham. The refuge in Staffordshire also contacted Housing Options to say they could not get a reply from Emma when they attempted to make contact and so would have to let their vacant room go as there was a high demand from other victims.

2.3.92 On 29th July the Housing Officer contacted Health and Adult Services. They confirmed that previous concerns were self-neglect, the state of her property, mental health issues and her relationship with Thomas who had numerous convictions. Although police believed Emma should access supported living, Emma declined and did not want any additional support. She was allocated accommodation which was independent living for older people. However, she was asked to leave after three days as she had been abusive to staff, residents and visitors. Emma was then placed back at the temporary Bed & Breakfast accommodation.

2.3.93 Enquiries continued into August with a request for a social and physical needs assessment. However on 15th August, Housing Options were notified by the Bed & Breakfast owner that Emma had left the property with a man, and had taken her belongings. The room at the property was then cancelled. On 18th August, Emma attended the Housing office. She confirmed to the Housing Options manager that she had stayed with Thomas for the last few days. She was given an emergency 'crash pad bed' on the ground floor of a homeless hostel. The following week, more suitable accommodation was offered, which was staffed seven days a week. Emma was reluctant; first citing that she did not know where the new accommodation was. Then she said she couldn't walk there. The location of the bus stop was given to her

along with her bus fare but Emma insisted she was given a taxi which was declined. Emma finally refused to go when it was explained there was a 'no visitor' policy at the new premises.

2.3.94 On 25th August 2016, the manager at the homeless hostel rang the Housing Officer to state that Emma was going to move back in with Thomas. The Housing Officer then spoke to Emma to explain that if she went back to Thomas, then City of York Council would not provide any more accommodation for her as she was no longer fleeing violence from him. The professional advised her to think carefully about this before she moved in with Thomas. Later that day, the hostel staff rang Housing Options to confirm Emma had left in a taxi and said she was going back to Thomas. As she had returned back to a property where she already held a joint six month tenancy the Housing Officer was satisfied Emma was no longer 'homeless.'

2.3.95 Emma rang again two weeks later on 7th September to say she had nowhere to stay that night. She was given a bed at a homeless hostel and advised to come into the housing office the next day. However, Emma did not attend and there was no further contact with her.

Bradford District Care NHS Foundation Trust

2.3.96 Bradford District Care NHS Foundation Trust (BDCFT) provides care for people of all ages who have community health and mental health needs. The Trust also provides specialist support for people with learning difficulties and physical health needs. BDCFT had several contacts with Emma and also one contact with Thomas during the timeframe considered by this review.

2.3.97 BDCFT records show 13 separate entries relating to Emma. She accessed two of BDCFT's services; (a) The First Response Service (which also includes 'tele coaches') and (b) The Accident and Emergency Liaison Team, which is based at Bradford Royal Infirmary. Nine of these thirteen entries were queries or requests for advice from other agencies (e.g. police or probation service, or alternative mental health service providers). Four of them were direct contact with Emma. In turn, two of these direct contacts were via 'tele coach' and two were in person. A 'tele coach' is the first point of contact once a member of the public gets in touch with the service. They are staff who are experienced in responding to and assessing a person's mental health needs and provide guidance to help and support the management of the immediate situation.

2.3.98 On 10th May 2017, the First Response Service received a call from the police. Officers were concerned about Emma's mental health presentation. The FRS practitioner spoke with Emma on the telephone. Emma reported she had been suicidal and she had been in prison for six months. She stated that her current house was not suitable and she was unable to move around in it. Medication was discussed. When Emma was asked about any plans to

end her life she replied, “That’s irrelevant.” Police were informed that Emma’s concerns were a social issue and that she would not answer questions relating to her mental health. The FRS professionals told police that they would ring Emma back later that day. However, when they did call back there was no reply. A message was left but Emma did not respond.

2.3.99 There was a further call to the First Response ‘tele coach’ service on 15th May. The call again originated via the police. The practitioner spoke with Emma who stated she “wouldn’t do anything stupid.” Issues around accommodation were discussed and Emma confirmed she was due to see her probation officer. No acute mental health concerns were identified and Emma stated she no longer wished to engage with the First Response Service. The FRS practitioner subsequently spoke directly with the probation service.

2.3.100 On 17th May 2017 Emma was seen by a Psychiatric Liaison Nurse (employed by the Bradford District Care Foundation Trust but based within the Accident & Emergency Department at Bradford Royal Infirmary). Also present was the Safeguarding Named Nurse (employed directly by the Bradford Teaching Hospitals Foundation Trust). Emma had called an ambulance that morning due to mobility issues and mental health problems. Emma denied being suicidal. She stated she had a partner (Thomas) - he moved to Bradford and has a tenancy at the property that she is living in. They were to live there together, however, Thomas had met someone else and had moved out. Emma was not aware of this until she came to Bradford. Over the past 10 days Emma had apparently been contacting her probation officer and complained that the flat was not adequate for her needs. She stated she was unable to leave the flat. The Psychiatric Liaison Nurse mental health opinion is recorded as: ‘Emma was sat in a wheelchair in a cubicle dishevelled but appropriately dressed. Subjectively she reported to suffer with anxiety however did not present as anxious. No psychotic symptoms evident or reported. Has insight and capacity. Denied any risks to self or others.’ There was no acute mental illness and Emma’s presentation was identified as social needs led.

2.3.101 On 26th October 2018, Emma was seen again in the Accident and Emergency Department at the BRI by a Psychiatric Liaison Nurse. She had stayed at a male friend’s house the night before and claimed that he and his partner had stolen money and various other items from her. Emma also alleged that she had been bullied and harassed by this couple. The risks were identified as Emma presenting as vulnerable. She expressed fleeting thoughts to end her life ("I feel like jumping in front of a car") but denied any actual intent to act upon this. She was extremely distressed and tearful initially and had to be escorted to the cubicle by a police officer. She was well dressed, though slightly unkempt in her overall appearance, salivating excessively as she spoke, with poor dental hygiene apparent. Emma appeared significantly underweight. She was well orientated to time, place and person. She spoke to her male friend (Thomas) on the telephone shortly

after entering the cubicle and had an animated conversation with him during which Emma repeatedly asked him "do you want to see me dead?". The outcome of assessment is recorded as 'suicidal ideation in response to social issues, exacerbated by possible financial/emotional abuse and maladaptive coping mechanisms. Plan: Discuss with Harrogate Services. Discuss with BRI Safeguarding team. Emma plans to seek a possible restraining order against her friend and his partner.'

2.3.102 Later the same day, the Psychiatric Liaison Nurse was asked to see Emma again whilst in the A&E Department as she was reportedly expressing thoughts to throw herself in front of a car. She again described feeling despair with regards to the alleged financial abuse from her friend and that she had not been supported adequately in the community. Emma refused to engage with the GP. She did however agree for the Liaison Nurse to contact the GP after encouragement. Hospital safeguarding practitioners reported that Emma was known to adult social care. Emma also stated that she would not leave the hospital until she had spoken to the police. The police were contacted, but Emma then declined to speak with them.

2.3.103 There were further information exchanges between BDCFT and the police in October 2018 and January 2019 and with colleagues in North Yorkshire mental health services in January 2019, but the entry from 26th October 2018 was the last direct contact between BDCFT and Emma.

2.3.104 There was one contact with Thomas. This was on 22nd January 2019 and was a referral to Acute Care Services by the police and related to anti-social behaviour with his neighbours and anxiety.

<u>Bradford Teaching Hospital NHS Foundation Trust</u>

2.3.105 Bradford Teaching Hospital NHS Foundation Trust submitted their own IMR for the Domestic Homicide Review. They are a separate Health Trust to the BDCFT. They had only one contact with Emma. This was on 26th October 2018. The Psychiatric Liaison Nurse who dealt with Emma on that date was based within BTHFT premises but was actually employed by BDCFT. The episode is already captured within the summary of the BDCFT response (above). To confirm, the role of the safeguarding practitioner within BTHFT, is to discuss with patients any disclosures of abuse made and ascertain their views and wishes in accordance with the joint multi-agency safeguarding policy and procedures (West Yorkshire, North Yorkshire and York). The practitioners liaise with relevant partner agencies as required and ensure referrals are made in accordance with the patient wishes They will see patients jointly with a psychiatric liaison nurse from BDCFT who is based in the Accident and Emergency Department within Bradford Royal Infirmary, as required.

NHS Bradford City, Bradford District and Airedale Wharfedale & Craven CCGs (on behalf GP Practice for perpetrator)

2.3.106 Thomas moved around frequently and lived in many areas of the UK. He registered with a GP Practice in Bradford on 9th November 2017. He had 15 appointments or telephone calls to the GP between November 2017 and February 2019. These related to issues around anxiety. He was prescribed medication and 'talking therapy.'

2.3.107 On 14th December 2017 a DLS incapacity form was completed. This was a request from the Health and Disability Assessments.

2.3.108 On 4th April 2018, there was a GP review. Thomas had some slurring of his words. He denied alcohol or illicit substances, denied suicide risk and medication was issued.

2.3.109 There are no notes on Thomas' GP records of his partner, ex-partners or any matters relating to domestic abuse.

North Yorkshire Police

2.3.110 North Yorkshire Police had extensive involvement with both the victim and perpetrator over many years. During the timeframe set for this Domestic Homicide Review (2016-2019), the Force had over 100 recorded 'occurrences' (contacts or follow up actions) with Emma or Thomas. Many of the calls were not domestic abuse related and were connected to Emma's other vulnerabilities. However a significant number (21 in total) are considered as related to domestic abuse.

2.3.111 The first incident of domestic abuse during this timeframe was on 11th January 2016. Emma called 999 at 3.36am. The police call-handler found it difficult to understand what she was saying, but it was believed Thomas was outside her property in Harrogate. She said he had followed her from Birmingham. He had also been ringing her. Emma stated they were in a relationship and that he was quite controlling. Emma also said she was scared. The call was categorised for an 'immediate response' and officers attended promptly. However, when they arrived they could not get an answer at the door. Staff in the Force Control Room tried to re contact Emma but her telephone went to 'voicemail.' Officers did not attempt to force entry to the property and the incident was left on hold for several hours. At 7.33am a supervising officer reviewed the incident and sent a Police Community Support Officer (PCSO) to Emma's address. Again there was no reply and enquiries at other known addresses could not find Emma. Finally, at 2.17pm, Emma answered her door. She told the officer that the man she had been staying with in Birmingham was no longer at her property. She stated he was 'just a friend' and that she planned to return to Birmingham in the next couple of days.

2.3.112 There are two further entries on the police log for this incident. The first follows the result of an enquiry North Yorkshire Police sent to colleagues in the West Midlands Police. It records confirmation that Emma was sharing a one roomed bedsit with Thomas in Birmingham and that she appeared to be in 'some sort of relationship with him'. The second entry confirms that Thomas has numerous convictions including for harassment and assault. There was no submission of a domestic abuse, stalking and harassment (DASH) risk assessment (Form 253 which is the nationally recognised police report to record domestic abuse incidents).

2.3.113 The next domestic abuse related incident dealt with by North Yorkshire Police was on 7th March 2016. At 12.40am, Emma dialled '999' to report that her partner, Thomas, kept ringing her. She was advised to unplug her telephone. Emma confirmed to the call-taker that Thomas was not at her premises and that he was in Newcastle. As there was no assessed immediate danger, Emma was offered an appointment with police for 9th March. She declined. The following day a PCSO attended. Emma would not permit the PCSO to enter so they had a conversation on her doorstep. Emma stated she was fit and well and was not in any danger of harm. The PCSO advised her of the domestic abuse support agencies that were available. No further action took place. The PCSO did not submit a 'Form 253' (domestic abuse risk assessment) and so no record of a domestic abuse incident taking place was recorded on the Force systems.

2.3.114 The third domestic abuse related incident was in York and occurred on 18th July 2016. Emma called '999' to report she had been assaulted and wanted police to attend her address. She was crying and whispering to the call-taker that she was not safe. She was asked by the call-taker if this was 'domestic related' to which Emma replied "yes". She also stated she needed an ambulance. The ambulance service were contacted and police officers immediately attended Emma's address. Thomas was not present. Emma told the attending officers that they were no longer in a relationship but that they did house share. She stated Thomas had punched her in the face and kicked her leg. There was no other accommodation free so officers gave Emma security advice and placed a 'marker' on the address. They began to make enquiries to trace and arrest Thomas. Officers had completed a 'form 253' domestic abuse risk assessment (the assessed level of risk was 'medium' risk). Emma's replies to questions recorded on the risk assessment included:

- Are you very frightened? Answer: 'Yes.'

- What are you afraid of? Answer: 'Further violence.'

- Do you feel isolated from seeing family and friends? Answer: 'Yes.'

- Have you separated or tried to separate in the last year and is the abuse happening more often? Answer: 'Yes.'

2.3.115 Emma made a further 11 calls to police (most of them on the '999' system) over the following four hours. The reasons varied but were mainly to insist she wanted to withdraw her complaint, to say that the incident had not happened, to speak to the attending officer and to speak to the Inspector in charge. She was aggressive during most of the calls. During a subsequent visit, it transpired that Thomas had attended the address after police had left.

2.3.116 Later that same day, Thomas was interviewed and denied any offences. This was a formal police interview held under caution at the police station. He also stated they had never been in a relationship. A supervising officer recorded there was no complaint, no injuries and no corroborating evidence. No further action was taken in relation to the original assault allegation.

2.3.117 Two days later, a specialist domestic abuse officer employed by North Yorkshire Police reviewed the incident. They forwarded the report to 'IDAS' (the Independent Domestic Abuse Service) and ensured there were domestic abuse 'flags' on the address.

2.3.118 There were three more domestic abuse related incidents dealt with by North Yorkshire Police during 2016. These featured Emma making allegations of assault and violence against Thomas and abandoned '999' calls. Again, Emma did not substantiate the allegations, was abusive to call-takers and proved difficult to trace. No crimes were recorded and no 'form 253' domestic abuse risk assessments were carried out.

2.3.119 There were five domestic abuse related occurrences during 2017. The first of these was on 26th July 2017. Emma rang '999' at 12.59am from her address in Harrogate to report a male (Thomas) continually contacting her and making nuisance telephone calls. Emma was logged as not making much sense and having mental health issues and learning difficulties. She was asked to call back in the morning if she wanted to make a complaint. The call-taker passed the incident to the local police Safer Neighbourhood Area.

2.3.120 It appears to have been four days later when a PCSO from the Neighbourhood Police Team attended Emma's address. They confirmed Thomas was ringing Emma quite often and this upset her. She asked the officer to ring Thomas and tell him to stop. The officer completed a 'vulnerability risk assessment' but not the recognised form 253 domestic abuse risk assessment. The PCSO recorded that Emma had support from neighbours and external agencies including the Homeless Project and the Probation Service. They noted 'She just said that his calls were annoying. I do not believe she is at risk. Both parties suffer from mental health issues.' The PCSO also recorded that Emma became annoyed as they had attended her premises. She did not want her neighbours to see the police at her door. As no form 253 was completed then no specialist domestic abuse officer followed up any enquiries.

2.3.121 The other incidents connected to domestic abuse during 2017 included:

(a) August 2017: A call via West Yorkshire Police who were investigating an allegation by Emma against Thomas of assaulting her in a shop in Bradford. Emma had declined to wait at the scene and West Yorkshire needed a welfare check to see if she was okay. This call was resolved as Emma actually returned to the shop in Bradford while police were still there.

(b) August 2017: A historic allegation of a theft of her television by Thomas while she was in prison. The call-handler advised Emma this was a civil matter. Emma went on to say she had been assaulted by Thomas in Bradford. Eventually, North Yorkshire Police were able to confer with colleagues in West Yorkshire Police and confirm this was the matter they were already investigating. However, they did ask North Yorkshire to obtain a witness statement from Emma. She declined to provide one and stated she did not want any action taking.

(c) September 2017: (Again via West Yorkshire Police), Emma reported Thomas was harassing her - contacting her every day and had previously trapped her in his house in Bradford. Apparently Thomas had made counter allegations against Emma. West Yorkshire Police were requesting officers visited Emma at her home in Harrogate to conduct a welfare check and to ask if she had any evidence to support her allegations. When North Yorkshire Control Room spoke with Emma, she declined to see officers as she was going away on holiday. She did add that Thomas had been texting her to go over to Bradford 'even though he has got someone else'. This information was shared with West Yorkshire Police. Neither organisation completed a domestic abuse risk assessment.

(d) October 2017: Emma had contacted North Yorkshire Police alleging Thomas had stolen £150.00 from her. She stated she gave him the money while she was at his address (in Bradford) because she was frightened of him and that it happened 'while his new girlfriend was there.' Emma said she wanted him to be arrested and wanted a restraining order so that he did not come to Harrogate. While still making this call to the police Control Room, Emma began talking about a church mission and then about a friend who had died on Christmas Eve. She then started shouting at the call taker. The conversation went round in circles and Emma became more abusive. Eventually the call-taker liaised with a supervising officer who agreed the best way forward would be for an officer to visit Emma the next morning. Emma made subsequent calls varying from cancelling police attending to her needing food. Eventually a PCSO attended Emma's address. The officer noted she was very hostile and refused to speak with them. She told the officer the matter would be dealt with by West Yorkshire Police and she would call North Yorkshire if she wanted them. There was no domestic abuse risk assessment completed and no specialist domestic abuse officer was made aware of the incident.

2.3.122 The first incident dealt with by North Yorkshire Police in 2018 was reported via West Yorkshire Police on 6th January. Emma had called them requesting

they speak with a male (Thomas), with whom she used to be in a relationship over a year ago and to tell him she does not want him to contact her anymore. She stated he keeps calling her which was causing her distress. He had apparently threatened to file a harassment order against her, was asking her for money, making threats regarding her money and asking her to come to his house. When North Yorkshire Police left a message on Emma's phone she rang back but wanted to speak to a specific officer who was not on duty. She was abusive and stated she would be contacting 'Julia' (believed to refer to the North Yorkshire Police and Crime Commissioner). An officer from the Force service desk spoke with Emma on the telephone two days later. They confirmed Thomas had been persistently ringing asking for money. Emma was advised to stop swapping her SIM cards, keep one number and not to divulge it to Thomas. They noted on the police log 'this is not domestic and hopefully the matter will cease if she heeds to advice given.' There was no consideration of safeguarding, no consideration of harassment nor any domestic abuse risk assessment submitted.

2.3.123 Emma contacted North Yorkshire Police on 13th January 2018 to repeat the allegation made several months earlier relating to Thomas and her 'stolen' television. An officer from the service desk rang Emma the next day. She stated she had 'made things up because of her mental health issues.' She confirmed she did not want to see a police officer.

2.3.124 In March 2018 Emma reported that her ex-partner, Thomas, had been to her address that day and was harassing her. She also stated he had stolen money from her and this had been going on for months. The police call-taker added a comment to the police message: 'Emma is well known for hoax calls. There is nothing really domestic abuse related but he is linked as her ex-partner.' Emma was advised to dial '999' if the male attended her address. An appointment was made for an officer to visit Emma a few days later. That attending officer recorded they had submitted a form 253 domestic abuse risk assessment 'for completeness.' It is not clear what this means. The officer recorded they spoke with Emma at length about her ex-partner who keeps phoning and texting her. The officer also recorded that Emma's neighbour told her Thomas had visited her address while Emma was out. Despite the harassment and stalking allegations clearly being made, the officer finalised the incident as 'no offences disclosed.' Subsequently a specialist domestic abuse officer reviewed the incident. They noted the circumstances described but agreed the assessment was a 'standard' risk. Further comment on the handling of this incident will be made in the analysis section of this review.

2.3.125 There were three more incidents reported to North Yorkshire Police by Emma during April and May 2018. Each related to allegations of Thomas repeatedly calling and asking for money. There was also mention of him threatening to tell her parents she had been to prison if she did not give him money. Despite the information already on police systems, none were

recorded as domestic abuse incidents. The messages noted Emma's 'learning difficulty' or that she is known for 'hoax calls' or 'verbal abuse.' On one call, the police call-taker recorded they believed this was not a hoax call. However, no action was taken against Thomas. During one police attendance, Thomas rang Emma while the officer was still there. At her request, the officer spoke to Thomas. He was advised if he wished to be reimbursed for money he should contact a solicitor. The police record he was told not to contact Emma as his contact was 'unwanted'.

2.3.126 On 1st November 2018 Emma called North Yorkshire Police to report Thomas had stolen £350.00 of her benefit money from her. The call-taker found it difficult to understand Emma as she kept talking about other matters. However, they did note Thomas' details as a 'suspect' for the theft and that he lived in Bradford. When asked what the relationship was, Emma replied he was a 'friend'. An appointment was made for an officer to attend Emma's address the next day. When the officer did visit Emma, they noted she suffered ill health and mental health issues. They also observed her home was in a poor condition and that she appeared to be sleeping in a chair in the front room surrounded by discarded magazines and food wrappers. She told the officer she had given Thomas £350.00 to buy a PS4 game and that she wanted the money back. The officer recorded they advised Emma this was a civil matter and not a theft.

2.3.127 On 3rd January 2019, Emma rang North Yorkshire Police from her home in Harrogate to report she had been sexually abused by her friend, Thomas, a week earlier on 27th December. She stated Thomas' partner was in bed at the time. She told police that Thomas had filmed the abuse on his mobile phone. Emma went on to say that she had also been physically assaulted by Thomas' partner who had hit her over the head. She gave the name and age of his partner and said she now had a lump on her head. Emma then told police how Thomas had made her go to the Post Office and withdraw £100.00 for him. He allegedly told her not to go to the police as 'it was the worst thing she could do.' She also said Thomas had stolen her new mobile phone. All of these incidents had taken place while she was staying at his house in Bradford between 25th December and 2nd January. Finally, Emma said she had used taxis from Harrogate to Bradford and back and that she had not kept her clothing from the night of the sexual assault. She described the clothing to police and told them she had left the items in a box in the house in Bradford.

2.3.128 Two officers from North Yorkshire Police's Serious Crime team attended Emma's address that same afternoon and spoke to her about the incident. They noted Emma had mental and physical health issues that made communication difficult. The officers probed the detail of the sexual abuse but Emma did not give much more detail other than Thomas had tried to make her touch him sexually. She kept reverting back to property items she had originally given to him as a gift but now she wanted them back from him. The officers told her that was not a police matter and Emma became

abusive. The officers noted that any forensic evidence was still within the valid timeframe if Emma had been raped. However, they did not believe she could consent to this process with a full understanding. They could not establish the extent of offending against her and decided therefore to make a request to Adult Social Care to provide support and assist with communication. Finally, the officers noted Emma was living in 'squalid' conditions, and they included this information on their subsequent referral to Adult Social Care.

2.3.129 Later that afternoon, the Detective Sergeant supervising the enquiry recorded that until the Adult Social Care support was in place, they did not propose to make any further contact with Emma. As the offence had taken place in the West Yorkshire area, the decision was for the report to be passed to West Yorkshire Police for 'consideration of scenes and suspect management in their area.' The supervisor followed up the report with a telephone call to West Yorkshire. Likewise they submitted the referral to Adult Social Care and followed this up with a telephone call to a social care advisor. There is no record of any safeguarding plan being put in place to protect Emma while matters progressed.

2.3.130 Three days later, an officer from West Yorkshire Police emailed the North Yorkshire Police Control Room. They referenced the sexual assault reported to North Yorkshire Police on 3rd January. The officer stated West Yorkshire Police had been unable to make contact with Emma and the request was for North Yorkshire officers to speak with Emma to ascertain her wishes in relation to the allegation. If she was unwilling to make any complaint then they asked that she signed an officer's pocket notebook to confirm this.

2.3.131 Over the following four days, North Yorkshire Police attended Emma's address six times trying to contact her. Officers noted that the ground floor flat looked empty. They also traced her most recent known telephone numbers. On 9th January, the Force Control Room rang Emma's mobile phone and a male answered who declined to give his name. Emma could be heard in the background and did not want to speak with the police. (The police Control Room staff recognised Emma's voice from previous interactions with her). She said she would call back when she was up and about. The Control Room advised that police needed to speak with her in person. Later the same day, police again rang the mobile number. There was no reply and a voicemail was left. That afternoon, an Inspector reviewed the police log. They recorded that North Yorkshire Police had made all reasonable attempts to contact Emma and an email was sent to West Yorkshire Police to inform them that North Yorkshire Police were closing the log.

2.3.132 In addition to the 21 incidents between 2016 and 2019 dealt with that could be linked to domestic abuse, there were many more contacts between Emma and North Yorkshire Police over that three-year time frame being considered by this review. The other incidents related to issues ranging from

arguments with neighbours, to being detained for theft, to assisting the ambulance service with entry to her property, through to her social and mental health problems. There were also a significant number of calls coded as 'hoax' calls that related to times when Emma was in distress and stated she had no food or wanted a lift home or was incoherent in what she actually wanted.

2.3.133 There were two calls to North Yorkshire Police relating to Thomas (far fewer as he lived most of this time outside the North Yorkshire Police area). On 3rd September 2016, his landlord in York rang police for advice. He stated Thomas was being threatening and was worried he would not vacate the property when his tenancy ran out. He described Thomas as 'dangerous' and said he believed he had mental health issues. The landlord just wanted police to log his call and did not want any action taken.

2.3.134 The second call relating to Thomas was on 8th September 2016. A neighbour stated Thomas had just moved into their street. He told his female neighbour he had anxiety and struggled to leave the house. She had therefore offered to get his shopping for him. He gave her £30.00 to do so. Later, Emma rang the neighbour and accused her of stealing Thomas' money and threatened to report her to the police. The Force Control Room advised her against any future dealings with Thomas.

<u>Harrogate Borough Council</u>

2.3.135 Harrogate Borough Council had contact with Emma from two separate departments. These were the Housing section and the Community Safety Hub.

2.3.136 Emma was released from HMP Low Newton on 7th July 2017. She moved to temporary accommodation at a hostel in Harrogate. An application for permanent accommodation was made on 10th July 2017. Emma was assisted in this by both a Housing Officer and a Probation Officer. She was the sole applicant. There are sections on the application form that include 'domestic violence, mental health difficulties and physical disability'. The latter two were 'ticked' with comments relating to Emma's vulnerability. The section on 'domestic abuse' was not completed.

2.3.137 Due to Emma's recorded physical disability (fractured femur and hip) and her mental health issues (suicide attempts and anxiety) the Housing Officer made a referral to 'Stonham', a charity housing support service.

2.3.138 An introductory tenancy (12 month's duration) commenced on 24th July 2017. The property allocated was owned and managed by Harrogate Borough Council. Early in the tenancy, Emma went into rent arrears and she received several visits from Housing Officers to try to rectify this. She would not let professionals enter her property and the conversations took place on the doorstep or through the window.

2.3.139 Due to the rent arrears the introductory tenancy was extended from 12 to 18 months. Ultimately, the problem with the arrears was resolved by the transfer of Universal Credit payments directly to the Council.

2.3.140 In October 2018, Emma made an application to transfer from her current accommodation. She told staff that her bathroom was unsuitable for her needs and that she needed a wet room. Again, she was the sole applicant. Again, her physical disability and mental health needs were noted but there was no indication on the application form of domestic violence. There were more details on this application relating to social needs. These included assistance with daily living tasks, basic hygiene and assistance with shopping and budgeting. A referral was made to the Community Voluntary Service ('Help at Home') to assist Emma.

2.3.141 Emma continued to contact the Housing section on a sporadic basis to discuss rent or other connected matters. The last such conversation was in October 2018.

2.3.142 The Harrogate District Community Safety Hub was established in 2016 and was initially set up as a pilot project to provide a multi-agency response to vulnerable people and victims of anti-social behaviour. The model used was for fortnightly meetings attended by partner agencies. The Hub does not consider domestic abuse incidents. Any cases that may feature domestic abuse are referred to the MARAC (Multi Agency Risk Assessment Conference).

2.3.143 A referral relating to Emma was made in February 2018 by the police. Initially, the referral had been made to SAFE (Service for Adults Facing Exclusion) but it was diverted to the Hub as it was not considered to be the requisite level to meet the criteria of SAFE. The reasons for Emma's referral was that she had made a significant number of '999' calls to emergency services and to the council's housing section. There had been 36 such calls between July 2017 and January 2018. Many of the calls were considered either a hoax or a misuse of the '999' system. It was also noted Emma had physical and mental health needs and had previously made threats of suicide. She lived in a property which was not hygienic and was sparsely furnished.

Emma's case was discussed at the Hub meeting on 6th March 2018. There were representatives present from Harrogate Borough Council, North Yorkshire Police, Tees Esk & Wear Valleys NHS Trust and the Probation Service Trust. The issue of domestic abuse was not raised or discussed by any representative at the meeting, yet the information about Emma suffering domestic abuse was held on police, health and probation systems. An action from the meeting was to ask Emma to enter into an 'Acceptable Behaviour Contract' (ABC) The terms of the contract were:

- *Must not contact North Yorkshire Police on 101 or 999 unless it is a genuine emergency*

- *Must not be rude and abusive to North Yorkshire Police call-takers*
- *Must not act in an anti-social manner in a public place at any time*
- *Must not contact Harrogate Borough Council Housing Services unless there is a genuine need for help or information*

The rationale of this contract will be considered in the analysis section of this overview report.

2.3.144 On 22nd May 2018, Emma's case was reviewed and it was agreed her behaviour had improved to the extent the 'ABC' itself was managing her behaviour. That concluded the involvement of the Community Safety Hub.

Office of Police, Fire & Crime Commissioner

2.3.145 There was a brief contact between Emma and the OPFCC. This related to a complaint Emma had made that her injuries from an assault (in April 2014) were not outlined to the court. She therefore believed the defendant was not correctly dealt with. The OPFCC reviewed the matter and was satisfied that North Yorkshire Police had asked the Crown Prosecution Service (CPS) to delay the proceedings until the full medical evidence was available. The CPS did not do so and apologised for this. This information was passed to Emma by the OPFCC by way of letter. The actual assault was not perpetrated by Thomas nor was it 'domestic' related. It did though cause Emma a permanent disability with a serious injury to her leg (broken femur).

Section 3: Family involvement and Perspective

3.1 Family Involvement

3.1.1 Initial family contact was facilitated by the police Family Liaison Officer (FLO). The FLO had already built up a relationship with the family during the criminal investigation and trial process. The FLO introduced the Independent Author to the family.

3.1.2 The family declined the direct support of a specialist advocate. The role of an independent advocate was explained to the family. They decided they did not require this additional support.

3.1.3 The Independent Author for the Domestic Homicide Review continued to liaise with the family directly and update them regularly with developments. The Terms of Reference were shared with family members.

3.1.4 The Independent Author met with the family in person in September 2020. They were able to review the draft report prior to its completion and had the opportunity to comment.

3.2 Family Perspective

3.2.1 Emma had a difficult childhood and accessed services from a young age. She lived at home with her parents and younger sister. However, when her behaviour became more challenging she was supported by professionals from social care.

3.2.2 The Independent Author had several meetings with Emma's sister and is grateful for the information she provided which gave a longer term perspective to Emma's life and experiences. The sister agreed to be the main family contact and assisted by passing on information from her mother. Their mother is elderly and following post cancer treatment, now suffers with anxiety (shared with permission of the family) and so did not want to be directly involved with the Domestic Homicide Review. As Emma's sister said to the independent author about her mum; "It's just too much for her."

3.2.3 Emma was transferred from a mainstream primary school to a 'special' class. The family recall this was not due to learning difficulties but was more linked to Emma's disruptive behaviour.

3.2.4 The sister remembers that both girls needed an operation on their feet when they were young children. The operation went well and medical practitioners continued to see the girls to monitor their recovery. Their mother recalls that during one examination the doctor responsible for their treatment had also looked at Emma's wrist and simply said "she needs to see a psychiatrist." There were no marks on the wrist so their mother found the whole incident a

little strange. Emma did subsequently see a psychiatrist but the family do not believe anything followed from this.

3.2.5 Emma transferred from a mainstream secondary school to a special boarding school. She stayed there during the week but came home at weekends. At age 16 years, Emma attended an adult training centre. Her sister cannot remember Emma ever having a job. Her challenging behaviour continued throughout her teenage years and Emma was assigned her own social worker. On her 18th birthday, Emma was living in a supported living environment but remained within her hometown in Shropshire.

3.2.6 Emma continued to engage in disruptive behaviour and this included involvement in minor crime such as theft. For this reason, she moved to the Swansea area when she was in her late teens. The family believe she lived there for about two years. At some point in her early 20s, Emma's social worker arranged for her to move to accommodation in Yorkshire.

3.2.7 Emma's sister married a soldier and so she spent many years living outside the UK and did not see Emma very often. She had not seen her sister for about 10 years prior to Emma's death. Emma did keep in regular contact with her mother. She telephoned her mum every week; sometimes daily. Home visits became less frequent as the years passed and Emma's sister believes this was because of Emma's chaotic lifestyle and possibly due to money problems to pay for the travel. The last time Emma's sister saw her she did notice she was painfully thin, she had very poor dental hygiene and she walked with a stoop.

3.2.8 The family are aware that Emma did not have an operation (against medical advice) in April 2014. They have expressed concerns about this. Although an Independent Mental Capacity Advocate (IMCA) was involved in the decision-making, the family are sure that any refusal by Emma to have the operation would have been because Emma had always been petrified of needles.

3.2.9 None of the family had met Thomas but they were aware Emma was in a relationship. (The family believe it was more of an 'on/off relationship' rather than something permanent). Emma's mother had spoken on the telephone with Thomas. She found him manipulative. For example, he once said to Emma's mum "I bet you would want to know if she had been in prison."

3.2.10 Emma's sister still has fond memories of her sibling. She knows Emma could be very disruptive and indeed the girls would quarrel. Emma's sister was frustrated when Emma would take her toys and not return them. She remembers playing 'board' games but that Emma would refuse to play if she could not win. She also remembers family days out. They would play 'rounders' but Emma would only ever want to 'bat' and would simply refuse to 'field' during the game. But Emma had a good heart and could be very caring if she chose to be. She loved the family dogs and would regularly bring her mother flowers.

3.2.11 Emma did have many challenges in life but the family know that she was vulnerable. They believe that Thomas was aware of Emma's vulnerabilities and preyed on these.

3.2.12 Following the trial verdict, Emma's sister provided a victim impact statement to the Court. She stated that Thomas had 'disposed of Emma like a piece of trash.' She expressed how she missed her sister and now had to support her two elderly parents in coming to terms with something no parent should have to come to terms with.

Section 4: Equality and Diversity

4.1.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

4.1.2 The characteristics relevant to this review are disability and age.

4.1.3 Thomas did not have a formally diagnosed disability but may have suffered from anxiety and depression. Emma had a physical disability, a learning difficulty and mental health problems. Professionals involved in this case were conscious of these, but in a minority of incidents may have displayed an unconscious bias in the stance they adopted. Any impact on service delivery is fully addressed in the analysis section of this report.

4.1.4 There was a 13 year age gap between the victim and perpetrator (Emma was 13 years older than Thomas).

Section 5: Dissemination

5.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The victim's family
- The perpetrator's Offender Manager, National Probation Services
- North Yorkshire Community Safety Partnership
- North Yorkshire Safeguarding Adults Board
- Bradford Safeguarding Adults Board
- City of York Safeguarding Adults Board
- North Yorkshire Police Fire and Crime Commissioner
- Domestic Homicide Review Panel (North Yorkshire)
- The Home Office Domestic Homicide Review Team

Section 6: Analysis

6.1.1 The victim and the perpetrator both had extensive contact with many agencies over several years. An initial scoping exercise by the Domestic Homicide Review panel revealed that both Emma and Thomas had lived at several addresses across the United Kingdom. This meant that a significant number of agencies were contacted to assist with the review. Although date parameters were agreed for researching agency involvement over a three year period 2016-2019 (when they were known to have been in some form of relationship), it was necessary to carry out further in depth work going back decades. This enabled a much more detailed understanding of the victim's vulnerabilities and of the perpetrator's previous offending, especially his violence towards former partners.

6.1.2 With more than 20 organisations involved in this review, the analysis will focus on each agreed term of reference. This will provide a true multi-agency response to the key questions posed by the Domestic Homicide Review panel and identify learning from Emma's tragic death.

6.1.3 Emma was murdered by her former partner. Although there were mixed interpretations of the nature of the relationship between Emma and Thomas, there is no doubt that the circumstances of her death warranted a Domestic Homicide Review. However, it should also be noted that Emma was a very vulnerable person in terms of her issues with an adverse childhood experience, her mental health, a physical disability, a learning difficulty and at times, her own self-neglect. She was a lonely vulnerable woman without a friendship network. Although she telephoned her mother regularly, she rarely visited her family.

The terms of reference were agreed at the initial Domestic Homicide Review Panel on 10th January 2020:

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

6.2.1 Emma displayed many vulnerabilities. Some of these were clear to staff who were supporting her. However, some of her issues were not so apparent. There are many examples listed throughout this review of practitioners who were mindful of her vulnerabilities. This resulted in staff making appropriate referrals to other services that could assist with her mobility problems or social care. The nature of her relationship with Thomas was not identified by

all professionals. However, in the majority of cases, there were references on agency systems which clearly referenced him as her ex-partner. Emma used the term ex-partner frequently when describing their relationship. Thomas never used this term to professionals. He always maintained they were friends or former friends.

6.2.2 Emma attended the office of Housing Options at City of York Council in July 2016. Their records say she presented as 'chaotic and unkempt'. She wanted to move to another property as she was in fear of her former partner, Thomas. Positive action was taken; Housing staff made a referral to the Independent Domestic Abuse Service (IDAS) and telephoned a women's refuge with a vacancy in Staffordshire. However, such disclosures were not always so clear, and many times agencies were not sure of exactly what they were dealing with.

6.2.3 In January 2018, Emma attended Harrogate District Hospital after threatening to harm herself with a knife. The mental health liaison team recorded that they would inform Emma's social worker of her attendance at the Accident & Emergency Department. But although they recorded she disclosed a 'friend' had stolen both of her mobile phones, there is nothing to indicate any conversation with her about who this friend was or the nature of their relationship.

6.2.4 There were several entries in the NYCC Health & Adult Services (HAS) notes in 2018 relating to domestic abuse. On 6th May, Emma telephoned the Emergency Team requesting to be re housed to Birmingham as she was afraid of her ex-partner. Emma was not willing to give any information about the ex-partner and did not want police informing. On 26th October, HAS received a telephone call from Bradford Royal Infirmary (BRI) where Emma had attended and told staff a friend in Bradford was tampering with her phone and taking her money. At the BRI, the Psychiatric Liaison Nurse (employed by BDCFT), together with the Safeguarding Nurse (employed by BTHFT) recorded Emma felt 'bullied and harassed' by her male friend (Thomas) and his partner. They also noted an 'animated telephone conversation' between Thomas and Emma when she shouted, 'Do you want to see me dead?' There was no exploration of any domestic abuse with Emma at the BRI, nor was any further action by HAS recorded in their notes. On 5th November HAS received a Safeguarding Adults referral from North Yorkshire Police. The referral stated Emma was being taken advantage of by Thomas. The contact states 'Does this person continue to be at risk of harm?' A: 'Unknown as Emma states will cease contact with him ….but there is previous history of domestic violence between them.' The outcome noted that care and support were required for Emma in terms of nutrition, clothing, hygiene, and financial matters but there were no further references to any domestic violence concerns being explored.

6.2.5 The HAS and BRI notes are an indication of a common problem experienced by many agencies, when professionals were trying to take action and provide support. Emma frequently moved across organisational boundaries, i.e. accessing hospital, police or social care services between different Health Trusts, Police Forces or Local Authority areas. It was a challenge to 'grip' the problem and staff were not always clear regarding ownership of the presenting issue.

6.2.6 Emma's GP was never made aware by any agency of any issues relating to Emma suffering domestic abuse. During a home visit in November 2018, the GP made a comprehensive assessment of her needs. These included her hip pain, walking with a frame with difficulty, her unkempt appearance, no bedding, a soiled mattress and 'not being able to look after herself'. They recorded that she was distressed. It is positive that the GP made a prompt referral to Adult Social Care and followed this up with a telephone call. However, during the home visit, the GP heard a telephone conversation between Emma and a 'male.' They heard the male shouting at Emma. The same male was abrupt with the GP when they attempted to speak with the man. There is no recorded action of any professional curiosity to try to explore the nature of Emma's relationship with this male.

6.2.7 North Yorkshire Police had extensive involvement with Emma. Their systems clearly record her as a victim of domestic abuse at the hands of her former partner, Thomas. However, there are several examples of officers or staff failing to recognise the issue they were dealing with. In January 2016, Emma rang '999' to report Thomas was outside her property, that he had followed her from Birmingham and she 'was in a relationship with him but he was quite controlling.' Even though all this information was provided, North Yorkshire Police did not 'code' the incident as domestic abuse nor did they complete a domestic abuse risk assessment. As well as breaching Force protocols to complete such a risk assessment in all cases of domestic abuse, their lack of recognition of the domestic abuse meant there was no follow-up action by their specialist domestic abuse officers. A similar outcome occurred two months later when Emma reported Thomas was constantly ringing her. A PCSO attended but they did not submit a domestic abuse risk assessment. Despite reference to Thomas being an ex-partner, the Force Control Room amended the 'code' of the incident from domestic abuse to 'anti-social behaviour.' Once again, this meant that specialist domestic abuse officers were not informed.

6.2.8 On a third call in July 2016 (when Emma reported being assaulted by Thomas) the incident was dealt with positively by North Yorkshire Police. As well as completing a full domestic abuse risk assessment, officers also noted Emma's other vulnerabilities linked to her mental health problems and physical disability, her learning difficulty, and her poor self-care. The officers submitted an Adult Safeguarding referral in addition to the domestic abuse

risk assessment.

6.2.9 There were also several incidents of domestic abuse reported, that took place in West Yorkshire but were then reported to North Yorkshire Police or were referred to North Yorkshire from West Yorkshire for a victim contact. This happened when Emma moved frequently between Thomas' house in Bradford (West Yorkshire) and her own home in Harrogate (North Yorkshire). In several cases there was no domestic abuse risk assessment completed. Although the victim and perpetrator cross County boundaries, the matter should be effectively concluded. Without a domestic abuse risk assessment, Emma was left in a vulnerable position. The true extent of the relationship was never 'gripped' by anyone. The lack of risk assessments meant the necessary follow-up action by specialist domestic abuse officers did not take place. Emma was leading a chaotic life but professionals needed to adapt to these circumstances. The presence of a 'Force boundary' was a major obstacle to any coordinated effort.

6.2.10 On other occasions, Emma was incredibly challenging to deal with (for example in October 2017 when Emma reported Thomas had stolen money from her). North Yorkshire Police recorded that Emma was rambling and then became abusive. She then screamed at the police call-takers. Police Community Support Officers were despatched to Emma's home. She was hostile and refused to speak with them. Once again, there was no domestic abuse risk assessment completed (even though the North Yorkshire Police systems clearly list them as 'ex-partners'). Irrespective of how challenging and difficult Emma was to deal with, she remained vulnerable and at risk of further domestic abuse.

6.2.11 During other events reported, officers noted 'this is not a domestic' and cite previous experiences with Emma and the event is more linked to her 'mental health'. Whilst there is no doubt Emma's mental health issues affected the way she communicated; this did not mean there was not a domestic abuse incident. North Yorkshire Police repeatedly failed to recognise the context of domestic abuse in relation to Emma's calls for assistance.

6.2.12 West Yorkshire Police had far more dealings with the perpetrator as Thomas resided for long periods in Bradford. He was a frequent caller due to many disputes with various neighbours. There were many counter allegations. In relation to Emma she would often report an incident involving Thomas, but by then had gone home to North Yorkshire which led to some of the cross-boundary issues already described.

6.2.13 Officers in West Yorkshire also did not recognise the indicators of domestic abuse. During one incident, reported by Emma in August 2017, she made allegations of assault and false imprisonment. She was still present at Thomas' house when officers arrived. They noted there 'were no signs that

anyone had been held against their will'. They noted the keys had always been in the back door near where Emma had been sleeping (but the notes do not explain how the police were able to confirm the keys had always been in the door). They noted Emma's account to be inconsistent. This may have been the case, but with a potential learning difficulty and mental health problems, it does not mean her account was not true or that elements of it were not true. The officers also noted 'she could have left the property at any time'. We do not know if Emma's account was truthful. But this comment suggests a lack of understanding of the fear that is often present with victims of domestic abuse; who may be able to physically leave but are too frightened to do so. Finally, (and most concerning of all), the officers recorded that the occupants of the address (i.e. Thomas and his new partner) are 'seemingly of good character'. This demonstrates a complete lack of thoroughness in conducting elementary background checks. By this stage, Thomas had many convictions including for violence and harassment. He had also been prosecuted for breaching a restraining order in relation to a former partner. He could not be described as 'of good character'.

6.2.14 Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company had responsibility for managing Emma after she was released from custody in 2017. Although it is clear from their own agency records that Emma was a potential victim of domestic abuse, the case managers lacked sufficient professional curiosity and did not explore the incidents which they knew involved Emma and Thomas. Some of this included direct disclosures from Emma either to probation or police officers and so it is disappointing that this was not progressed with Emma. Her case managers were well placed to carry out this proactive work as Emma was still bound by obligations to her post sentence supervision requirements.

6.3 Did the agency have policies and procedures for domestic abuse, stalking and harassment? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in the case of this victim and perpetrator? Were these assessment tools, procedures and policies professionally accepted as being effective?

6.3.1 Not all the agencies involved in this Domestic Homicide Review have stand-alone domestic abuse policies in place. Some do refer to domestic abuse procedures or protocols within a wider safeguarding policy.

6.3.2 The City of York Council Housing Options section do not have a domestic abuse policy in place. However, during their contact with Emma they did correctly identify domestic abuse as a factor and made subsequent referrals to a specialist independent domestic abuse support service (IDAS).

6.3.3 Tees, Esk & Wear Valleys Health Trust (TEWV) have domestic abuse procedures in place, which includes stalking and harassment. The agency also employs two dedicated 'MARAC advisors' who specialise in domestic

abuse and act as a source of advice and deliver training for staff. There are references in the TEWV records of Emma alleging domestic abuse by Thomas (two separate incidents in July 2016). One of these was during an assessment by the triage team. Emma was distressed and said she was fleeing domestic abuse. The notes state that police had investigated and no charges had been brought. Police were apparently arranging to take Emma to a hostel. On the second incident, the Accident & Emergency Liaison & Psychiatry team had contact with Emma. She was aggressive and had to be removed from the department by the police. Whilst it is natural for an agency to assume another agency is already dealing with a victim this may not always be the case. The specialist 'MARAC advisors' at TEWV were not contacted. Their advice may have presented the opportunity to confirm with the police that matters had progressed thoroughly. There is no 'lead' agency for domestic abuse and any organisation can raise concerns or professional challenge.

6.3.4 West Yorkshire Police management of domestic abuse incidents is directed by the Force Domestic Abuse Policy. This policy is regularly reviewed by a senior officer and has been updated/amended to incorporate new legislation or initiatives. Officers are required by the policy to complete a 'DASH' risk assessment in respect of the victim at all domestic abuse incidents. The compliance by West Yorkshire Police with this requirement was inconsistent. The Force did not always complete a DASH risk assessment either through a lack of identification of domestic abuse or because the victim (Emma) had already returned to her home in North Yorkshire. The DASH assessment is victim-led. North Yorkshire Police did not complete risk assessments with Emma in most instances when West Yorkshire had raised a query to visit her. These cross-Force issues need to be tightened with much greater clarity of ownership of the assessment of risk.

6.3.5 There was a further breach of West Yorkshire's own domestic abuse policy in January 2018 when a silent '999' call was traced to Thomas' address. A woman was heard shouting to leave her alone or she will call the police. The male demanded an apology and made threats to smash something up (it was unclear if this related to the phone or the female). West Yorkshire Police rang the telephone number. Thomas stated they had a disagreement but this was now sorted out. The female (not Emma on this occasion) gave a similar account over the telephone. The log was then finalised. No police officer ever attended. Policy would require officers attend the address in person for all potential cases of domestic abuse to check on the welfare of any victim and establish if offences had taken place.

6.3.6 The victim's GP Practice together with Bradford District Care Foundation Trust do not have stand-alone policies for domestic abuse but do contain guidance around domestic abuse and procedures to follow within their wider safeguarding policies. Other Health organisations such as Bradford Teaching Hospitals Foundation Trust do have a stand-alone policy for domestic abuse

6.3.7 North Yorkshire County Council Health and Adult Services (HAS) also have elements linked to domestic abuse within their wider safeguarding policy. The agency also works to the requirements of the Care Act 2014 to fulfil its responsibilities in protecting vulnerable people in need of support services. During their contacts with Emma, HAS did not always explore the potential for Emma being a victim of domestic abuse within the wider presentation of her vulnerabilities. There should be a more focussed approach to ensure the opportunity for intervention by HAS practitioners is not lost. However, Emma did repeatedly decline an offer for a full assessment of her needs.

6.3.8 The Yorkshire Ambulance Service (YAS) have a safeguarding policy that includes how to deal with concerns of domestic violence and abuse. However, YAS staff do not undertake risk assessments. Whilst it is accepted the ambulance crews spend only a limited amount of time with patients, there will be incidents when they are the only agency involved. Training in speaking to victims about partial disclosures of domestic abuse could be a valuable tool in protecting vulnerable people at risk. On occasion, the attendance of an ambulance crew may be the only opportunity when a victim is willing to disclose.

6.3.9 Harrogate Borough Council does have a domestic abuse policy in place. However, this was drafted in 2012 and thus now requires a full review/ update to ensure it incorporates the raft of developments in the field of domestic violence and abuse that have taken place in the last eight years. The current policy does not include procedures for DASH or other risk assessment processes.

6.3.10 Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company have policies on domestic abuse and safeguarding vulnerable adults. These were not followed after their systems recorded clear domestic abuse taking place.

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

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

6.4.1 Emma was never referred to or discussed at any MARAC. For a substantial number of incidents, the issue of domestic abuse was not correctly identified which meant that there was no subsequent risk assessment and hence no involvement of the MARAC. Even where there was a risk assessment, the grading was ‘medium’ or ‘standard’ risk and not ‘high’ risk which would have warranted a MARAC referral. However, some of these risk assessments were conducted in relation to the single incident which was being dealt with by that professional. There was rarely a consideration of the full case history or other valid considerations (for example Thomas’ previous domestic abuse offending). By dealing with an incident in isolation, the true level of risk was

not captured. We do know that Thomas had been listed at a MARAC meeting in Nottinghamshire in 2014 with a different partner. He had been investigated for assault, strangulation and harassment of his wife. A number of actions were agreed at the meeting which protected the victim.

6.4.2 The multi-agency forum where Emma's situation was discussed was the Harrogate District Community Safety Hub. This group was set up in 2016 to provide a multi-agency response to vulnerable people and victims of anti-social behaviour. The Hub meets every fortnight and any agency can make a referral. In Emma's case, North Yorkshire Police referred her to the group in February 2018. The Hub do not deal with domestic abuse cases and if domestic abuse features during a discussion this is referred on to the MARAC as the recognised forum. Emma had made a considerable number of calls to both the emergency services and to the Council's housing section. 36 calls had been made between July 2017 and January 2018. 21 of these were considered to be hoax calls. Emma's mental health, physical health and recent threats of suicide featured as reasons for the referral. The referral states:

'*There is nothing recent to suggest that she is vulnerable to abuse or exploitation by others although she is recorded as being a vulnerable person due to her learning disabilities.'*

This statement is simply not correct. This referral to the Hub was in February 2018. There had been many recent incidents linked to domestic abuse or exploitation:

1/. On 20th August 2017, Emma had entered a shop in Bradford pleading with staff "Hide me". She then made serious allegations of assault and false imprisonment to West Yorkshire Police against Thomas. An initial log was sent to North Yorkshire Police to visit Emma at home but was then cancelled as Emma had been traced in Bradford. The West Yorkshire Police log also states 'Harrogate First Response Crisis team informed'.

2/. On 21st August 2017, North Yorkshire Police received a report directly from Emma alleging Thomas had stolen her television.

3/. On 22nd September 2017, Emma reported to West Yorkshire Police that Thomas was constantly harassing her. West Yorkshire Police sent a request to North Yorkshire Police to visit Emma at her home and obtain more details.

4/. On 27th October 2017, Emma reported to West Yorkshire Police that she was being 'terrorised' by Thomas.

5/. On 6th January 2018, Emma reported to West Yorkshire Police that Thomas was pestering her for money and asking her to go to his house. This information was passed to North Yorkshire Police with a request to visit Emma at her home and obtain further details. The initial response from the North Yorkshire Police Control Room was to advise that Emma was a persistent hoax caller and was seen by North Yorkshire Police on an almost

daily basis. They stated Emma had mental health issues, learning disabilities, a vulnerable adult marker, and a restraining order in relation to another male. A North Yorkshire officer did attend Emma's home on 8th January and advised her not to give her number to Thomas. The text of the officer's update on the police log is:

"They concluded there was no domestic abuse, only that Thomas was being persistent in his requests but not being threatening or demanding."

This is a disappointing closure to this log and demonstrates a complete lack of understanding around issues of stalking and harassment. National training has taken place across police areas in recent years which gives clear guidance that there does not need to be any element of threats or demands to constitute harassment or even stalking.

6.4.3 This referral to the Community Safety Hub was not robust and clearly police systems had not been fully checked in advance. Some of the incidents in West Yorkshire had been forwarded directly to agencies in North Yorkshire. Others that were dealt with entirely within the West Yorkshire area should still have been flagged via the 'Police National Database' which facilitates the proportionate exchange of information between Force areas.

6.4.4 The outcome of the Community Safety Hub meeting was to ask Emma to sign an 'Acceptable Behaviour Contract' to agree 'not to contact police or the council unless it is a genuine emergency or a genuine need for help or information'. There does not appear to be any 'support' element to the contract. No key worker was assigned to Emma to help this vulnerable woman with an apparent learning difficulty and mental health problems to understand how she should comprehend what was a 'genuine' reason.

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

6.5.1 Agency compliance with their domestic abuse protocols has already been considered. This section of the overview report will focus on Information Sharing Protocols. Most organisations now have ISPs in place as this is essential to effective multi-agency working.

6.5.2 There were gaps in the sharing and recording of information, particularly between separate police services; West Yorkshire Police and North Yorkshire Police. There are many examples cited where one Force was called by Emma or Thomas. Then when Emma returned home (across a county boundary) problems occurred on information exchange. There were plenty of incidents where information was shared correctly. However, it was not uncommon for there to be a real diluting of ownership (especially in relation to the completion of DASH risk assessments). Over several years,

there was a pattern where West Yorkshire would request a visit to Emma (for welfare or to gather more information) and then no subsequent risk assessment was carried out. The originator and receiver were not specific in what was being required or what was being delivered. This created a significant lack of services which may have followed from the DASH risk assessment.

6.5.3 Following serious sexual assault allegations made by Emma against Thomas in January 2019, North Yorkshire Police officers carried out a home visit. It was apparent to the officers that Emma had some communication issues and would require support services in place. They also observed her poor home living conditions and her own poor self-care. To their credit, they prepared a comprehensive report for further support services from Adult Social Care and also sent the details to colleagues in West Yorkshire Police as this was where the crime had occurred. The North Yorkshire Police supervising officer noted the investigation would be passed to West Yorkshire for 'consideration of scenes and suspect management in their area'. However, the officer also recorded that they would not make contact with Emma until support services from Adult Social Care were in place. There are two issues with this; firstly, there does appear to be confusion regarding two distinct roles. Part of the referral was to improve Emma's hygiene and living conditions. But the other part was to obtain specialist support from an Independent Sexual Violence Advocate (ISVA) or similar; due to Emma's learning difficulty and with this being a traumatic sexual offence she was reporting. Although North Yorkshire Police recorded they were leaving the crime scene and suspect management to West Yorkshire Police, they were still the contact with the victim. The subsequent support to Emma in terms of assisting with any interview, statement or intimate examination was lost because of confused lines of communication. It is true that Emma became difficult to trace but she was already recognised as vulnerable and the police actions should have allowed for this.

6.5.4 There were positive examples of information exchange between agencies and these should be acknowledged. For example, even when Emma accessed services away from her home (i.e. Bradford District Care Foundation Trust) there is clear evidence that practitioners shared information with colleagues in other Health Trusts and with police and probation services where appropriate. Likewise, when Emma made a housing application with City of York Council they understood her vulnerabilities and were able to exchange information with partners from Adult Social Care, mental health services and police. On a separate matter they were able to assess Emma's tenancy by proportionate exchange of information with their counterparts at Harrogate Borough Council relating to alleged fraudulent housing benefit claims.

6.6 What were the missed opportunities for intervention? Do assessments and decisions appear to have been reached in an informed and professional way?

6.6.1 The single incident that stands out as a missed opportunity to intervene and protect Emma is immediately following the allegation of sexual assault in January 2019. This has already been commented on at length. In summary, these matters are now subject to an investigation by the Independent Office for Police Conduct. The purpose of this Domestic Homicide Review (DHR) is not to duplicate any IOPC enquiry. This review is about identifying learning so that improvements can be made to services and better protect the vulnerable. Within this DHR, it will suffice to note here that there is no evidence of any risk assessment or support plan to both gather evidence regarding the allegation but in particular to protect a vulnerable victim while the investigation takes place. The relationship between Emma and Thomas was well documented and this should have meant a full safety plan being put in place including advice around Emma staying away from Thomas. The 'forensic window' relevant to sexual offence investigations was lost as was the opportunity to seize Thomas' phone.

6.6.2 The other area of missed opportunities is regarding the numerous failures to correctly identify and record a domestic abuse incident. This prevented proper risk assessments and potential referrals to forums such as the MARAC. This would have meant a much more holistic approach could have taken place; noting Emma's complex array of vulnerabilities, exploring Thomas' lengthy and violent offending history and setting multi-agency actions to protect Emma.

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

6.7.1 The arena of risk management plans has been reviewed already. In relation to appropriate services being offered there are many examples of Emma accessing a variety of services. She had complex needs, which included a physical disability, some mental health concerns, an apparent learning difficulty, and issues with her own self-care which led to poor hygiene, a lack of food and what are often described by professionals as 'squalid' living conditions.

6.7.2 From some of the comments on agency records and from some of the referrals that took place, there does appear to be confusion by some professionals of the type of vulnerability they were dealing with. With a threat of suicide, then clearly mental health services should be involved but there

were occasions when they were called when the issue appears to be one of social care. Agencies note a 'learning difficulty' but do not elaborate on what this is or how it had affected Emma and her ability to look after herself or protect her from abuse or exploitation. Within the Housing Options notes there is a reference to exploring how Emma can manage a tenancy. Without such regular consideration and a multi-agency approach it would be difficult for any agency to operate in isolation.

6.7.3 A referral to 'SAFE' (Service for Adults Facing Exclusion) was made by the police in February 2018. The referral was rejected and Emma's case then diverted to the Harrogate Community Safety Hub (which was not the appropriate forum for her needs). The decision to reject the referral was recorded that Emma's case did not match the 'requisite level to meet the criteria of SAFE.' She had significant contact across agencies together with a whole raft of vulnerabilities. SAFE is a service set up by the Harrogate Homeless Project in 2017 and contains a broad range of Board members. Within its terms of reference it states:

SAFE will offer an innovative and flexible response to a core group of individuals that remain marginalised, face severe multiple and complex needs and exclusions, are resistant to engage in resettlement, and have ineffective contact with services.

A referral to SAFE is assessed by the Harrogate Homeless Project (HHP) pathways manager. A scoring matrix determines the threshold.

6.7.4 There were only two referrals to the Independent Domestic Abuse Service (IDAS) in relation to Emma. This is disappointing given the volume of contacts linked to domestic abuse. Emma's vulnerabilities led to loneliness and this placed her at risk of exploitation by a person who understood her frailties. Support from a professional such as an IDVA (Independent Domestic Violence Advocate) or domestic abuse outreach worker could have carefully considered the issue of domestic abuse and how this fitted with many of Emma's other vulnerabilities.

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

6.8.1 There is absolutely no doubt that Emma was an incredibly challenging person for professionals to work with. She contacted agencies dozens (and in some cases hundreds) of times. She was abusive and aggressive. She would misuse the '999' system sometimes to get a lift home. She was difficult to find. She often did not respond to voicemails or other messages. She would not answer the door or not allow professionals into her home and

they had to have dialogue on her doorstep. She travelled regularly between Harrogate and Bradford and at other times between York and Bradford and then to other areas of the UK (i.e. Shropshire, Birmingham, or Leicester). This behaviour presented difficulties for agencies to manage her behaviour or expectations.

6.8.2 It is clear from many agency records that committed professionals tried their absolute best to support Emma and spent considerable periods of time with her. But a coordinated response was never achieved.

6.8.3 Most agencies became involved with Emma as an adult. With such infrequent contact with her family and accepting that Emma was difficult to communicate with, very little was known about her childhood, her teenage years or her earlier adult life. No professional was ever able to fully understand Emma's experiences or vulnerabilities.

6.9 Was anything known about the perpetrator? Were they subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or previously had been in place?

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

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

6.9.1 Thomas was well known for offences of violence and as a perpetrator of domestic abuse. He had assaulted former partners and been convicted of harassing them. He had a restraining order in place to protect a former partner.

6.9.2 He has never been subject to MAPPA supervision as he did not fit into the required MAPPA categories to warrant such monitoring. Nor was he ever nominated as a MATAC perpetrator (the MATAC scheme was not operational until the very later stages of the incidents involving him).

6.9.3 Thomas had been investigated for domestic abuse incidents by Nottinghamshire Police, West Midlands Police, West Mercia Police, West Yorkshire Police and North Yorkshire Police. In addition, he was investigated by Leicestershire Police for an alleged sexual assault on a female with learning difficulties. He had been listed as an offender at a MARAC meeting with a former partner in 2014.

6.9.4 The creation of a Police National Database (PND) was the key recommendation of the Bichard inquiry that followed the Soham murders in 2002. Since its launch in 2006, all UK Police Forces have had the facility to exchange and share information regarding persons who may commit offences or come to police notice for other reasons. The database does not rely on a charge or conviction (a requirement of the Police National Computer). Rather, it allows officers to check with other police areas if a person who comes to their notice could be a risk. Protocols are in place to ensure such data requests can be made legally and proportionately. The PND is to be used solely for a "policing purpose". Policing purposes are protecting life and property; preserving order; preventing the commission of offences; bringing offenders to justice; and any duty or responsibility of the police arising from common or statute law.

6.9.5 As well as the dozens of incidents involving Emma in Birmingham, Harrogate, York and Bradford, Thomas was also known to Nottinghamshire Police for assaulting his wife in 2008 and for harassing the same victim four years later. Both cases did not progress to court but the information supporting the allegations was available. West Mercia Police held information regarding Thomas assaulting a new partner in Shropshire in 2014. The woman was particularly vulnerable but was supported through to court proceedings where Thomas was convicted and sentenced to a term of imprisonment. He was also given a restraining order for this offence. He subsequently breached the restraining order. These offences are readily available to any officer checking on the Police National Computer (PNC).

6.9.6 Thomas was also a frequent caller to West Yorkshire Police for a large number of neighbour disputes. Neighbours alleged Thomas was abusive or was harassing them and he in turn made several counter allegations.

6.9.7 He had some dealings with medical professionals regarding his mental health. Thomas was referred by his GP to the Improving Access to Psychological Therapies (IAPT) service. The referral acknowledged his history of chronic anxiety and long term problems with depression, and how this had a significant impact on his day to day functioning. Thomas reported he had no current thoughts to harm himself or others. He agreed to be added to the 'self-guided help list' but when an appointment was offered he failed to attend.

6.9.8 His most recent period of supervision by a probation service was in 2015 by the CRC in Staffordshire and West Midlands. This followed his conviction at Birmingham Magistrates Court in February 2015 for an assault. The victim was a male and it was not a domestic abuse related attack.

6.9.9 However, in March 2015, a domestic abuse 'risk flag' was uploaded onto his probation records. A 'Spousal Assault Risk Assessment' (SARA) assessed him as a 'medium risk of violence' towards partners and 'medium risk of serious harm' towards his ex-wife. It also assessed him as a 'medium risk of serious harm' towards the public. These domestic abuse concerns are

highlighted on Thomas' electronic probation records. In April 2015 he again appeared at court for a breach of a restraining order. This appearance related to an offence which had originally occurred in January 2015 when Thomas contacted an ex-partner thus breaching the requirements of the order.

6.9.10 All of this information was available to their CRC colleagues in Humberside, Lincolnshire, and North Yorkshire. They were managing Emma after her release from prison in 2017 but they had full details of Thomas and clear disclosures from Emma that she was or had been in a relationship with Thomas. The same information was accessible by the police in West Yorkshire and North Yorkshire. There is no evidence that any officer ever considered making a disclosure to Emma, under the Domestic Violence Disclosure Scheme ('Claire's Law') of his previous offending.

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

6.10.1 When reviewing the protected characteristics pertinent to these events, it is absolutely clear that consideration for vulnerability and disability were necessary. In fact, such considerations were crucial. There does not appear to have been any issues relating to either the victim or perpetrator regarding language barriers, religious views, ethnicity, or cultural issues that impacted on the service they received from any agency.

6.10.2 Emma had contact with services from a young age (believed to be around 9 or 10 years old). She may have disclosed an adverse childhood experience but the records of any details of these experiences are no longer available. It is believed she had contact with Children's Services from the mid-1970s. There are repeated references across agencies to Emma's mental health. There was never a formal diagnosis but the term 'personality disorder' is used. Emma may have had a learning 'difficulty' but it cannot be established what this was, or exactly how this manifested itself in Emma's daily life. Some professionals describe her 'poor communication' or others state she was 'challenging'. Her family confirm she attended a 'special' school but this was not through a lack of intelligence. It was believed to be linked to her perceived disruptive behaviour. She also had to live with a physical disability from 2014. She had suffered a broken femur during an assault (the assault was not domestic abuse related). She would not consent to an operation to treat her broken leg. This meant she suffered pain and mobility problems for the rest of her life.

6.10.3 Under the Care Act 2014, local authorities must carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care. They should focus the assessment on the

person's needs and how they impact on their wellbeing and the outcomes they want to achieve. The Care Act sets out the six principles of safeguarding:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

The Care Act introduced a general duty on local authorities to promote an individual's 'wellbeing'. This means that they should always have a person's wellbeing in mind and when making decisions about them or planning services.

Wellbeing can relate to:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support)
- social and economic wellbeing
- suitability of living accommodation

There was a clear gap in provision when Emma was released from custody in May 2017. Her accommodation was not suitable for her needs and she was recalled to prison. This was repeated when she presented as homeless in York (though staff did their best in terms of emergency accommodation until more suitable premises could be found). However, Emma had choices which she made and these should be respected. The HAS notes in 2016, 2017 and 2018 all record that Emma declined an assessment and declined any package of support. She would agree to a specific offer (e.g. food supply or furniture) but would not engage with services to facilitate a full needs assessment.

6.10.4 Thomas had some form of mental anxiety or depression. Following a discussion with his GP, he was referred on to a specialist (IAPT) service but he failed to keep his appointment. He does not appear to have suffered abuse or neglect due to any problems he may have had.

6.10.5 There are many examples within agency records of how Emma's vulnerabilities impacted on the way she was dealt with by agencies:

6.10.6 North Yorkshire Police dealt with two incidents (January and March 2016). On both occasions Emma alleged problems with Thomas. At the January incident, officers made a good quality safeguarding referral to social care. They noted Emma's vulnerabilities. The problem at that incident was that

Emma's vulnerabilities masked the underlying domestic abuse that had taken place (Emma believed Thomas had followed her to Harrogate from where they had been staying together in Birmingham). Although the police officers submitted the safeguarding referral they did not submit a domestic abuse risk assessment so this information was lost. At the March 2016 incident, North Yorkshire Police submitted another comprehensive safeguarding referral. They noted Emma had '*medical conditions, both physical and mental, epilepsy, a learning difficulty, anxiety and depression. Her personal hygiene is poor.'* The police also submitted a domestic abuse risk assessment on that occasion.

6.10.7 Housing Options at City of York Council became involved with Emma in July 2016. They had received a referral from North Yorkshire Police who believed Emma would be best accommodated in supported housing due to her multiple vulnerabilities. The following month, the Housing Officer contacted a social worker as they wanted to assess the extent of Emma's learning difficulties. Their concerns were if Emma was actually able to manage a tenancy (she had been in arrears before). Unfortunately, the social worker's response was that they were unaware of a need for any further assessments. This was an opportunity (if Emma had consented) to explore the learning difficulty more fully.

6.10.8 When Emma was finally released from custody in July 2017, she approached Harrogate Borough Council Housing Department. Their staff noted Emma's vulnerabilities as '*suffers from anxiety and has a history of suicide attempts. Mobility issues due to fractured hip and femur.'* Although there is no mention of learning difficulties, the Housing Officer did make a referral to 'Stonham' (a registered housing charity specialising in provision of supported living). The following year when Emma asked for a change in accommodation, the Housing Officer made a referral to CVS (Community Voluntary Sector) to obtain additional items such as a sofa, rugs, curtains and a table and chairs.

6.10.9 The Yorkshire Ambulance Service made three separate referrals to Health and Adult Social Care (HAS) during 2018. This followed the ambulance crews attending calls for assistance. Their referrals listed Emma's problems as nutrition, clothing, hygiene and financial matters. But Emma declined the subsequent HAS offer for a full assessment.

6.10.10 On two occasions in 2018, Emma attended Harrogate District Hospital Emergency Department following threats or attempts at self-harm. During both incidents, the mental health liaison team were contacted to conduct assessments.

6.10.11 In November 2018, during a home visit, Emma's GP rang the (TEWV) Harrogate Crisis Resolution & Intensive Home Treatment team. The doctor reported poor mobility, hip pain, dirty accommodation, and poor self-care. The GP was advised there did not appear to be any mental health concerns and was asked to contact social care for an assessment. This is not a

criticism of the GP or the mental health team. It is used as an example to illustrate how complex Emma's needs were and how all agencies struggled to find a route through them to get Emma the support she needed, but often would not agree to.

6.10.12 Professionals from across agencies did try to make positive interventions with Emma. The issues were the differing nature of her vulnerabilities (physical mobility, mental health, learning difficulty or social/hygiene needs) together with her frequent refusal to consent for a full needs assessment. Sadly on many occasions, as agencies attempted to intervene, Emma had already moved on to the next 'crisis' episode.

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

6.11.1 There is evidence throughout all agency records of oversight and direction from managers or other senior professionals. However, in some instances (for example in reviewing all of Emma's police involvement as a domestic abuse victim) a senior professional could have reviewed the 'whole picture' rather than any single individual incident. This was especially necessary as Emma had contact with so many services cutting across county boundaries.

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

6.12.1 The murder of Emma is the fourth domestic homicide within North Yorkshire since the introduction of Domestic Homicide Reviews as a mandatory process. One features a male victim. Emma is the third female victim.

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

6.13.1 There was no restructuring in any agency that impacted on this case.

6.14 How accessible were the services for the victim and perpetrator?

6.14.1 Emma and Thomas were both frequent callers and users of services. There is no suggestion they did not feel able to contact a particular agency. There are many examples of them both being referred on to more specialist services (e.g. housing charities or mental health services). There is a gap in the frequency of referring Emma on to more specialist domestic abuse support services.

Section 7: Conclusions, lessons learned and recommendations

7.1 Conclusions and lessons learned

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

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

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

7.1.4 Emma was assaulted (not a domestic related assault) in April 2014. She suffered a broken femur. Clinicians wanted to operate but Emma would not consent. A capacity test was conducted under the Mental Capacity Act 2005 which determined Emma did not have the capacity to make such a decision. Protocols were correctly followed and an Independent Mental Capacity Advocate (IMCA) was contacted to speak with Emma. Under the 'Deprivation of Liberty' safeguards, a 'best interest' decision was taken on Emma's behalf. That decision was not to operate. This was six years before this Domestic Homicide Review and we should avoid applying hindsight to that decision. An operation without consent (and with no family to consult) is an invasive procedure and would require sedation of the patient against their will. This was balanced against the medical prognosis that without such an operation, Emma would be permanently disabled. We do not judge this decision taken in April 2014. However, the lack of an operation did then make Emma more vulnerable and led to pain and lack of mobility. This in turn meant she would be a frequent caller to police or ambulance services. The frequency of these calls could mask other vulnerabilities in her life.

7.1.5 There is evidence of unconscious bias being displayed during a minority of interactions between Emma and front line professionals. Comments on incident logs such as 'Both parties suffer from mental health issues' or

‘Emma is well known for making hoax calls’ suggest that in some situations staff had some preconceived ideas of what they were facing. This is not to say that the mental health issues or hoax calls were not a reality. But the danger is that professionals could allow the circumstances of an incident to fit within these parameters. This would prevent a more investigative mindset to what was actually taking place. It should be stressed this was a minority of incidents. In a large number of cases, staff noted the presenting conditions and dealt with them as effectively as they could in the circumstances.

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

7.1.7 The lack of submission of domestic abuse risk assessments meant there was never a full picture established on the level of domestic abuse taking place in the relationship. Even the incidents that were correctly recorded did not result in any coordinated action to protect Emma from domestic abuse. The incidents were dealt with in isolation. All incidents that were risk assessed were graded as ‘standard’ or ‘medium’ risk. Such assessments are victim led and staff must take care to use professional judgement, especially if a victim is being challenging or not willing to engage. At no time did any manager intervene to review all the incidents that were taking place. There was no consideration of how Emma’s vulnerabilities placed her at greater risk from a manipulative individual. These vulnerabilities, together with the perpetrator’s propensity for using violence towards his partners suggest that, taken together, these became high risk incidents and should have been referred to the MARAC to consider how best to protect the victim. This never took place.

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

7.1.9 The chaotic lifestyle of the victim and perpetrator meant that records were held by agencies that spanned many geographical locations. They frequently accessed services across Police Force areas, across different Health Trusts across probation services and across Local Authorities. There were some good examples of effective information exchange between agencies. However, there were many examples of poor communication. In addition to the lack of use of the PNC and PND systems already outlined, there were specific problems encountered between West Yorkshire Police and North Yorkshire Police. Greater clarity was needed to confirm which Force had ownership of an enquiry. If a query was raised between the two police organisations then it needed to be much more explicit in what was being asked and what the expectations were of the originator. Examples of this included repeated problems of sending details about an incident in one county, but not being clear which Force was conducting the domestic abuse risk assessment.

7.1.10 In 2017, officers too easily dismissed Emma's allegations of being held against her will. This suggests a poor understanding of coercive control. Any lack of physical restraint was irrelevant when considering Emma's learning disability and lack of mobility. Positive action should have been taken.

7.1.11 National protocols exist between Police Forces on areas of jurisdiction. Police officers retain their powers throughout England and Wales. But procedures rightly exist which means it is rare for officers from one Force to operate on any routine basis across Force boundaries. However, this does not mean such cross-border cooperation cannot take place. When a serious sexual assault was reported in January 2019 there were several delays whilst messages were passed between West Yorkshire and North Yorkshire Police. Complex issues such as management of the crime scene or suspect, and support for the victim or forensic capture were not managed effectively. It would have taken a simple telephone call for officers investigating such a serious crime to travel across a county boundary to complete the full investigation. This would have prevented unnecessary delays and not lost

vital evidence. The actual locations; Bradford and Harrogate, are only 19 miles apart.

7.1.12 There was no safety plan put in place to protect the victim following her allegations of sexual assault. Thomas was a known violent offender and had previously been investigated for similar offences perpetrated against a female with a learning difficulty. The lack of a safety plan suggests no consideration was given to Emma's ongoing protection while the investigation progressed.

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

7.1.14 Some agency records give only limited details of disclosures made by Emma. They do not contain any references to any proposed follow-up actions or planned multi-agency dialogue to progress any information they held.

7.2 Recommendations

Recommendation 1:

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

Recommendation 2:

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

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

(ii) *Training* in the recognition of 'unconscious bias'. Repeat callers can involve a significant use of an agency's time and resources. Despite the

best intentions of staff, unconscious bias can develop into an individual's mindset, especially if they are faced with abusive language. A vulnerable person may exhibit abuse and may make hoax calls but this does not mean they are not at risk of abuse or exploitation from others. Training is a good way to guard against the onset of unconscious bias.

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

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

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

Recommendation 3:

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

Recommendation 4:

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

Recommendation 5:

West Yorkshire and North Yorkshire Police develop or revise their protocols for effective use of the Police National Database (PND). If there is any suggestion a

victim or a perpetrator of domestic abuse has lived elsewhere in the UK, then the default position should be that PND is checked to review any incidents that have taken place elsewhere.

Recommendation 6:

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

Recommendation 7:

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

Recommendation 8:

The relevant partner agencies review the role, remit and structures of the Harrogate Community Safety Hub. Such forums can be valuable in developing effective multi-agency working to reduce crime and disorder. However, the group requires protocols confirming the roles of attendees both before and after the meeting of the group (i.e. including researching information held on internal databases before the meeting and updating any actions post meeting). There should be formal reporting mechanisms to the MARAC if domestic abuse concerns are highlighted.

Recommendation 9:

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

Recommendation 10:

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

References:

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

'Advice for victims and professionals' (Paladin national stalking advocacy service)

MAPPA guidance (Ministry of Justice 2012)

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Office for National Statistics (ONS) data 2015-2019 (HM government)

Joint national protocol CPS/ police for prosecution of Domestic Abuse cases (revised 2018)

Surviving Economic Abuse (national UK charity) online information (2020)

Domestic Violence Disclosure Scheme (DVDS) – Home Office assessment of national rollout (2015)

APPENDIX 1: Single Agency recommendations

The majority of single agency recommendations from the IMR authors have been absorbed into the overarching recommendations made by the independent author.

This appendix records the remaining single-agency recommendations directly applicable to that particular agency

North Yorkshire Health and Adult Services

- Assessment teams to be trained on procedures for frequent callers. North Yorkshire County Council has a policy on unreasonable persistent complaints. This will achieve consistency of approach across teams.

- Design and implement a quality assurance framework to align with the newly created practices and processes linked to making safeguarding more person-centred.

West Yorkshire Police

- NIL

Bradford Teaching Hospitals Foundation Trust

- All staff to be reminded that contact names and numbers of other professionals are to be recorded in notes and chronologies of contacts.

Yorkshire Ambulance Service

- NIL

NHS North Yorkshire Clinical Commissioning Group (on behalf GP Practice)

- When concerns are raised regarding the whereabouts of a vulnerable patient, the actions taken and outcome of these should be clearly documented.

Harrogate Borough Council

- The Local Authority to amend the housing application form to update with the nationally agreed definition of domestic abuse

Tees, Esk & Wear Valleys NHS Foundation Trust

- NIL

Bradford District Care NHS Foundation Trust

- Review the FRS documentary gaps to ensure full capture of ethnicity, religion, language and cultural needs.

- Strengthen the documentation in relation to information gathered during a mental health assessment to include protective factors and social circumstances within the record. Any gaps in assessments to be clearly recorded as 'not assessed' rather than leaving blank.

Harrogate District Foundation Trust

- The Emergency Department should develop a 'pain management' leaflet with an easy read version readily available, to support patients who attend the department experiencing chronic pain.

North Yorkshire Police

- NIL

Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company

- When an open case is passed to a new practitioner, a discussion takes place with a line manager to ensure relevant concerns are discussed and documented. Any safeguarding concerns to be prioritised and existing safeguarding contacts to be shared and noted.

- OASys/Delius review should be completed on HDC recall to evidence the reasons for that recall. This will prompt further safeguarding checks.

- Workloads to be maintained at a level where case managers are able to dedicate proactive attention to their caseload.

- All newly appointed case managers to receive regular and reflective supervision where cases are discussed and management oversight of all cases is recorded.

- Refresher training to be accessed by practitioners in respect of tracing information held on the national Delius case management system.

City of York Council

- NIL