HARTLEPOOL BOROUGH COUNCIL

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY REPORT

Death of Annie August 2018

Report produced by David Pickard
on behalf of the Safer Hartlepool Partnership

Completed June 2019

INDEX Page

1. The Review Process

1.1 This executive summary of the overview report outlines the process undertaken by the Safer Hartlepool Partnership Domestic Homicide Panel in reviewing the murder of Annie, who was a resident in their area.

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

Name	Who	Age	Ethnicity
Annie	Victim	29	White British
Perpetrator	Perpetrator	30	White British

1.3 The perpetrator pleaded guilty to her murder in January 2019 and was sentenced to life imprisonment and ordered to serve a minimum term of 29 years on 6th February 2019.

1.4 This review began on 14th August 2018. The start of the review was delayed by complicating factors within the police investigation. Initially there were a number of lines of enquiry into Annie's murder. Once the suspect had been formally identified and charged advice was taken from both the Police and Crown Prosecution Service to ensure the commencement of the DHR would not interfere with the pending criminal proceedings. Once that stage had been reached an independent chair and author was appointed and the DHR panel was constituted. The DHR panel met on eight occasions, the last meeting being on 20th May 2019. The report was concluded on 21st June 2019, following consultation with Annie's family.

2. Contributors to the review

Agency

Hartlepool Borough Council
Tees Esk Wear Valley NHS Foundation Trust
Hartlepool Borough Council
Cleveland Police
Harbour
North Tees and Hartlepool NHS Foundation Trust
Hartlepool and East Durham Mind
National Probation Service
Thirteen
Hartlepool & Stockton on Tees Clinical Commissioning Group

3. The review panel members

3.1

Dave Pickard	Independent Chair	
Denise McGuckin	Director of Regeneration and Neighbourhoods	Hartlepool Borough Council
Karen Agar	Associate Director of Nursing (Safeguarding)	Tees Esk Wear Valley NHS Foundation Trust
Sally Robinson	Director of Children's and Joint Commissioning Services	Hartlepool Borough Council
Lindsay Robertson	Head of Quality and Adult Safeguarding	Hartlepool & Stockton on Tees Clinical Commissioning Group
Jill Harrison	Director of Adult and Community Based Services	Hartlepool Borough Council
Mark Haworth	Detective Inspector	Cleveland Police
Lesley Gibson	Chief Executive	Harbour
Lindsey Robertson	Deputy Director of Nursing, Patient Safety and Quality	North Tees and Hartlepool NHS Foundation Trust
Rachel Parker	Community Safety Team Leader	Hartlepool Borough Council
Gaynor Goad	Manager	Hartlepool and East Durham Mind
Ann Powell	Director	National Probation Service
Kay Glew	Director of Neighbourhoods	Thirteen
Jean Golightly	Director of Nursing and Quality	Hartlepool & Stockton on Tees Clinical Commissioning Group

3.2 The DHR review panel was satisfied that the chair and members were independent and did not have any relevant operational or management involvement with the events under scrutiny.

4. Chair and Author of the overview report

4.1 Dave Pickard was chosen as the DHR Independent Chair and Author. A retired Assistant Chief Constable he was judged to have the skills and experience for the role. He is currently Independent Chair of two Local Safeguarding Children Boards in the north of England. Whilst the Independent Chair/Author was not experienced in carrying out Domestic Homicide Reviews, he was experienced in leading on a number of high level criminal investigations during 30 years' service within Durham and Cleveland Police. On retiring from Cleveland Police in 2014 he undertook the role of Independent Chair of two local Safeguarding Children Boards and oversaw a number of complex serious case reviews. The majority of the panel members had no direct involvement in this tragic case, however as is the case in small geographical areas a number had had some involvement from a management perspective i.e. Director of Children's services. The Police representative had overseen an investigation relating to the injury of one of the children some

months after the event in the role as DI of the Unit, no charges were made and everyone exercised independence throughout.

5. Terms of Reference

5.1 The purpose of a DHR 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 on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co- ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

Timeframe under review

The DHR covers the period 1st January 2013 to the date of Annie's murder In August 2018.

Specific Terms

i) To establish the history of the victim and perpetrator's relationship and provide a chronology of relevant agency contact with them, the children of the family, and the parents of the victim and perpetrator. The time period to be examined in detail is 1st January 2013 to 3rd August 2018. Agencies with knowledge of the victim and perpetrator in the years preceding this timescale are to provide a brief summary of that involvement. Any interaction with family members or friends which has relevance to the scope of this review should also be included.

ii) To examine whether there were signs or behaviours exhibited by the perpetrator in his contact with services which could have indicated he was a risk to the victim or others.

iii) Where any mental health diagnosis was made in relation to the perpetrator, did this influence the response to any domestic abuse or risk issues; the decision making in addressing wider complex family issues; or the making of referrals to other support services

iv) Agencies reporting involvement with the victim and the perpetrator to assess whether the services provided offered appropriate interventions and resources, including communication materials. Assessment should include analysis of any organisational and/or frontline practice level factors impacted upon service delivery, and the effectiveness of single and inter-agency communication and information sharing both verbal and written. Did full and relevant information sharing take place? Was there evidence of a multi-agency and coordinated approach to assessment and management of risk? If not, why did this not occur and what were the implications of this as regards effective management of the case?

v) Did any agency hold any information provided by broader family networks or informal networks? Was this information responded to and acted upon appropriately?

vi) Was your agency aware of any influence from social networking or web-based sites which may have/did impact on the behaviour of the perpetrator?

vii) To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

viii) To examine the level of domestic abuse training undertaken by staff who had contact with the victim and/or the alleged perpetrator, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC), and to appropriate specialist domestic abuse services.

ix) To determine if there were any barriers which may have affected the victim's ability to disclose abuse or to seeking advice and support.

x) In liaison with the Advocacy After Fatal Domestic Abuse advocate the Chair to contact family, friends, and colleagues to invite their contributions to the Review and, whilst acknowledging the pitfalls of hindsight, seek their views as to whether anything needs to change to reduce the risk of similar events in future.

6. Summary chronology

6.1 The relationship with the perpetrator began in 2006 and a year later had their first child. Although outside of the time frame of this DHR in 2007 Children's Services were involved in supporting the family and reference is made to a suspected violent relationship between the perpetrator and Annie. This domestic abuse was never disclosed or formally reported to any agency by

Annie, however Annie's family, were firmly of the belief that the perpetrator was both physically assaulting and controlling Annie following the birth of their first child. It is the view of the family that Annie was protecting the perpetrator despite this abuse. Children's Services closed their case in 2008 as Annie had fully engaged with the support received although the perpetrator's engagement was more limited.

6.2 Annie and the perpetrator had a second child in 2010. There were no reported concerns by any agencies although Annie's family continued to believe that the perpetrator was still abusive towards Annie. He would attempt to control her behaviour and to limit contact with her family.

6.3 In January 2012 Annie reported a domestic abuse incident to the police. She had found evidence that the perpetrator had been contacting other women online and when she challenged him on this, he grabbed her with both hands and dragged her out of the house, by her hair in front of their children. The perpetrator was arrested and received a caution for the offence of common assault. A risk assessment was conducted which resulted in a standard risk and the children were seen and spoken to. This was the first and only incident of domestic abuse that Annie formally reported to the police.

6.4 Two days after this incident the perpetrator contacted the police stating he had slit his wrists. He was taken to hospital by ambulance and treated for superficial injuries. This was the first of a number of self-harming incidents by the perpetrator carried out in the following years.

6.5 Within the timeframe of this review, the first contact with Children's Services was in December 2013 when a referral was received requesting a social care assessment of the family due to concerns that the perpetrator was abusing the children emotionally. A core assessment was completed which commenced a period of statutory involvement with the family with services being provided to the children and their parents under section 17 of the Children Act, 1989.

6.6 Over the following 16 months, the case remained active to children's social care whilst a programme of support was provided to tackle the risk factors identified in the assessment. These interventions included parenting and relationship sessions with both parents, regular home visits and contact with the children, Child in Need review meetings involving professionals working with the children and/or their parents and referrals for specialist support services identified as needed to meet the parent's needs. This included a referral for Annie to Harbour's Freedom Programme in accordance with the plan to address the risk factors related to domestic abuse. Following this referral, the records indicate that Annie completed the Freedom Programme offered by Harbour. At the same time as the referral was made for Annie, a corresponding referral to the Harbour perpetrator programme was discussed with the perpetrator, however he declined this referral. He was subsequently referred to MIND to access support services regarding his own mental health. An appointment was offered by MIND but the perpetrator did not attend this.

6.7 In February 2014 the perpetrator was referred to the TEWV single point of access for an assessment of symptoms of hyper-sexuality and mood swings. He was offered two appointments which he failed to attend. In April of 2014 the perpetrator informed the social worker he would agree to a referral to the Harbour perpetrator programme and this was made within two days of the discussion. Records indicate the perpetrator was offered two appointments by Harbour but did not attend these and therefore, the case was closed by Harbour.

6.8 At the beginning of July 2014 Annie indicated to her social worker that she and the perpetrator had split up as he was continuing to control her and that she wanted to stop feeling scared of him, but they were still living in the same property. Shortly after this a safeguarding strategy meeting was held in response to an allegation by Annie's oldest child that the perpetrator had hit them and there was bruising to the shoulder. This incident was a precipitator for Annie to inform the social worker that she wanted to leave the perpetrator and she was supported to move to her mother's home. With regard to the outcome of the child protection investigation, an interview was undertaken with the child and the injury was medically examined. During interview the child said that a sibling had bitten them causing the injury. The conclusion of the medical examination was that a child's bite could not be ruled out and therefore the allegation was not substantiated.

6.9 Annie and the perpetrator remained separated and the following six months were quite a settled period for Annie and her children. Annie secured her own property later in July 2014 and she remained at this address until her death.

6.10 Between July and October 2014, the perpetrator sought advice from the social worker regarding his own needs in relation to mental health and accommodation. At his request he was re-referred to the perpetrator programme but failed to attend two appointments offered by the service. This was the third attempt to refer the perpetrator to the perpetrator programme. In July 2014 the perpetrator came into contact with TEWV mental health services after he was referred to the Crisis Team due to experiencing suicidal thoughts and relationship difficulties. On 30th July 2014 this led to a referral from TEWV to both the police and children's services that the perpetrator had advised his worker he had access to a shotgun. Annie's social worker contacted Annie to ensure she was aware of this information. The police investigated this allegation and found no evidence of the perpetrator having access to a shotgun. He indicated it was a throw away comment to the member of staff from TEWV.

6.11 In May 2015 it became apparent that Annie and the perpetrator has resumed their relationship and in January 2016 Annie gave birth to their third child. The perpetrator continued to have suicidal thoughts and was referred to TEWV Crisis Team and received some short-term support.

6.12 There was no further relevant contact with the family from July 2016 to May 2017.

7. Key Events

7.1 On the 15th May 2017 Annie attended the Urgent Care Centre in Hartlepool with her youngest child who had sustained a puncture wound to the face. They were referred to James Cook University Hospital in Middlesbrough where the child was admitted. Annie indicated that the injury was caused when the perpetrator accidently discharged an air rifle and a foreign body ricocheted from the kitchen floor hitting the child in the face. The remaining children were placed with family members under safeguarding arrangements for neglect and the perpetrator was arrested by the police on suspicion of assault on the youngest child. During the investigation the police spoke to Annie's brother who provided a statement to police detailing prolonged emotional and physical domestic abuse by the perpetrator on Annie.

7.2 Both Annie and the perpetrator were investigated by the police over the injuries sustained by the youngest child. No further police action was taken with Annie whilst the perpetrator was released on police bail pending further police investigations. The perpetrator moved out of the family home.

7.3 Following child safeguarding investigations on the 14th of June 2017 all three children were taken into the care of Hartlepool Borough Council and were placed in foster care.

7.4 There then followed a period from July 2017 to March 2018 where the perpetrator self-harmed on six occasions, took an overdose and had a fall from his 1st floor flat window. He was open to TEVW Affective Disorders Team from July 2017 – May 2018 and the ADHD team co worked with them until November 2017. He was allocated a Care Coordinator and managed under the Care Programme Approach (CPA). He was provided support to monitor his mental state and associated risks.

7.5 In August 2017 he was detained and assessed at the Crisis Assessment Suite under Section 136 of the Mental Health Act (1983) in August 2017. It was noted that no major risks were identified, and the perpetrator was discharged from Section 136 to be followed up by the Affective Disorders Team.

7.6 Also in August 2017 the perpetrator was seen by TEWV – AMH Hartlepool Affective Disorders. At end of the consultation the perpetrator became over familiar with female member of staff and a decision was made for the perpetrator not to be seen by any lone female worker or alone at his home address.

7.7 There are five references in the TEWV electronic care records where Annie had accompanied the perpetrator to his appointments, or in crisis, however she was not proactively engaged in the assessment process. It was indicated that a carer's assessment should be completed with Annie which was not done. His risk to others was assessed as low throughout his treatment with TEWV despite the decision at 7.6 above.

7.8 The perpetrator's pharmacist and TEWV staff contacted his GP to suggest a review of medication as the perpetrator believed that the Ropinirole was aggravating his impulsiveness. The GP made a referral for the perpetrator to the neurology department at James Cook University Hospital, Middlesbrough in November 2017. An appointment was made to see the perpetrator at the neurology department in February 2018 however he failed to attend.

7.9 The psychological assessments were concluded in February 2018 and it was suggested that the perpetrator had 'significant traits of schizotypal[1], schizoid and depressive personality patterns. It was noted that these were unlikely to be at the level of pervasiveness to be considered as a personality disorder'.

7.10 In April 2018 a plan was agreed with the perpetrator to; access bereavement services if he decided this may be of benefit in the future, continue to use meaningful activities and use behavioural activation to improve and maintain his mood. The discharge plan from the Affective Disorders Team incorporated relapse prevention planning and guidance within it for others about how to help him at times of acute stress. Current risks were assessed and addressed by the team and he was discharged from the service on 19/04/2018. This was the last contact the team had with the perpetrator and the referral was closed down on 04/05/2018. The formal diagnosis recorded at the time of discharge was 'Recurrent Depressive Disorder'[2].

7.11 As part of the ongoing assessment of both Annie and the perpetrator's suitability to have their children returned to them by Children's Social Care, the perpetrator agreed to attend a Perpetrator Programme at Harbour which he commenced in August 2017.

7.12 On the 27th September 2017 following information sharing between staff from Children's Services, Harbour and Cleveland Police a Potential Dangerous Person (PDP) referral concerning the perpetrator is made to Cleveland Police by one of their Detectives.

7.13 On the 16th October 2017 Harbour remove the perpetrator from programme due to his mental health issues and a failure to answer phone calls and texts.

7.14 In October 2017 Cleveland Police analytical team reviewed the PDP referral and determined that the perpetrator posed a high risk. They then carried out a PDP screening meeting re the perpetrator. The MAPPA co-ordinator was informally consulted with and recommended a multi-agency meeting for information sharing and to identify any actions with regard to safeguarding. This was passed to a Detective Inspector to arrange, this meeting never took place.

7.15 In December 2017, Cleveland Police held a Force Tasking and Co-ordinating meeting where the perpetrator was raised under the area of individuals suspected of committing other sexual offences and that he had been referred

[1] People with schizotypal personality disorder are often described as odd or eccentric and usually have few, if any, close relationships. They generally don't understand how relationships form or the impact of their behaviour on others.
[2] Recurrent depressive disorder is diagnosed when an individual has suffered at least 2 depressive episodes.

as a PDP having been assessed as high risk by the analytical team. The outcome was the endorsement of the DI CAIU (Detective Inspector Child Abuse Investigation Unit) to manage.

7.16 In January 2018, Annie self-referred to Harbour and commenced one to one support and attendance at Harbour's Freedom Programme, Counselling Service, and Recovery Programme.

7.17 On the 22/1/18 Care Orders were obtained for all three children at the Family Court.

7.18 In February 2018, Annie attended an initial assessment and intervention at Hartlepool & East Durham Mind and subsequently completes 10 sessions.

7.19 In February 2018, at the Cleveland Police Force Tasking and Co-ordinating meeting, the perpetrator was raised where it was identified that there had been no update on actions taken. As no intelligence had been received on the perpetrator since October, the decision was to discharge him from the meeting and for the DI CAIU to continue to manage the perpetrator.

7.20 On the 3rd of August 2018 Annie is murdered by the perpetrator.

7.21 Three days later Cleveland Police received Information from witnesses stating that three weeks prior to her death Annie had told them that the perpetrator had threatened to stab her.

8 Conclusions

8.1 The conclusions and identified lessons learnt in the following section are found from four key events:

- The police investigation into the injury to the youngest child
- The sustained period of self-harming by the perpetrator and the associated response
- The PDP referral
- Why Annie chose not to disclose the threats made to her by the perpetrator

8.2 The police investigation into the injury took an excessive amount of time. An advice file on potential charges against the perpetrator was submitted to the Crown Prosecution Service (CPS) in February 2018 some 10 months after the originating incident. CPS indicated that they were willing to consider firearms and neglect charges however the Detective Inspector overseeing the case wished to pursue an assault charge. The CPS indicated further evidence would be required before they would consider this, resulting in significant further delay, whilst additional medical and ballistic evidence was obtained. At the time of Annie's murder, the case was still unresolved.

8.3 During this time the perpetrators mental health declined, and all the children

were taken into care. Annie and the perpetrator separated but did maintain contact however it was not clear what the nature of this continuing contact was.

8.4 Annie's brother disclosed to the police, during this investigation, his view that Annie had suffered prolonged emotional and physical domestic abuse by the perpetrator during their relationship. This was limited exploration of this disclosure by the police as they seemed to perceive Annie as supporting the perpetrator and not as being potentially vulnerable. Added to this was their belief that as the children were now safeguarded, it reduced the priority of the investigation due to capacity issues. This was a missed opportunity for the police to better understand the relationship between Annie and the perpetrator and to explore the potential of Annie being a victim of domestic abuse as part of the investigation. The focus of the investigation appeared to be only on the child and not the potential vulnerability of Annie.

8.5 From July 2017 to March 2018 the perpetrator self-harmed on six occasions, took an overdose and had a fall from his 1st floor flat window. There were substantial interventions from teams within TEVW during this period. There is a parallel independent MHHR on-going and, to prevent duplication of enquiry, that review will examine the effectiveness of the clinical interventions, relevant safeguarding procedures, information sharing and the quality of the associated risk assessments from those agencies delivering that service to the perpetrator. Despite that parallel enquiry the DHR panel were still able to make conclusions from these events.

8.6 Throughout his treatment with TEVW risk assessments were normally updated and the perpetrator was assessed as being low risk to others. This was despite the fact that a decision had been made the perpetrator was not to be seen either at his home address or by a lone female worker. This decision was not shared with any other agency until TEWV were notified of the PDP referral. It is not clear how the decision for lone workers not to see the perpetrator, or at his home address and the notification of the PDP referral, impacted on the risk assessment that he was a low threat to others, or whether it should have triggered a re-assessment of that risk.

8.7 There are five references in the TEVW Electronic Care Records (ECR) where Annie had accompanied the perpetrator to his appointments, or in crisis, however she was not proactively engaged in the assessment process. These were missed opportunities to gather further information to aid decision making in the wider family context and to inform future assessments or referrals to appropriate support services for both the perpetrator and Annie. There are records to indicate that she was offered and accepted a Trust information leaflet for relatives or carers, she was given advice when she contact the Crisis Resolution Team and that she was to be offered a carer's assessment. There is no evidence that the carer's assessment took place.

8.8 Following the review of the perpetrator's ECR, it was identified that there were potential risks to the following; Annie, their children and professionals. TEWV's involvement predominately focused on risk to self, the children and

professionals. The references made to ‘relationship difficulties’, ‘heated arguments’, ‘controlling behaviour’ and ‘history of domestic violence’ that are evident in the perpetrator’s ECR, suggests that further exploration around these comments or concerns may have led to a better indication of the potential risks in the relationship between him and Annie. It is noted that there are no records to suggest that domestic abuse was discussed in any depth with the perpetrator or Annie or other agencies involved. There continued to be no further acknowledgement of these risks to Annie, or any new partners, after TEWV services were made aware that he was attending the ‘Harbour Preventions Programme.

8.9 Following the perpetrator’s PDP referral to Cleveland Police he was assessed as a high risk and the task to the Detective Inspector was to arrange a multi-agency meeting to manage the potential threat. That meeting never took place.

8.10 There appears to be no explanation as to why the required multi-agency meeting or implementation of interim risk management strategies did not happen, other than human error. There were opportunities to identify and correct this at the Force Tasking and Co-ordination meetings that did not happen. The fact that a multi-agency meeting did not take place was a significant missed opportunity to consolidate and share intelligence/ information on the perpetrator. It would have allowed a clearer assessment on whether he reached the threshold of a PDP and the potential implementation of appropriate risk management strategies.

8.11 There was no professional challenge to Cleveland Police from those involved in the original PDP referral: the social worker, detective constable, Harbour worker and subsequently the TEVW worker who had been made aware of the referral, as to why nothing seemed to be happening after the referral. If this challenge had occurred, it would probably have prompted the multi-agency meeting.

8.12 January 2018 appeared to be a significant time for Annie in understanding her current domestic situation. She had come to understand the negative and undermining effect that the perpetrator’s coercive and controlling behaviour was having on her and her overall parenting ability. Her children had been made subject to a care order at the family court, however she was given hope, that it may be possible to get her children back, as the family court had ordered a further assessment of Annie as a single carer as part of the final court decision. This motivated her to successfully undertake a number of programmes with both Harbour and Hartlepool & East Durham Mind.

8.13 What did not become apparent until after Annie’s murder and was discovered during the police investigation, was the number of threatening social media messages and texts Annie received from the perpetrator. Of particular note some three weeks prior to her death, Annie told two friends she had made as fellow participants at Harbour whilst at the Freedom Programme, that she had received a text from the perpetrator stating he was going to stab her. She

asked these friends to promise not to say anything to anyone about this and they thought Annie did not believe the threat from the perpetrator.

8.14 There are a number of potential reasons why Annie chose not to disclose the threats she had received:

- She did not believe them;
- She felt the disclosure would harm the chance of her children being returned to her; or
- A combination of both.

8.15 On the balance of probabilities the fear of disclosing the threats preventing Annie getting her children back was probably the primary reason she did not disclose.

8.16 Annie received significant support from both Harbour and Hartlepool & East Durham Mind. However, the question remains, did those agencies and others that had contact with her recognise her potentially increased vulnerability in failing to seek help for fear of not getting the children back?

8.17 Despite the missed opportunities identified above it is the belief of the Panel members that Annie's murder was not predictable. From January 2018 Annie had separated from the perpetrator and was successfully moving on with her life building both her confidence and self-esteem. There was no relevant interaction with the perpetrator by any agency from the end of March 2018 until he killed Annie four months later. After her death it did become known that the perpetrator had threatened Annie on numerous occasions prior to her death however this was not disclosed to any agency to act upon. Annie indicated to those agencies she was working with that she was happy and well. Under all the circumstances none of the agencies involved had any evidence or suspicion that the perpetrator was about to carry out a deadly attack on Annie. By the very nature that Annie's murder was not predictable it was also not preventable as none of the agencies involved had any evidence or suspicion that the perpetrator was about to carry out a deadly attack on Annie.

9. View of Annie's family

9.1 The family had the following thoughts on some of the contents of this report, below is a summary, the full details are contained in the overview report:

- They were frustrated over the way the Potentially Dangerous Person (PDP) referral for the perpetrator had been managed by Cleveland Police and felt that this was a significant missed opportunity to help Annie.

- They struggled to understand how staff within the Tees Esk and Wear Valleys NHS Foundation Trust (TEVW) could identify the perpetrator as potentially posing a threat to their lone female workers, but this risk was not identified in relation to any other woman.

- A sense of disappointment with how the police carried out the investigation into the injury caused to Annie's youngest child. The family fully understood the reasons why Annie was also investigated over this matter but felt there was no attempt to understand the domestic abuse Annie was suffering from the perpetrator. This was despite the fact the police were informed by a close family member the previous day that historical domestic abuse existed in their relationship and had previously reported domestic abuse incident.

- Family members appreciated, as much as Annie did not disclose directly to a service that she felt in danger of her life, she did disclose this to friends and carried a personal alarm. They believe more training needs to be done to understand why someone in Annie's situation would not openly disclose that she felt she was in danger to the services she has involvement with. They firmly believe the reason for Annie not disclosing was the fear of not getting her children back and feel there needs to be a better understanding of how the removal of children from the home impacts a parent and especially a parent suffering or recovering from domestic abuse.

9.2 The frequent contact with the family was greatly assisted by the advocate from the charity Advocacy After Fatal Domestic Abuse who regularly visited the family with the DHR chair. Her support to the family and the Chair was commendable and therefore also to the outcomes of the DHR.

10. **Lessons to be Learned**

10.1 Annie had not since 2012 indicated any domestic abuse or coercion and control from the perpetrator, but often such abuse is hidden by the victim and in this case. Women's Aid[3] and their work with the Women's Aid federation of services, found that domestic abuse is very common, however this is often difficult to accurately quantify. Domestic abuse is a largely hidden crime, occurring primarily at home. Women often don't report or disclose domestic abuse to the police (HMIC, 2014)[4] and may underreport domestic abuse in surveys, particularly during face-to-face interviews (ONS, 2015)[5]

10.2 Both in the police investigation of the injury to the youngest child and in the interactions with TEVW more could have been done to understand the true nature of the relationship between Annie and the perpetrator.

10.3 The time it took to investigate the injury to the youngest child was excessive.

[3] Women's Aid womensaid.org.uk

[4] Her Majesty's Inspectorate of Constabulary (HMIC). (2014) *Everyone's business: Improving the police response to domestic abuse*. Published online: HMIC, p. 31

[5] Office for National Statistics (ONS). (2015). *Crime Statistics, Focus on Violent Crime and Sexual Offences*, 2013/14. *Chapter 4: Intimate personal violence and partner abuse.* Published online: ONS, p. 3

10.4 Agencies tended to focus on the need to safeguard the children at the expense of exploring the potential vulnerability of Annie.

10.5 The rationale of TEVW's risk assessment process was not always clear particularly how it was re-assessed to take into account new information such as the PDP referral. The decision for TEVW workers not to see the perpetrator at home or alone was not communicated to other agencies.

10.6 The PDP referral was mis-managed by Cleveland Police. Partners had limited knowledge of the process as it was an internal only policy and not publicised, despite other police forces choosing to do so. Cleveland Police, independently from the DHR, carried out an internal review of how they handled the referral which did not involve or was shared with partners.

10.7 There was no professional challenge from other agencies to the police over what had happened to the PDP referral.

10.8 Part of the rationale for the PDP referral was intelligence that the perpetrator was watching beheading videos. This did not result in a Prevent referral.

10.9 Understanding why Annie did not seek help or disclose the significant threats made to her by the perpetrator.

11. Recommendations from the Review

11.1

a) Cleveland Police review their domestic abuse training for officers and staff to satisfy themselves and the Safer Hartlepool Partnership that it effectively encompasses and addresses the hidden signs of domestic abuse.

b) Cleveland Police ensure that the decision-making rationale for prioritisation of investigations is clearly recorded.

c) Cleveland Police review the governance and oversight of investigations with regard to timeliness and ensuring all available evidence is captured.

d) TEWV to ensure all frontline staff attend Domestic Abuse training focussing on staff always considering potential vulnerabilities of other members of the household when undertaking assessments of a patient's mental health and associated risks encouraging the adoption of a think family approach.

e) TEWV to provide guidance to staff when working with the perpetrator of domestic violence and including this within the Domestic Abuse policy.

f) TEWV to ensure effective supervision processes are in place so that when a carers assessment is offered that it is completed.

g) When there is multi-agency involvement in a patient's case, TEWV to ensure open channels of communication should be maintained with all agencies involved.

h) When there is multi-agency involvement in a patient's case, TEWV to ensure any alerts pertaining to potential risks should be shared across all agencies.

i) All safeguarding concerns should be recorded in line with TEWV processes, policies and procedures.

j) TEWV to review their risk assessment arrangements to ensure it captures new information and intelligence.

k) NHS England (North) share the MHHR report when finalised with the Safer Hartlepool Partnership to ensure co-ordination between relevant recommendations.

l) The Safer Hartlepool Partnership to seek assurance that the 11 recommendations from the Cleveland Police internal review are implemented.

m) Cleveland Police should engage with partner agencies, particularly the National Probation Service, in reviewing multi-agency knowledge and where appropriate involvement in the identification and management of a PDP.

n) Once the above has been achieved all agencies to ensure that their staff are aware of the PDP policy and process.

o) All agencies to review their policy on encouraging professional challenge and ensure staff are confident to do so including encouraging and listening to challenge from third sector organisations.

p) The Safer Hartlepool Partnership to review the effectiveness of Prevent training and that multi-agency staff recognise when and how to make a referral.

q) All agencies to ensure that staff recognise the increased vulnerability of carers who have a child(ren) taken into a care and how they may not seek help or disclose risks to themselves when in the process of seeking to get the child(ren) back.

r) As above but for carers worried about having a child(ren) taken into care.

s) The Safer Hartlepool Partnership to share this DHR report with the Commission on Domestic & Sexual Violence and Multiple Disadvantage.

t) The Home Office to consider placing the guidance for the identification

and management of PDP's on a statutory footing to mirror MAPPA to prevent differing practices across England and Wales

11.2 Action Plans to address these recommendations and the single agency recommendations from the respective IMR's can be found in the DHR overview report.

GLOSSARY

Agencies organisational Description	
Hartlepool Borough Council	Is the local authority of the Borough of Hartlepool. It is a unitary authority, with the powers and functions of a non-metropolitan county and district council combined.
Tees Esk Wear Valley Foundation Trust	Tees, Esk and Wear Valleys Foundation NHS Trust is an NHS trust that provides mental health services. It covers the 1.4 million people living in County Durham, Teesside, North East Yorkshire and York, England.
Hartlepool & Stockton Clinical Commissioning Group	Clinical Commissioning Group - Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Cleveland Police	Cleveland Police is responsible for policing the area of former county of Cleveland in north east England including Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland.
Harbour	Harbour works with families and individuals who are affected by abuse from a partner, former partner or other family member.
North Tees and Hartlepool Foundation Trust	Provide integrated hospital and community-based services to around 365000 people living in East Durham, Hartlepool, Stockton on Tees and surrounding
Hartlepool and East Durham Mind	Involving individuals and communities in mental health support and wellbeing
National Probation Service	The National Probation Service for England and Wales is a statutory criminal justice service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties
Thirteen	Landlord and housing developer, providing homes for rent and sale providing customers with homes, support and opportunities to grow.