North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of Dianne

September 2018

EXECUTIVE SUMMARY

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Contents

1/. The Review Process

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

1.2 Dianne is the victim's real name. Dianne's family made a specific request that her real name was used throughout this review. The perpetrator in this case is referred to by the pseudonym, 'Margaret.'

Subjects of the Review:

The victim; Dianne, a female aged 70 years at the time of her death.

The perpetrator; 'Margaret', a female aged 65 years at the time of the murder.

1.3 Criminal proceedings were completed on 8th April 2019. The perpetrator appeared at Leeds Crown Court. She pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility. Her plea was accepted by the prosecution following submission of psychiatric reports. On 3rd May 2019, Margaret was sentenced to life imprisonment with a minimum tariff of eight years imprisonment.

1.4 This process began with an initial meeting of the North Yorkshire Review Group on 5th October 2018 when the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with the victim and perpetrator prior to Dianne's death were contacted and asked to confirm their involvement with them. Seven of the agencies confirmed their contact and were asked to secure their files.

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

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

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

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

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

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

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

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

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

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

2/. Contributors to the review

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

- NHS Scarborough and Ryedale Clinical Commissioning Group (victim's and perpetrator's GP)

- North Yorkshire Police

- Independent Domestic Abuse Service (IDAS)

- Scarborough Borough Council (Customer First, Housing and Community Impact teams)

- North Yorkshire County Council Health and Adult Services.

- Age UK

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

3/. The Review Panel members

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

- Steven Hume – Community Safety and Security Manager, Stockton-on-Tees Borough Council and appointed Independent Chair.
- Odette Robson – Head of Safer Communities, North Yorkshire County Council.
- Detective Superintendent Allan Harder –North Yorkshire Police.
- Olwen Fisher – Designated Professional, Adult Safeguarding, NHS Scarborough & Ryedale CCG.
- Nicola Cowley - Named Nurse for Safeguarding Adults, York Teaching Hospital NHS Foundation Trust.
- Chris Davies – Head of Client Services, IDAS (Independent Domestic Abuse Services) North Yorkshire and York.
- Shan Thistleton -Senior Audit Officer, Scarborough Borough Council.
- Christine Appleyard – Head of Practice, Personalisation and Safeguarding, North Yorkshire County Council Health and Adult Services.
- Mike Cane – Independent Author and Safeguarding Consultant

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

4/. Author of the overview report

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

5/. Terms of Reference for the review

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

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

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

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

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

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

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

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

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

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

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

- Did any staff make use of available training?

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

- How accessible were services for the victim and perpetrator?

6/. Summary chronology

6.1 The victim, Dianne, was 70 years old at the time of her death. It is not clear exactly which date she met Margaret, but they had known each other for around 30 years. Dianne has an adult daughter from an earlier marriage.

6.2 The perpetrator, Margaret, was 65 years old at the time of the murder. She has an adult son and daughter from an earlier relationship.

6.3 Dianne and Margaret were initially friends but over time this developed into an intimate relationship. The couple lived at different locations around the UK; travelling and settling as determined by their occupations. Dianne had worked as a nurse, a care worker, a bookkeeper and a pub landlady. Margaret had worked as a bus driver, cleaning supervisor and a pub landlady. Eventually they settled back in their native Yorkshire. They lived in Leeds but rented a caravan on the North Yorkshire coast. They liked the area so much that eventually they moved full time to a property in a village a few miles from Scarborough.

6.3 Dianne reported domestic abuse to the police which she suffered at the hands of Margaret. The first report to North Yorkshire Police was on 1st January 2012 when she reported an assault. Margaret had grabbed her by the throat and threatened to kill her. She banged Dianne's head off the floor repeatedly. Officers noted Dianne had a head injury. Margaret had left before police arrived. The following morning, Dianne re-contacted police to state she wanted to withdraw her allegation. Officers continued with their enquiry and Margaret attended the police station as a 'voluntary attendee'. She denied the allegation and made counter allegations against Dianne but did not want to make any formal complaint. Although Dianne indicated they would separate, the couple did in fact resume their relationship almost immediately.

6.4 Several further incidents of domestic abuse were reported in February and March 2012. These ranged from assaults to threats, harassment and financial abuse. Although Dianne had contact with professionals from police and her GP, no agency assessed her at high risk of harm. From March 2012, there were no further incidents of domestic abuse reported for over five years. In June 2017, Margaret made an allegation of assault against Dianne. Dianne was arrested but denied the allegation, stating it was Margaret who had threatened her, and that Margaret was a bully. No further action was taken.

6.5 It was another full year before Dianne next called police to report Margaret was being aggressive and threatening her. The incident was assessed as standard risk and no further action was taken.

6.6 In January 2017, Dianne had a major operation (*femoro-popliteal bypass – reverts the hardening of arteries).* The operation had complications which meant a significant

deterioration in her health and an increase on her reliance on Margaret for physical help in performing daily activities and in particular around transport. This entirely changed the power dynamics within the relationship.

6.7 Dianne made a decision to end the relationship but wanted to do so in a calm and measured way. She did not inform Margaret of her plans. Dianne had contact with several agencies throughout the summer of 2018 (including Scarborough Borough council Housing Team, North Yorkshire Health and Adult Services, AGE UK and the Independent domestic Abuse Service). Dianne was not identified as a victim of domestic abuse by any of these organisations (due partly to Dianne describing her relationship with Margaret as 'friends').

6.8 Dianne began to make bids on properties in her local area and also spent some time staying at her daughter's house and away from the home she shared with Margaret.

6.8 In September 2018, Margaret made a '999' call to police stating she believed she had killed her partner. She was arrested shortly afterwards and subsequently charged the following day.

7/. Key issues arising from the review

7.1 There are several examples of good practice both within and between agencies aimed at protecting Dianne.

7.2 Domestic abuse was not always recognised. Although some agency records showed they were in an intimate relationship, many agencies had them recorded as 'friends.'

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

7.4 There were lengthy periods (spanning several years) when no domestic abuse was reported.

7.5 Alcohol played a major part in both their lives.

7.6 Margaret had suffered an 'Adverse Childhood Experience.'

7.7 The surgery which Dianne went through in 2017 led to a significant deterioration in her health.

8/. Conclusions and lessons learned

8.1 This was a tragic case involving the death of a frail, 70 year old woman. She had been in a relationship with her female partner for around 30 years. Although Dianne chose to disclose the true nature of her relationship to some organisations (i.e. the emergency services) and she had Margaret recorded as her next of kin with her GP, she did not divulge the intimacy of their relationship to other organisations. This meant she was not identified as a victim of domestic abuse and this subsequently prevented her from accessing the most appropriate services.

8.2 There were occasions when even agencies that had recorded the true nature of the relationship did not submit the correct documentation recording the incident as a domestic abuse incident. Such episodes were therefore not reviewed by specially trained staff.

8.3 On several occasions, the true level of risks she faced were confirmed but these did not result in the correct risk assessment being made. In particular, there was insufficient rigour applied when reviewing previous reported incidents. Inconsistencies in Dianne's responses were not challenged when clearly, she was minimising the effects. This too prevented Dianne accessing other forums (such as the MARAC process).

8.4 There were unreported episodes of domestic abuse. The family have confirmed that Dianne often had bruising and we know that she stayed in a refuge in Scarborough for a week. The agency records for the refuge have been destroyed but we know that no other organisation had contact with Dianne at that time. We can reasonably speculate this was unreported domestic abuse.

8.5 Dianne's operation in January 2017 completely changed the power dynamics within the relationship. She became frail and much more reliant on Margaret for support. Margaret abused this position and engaged in bullying behaviour.

8.6 Dianne's family confirm she did fear loneliness and did not want to move out of her own community. This, plus other issues such as her having pets, severely restricted the types of accommodation she could bid for. Dianne was prepared to put up with Margaret's behaviour while waiting for the right property to become available so that she could leave the relationship.

9/. Recommendations

Recommendation 1:

All agencies within the North Yorkshire Community Safety Partnership should review their risk assessment training arrangements for domestic abuse cases. The training should ensure staff are confident in making risk assessments based on victim responses, known facts and professional judgement. All training must include a review of the relationship history and any changes in the circumstances of the victim and perpetrator.

Recommendation 2:

All front line staff should receive training in the early identification and recording of domestic abuse. Such training should include the importance of enquiring routinely and sensitively about a person's experience in private and exploring intimate relationships / partners or ex-partners, same-sex relationships and wider family structures. It is vital that domestic abuse is identified by practitioners at an early stage if the right specialist services are to be offered to victims and perpetrators; and that the physical and psychological factors experienced as a result of violence and abuse are recognised and appropriately supported by practitioners involved in ongoing general health and care services. The training should include recognition of psychological abuse, economic abuse, harassment and coercive control.

Recommendation 3:

The North Yorkshire Community Safety Partnership should conduct a review of the arrangements for its 'Community Impact Team / Community Safety Hub' multi-agency meetings. This review to include governance arrangements and a particular focus on the aims and objectives of the CIT / CSH . Any review to ensure delegates are aware of their responsibilities in relation to preparation, interrogation of their systems, contribution at multi-agency meetings and post meeting responsibilities.

Recommendation 4:

All agencies involved in protecting the vulnerable should work together to confirm the most appropriate organisation is working with a vulnerable victim/patient /client /service user. This requires a full understanding of different risk assessment methods and confidence in Information Sharing Protocols.

Recommendation 5:

The Community Safety Partnership, Safeguarding Vulnerable Adults Board and Local Safeguarding Children Board should map out structures and governance arrangements to reduce duplication, build a mutual understanding and get the right services to vulnerable people. This process should include an illustration of referral pathways.

Recommendation 6:

The North Yorkshire Community Safety Partnership should review its Information Sharing Protocols (ISPs) so that staff are confident in making lawful and proportionate requests for inter-agency information to help protect the vulnerable. Any revised Information Sharing Protocol to be circulated as widely as possible.

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