Domestic Homicide Review.

Overview report into the death of: Mary, September 2019.

West Cumbria Community Safety Partnership.

Report author: David Banks.

Report completed: April 2021.

1. Preface.

1.1 This review has been undertaken in order that lessons can learned to better protect others in the future. The review was commissioned by West Cumbria Community Safety Partnership on receiving notification of the death of Mary in circumstances which appeared to meet the criteria of section 9(3) of the Domestic Violence, Crime and Victims Act 2004.

1.2 The West Cumbria Community Safety Partnership, and the Domestic Homicide Review Panel members offer their deepest sympathy to all who have been affected by the death of Mary, in particular Mary's immediate family.

1.3 The family were represented during the domestic homicide review process by Mary's sister, Sharron, who was able to attend the review meetings and provide an invaluable insight of Mary's life and experiences, both as a child and adult.

1.4 The following letter was provided to the panel by Mary's family:

Mary.

"I wanted to describe my sister in an honest way and give a little picture of her personality. She was funny, loving, her presence lit up a room with her smile, kind, had the most infectious laugh that made you laugh, clever and beautiful. Mary always had a solution if you had a problem. She always was the big sister we looked up to throughout our childhood and adult life.

Life was not always kind to her and she had her fair share of problems including abuse from her husband and regrettably no children of her own due to losing 2 babies that she never got over.

Mary was a strong person who was truthful and honest in her opinions. She was always supportive of anything I did in life including jobs and family life. Unfortunately, her alcohol problems and abusive relationships changed her. She didn't really have her sparkle anymore. I tried so hard to help her... we all did, but she always ended up back with these partners.

She was much loved, and she is very missed by us all. Life will never be the same without her being here. It wasn't her time but unfortunately it was taken from her."

1.5 The Independent Chair would like to thank the Review panel for their participation and contributions to this domestic homicide review.

2. Introduction.

2.1 This domestic homicide review examines agency responses and support given to Mary, a resident of West Cumbria, prior to being killed by her partner, James, in September 2019.

2.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse prior to the homicide, whether

support was accessed within the community and whether there were any barriers to local delivery and access to support. By taking a holistic approach the report seeks to identify appropriate solutions to make the future safer.

2.3 The scope of this review concentrates on the period November 2013 to September 2019, the latter being the month of Mary's death. Contact with agencies by both Mary and James was often sporadic during this period. Some more general information prior to November 2013 is included in the report to provide a full and balanced background to Mary's life.

2.4 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

3. Timescales.

3.1 This full review panel first met on 27th August 2020. This first meeting, initially planned for Spring 2020, was delayed, initially to allow the criminal trial to take place and then because of the Corona Virus pandemic. The review was concluded April 2021.

4. Confidentiality.

4.1 The findings of each review are confidential. Information is available only to participating officers and professionals and their line managers, until the review has been approved for publication by the Home Office Quality Assurance Panel. To protect the identities of the victim, perpetrator, and their family, pseudonyms (approved by the victim's family) have been used throughout the review.

4.2 The victim will be known as Mary. Mary was a white, British female and was 64 years of age at the time of her death.

4.3 The perpetrator will be known as James who is a white, British male. James was 62 years of age when he unlawfully killed Mary.

5 Terms of reference.

5.1 The terms of reference for this review were set by the review panel and are listed below:

5.2 Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?

5.3 Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

5.4 Did agencies have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator?

5.5 Did the agencies have policies and procedures in place for dealing with concerns about domestic violence?

5.6 Were these assessment tools, procedures and policies professionally accepted as being effective?

5.7 Was the victim subject to a MARAC?

5.8 What risk level was the victim assessed at?

5.9 Did the agencies comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?

5.10 What were the key points or opportunities for assessment and decision making in this case?

5.11 Do assessments and decisions appear to have been reached in an informed and professional way?

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

5.13 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 sign-posted to other agencies?

5.14 Was anything known about the perpetrator, for example, were they being managed under MAPPA?

5.15 Had the victim disclosed to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?

5.16 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?

5.17 Are their 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?

5.18 Are their ways of working effectively that could be passed on to other organisations or individuals?

5.19 Were senior managers or other agencies and professionals involved at the appropriate points?

5.20 Are lessons to be learned from this case relating to the way in which agencies work to safeguard victims and promote their welfare, or the way they identify, assess and manage the risks posed by perpetrators?

5.21 Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

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

6 Methodology.

6.1 On notification of the domestic homicide, all relevant agencies were contacted. Agencies were asked to secure their files if contact was confirmed.

A West Cumbria Community Safety Partnership meeting was held on 29th October 2019. As a result of this meeting, the following agencies were identified as possibly having information on the family: Adult Social Care, General Practice (represented by CCG) North Cumbria Clinical Commissioning Group, North Cumbria Integrated Care NHS Foundation Trust, the North West Ambulance Service; Cumbria Constabulary; Castles & Coasts Housing Association; the National Probation Service and Cumbria and Lancashire Community Rehabilitation Company.

6.2 During the DHR the Police Service of Scotland, Crown Prosecution Service, Unity alcohol and drug recovery service, Northumberland Tyne and Wear NHS Foundation Trust (Mental Health) and Your Housing Group were identified as possessing information that may be relevant to the DHR.

6.3 All agencies who had contact with the individuals subject of this DHR have submitted a chronology. Those agencies with relevant, direct contact have also supplied an Individual Management Review (IMR).

6.4 The panel is grateful to Your Housing Group and the Crown Prosecution Service who provided IMR's at short notice.

6.5 To provide an independent, victim centred perspective during the DHR, the panel requested specialist representation from an Independent Domestic Violence Advisor (IDVA). This representation was provided by Sarah Place of Victim Support and was invaluable.

6.6 Previous Domestic Homicide Reviews have been considered. This allowed the panel to consider if lessons identified in those reviews had been implemented, and learning disseminated across the partnership. Specifically, findings and recommendations following a DHR into the death of Karen in Carlisle during 2017[1] have been considered.

6.7 The overview report is based on findings gathered during the DHR process.

7. Involvement of family, friends, work colleagues, neighbours, and the wider community.

7.1 Contact with Mary's family.

[1] DHR relating to the death of Karen in Carlisle, Cumbria during 2016. Online. Published September 2018. Accessed March 2021. Available from: https://www.eden.gov.uk/

7.2 Mary's family asked to be represented by her sister, Sharron, during the DHR. They were provided with the Home Office DHR leaflet for family members and were supported by a Victim Support homicide case worker. Sharron "virtually attended" the majority of DHR meetings. Additionally, the family were consistently updated by the DHR Chair and DHR coordinator during the review. The family have viewed the DHR report in private, were given ample time to do so, commented positively on its content and recommendations and requested no amendments.

7.3 The panel would like to thank Mary's sister, Sharron, for acting as spokesperson for her family, an incredibly difficult role to undertake and one which was carried out with absolute dignity and a simple desire: that lessons learnt from this tragic death can be used to prevent similar deaths in the future. By providing a verbal picture of Mary's life during an early panel meeting Sharron enabled the panel to understand Mary's life and experiences, both as a child and adult. Additionally, Sharron's "virtual attendance" at the majority of DHR meetings enabled panel members to maintain a clear focus on the task before them and to view this tragic event very much with the reality of Mary's life in mind.

7.4 The contribution to this DHR by Mary's family has been invaluable in enabling the panel to see Mary's life in its entirety and not just focus on the sequence of events prior to Mary's unlawful killing. A letter has been provided to the panel by the family and is positioned within the preface to this report.

7.5 Contact with friends and neighbours.

7.6 The DHR panel made significant efforts to trace friends of Mary that were willing to take part in the DHR. This included enquiries with neighbours in the block of flats she had lived, and a local letter drop. These efforts proved fruitless. Mary had become isolated from the support of immediate friends and neighbours. Previous partners of the perpetrator have not responded to invitations to take part in the D.H.R. This is their right which the Chair and panel have respected. Any information included within the report which relates to James' previous relationships has been redacted to ensure the anonymity and right to privacy of those concerned.

7.7 Contact with employers.

7.8 Neither Mary nor James had been in employment for several years. Previous employers have not been traced as part of this DHR.

7.9 Contact with the perpetrator.

7.10 The Chair of the DHR, David Banks, wrote to James in person, via his solicitor, and via H.M.P. Offender Manager Unit (O.M.U.) post-conviction inviting him to partake in this DHR. To date, no response has been received from James.

8. Review panel members and overview managers.

8.1 The panel met a total of five times. Except for the NPS, the panel, including IMR authors, have not directly line managed any members of staff that had contact with the victim or the perpetrator prior to the homicide.

8.2 *List of panel members:*

David Banks, Independent chair and author.

Clare Stratford, Community safety coordinator – CSP.

Sarah Place, Senior Independent domestic violence advisor (IDVA), Victim Support.

8.3 Agency representatives:

Andrew Horrobin, Senior Manager, Safeguarding Adults, Cumbria County Council.

Sarah Joyce, Service Manager, Safeguarding Adults, Cumbria County Council.

Martin Hodgson, Detective Inspector, Cumbria Constabulary.

Angella Rush Detective Constable Cumbria Constabulary, (since retired)

Caine McIntyre, Detective Inspector Police Service of Scotland

Doctor Amanda Boardman, GP, Safeguarding Lead North Cumbria Clinical Commissioning Group.

Kelly Marsden, Named Nurse, Safeguarding Adults lead, North Cumbria Integrated Care NHS FT

Kate Allen, Specialist Safeguarding advisor, North Cumbria Integrated Care NHS FT, (later for North Cumbria Clinical Commissioning Group).

Sheona Duffy, Case Review Officer Safeguarding and Public Protection Team Cumbria, Northumberland Tyne and Wear NHS Foundation Trust.

Matthew Brierley, Lead Nurse UNITY Alcohol and Drug Recovery Service.

Emily Kirkbride, Senior Probation Officer (Courts), National Probation Service, Cumbria.

Louise Fisher, Deputy Director, Cumbria and Lancashire Community Rehabilitation Company (Sodexo).

Anna Bates, Head of Housing, Castles and Coasts Housing Association

Dawn Clark, Housing Services Director, Castles and Coasts Housing

Association.

Elizabeth Kelly, Customer Operations Manager, Allerdale Borough Council.

Andrew Seeking, Chief Executive, Allerdale Borough Council.

Licia Inniss, Designated Safeguarding Manager, Your Housing Group.

Alison Turner, Head of Older Peoples Services, Your Housing Group.

Matthew Harvey, District Crown Prosecutor, Crown Prosecution Service.

8.4 Overview managers who did not attend panel but received minutes, email correspondence etc.

8.5 Andrew Horrobin, Senior Manager, Safeguarding Adults, Cumbria County Council.

Detective Chief Inspector Craig Smith, Cumbria Constabulary.

Lisa Thornton, Interim Head of Cluster, National Probation Service, Cumbria.

Phil O'Donnell, Director, CLCRC (oversight of submissions not minutes).

Jan Grey, Safeguarding Consultant, Cumbria, Northumberland Tyne and Wear NHS Foundation Trust.

Paula Marshall, Director of Housing and Customer Service, Your Housing Group.

9. Author of the overview report and panel chair.

9.1 The chair and author of this overview report has almost forty years' experience working in the criminal justice (CJ) and violence against women and girls' sectors. He has completed the accredited DHR Home Office training for Chairs and independent report writers.

9.2 The author has extensive experience working in the field of domestic abuse, coercive control, and stalking, both operationally and strategically. He served as a police officer in Cumbria for thirty years during which time he was able to specialise in the field of public protection, wider criminal investigation and multi-agency working. He has experience in undertaking the role of Chair at Multi-Agency Risk Assessment Conferences (MARAC),[2] and led many investigations into the abuse of those most vulnerable in society, including victims of domestic abuse.

9.3 The author retired from the police service during 2012. Since 2014 to date the Chair has worked as an associate to the national domestic abuse charity, SafeLives. Roles have included working with public bodies and the third sector to further develop responses to domestic abuse, including MARAC processes and delivering the Domestic Abuse Matters change programme, which is

[2] Multi- agency risk assessment conference (MARAC). Marac is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. Together, the meeting writes an action plan for each victim.

Online. Accessed March 2021. Information available from:

https://safelives.org.uk/practice-support/resources-marac-meetings

focussed on identifying coercive controlling behaviour (CCB) within abusive relationships.

9.4 The author has complete independence from the agencies and individuals involved with this review.

10 Parallel reviews.

10.1 Cumbria Constabulary (CC) conducted a homicide investigation following Mary's unlawful death. This matter was finalised when James appeared before Carlisle Crown Court and was sentenced to three years imprisonment.

10.2 Her Majesty's Coroner for West Cumbria has opened an inquest into the death of Mary. This matter is ongoing.

11 Equality and diversity.

11.1 The Equality Act[3] came into force on 1st October 2010. The purpose of the Act is to protect people from discrimination in the workplace and wider society and advance equal opportunities for all. The protected characteristics within the Equality Act are age, sex, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and sexual orientation.

11.2 Mary was a white British woman, aged 64 at the time of her unlawful killing. For a number of years Mary received professional support to manage her mental health.

11.3 James was a white British male, aged 62 years when he unlawfully killed Mary. Medical records indicate that James suffered an acquired brain injury as a child.

11.4 Both Mary and James misused alcohol.

11.5 The review panel gave due consideration to equality and diversity during this DHR. The protected characteristics considered most relevant to the unlawful killing of Mary, by James, were sex, age and disability. The rationale to support the review panel's view is outlined below.

11.6 Sex.

11.7 Mary was female. James is a male. The Crimes Survey for England and Wales 2020[4] estimated that 2.3 million adults aged 16 to 74 years experienced D.A. in the preceding year. Of these 1.6 million were women and 757.000 men. Home

[3] . The Equality Act 2010. Published October 2010.Gov.UK. Online. Accessed March/ November 2021. Available from:

https://www.gov.uk/guidance/equality-act-2010-guidance

[4] Office of National Statistics. Domestic abuse victim characteristics, England and Wales: year ending March 2020. Published November 2020. Online. Accessed March 2021. Available from:

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domestica-busevictimcharacteristicsenglandandwales/yearendingmarch2020#main-points

Office research titled "Domestic Homicide Reviews: Key finding from analysis of domestic homicide reviews, December 2016"[5,p3] evidenced the majority of principal suspects in domestic homicide cases were male (87% for combined years 2010/11 to 2014/15).

11.8 The C.P.S. "Violence Against Women and Girls report 2018/19"[6] outlined that of the 117,568 defendants prosecuted, 109,081 (92.9%) were males, 8,376 (7.1%) females. These statistics remain consistent "year on year".

11.9 Research and analysis by Michael. P. Johnson titled "A Typology of domestic violence, intimate violence, violent resistance and situational couple violence"[7] provides evidence that male perpetrators of DA are more likely to coercively control female victims. This impacts negatively on victims physical and mental health, self-esteem, independence, and reduces their ability to work thus creating a cycle of economic dependence.

11.10 Disability.

11.11 Mary received professional support for a number of years to manage her mental health which was impacted by previous and ongoing abusive relationships and the loss of two babies born out of a previous relationship. James suffered an acquired brain injury as a child which did not require ongoing treatment.

11.12 The Equality Act 2010[8] considers mental health a disability if it has a long-term effect on an individual's normal day-to-day activity. "Long term" is defined as lasting, or is likely to last, 12 months.

11.13 Domestic abuse charity SafeLives report, "Spotlight, disabled people and domestic abuse"[9,] evidenced disabled women are twice as likely to be victims of DA than non-disabled women and they are likely to suffer abuse longer than

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[5] Domestic Homicide Reviews: Home Office research, key findings from analysis of domestic homicide reviews. Online. Accessed March 2021. Published December 2016: Available from:

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

[6] Crown Prosecution Service (C.P.S.) Violence against women and girls report. 2018/19 (data section). Accessed March 2019. Online. Available from:

https://www.cps.gov.uk/sites/default/files/documents/publications/cps-vawg-report-2019.pdf

[7] Johnson M.P. (2008) *A typology of Domestic Violence, intimate terrorism, violent resistance, and situational couple violence,* Northeastern University Press, Boston. P37-43.

[8] The Equality Act 2010. Published October 2010.Gov.UK. Online. Accessed March/ November 2021. Available from: https://www.gov.uk/guidance/equality-act-2010-guidance

[9] SafeLives. Spotlight 2. Disabled people and domestic abuse. Published March 2017. Online. Accessed November 2021. Available from: https://safelives.org.uk/knowledge-hub/spotlights/spotlight-2-disabled-people-and-domestic-abuse

non-disabled women prior to accessing support (3.3 years / 2.3 years respectively). Additionally, a SafeLives report, "Spotlight 7. Domestic abuse and mental health"[10] evidenced the additional vulnerabilities faced by victims with mental health conditions including an increased likelihood of debt and substance misuse. This research also highlighted victims are more likely to access their GP or accident and emergency services (A and E) prior to accessing DA specific support.

11.14 Research by Dr Sian Orem PHD et al "Violence Against Women and Mental Health"[11] provides evidence mental health problems are a common consequence of experiencing domestic abuse. The findings are consistently supported by similar research.

11.15 Home Office research of Domestic Homicide Reviews titled "Key finding from analysis of domestic homicide reviews" (December 2016) found mental health issues were present in 25 of the 33 intimate partner homicides analysed[12,p3].

11.16 During her earlier life Mary suffered the loss of two babies born out of a previous relationship. Research published by Grace H et al "Bereavement experiences after the death of a child"[13] analyses the impact of child death on the surviving parent(s). They are found to suffer a broad range of difficult mental and physical symptoms. As with many losses, depressed feelings are accompanied by intense feelings of sadness, despair, helplessness, loneliness, abandonment, and a wish to die. Parents often experience physical symptoms such as insomnia or loss of appetite as well as confusion, inability to concentrate, and obsessive thinking. Extreme feelings of vulnerability, anxiety, panic, and hyper-vigilance can also accompany the sadness and despair.

11.17 Age.

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[10] SafeLives. Spotlight 7. Domestic abuse and mental health. Published May 2019. Online. Accessed November 2021 www.safelives.org.uk. https://safelives.org.uk/spotlights/spotlight-7-mental-health-and-domestic-abuse

[11] Oram, S., Khalifeh, H., & Howard, L.M. (2016). Violence against women and mental health. Published November 2014. The Lancet Psychiatry, V4 (2): p159-170.

https://DOI.org/10.1016/S2215-0366(16)30261-9

[12] Domestic Homicide Reviews: Home Office research, key findings from analysis of domestic homicide reviews. Online. Accessed March 2021. Published December 2016: Available from:

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

[13] Christ, Grace & Bonanno, George & Malkinson, et al. Researchgate. January 2003. Bereavement Experiences after the Death of a Child. When children die: Improving palliative and end-of-life care for children and their families. Accessed July 2022. Available from:

https://www.researchgate.net/publication/253725159_Bereavement_Experiences_after_the_Death_of_a_Child

11.18 Mary was aged 64 years at the time of her death, James was aged 62.

11.19 Data gathered during the Crime Survey for England and Wales published November 2020[14,c12] provides evidence that 4.4% of females and 1.9% of males, aged 60 to 74 years, experienced domestic abuse in the last year.

11.20 Research titled "Domestic violence and mental health in older adults"[15] by L. Knight and M. Hester suggested that, although domestic abuse prevalence figures are variable, the likely lifetime prevalence for women over the age of 65 is between 20–30% and that physical abuse is suggested to decrease with age, but rates of emotional abuse appear to be stable over the lifespan.

11.21 Findings of research conducted by the national DA charity SafeLives, titled "Spotlight 1. Older people and domestic abuse"[16] concluded victims aged 61+ are more likely to experience abuse from a current partner than those 60 and under (40% v 28%), are less likely to attempt to leave the perpetrator in the year before seeking help and were more likely to live with the perpetrator after getting support (32% v 9%). The research additionally highlights a lack of provision of DA services designed to support older victims of DA, that older people can be unaware of services that are available to support them and a generational belief that marriage is for life, regardless of abuse within the relationship.

12. Dissemination.

12.1 The report will be sent to a designated senior manager in the following agencies:

Independent Chair and members of West Cumbria Community Safety Partnership,

Police and Crime Commissioner for Cumbria Constabulary.

Cumbria Constabulary- Chief Constable.

Cumbria Constabulary- Public Protection lead.

Police Service of Scotland- Chief Officer.

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[14] Office of National Statistics. Domestic abuse victim characteristics, England and Wales: year ending March 2020. Published November 2020. Online. Accessed March 2021. C12. Available from:https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2020#main-points

[15] Domestic violence and mental health in older adults. L. Knight and M. Hester 2016. Journal. Published August 2016. Online. Accessed November 2021. Available from: Domestic violence and mental health in older adults: International Review of Psychiatry: Vol 28, No 5 (tandfonline.com)

[16] SafeLives. Spotlight 1. Older people and domestic abuse.
Published October 2016. Online. Accessed November 2021. Available from:
https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

Police Service of Scotland, Public Protection lead.

Clinical Commissioning Group (North) Chief officer.

NCIC, NHS Foundation Trust Director.

Mental Health and Disability Trusts Chief executive.

Cumbria County Council Chief officer.

North West Ambulance Service Trust, Chief officer.

Allandale Borough Council, Chief executive, Andrew Seekings.

Your Housing Group Chief Executive, Brian Cronin.

Stephanie Murphy, Chief Executive, Castles and Coasts Housing Association.

Crown Prosecution Service, North West.

CNTW NHS trust.

NPS, Cumbria Chief Officer.

Sodexo (CLCRC) Chief officer.

Safeguarding Adults, CCC, Assistant Director.

Unity Substance Misuse Service.

Claire Powell Victim Support account manager, Cumbria & Lancashire Victim Services.

UNITY Alcohol and Drug Recovery Service.

13. Background information.

13.1 Mary was a resident of West Cumbria, having moved to the County in her later teenage years.

13.2 Between October 1993 and November 1994 Mary reported to police in Cumbria that, on three separate occasions, she had been a victim of assault by a previous husband (now deceased).

13.3 James is known to have been a perpetrator of domestic abuse during previous, long-term relationships.

13.4 During the course of their relationship, Mary's partner, James, usually lived with her. James retained rented accommodation in Scotland. No one else lived with them.

13.5 James and Mary had been in an intimate relationship for at least five years.

13.6 September 2019, the North West Ambulance Service (NWAS) were called to Mary's home, by James, who stated he was unable to wake her.

13.7 The ambulance crew and attending doctors were spoken to at the property by James, he told them both had been drinking vodka heavily, that Mary had fallen earlier that day, that they had a fight and Mary may have "hit her head".

13.8 Mary was found to be unconscious in the bedroom of the house. Medical examination showed significant head injuries and bruising to the chest.

13.9 Paramedics requested Police attend the address as the injuries were considered non accidental and James was becoming increasingly agitated and aggressive towards the crew and an attending doctor whilst they were administering care to Mary.

13.10 Mary was anaesthetised and subsequently conveyed to the Cumberland Infirmary, Carlisle (CIC).

13.11 The injuries sustained by Mary proved to be incompatible with life, she never regained consciousness and died in hospital.

13.12 James was initially arrested on suspicion of assault. Following Mary's death James was charged with the murder of Mary. This charge was later reduced to manslaughter[17].

13.13 James subsequently appeared at Carlisle Crown Court (CCC) and pleaded guilty to the manslaughter of Mary. James was sentenced to three years imprisonment.

14. Chronology.

14.1 Prior to her relationship with James, Mary had been a victim of domestic abuse. The details are as follows.

14.2 Between October 1993 and November 1994 Mary reported to police in Cumbria that, on three separate occasions, she had been a victim of assault by a previous husband (now deceased). On each occasion the assaults resulted in bruising to Mary. On one occasion the bruising was to Mary's face. Following one of the incidents her husband was arrested. On the remaining occasions Mary told the police she did not want to make a formal complaint against her husband, and he was not arrested.

14.3 James was responsible for domestic abuse within previous relationships. The exact dates and detail of these relationships are not known.

14.4 The Police National Computer (PNC) has two recorded convictions against James for criminal damage to property, committed in Cumbria during 1986 and 1989. The method used to commit the crimes is recorded as the deliberate use of force. The respective addresses of James and the victim of the damage suggest they were not living together. The damage was committed at the same victim address on both occasions. In relation to the 1986 conviction the perpetrator and victim are described as "known to each other". PNC also shown James appeared

[17] C.P.S. Murder and manslaughter. Legal guidance. Published 2017. Online. Accessed July 2022. Updated 18/03/2019: https://www.cps.gov.uk/legal-guidance/homicide-murder-and-manslaughter.

before Aberdeen Sherriff's Court during 2008 for breach of the peace. The offence record highlights domestic abuse being an aggravating factor.

14.5 The Police Service of Scotland crime recording system indicates James was a victim of violence (non domestic). Other than incidents involving Mary, the last reported incident in Scotland was in 2010.

14.6 On 25th September 2000 Mary became sole resident of a flat, situated within a block of four, in West Cumbria. The flat was managed by Derwent and Solway Housing Association (DSHA).

14.7 Between 14th March 2010 and 2014 DSHA received numerous complaints from Mary and others relating to anti-social behaviour emanating from a flat within the block.

14.8 On 12th April 2013 an injunction was imposed against the individual responsible for the anti-social behaviour. This injunction was achieved following effective partnership working between Cumbria Constabulary (CC), DSHA and the collation of evidence provided by residents, including Mary. Consequently, there was a significant reduction in the reports of anti-social behaviour.

14.9 26th September 2013 Mary was admitted to Cumberland Infirmary Carlisle (CIC) as an inpatient presenting with episodes of dizziness/falls and dehydration. Mary's past medical history was summarised as bulimia, anxiety and depression. At this time, it was documented that Mary lived alone.

14.10 Mary was discharged from CIC on 30th September 2013.

14.11 On 20th March 2014 Mary made a complaint to police of anti- social behaviour involving occupants of the same flat she and others had previously reported. The police attended, recorded the matter, and shared details of the incident with DSHA. Mary was advised to also report further ASB to DSHA and Environmental Health (EH).

14.12 15th April 2014. A police officer (PO1) from CC and a housing officer (HO1) from DSHA visited the occupants of the flat from which ASB had allegedly been emanating. Whilst present a report was made by the flat occupant's girlfriend (GF) that Mary was in a new relationship with a male named as James, that they consumed alcohol heavily, that James would stay at the flat for three to four weeks at a time and then be absent. During the conversation both were categorised by the GF as alcoholics. GF reported that she was recently woken up by Mary and James arguing, sounds of scuffling and that a loud bang was heard after which everything went quiet. GF reported Mary may have been knocked out, but shortly after she was heard to start swearing and doors were heard to slam. The flat occupants were asked by PO1 and HO1 to call the police if such an incident occurred again. Immediate attempts were made by PO1 and HO1 to visit Mary at her flat. No response was received. Subsequent attempts to visit Mary at the flat and letters sent by HO1 received no response.

A domestic abuse stalking harassment risk identification checklist (DASH)[18] was not completed by HO1 or PO1. The information was not entered onto CC systems as an incident requiring further investigation. The information was initially recorded on DSHA records.

14.13 6th June 2014 Mary attended a scheduled appointment with a Community Psychiatric Nurse (CPN) for ongoing support with her mental health. The support was provided by Allerdale Community Mental Health and Recovery Team (ACMHART) and had been ongoing since October 2011. During the appointment Mary shared that James had been verbally abusive. No further detail was recorded.

14.14 27th June 2014. HO1 carried out a "cold call" on Mary at her home regarding the ASB complaint she had previously made and the suspicion that Mary may be subject of DA. Mary and James were present. Mary was believed to be under the influence of alcohol and looked withdrawn and unkempt. The flat was in disarray. James left the flat after loitering in other rooms and his presence being detected by HO1. Following initial discussion regarding the previous complaint of ASB, HO1 asked Mary if she was suffering DA, perpetrated by James. Mary was recorded as being initially dismissive but then asked if people had really heard them arguing. This was confirmed by HO1 who cited that the level of swearing was causing a nuisance, upsetting children and that there were concerns for her safety. Mary became slightly weepy, said James did not live with her and that she was sick of him being around. HO1 advised that she had to note that the flat was in disarray and that this was not the 'norm' for what she knew of Mary and, that if she was having difficulty in getting the male to leave, DSHA would help her. HO1 reminded Mary that she had a mobile phone number to contact HO1 on, if ever needed, this being a line of communication Mary had used previously when reporting anti-social behaviour within the block of flats. Details of the DA were added to DSHA records, and a letter was sent to Mary, which, in part, read as follows;

"I feel that I must also note that when I visited you, we discussed about the reports of domestic abuse/ violence that is being heard occurring at your home. The community have been worried about your safety and have been asked to contact the Police should they fear for your safety, or should they be caused a

[18] Domestic Abuse stalking, harassment, risk identification check list (DASH/ DASH RIC) is a structured, professional judgement risk assessment tool designed to inform levels of risk, aid risk-management plans, and do so by using a common language because other practitioners from other disciplines use the same tool. The Domestic Abuse Questionnaire (DAQ) used by the Police Service of Scotland is a version of the DASH.
Published 24th February 2015. Online. Accessed March 2021. Available from https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

noise nuisance. You informed me that you were asking your partner to leave, and I informed you that I was concerned that you were looking distressed whilst I was present. However, you informed me that you were ok and did not require any help."

14.15 Following the interview with Mary, no assessments were undertaken to formally assess the level of risk Mary faced and no other safeguarding referrals were made.

14.16 21st August 2014. During an appointment with a CPN Mary reported concerns regarding James' drinking. This matter was not linked to the earlier information provided by Mary to a CPN, that her partner was verbally abusive.

14.17 30th August 2014. Mary contacted CC complaining of being assaulted by James. Mary told the attending police officer, PO2, that James dragged her off a chair onto the floor, causing her head to bang on the floor. As a result, Mary sustained bruising to her right upper arm and her right thumb. Mary did not feel able to provide a written statement to officers regarding the incident. James was arrested on suspicion of assault occasioning actual bodily harm (ABH). Both Mary and James denied being in an intimate relationship. A crime for assault was recorded and a DASH completed, the level of risk was recorded as "standard". When completing the DASH Mary described risk factors which included ongoing and escalating physical and verbal abuse which was occurring daily, economic abuse which is documented on the DASH as "I have given him loads of money to get him out of debt, but he doesn't appreciate it at all" and that the perpetrator would not stop unless he was made to leave.

14.18 James was interviewed by a Detective Constable (DC1) and made admissions regarding the allegation. James received a simple caution for assault on Mary.

14.19 29th October 2014. The DASH completed 30th August 2014 was reviewed for the purposes of quality assurance and compliance, this being nearly two months after initial submission. The risk level identified in the DASH, standard, remained unchanged.

14.20 30th October 2014 Mary was seen at home by a CPN. It is recorded that James appeared to encourage the victim to drink wine. This was not explored further during the visit.

14.21 6th November 2014. Mary attended a routine CPN appointment. Information gained during previous appointments regarding possible indicators of domestic abuse were not discussed or probed further.

14.22 13th January 2015. CC received a 999 call from a neighbour of Mary concerned for his own welfare. PO3 attended and found four people at the address including Mary. All appeared to be intoxicated. During routine enquiry it was established the welfare concerns were unfounded. Mary was present, she confirmed she and James were in a relationship. PO3 submitted an intelligence report regarding this incident.

14.23 15th January 2015. Following a discussion with her CPN, Mary was discharged from Allerdale Community Mental Health Trust (ACMHT). Mary reported being

symptom free, was happy to be discharged, reported she had a good network of supportive friends and that she was functioning well in the community. On discharge Mary and the CPN agreed contingency, coping and staying well plans. Mary and her GP's practice were advised to re- refer for reassessment if Mary suffered a deterioration of her mental health.

14.24 9th April 2015. GP practice attempted several times to invite Mary for a review of her previously diagnosed depression and prescribed medication. The invitations were to no avail in the short term.

14.25 4th June 2015. Mary contacted CC then cleared the line. CC control room tried to ring back. Initially there was no reply but eventually contact was made. Mary told the operator everything was alright and now she did not require police, that she had been drinking and was safe and well. Mary was informed officers would come round and speak to her in person which she accepted.

14.26 Officers attended. Mary and James were present. It was noted that Mary and James were both heavy drinkers. Mary told officers she was on prescribed medication, Prozac. She told officers she had forgotten to take her tablets that night and became very agitated, that a verbal argument broke out and she called the police for someone to talk to. Advice was given to both parties. No one was believed to be subject of any crime. A DASH was submitted by PO4. On the DASH Mary did not consent to her information being shared with other agencies. No safeguarding referral was completed to Adult Social Care (ASC) in respect of Mary's care and support needs.

14.27 When the DASH was reviewed by the Cumbria Constabulary Public Protection Unit (PPU) it was noted "Second recorded PVP DA in the last twelve months. Both referred persons having alcohol misuse issues. No disclosures. No victim letter sent."

14.28 29th July 2015. Mary attended an appointment with her GP for shoulder pain. Whilst present the GP discussed other medical issues and her recent discharge from the CMHT. The GP explored with Mary issues around domestic abuse. Mary said she was in a good relationship and that she was keen to stay on her prescribed medication as she felt stable.

14.29 24th August 2015. During a consultation with her GP regarding an eye disorder Mary indicated she had recently consumed a large amount of alcohol. This prompted the GP to ask Mary if she had an alcohol related problem. Mary stated not and was referred to ophthalmology.

14.30 15th December 2015. Mary returned from a holiday with James and, following the impact of Storm Desmond on her home, was temporarily moved by her housing provider, DSHA, as a sole tenant to other local accommodation. This move was driven by crisis management during a period of unprecedented flooding which resulted in significant damage being caused to local housing stock. Mary's new address was managed by DSHA and had staff on site 24/7. A handover book was used at these premises to record significant events or issues.

14.31 3rd January 2016. A resident of the apartments complained to staff that Mary and a female friend had been trying to gain access to his flat whilst they were drunk. This was recorded in a handover book.

14.32 13th January 2016. A resident of the apartments complained to staff regarding arguing and loud music coming from an apartment she referred to as "the one occupied by Mary and James". Staff provided reassurance that they would make the flat occupants aware of the complaint and ask them to modify their behaviour. When staff spoke to Mary and James it was noted that James was initially calm but then became confrontational and started complaining it was like living in a prison camp. The staff noted that James smelt of alcohol and recorded in the handover book what they had done. There is no record of the cause of the arguing being discussed with Mary or James.

14.33 22nd January 2016. Staff member at the accommodation emailed the scheme manager and the housing officer responsible for Mary's former address explaining "James and Mary have just caused slight disruption in the communal area, just James telling Mary to hurry up in the loo whilst there is people in the area and opening the door" Mary was seen to leave the toilet in an unkempt condition and the two went off to their apartment. The staff member was informed that James and Mary had two bottles of wine in the bistro.

14.34 The staff due to work nights at the housing scheme were notified of the incident. No further reports of ASB or DA were received that night. No safeguarding referrals were made.

14.35 12th February 2016. Following a complaint from a resident at the apartments, a staff member recorded in the handover book "Rowdy tenants arrived in, sat in seating area arguing and swearing. One resident made himself scarce, James was very vocal, drunk etc. Please advise in case this happens again". No other action was taken.

14.36 4th March 2016. A staff member recorded in the handover book, "Flat number (occupied by Mary and James). Terrible row, foul language whilst I was collecting rubbish".

14.37 15th March 2016. A member of staff noted in the handover book "Flat number (occupied by Mary and James) *had an accident* at front door, and into main corridor and sofa – removed stained seat cover and washed down front entrance and main corridor".

14.38 20th March 2016. Member of staff recorded in the handover book a complaint from a resident of the flats "phoned re James, loud music, (staff members) spoke to (James) as of 6.45 all is ok, but the music was loud". This is followed by another entry in the handover book by the same staff member which reads. "Follow on to above (James) made his annoyance known to me on his way out and wasn't happy!! I said all is ok now, he wanted to know who made complaint, of which I of course said I could not divulge this".

14.39 Date unknown between January and May 2016. A member of staff from the apartment block recalls James approaching the reception, to ask for help as

Mary had fallen and hurt herself. A staff member went to Marys' flat and saw Mary on the floor in the bathroom, naked and with blood and hair on the floor. The staff member contacted an ambulance which attended. No safeguarding referrals were made.

14.40 8th May 2016. CIC records indicate Mary attended the accident and emergency department (A and E) where she was initially triaged, had a head wound cleaned steri-strips applied and advice given. The record is non-specific regarding the type of advice given however it goes to record that Mary had "meniers disease and felt dizzy, fell, hit head on toilet, patient able to re-call events. Patient states she also drank approx. ½ bottle of sherry, lac to l eyebrow" (Laceration to left eyebrow) and left A and E prior to her treatment being completed. A letter was generated to the patients GP advising of the incident. This letter was received by the Marys GP's and added to her medical records.

14.41 10th June 2016. Mary moved back to the address from which she had been originally displaced following the impact of Storm Desmond. Mary is recorded as being the sole tenant.

14.42 7th September 2016. Mary contacted the police by telephone whilst James was believed to be asleep in the flat. James was said to be upset and angry due to dealing with his terminally ill father and had got drunk. The suggestion was that this was normal and that he had previously punched Mary to the face causing a bruise under her left eye. Mary stated she had not been assaulted that night. James joined the phone call and claimed Mary had mental health problems and that he had hit her in self-defence in the past. Both parties appeared to be under the influence of intoxicants.

14.43 PO5 attended. Mary denied that James had assaulted her and said the bruise on her face was a result of falling over when drunk. For reasons which were not recorded at the time, Mary declined to make a formal complaint. No arrests were made. James agreed to go elsewhere for the remainder of the night. A DASH was completed and submitted by the attending officer. The level of risk identified was recorded as standard.

14.44 A CC supervisory/ quality assurance intervention following the initial outcome resulted in Mary being revisited by PO6 later the same day and spoken to alone. James was back at the address. Mary confirmed calling CC the previous night as James was upset and angry due to his father's terminal ill health. Mary explained James had been drinking more due to this and that when drunk he gets angry and a few days earlier he had punched Mary in the face causing a black eye. The previous night James had been drunk and upset again and Mary had been concerned things might escalate. Mary said she did not want the police to investigate, refused the officer permission to take photographs of her injuries and stated she would not make a statement of complaint. Mary declined any referrals for IDVA support and was told a crime report for assault would be recorded. Mary was advised to make further contact should anything else happen. She was asked by the officer if she wanted James spoken to or made to leave and she said she did not want either. Mary said she did not want to cause

James any more upset and wanted to support him. A DASH which had been initially completed by PO5 was not updated. No arrests were made.

14.45 12th October 2016, during a routine G.P appointment there was a further review of Mary's mental health. Mary reported that she was feeling low and referral to First Step mental health talking therapy support organisation was discussed. Mary did not indicate DA was an issue in her life.

14.46 30th December 2016. Mary contacted the police stating the previous night she had been assaulted in her home address by James, the outcome being she was extensively bruised. James interrupted the call to the police operator and said Mary was talking rubbish. Both sounded intoxicated. Mary said that the situation was escalating. Officers attended Mary's home and she stated that James punched her in the face causing bruising. Officers used bodycam to record the incident which included the recording of Mary's account.

14.47 James was arrested on suspicion of assault and conveyed to a local designated police station. Whilst his initial detention was being authorised the Custody Sergeant assessed the level of risk James may pose to himself, staff, and other detainees. During this process James indicated he had consumed a significant amount of alcohol in the proceeding 24 hours. When asked if he was dependent on alcohol James said he had received treatment in Scotland previously. James declined a referral to an independent drug/alcohol referral scheme worker.

14.48 31st December 2016. A detailed statement was taken from Mary by police regarding the assaults on her. The key points are summarised as follows. Mary disclosed that prior to the assault she had consumed half a bottle of wine and James had consumed a bottle of sherry. She described James as having been drunk, agitated, argumentative and aggressive in the way he was talking. They had talked about his father who was terminally ill. Mary expressed that she thought James' father was not a nice person. James was abusive and belittling towards her whilst waving his arms aggressively. Mary stated she started to cry whilst James paced up and down the room telling her to ring the police. Mary said that she would and opened her dressing gown and pointed to all the bruises that she had on her body that James had caused when assaulting her previously. The statement records that Mary told James the assaults would not happen again and that he replied to her in a smug and patronising tone "You just bruise easily" and James then punched Mary with his clenched fist to her left cheek. James immediately apologised saying "'I'm sorry, it's my Dad" He started to cry. At that point Mary had called the police. During the statement Mary outlined further incidents of domestic abuse, saying she sometimes felt as though she was black and blue all over her body as a result of assaults. During one incident Mary described how James grabbed her by the hair and dragged her out of bed. As he was doing this, he was calling her a "dirty fucking bitch" and saying, "You deserve to die". He punched her repeatedly to the face and body whilst on the floor. During this assault Mary said she had been sober and thought that she had passed out. It was said that James frequently takes his frustration out on Mary and beats her up. Mary said she was scared of James.

14.49 A crime report and DASH were recorded by PO7. The risk level identified during completion of the DASH was recorded as "standard." Mary asked for her details not to be shared with any other agencies, including independent domestic violence advisors (IDVA) or Victim Support (VS).

14.50 The DASH was not subject to CC quality assurance processes until 17th February 2017 and during this process the level of risk identified was reviewed and remained "standard".

14.51 Police consulted with CPS direct. During the consultation CPS authorised charging James with two counts of assault on Mary. CPS additionally requested police discuss with Mary if she would support a restraining order (RO)[19] being requested against James when he appeared for sentencing before the Court at a later date. In the meantime, James was released from Police custody on conditional bail not to contact the victim in any way or approach her home.

14.52 Whilst being released from custody James was subjected to an "Exit risk assessment" during which the services of a local drug and alcohol service were again explained to him. He declined any support indicating he intended to move to Scotland.

14.53 9thJanuary 2017. Mary contacted police indicating she no longer wanted action to be taken against James for the assaults on her and provided PO 8 a statement to that effect. This statement was subsequently forwarded to the CPS.

14.54 13th January 2017. A 999 call was received by the police from a neighbour of Mary who reported that James had Mary by the throat. They had heard this from another, named neighbour, within the complex of flats.

14.55 PO9 and 10 attended. Mary was spoken to, denied being assaulted and is reported as having no visible injuries.

14.56 The attending officers did not speak to the witness that had seen Mary being held by the throat and this serious assault was not recorded or investigated. A DASH was not completed assessing the level of risk faced by Mary.

14.57 James was arrested for breach of bail conditions which were in place following his previous arrest. He was detained at the nearest designated police station and again subject to a risk assessment when being received into Custody. During this process James indicated that he had not consumed alcohol within the last 24 hours. When asked about his alcohol consumption James explained he was a recovering alcoholic and that he had not consumed alcohol for two days.

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[19] Protection from Harassment Act 1997. (Amended 2004 by Section 12 of the Domestic Violence, Crime and Victims Act 2004 (DVCVA 2004) (Online). London.Legislation.co.UK. Accessed March and November 2012. Available from:

https://www.legislation.gov.uk/ukpga/2004/28/section/12

When asked if he wanted to see or be contacted by an independent drug/alcohol referral scheme worker he declined.

14.58 14th January 2017. James appeared before West Cumbria Magistrates Court for breach of bail. He pleaded guilty to the two pending offences of assault by beating. The information regarding the alleged strangulation of Mary had not been provided to the CPS. James was remanded on bail for sentencing by the same Court. Bail conditions were put in place to protect Mary from James.

14.59 20th January 2017. James appeared before the Magistrates Court. An advocate of the Crown Prosecution Service outlined the allegations against James.

14.60 The Court sentenced James to a Suspended Sentence Order of 84 days custody suspended for 12 months with 50 Rehabilitation Activity Requirement days, £85 costs, £115 victim surcharge.

14.61 National Probation Service staff (NPS) prepared an “on the day” pre-sentence report (PSR) to assist the Court with deliberations when considering the sentencing of James. Established risk assessment tools were used when completing the PSR. This report was accepted by the Court. The NPS had requested all relevant information from the Police but were not provided with details of the recent alleged strangulation to assist them when assessing the level of risk posed by James.

14.62 Post sentence the case was allocated to Cumbria and Lancashire Community Rehabilitation Company (CLCRC) to manage the sentence of the Court. CLCRC had access to previous convictions and past Police DA call out information as part of the supervisory process. They were not provided with details of the alleged strangulation. The case was managed by a Responsible Officer of the CLCRC (RO1) supervised by a Senior Probation Officer (SPO1).

14.63 Financial assistance was given to James to ensure he was able to attend CLCRC appointments some 20 miles from his home.

14.64 During initial appointments James told RO1 he was now living with the victim, Mary, and that he had a separate address in Scotland. James said he was Mary’s carer, was a recovering alcoholic and had an acquired brain injury. James saw his offending within the context of his alcohol use and therefore it was assessed that he did not take responsibility for his behaviour. He claimed to be abstinent from alcohol.

14.65 Risk levels in relation to James were assessed, risk management and sentence plans were created. The factors linked to offending were identified as alcohol, mood swings and anger possibly linked to the acquired brain injury.

14.66 James subsequently attended CLCRC for supervision with RO1 on twenty-two occasions. The focus of contact included alcohol use, triggers to domestic abuse and his personal circumstances including his intimate and family relationships and accommodation. Voluntary attendance at a domestic abuse perpetrator programme (Turning the Spotlight) was explored but not progressed. He was also encouraged to self-refer to Unity, a Substance Misuse Service, to access services around his alcohol use.

14.67 29th March 2017. A self-referral was received at Unity substance misuse service for James. It is not specific on records exactly how the referral came about but the record content indicates the referral was likely to have been prompted by advice from the NPS/ CLCRC. The self-referral states that James had recently assaulted his partner whilst under the influence of alcohol. The referral goes on to say that James felt at the time he had control over his alcohol use and that he was away from home in Scotland on a regular basis.

14.68 James was offered an appointment for a meeting with Unity on the "Your Choice programme" at Workington Unity Office on 11th April 2017.

14.69 11th April 2017 James phoned the Unity Office to explain that he was on the bus to Workington, but he was running late, so could not attend the meeting. A further appointment was provided for another Your Choice meeting on 21st April 2017. James did not attend that meeting and his referral was closed.

14.70 21st May 2017. Scotland. An anonymous person that identified themselves as a neighbour contacted the Police Service of Scotland (PSoS) regarding a loud ongoing argument within a neighbouring flat, this being the flat retained by James in Scotland.

14.71 Police attended the flat. Mary and James were present and spoken to. Neighbours were spoken to. No criminal offences were identified. The matter was finalised as a DA incident, however a domestic abuse questionnaire risk assessment (DAQ)[20] was not completed as the officers did not consider the incident to be a domestic incident requiring a DAQ. The attending Officers did record the incident on a vulnerable person's data base record (VPD)[21]. The incident did not reach the threshold for information sharing with partner agencies.

14.72 30th October 2017, following a report from a neighbour of Mary's that over a three day period behaviour described as anti-social and arguing had been emanating from the flat Castles and Coasts Housing Association (CCHA) sent the complainant a log book to record any further issues. Neither Mary nor James were spoken to in person by the housing provider.

14.73 10th January 2018. James attended his last appointment with RO1 at CLCRC. During the appointment James reported that his elderly father had died and that he had remained within a relationship and living with Mary throughout the duration of his sentence. The impact of his father's death was not considered, nor any potential ongoing risks posed to others at the point of exit from probation

[20] The Domestic Abuse Questionnaire (DAQ) used by the Police Service of Scotland is a version of the domestic Abuse stalking, harassment, risk identification check list (DASH/ DASH RIC). Published 24th February 2015. Online. Accessed March 2021. Available from https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

[21] The Vulnerable Person database report (VPD). The VPD is used by the Police Service of Scotland is to record details of vulnerable persons on a Vulnerable Persons data base which is accessible to Police Service of Scotland and partner agencies.

supervision. CLCRC records do not highlight any specific contact with Mary during the duration of the court imposed sentence however, RO1 recalled that Mary often accompanied James to the office for his appointments although she was not present during interviews.

14.74 10th June 2018. PSoS were contacted by a neighbour of James who wished to remain anonymous regarding a disturbance at James' address in Scotland. Officers attended. James and Mary were found to be at the flat. Both denied any disturbance and the attending officers, using professional judgement based on the information provided to them by Mary and James, recorded the matter as being believed to be malicious, it was ultimately classified by PSoS as a false call and not one relating to DA.

14.75 26th June 2018. A neighbour who wished to remain anonymous called PSoS regarding a disturbance between a male and female at the same address in Scotland. Officers attended. There was no reply at the address and the flat was in darkness, consequently the occupants were not spoken to. Enquiries with neighbours indicated the premises had been quiet all night. This incident was then recategorised as "none DA", Assist Member Of The Public' and closed.

14.76 29 Sep 2018. PSoS received a further complaint from an anonymous person regarding a disturbance at the address used by James. Officers attended. There was no audible disturbance on their arrival. James was present along with a person that identified themselves as a friend, not a partner. It was established the friend was Mary. As the couple claimed to be friends who had been arguing regarding James' fathers Will, the matter was not categorised as DA, however a vulnerable person database report (VPD) was submitted.

14.77 13th October 2018. PSoS were contacted by an anonymous neighbour regarding an argument at James' address. Officers attended, the occupants, James and Mary, were spoken to and claimed to have been in bed. No evidence was found that a domestic incident had been taking place. The incident was closed as a false call to police.

14.78 September 2019. Following a call to the North West Ambulance Service (NWAS) a double crewed ambulance attended the home of Mary in West Cumbria. James invited them inside and let the crew into the bedroom where they saw an unconscious woman, Mary, on the floor breathing very heavily. On assessment Mary was seen to have suffered significant head injuries. James confirmed he had caused the injuries by hitting Mary. James went onto explain that he had found Mary on the floor at approximately 2100hrs after they had finished fighting and that he did not call an ambulance for an hour because he presumed, she was sleeping.

14.79 The NWAS crew requested and were subsequently joined by attending Doctors and CC.

14.80 Further examination of Mary revealed that she had bruises all over her chest, abdomen, back and upper and lower limbs. Mary was unconscious, naked and covered with a duvet. The injuries were so significant that the NWAS crew were

unable to continue without senior clinical support and were then subsequently assisted by two attending Doctors.

14.81 Mary was conveyed to CIC and subsequently admitted to the Intensive Therapy Unit.

14.82 NWAS completed a safeguarding referral to Adult Social Care (ASC) in respect of the incident and completed a capacity to consent form which listed the reasons for administering treatment whilst the patient could not consent.

14.83 Police Officers at the scene arrested James on suspicion of causing grievous bodily harm with intent and he was conveyed to a designated police station.

14.84 A risk assessment was completed on arrival at the police station. James indicated he had consumed half a bottle of sherry and 2 or 3 cans of lager within the last twenty four hours. James indicated he was not currently dependant on alcohol. The Custody Officer indicated he was not entirely in agreement with this comment, that James was repetitive, argumentative and occasionally abusive.

14.85 During subsequent police interviews James answered "no comment" to the majority of questions asked of him. James was initially charged with grievous bodily harm with intent on Mary, contrary to s18 of the Offences Against the Persons Act 1861[22].

14.86 12th September 2019. A safeguarding referral from NWAS to ASC was actioned as a safeguarding adult referral. Immediate discussion with an ASC team Manager took place and the matter was allocated for information gathering under Section 42 of the Care Act 2014[23]**.** Services worked closely together at this point to try to ensure the involvement of the persons voice in the safeguarding S 42 enquiry. It was confirmed in these discussions that discharge of Mary from hospital would not take place until a multi-agency safeguarding plan was put in place. Case files also indicate close working between all agencies involved at this point, police, health, ASC.

14.87 September 2019. Whilst still being treated within the intensive therapy unit Mary sadly died as a result of the injuries she sustained in the violent attack by James. Following Mary's death, James was charged with the murder of Mary.

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[22] Grievous bodily harm. Offences Against the person Act 1861. Section 18. (Online) Accessed July 2022. Available from: https://www.legislation.gov.uk/ukpga/Vict/24-25/100/contents

[23] The Care Act of 2014.S42). (Online). Legislation. Co. Uk. London. Accessed March and November 2021. Available from: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

14.88 James later appeared at Carlisle Crown Court (CCC) where the Court accepted his guilty plea to manslaughter. James was sentenced to three years imprisonment.

15. Overview.

15.1 On 25th September 2000 Mary became sole tenant of a rented flat, situated within a block of four, in a West Cumbrian town. The flats were owned by an established social housing provider. During the time span of this DHR Mary's places of residence were managed by two different, established social housing providers. Whilst Mary was registered as a sole tenant in the accommodation, the review has shown James invariably lived with her.

15.2 The key services Mary and James had contact with during the timescales of this review were Housing Associations, Cumbria Constabulary, the Police Service of Scotland, the National Probation Service, Cumbria and Lancashire Community Rehabilitation Company, a GP practice (represented by CCG on the panel), Integrated Care (Accident and Emergency), and the Community Mental Health and Recovery Team.

15.3 Housing Associations.

Between 14th March 2010 and 2014 Mary's housing provider, Derwent and Solway Housing Association, (DSHA), received numerous complaints from Mary and other residents regarding incidents of anti-social behaviour (ASB) being caused by a resident of the flats. Mary and other residents supported the housing provider and Cumbria Constabulary (CC) in obtaining an injunction against the individual responsible for the anti-social behaviour.

15.4 The first occasion concern was reported that Mary may have been a victim of domestic abuse was on 15th April 2014. Whilst investigating reports of ASB, police and a DSHA housing officer were told by a neighbour of Mary's that she was in a "new relationship" with a male named as James and that both consumed alcohol heavily. It was reported that Mary and James had previously been heard arguing, scuffling and that Mary may have been knocked out. The individual that supplied the information was asked to report any future, similar behaviour. The police and housing officers immediately called at Mary's flat but got no response.

15.5 Police did not follow up this initial report or record it on police systems.

15.6 The housing officer attempted to contact Mary on a number of subsequent occasions and eventually spoke to her at her home on 27th June 2014. James was also present at the flat. Mary was spoken to alone. Mary was asked if she was suffering DA, perpetrated by James. She said not. The housing officer noted the flat was in disarray and that this was not the 'norm' for Mary. Mary was told that if she was having difficulty in getting James to leave, the housing association would help her. Mary was encouraged to report any future issues of abuse. Details of the DA were added to housing association records and a letter was sent to Mary which, in part, referred to the suspected domestic abuse and concerns within the local community for her welfare. No Domestic Abuse

Stalking and Harassment Risk Identification Checklist was completed to assess the level of risk Mary faced and potentially initiate information sharing with partner agencies including DA support services.

15.7 A sequence of events then occurred over several years involving contact with Mary's housing providers:

15.8 December 2015, following the impact of Storm Desmond, Mary was rehoused to temporary accommodation within a local housing complex. James lived with her. This site was owned/ managed by DSHA a former subsidiary of Your Housing Group. At the housing complex staff were on site 24/7. A handover book was used by staff to record significant events or issues. Eight incidents were recorded as having been witnessed by staff or other residents involving James and/ or Mary. The incidents included Mary trying to access the wrong flat whilst drunk, complaints about arguments and swearing being heard in Mary's flat, Mary being seen unkempt at the entrance to her flat, James asking for an ambulance as Mary had allegedly fallen and injured her head and, lastly, James being aggressive when confronted about incidents that had been reported to staff. None of the eight issues were dealt with, singularly or collectively, as safeguarding issue(s) via established local safeguarding processes.

15.9 Subsequently Mary moved back to her original address and ownership/ management of the flat changed to a new housing provider, Castles and Coasts Housing Association. During October 2017 a neighbour reported to the housing association that, over a three day period, behaviour described as anti-social and arguing had been emanating from Mary's flat. The housing association dealt with this issue as one of solely anti-social behaviour and sent the complainant a logbook to record any further issues. Neither Mary nor James were spoken to in person by the housing provider.

15.10 Cumbria Constabulary.

15.11 During the period 15th April 2014 to September 2019, Cumbria Constabulary responded to eight incidents involving Mary. Typically, the incidents involved a request for police assistance as Mary was being subjected to domestic abuse by James. The requests for police assistance were made either by Mary direct to the police or by other residents of nearby accommodation. The incidents are summarised as follows:

15.12 15th April 2014 (as described in the first incident within the Housing Associations section above). A report from a member of the public direct to a police officer, who was working alongside a housing officer, that Mary was being subject to DA by her new partner, James. No response was gained at Mary's flat, and the matter was not recorded on police systems or progressed further by the police.

15.13 20th August 2014. Mary contacted Cumbria Constabulary complaining of being assaulted by James. Police attended, Mary was spoken to and denied being "in an intimate relationship" with James and, for an unspecified reason, declined to provide a statement of complaint to the officers. Officers did complete a DASH with Mary to ascertain the level of risk she faced. The risk level was graded as

standard even though Mary told the officers she was being physically and verbally abused, the abuse was becoming much more frequent, that she was frightened, and is quoted as saying “he will keep hitting me if he doesn’t leave”. Other aggravating factors including substance misuse, vulnerability due to isolation, age and economic abuse described as “I have given him loads of money to get him out of debt, but he doesn’t appreciate it at all” were also present.

15.14 The DASH was not subject to quality assurance by CC processes for approximately two months.

15.15 Following the incident on 20th August 2014 James was arrested and later received a simple caution for assault on Mary.

15.16 4th June 2015. Mary contacted police then cleared the line. CC control room proactively recontacted Mary who told the operator everything was alright and she did not require police attendance. Mary appeared under the influence of intoxicants and stated she was safe and well. Officers were despatched to check on her welfare. Mary and James were present. It was noted that Mary and James were heavy drinkers. Mary also told officers she was on prescribed medication, and she had forgotten to take her tablets that night and had become agitated. Mary added that a verbal argument had taken place and she had called the police for someone to talk to. Advice was given to both parties. No one was identified as subject of a crime. A DASH was submitted, graded standard. It is recorded on the DASH that Mary did not consent to her information being shared with other agencies. No other safeguarding referrals were made.

15.17 The Public Protection Unit (PPU) quality assured the DASH promptly. It was noted that this was the second incident within a twelve month period involving Mary and James, that both misused alcohol and no disclosures of DA had been made. This quality assurance process referenced the previous incident reported on 30th August 2014 but failed to identify that the risk level identified on that previous occasion had been underassessed. Again, there is no record of safe referrals to other agencies being considered.

15.18 7th September 2016. Mary contacted CC alleging assault by James. James interrupted the call and claimed Mary had mental health issues. Both parties appeared to be under the influence of intoxicants. Officers attended. Mary denied being assaulted by James, James agreed to spend the remainder of the night at a different address. A DASH was completed with Mary and graded the risk faced by Mary as “standard”.

15.19 Following a supervisory intervention regarding the outcome of the incident attended on 7th September 2016, Mary was revisited by police. She was spoken to alone although James was known to be elsewhere in the flat. Mary told the police James had punched her when drunk and his general behaviour was worsening due to his father’s ill health. Mary was clear she wanted to support James and that she did not want the police to investigate the assault, declined the police permission to take photographs of her injuries and stated she would not make a statement regarding the abuse. Mary said she did not want referrals for DA outreach support in relation to the abuse she was suffering. Officers

asked Mary to make further contact should anything else happen. Mary was specifically asked if she wanted James arrested or made to leave and she said she did not want either. This course of action was approved by a supervisor of the attending officer. The DASH completed following the initial contact with Mary on 7th September was not updated with the additional information from Mary that she had been assaulted and that her situation was worsening and the level of risk she faced was not reassessed. However, the incident log and crime report were updated. It was a month before the DASH relating to this incident was subject to QA. No referrals were made to Adult Social Care for consideration in relation to Mary's situation and her being a potentially vulnerable adult in need of care and support.

15.20 30th December 2016. Mary contacted CC alleging assault by James. Officers attended, bodycam was used to record evidence including an initial account of DA. Mary later provided a witness statement alleging numerous assaults resulting in significant injuries, one such assault included a threat to kill her whilst being dragged around by the hair. James was arrested. A crime report and DASH were recorded. The level of risk identified during completion of the DASH was recorded as standard.

15.21 James was charged with two counts of assault on Mary and released on conditional bail, not to contact the victim in any way or approach her home. Whilst in police custody James was offered referral to substance misuse services which he declined.

15.22 When considering the case against James, CPS requested Police contact Mary and discuss with her an application for a restraining order (RO) to protect her from James following sentencing by the Court. This request was not completed.

15.23 On the 9th of January 2017 Mary contacted CC indicating she no longer wanted criminal proceedings to be taken against James for the assaults on her and provided a statement to this effect. This new information was subsequently passed to the CPS.

15.24 13th January 2017. A "999" call was received by CC control room from a neighbour of Mary who reported James had been seen holding Mary by the throat. Police attended. Mary denied being assaulted and had no visible injuries. The attending officers did not interview the witness that had allegedly seen Mary being held by the throat. This assault was not recorded as a suspected crime or investigated further, neither was a DASH completed to assess the level of risk Mary was now facing in light of the latest alleged incident of strangulation.

15.25 James was arrested for breach of bail conditions and again offered referral to a substance misuse service whilst in custody, he declined.

15.26 The following day James appeared before West Cumbria Magistrates Court for breach of bail. He pleaded guilty to the two pending offences of assault by beating previously charged. James was remanded on bail for later sentencing by the same Court, with bail conditions imposed to safeguard Mary.

15.27 Crown Prosecution Service.

15.28 James appeared before the Magistrates Court on 20th January 2017 in connection with the assaults on Mary. CPS were unable to request a RO against him as their previous request to Police to ascertain Mary's view regarding application for one had either not been followed up or, if it had been followed up, the CPS had not been made aware of the outcome. Despite the potential evidential difficulties caused by the victim, Mary, asking for the prosecution to be discontinued the case was proceeded with.

15.29 National Probation Service.

15.30 Prior to sentence being considered by the Court, the National Probation Service staff (NPS) prepared an "on the day" pre-sentence report to assist the Court with their deliberations. The NPS had requested, and were in receipt of, domestic call-out information from police to inform their report but had not been provided with details of the recent alleged strangulation to assist them when assessing the level of risk posed by James. Despite this, NPS reports are the first that record the presence of coercive, controlling behaviour (CCB) within the relationship and the additional risk this toxic form of DA poses. The following is recorded "I assess that the offences are (James') attempts in exerting power and control over the victim. He has poor emotional management skills, which are significantly exacerbated whilst he is intoxicated."

15.31 James received a Suspended Sentence Order of 84 days prison custody, suspended for 12 months, with 50 Rehabilitation Activity Requirement days and £85 costs, plus £115 victim surcharge.

15.32 Cumbria and Lancashire Community Rehabilitation Company. (CLCRC).

15.33 James completed the sentence imposed by the Court, 50 Rehabilitation Activity Requirement days under the supervision of Cumbria and Lancashire Community Rehabilitation Company (CLCRC). James complied with the requirements of the sentence. He was provided with financial support to attend appointments some twenty miles from his home. During the supervision period James was encouraged to self-refer to a substance misuse service although he did not attend appointments he was offered.

15.34 Police Service of Scotland.

15.35 Following the conviction for assault on his partner, James and Mary spent time living at a flat retained by James in Scotland.

15.36 Between 21st May 2017 and 13th October 2018, the Police Service of Scotland (PSoS) were contacted on five separate occasions by an anonymous neighbour of the address used by James and Mary in Scotland. All the calls to PSoS were made using the same mobile phone number and officers always attended to investigate the initial reports. The last calls were received within a period of four months. In summary:

15.37 The first occasion officers attended James and Mary were present. The incident was assessed as a verbal dispute having taken place and no crime committed. A domestic abuse risk assessment tool called a domestic abuse questionnaire (DAQ) was completed and recorded no risks being identified. The DAQ, along

with a vulnerable person's database (VPD) record, were recorded on PSoS systems. Due to the incident being recorded as involving no presence of risk, no information was shared with partner agencies.

15.38 When attending the second incident the attending officers established Mary and James were present at the flat. Both denied any disturbance and the call was categorised as believed to be malicious and closed on PSoS systems under the classification of a false call and not one relating to DA.

15.39 The third reported incident was of a disturbance between a male and female, there was no reply at the flat, the flat was reported by officers as being in darkness. Enquiries with neighbours indicated the premises had been quiet all night. This incident was categorised as 'Assist Member of The Public' and closed on police systems. No further attempts were made to trace the flat occupants.

15.40 The fourth incident was reported as a disturbance. On arrival, attending officers found no trace of an audible disturbance. James was present in the flat along with Mary who categorised their relationship as being friends, not partners. The couple said they had been arguing regarding James' fathers will. The matter was not formally categorised as DA however a vulnerability related report (VPD) was submitted.

15.41 On the fifth and final occasion PSoS spoke to James and Mary, they found no evidence that a domestic incident had been taking place and the matter was finalised as a false call to police.

15.42 G.P. practice (represented by CCG on the panel).

15.43 For many years Mary was registered with, and accessed, a local G.P. practice. The practice had access to Mary's medical history including the non-recent loss of babies and more recent loss of adult family members (brother and mother) and a former partner. Post 2013 records show at least three occasions when Mary was asked about her mental health, twice during appointments specifically put in place for a mental health review, the other was an opportunity taken during a routine appointment. Similarly, it is recorded that during one appointment a GP used the opportunity to enquire if Mary's personal relationship was a healthy one. Mary said it was.

15.44 Mary's suffered long-term health conditions. The most recent diagnosis of Mary's mental health was completed by a consultant psychiatrist following her referral for Community Mental Health Support in 2011. This diagnosis followed Mary disclosing to her G.P. in 2010/11 that her mental health was being affected following the recent death of her partner. The referrals between General Practitioners and the Community Mental Health Team referenced Mary's wider medical history. Following the 2011 referral Mary received four years of community based mental health support.

15.45 Medical records held in relation to James indicate a previous head injury which affected his memory and that he had a history of alcohol dependency. When asked about alcohol consumption during a new patient health check, James is

recorded as having told clinicians that he had his drinking under control. There is no information on his records regarding domestic abuse.

15.46 Allerdale Community Mental Health and Recovery Team. (ACMHART).

15.47 Between 2011 and January 2015 Mary was referred to, and accessed, services provided by Allerdale Community Mental Health and Recovery Team (ACMHART). Medical professionals involved in Mary's health care at this point had access to medical records supplied with the most recent referral and previous referrals. The support to Mary is recorded as being provided within the framework of The Care Programme Approach[24]. Letters detailing the support being provided to Mary were sent to her G.P. following initial assessment in 2011, following a care and treatment review in 2012 and at discharge in January 2015. Information detailing reported domestic abuse by a previous partner, which Mary disclosed when being supported by ACMHART, was not included within the letters.

15.48 A care plan and recovery plan was in place along with a plan, on discharge, for dealing with crisis, staying well and identified coping strategies.

15.49 Between 5th June 2014 and January 2015 Mary attended her last 5 five appointments with ACMHART. During these appointments Mary shared that James had been verbally abusive, that he drank alcohol to excess, and he encouraged her to drink wine. A discussion took place to ensure Mary recognised domestic abuse and how it impacted on her mental health. At a later meeting Mary shared that the relationship had resumed after a break.

15.50 North Cumbria Integrated Care (NCIC) NHS Trust. (A and E).

15.51 On 8th May 2016. Mary attended NCIC A and E dept. Mary was initially treated for a head wound. The attendance record indicates Mary had "meniers" disease, felt dizzy, fell and hit her head on the toilet causing a laceration to her eyebrow. Mary was able to re-call the incident to staff. She also said she had drunk approximately half a bottle of sherry and subsequently left A and E prior to her treatment being completed. The explanation for the injury was accepted on face value. A letter was forwarded to Mary's G.P. informing them of the attendance at A and E.

15.52 North West Ambulance Service. (NWAS).

[24] NHS.UK. The Care Programme Approach (CPA) is a package of care for people with mental health problems. NHS.UK. Online. Accessed November 2021. Available from:

https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

15.53 September 2019. North West Ambulance Service attended Mary's home where she was found to have received significant head injuries. Mary was admitted to Cumberland Infirmary, Carlisle where intensive treatment was provided.

15.54 NWAS made appropriate safeguarding referrals and Adult Social Care (ASC) put in place actions to safeguard Mary had she subsequently been released from hospital.

15.55 The injuries Mary received, when violently assaulted, proved incompatible with life. Mary passed away whilst still being treated at Cumberland Infirmary, Carlisle.

16 Analysis.

16.1 The chronology, individual IMRs and important contributions received from Mary's family, have been carefully analysed within this report to ascertain if the actions of agencies involved with this DHR were appropriate, and whether they acted in accordance with their established procedures and guidelines. Where they have acted accordingly, the panel has also attempted to go beyond 'evaluating if procedure was followed, to checking it was sound', as stated in the revised Home Office guidance. Simply put, are agencies' policies and procedures fit for purpose? Are they good enough to safeguard victims? The detailed chronology and overview will not be repeated as part of the analysis. This section will provide analysis of agency involvement.

16.2 Some terms of reference have been dealt with jointly within sections of the analysis. Where this is the case, the key TOR is highlighted in bold type, others which are closely related to the key TOR are listed in light type.

16.3 Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?

Did the agencies have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator?

Did the agencies have policies and procedures in place for dealing with concerns about domestic violence?

Were these assessment tools, procedures and policies professionally accepted as being effective?

Had the victim disclosed to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?

Was the victim subject to a MARAC? What risk level was the victim assessed at?

Did the agencies comply with domestic violence 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?

Were senior managers or other agencies and professionals involved at the appropriate points?

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

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?

Was it reasonable to expect them (professionals), given their level of training and knowledge, to fulfil these expectations?

Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families?

Are there ways of working effectively that could be passed on to other organisations or individuals?

How accessible were the services for the victim and perpetrator?

16.4 During the timescales considered within the scope of this DHR, the unlawful killing of Mary was the only domestic homicide within her hometown. The commission of this crime had a localised community impact. Over proceeding years other domestic homicides have been committed elsewhere within the County of Cumbria.

16.5 Multi-agency policies and procedures were in place to allow for risk identification and assessment when practitioners dealt with domestic abuse. Referral processes were in place to safeguard victims at highest risk of harm. Tools were available to assist professionals' decision making when confronted with circumstances which may amount to domestic abuse. In particular, the tool used by professionals to identify domestic abuse and when assessing the level of risk faced by victims of DA in Cumbria was/is the domestic abuse stalking harassment risk identification checklist (DASH or in Scotland, the DAQ). The DASH/ DAQ risk assessment gives practitioners from all agencies a consistent and simple tool to use when they encounter adult victims of domestic abuse. Using this process risk levels faced by victims can be assessed as standard, medium or high. Those who are identified at high risk of harm should be referred to an independent domestic violence advisor (IDVA) to provide specialist support and to a multi-agency risk assessment conference (MARAC) which enables a multi-agency response to manage the risk faced by the victim. Referrals for high risk DA can be completed with or without the victim's consent. Those

identified at standard and medium risk of harm can be referred for DA outreach support, but only with their consent. Despite the presence of policies and procedures to guide the response of practitioners when dealing with domestic abuse some agency actions were inconsistent. A theme has been a failure to identify and record the level of risk posed by domestic abuse or, where risk has been identified, a failure to assess the level of risk faced by Mary accurately and then share that information with other agencies in accordance with established local procedures. The analysis now explores these issues.

16.6 **Derwent and Solway Housing Association (DSHA, which merged with Two Castles Housing Association to form Castles & Coasts Housing Association in July 2017).**

16.7 During 2014 a resident of the flats that Mary lived in reported to police and housing officers that Mary was believed to be the victim of DA. The perpetrator was named as James. This was the first occasion authorities were made aware that James may be the perpetrator of abuse against Mary. At the same time concerns were raised that Mary and James consumed excesses of alcohol. The information provided was clear and was recognised as being indicative of DA. An immediate attempt was made by the officers to visit Mary at her home, but she was not in. From this point the police failed to record details of the alleged abuse on their systems and took no further action. If this information had been recorded effectively then subsequent contact with Mary would have followed and a timely opportunity to explore the alleged abuse would have arisen.

16.8 The housing officer did record details of the allegation on an internal system and, whilst efforts were made to contact Mary it seems those efforts lacked urgency. More than two months later Mary was spoken to at home by the Housing Officer. Mary was recorded as being initially dismissive but then asked if people had really heard them arguing. She did say that she wanted James to leave the flat. Mary was seen to be unkempt, under the influence of alcohol and looked withdrawn which was noted as being unusual. The flat was in disarray. Ongoing support was offered to Mary which was declined. A line of communication using text messages was established. Details of the visit were added to housing records and a letter was sent to Mary again offering ongoing support. A DASH risk assessment was not completed, and the level of risk faced by Mary within the relationship was not established using an effective method of risk assessment.

16.9 It follows that, because no risk assessment was conducted, no referrals to partner agencies were considered or undertaken in relation to the suspected DA. Similarly, given the downturn in Mary's appearance, suspected alcohol misuse and apparent intoxication when spoken to by the housing officer, coupled with her flat being in disarray and being a victim of DA, it does not seem that potential wider vulnerabilities were identified or considered as being appropriate for safeguarding referral as a potentially vulnerable adult, for example a referral under the provisions of the Care Act 2014. The suspected perpetrator of the DA, James, was not interviewed by either agency regarding

this matter and not held to account for his behaviour. None of the omissions were identified by supervisory or internal QA processes.

16.10 If agencies do not record and investigate incidents of DA effectively then the full extent and level of risk faced by victims will not be understood and their safety will not be managed effectively using established safeguarding procedures, for example MARAC, the Criminal Justice process or signposting to other support agencies.

16.11 Despite the missed opportunities in response to the third-party report, police and housing officers showed some awareness and sensitivity to the needs of Mary and James. It was good practice that they immediately tried to visit Mary at her home. This initial, proactive approach illustrated they both understood the information they had received as being indicative of DA and they realised Mary may be at risk of harm from James. Similarly, it was good practice that the housing officer eventually recorded details of the information on internal records and persisted with efforts to contact Mary, ensuring she was alone when they eventually met. The approach to Mary was empathetic but lacked urgency. The housing officer was vigilant, recording what she had seen when visiting Mary for internal records. Clear offers of ongoing support were made, in person and by letter.

16.12 Following the impact of Storm Desmond during 2015 Mary was rehoused for approximately six months. James lived with her. Whilst living at this temporary accommodation a total of eight incidents occurred that were recorded in the onsite handover book. Some were witnessed by staff, others by residents. The incidents involved Mary trying to access the wrong flat whilst drunk, complaints of loud music, arguments and swearing being heard in Mary's flat, Mary being seen in an unkempt state at the entrance to her flat, James asking for an ambulance as Mary had allegedly fallen and injured her head and, lastly, James being aggressive when confronted about incidents that had been reported to staff.

16.13 It is clear Mary was vulnerable and in a relationship that was abusive. None of the eight issues were dealt with, singularly or collectively, as any type of safeguarding issue(s) via established local safeguarding processes. The use of a handover book achieved little other than being a means by which staff starting their shift could self-brief regarding earlier events. The overall use of the handover book was ineffective. It seems no one person had a clear, collective overview of events involving Mary and James or, if they did, they did not understand the significance of the events, did not recognise the clear presence of DA and the wider vulnerability of Mary as a vulnerable adult and failed to act effectively to safeguard. James was not challenged regarding his behaviour. Omissions in service were not identified and rectified by supervisory processes.

16.14 Professional curiosity should have identified domestic abuse when responding to some of the "stand alone" incidents. If the incidents had been viewed collectively then both domestic abuse referrals and a safeguarding referral under the provisions of the Care Act 2014 (Mary being an individual with needs for care

and support, at risk of abuse or neglect and unable to protect themselves) should have been initiated. In turn this may have afforded Mary specialist, local authority, support.

16.15 **Cumbria Constabulary.**

16.16 When analysing the police response to incidents the panel considered approved professional practice, provided to police forces in England and Wales by the College of Policing (formerly the National Centre for Policing Excellence).

16.17 The guidance within the approved professional practice[25] is clear that when responding to DA officers have a duty to take positive action and that often this will mean making an arrest, provided the grounds exist and it is a necessary and proportionate response. Officers must be able to justify the decision not to arrest in those circumstances. The guidance additionally states that in some situations other positive approaches may be more appropriate for example domestic abuse can occur where the conduct does not amount to a criminal offence and a criminal justice outcome is not possible. Taking positive action, in particular arresting suspected perpetrators when the lawful grounds exist, sends perpetrators a clear message - that their behaviour is unlawful and unacceptable. Equally a clear message is sent to the victim, that the abuse being suffered is unlawful and that officers will act to protect them. It also allows officers opportunity to fully assess the risks being faced and to safety plan effectively.

16.18 As explored above, when the police worked in partnership with a Housing Officer the police failed to take any form of positive action other than initially calling at Mary's home in an initial attempt to trace her.

16.19 30th August 2014. Mary contacted CC complaining of being assaulted by James. Officers attended and took positive action, arresting James on suspicion of assault. Mary and James denied being in an intimate relationship. For an unspecified reason Mary felt unable to provide a written statement supporting a criminal investigation. James later received a "simple caution" for assault on Mary. According to the DASH completed at the time, Mary consented for her details to be shared with other agencies.

16.20 Completion of a DASH, even though the couple denied they were in an intimate relationship, was good practice as they clearly were in a relationship. The level of risk was assessed as "standard" and a crime for assault was recorded. A review of information held within the DASH shows it is comprehensive in content,

[25]The College of Policing. Policy for arrest and other positive approached to domestic abuse including cautioning offenders. https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/#cautions

but the assessment of Mary as being at "standard level of risk" is an underassessment of the risk that was present. The DASH shows Mary is being physically and verbally abused, the abuse is becoming much more frequent, that she is frightened. Mary is quoted in the DASH as saying, "he will keep hitting me if he doesn't leave". Other aggravating factors including age, substance misuse, vulnerability due to isolation, economic abuse which Mary described as "I have given him loads of money to get him out of debt, but he doesn't appreciate it at all" are present.

16.21 Economic abuse is increasingly recognised as a tactic of coercion and control used by perpetrators of DA. The report "Economic Abuse is your past, present and future" by UK charity Surviving Economic Abuse[26], illustrates economic abuse can include exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

16.22 The Domestic Abuse Act 2021[27] now recognises and specifically defines economic abuse as "behaviour that has a substantial adverse effect on a victim's ability to - (a) acquire, use or maintain money or other property, or (b)obtain goods or services and.

16.23 The specific impact of economic abuse suffered by Mary, as part of the wider coercion and control she was subject to, was only once recognised and briefly documented by CC. The full extent of economic abuse present will never be known. Giving money to James to pay off his debts certainly impacted negatively on her life. It seems that by "borrowing" Mary's money and not paying her back James was effectively controlling some or all of her income and reducing Mary's ability to use her own money for her own purposes.

16.24 The combination of risk factors present when an officer interviewed Mary on the 30th August 2014 indicate Mary, was at a "high" level of risk and a referral to the MARAC process based on either level of actuarial risk identified combined with professional judgement or the identification of escalation and professional judgement should have taken place.

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[26] "Economic abuse is your past, your present, your future." Surviving Economic Abuse. Roundtable report. Published 2018. Online. Accessed July 2022. Available from: https://survivingeconomicabuse.org/wp-content/uploads/2020/11/SEA-Roundtable-Report-2018-1.pdf

[27] Domestic Abuse Act 2021. (Online) Legislation.Gov.UK. Accessed July 2022. Available from: https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

16.25 A MARAC referral would have enabled multi-agency information sharing; a co-ordinated action plan would have been developed and effective safety planning for the victim undertaken which would have included actions to safeguard Mary and divert or disrupt James. This was a missed opportunity.

16.26 In relation to the "simple caution"[28] administered to James following this incident, the Cumbria Constabulary policy for use of cautions at that time was as follows.

16.27 "*Simple cautions.*

A simple caution should be used for low-level offending. Only in exceptional circumstances should it be used to deal with more serious offences.

Decisions to issue simple cautions must be made in accordance with the Director of Public Prosecution's Guidance on Charging 5th Edition.

The police retain the authority to issue a simple caution in all cases other than cases involving indictable-only offences.

Police officers can also take advice from the CPS at any stage in an investigation on whether a simple caution is appropriate, as set out in the Director's Guidance on Charging".

16.28 In the circumstances of this case and administration of a "simple caution", the evidential test was passed. James had previous convictions, including one which was DA related and the full circumstances of the assault, when taking account of all available information including content of the DASH, were not akin to low level offending. However, a potential barrier to a successful prosecution was no visible support from the victim to proceed with the matter and, at this time, evidence led prosecutions, without the visible support of a victim, were not routine practice. Police did not take the opportunity to consult with CPS regarding the case.

16.29 The DASH regarding this incident was not subject of quality assurance for eight weeks and was not shared with a Public Protection Unit specialist as per CC policy. The under assessment of risk was not identified during any policy compliance or QA processes and this process took too long. As a result of not identifying the high level of risk Mary faced, she did not receive the level of safeguarding to which she was entitled.

16.30 4th June 2015. Mary contacted police then cleared the line. CC control room proactively recontacted Mary who told the operator everything was alright, and she did not require police. Mary appeared under the influence of intoxicants and

[28] Charging (The Director's Guidance) 2013 - fifth edition, May 2013 (revised arrangements) Published 2013.
https://www.cps.gov.uk/legal-guidance/charging-directors-guidance-2013-fifth-edition-may-2013-revised-arrangements

stated she was safe and well. Officers were despatched to check on her welfare. Mary and James were present. It was noted that they were both heavy drinkers. Mary also stated she was on prescribed medication. She stated that she had forgotten to take her tablets that night and became very agitated. Mary added that a verbal argument had taken place and she called the police for someone to talk to. Advice was given to both parties. No one was identified as subject of any crime. A DASH was completed which assesses the level of risk to Mary as standard. Consent to share her information with other, relevant agencies, was declined by Mary.

16.31 Proactive reengagement with Mary by CC control room staff illustrates both sensitivity to the needs of Mary, a known DA victim, and that she may require safeguarding. This was good practice.

16.32 PPU reviewed the DASH in a timely way. During the review it was noted this was the second incident within a twelve month period, that both parties misused alcohol and no disclosures had been made. This QA processes failed to identify that the risk level assessed following the previous incident, reported 30th August 2014, had been underassessed. Similarly, the increased risk posed by the presence of a trio of vulnerabilities [29 p75] domestic abuse, substance misuse and indicators of poor mental health within the relationship were not recognised. Had the omissions been identified during the review which looked collectively at the current and previous incidents of DA then a MARAC referral should have followed. This would have enabled the safeguarding of Mary and opportunities to divert or disrupt James' abusive behaviour.

16.33 At this time Mary was 57 years of age, was described as in a confused and agitated state, misusing alcohol and taking prescribed medication. Referrals to the local authority using the criteria of the Care Act 2014, that Mary was an individual with needs for care and support, at risk of abuse or neglect and unable to protect themselves, are not recorded as having been considered or completed.

16.34 7th September 2016. Mary contacted CC and alleged assault. James suggested Mary had mental health problems. Both parties appeared to be under the influence of intoxicants. An officer attended and Mary denied being assaulted by James, James agreed to spend the remainder of the night at a different address. The officer resumed from the incident. A DASH was completed and graded standard, based on the initial information given by Mary and James.

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[29] Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 to 2014. Sidebotham, P.,Brandon, M. et al (2016). London: Department for Education. Assets publishing service. Online. Accessed December 2021.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

Again, the increased risk posed by the trio of vulnerabilities, DA, substance misuse and mental health concerns alleged by James, were either not fully understood or considered.

16.35 Following a supervisory intervention regarding the initial outcome of the incident on 7th September 2016, Mary was revisited by an officer and spoken to alone. James was present and supervised by a second officer elsewhere in the flat "out of earshot" of Mary. Mary was able to tell the officer that James had punched her when drunk and his general behaviour was worsening due to his father's ill health. Mary was clear she wanted to support James and that she did not want the police to investigate, refused the officer permission to take photographs of her injuries and stated she would not make a statement. Mary said she did not want referrals for DA outreach support. Mary was advised to make further contact should anything else happen. Mary was asked if she wanted James arrested or made to leave and she said she did not want either. The officer's course of action was approved by a supervisor. The initial DASH completed when an officer attended the first incident was not updated however the incident log and crime report were.

16.36 It was a month before the DASH relating to this incident was subject to QA. The initial supervisory intervention which led to the revisit of Mary was good practice however, opportunity to take positive action by arresting James and fully assess the risks Mary faced was missed. This inappropriate outcome was supported by the officer's supervisor. The DASH is submitted without the level of risk to the victim being properly identified or assessed. An evidence led prosecution without victim support was not considered. Internal policy compliance and QA processes failed to identify any of the omissions.

16.37 Some three months later a series of events then occurred which need to be analysed both as single events and collectively.

16.38 30th December 2016. Mary contacted CC alleging assault by James. An officer attended, bodycam was used to record evidence including an initial account of DA. Mary later provided a witness statement alleging numerous assaults resulting in significant injuries, one such assault included a threat to kill her whilst being dragged around by the hair. James was arrested. Whilst being processed in CC custody suite James was offered and declined a referral to an independent substance misuse service. A crime report and DASH were recorded. The level of risk identified during completion of the DASH was recorded as standard. Mary indicated she was not willing for her details to be shared with any support agencies, including independent domestic violence advisors (IDVA) or Victim Support.

16.39 Following the arrest, James was charged with two counts of assault on Mary and released on conditional bail not to contact the victim in any way or approach her home. Whilst being released from custody James was subjected to an "Exit risk assessment" during which he was again offered a referral to a local drug and alcohol service. He declined any support. When considering the case

against James, CPS requested police to contact Mary and discuss with her application for a restraining order (RO) against James when he appeared in Court for sentencing.

16.40 On the 9th of January 2017 Mary contacted CC indicating she no longer wanted action to be taken against James for the assaults on her and provided a statement to this effect. This new information was subsequently passed to the CPS.

16.41 13th January 2017. A "999" call was received by CC control room from a neighbour of Mary who reported James had been seen holding Mary by the throat. Police attended. Mary was spoken to, denied being assaulted and had no visible injuries. The attending officers did not interview the witness that had seen Mary being held by the throat. The assault on Mary, with a seriously aggravating factor of strangulation present, was not recorded or investigated, neither was a further DASH completed to reassess the level of risk Mary was facing. The matter was dealt with as a breach of bail conditions. James was arrested, again, whilst James' detention was being processed, he was asked if he wanted to see or be contacted by an independent drug/alcohol referral scheme worker, he declined. The following day James appeared before West Cumbria Magistrates Court for breach of bail. He pleaded guilty to the two pending offences of assault by beating previously charged. James was remanded on bail, with conditions imposed to safeguard Mary, for sentencing by the same Court.

16.42 Following report of the incidents 30th December 2016 officers of CC took seriously the assault allegations. Positive action was taken to arrest the perpetrator of the abuse and bodycam was used to obtain an initial record of Mary's account, overall demeanour and physical appearance. James was charged with allegations of assault and released on conditional bail including a requirement not to contact/ approach Mary. During the subsequent incident on 13th January positive action was also taken by officers of CC when arresting James for breach of bail conditions. CC identified James was misusing alcohol and offered him opportunity for referral to a substance misuse service on at least three occasions which was good practice.

16.43 Despite the good practice identified and outlined there were gaps in the response to the most recent series of incidents. When the DASH was completed to assess the level of risk Mary faced, risk was assessed as "standard." Given the nature of the incident described and the previously reported incidents the level of risk present was high. The underassessment of the risk level present was not identified by supervisors or QA processes. Had the level of risk Mary faced been assessed correctly this would have enabled information sharing with local, specialist, DA advocacy services who would have been able to offer support to Mary based on her needs. Similarly, the matter would and should have been referred into the MARAC process which would have resulted in a multi-agency opportunity to manage the risk faced by Mary and divert or disrupt James. It was clear by now that Mary was the victim of a pattern of incidents of controlling, coercive, threatening behaviour, violence and abuse within an intimate relationship, a crime which was neither recorded nor investigated. Based

on the previously described incidents and judged against National Crime Recording Standards (NCRS)[30 p8] a crime should have been recorded.

16.44 Following the breach of bail officers of CC failed to record and investigate crime effectively, including a third-party allegation of assault by strangulation and the crime/ presence of coercive and controlling behaviour (CCB). During previous incidents, examples of CCB included violence, threats of violence, emotional abuse, economic abuse, both the victim and perpetrator minimising the abuse, isolation and the perpetrator adopting an overall dominant position within the relationship. The presence of CCB within an abusive relationship is an established indicator of increased risk to the victim in terms of physical and long term psychological harm[31. p37-45].

16.45 The breach of bail and CCB were part of a wider pattern of abuse against Mary, but no DASH was completed to assess the level of risk Mary continued to face and wider opportunities to refer Mary for support were again missed. None of the foregoing omissions were identified by CC internal quality assurance processes.

16.46 When James appeared before the Magistrates Court on 20th January 2017 in connection with the assaults on Mary CPS were unable to request a restraining order against him. This was because their previous request to Police to ascertain Mary's view regarding application for such an order had either not been followed up or, if it had been followed up, the CPS had not been made aware of the outcome. Not being able to secure a restraining order was another missed opportunity which may have allowed the Court to further safeguard Mary and disrupt James' abusive behaviour.

16.47 September 2019. Following a request from NWAS, CC Officers attended the home of Mary. James was arrested on suspicion of causing grievous bodily harm with intent and he was conveyed to a designated police station. Whilst being documented at the police station James was offered and provided with the support of an appropriate adult and solicitor which was in line with Police and Criminal Evidence Act 1984 Codes of Practice for the detention treatment and

[30] National Crime recording standards and Home Office counting rules. Vision and purpose statement. Published April 2014. Online. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1083847/hocr-complete-april-22.pdf

[31] Sharp-Jefffs N, Kelly L. Domestic Homicide Review (DHR) Case Analysis Report 2016, Nicola Sharp- Jeffs and Liz Kelly. Published June 2016. Online. November 2021. P7. Available from:http://repository.londonmet.ac.uk/1477/1/STADV_DHR_Report_Final.pdf

questioning of persons.[32] Again referral to a substance misuse service was offered which was declined.

16.48 A DASH risk assessment was completed that assessed the level of risk faced by Mary as high risk.

16.49 James was later charged with the murder of Mary.

16.50 This latest incident of domestic abuse resulted in the death of Mary. Positive action was taken to arrest James and a comprehensive police investigation followed. Whilst in custody the perpetrator was offered a referral to substance misuse services which was declined and was assisted, advised and by an appropriate adult.

16.51 On this occasion the risk that Mary faced within her relationship was correctly identified as high. Had Mary survived this would have enabled the MARAC process to take place and effective safety planning to have been undertaken.

16.52 **Crown Prosecution Service (CPS).**

16.53 During early 2017 James appeared before West Cumbria Magistrates Court twice, first for breach of bail and then later for sentencing in relation to assaults on Mary. On each occasion an advocate of the Crown Prosecution Service (CPS) outlined the allegations against James.

16.54 CPS records clearly outline the Prosecutor considered applying for a remand in custody following the breach of bail and, in fact, whether the case should be proceeded with at all, as Mary had provided a written statement withdrawing her visible support for a prosecution. The Prosecutor documents a rational which includes all the information he had been provided in the police file of evidence and wider public interest issues. Unfortunately, the CPS had not been provided with any details regarding the incident of alleged strangulation which was not investigated by CC and would have presumably further assisted any decision making. The approach taken by the Prosecutor is balanced and takes account of the victim's statement indicating she wished the matter to be discontinued. Despite this, the Prosecutor recommends the matter be proceeded with as a matter of public interest given the level of threat faced and previous character of James. This was good practice during which the risk to Mary was carefully considered.

16.55 When James next appeared before the Magistrates Court, 20th January 2017, it was for sentencing in connection with the assaults on Mary. Following the case,

[32] Police and Criminal Evidence Act 1984 Codes of Practice for the detention treatment and questioning of persons. Online. London. Gov. UK. Published 26th March, 2013. Updated 180620. https://www.gov.uk/guidance/police-and-criminal-evidence-act-1984-pace-codes-of-practice

the prosecutor completed a hearing record sheet which, when reviewed, has been found to be limited in content.

16.56 Following the assault which led to the death of Mary, James was initially charged with grievous bodily harm with intent contrary to s18 of the Offences Against the Persons Act 1861. Upon Mary's death, two weeks after the initial assault, James was charged with Mary's murder. The decision to charge James with murder was made on the Threshold Test[33] as the seriousness of the circumstances justified an immediate charging decision and there were substantial grounds to object to bail. However, this meant that not all key evidence was available at the time the charging decision was made. Subsequently, the Crown Prosecution Service received a full file of evidence from police. This included the pathologist report, toxicologist findings, forensic reports, and witness statements. Upon receipt of this information, it was concluded that there was insufficient evidence to demonstrate that James intended to kill or cause grievous bodily harm to the victim, which are the elements necessary to prove intent for the offence of murder. The pathology and forensic evidence were not consistent with a sustained assault having occurred. The pathologist was of the view that the findings were consistent with James' account of pushing the victim over but did not prove that he did. However, given the admissions made at the scene by James, there was sufficient evidence to prove he had committed an unlawful act which led to Mary's death and was responsible for her manslaughter. In the circumstances the charging decisions were appropriate.

16.57 **National Probation Service (NPS).**

16.58 20th January 2017. National Probation Service staff (NPS) prepared an "on the day" pre-sentence report to assist the Court when considering the sentencing of James. This report was accepted by the Court and enabled the principles of Transforming Summary Justice (TSJ)[34] guidance to be adhered to. One of the expected outcomes of using the TSJ process is to expedite the CJ process and therefore reduce the impact on victims and witnesses. Following the TSJ process was good practice and in line with national best practice.

16.59 The NPS were in receipt of domestic abuse call-out information, requested from the police, to assist them when assessing the level of risk posed by James and when preparing the pre-sentence report. The information provided by police did not include details of the recent alleged strangulation. Despite this, NPS reports

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[33] The Threshold Test. The Code for Crown Prosecutors, issued by the Director of Public Prosecutions (DPP). under section 10 of the Prosecution of Offences Act 1985. Version 8. Accessed July 2022. Online. Available from: https://www.cps.gov.uk/publication/code-crown-prosecutors

[34] Transforming Summary Justice – An initiative designed to improve how cases are dealt with at the Magistrates Court. Guidance to CPS. Published 1st September 2015. Online. Accessed March 2021. Available from:

https://www.cps.gov.uk/publication/transforming-summary-justice-criminal-justice-system-wide-initiative-improve-how-cases

are the first that record the presence of CCB within the relationship and the additional risk this poses as a most toxic form of DA. The following is recorded "I assess that the offences are (name) attempts in exerting power and control over the victim. He has poor emotional management skills, which are significantly exacerbated whilst he is intoxicated." The identification of CCB and the additional risk this posed within the relationship was good practice.

16.60 **Cumbria and Lancashire Community Rehabilitation Company (CLCRC).**

16.61 The sentence imposed by the Magistrates Court on 20th January 2017 was managed by a suitably trained staff responsible officer and supervised by a senior probation officer, both of CLCRC. During appointments James told the responsible officer he was now living with the victim, Mary, that he had a separate address in Scotland, that he was Mary's carer and a recovering alcoholic with an acquired brain injury. It was assessed that James did not take responsibility for his behaviour. He claimed to be abstinent from alcohol. Risk management and sentence plans were created, and the factors linked to offending were identified as alcohol, mood swings and anger possibly linked to the acquired brain injury. Whilst formulating the risk management plans CLCRC were not provided with information regarding the alleged, recent strangulation of Mary by James. The focus of contact with James included alcohol use, triggers to domestic abuse and his personal circumstances including his intimate and family relationships and accommodation. CCB was not clearly identified as a risk.

16.62 From an early stage financial assistance was given to James to enable his attendance at twenty two CLCRC appointments some 20 miles from his home. This was good practice. Voluntary attendance at a domestic abuse perpetrator programme (Turning the Spotlight) was explored but not progressed. James was encouraged to self-refer to Unity, Substance Misuse Service, to access services around his alcohol use. A risk assessment of James using an established process, OASys[35] identified that risk was increased whilst he lived with his partner.

16.63 Some actions to monitor and manage risk were not undertaken including home visits, one to one contact with the victim, requests for additional recent Police domestic abuse call out information or multi-agency referral.

16.64 CLCRC IMR highlights an omission identified during the management of James in the context of failure to fully implement the risk management and sentence

[35] OASys is an offender assessment system used to assess the risks and needs of an offender. Justice.gov.uk. Online. Accessed March 2021. Available at:

https://www.justice.gov.uk/downloads/offenders/psipso/psi-2016/psi-18-2016-pi-17-2016-public-protection-manual.pdf

plan. In part this relates to the extent of CCB within the relationship not being recognised. It reads as follows.

"(James') alcohol use and acquired brain injury will have impacted on his level of engagement but there appears to have been an overriding assumption that alcohol was the key area linked to risk of harm and reoffending. This appears to have detracted from a focus on domestic abuse offending behaviour interventions." Again, the extent to which this perpetrator of DA coercively controlled his victim was not clearly identified as a risk and used to fully identify risk and influence the risk management and sentence plan."

16.65 Police Service of Scotland (PSoS).

16.66 Between 21st May 2017 and 13th October 2018 PSoS were contacted on five separate occasions by an anonymous neighbour of the address occasionally frequented by James and Mary in Scotland. All the calls to PSoS were made using the same mobile phone number and officers always attended to investigate the initial reports. The last four of the calls were received within a period of four months.

16.67 The first occasion officers attended James and Mary were present. The incident was assessed as a verbal dispute only having taken place and no crime committed. A DAQ, scoring zero, was subsequently submitted along with a VPD. Due to the incident being recorded as involving no presence of risk, no information and shared with partner agencies.

16.68 When attending the second incident Officers established Mary and James were at the flat. Both denied any disturbance and the call was categorised and closed on PSoS systems as being believed to be malicious, it was classified as a false call and not one relating to DA.

16.69 The third incident was a reported disturbance between a male and female, there was no reply at the flat, the flat was reported as being in darkness. Enquiries with neighbours indicated the premises had been quiet all night. This incident was recategorised as 'Assist Member of the Public' and closed on police systems.

16.70 The fourth incident was a report of a disturbance. On arrival attending Officers found no trace of an audible disturbance. James was present in the flat along with Mary who categorised their relationship as being friends, not partners. The couple said they had been arguing regarding James' fathers will. The matter was not formally categorised as DA however a vulnerability related report was submitted.

16.71 On the fifth occasion PSoS spoke to the James and Mary, found no evidence that a domestic incident had been taking place and the matter was finalised as a false call to police.

16.72 In summary PSoS staff attended each of the incidents promptly and did investigate each with varying levels of effectiveness. When Officers spoke to James and Mary they minimised incidents which will have made the task of the officers more difficult. That said, there was a lack of consistency in the responses and

officers sometimes lacked professional curiosity. For example, given the information held on police systems, in particular the Police National Computer (PNC) and Police Scotland crime recording systems relating to James it is difficult to understand how a DAQ was scored at zero or, at the very least, why information held on systems wasn't referred to as part of the officer's professional judgement within the DAQ. Additionally, after attending a report of DA when the initial visit did not result in contact with either James or Mary the matter was closed as not being related to DA and no later efforts made to revisit them to ensure they were safe and well. Lastly, the call to each of these incidents was made from the same mobile phone number. As the number of incidents reported increased this common factor was not identified. Had it been officers may have been able to re-contact the caller and develop a clearer picture regarding the ongoing abuse of Mary about which the caller was clearly trying to make the Police aware.

16.73 Castles and Coasts Housing Association (CCHA).

16.74 Following a report from a neighbour of Mary's that over a three day period behaviour described as anti-social and arguing had been emanating from the flat CCHA sent the complainant a log book to record any further issues. This response was clearly designed to deal with the alleged ASB. Neither Mary nor James were spoken to in person by the housing provider. The response was not suitable for dealing with the underlying DA reported as arguing.

16.75 **GP practice (represented on the DHR by North Cumbria Clinical Commissioning Group, NCCCG).**

16.76 Mary was a patient at a locally based general practice.

16.77 Mary's GP practice provided for her long-term support and treatment of diverse health conditions. The practice had access to Mary's full medical history. Mary's medical history was considered appropriately when receiving GP support.

16.78 Neither Mary or James divulged to general practitioners that they were partners or that their relationship was abusive.

16.79 During 2010/11 Mary disclosed to her G.P. that her mental health was being affected following the recent death of her partner. Mary was referred for, and received, four years of community mental health support. The referrals between General Practitioners and the community mental health team referenced Mary's medical history.

16.80 Between September 2013 and 2017 Mary regularly accessed her GP. Appointment records show at least three occasions where Mary was specifically asked about her overall health conditions. Similarly, it is recorded that during one appointment the GP took an opportunity to enquire if Mary's personal relationship was a healthy one. Mary said it was.

16.81 Medical records held in relation to James indicate a previous head injury which affected his memory and that he had a history of alcohol dependency. He is recorded as having told clinicians that he had his drinking under control when

asked about this at his new patient health check, and at a later consultation in 2019. There is no information on his records regarding domestic abuse.

16.82 The medical care provided to Mary by her GP's was centred on her best interests. DA was considered as an issue potentially impacting on her health and wider quality of life. GP's that supported Mary were sensitive to her needs and delivered a good level of care. Routine and targeted enquiry was used during appointments to check out Mary's overall health and to ascertain if Mary's personal relationship was a healthy one. Long term mental health support was provided by a community-based service.

16.83 Allerdale Community Mental Health and Recovery Team. (ACMHART) (Service now provided by Cumbria, Northumbria Tyne and Wear NHS Foundation Trust).

16.84 Between 2011 and January 2015 Mary accessed services provided by ACMHART. Between 5th June 2014 and January 2015 Mary attended her last 5 five appointments with ACMHART. During appointments Mary shared that a previous partner had been physically and emotionally abusive. She also shared that her current partner, James, had been verbally abusive, that he drank alcohol to excess, and he encouraged her to drink wine. The focus of support being provided to Mary was for her mental health. Records show the disclosures of abuse were not linked or probed effectively, revisited during subsequent appointments or recognised as a pattern of behaviours that indicated Mary may have been a victim of domestic abuse. None of the information was subjected to risk assessment using the DASH process.

16.85 The information regarding James abusing Mary was not sufficiently scrutinised or considered, neither was the impact of her previous negative life experiences. The information was not subject to formal risk assessment or shared with other agencies. Enhanced professional curiosity should have identified the extent of Mary's vulnerability. Mary was a repeat victim of DA, in a new relationship where she was again subject to abuse. Had the extent of Mary's vulnerability and the level of risk she faced been identified then safeguarding referrals could have been made.

16.86 North Cumbria Integrated Care (NCIC) NHS Trust. (A and E).

16.87 8th May 2016. Mary attended NCIC A and E dept where she was initially treated for a head wound. The attendance record indicates Mary was able to re-call the details of the incident leading to the injury as a fall along with the surrounding circumstances. Mary left A and E prior to her treatment being completed. The explanation for the injury was accepted on face value.

16.88 A and E practice dictates where patients do not stay in the department to be seen and no critical health need or safeguarding concern was identified at triage then it is expected that the individual will re-present or contact their GP if they require further support. If staff have concerns for the immediate safety of a patient who has left the department, they will normally contact family members to confirm welfare or request police complete a welfare check. As there was no

safeguarding concern identified the clinicians did not feel this was necessary. In the circumstances this was an appropriate response. Additionally, a letter was generated to the patients GP advising of the incident. Again, this was appropriate in the circumstances.

16.89 Unity substance misuse service.

16.90 On the 29th of March 2017 a referral was received by Unity Substance Misuse Service in relation to James. The self-referral originated from the work of NPS/ CLCRC. James was swiftly offered an appointment at a venue approximately 20 miles from his home. James subsequently rearranged this appointment saying he was running late on public transport. A further, very timely appointment was provided which James did not attend. This flexibility to support James was good practice.

16.91 North West Ambulance Service. (NWAS).

16.92 11 Sep 2019. Following a call to NWAS a double crewed ambulance attended the home of Mary. James was present. Mary was found with significant injuries and conveyed to CIC where she was provided immediate medical support. Mary would never recover. Whilst dealing with the initial incident NWAS appropriately requested the support of doctors and the police at the scene. After conveying Mary to CIC, NWAS completed a safeguarding referral to ASC. Once these referrals were received by ASC procedures were implemented within the scope of The Care Act 2014. This was good practice.

16.93 Adult Social Care (ASC).

16.94 12th September 2019. Following receipt of the referral from NWAS, ASC allocated the matter for information gathering under the provisions of Section 42 of the Care Act 2014. This was the first referral ASC had received in respect of Mary and resulted in effective partnership working between services to plan an effective safeguarding response and involvement of the victim's voice, when possible, in the safeguarding enquiry. Setting up this safeguarding process was good practice. Mary died as a result of the violent assault by James whilst being treated in hospital consequently the planned response was not delivered.

16.95 Was anything known about the perpetrator, for example, were they being managed under MAPPA?

16.96 The only time James engaged regularly with a known service followed him being sentenced for assaults on Mary in 2017. He attended appointments with the CLCRC as required.

16.97 When James unlawfully killed Mary he was not being managed under any public protection arrangements.

16.98 James has previous convictions in England for criminal damage in 1986 and 1989. He has a previous conviction in Scotland during 2008 for breach of the peace. DA is recorded as being an aggravating factor. These convictions indicate he used abusive behaviour during previous relationship(s). James misused alcohol over a significant period.

16.99 The Police Service of Scotland crime recording system indicates James was also a victim of violence (non domestic) during 2010.

17 Conclusions.

17.1 Conclusions and lessons learnt from this tragic incident have concentrated on the effectiveness of support and interventions provided to Mary and James by local services, subsequent service development and the current provision of services within the local community. The key themes that have emerged follow.

17.2 For much of Mary's adult life she worked successfully within the hotel and hospitality industry. Prior to her death Mary had become isolated from family, friends and former colleagues.

17.3 James was solely responsible for the unlawful killing of Mary.

17.4 Prior to Mary being abused by James she was a victim of domestic abuse in at least two previous relationships. Long term domestic abuse and the loss of two babies born out of a previous relationship impacted on Mary's health. Mary accessed local medical services in efforts to manage her health needs and accessed the police in times of crisis when the abuse escalated in her relationship with James. Despite the consistent abuse Mary suffered at the hands of James she was, on occasions, protective of him citing James' health and wellbeing as her main concern.

17.5 Identifying domestic abuse, assessing risk accurately and multi-agency information sharing.

17.6 The only known disclosures of domestic abuse made by Mary were to the professionals outlined within this DHR. No disclosures are known to have been made to friends or family.

17.7 This review has shown the level of abuse and risk Mary faced during her relationship with James was not consistently identified, understood, and assessed by several agencies. For example, housing officers had opportunities to identify and record domestic abuse when they received reports regarding Mary and James. Similarly, Cumbria police officers failed to record an incident of abuse when it was alleged by a third party that Mary had been the victim of strangulation by James. Police Service of Scotland attended several incidents involving Mary and James. None were recorded as being domestic abuse. Where the police had access to James' full offending history for DA, all be it some is decades old, it is not clear his history was considered as part of the risk he posed.

17.8 On occasions when abuse was recognised and recorded by officers of CC then a recognised risk assessment tool was used to assess the level of risk present. The officers completing the risk assessment sometimes failed to understand and/ or accurately assess the level of risk present. One DASH report outlines Mary was being physically and verbally abused, the abuse was becoming much more frequent, she was frightened, and is quoted as saying "he will keep hitting me if he doesn't leave". Other aggravating risk factors present were substance misuse, vulnerability due to isolation, economic abuse and Mary's age. The risk

level was assessed as standard when in fact, based on the information available at that time, Mary was at a high level of risk of harm from James.

17.9 Whilst Mary was undergoing a series of appointments with a community based mental health team, she provided snippets of information which, if joined up, were a possible indicator of DA. Enhanced professional curiosity may have identified the domestic abuse Mary was suffering.

17.10 There were occasions when Mary was asked by professionals if she was a victim of DA. Sometimes she said not. On other occasions Mary made partial disclosures which were indicators that she was a victim. Mary also fully disclosed incidents of abuse by James. Considering the overall circumstances Mary faced it is likely that denials and limited disclosures of abuse were as a result of fear, being isolated from support and trapped by the coercion and control James exercised over her on a daily basis. It was also the case that the relationship with James was not the first time Mary had suffered domestic abuse. Over time it is likely Mary had become conditioned to believe that abuse within a domestic setting was the norm and to be expected.

17.11 The presence of coercive controlling behaviour within the relationship, Mary's age, isolation and the trio of vulnerabilities, substance misuse, mental health and domestic abuse are rarely identified as significant risk factors. The overall vulnerability Mary faced was not understood by agencies that were involved with Mary.

17.12 As a result of the level of risk Mary faced not being assessed accurately as "high" then, on occasions, multi-agency information sharing thresholds were not met and information which could have been shared, with or without her consent, remained within single agencies. Consequently, Mary was not offered the specialist support and interventions she was entitled to as an individual at high risk of harm from domestic abuse. Mary was not offered or provided the support of an independent domestic violence advisor and referral to MARAC and other safeguarding processes.

17.13 Effective partnership working also failed when a straightforward request to police by the C.P.S. to have Mary asked if she would like a restraining order applied for in respect of James was not progressed. Supervisory processes did not identify that the request from C.P.S. had not been progressed. As a result, no application for a restraining order was made to the Court. An opportunity to safeguard Mary was missed.

17.14 Supervisory oversight and quality assurance.

17.15 Where this review has identified shortfalls relating to practitioners' initial responses, little evidence has been found of supervisory interventions which addressed them. Supervisory oversight and quality assurance processes were not adequate.

17.16 It does not seem supervisors considered the "big picture" regarding incidents some agencies attended. Mary was a victim of severe and prolonged domestic abuse, suffered poor mental health and consumed excesses of alcohol which,

on occasions, left her incapable of looking after herself. Opportunities to safeguard were missed.

18. Lessons learnt.

18.1 Are lessons to be learned from this case relating to the way in which agencies work to safeguard victims and promote their welfare, or the way agencies identify, assess and manage the risks posed by perpetrators?

18.2 During the DHR process the panel not only considered agency involvement with Mary and James, they also reflected on recent local service developments of practice, some of which are ongoing. These service developments have been implemented to achieve effective safeguarding practices which are fit for purpose. The service developments have been driven by the impact of a separate DHR relating to the murder of "Karen" in Cumbria, formal recommendations born out of inspection processes, and legislative changes. The actions already taken by agencies are intended to develop practice in some of the areas of concern also highlighted within this DHR. Because of the striking similarity of issues identified the actions already taken, or in progress, are considered of relevance to this DHR and are therefore described below.

18.3 Cumbria Constabulary.

18.4 Specific to CC, the panel additionally considered the impact of inspections of CC by Her Majesty's Inspector of Constabularies (HMIC) during 2014[36] and 2015[37]. Key recommendations from these previous opportunities to develop professional practice were the implementation of training that reinforces "front-line" risk identification, and risk management strategies for domestic violence and abuse, including coercive control and the links between domestic abuse and sexual violence, across all agencies. This training should encourage routine enquiry in practitioners and managers undertaking assessments, and those managing responses."

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[36] HMIC report – Cumbria Constabulary approach to tackling domestic abuse, 2014. Published 27th March 2014. Online. Accessed March 2021. Available from:

https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/2014/03/cumbria-approach-to-tackling-domestic-abuse.pdf

[37] HMIC (Now HMIC FRS) 2015 PEEL report re Vulnerabillity. Published December 2015. Online. Accessed March 2021. Available from:

https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/police-effectiveness-vulnerability-2015-cumbria.pdf#:~:text=HMIC%20found%20that%20Cumbria%20Constabulary%20identifies%20vulnerable%20people,domestic%20abuse%20and%20sexual%20violence.%20This%20is%20listed

18.5 The 2015 inspection of Cumbria Constabulary by HMIC regarding Vulnerability found that the force required improvement in its understanding of vulnerable victim's needs and risks and outlined domestic and sexual abuse as an area for further training

18.6 Since 2017 a force-wide "face to face" training packages have been completed regarding DA, including specifically coercive control, risk assessment and identification, evidence led prosecutions and use of "hearsay" evidence. This has been supported by Safeguarding hub supervisors delivering county wide safeguarding training which included a focus on risk identification, including the importance of conducting full background checks of those involved, and referral in cases of DA, Training will be ongoing.

18.7 The safeguarding hub has received additional staff and established more effective ways of working, as a result DA reports are reviewed in a more efficient and timely fashion.

18.8 A comprehensive process of reviewing incident logs has been instigated to ensure that every crime disclosed by a victim is recorded and investigated. This change to working practices resulted a grading of outstanding in relation to crime data and integrity when the Force was inspected by HMICFRS during 2018.

18.9 An "escalation process" is now in place which CPS can use if requests for action on Court files have not been progressed in a timely fashion.

18.10 Historically, DA incidents were recorded using a paper DASH report. Since 2015 CC moved to 'smart phone' based pocketbooks. During 2020 these devices have been updated and now feature an app that prompts officers to ask each DASH question and record the result.

18.11 College of Policing guidance and approved professional practice for the use of Cautions in cases of DA has been adopted by the Force.

18.12 Introduction of a supervisor based quality assurance process to manage the investigation and "handover" of files between departments.

18.13 A process based on the pneumonic "HANDOVER" has been introduced which tasks supervisor to review DA reports and documenting what they have done on Force systems.

18.14 Best practice in taking DA withdrawal statements has been communicated to first responders and a process of "dip sampling" to ensure the process if being adhered to is now in place.

18.15 Best practice in relation to considering/ requesting restraining orders at Court, including reference to the service provided the National Centre for Domestic Violence[38] has been reinforced. A dip sampling process is in place to identify if best practice is being adhered to.

18.16 All newly promoted and acting Sergeants are tasked to read a local domestic homicide review report as part of their preparation for performing their new role.

18.17 **Police Service of Scotland.**

18.18 Following the introduction of CCB legislation in the Domestic Abuse Scotland Act 2018, classroom based "DA Matters" training, which focuses on perpetrator tactics and the experience of DA from a victim's perspective was delivered to all first responders, civilian staff with public facing roles and managers up to the rank of Chief Inspector. This training has been adopted by PSoS as entry level training for all roles it is relevant to.

18.19 A revised Police Service of Scotland operating protocol which governs the response to DA has been recently implemented to support the training provided and staff are fully aware of the expectations of them when dealing with DA, including conducting full background checks on relevant parties.

18.20 **Your Housing Group (Y.H.G.).**

(Derwent and Solway Housing Association (DSHA) was a former subsidiary of Your Housing Group (YHG) and merged with Two Castles Housing Association to form Castles & Coasts Housing Association (CCGA) in July 2017).

18.21 YHG have undertaken a Safeguarding Peer Review. A DA Safeguarding training strategy was implemented, and a training programme was commissioned and commenced in March 2016. Domestic abuse training is available to all staff within the organisation and is mandatory for certain roles. This training includes controlling or coercive behaviour in an intimate or family relationship. All YHG staff complete a safeguarding awareness course as part of their induction. Safeguarding and DA training is refreshed every three years regardless of role or responsibility.

18.22 To ensure that the training policies and procedures are embedded, YHG complete regular audits. In January 2021, an audit was completed on the management of domestic abuse incidents.

[38] The National Centre for Domestic Violence was established in 2003 to help survivors of domestic violence and abuse obtain protection against an abuser, as well as offering services to the police, probation service, domestic abuse agency workers, the legal profession and judiciary. March 2021. Information available online: https://www.ncdv.org.uk/

18.23 YHG have a dedicated Designated Safeguarding Manager and Designated Safeguarding Officer who support with the delivery of Your Housing Group's strategic approach to safeguarding.

18.24 The YHG Safeguarding Policy and Domestic Abuse Policy are reviewed biannually and shared with Local Authorities to ensure they meet statutory requirements.

18.25 YHG have contacted local MARAC Coordinators to ensure that Your Housing Group are part of these forums and that housing is considered as part of the multi-agency approach. YHG actively encourage staff to attend MARACs within the local areas.

18.26 YHG staff have been in receipt of guidance regarding the importance of effective recording and documentation, including data protection principles.

18.27 **Castles and Coasts Housing Association.**

(CCHA was formed in 2017 following the merger of Your Derwent and Solway and Two Castles Housing Associations).

18.28 Following the merger of CCHA and DSHA a full end to end review of Safeguarding was undertaken and the following measures were implemented:

18.29 All new staff members receive safeguarding training, which includes Domestic Abuse, as part of their induction. Subsequent, mandatory, safeguarding training is provided annually to all staff.

18.30 Safeguarding has clear ownership within the organisation from Board through to departmental staff members.

18.31 Safeguarding including DA is reported to CCHA's Audit and Risk committee quarterly.

18.32 The DA policy is currently being reviewed, as part of CCHA DAHA Make a Stand Pledge (a national initiative designed to support those experiencing DA) and further DA specific training will be rolled out, as part of this.

18.33 CCHA now have a named Safeguarding Champion for each department across the organisation, this is in addition to the Safeguarding Team which also has two dedicated and trained DA Champions.

18.34 The safeguarding team meet every two months and a session including anonymised case studies is included to ensure learning points are cascaded. Moving forward all named SG Champions will attend the meeting to ensure they are aware of these case studies and learning points.

18.35 "Good job" postcards have been adopted to encourage referrals across the organisation.

18.36 The Internal Audit Association (TIAA) are carrying out an audit of our Safeguarding during 2021.

18.37 A long term (2/3 year) plan is being put in place to apply for DAHA accreditation with a quarterly review to ensure progress is being made.

18.38 **NCIC (Accident and Emergency).**

18.39 Specific training has been delivered regarding domestic abuse. Bespoke and high intensity training has been delivered to emergency departments with a further session to capture additional staff planned. The training is broad and includes victim experience and how victims may present at different stages in a relationship. The suite of guidance which staff are directed to has been reviewed. Briefings are included in every monthly safeguarding newsletter which is shared with staff teams through the governance structure.

18.40 "Seven minute briefings", information on a page which is easy to read and captures key messages, information and key contacts, have been developed to cover; coercive control, unexplained injuries in adults and routine enquiry.

18.41 The training has been supported by the introduction of a "Think Family screening tool" – where A&E staff will routinely ask for family/friend and network details for anyone presenting with alcohol/drug concerns and/or injuries sustained by another or by self.

18.42 Adult Social Care.

ASC have developed and introduced a process which enables Cumbria Constabulary Safeguarding Hub immediate access to their electronic IT system, this enables CC to establish if an adult is an "open case" to ASC and where there are safeguarding concerns– either open or closed. This approach is intended to allow timely access to ASC information by the Safeguarding Hub and enhance service provision.

18.43 Lessons learnt specific to this D.H.R.

18.44 Police Service of Scotland.

18.45 The domestic abuse coordination unit will detail the learning from this DHR to all staff and will stipulate guidance to first responders regarding professional curiosity, in particular reports of DA requiring supervisory review/sign off to confirm the perpetrator and victim are spoken to before closure of any incident. This initial messaging will be revisited during subsequent, classroom based, DA training. Initial messaging completed May 2021. Training will be ongoing.

18.46 North Cumbria Clinical Commissioning Group – Primary Care service.

18.47 NCCCG safeguarding team to develop a Domestic Abuse Policy for GP practices. This should be developed and disseminated to practices by end January 2021. Note. This action has been completed.

18.48 NCCCG safeguarding team to include domestic abuse in its Safeguarding Training programme. Note. Training delivery commenced 14th October 2020. This was recorded and is available for those unable to attend. It included information about Routine Enquiry. Action completed.

18.49 NCCCG safeguarding team to work with the Health Pathways team to develop guidance on domestic abuse and what practitioners should do if there is a disclosure of DA by one of their patients. Note. Completed January 2021, Domestic Abuse Health Pathway provided for use within GP practices.

18.50 North Cumbria Integrated Care NHS Foundation Trust.

18.51 NCIC is developing a safeguarding champions programme whereby departments will have a dedicated "Safeguarding champion" to provide an enhanced level of safeguarding support and guidance within their setting. The programme will start 27th April 2021.

18.52 A rolling programme of training and awareness raising to ensure safeguarding is embedded firmly in the organisation has been implemented and is ongoing.

18.53 **Cumbria and Northumberland Tyne and Wear NHS Foundation Trust (Mental Health) (service formerly provided by ACMAHRT).**

18.54 Safeguarding team to provide briefing sessions to CMHART to support staff in developing knowledge in identifying domestic abuse, including how previous life experiences including grief can impact on victims of abuse and how to respond. This will include how to assess risk, access and complete MARAC risk assessments and referrals. This is to be completed by May 2021.

Update July 2022. Session was delivered in July 2021, reporting of incidents leading to a number of outcomes have increased by over 60%. The outcomes in response to the incidents have included referrals to MARAC, safety planning, police involvement and LA safeguarding referrals. Action completed.

18.55 Cumbria and Lancashire CRC.

18.56 Note. CLCRC's individual action plan was delivered by 26th June 2021, when national restructure of CRC's and the NPS took place. Multi-agency actions will be taken forward within the unified Probation Service.

18.57 Three key areas were identified for CLCRC to take forward; one related to an individual development plan, one to improved line management oversight and the last a thematic domestic abuse audit across the organisation to assure adherence to the required standards of practice. The individual staff member issues are being progressed and not commented on further in this review.

18.58 During December 2020, CLCRC undertook a further audit of 52 cases where there was an active domestic abuse perpetrator risk register. The primary focus of the audit question set was to provide assurance that the risk posed by DA perpetrators was being appropriately managed during the delivery of the organisation's Exceptional Delivery Model (EDM) due to covid19. The findings indicated that 56% of cases were rated as good or outstanding. This was a slight decline to the findings in August 2020 although the two are not directly comparable as the audit question set differed. Areas of practice development are noted. Further audits are scheduled to take place, as part of the N.P.S.

18.59 National Probation Service.

18.60 For the Probation Responsible Officer to undertake domestic abuse checks in the relevant police force area whereby they know or become aware of a perpetrator residing or temporarily staying at an address other than his/her main residence. Time to complete - 1st June 2021. **UPDATE.** Staff are aware, and do

complete, DV and intel checks on cases in their supervision. Management oversight is in place across the probation caseload to ensure appropriate consultation and oversight of cases and this has been further enhanced by the role out of the national Touch Points Model across the probation service. This model is partially implemented in Cumbria, with further roll-out currently ongoing following the probation unification in June 2021. Target date, to be fully implemented and operational by March 2022. Action completed.

19 Multi-agency recommendations identified by the D.H.R. panel.

19.1 The following multi-agency recommendations were identified by the D.H.R. panel.

19.2 UNITY, NPS, CLCRC.

19.3 Identify a process which supports service users that are self-referring between agencies. **Note**, as a consequence of this action a process had been developed which actively support those that are choosing to self-refer between substance misuse, NPS and CLCRC - this process went live on 01032021 and will be subject of three monthly reviews by a scrutiny panel. **Action complete.**

19.4 UNITY, CLCRC, NPS.

19.5 Identify, implement, and disseminate to other agencies best practice, including practice developed during the COVID 19 pandemic, regarding the use of technology and social media, which will *safely* enhance service provision and client contact within a geographically large County containing many remote or isolated communities many with an ageing population.
Time to complete – Completed.

NPS/ UNITY update. In response to the COVID-19 pandemic and restrictions imposed by Government guidelines, Probation providers were required to work under a range of exceptional delivery models (EDMs). This resulted in rapid changes in practice, with offices closing and staff working from home conducting supervision using a mix of office based and remote contacts. Type and frequency of contact was commensurate with assessed levels of risk and need. This use of alternative supervision methods provided valuable learning to inform the future delivery of sentence management in the community and development of a blended model for supervision. The unified Probation Service Target Operating Model includes the ambition to utilise new digital/telecommunication technologies as part of innovating and refreshing the approaches taken to engagement with people on probation moving forward. In support of this, revised National Standards were published 26th June 2021. People serving a Community Order, Suspended Sentence order or released subject to Licence, will receive a minimum of one face-to-face appointment every calendar month with a Probation Practitioner. This standard ensures that direct face to face contact (where a Probation Practitioner and the individual they are supervising are in the same physical space) remains central to the supervision process. Whilst this can be complemented by other types of contact, direct contact enables the gathering of information which may not be obvious via video call or telephone. In Cumbria, this is

particularly welcomed given the geography of our County. Going forward, the probation service nationally is awaiting the publication of revised Smarter Working guidance which is expected to be published at the end of Summer 2022. The reliance on digital technology and remote working has increased. Due to this both services now have enhanced digital platforms that reflect national standards. Individuals accessing the service have more choice and control in respect of their engagement with services, and the services have a wider reach of service provision due to increased use of technology and online programmes. All good practice identified is available for other agencies to consider.

Best practice identified by both UNITY and the NPS is available for consideration by other agencies.

19.6 Police, NPS, CLCRC, V.S./ IDVA.

19.7 Review current information sharing practices to ensure information shared between agencies, particularly when CC are the holder of the information, is sufficient to allow for effective risk assessment and management processes, including MARAC, MAPPA and CJ processes. This will enhance public safety.

Time to complete – this matter is already being progressed, action to be completed by 1st October 2021.

Update July 2022. Established arrangements are in place for the probation service to receive relevant domestic abuse information from the Cumbria Police Disclosure Unit in all relevant cases. Following the probation unification in June 2021, a Northwest wide review of arrangements is currently ongoing, with a view to ensure consistent practice across the region. Positively, Cumbria has seen an increase of 0.5 FTE in staffing to complete disclosure requests on behalf of the probation service. In January 2022 a joint Thematic Inspection of MAPPA is taking place in Cumbria and any actions resulting from this can be considered within the wider context of the DHR action plan if applicable. Practice changes nationally, in effect from Monday 4th April 2022, now also necessitate the undertaking of mandatory domestic abuse (and child safeguarding) checks in all cases whereby an electronically monitored curfew requirement is being considered as part of sentence. Though not directly relevant in this case, it does offer additional safeguards whereby a domestic abuse perpetrator may be being considered for such a requirement as part of sentence. It remains a challenge obtaining information on cross border cases, as set out below. In terms of oversight of cases, Touchpoints Management Oversight is now fully implemented within Cumbria Probation Delivery Unit, thereby offering scrutiny of cases where DV is a relevant issue. **Action complete**.

19.8 Cumbria Constabulary, PSoS and NPS.

19.9 Agree a cross border process with key stakeholders to facilitate domestic abuse checks by the Probation Service Responsible Officer for perpetrators residing in Scotland. This will enable the probation service to gain a full history of perpetrator offending history and manage any risks they pose more effectively.

Time to complete, 1st August 2021. Action ongoing. Revised target date December 2022. **Update.** Cross Border work was ongoing pre COVID linked to the proximity of Cumbria to Scotland and individuals travelling between areas. Although staff are aware to make requests for information, no formal process has been established due to delays in this work caused by COVID and the focus on probation unification.

Update. July 2022. Work in this area was commenced 2019. Initial efforts by agencies to progress this action as a part of that work have shown it is not achievable at a local force or probation delivery level – it is one that requires national consideration. Agencies will forward the action for progression at national level. To be completed by December 2022.

19.10 The Cumbria MARAC Steering Group.

19.11 As part of the ongoing review of the multi-agency MARAC process, ensure that the referral criteria into MARAC, including "repeat cases" is not altered in a way which does not reflect national best practice and risks reducing the availability of support to DA victims identified as at high risk of harm. Consequently, all victims at high risk of DA receiving the support and services to which they are entitled thereby reducing the risks they face.

Time to complete – this matter is already being considered, action to be completed by 1st September 2022.

19.12 All agencies.

19.13 Design and embed recurring DA and safeguarding training, including MARAC related training, at all levels. The training should include, but not be limited to, identifying and understanding trauma informed practice, domestic abuse within older people's relationships, the impact on a person's mental health, economic abuse and substance abuse, including the misuse of alcohol and the impact of previous negative life experiences. The training should be designed to complement current ongoing initiatives, develop a culture of professional curiosity and combat compassion fatigue. The outcome will result in more consistent identification of DA with more effective interventions which will make victims safer. Time to complete – December 2023 - this matter is already being progressed by agencies, training is being delivered and is ongoing.

19.14 **Update.** Action ongoing. So far Victim Support (VS), Cumbria implemented an older person DASH after some IDVAs completed Safe Lives older people suffering DA professional development accreditation. This adapted risk assessment tool has been shared with the MARAC steering group and embedded into the MARAC referral portal for Cumbria. Additionally, Professor Jane Monckton Smith's intimate partner homicide timeline has been merged into the DASH risk assessment tool and these newly merged risk assessment tools are being piloted locally and nationally. VS Cumbria is taking part in the evaluation of the new tools. These tools have also been shared with partners agencies and free training offered. Cumbria's DA strategy group have approved the use of VS's newly merged DASH/ homicide timeline risk assessments for use by all partners in Cumbria. VS have also been commissioned to provide training to all

partners via Cumbria County Council – training will also be included on how they can be used to assist case workers and professionals to form their own professional judgement when assessing and identifying risk with a view to implementing support & safety planning and prevent risk escalation. This training is due to start in the Autumn 2023.

19.15 All agencies.

19.16 Introduce single and multi-agency scrutiny panels which will allow for review and reflection of the County wide response to DA, including the MARAC process and outcomes, thereby allowing opportunities to identify good practice and development opportunities where poor or inconsistent practice is identified.

Note. The CPS and police have in place a three monthly scrutiny process which may be suitable for wider consideration between agencies.

Time to set up a structure for this process and implement first scrutiny panel by 1st October 2021. Action completed.

19.17 All agencies (led by Cumbria Safeguarding Adults board and Cumbria Safeguarding Children Partnership). A programme of work across the CSCP and CSAB which sets the standards and expectations for practitioners and senior leaders in relation to professional curiosity. This will draw on a variety of learning methods/tools to improve understanding and support practice in relation to professional curiosity. There will be an expectation that all agencies reflect these standards within their organisational policies. In turn this will develop professional practice.
Stages: A series of 5-minute briefings, quick guides and guidance with reminders for practitioners how to be more professionally curious. This will include
1. Delivery of 'What is Professional Curiosity?' lunch and learn sessions, this will be facilitated by the partnership for all practitioners across the system.
2. A standard slide deck for use in team meetings and further lunch and learn sessions is currently being developed across the CSCP and CSAB.
3. A suite of videos using case studies based on a supervision session which are tailored for service areas using learning from reviews will be developed. The case studies can support supervision and reflective practice.
4. Develop professional curiosity area on "learning zone" (local IT based learning system). Develop a dedicated area on websites with information, including quick guides, guidance, videos.

Commencing September 2022 and of six months duration.

19.18 All providers of social housing.

19.19 Adopt a formal policy of working towards/ gaining domestic abuse housing association (DAHA) accreditation within timescales which are achievable, progress being reviewed on a quarterly basis. This will enable housing providers to deliver safe and effective responses to DA including how best to engage with victims and perpetrators.

Time to complete, March 2023, progress reviewable quarterly.

20. Appendix one: glossary of terms.

A and E	Accident and emergency services.
ACMHART	Allerdale Community Mental Health and Recovery Team
ACPO	Association of Chief Police Officers
ASB	Anti-social Behaviour
ASC	Adult Social Care
CC	Cumbria Constabulary
CCB	Coercive controlling behaviour.
CCC	Carlisle Crown Court
CCHA	Castles and Coasts Housing Association.
CIC	Cumberland Infirmary, Carlisle
CJ	Criminal justice
CMHT	Community Mental Health Team
CNTWNHS PFT	Cumbria, Northumbria, Tyne and Wear Partnership NHS Foundation Trust
CPN	Community psychiatric nurse.
CPS	Crown Prosecution Service
CLCRC	Cumbria & Lancashire Community Rehabilitation Company
CSP	Community Safety Partnership
DAHA	Domestic abuse housing association accreditation.
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist.
DAQ	Domestic Abuse Questionnaire

DHR	Domestic Homicide Review
DPP	Director of Public Prosecutions.
DV or DA	Domestic Violence or Domestic Abuse
DSHA	Derwent and Solway Housing Association
DSA	Detective Sergeant
EA	Environment Agency
GF	Girlfriend
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabularies
HMPS	Her Majesty's Prison Service
HOI	Housing Officer
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Review
James	Perpetrator
LA	Local Authority
MARAC	Multi- Agency Risk Assessment Conference
NCCCG	North Cumbria Clinical Commissioning Group
NCDV	National centre for domestic violence.
NCRS	National Crime Recording Standards
NFA	No Further Action
NPS	National Probation Service
NWAS	North West Ambulance Service
OASys	Offender Assessment System

OIC	Officer in Charge
OOCD	Out of Court Disposal.
PACE	Police and Criminal Evidence Act.
PNC	Police National Computer
PO	Police Officer
PPU	Public Protection Unit
PSoS	Police Service of Scotland
QA	Quality Assurance
RO	Restraining order.
TIAA	The Internal Audit Association
TOR	Terms of Reference
VPD	Vulnerable Persons database
VLO	Victim Liaison Officer
VS	Victim Support
YHG	Your Housing Group