REDCAR AND CLEVELAND
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
incorporating a
LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

'Elizabeth'

Died – Winter 2019

OVERVIEW REPORT

FINAL VERSION

October 2021

Chair and Author — Carol Ellwood QPM
Independent support to Chair — Ged McManus

CONTENTS

Family tribute to Elizabeth

'Elizabeth was a beautiful outgoing sociable girl, then she met John and things changed more or less straight away, she stopped seeing her friends and family. He tried to control Elizabeth over the years, and she went from being a gorgeous outgoing family orientated girl into a person who was put down and beaten by a man, but she seemed to think this was acceptable behaviour. It's not, it's abuse, Domestic Abuse. Elizabeth ultimately paid the price with her life.

Report it, there is no shame in this, there is always someone who will help you. She was 34 years old and left 6 children without a mother, she was trying to change a vile creature that would never change, they never do.

I am a grandmother who now looks after 4 of those children. It's the children who also pay the ultimate price of what he has done.'

1. INTRODUCTION

1.1 The panel offers its sincere condolences to Elizabeth's family.

1.2 This report is a combined domestic homicide review and local children safeguarding practice review, which examines how agencies responded to, and supported, Elizabeth, and her children, residents of Redcar, prior to Elizabeth's death in the winter of 2019.

1.3 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.4 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order 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 in order to reduce the risk of such tragedies happening in the future'[1].

1.5 Elizabeth had been in a relationship with John for approximately two years. Elizabeth was the Mother of six children, John was the Father of two of these children.

1.6 Elizabeth was found deceased at her home address. John was arrested and charged with the murder of Elizabeth and remanded into custody. A Home Office post-mortem determined the cause of Elizabeth's death as -

'The post-mortem examination has shown that Elizabeth has died as a result of a significant blunt force head injury. This had resulted in diffuse axonal injury (widespread nerve fibre injury) together with bleeding into the corpus callosum and gliding-type contusions i.e. damage to the vasculature of the brain associated with diffuse traumatic axonal injury. This grade 2 diffuse axonal injury is necessarily associated with profound and immediate or almost immediate loss of consciousness'.

1.7 Following the death of Elizabeth legal arrangements were made for the care and custody of Elizabeth's children.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.8 On 14 January 2020 John was found deceased in his prison cell. John had hung himself.

1.9 An inquest into Elizabeth's death determined that she had been unlawfully killed.

1.10 The report was seen by Elizabeth's family who have contributed to the review. The review panel thank the family for their contribution

2. TIMESCALES

2.1 On 29 January 2020 Redcar and Cleveland Community Safety Partnership determined the death of Elizabeth met the criteria for a domestic homicide review [DHR]. The circumstances surrounding the case were discussed on 25 February 2020 at a meeting held by South Tees Safeguarding Children Partnership (STSCP) where a recommendation was made that the case met the criteria for a local child safeguarding practice review [LCSPR] in accordance with Working Together 2018[2].

2.2 It was agreed that the two processes would be combined, to avoid duplication, and ensure that any identified learning was considered within both review processes. The decision to hold a joint review is covered within paragraph 22 & 23 Home Office Statutory Guidance on Domestic Homicide Reviews and paragraph 29 Working Together 2018. Notification was made to the National Safeguarding Child Practice Review Panel who confirmed in writing the agreement for a joint review to take place. The Home Office were notified of the decision to hold a joint review on 27 March 2020. The Chair has had access to these confirmations.

2.3 The first meeting of the review panel took place on 7 October 2020. Thereafter the panel met five times. During the Covid-19 pandemic, panel meetings were held virtually, and contact was maintained with the panel via email and telephone calls.

2.4 At the beginning of 2020, Redcar and Cleveland Borough Council were subjected to a cyber attack which impacted accessibility to relevant files and computer systems. This was followed by the Covid-19 pandemic. These two events impacted the commencement of the review.

2.5 The review covers the period 21 December 2015 (date of John's prison release) to 02.01.20 (date after death to capture immediate safeguarding).

2.6 The review was presented to Cleveland and Redcar Community Safety Partnership and South Tees Safeguarding Children Partnership on 7 October 2021 and concluded on 19 October 2021 when it was sent to the Home Office.

[2] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, perpetrator, and children, all of whom are subjects of the review. The pseudonyms were agreed with Elizabeth's family.

3.3 This table shows the age and ethnicity of the subjects at the time of Elizabeth's death.

Name	Relationship	Age	Ethnicity
Elizabeth	Victim	34	White British female
John	Perpetrator	27	White British male
Grace	Daughter of victim	Secondary school age	White British female
Hope	Daughter of victim	Secondary school age	White British female
Leighton	Son of victim	Primary school age	White British male
Stewart	Son of victim	Primary school age	White British male
Charles	Son of victim and perpetrator	Pre-school age	White British male
Harmony	Daughter of victim and perpetrator	Pre-school age	White British female

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference on 23 October 2020, following the first meeting. These were shared with the family who were invited to comment on them.

4.2 **The purpose of a DHR is to**:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016][3] Section 2 Paragraph 7

4.3 **Local Child Safeguarding Practice Review**

The LCSPR will be conducted in accordance with the requirements set out in:

- The Children Act 2004[4] as amended by the Children and Social Work Act 2017[5]
- Working Together 2018
- Tees multi-agency Children's Safeguarding Policy and Procedures

4.4 **Specific Terms**

[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[4] https://www.legislation.gov.uk/ukpga/2004/31/contents

[5] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

1. What indicators of domestic abuse, including coercive and controlling behaviour,[6] did your agency identify for Elizabeth?

2. What knowledge did your agency have that indicated John might be a perpetrator of domestic abuse against Elizabeth and what was the response? Did that knowledge identify any controlling or coercive behaviour by John?

3. How did your agency assess the level of risk faced by Elizabeth and her children from John, which risk assessment model did you use and what was your agency's response to the identified at risk?

4. What services did your agency provide for the subjects of this review; were they timely, proportionate and of an acceptable level in relation to the identified levels of risk?

5. In the context of the family arrangements, what consideration did your agency give to any mental health issues or substance misuse in the couples' relationship when identifying, assessing and managing risks around domestic abuse, including domestic abuse in previous relationships?

6. In the context of the family arrangements, what did your agency do to safeguard any children exposed to domestic abuse?

7. How did your agency capture the voice of the children, including their wishes and feelings in relation to their lived experiences? Did your agency experience any barriers in gathering this information?

8. What was your agencies' response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?

9. Were the victim, perpetrator and children informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

10. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

11. How effective was your agency's supervision and management arrangements for practitioners involved with the family. Did managers have effective oversight of the case?

12. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to the subjects of this

[6] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

review, or on your agency's ability to work effectively with other agencies?

13. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

14. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

15. What knowledge did family, friends and employers have that Elizabeth was in an abusive relationship and did they know what to do with that knowledge?

16. Were there any examples of outstanding or innovative practice?

17. What learning did your agency identify in this case.

5. METHOD

5.1 Cleveland Police informed Cleveland and Redcar Community Safety Partnership on 8 January 2020 of the death of Elizabeth, and that the case potentially met the criteria for a domestic homicide review. On 11 August 2020 Carol Ellwood-Clarke was appointed as the Independent Chair and Author for the review.

5.2 The first meeting of the review panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. The Chair provided training to those authors completing IMR's.

5.3 The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.4 The Police provided the review with access to relevant information gathered during the criminal investigation in relation to the relationship between Elizabeth and John. This has been included within the report as necessary.

5.5 There has been no contact with John for the purposes of this review, as he died prior to the review starting.

5.6 The Chair of the Community Safety Partnership agreed for an extension of the timeframe for the review due to the delay in the review starting and he impact of the Covid-19 pandemic. The Home Office were notified of the extension.

5.7 The draft report was shared with family, and they were invited to make comment. [See Section 6]

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY.

6.1 The Chair wrote to Elizabeth's Mother, to inform her of the review and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[7].

6.2 The Chair spoke with Elizabeth's Mother who provided valuable information to the review which has been included within the report. The Chair maintained contact with the National Homicide Worker for the case, to provide updates for the family at key points in the review process.

6.3 The Chair wrote to Elizabeth's neighbour and friend inviting them to contribute to the review, however no response was received.

6.4 John's death occurred before the commencement of the review and therefore engagement was not undertaken.

6.5 In the absence of contact with friends the Chair sought information provided during the criminal and coronial investigation to help the review understand any knowledge of friends and the wider community in relation to domestic abuse.

6.6 The panel considered if it was appropriate to seek engagement with the children. The panel acknowledged that children can provide valuable information, but recognised that any engagement would need to be planned and undertaken with specialist support.

6.7 The Chair discussed engagement with the Children's Social Worker and panel member from Children's Social Care. The Social Worker had a good relationship with all the children and had been their Social Worker since the death of Elizabeth. The Social Worker provided information in relation to the ongoing work that was taking place with the children and the emotional impact that this had. The Social Worker informed the Chair that recent events including the publication in the media, and local community in relation to the inquest of John, had had an adverse effect on the children.

6.8 The Chair in agreement with Children's Social Care determined that it was not appropriate at this stage to seek engagement with the children. The Chair asked the Social Worker to attend a meeting with the family, alongside the National Homicide Worker. The Chair made this decision so that the Social Worker would be informed of the report and be able to

[7] https://aafda.org.uk/

support the family after the report had been shared. It was agreed that a copy of the final report would be held on the children's Social Care file.

6.9 In July 2021 the Chair met the family, in the presence of the children's Social Worker and National Homicide Worker and discussed the report in detail. A copy of the report was left with the family, who were invited to make additional comments. A copy was also shared with the Children's Social Worker and National Homicide Worker.

7. CONTRIBUTORS TO THE REVIEW.

7.1 This table show the agencies who provided information to the review.

Agency	IMR[8]	Chronology	Report
Alliance Psychological Services			✓
Cleveland Police	✓	✓	
Holmes House			✓
Housing Benefits Team			✓
National Probation Service – Cleveland Area	✓	✓	
Redcar & Cleveland Borough Council - Children's Social Care	✓	✓	
Redcar & Cleveland Borough Council – Early Help	✓	✓	
Redcar & Cleveland Borough Council – School Inclusion	✓	✓	
Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service	✓	✓	
Route 2	✓	✓	
South Tees Hospital NHS Foundation Trust			✓
Tees, Esk and Wear Valleys NHS Foundation Trust	✓	✓	✓
Tees Valley Clinical Commissioning Group	✓	✓	
Thirteen Housing Group Ltd	✓	✓	

7.2 The following agencies were written to as part of the scoping process for the review, but held no information –

1. Foundations
2. Change Grow Live
3. MIND
4. We Are With You[9]

[8] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

[9] https://www.wearewithyou.org.uk/services/redcar-and-cleveland/

5. Lifeline

7.3 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members

Name	Job Title	Organisation
Karen Agar	Associate Director of Nursing (Safeguarding)	Tees Esk and Wear Valleys NHS Foundation Trust
Gary Besterfield	Service Manager	We are With You
Karen Bowers[10]	Service Manager	Redcar & Cleveland Borough Council, Adult Social Care
John Bye	Named GP for Safeguarding Children	Tees Valley Clinical Commissioning Group
Mandy Cockfield	Service Manager	Redcar & Cleveland Borough Council, Adult Social Care
June Craven	Safeguarding Officer for Schools	Redcar & Cleveland Borough Council
Gordon Bentley[11]	Senior Adult Safeguarding Officer	Tees Valley Clinical Commissioning Group
Jayne Bulmer	Service Manager	Redcar & Cleveland Borough Council, Children's Social Care
Kate Dawson	Health Visiting and School Nursing Lead Nurse	Redcar & Cleveland Borough Council, School Nursing
Jayne Downes	Detective Chief Inspector	Cleveland Police
Carol Ellwood-Clarke	Chair and Author	Independent
Patricia Fenby	Detective Inspector	Cleveland Police
Emma Geldart	Project Manager	Foundation
Jay Hosie	Service Lead – Community Safety & Compliance	Redcar & Cleveland Borough Council
Claire Mahoney	Assistant Director Education and Skills	Redcar & Cleveland Borough Council

[10] Attended first panel meeting.
[11] Replaced Alison Peevor after third panel meeting.

Julie McDowell	Inclusion Lead	Redcar & Cleveland Borough Council, School Inclusion
Ged McManus	Support to Chair and Author	Independent
Janice McNay	Head of Governance & Compliance	Thirteen Housing Group Ltd
Amy Meadows	Support Officer - Neighbourhoods and Customer Services	Redcar & Cleveland Borough Council
Rachel Paterson	Prevention Team Leader	Redcar & Cleveland Borough Council, Early Help
Alison Peevor	Head of Quality and Adult Safeguarding	Tees Valley Clinical Commissioning Group
Rosana Roy	Senior Probation Officer	National Probation Service – Cleveland Area
Susan Taylor	Named Midwife/Nurse Safeguarding Children.	South Tees Hospitals NHS Foundation Trust
Gary Watson	Partnership Manager	South Tees Safeguarding Children Partnership

8.2 The Chair of Redcar and Cleveland Community Safety Partnership was satisfied that the panel Chair was independent. In turn, the panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met five times and matters were freely and robustly considered. Outside of the meetings the Chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors.

9.2 Carol Ellwood Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHR's and other safeguarding reviews. Carol retired from Humberside Police in 2017 after thirty years during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[12].

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board. He served for over thirty years in South and West Yorkshire Police services in England. Prior to leaving the police service in 2016 he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.4 Between them they have undertaken over sixty reviews including: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking DHR's.

9.5 Neither practitioner has worked for any agency providing information to the review.

[12] https://safelives.org.uk/

10. PARALLEL REVIEWS

10.1 The Chair notified Her Majesty's Coroner that a DHR was being undertaken. Her Majesty's Coroner for Teeside opened and adjourned an inquest into Elizabeth's death. In October 2020, it was determined that Elizabeth had been unlawfully killed.

10.2 Cleveland Police undertook a criminal investigation into the circumstances surrounding the death of Elizabeth. John was charged with the murder of Elizabeth.

10.3 The Chair is not aware that any other agency has conducted a review or investigation into Elizabeth's death nor intends to do so.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women.

A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[13]

11.3 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.4 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.5 Elizabeth had a history of anxiety and depression since her teenage years, for which she had been referred into and self-referred to Mental Health Services. Her engagement with services was inconsistent with appointments often cancelled or not attended. This resulted in her being frequently referred back to services. Elizabeth was prescribed medication to assist with her anxiety and depression, this included Diazepam 2mg[14] and Mirtazapine 30mg[15]. These medications were reviewed regularly including during her pregnancies.

11.6 In February 2015 Elizabeth attended hospital after an accidental overdose of paracetamol. At this time, Elizabeth was pregnant and suffering with an abscess in her mouth. Elizabeth sought medical advice due to consuming over the recommended dosage of paracetamol. Elizabeth was known to consume alcohol, often to excess, and along with her mental health

[13] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[14] https://www.nhs.uk/medicines/diazepam/

[15] https://www.nhs.uk/medicines/mirtazapine/

resulted in involvement with Children's Social Care due to the impact on her children.

11.7 Elizabeth had regular contact with her GP throughout the timescales of the review. These contacts were predominantly in relation to health ailments, mental health and pregnancy matters. Only significant contacts have been analysed within the terms of reference for this review.

11.8 John had a history of anxiety and aggressive outbursts. From the age of 11-12yrs John was known to misuse substances. In 2010 John was referred for early intervention due to drug induced psychosis. Following assessment his case was closed. John was referred into Mental Health Services in the community and in prison but did not engage.

11.9 Throughout this review there was a pattern of the children not attending scheduled appointments for development reviews and inoculations. The children did have their mandated health visitor development reviews. The review has seen entries where these were discussed with Elizabeth. The CCG have identified learning around this area and made relevant recommendations. See Term 17.

11.10 All subjects of the review are white British. At the time of the review, they were living in an area which is predominantly of the same demographic and culture[16].

[16] In the 2011 census the population of Redcar and Cleveland was 135,177 and is made up of approximately 51% females and 49% males. The average age of people in Redcar and Cleveland is 42, while the median age is higher at 43. 95.5% of people living in Redcar and Cleveland were born in England. 99.3% of people living in Redcar and Cleveland speak English. The religious make up of Redcar and Cleveland is 70.4% Christian, 21.9% No religion, 0.4% Muslim, 0.1% Buddhist.

12. DISSEMMINATION

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

- The Family
- Redcar and Cleveland Community Safety Partnership
- South Tees Safeguarding Children Partnership
- All agencies that contributed to the review
- Cleveland Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, OVERVIEW AND CHRONOLOGY

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The narrative is told chronologically and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies and input from Elizabeth's family. The below is not a chronological involvement of all health appointments in relation to ante-natal and child immunisation and development checks. The events are cross referenced to the events table contained within Appendix C. Detailed analysis of the contacts appears at section 14.

13.1 Elizabeth

13.1.1 Elizabeth was an outgoing child, who was popular at school with lots of friends. Elizabeth left school with some qualifications. Elizabeth has two brothers and had a close relationship with her older brother. At the age of 18 Elizabeth had her first child and was married. This relationship was described as violent and ended soon after the birth of her eldest child. At the age of 20yrs Elizabeth moved out of the area to work. Elizabeth's eldest child went to live with her Father.

13.1.2 In 2006 Elizabeth returned to the Redcar area and began working in a canteen at a local factory. After about a year Elizabeth stopped work as she was pregnant with her second child.

13.1.3 Elizabeth was described as a loving Mother to her six children, who always wanted to do the best for her family and children. Elizabeth's Mother stated that Elizabeth often chose the wrong type of partners and always seemed to be attracted to the 'bad boys'.

13.2 John

13.2.1 John was born and raised in Cleveland. His parents separated when he was six years old. John's Mother re-married and John told professionals that his relationship with his stepfather and siblings was generally positive.

13.2.2 John's behaviour throughout his early teenage years caused extensive problems within the family home. John was known to the Police. At the age of fifteen John was expelled from school and he went to live with his Grandparents. From the age of 18 years John spent time in prison, returning to live with his Grandparents on release.

13.2.3 John had a long history of alcohol and illicit drug use from the age of 12. John told professionals that there was a family history of schizophrenia in two of his paternal cousins, both diagnosed under the age of 20, and a history of depression on the maternal side of his family. John has a child from a previous relationship with whom he has no contact.

13.3 Elizabeth and John's relationship

13.3.1 Elizabeth and John relationship began in 2018, although information in agency records indicate that they knew each other prior to this time. Elizabeth's Mother told the Chair that Elizabeth was aware of John's past offending behaviour and that Elizabeth had told her that 'she could be the one to change him'. Elizabeth's Mother told the Chair that she was aware of abuse within their relationship and described incidents of controlling behaviour and physical abuse. These are covered in Term 15.

13.4 The children

13.4.1 Elizabeth was the Mother to six children, five of whom lived with her. John was the Father to the two youngest children. Elizabeth's eldest child visited the family home frequently. The children of school age attended schools within the local area. Towards the end of 2019, Stewart had been assessed by CAMHS following a referral regarding concerns of his behaviour.

13.5 Information known prior to the start of the review.

13.5.1 Elizabeth and her children were known to Children's Social Care from 2013. There were no assessments from the first contacts, with Early Help services being identified as the most appropriate. Referrals during 2014 to 2016 resulted in three separate periods of involvement with the case closing in April 2016. Concerns were linked to domestic abuse, alcohol misuse and Elizabeth's mental health. Elizabeth was referred to the Freedom programme[17] and invited to attend a 12-week Mellow parenting course[18]. In July 2015, a Section 47 enquiry was undertaken by Children's Social Care due to sexual abuse of Hope by a family member. This resulted in a criminal investigation and conviction.

[17] https://www.freedomprogramme.co.uk/
[18] https://www.mellowparenting.org/

13.5.2 The Police attended domestic abuse incidents between Elizabeth and her then partners. This resulted in referrals to Children's Social Care. Elizabeth was identified as the victim in these incidents.

13.5.3 Since 2014 Elizabeth was known to Mental Health Services. It was documented that Elizabeth had taken an overdose at the age of 18, with one of the factors being that she was in a 'violent' relationship. Elizabeth described a 'difficult childhood' with adverse early childhood experiences which appeared to have impacted on her abilities around attachment and adjustment. During contact with services Elizabeth described how 'she often goes for the wrong type' describing relationships that were abusive and controlling.

13.5.4 At the age of 13 John was referred to CAMHS[19] due to aggressive behaviour towards his younger sibling. He was diagnosed with conduct disorder. In 2010, John was assessed by Early Intervention Psychosis (EIP) team. The outcome was that his psychotic symptoms were as a result of drug induced psychosis. John admitted to using illicit substances and alcohol which exacerbated his mental health symptoms. John's engagement with Mental Health Services was poor.

13.5.5 John's criminal behaviour included offences of anti-social behaviour, criminal damage, and violence. In 2010, at the age of 18, John assaulted his Mother, for which he received a custodial sentence.

13.5.6 In January 2015 John was sentenced to 30 months imprisonment for an offence of wounding (Section 20 Offences Against the Person Act 1861) on his partner. The victim attended the hospital with suspected fractures to her right temple, swelling to the face, a ripped ear lobe, bruising to the body (including a foot mark on her back) and a cut above her eye which required stitches. This was a domestic abuse assault.

13.6 Events within the timeframe of the review

2015

13.6.1 On 21 December, John was released from prison on Home Detention Curfew. The following day, John was issued with his first warning by his Offender Manager, having breached the non-contact licence condition of

[19] Child and Mental Health Services

his licence by sending a Christmas card to his ex-partner and a breach of his exclusion zone. An OASYs risk assessment completed upon release assessed John as being high risk to his ex-partner. Five days after his release the Police attended a fight between John and his brother. John was interviewed by the Police, he admitted being involved in a fight, but did not admit to causing the injuries. John's brother did not co-operate with the investigation and no further action was taken. John's brother had substantial injuries which required treatment including slash/cuts to face.

2016

13.6.2 On 7 January during contact with his Offender Manager John was seen to have love bites on his neck. John stated that he had been sexually intimate with a female. This female was Elizabeth. John stated he had no intention to see her again. This is the first recorded contact of Elizabeth and John together. Six days later, on 13 January, John was recalled to prison by his Offender Manager for breach of licence due to his behaviour and breach of exclusion zone.

13.6.3 John was deemed eligible to undertake RESOLVE (non-intimate violence programme) whilst in prison to address his offending behaviour. John commenced on the programme in April, which he finished in June.

13.6.4 Throughout 2016, Elizabeth had contact with her GP and Mental Health Services. Elizabeth's engagement with Mental Health Services was inconsistent; however, there was evidence that Elizabeth had undertaken some work around self-esteem, cognitive behaviour therapy. Through the mellow parenting course and parenting puzzle, Elizabeth reported to have increased her knowledge around coping strategies for her mental health.

13.6.5 Children's Social Care were involved with Elizabeth and her children, and a referral was made to Sure Start to provide support and services. In addition, referrals were made for Stewart due to concerns raised around his behaviour.

13.6.6 In October, Elizabeth moved into accommodation provided by Thirteen Housing Group Ltd. Elizabeth was still living in this house at the time of her death. Visits to the property by Thirteen Group Housing Ltd were due to small repairs, which did not raise concerns. Elizabeth was in receipt of housing benefit, which did not cover the full amount of the rent payable and on the occasions that the rent went into arrears, Elizabeth fully co-operated and made changes to her payment to reduce the deficit.

2017

13.6.7 In January, John was released from prison. During contact with his Offender Manager John stated that whilst in prison he had received letters from Elizabeth who had also visited him on a few occasions. John told the Offender Manager that Elizabeth was not aware of his release and that he had no intentions of contacting her. A Spousal Assault Risk Assessment (SARA)[20] was completed. Enquiries were made regarding John's accessibility to domestic abuse programmes, with John eventually being referred to Route 2, which he commenced in February. John's licence conditions ended in March, and he was no longer under the supervision of Probation. John failed to attend any further appointments with Route2 after the end of his licence.

13.6.8 In June, Grace disclosed abuse by a family member. This matter was investigated by Children's Social Care and the Police. The offender was subsequently charged with criminal offences.

13.6.9 Towards the latter part of the year, and early 2018, the Police received several reports that Grace had gone missing from her home. (Grace lived with her Father). Missing persons policies and procedures were followed, and Grace was seen by professionals and referred to Children's Social Care and Vulnerable, Exploited, Missing, Trafficked (VEMT)[21]. A referral was made for Targeted Youth Support work to be undertaken; however, this was not progressed as consent was not provided.

13.6.10 In October Elizabeth contacted the Police and reported a serious crime from when she was a child. The offender was a family member. Elizabeth did not provide the Police with details of the offence and after the initial contact she stated that she did not wish at that time to progress the complaint due the stress it may cause. Elizabeth was currently pregnant. The offender was not made aware of the complaint.

13.6.11 On 22 December, Grace disclosed that during a visit to her Mother's house, (Elizabeth) there had been a strong smell of cannabis. Grace expressed

[20] The Spousal Assault Risk Assessment Guide (SARA) helps criminal justice professionals predict the likelihood of domestic violence by screening for risk factors in individuals who are suspected of, or who are being treated for spousal abuse.
[21] https://www.middlesbrough.gov.uk/children-families-and-safeguarding/safeguarding-children/vulnerable-exploited-missing-trafficked-vemt

concerns for her younger siblings. Present at the house was John, who was described as Elizabeth's partner. The school completed a SAFER[22] referral to Children's Social Care. Advice and Information was given to Elizabeth.

13.6.12 At the end of December John was seen by his GP, he was accompanied by a female who he referred to as his 'Girlfriend'. There are no details as to who this female was. John reported anxiety and increased paranoid thoughts. John was referred to Mental Health Services. Appointments were made for early in 2018; however, John failed to attend, and he was discharged back to his GP.

2018

13.6.13 John attended a further appointment with a GP in February, where he reported anxiety. A further referral was made to Mental Health Services. Subsequent appointments were made, which were not attended, and it was not until 15 June 2018 that John attended as appointment with Mental Health Services. John was accompanied by Elizabeth. John was seen again, on 19 July, where he described fluctuating mood and 'hearing whispering' linked to stress reaction. John stated he had not worked since January 2018. The outcome of the assessment was that John's symptoms were linked to stress and he was discharged back to his GP. On hearing the outcome, John became angry and left the assessment room having shouted expletives at the clinician. There was no further contact with Mental Health Services.

2019

13.6.14 In March, the school spoke to Elizabeth and John after Stewart had been observed to be over emotional. Elizabeth and John reported that Stewart was upset and finding it difficult that their relationship had ended. The learning mentor and class teacher provided support to Stewart through the PSHE[23] curriculum.

13.6.15 Later that month, John and Elizabeth were seen together and described as being in a relationship during appointments with a GP and Health Visitor.

[22] https://www.teescpp.org.uk/contact/redcar-cleveland
SAFER - SITUATION, ASSESSMENT, FAMILY, EXPECTED RESPONSE, RECORDING)
[23] PSHE stands for Personal, Social, Health and Economic education.

13.6.16 During April, Elizabeth and John engaged with the school in seeking support for Stewart due to his behaviour, which included talk of death and suicide and threats of violence towards other. Stewart had seen a GP and had been referred to CAMHS. Whilst waiting for the CAMHS appointment, Stewart attended nine 1:1 support sessions with the school learning mentor. Stewart attended CAMHS on 15 November 2019.

13.6.17 On 20 May, the school made a SAFER referral to Children's Social Care after Stewart disclosed that John had been fighting with an Uncle. Elizabeth told professionals that Stewart had overheard a conversation about an historical incident. Three days later, Elizabeth saw her GP and reported that she felt she was suffering with post-natal depression. It was agreed for contact to be made with the Health Visitor and for a review in two weeks' time. The incident was not received in South Tees Multi Agency Children's Hub (MACH)[24] until 5 June.

13.6.18 On 30 May, Elizabeth was seen at home by a Health Visitor. This was the only time that Elizabeth had been seen alone without John present. Elizabeth told the Health Visitor that she had been snappy and irritable with John, which had caused a lot of friction between them and that they had had a few days living apart. Elizabeth further stated that John was returning home today, and that the days apart had helped. The family told the Chair that John's Mother paid for him to stay in a caravan with his brother, but following a fight with his brother, John had been asked to leave the campsite. John was collected by his Mother, who returned him to live with Elizabeth.

13.6.19 On 5 June, Children's Social Care received a referral from Stewart's school. Stewart had told his teacher that John had had a fight with his brother. John was drunk and during the incident damage was caused in the home, and they had to leave the house. Elizabeth was asked about the incident and denied that it had happened. At the end of June, the Health Visitor discussed the referral with Elizabeth and John, who claimed that Stewart had overheard a conversation regarding an incident that had happened some time before.

24 https://www.middlesbrough.gov.uk/sites/default/files/MACH%20BRIEFING%20NOTE%2008.05.19.pdf

13.6.20 In August Elizabeth self-referred to Mental Health Services and was seen by Alliance Psychological Services. Elizabeth reported low mood and anxiety around a relationship breakdown.

13.6.21 On 23 October, the school made a SAFER referral to Children's Social Care after Stewart disclosed to the learning mentor that 'Daddy had hit mammy, squished her eyes and banged her head on the door'. The disclosure about 'squished eyes' was not recorded on the referral. Elizabeth denied the assault had happened and stated that Stewart struggled with reality and fantasy. The referral was allocated to Early Help, which was then sent to the School Nurse to undertake work with Stewart at Level 2[25].

13.6.22 On 8 November, Elizabeth informed the School Nurse that she had separated from John three weeks earlier. Elizabeth described the relationship as 'amicable', and that John was supporting with childcare. On 15 November Stewart attended an assessment with CAMHS. Elizabeth and John attended the appointment. It was agreed to complete an ADHD[26] screening process and to identify any social and communication difficulties. It was agreed that the clinician would contact MACH to enquire about the SAFER referral that school had made prior to half term and if required to submit another referral, which CAMHS later did. The outcome for the SAFER referral from the MACH, was for a keyworker to be allocated. This did not happen, and the SAFER referral was linked to the existing open case held by the school Nursing Service.

13.6.23 On 19 November, Elizabeth telephoned the School Nurse. During the conversation Elizabeth stated that John was back at home. There were further unsuccessful calls with Elizabeth, and a letter was sent to Elizabeth with an appointment for 2 January 2020.

13.6.24 On 16 December contact was made between the School Nursing Service and Early Help Co-ordinator to discuss the SAFER referrals and case allocation. It was confirmed during this discussion that a keyworker would not be allocated.

13.6.25 On 30 December the Police received a report from a 16 year old female that she had been approached by a male who had been under the

25 https://www.teescpp.org.uk/media/1080/r_c_lscb_local_framework_and_protocol_for_the_assessment_of_children_in_need_and_their_families_december_2014.pdf

26 https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

influence of alcohol and had asked for contact details via social media. The caller named the person as 'John', and requested the details be recorded for information. It was only confirmed by the victim after the death of Elizabeth that the male was the same John, responsible for Elizabeth's death.

13.6.26 At the end of the year, Police attended Elizabeth's home address and found her deceased. John was arrested away from the scene in the company of the two youngest children. John was charged with Elizabeth's murder. Emergency arrangements were made for the placement of Elizabeth's five younger children. Grace was living with her Father. Subsequent childcare arrangements have been undertaken with Children's Social Care.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Elizabeth?

Cleveland Police

14.1.1 The Police had no reports of domestic abuse between Elizabeth and John. The Police were not aware that Elizabeth and John were in a relationship.

14.1.2 The Police held information that Elizabeth had been a victim of domestic abuse, in previous relationships, which were outside the timescales of the review.

14.1.3 The Police now have a dedicated Domestic Abuse Unit which incorporates a Domestic Abuse Solution Team. The Force is currently training all front-line Police Officers in domestic abuse, with a focus on coercive and controlling behaviour, via a bespoke training programme devised by the College of Policing and Safelives in response to the Her Majesty's Inspectorate of Constabulary (HMIC) report – 'Everyone's business; Improving the Police response to domestic abuse' 2014[27]. The training programme is being rolled out to all Police Forces, in England, Wales and Scotland.

National Probation Service (Cleveland Area)

14.1.4 The National Probation Service were not involved with Elizabeth; however, they did supervise John following his conviction in 2015 and until the expiration of his licence. Whilst there was no evidence that John and Elizabeth were in a relationship during this time, there was information that they had been in contact. John had told his Offender Manager that Elizabeth had written to him and visited him whilst he was in prison, and that they had been intimate shortly before his recall in early 2016.

14.1.5 Following these contacts, John remained in prison for twelve months. The Probation Service had no information that Elizabeth and John's contact continued during this time. The Probation Service did identify that further information was not gathered from John by the Offender Manager in relation to Elizabeth, which would have resulted in safeguarding measures being implemented for her and her children, which should have resulted in a SAFER referral.

[27] https://www.justiceinspectorates.gov.uk/hmicfrs/publications/improving-the-police-response-to-domestic-abuse/

Children's Social Care and Early Help

14.1.6 Information was held by Children's Social Care that identified Elizabeth as a victim of domestic abuse. This included information related to Elizabeth's previous relationships.

14.1.7 In October the school submitted a SAFER referral which described Stewart as being violent, talking about slashing, stabbing and chainsaws and people wringing birds' necks. Stewart also described 'incidents between Mum and Dad' and Dad hurting Mum. Stewart was sleep walking and waking up screaming.

14.1.8 The CAMHS professional in the MACH confirmed that Stewart had an appointment with CAMHS on 15 November 2019. On 6 November, the referral was transferred by the Early Help Co-ordinator (EHC) to the School Nurse, and for contact to be made with Elizabeth to ascertain support needs and to complete a health needs assessment for Stewart. The outcome was recorded as - Stewart displaying challenging behaviour at home and school, mum thinks there may be some underlying mental health issues, Stewart is awaiting assessment for CAMHS. The EHC referred to the threshold document - anger and frustration issues level 2, disruptive behaviour level 2.

School Inclusion

14.1.9 The school made two SAFER referrals following disclosures by Stewart, (May and October 2019). The first SAFER referral related to a fight between John and his brother. No further action was taken after Elizabeth stated Stewart had overheard a conversation about a historical incident. The second SAFER referral contained concerns about Stewart's behaviour and his cognitive ability. Within the referral it detailed – ' Stewart comes out with stories about chain saws and people wringing birds' necks. He also says that there are incidents between mum and dad. He also comes out with stories about his peers injuring their parents and mum feels that she is at her 'wits end' as she can't understand why he is coming out with these stories' and 'Mum feels that there is a problem with Stewart differentiating between fact and reality. This is causing arguments at home between mum and dad around parenting'.

14.1.10 The review was provided with additional information that Stewart had told his Learning Mentor 'that Daddy had hit mammy, saying he had squished her eyes and banged her head on the door'. This detail was not contained within the SAFER referral and therefore not passed onto the School Nurse who had been allocated a piece of early help work to undertake. The panel agreed that this was a missed opportunity. The School Nurse did not have

access to the SAFER referral. The school had spoken to Elizabeth who denied that there had been violent incidents and stated that Stewart struggled with reality and fantasy. Elizabeth was seen to have no visible injuries and agreed to the referral being made. Elizabeth was signposted to agencies that could offer support.

14.1.11 The panel reflected on the difference in the information that was known and what was shared within the SAFER. The panel agreed that, had the level of detail of the disclosure that Stewart made to the Learning Mentor, and the accurate recording of the voice of the child around the domestic abuse been contained within the SAFER, then consideration would have been given to allocating the SAFER to a Social Worker.

14.1.12 The panel were informed that since February 2021, training sessions have been offered to schools and colleges by the Safeguarding Officer for Schools and the MACH Team Manager. The sessions were aimed at guiding schools through making the decision to make a referral using the signs of safety framework, considering the scaling question and completing the referral form. The sessions have been well attended and further sessions are planned for the next academic year building on what has been delivered. The panel acknowledged the work that has already been undertaken around the importance of detailed and accurate recording of information, including recording the exact details when a child makes a disclosure and communications between professionals. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 1].

<u>School Nursing and Health Visiting Service</u>

14.1.13 The Health Visitor was aware that Elizabeth had been the victim of domestic abuse in a previous relationship. John was present for most of the home visits, with only 3 home visits taking place where John was not visible to the Health Visitor, this limited the opportunity to screen for domestic abuse. The Health Visitor did screen for domestic abuse on one occasion and Elizabeth denied any violence in her relationship with John. The Health Visitor did note Elizabeth's behaviours and presentation within her documentation, noting good eye contact, smiling and relaxed presentation. Whilst John's presence could be interpreted as controlling behaviour, at the time of the visits, the Health Visitor did not feel that this was a matter of concern.

14.1.14 The presence of John in the home created a barrier to the Health Visitor in repeating the domestic violence screen. The review panel agreed that it would have been beneficial to utilise a written screening tool when John was in the kitchen or request for Elizabeth to attend the clinic. In reaching

this conclusion the review also took cognisance that there were no visible indications that Elizabeth was being abused such as evidence of bruising, injuries, presentation, home conditions or observed interactions between Elizabeth and John.

14.1.15 The Health Visitor was aware of Elizabeth and John's separation in May 2019 and the subsequent reconciliation. During that contact, Elizabeth informed the Health Visitor that she had been snappy and irritable which had caused friction with John, who had then left to stay at his Mother's address. Elizabeth commented that John was supportive, which gave assurances to the Health Visitor. The Health Visitor was not aware that John was a perpetrator of domestic abuse.

14.1.16 The panel considered this contact in May and acknowledged that this was a vulnerable time for Elizabeth who had just given birth to her youngest of six children, the baby was three weeks old. Elizabeth had recently seen her GP and discussed that she felt she had post-natal depression and during that consultation it was recorded "Thinks has post-natal depression, struggling with breast feeding…..feeling low, resentful of partner, feels positive and loving towards baby, struggling to sleep and not eating much – good eye contact'. The GP had alerted these concerns to the Health Visitor who had made further contact with Elizabeth.

14.1.17 An article in the British Medical Journal[28] provides details of research undertaken during 1999 across 13 GP practices in East London, involving 1207 women over the age of 16 years. The research found that pregnancy within the past 12 months doubled the risk of physical violence, 15% reported violence during their pregnancy; just under 40% reported that violence started whilst they were pregnant, whilst 30% who reported violence during pregnancy also reported they had at sometime suffered a miscarriage as a result.

14.1.18 The panel agreed that the GP and Health Visitor had been pro-active in sharing information and concerns and discussing these with Elizabeth. However, the panel felt that further exploration should have taken place in relation to the comments Elizabeth had made around the 'friction' between herself and John, given that this could have been an indicator of domestic abuse. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 2]

14.1.19 It was noted that the School Staff Nurse inquired about all the children's surname being that of John's. Elizabeth stated that John was the Father to

[28] https://www.bmj.com/content/324/7332/274.short

Hope, Stewart and Leighton; however, this information was untrue. It was not clear as to whether the children's names had been officially changed to John's surname by deed poll. The changing of the children's surname could be considered as an indicator of coercive control.

14.1.20 The School Nurse was allocated a piece of early help work from a SAFER in October 2019. It is now known that the SAFER did not contain the concerns about the domestic abuse between Elizabeth and John.

Tees Esk and Wear Valleys NHS Foundation Trust

14.1.21 In June and July 2018 there were two contacts with John where he disclosed behaviours which would have had an impact on Elizabeth and the children. Elizabeth accompanied John to the appointments. These included an incident which Elizabeth described when she was having a coffee with a friend, John was upstairs and when he came down, he wanted to know what her friend had said on the text. Elizabeth also stated that she was constantly having to reassure John until he 'calms down' and that he constantly checks her texts. The panel recognised that these incidents were indicators of coercive and controlling behaviour. They were not explored further during the consultation. Tees Esk and Wear Valleys NHS Foundation Trust have undertaken work over the last 2 years to assure that clinicians are trained and skilled to respond to indicators of domestic abuse.

14.1.22 Elizabeth had significant and enduring mental health problems which can be an indication of domestic abuse, but there was no evidence this was explored as such during her contact with Mental Health Services.

14.2 Term 2

What knowledge did your agency have that indicated John might be a perpetrator of domestic abuse against Elizabeth and what was the response? Did that knowledge identify any controlling or coercive behaviour by John?

Cleveland Police

14.2.1 The Police held information that John was a perpetrator of domestic abuse against a previous partner. This included a conviction and imprisonment for an assault in 2015. This incident resulted in a referral to MARAC. Due to John's conviction (30 months) the case was archived from MARAC after 12 months. There is now a process whereby the MARAC chair will add an action for a notification for the release from prison of perpetrators. This action is passed to the Domestic Abuse Solutions Team and the case is

then heard at MARAC to establish if the case needs to be re-opened and activated for the prison release date.

14.2.2 As previously stated the Police were not aware of the relationship between Elizabeth and John, which prevented them considering safeguarding measures such as a disclosure to Elizabeth under the Domestic Violence Disclosure Scheme (DVDS)[29].

14.2.3 In December 2015 John was involved in an altercation with his brother. John had been released from prison on licence five days earlier. The victim and witnesses did not co-operate with the Police investigation, John was interviewed and although admitted to being involved in an altercation, he denied causing injuries to his brother and partner. A DASH risk assessment was completed, but not shared as consent had not been provided. A SAFER referral was submitted due to a young child being present in the house (not a subject of this review). The case was closed with no further action being taken.

National Probation Service (Cleveland Area)

14.2.4 The Probation Service had indicators that John was a perpetrator of domestic abuse. This information related to a previous partner. Although John had mentioned to his Offender Manager in early 2016 that Elizabeth had written to him, and visited him in prison, prior to his release in 2015 and that they had had contact upon release, this was understood to be a casual relationship, shortly after which, John was recalled to prison. The Probation Service held no information that the relationship continued after January 2016.

Children's Social Care and Early Help

14.2.5 Children's Social Care were aware that John was a perpetrator of domestic abuse from two other children who had been referred. These incidents were prior to the timescales for this review. There was no evidence that John's Social Care record was reviewed at the point of the information from the school being received in June 2019 or subsequent referrals. The IMR Author from Children's Social Care informed the review, that had the records been considered the outcome at that time would have remained the same and the matter would still have been managed by Early Help.

14.2.6 The SAFER referral from the school in October 2019 did not contain all the information held by the school which including information that could have

[29] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

identified John as a perpetrator of domestic abuse against Elizabeth. [See 14.1.10]. This resulted in the focus on the referral being in response to Stewart's behaviour and educational needs and therefore the domestic abuse was not addressed or shared amongst agencies.

School Inclusion

14.2.7 The school had a disclosure from Stewart that indicated John was a perpetrator of domestic abuse in October. This disclosure was not shared by the school. See Term 1.

14.2.8 The disclosure from Stewart in May in relation to John fighting with his brother was domestic abuse. Professionals accepted Elizabeth's account that the incident had not occurred, and that Stewart had overheard a conversation about a historical event. This incident was not recognised by professionals as domestic abuse. The panel identified learning around the wider definition of domestic abuse amongst family members. [Recommendation 3]

School Nursing and Health Visitor

14.2.9 The Health Visitor was not aware of John's previous conviction for domestic abuse. The indicators of John being a perpetrator of domestic abuse are analysed in Term 1.

Route 2

14.2.10 John had been referred to Route2 in February 2017. The referral was made to address his offending behaviour in relation to his domestic abuse conviction as no work had been undertaken whilst in prison. During an initial meeting, John indicated that his goals were to –

- See his son.
- Learn how not to be aggressive in future relationships.
- Learn how to manage emotion in relationship.

It was agreed that John would complete a minimum of eight sessions. During John's second appointment he carried out the following exercises –

- The Iceberg
- Assertiveness Test
- Relationship timeline

14.2.11 John's third appointment was arranged for 4 April. John did not attend this or subsequent appointments and was discharged from the service. John's licence had ended at this time and there was no legal requirement for him to attend and engage in work to address his offending behaviour.

Tees Esk and Wear Valleys NHS Foundation Trust

14.2.12 John had disclosed his conviction of domestic abuse during contact with the service in June and July 2018. At this time John described an incident when he had confronted Elizabeth and his mum with regards to the whispering, he thought he could hear. Despite John's history of domestic abuse, this behaviour was seen as a symptom of his paranoia, potentially linked to his mental health, and not an indicator of domestic abuse. John also talked about his relationship, and described Elizabeth as being supportive.

14.2.13 The clinician did ask Elizabeth and John if there were any concerns, but the response was no, and this was not explored further. There were no concerns noted regarding safeguarding towards his children. Elizabeth described John as a good Father. John denied any risk to self or others. John was treated as the service user and support/intervention to help with his presenting difficulties were discussed, the review identified that John's overall presentation was not considered within the context of the family, using the 'Think Family' approach which has been promoted across the Trust.

14.2.14 There was no liaison with multi-agency partners during these two contacts, despite it being known that Health Visiting and Maternity services were involved with the family due to Elizabeth being 35 weeks pregnant and there being three children in the family home.

Tees Valley Clinical Commissioning Group

14.2.15 The GP practice were not aware of John's conviction for domestic abuse. This information is not held within medical records.

14.3 Term 3

How did your agency assess the level of risk faced by Elizabeth and her children from John, which risk assessment model did you use and what was your agency's response to the identified at risk?

Cleveland Police

14.3.1 Cleveland Police were not aware of the relationship between Elizabeth and John. Had the Police been aware of any domestic abuse incidents these

would have been assessed using a DASH[30] risk assessment as part of a Public Protection Notice (PPN) and consideration of disclosure by a DVDS.

National Probation Service (Cleveland Area)

14.3.2 A referral was made Children's Social Care in May 2016, but this was in relation to a registered sex offender who was known to Elizabeth. The referral was submitted by the Offender Manager supervising the sex offender and not John. John's name was mentioned within the referral; however, the link was tenuous and in the context of a casual sexual encounter. John was in prison at that time. There was no record of a conversation between the Offender Managers.

14.3.3 Referrals were made to mental health and substance misuse agencies. The Probation Service had no direct contact with Elizabeth or her children.

14.3.4 John had two periods in prison in relation to his conviction for domestic abuse –

- September 2014 – December 2015 (15 months)
- January 2016 – January 2017 (12 months)

When John returned to prison in January 2016 his Offender Manager enquired about his eligibility to undertake a domestic abuse programme. It was agreed that John would be allocated a place on RESOLVE, a programme which responds to non-intimate violence. The RESOLVE team had liaised with the intimate partner violence Treatment Manager prior to placing John on RESOLVE to see if he would be able to access the Healthy Relationship Programme (HRP). It was highlighted that John would not have time to complete HRP or Self Change Programme (SCP), both of which were high intensity programmes at the time, prior to his release.

14.3.5 The review panel were informed that the prison did not deliver Building Better Relationships and therefore RESOLVE was the only option available. John's report from RESOLVE stated that he explored aspects of his relationships during the programme.

14.3.6 Following John's release in January 2017, his Offender Manager progressed finding John a community-based perpetrator programme. John was referred to and accepted on Route2; however, John only attended two sessions, and did not complete the programme. John's licence ended in

[30] Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool. The DASH risk assessment tool was developed by ACPO (Association of Chief Police Officers), Laura Richards, in conjunction with SafeLives, formerly CAADA (Coordinated Action against Domestic Abuse) to create a common tool for both police and non-police agencies when identifying and assessing victims of domestic abuse, stalking and harassment and honour based violence..

March 2017 and there was no legal requirement for him to continue with Route2. The panel felt that the lack of work to address his offending behaviour was a missed opportunity to assess and understand the risk that he posed as a perpetrator of domestic abuse.

Children's Social Care and Early Help

14.3.7 In November 2019 Children's Social Care received a referral from CAMHS. The referral requested for a keyworker to be allocated to the family. The referral was actioned by MACH. Elizabeth did not give her consent for a Child and Family assessment to be completed. For the referral to have been progressed then there would have needed to have been evidence that the children were at risk or were likely to be at risk of significant harm. No further action was taken on the referral.

14.3.8 The panel considered the outcome of this contact and agreed that based on the information known at that time, the decision was appropriate. However, the panel have learnt that there was information known that could have resulted in a different outcome and the case being progressed at a different threshold level had that information been known by Children's Social Care and Early Help. [See 14.1.10]

School Nursing and Health Visiting

14.3.9 The Health Visitor screened for domestic abuse on 17 April 2019. Elizabeth was asked the HARK[31] questions (Humiliation, Afraid, Rape and Kick) and scored zero on answering the four questions. Elizabeth reported she had previously been a victim of domestic abuse in a previous relationship; and reported that this was not a feature of her relationship with John. Elizabeth informed the Health Visitor that she had previously completed the Freedom programme.

14.3.10 The Health Visitor regularly assessed Elizabeth's mood and anxiety in addition to body language, non-verbal and verbal communication, and Elizabeth's physical presentation. The Health Visitor used the Whooley[32] questionnaire to assess maternal mood. The Health Visitor assessed Elizabeth's mental health six times using the Whooley screening tool, Elizabeth denied low mood in all of these assessments. I

[31] HARK assessment tool:
LOINC 76499-3 — Humiliation, Afraid, Rape, and Kick questionnaire [HARK]
[32] Whooley screening tool:
Home | Whooley Questions (ucsf.edu)

14.3.11 The Health Visitor discussed concerns around Elizabeth's low mood in May 2019 following contact from her GP. Elizabeth had been re-started on anti-depressants at this time. [See 14.1 16].

Tees Valley Clinical Commissioning Group

14.3.12 GP's see patients within a 10-minute appointment and do not generally undertake a specific domestic abuse risk assessment. GP's should demonstrate professional curiosity when a patient's presentation indicates where domestic abuse may be a factor. There was no evidence the GP practice assessed the level of risk faced by Elizabeth and her children from John. The Primary Care contacts with the subjects of the review did not identify indicators of domestic abuse.

14.4 Term 4

What services did your agency provide for the subjects of this review; were they timely, proportionate and of an acceptable level in relation to the identified levels of risk?

Children's Social Care and Early Help

14.4.1 Prior to the timescales of this review the focus of the involvement with Elizabeth and her children centred around alcohol misuse, domestic abuse incidents and Elizabeth's poor mental health. The assessments identified the need for support with these issues, and as early as 2014 Elizabeth was referred to the Freedom project, where she attended 7 out of 14 sessions. The case notes from the Freedom project, held limited information and it was unclear what sessions Elizabeth attended and how she participated. Elizabeth was offered and attended Mellow Parenting and Parenting Puzzle.

14.4.2 In July 2015 a strategy meeting was held following an allegation of sexual abuse made by Hope. The perpetrator is not a subject of this review and this incident is outside the timescales of the review. Further concerns were raised over Elizabeth's alcohol misuse. Appropriate services were identified, and Elizabeth attended and engaged with the support offered. It was evident within the records that despite initial positive steps, when circumstances were challenging Elizabeth returned to alcohol use as a coping mechanism. Her partner at that time was reported to be controlling and derogative about Elizabeth. The relationship ended during the assessment and there was limited detail about him within the assessment completed by the social worker. This period of involvement ended in April 2016.

14.4.3 In December 2017 Grace made an allegation of sexual abuse against the same male who had been convicted of sexual abuse of Hope. During this time Elizabeth had supervised contact with the children due to concerns raised by Grace. Whilst the case was being investigated, there were concerns about Elizabeth's alcohol misuse and during a Social Worker visit it was noted that home conditions were messy and untidy, and Elizabeth smelt of alcohol; but was not intoxicated. The concerns raised by Grace were investigated, and it was concluded that Elizabeth could meet the needs of her children and no further action was taken.

14.4.4 Between August 2017 and January 2020 there were two contacts received by MACH that did not result in a referral. The first was from Stewart's school when Stewart told a teacher there had been a fight at home. (June 2019). The MACH Social Worker spoke with the Health Visitor and Elizabeth. There was no evidence that there was any exploration by MACH in relation to John. Information was passed to Early Help to offer support to the family.

14.4.5 The second contact was from CAMHS following Stewart's assessment in November 2019. The contact requested a Keyworker be allocated to the family. This was actioned by MACH, but Elizabeth did not give her consent and no further action was taken. See Term 2 and 3.

School Inclusion

14.4.6 During the timeframe under review Elizabeth's four eldest children attended schools in the local area. The children attended school regularly and their presentations and achievements were good.

14.4.7 In April 2016 during a multi-agency meeting held at school information was shared that Elizabeth had issues with alcohol for which she was receiving support from the relevant services. The children were discussed within pastoral meetings and support was also offered to Elizabeth. There were no safeguarding concerns raised during this time.

14.4.8 In 2017, Grace's school had concerns around her risk- taking behaviour and exploitation; as a result, Grace was referred into VEMT and completed work with Barnardo's. Grace made a disclosure in December 2017 and this was acted upon by the school who submitted a SAFER referral into MACH which resulted in a Section 47 investigation. The concerns on this referral are not related to any of the subjects of this review.

14.4.9 In 2019, the school submitted two SAFER referrals following disclosures from Stewart. Elizabeth and John engaged with the school to address Stewart's behaviour and the school provided nine 1:1 sessions for Stewart with the school learning mentor whilst he was waiting for an appointment

with CAMHS. The school learning mentor completed an Emotional Literacy Support Assessment with Stewart.

School Nursing and Health Visiting Service

14.4.10 Between February 2016 and November 2019 there were 31 direct contacts with one or more of the named family members, 26 of these contacts were with Elizabeth. Most of the contacts took place in the family home. Elizabeth engaged well with the Health Visitor and School Nurse, cancellation of appointments was few.

14.4.11 The Health Visitor provided services as described in the Healthy Child Programme Specification[33]. The contacts were appropriate and timely and based on needs analysis. Whilst the Health Visitor programme does not currently mandate an assessment of Males/Fathers, it would have been useful to explore and understand John's background to enable an assessment of any risk John posed to Elizabeth and her children.

14.4.12 The Health Visitor and School Staff Nurse documentation documented that Elizabeth and John's relationship broke down twice, each time reconciling. Elizabeth offered assurance that this relationship remained "amicable" after they had separated. On 30 May 2019, Elizabeth described "friction" between John and herself. There was no evidence that the Health Visitor explored this, to gain an understanding of the nature of the friction and what was meant by this.

14.4.13 The School Nurse was actively involved at the time of Elizabeth's death, however there had been 3 unsuccessful attempts to contact Elizabeth to review Stewarts behaviour and CAMHS care plan between 26 November and 13 December 2019 and therefore a letter had been sent which stated that the School Staff Nurse would undertake a home visit on 2 January 2020. The panel considered if a 'cold call' should have been undertaken but were assured that the sending of a letter was in accordance with practice, and that 'cold calling' would have taken place had there been any safeguarding concerns.

Tees Esk and Wear Valleys NHS Foundation Trust

14.4.14 The GP referred Stewart to CAMHS in August 2019 due to concerns about poor concentration, impulsivity, and sleep issues. The assessment identified possible social communication difficulties for Stewart and identified that an ADHD screening should be undertaken. Elizabeth

[33] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

reported that Stewart was easily led by peers and had been involved in some incidents including one with knife, flooding of the family home on six occasions and putting paper in the oven to burn. As part of the assessment both Elizabeth and John denied any parental mental health issues. Their previous mental health was not known by the professional undertaking the assessment. Elizabeth and John were informed of waiting times and were advised to engage in CAMHS workshops and early help support as well as Stewart continuing to access his school counsellor.

14.4.15 The CAMHS clinician contacted Children's Social Care to establish the outcome of the SAFER referrals but the practitioner was informed that information could not be shared with anyone other than the referrer. The Clinician contacted the school to seek the outcome and was informed that both SAFER referrals had been allocated to School Nursing Service. The CAMHS clinician submitted a SAFER referral with a request for a keyworker to be allocated to the family. This has been addressed under Term 3.

14.4.16 In 2014, Elizabeth self-referred to Talking Therapy service and was offered a place on the wellbeing course which she accepted but changed her mind due to anxiety levels. Elizabeth was then put on waiting list for 1-1 work which started in Oct 2014. The focus of the sessions were around low mood, anxiety and unhealthy relationship patterns using transactional analysis and Cognitive Behavioural Therapy.

14.4.17 Elizabeth and John's involvement and engagement with mental health services has been detailed in Section 11 and Term 1, 2 and 3.

<u>Tees Valley Clinical Commissioning Group</u>

14.4.18 Elizabeth had frequent contact with the GP practice, mostly in relation to her mental health needs. The care received in regard to her own health was appropriate and timely. There was no evidence or exploration of possible domestic abuse in relation the perpetrator in GP record.

14.4.19 John was seen frequently, there was little evidence to suggest the wider impact of his mental health problems on his family were considered or explored.

14.4.20 The children had few identified health needs requiring the attention of their GP and attended the surgery infrequently, mostly with minor infections. The children were not brought for several planned appointments, most notably for routine immunisations. As a result their immunisations were often delayed and sometimes significantly (by over two years in the case of Stewart).

14.4.21 The CCG has identified learning and made relevant recommendations regarding their primary care contact with the subjects of the review.

14.5 Term 5

In the context of the family arrangements, what consideration did your agency give to any mental health issues or substance misuse in the couples' relationship when identifying, assessing, and managing risks around domestic abuse, including domestic abuse in previous relationships?

National Probation Service (Cleveland Area)

14.5.1 John was assessed as medium risk of harm towards his ex-partner within the pre-sentence report. The IMR Author from Probation determined that a more appropriate risk assessment at that time would have been high risk. After John was released from custody his risk assessment was changed to high risk. As risk assessment is a dynamic process and risk needs re-assessing when circumstances and information change, it was appropriate that after John was released from custody his risk assessment was changed to high risk to his ex-partner in light of him making contact.

14.5.2 Probation staff undertook appropriate prison visits, liaison with prison staff regarding assessments for programmes and following completion of general violence programmes in the prison, as well as with the Victim Liaison Unit and the Public Protection Casework Section regarding licence conditions to protect victims. Probation staff also liaised with partner agencies regarding mental health, substance misuse and regarding specific domestic abuse work for John whilst on licence in the community.

Children's Social Care and Early Help

14.5.3 This has been addressed under Term 1,2,3 and 4.

School Nursing and Health Visitor Service

14.5.4 The Health Visitor was aware of Elizabeth's history of anxiety and there was evidence that the Health Visitor regularly assessed Elizabeth's mental health. Elizabeth reassured the Health Visitor that her anxiety was much improved and stated this was largely due to the support she was receiving from John and her engagement with mental health services. The Health Visitor also asked John and Elizabeth about any substance misuse. During an ante-natal appointment in June 2018, John denied any history of drug use.

14.5.5 Elizabeth and her children received all the Healthy Child Programme mandated assessments, in addition to appropriate visits/contacts to provide extra support.

14.5.6 The School Staff Nurse also directly asked Elizabeth whether Stewart's behaviours could be due to him witnessing any violence in the home, which Elizabeth denied. It is widely recognised that perpetrators of domestic abuse often purposefully limit any contact that the victim has with professionals and may be present to supervise any contact by being present at those contacts. The Health Visitor was spoken to as part of the review and stated that there was no evidence that John's presence was a matter of concern.

Route2

14.5.7 Route2 involvement with John was after a period of imprisonment. At that time he was not believed to be in a current relationship. The IMR Author for Route2 has identified that more investigation could have been carried out around John's relationship status at the time of his engagement with the service to confirm whether or not he was involved with a partner and a more comprehensive recording of that information.

14.5.8 Since May 2018 there has been a new Service Manager and the case management system has been reviewed and procedures put in place to ensure case management and recording is closely scrutinised and monitored on a regular basis. This has been acknowledged by RESPECT and full accreditation awarded in May 2020. The new procedures ensure clear understanding of clients contact with Route2 as well as other agency involvement, and that all this is clearly recorded, and is totally transparent.

Tees Esk Wear Valleys NHS Foundation Trust

14.5.9 Elizabeth and John received significant mental health support as individuals, but this was not considered in the context of the family arrangements. Domestic abuse was known in both of their relationships. This has been addressed in earlier sections of this report.

14.6 Term 6

In the context of the family arrangements, what did your agency do to safeguarding any children exposed to domestic abuse?

14.6.1 As covered in this section there was a lack of knowledge by agencies that the children were exposed to domestic abuse.

14.6.2 School Inclusion raised concerns via the submission of a SAFER referral, the details have been analysed earlier in this section.

14.7 Term 7

How did your agency capture the voice of the children, including their wishes and feelings in relation to their lived experiences? Did your agency experience any barriers in gathering this information?

Cleveland Police

14.7.1 The Police had no knowledge of Elizabeth and John's relationship prior to Elizabeth's death. It was decided due to the extreme distress the children were suffering that they were not to be video interviewed, and the only account captured was a verbal account which was provided by Hope following the discovery of Elizabeth.

Children's Social Care and Early Help

14.7.2 Grace had been reported missing and on five occasions she had a return to home missing interview as per policy. This provided an opportunity for her views and reasons for going missing to be captured. Grace was living with her Father during these events.

14.7.3 The review saw little evidence that the voices of the children were captured by agencies in relation to their lived experiences. This could be attributed by the lack of knowledge that some agencies had of domestic abuse and concerns about the home living conditions and any impact on the children.

14.7.4 There were no barriers identified in relation to engaging with the children and seeking information. It was acknowledged that agencies held information, including recording the voice of the child, throughout their interactions as part of statutory roles such as education and health visiting. None of these incidents identified safeguarding concerns that required further exploration around their lived experiences. The SAFER referrals submitted detailed the current behaviour and educational needs for Stewart.

14.7.5 The panel have been unable to gather further information in relation to the lived experiences of the children. During the homicide investigation a decision was made by the Police that the children would not be spoken to.

14.8 Term 8

What was your agencies' response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?

14.8.1 In May 2020, there was evidence of the voice of the child being clearly recorded in the missing from home interview conducted with Grace. This resulted in some positive change for Grace's personal living arrangements.

14.8.2 As detailed in Term 7 there was a lack of any awareness of the lived experiences of the children. Where concerns were raised these resulted in SAFER referrals being submitted. The response to these has been addressed earlier in Section 14.

14.9 Term 9

Were the victim, perpetrator and children informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

14.9.1 The review has seen evidence that the subjects of this review were informed of the options/choices to make informed decisions and were signposted to other agencies. The review has seen no evidence that services were not accessible. The review has highlighted that Elizabeth and John's engagement with mental health services lacked consistency which resulted in them being referred into services on more than one occasion.

14.10 Term 10

Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

14.10.1 John was referred into MARAC in 2011 following the assault on his Mother. John was also referred in 2014, after the assault against his ex-partner. This case remained live at MARAC for the following 12 months; there were no further incidents as John was in prison. There have been no further cases at MARAC involving Elizabeth and/or John. Details of changes to the MARAC process are detailed at 14.2.1.

14.10.2 In 2010, when John was a juvenile he was heard at MAPPA, however the risk was not deemed high enough risk and he was not accepted for MAPPA management.

14.10.3 John was managed at MAPPA Level 1 during his licence and there were no issues that indicated a referral to MARAC was needed during his licence. Although John sent a Christmas card upon release this would not have been enough for a MARAC referral as there was a Restraining Order which was enforced swiftly with a Final Warning being given the following day. Additionally, there was also an exclusion zone to protect the previous partner as part of his licence conditions which were enforced effectively with John being recalled within 24 days following release. There was management oversight of the case recorded at the point of recall and planning for re-release, as well as countersigning of the risk assessment / sentence plan.

14.10.4 All agencies had in place policies and procedures. The review has highlighted the importance of including males/Father's in assessments and ensuring that Health Visitor's consider DVDS when a victim of domestic abuse enters a new relationship.

14.11 Term 11

How effective was your agency's supervision and management arrangements for practitioners involved with the family? Did managers have effective oversight of the case?

14.11.1 All agencies involved in this review had in place supervision and management arrangements. The review identified no concerns that supervision and management oversight on this case was required.

14.11.2 There has been a review of safeguarding supervision guidance with Redcar and Cleveland Borough Council Health Visitor and School Nursing Service which now includes a trigger step approach to seeking supervision. A trigger is created when a victim of domestic abuse enters a new relationship. See Term 17.

14.12 Term 12

Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies?

14.12.1 The review identified no issues in relation to agencies capacity or resources in providing services to the subjects of this review or on agencies ability to work effectively with other agencies.

14.13 Term 13

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

14.13.1 Section 11 of this report covers matter relating to diversity and therefore will not be repeated here.

14.14 Term 14

Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

14.14.1 The panel were informed that there were several Local Child Safeguarding Practice Reviews currently being undertaken in which the feature of 'unknown males' within a home and relationship were not captured during assessments.

14.14.2 Awareness of domestic abuse within the community has featured in a previous DHR[34]. The panel have made a recommendation within this DHR in response to learning identified. [Recommendation 4]

14.15 Term 15

What knowledge did family, friends and employers have that Elizabeth was in an abusive relationship and did they know what to do with that knowledge?

14.15.1 During the Police investigation information was gathered that family and friends had been aware of the abuse within Elizabeth and John's relationship. On the evening of Elizabeth's death, she had been assaulted by John whilst at a friend's house. The friend had tried to intervene in the incident and in doing so had been assaulted by John. The friend told Police that she felt fearful and intimated during the incident and that John had made direct threats towards her during the attack.

[34] DHR1

14.15.2 One of the children told the Police that they had previously seen John kick one of their siblings. They also described an incident when John had punched and kicked Elizabeth down the stairs as she was holding a baby. During this attack John had pulled chunks of her hair from Elizabeth's head and the child described how Elizabeth's mouth had bled which dripped on the babies clothing. Elizabeth had placed the hair and bloodied clothing into a bag which the child had kept hidden in case her Mother ever went to the Police to report the assault. This evidence was seized by the Police during the homicide investigation.

14.15.3 The Chair was informed by Elizabeth's Mother that she was aware of John's previous convictions and history of violence, which she had discussed with Elizabeth; however, Elizabeth had told her that John had changed and that he was no longer like that. Elizabeth's Mother had been told about the assault on Elizabeth whilst she was holding a baby by one of her Grandchildren and that she had spoken to Elizabeth about the matter, which Elizabeth had denied. The Chair was informed by family, that after this incident John left the home for about a month, which was the longest period he had been out of the house. Elizabeth's Mother recalled another incident when she had been trying for several days to contact her via telephone, before eventually going to the house and finding Elizabeth with a scarf around her neck which was covering grip marks. John had been upstairs at the time and Elizabeth would not talk about how the marks had been caused. Elizabeth begged her Mother not to report the abuse to the Police for fear that her children would be taken from her.

14.15.4 Elizabeth's Mother said that John was controlling and described incidents whereby Elizabeth was not allowed to go to the shops unless she had one of the children with her and that whilst out of the house, she was not allowed to see or talk to anyone. Other examples included John demanding that all the children called him 'Dad' and Elizabeth not having as much contact with her Mother as she had done previously. The Chair was informed by family, that John would always want money so that he could buy alcohol and drugs and had even spoken to Elizabeth about growing cannabis in the loft at their home. Issues over finances had often caused arguments and Elizabeth's Mother had tried to help financially when she could. Elizabeth's Mother stated that she had always visited the family home on Christmas Day to watch the children open their Christmas presents, but that in 2019, for the first time John had said she could not go. Elizabeth's Mother told the Chair that on the night of her daughters' death, Elizabeth had been at a party at a friend's house, and throughout the day she had suffered repeated assaults by John over the course of

several hours. These attacks occurred in the presence of friends, none of whom contacted the Police, or tried to intervene.

14.15.5 The panel heard other evidence from friends who had informed the Police that Elizabeth's behaviour changed after she met John, whom they described as being controlling over Elizabeth. Neighbours described how as a couple they no longer socialised, and that John had built a 6' fence between properties so Elizabeth could no longer chat over the fence. Neighbours described how Elizabeth was a different person when she was not in the presence of John. One friend described seeing Elizabeth with clumps of hair missing as a result of her being assaulted by John.

14.15.6 The review established that family, friends, and the community were apprehensive about intervening or reporting matters due to fear or reprisals from John. This knowledge included that John had previously been violent towards family members and that he had been to prison due to convictions of violence.

14.15.7 The panel reflected on the information that was known by family, friends, and the community, which contrasted with the knowledge of professionals. The panel agreed that the information highlighted that the domestic abuse was known, but the fear of violence and potential repercussions prevented that information being shared with professionals.

14.15.8 The panel were aware that a range of national organisations such as Crimestoppers[35] provide a platform for anyone to raise concerns about domestic abuse, and that those concerns can be made anonymously. In addition, charities also provide information on reporting concerns for someone who is believed to be suffering domestic abuse.

14.15.9 The panel determined that information needed to be available within Redcar and Cleveland on how and when concerns can be raised, and what happens, including any information that is shared with the subjects of those concerned to be at risk or perpetrating abuse. The panel have identified this an area of learning and made a relevant recommendation. [Recommendation 4].

14.16 Term 16

Were there any examples of outstanding or innovative practice?

[35] https://crimestoppers-uk.org/keeping-safe/personal-safety/domestic-abuse

14.16.1 The panel did not identify any examples of outstanding or innovative practice on this case.

14.16.2 The panel acknowledged that contact with the subjects were timely and in accordance with policies and procedures in place. This included the submission of SAFER referrals by the school and engagement with external agencies. There was evidence of Health Visitors undertaking assessments of maternal health using an evidenced based tool kit and the school Nurse considering whether Stewart's behaviour could be linked to exposure of domestic abuse in the home.

14.16.3 A creche was provided for Stewart whilst Elizabeth attended the Freedom programme which alleviated the childcare barrier and provided an opportunity for staff to record observations on how Stewart presented in creche and his child development. This also provided an opportunity for Stewart to experience separation from Elizabeth in preparation for attendance at nursery.

14.17 Term 17

What learning did your agency identify in this case.

14.17.1 National Probation Service – Cleveland Area

Referrals to Children's Social Care where domestic abuse perpetrators are having contact with children.

14.17.2 Redcar & Cleveland Borough Council – Children's Social Care

Ensuring that a review of information held on individuals is undertaken in all instances . This should be standard good practice that any information held regarding an individual living with the family is considered as part of decision making.

14.17.3 Redcar & Cleveland Borough Council – Early Help

- Referral documentation and recording for Parenting and Freedom programmes. Including case notes on attendance and behavioural change.
- Robust supervision arrangements for Parenting and Freedom programme.
- MARAC attendance for Freedom programme facilitators.

14.17.4 Redcar & Cleveland Borough Council – School Inclusion

Sharing of SAFER referrals when siblings attend different education establishments.

14.17.5 Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service

- Gathering of information of new partner's, including access to children.
- Exploring parental relationships, especially at time of break ups and reconciliation.
- Seeing clients alone to facilitate opportunity to screen for domestic abuse.
- Supervision on cases where domestic abuse known.
- Awareness and application of DVDS.

14.17.6 Route 2

Recording in case management notes. Since May 2018 this has been addressed with scrutiny and monitoring by the Service Manager. The new procedures ensure clear understanding of clients contact with Route2 as well as other agency involvement, and that all this is clearly recorded, and is totally transparent.

14.17.7 Tees Valley Clinical Commissioning Group

- To increase professional curiosity and make further enquires/support for potential domestic abuse victims to disclose and accept help.
- Implementing standardised procedures such as managing 'child not brought'.
- Embedding the 'Think Family' approach as standard practice – recognising the potential impact on family members.
- Link family members in the clinical records system.

14.17.8 Tees Esk and Wear Valleys NHS Foundation Trust

The need to ensure that 'Think Family' is considered at all available opportunities and that domestic abuse is identified and responded to appropriately. The Trust has undertaken work over the last 2 years with most remaining part of ongoing processes to assure that clinicians are trained and skilled to respond to indicators of domestic abuse to reduce risk to all impacted by this. This includes:

- Widespread domestic abuse training to services.
- Ongoing domestic abuse and 'Think Family' principles part of mandatory children and adult safeguarding training.

- The Trust has 2 full time MARAC advisor posts that are fully embedded in the MARAC process across all localities. This includes advice and support for TEWV staff and specialist safeguarding supervision for cases that require this. In addition, the roles support the 'Think Family' approach.
- Domestic abuse procedure has been reviewed and circulated.
- Promotion of 'Think Family' approach.
- Project to develop and implement an electronic recording system called CITO which will streamline safeguarding processes to support identification and ensure action taken when risks identified.

The learning from this review will be used to support the implementation of the ongoing actions.

15. CONCLUSIONS

15.1 It was difficult for the review panel to understand what a typical day in the life of Elizabeth and her children looked like. Whilst some agencies were aware that Elizabeth and John were in a relationship, those agencies were not aware that John was a perpetrator of domestic abuse.

15.2 Elizabeth had been a victim of domestic abuse from previous relationships. At times of significant stress Elizabeth used alcohol as a coping strategy. This along with her mental health and poor home conditions resulted in contact with agencies. When Elizabeth recognised that she needed support, particularly in relation to her mental health, there was evidence that she sought support and was referred into services.

15.3 John was a known perpetrator of domestic abuse. Despite serving a prison sentence and time in the community on licence he did not complete any programme to address his domestic abuse offending.

15.4 Elizabeth and John had been in a relationship for two years, prior to Elizabeth's death. John was the Father of Elizabeth's two younger children. The Police and the National Probation Service were not aware of the relationship and therefore did not have an opportunity to provide Elizabeth with disclosure in relation to the risk that John posed.

15.5 The agencies who did know of the relationship, had some information of concerns that indicated domestic abuse. Professionals were reassured by Elizabeth's explanations which on reflection minimised any concerns of domestic abuse and did not seek to gather further information on John to inform those concerns.

15.6 Elizabeth's family, friends and community were aware of the abuse, but did not report this to professionals for fear of reprisals from John and a belief that the children would be removed from Elizabeth's care. This knowledge included information that Elizabeth was a victim of coercive and controlling behaviour. The panel recognised that raising awareness amongst the community needed to be broader than awareness raising on domestic abuse, with a need for a focus on providing information as to how agencies respond to concerns, and what can be expected from agencies when concerns have been raised. This also needed to address the sharing of the information to the victim and perpetrator.

15.7 There was a reoccurring theme within this domestic homicide review in relation to the accuracy of recording when safeguarding concerns were

raised and professionals utilising their 'professional curiosity' and seeking clarification as opposed to the acceptance of assurances at face value.

15.8 Elizabeth's family contributed to the review and provided information that helped the review panel understand the barriers that are faced by families, friends, and the community in reporting incidents of domestic abuse. The report was seen by Elizabeth's family and the review panel wished to express their appreciation of the contribution that the family made to the review.

16. LEARNING IDENTIFIED

16.1 Agencies Learning (taken directly from their IMRs)

16.1.1 Agency learning has been captured under Term 17.

16.2 The Domestic Homicide Review Panel's Learning (Arising from DHR panel discussions)

16.2.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at Term 17. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Information was held within agency records that identified concerns and evidence of domestic abuse. The full content of this information, including the voice of the child and detailed disclosures was not shared during SAFER referrals and amongst professionals which resulted in the information not being considered during multi-agency discussions around threshold and case allocation.
Learning
Information sharing between agencies must contain explicit language, including the exact disclosure, and voice of the child.

Learning 2 [Panel recommendation 2]
Narrative
Information was disclosed to professionals which identified safeguarding concerns, including domestic abuse, within the relationship and the home environment. When this was raised by professionals, reassurances were given that the information had been misinterpreted and that there were no risks or safeguarding concerns. This view was accepted by professionals, without challenge or further clarification.
Learning
Whilst engagement with families is a fundamental element of establishing a working relationship, professionals need to ensure they are proactive in verify information that has been provided and that they adopt a 'trust but verify' approach when working with families. This includes the accurate recording and verifying of all household members and significant others within a relationship.

Learning 3 [Panel recommendation 3]
Narrative
There were incidents of violence occurring within the wider family that were reported to Professionals. These incidents occurred in the presence of children and were not routinely recognised as domestic abuse. The outcome was that referrals were not made, which prevented information being shared with other Professionals involved in the case.
Learning
The awareness and implementation of the wider definition of domestic abuse, to include 'other family members' will ensure that information is shared, and professionals are aware of the family dynamics and risks that are present within households.

Learning 4 [Panel recommendation 4]
Narrative
People outside the household were aware of domestic abuse and coercive and controlling behaviour. These concerns were not reported due to fear of violence and reprisals, including the belief that children in the household would be removed from the home. This finding is consistent with many other DHRs and Redcar DHR1.
Learning
The panel felt that this illustrated a cultural acceptance of domestic abuse within some neighbourhoods of Redcar and Cleveland and that action was required to address the cultural issue. This may need to go beyond publicity as Redcar and Cleveland Community Safety Partnership already conducts extensive publicity around domestic abuse and should be within the domestic abuse strategy that is a requirement within the Domestic Abuse Act 2021.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that accurate information, including exact details of disclosures and the voice of the child are being shared between agencies where safeguarding concerns are known.
2	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are adopting a 'trust but verify' approach when working with families, which includes the accurate recording and verification of all household members and significant others to inform assessment and risk planning.
3	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are aware of the full extent of the definition of domestic abuse, in terms of 'family members' and are implementing safeguarding policies where incidents of domestic abuse are known.
4	That Redcar and Cleveland Community Safety Partnership's Domestic Abuse Strategy details how it will respond to the cultural acceptance of domestic abuse and improve the confidence of victims and witnesses to report abuse.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[36]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;

[36] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of Children's to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review. It does not contain a chronological list of all medical, midwifery, health visiting, and GP appointments attended or missed by the subjects of the review.

Events Table	
Date	**Event – Pre – Terms of Reference**
2005-2006	John known to CAMHS. Diagnosed with conduct disorder. Poor engagement.
05.03.08	Elizabeth recorded as carer for brother.
28.08.09	John sentenced to Community Punishment Order for breach of Anti Social Behaviour Order (ASBO). All Community hours completed
26.10.09	John sentenced for breach of licence, assault, criminal damage. Sentenced to Community Punishment and Rehabilitation Order for 18 months.
2010	John referred by GP to Mental Health Services. Numerous incidents of anti-social behaviour and subject to ASBO which he breached on several occasions. Threatening behaviour towards his siblings and elderly grandparents.
26.09.10	John arrested for assault on Mother and criminal damage.
07.10.10	John's medication stopped as he did not attend drugs and alcohol or psychiatric appointments.
12.10.10	John sentenced to 18 weeks custody for criminal damage, Section 39 assault. Issued with restraining order.
08.02.11	John arrested for witness intimidation, breach of bail and breach of restraining order
08.04.11	John sentenced to 18 months imprisonment for criminal damage, witness intimidation, breach of restraining order.
03.12.13	Police attended domestic incident between Elizabeth and partner.
05.02.14	John did not attend mental health review.
15.03.14	Police attended domestic incident between Elizabeth and partner. Referral made to Early Help.
29.04.14	Specialist nurse practitioner saw Elizabeth. Liaised with Sure Start and referred her to the Freedom course.
12.05.14 – 27.02.15	Elizabeth self-referred to Mental Health Services.
18.06.14	Referral to Early Help after Stewart found in street.
31.07.14	Referral to Children's Social Care regarding Elizabeth's care of children. Child and Family Assessment to be completed.
21.08.14	Elizabeth invited to attend 12-week Mellow parenting course.
05.09.14	Child and Family Assessment completed – no further action.
13.09.14	John seen at hospital emergency department and referred to Home Based Treatment Team.

15.09.14	Police attended incident at Elizabeth's home with partner.
19.09.14	School raised concerns to Children's Social Care.
21.09.14	John arrested for assault on partner.
24.09.14	Elizabeth seen by GP. Reported injunction in place against ex-partner.
12.11.14	Child and Family Assessment completed – case to remain open as Child in Need.
20.01.15	John sentenced to 30 months imprisonment for offence of wounding against partner.
22.01.15	Case closed to Children's Social Care.
03.02.15	Elizabeth seen at hospital after accidental overdose of paracetamol.
03.02.15	John screened for Personality Disorder.
15.05.15	Contact to Children's Social Care regarding risk to children.
13.07.15	Referral to Children's Social Care regarding risk to children. Child and Family Assessment completed, and support offered on a Child in Need basis.
04.08.15	Home Detention Curfew paperwork completed for John.
27.08.15 – 28.08.15	Elizabeth presented to assessment suite of Mental Health Services. Presented with low mood and anxiety. Discharged to care of GP. Information passed to Children's Social Worker.
28.08.15	Elizabeth seen at home by Crisis Team. Contact with Social Worker. Discharged back to care of GP.
16.10.15	Elizabeth contacted Lifeline. Referred for mental health assessment.
20.11.15	Elizabeth referred to a 4-week parenting puzzle course.
	Events within Terms of Reference
21.12.15	Elizabeth seen by GP. Referred to Mental Health Team.
21.12.15	John released from Prison.
22.12.15	John issued with 1st warning letter for breach of licence.
23.12.15	OASys risk assessment. John assessed as high risk to ex-partner.
26.12.15	Police attended incident between John and brother.
28.12.15	Police received call that John out drinking. Information logged.
07.01.16	John told Offender Manager of contact with Elizabeth.
12.01.16	Recall to custody initiated for John.
13.01.16	Elizabeth did not attend initial assessment appointment with Mental Health Services. Discharged back to GP.
14.01.16	John recalled to prison.
27.01.16	Correspondence between Treatment Programme in HMP Holme House and Offender Manager regarding RESOLVE.
28.01.16	OASys risk assessment. John assessed as high risk to known Adult and medium risk to children.
10.02.16	Specialist Nurse Practitioner contacted Social Worker regarding Elizabeth's alcohol consumption.
03.03.16	Stewart referred for assessment of behaviours.
04.03.16	Elizabeth seen by GP regarding anxiety. Referred to Mental Health Team.
25.03.16	Social Worker spoke to Elizabeth regarding incident with Stewart.

31.03.16	Elizabeth cancelled appointment with Mental Health Team.
05.04.16	Elizabeth cancelled appointment with Mental Health Team.
15.04.16	Elizabeth attended initial assessment with Mental Health Team.
19.04.16	Child in need review meeting. Case closed with support to be offered by community engagement and Sure Start.
26.04.16	John started RESOLVE.
06.05.16	Elizabeth did not attend appointment with Mental Health Team.
11.05.16	Elizabeth seen by Mental Health Team.
01.06.16	Children's Social Care contact with Elizabeth regarding risk to children.
20.06.16	Elizabeth cancelled appointment with Mental Health Team.
20.06.16	John completed RESOLVE.
12.07.16	Recorded that John to complete alcohol awareness course.
25.07.16	Elizabeth did not attend appointment with Mental Health Team. Discharged from service.
23.08.16	John's licence exclusion zone increased to protect previous partner.
04.10.16	Offender Manager received contact from DART.
17.10.16	Elizabeth moved to accommodation provided by Thirteen Group Housing Ltd.
18.01.17	Referral to Harbour for perpetrator work to be undertaken with John. Declined.
26.01.17	John released from Prison.
30.01.17	SARA assessment completed.
31.01.17	John referred to Mental Health Team.
31.01.17	Contact received by Children's Social Care regarding John's contact with child.
05.02.17	John seen in hospital with head injury.
07.02.17	John attended employment training and education appointment.
09.02.17	John seen by Mental Health Team.
23.02.17	John referred to Route2.
27.06.17	Children's Social Care received referral for Grace.
14.07.17	School contacted Social Worker.
14.10.17	Police received complaint of serious crime from Elizabeth.
23.11.17	Grace reported missing.
28.11.17	VEMT referral submitted for Grace.
07.12.17	Grace reported missing.
13.12.17	John seen by GP. Reported increased anxiety.
21.12.17	Grace reported missing.
22.12.17	School made Safer referral to Children's Social Care.
27.12.17	Report of serious crime from Grace.
29.12.17	John seen by GP with anxiety and increased paranoid thoughts.
02.01.18	John referred to Mental Health Team.
05.01.18	Grace reported missing from home.
17.01.18	Grace reported missing from home.
05.02.18	John did not attend appointment with Mental Health Team. Discharged back to GP.
23.02.18	John seen by GP for anxiety. Elizabeth present.

24.02.18	Elizabeth attended hospital after possible overdose of paracetamol.
21.03.18 – 07.04.18	Grace reported missing from home x 3.
13.04.18	Grace referred to Early Help. Keyworker allocated. Case closed Aug 2018.
23.04.18	John did not attend appointment with Mental Health Team.
15.06.18	John attended assessment with Mental Health Team.
09.07.18	John did not attend appointment with Mental Health Team.
19.07.18	John attended appointment with Mental Health Team.
07.03.19	Elizabeth informed school that she was no longer in relationship with John.
11.03.19	John seen by GP. Elizabeth present.
03.04.19	Stewart seen by GP with sleep disturbance and behavioural problems.
20.05.19	School made Safer referral to Children's Social Care.
23.05.19	Elizabeth seen by GP regarding post-natal depression.
30.05.19	Health Visitor conducted home visit. Elizabeth reported John had left the home for a few days after friction.
05.06.19	Children's Social Care received referral from school regarding incident in family home.
26.06.19	Health Visitor conducted home visit. Discussed recent referral.
19.08.19	Elizabeth self-referred to Mental Health Team.
21.08.19	GP received letter from Alliance Psychological Services Ltd that Elizabeth attended counselling session – low mood and anxiety around relationship breakdown.
22.08.19	John attended Consultant appointment at the Neurology department following a referral from his GP.
23.10.19	School submitted Safer referral. Progressed to Early Help.
7.11.19	School received email from Early Help Co-ordinator to undertaken work at Level 2 with Stewart.
8.11.19	Elizabeth informed School Nurse that she had separated from John 3 weeks ago.
14.11.19	GP received letter from Alliance Psychological Services Ltd stating that they have been unable to contact Elizabeth for reassessment and she had been discharged.
15.11.19	Stewart attended assessment at CAMHS. Elizabeth and John present.
18.11.19	Children's Social Care received referral from CAMHS.
18.11.19	Stewart placed on waiting list for ADHD assessment.
26.11.19 – 13.12.19	Three unsuccessful attempts to speak to Elizabeth about Stewarts behaviour and support needs.
27.11.19	GP received assessment report from CAMHS regarding Stewart.
30.12.19	Police received report that 16 year old female had been approached by male. Recorded that male believed to be John, but not identified. Caller wanted incident logging.
31.12.19	Elizabeth found deceased. John arrested by Police. Charles and Harmony placed in care of paternal Grandmother. Hope, Leighton

	and Stewart placed in care of family friend. Grace in care of Father.
2.01.20	Charles and Harmony placed in emergency placement. Strategy meeting and legal meeting held. Decision to issue care proceedings.

Appendix D

Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that accurate information, including exact details of disclosures and the voice of the child are being shared between agencies where safeguarding concerns are known.	Local	RC CSP task the newly formed DAP to commit to improving awareness and practice across the partnership	RC Domestic Abuse Partnership	DAP conducts an audit or partner agency to confirm that suitable and sufficient training, awareness& instruction has been carried out with all front line staff to ensure understanding and compliance DAP conducts an audit of partner agencies to ensure that robust supervision of front line staff encourages/challenges information sharing of disclosures	July 2022	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					DA Strategic Lead presents findings of audits back to RC CSP		
2	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are adopting a 'trust but verify' approach when working with families, which includes the accurate recording and verification of all household members and significant others to inform assessment and risk planning.	Local	RC CSP task the newly formed DAP to commit to improving awareness and practice across the partnership	RC Domestic Abuse Partnership	DAP conducts an audit or partner agency to confirm that suitable and sufficient training, awareness& instruction has been carried out with all front line staff to ensure understanding and compliance DAP conducts an audit of partner agencies to ensure that robusts supervision of front line staff encourages & challenges information sharing of disclosures DAP Strategic Lead presents findings of audits back to RC CSP	July 2022	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are aware of the full extent of the definition of domestic abuse, in terms of 'family members' and are implementing safeguarding policies where incidents of domestic abuse are known.	Local	RC CSP task the newly formed DAP to commit to improving awareness and practice across the partnership	RC Domestic Abuse Partnership	DAP conducts an audit or partner agency to confirm that suitable and sufficient training, awareness& instruction has been carried out with all front line staff to ensure understanding and compliance DAP conducts an audit of partner agencies to ensure that robust supervision of front line staff encourages/challenges information sharing of disclosures DAP Strategic Lead presents findings of audits back to RC CSP	July 2022	
4	That Redcar and Cleveland Community	Local	RC DA Lead to complete	RCBC	Draft Strategy consultation	30 November 21	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	Safety Partnership's Domestic Abuse Strategy details how it will respond to the cultural acceptance of domestic abuse and improve the confidence of victims and witnesses to report abuse.		DA Strategy inclusive of commitment to challenging cultural acceptance and improve community awareness to improve reporting.		Finalise & launch Strategy All partner agencies to be working to new DA Strategy	January 2022 June 2022	

National Probation Service – Cleveland Area						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	NPS Cleveland to take part in the roll out of pilot work on polygraph testing for Domestic Abuse cases when Covid restrictions allow.	Polygraph testing for Domestic Abuse offenders	This has been delayed somewhat by Covid but staff briefings about the new polygraph for Domestic Abuse are starting May 2021	To assist Offender Managers with risk management plans for Domestic Abuse offenders	Ann Powell	**3 year Pilot started in May'21 and ongoing**

National Probation Service – Cleveland Area						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
2	NPS to encourage Offender Managers to use professional curiosity and always liaise with each other when there is a link between Service Users and to undertake joint risk management plans and ensure that these are recorded accordingly.	Briefings, workshops and reminders to be provided reminding colleagues of the importance of Liaison between Offender Managers. Joint risk management plans	First quarter of 2021 - Quality Development Officers have completed professional development workshops with NPS staff including on the theme of professional curiosity May 2021 - Written briefings about professional curiosity shared with staff as back up to training – for discussion in team meetings	To ensure joint risk management plans when there are links between offenders and that the liaison between Offender Managers is recorded accordingly.	Ann Powell	Immediately and ongoing
3	NPS to encourage Offender Managers to use an investigative approach and to make relevant safeguarding referrals following home	Briefings, workshops and reminders to be provided reminding		Offender Managers to make safeguarding referrals following home visits or whenever there is information of children attending a house where a	Ann Powell	Immediately and ongoing

National Probation Service – Cleveland Area						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	visits or whenever there is information of children attending a house where a domestic abuse perpetrator resides.	Offender Managers to make safeguarding checks and / or referrals whenever there is information of children attending a house where a domestic abuse perpetrator resides.		domestic abuse perpetrator resides		

Redcar & Cleveland Borough Council - Children's Social Care						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	LCS must be reviewed for all adults detailed in referrals	MACH to detail within outcome of contact/ referral that information	Evidence of consideration to the information held by social care in all outcomes for referrals		D Harrison	With immediate effect.

Redcar & Cleveland Borough Council - Children's Social Care						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		held by the service has been reviewed and considered				

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Clear referral form for Freedom and single route for referrals all documented through the children's services system	Discussion to be held with MACH Manager about routing all Freedom referrals through the front door Exploration of using existing Family Hubs, Early Help or SAFER referral form	All referrals are made using the Families Together referral form. This referral form is in the signs of safety format and asks for detailed evidence of past harm and current risk. Referrals are made to the Families Together Email which are screened by Cath	There is a clear audit trail within the children's services system to demonstrate who referred, who screened the referral and what the outcome of the referral was. This will also aid future decision making should further referrals be received about the children in the family. This is now achieved. Julie Topley has now left the service so approved referrals now go direct to the Programme facilitator	Cath Prest/Julie Topley (Project Development Officer) Cath Prest/Julie Topley	28.02.21 21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		for Freedom referrals and decision about a single referral form and how it will be processed through the EHM system	Prest to ensure there has been an EHM or C&F Assessment. Cath also requests the referrer complete additional information if past harm is not detailed enough. Appropriate referrals are authorised and sent on to the Julie Topley for allocation to a Freedom Programme Facilitator. All referral forms are uploaded into the documents folder on protocol (if Social Care referral) or EHM (if Early Help referral)	to arrange planning meeting and home visit. The referrer is responsible for uploading the referral to Protocol/EHM		21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			There is now a clear evidence trail of referrals being received, screened, authorised, allocated and uploaded to the child's electronic file.	The Freedom Programme Facilitator ensures that a planning meeting takes place with referrer. The planning meeting is uploaded onto the child's electronic file	Freedom Programme Facilitator (Mandy Knights/Sue Porter or Ali Hatfield	21/10/21
2	All referrals for Freedom to be supported by an EHA or CIN Assessment so facilitators understand the whole family's needs	The Parenting Coordinator to reject any referrals without an EHA or CIN/CP assessment and encourage referrers to complete an EHA so the family's	All referrals are screened by Cath Prest (Resource Team Manager). If referral is not supported by an EHA or C&F Assessment they are not authorised for Freedom Programme provided by Cath's service. In these cases the referrer is signposted to	All women who attend the Freedom course have a whole family lead practitioner who is coordinating their plan and has worked with them to set goals and desired behavioural changes	Cath Prest (Resource Team Manager)	28.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		needs are understood, prior to determining if Freedom is the right provision for them	independent organisations who will accept referrals from other agencies, or self-referrals. Once the allocated worker is assigned a family they will make contact with the referrer to arrange a planning meeting. Referral form is checked and updated if necessary and desired outcomes are agreed as part of the Families Together Plan. This plan is also uploaded onto the child's electronic file (Protocol or EHM)	The Freedom Programme Facilitator ensures that a planning meeting takes place with referrer. The planning meeting is uploaded onto the child's electronic file.	Freedom Programme Facilitator (Mandy Knights/Sue Porter or Ali Hatfield	21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
3	Evidence of the past harm to predict future risk to be evident at point of referral	Use of Harm Matrix as part of referral and decision making on screening it	We have been unable to implement the Harm Matrix as part of the referral form as this is a barrier to many referrers. However, Cath Prest screens all referrals, ensuring that there is clear evidence of past harm detailed in the referral form. Referral Forms are returned for additional information if past harm is not evident. At allocation the referral form is sent to the Freedom Programme Facilitator so that	A more robust assessment of risk is in place for all women attending Freedom. Women and children are kept safe from harm.	Cath Prest/Julie Topley	28.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			she has all information relating to past harm. Following allocation a planning meeting is held between the referrer and the Freedom Programme Facilitator. The information on referral is checked and there is a plan produced with clear outcomes which is uploaded onto the child's electronic file.			
4	Ensure robust information sharing between facilitators and the lead practitioner (Social Worker or Early Help worker)	Joint supervision to be explored between Freedom	It has not been possible to implement joint supervision between the referrer and the	The Lead practitioner has more meaningful relationships with victims and the freedom facilitator, to ensure a shared approach to	Julie Topley Rachel Paterson Jayne Bulmer	15.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		facilitator and the lead practitioner. Routine recording of case notes by facilitators on either EHM or LCS but not limited to simply noting attendance or otherwise.	facilitator due to time constraints. However, we have developed a new recording template for each session of the freedom Programme (sample template attached). This recording template has been streamlined across the Freedom Programme delivery and includes a reflective analysis during debrief sessions. De-brief sessions are held between Julie Topley and the Freedom Programme facilitators in the	achieving outcomes and goals	Debbie Harrison Julie Topley/Freedom Programme facilitators Julie Topley/Freedom Programme facilitators	15.02.21 15/02/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			form of a group supervision and discussion. After every session of Freedom Programme the facilitator completes a detailed analysis of engagement, risk and highlights any areas of concern (as per attached template). These are uploaded to the child's electronic file within 7 days. This generates an alert for the referrer inviting them to read the recording and use in their ongoing assessment and		Freedom Programme Facilitator (Mandy Knights/Sue Porter or Ali Hatfield)	21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			interventions with the family. If immediate concerns are identified the Freedom Programme Facilitator will contact the referrer the same day. If not available, the team manager will be contacted to discuss and share information.			
5	Facilitator to develop a safety network and safety plan for children with the women attending the programme in conjunction with the Lead Practitioner	Freedom Facilitators work more closely with the lead practitioner and family in developing the safety plan, e.g. by	At the planning meeting between the referrer and the facilitator safety plans are discussed and agreed. The referrer may also arrange a Family Network Meeting	A more robust plan for managing risk within the family is evident and understood by all involved including the Freedom Facilitator. Women and children are kept safe from harm.	Julie Topley Jayne Bulmer Debbie Harrison Rachel Paterson	15.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		attending the Family Network meeting	to agree a safety plan with the family and identify support from wider family and friends. Once the planning meeting has been held the facilitator will contact the woman referred to discuss the Families Together plan and objectives. They will advise and support the woman to attend (virtually at present) ensuring she is attending from a place of safety and confidentiality and has access to the			

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			internet and Teams.			
6	Group supervision to be embedded in the Freedom Programme	Start using group supervision within the Freedom programme and record this on EHM/LCS.	The new recording template has been streamlined across the Freedom Programme delivery and includes a reflective analysis of risk, concerns and progress and these are further discussed with facilitators during debrief sessions. Group supervisions are held every 3 months with all Facilitators, chaired by Julie Topley. These are recorded under the Signs of Safety Group supervision log and via survey	More robust management oversight is evident of the Freedom programme and women's cases	Cath Prest Julie Topley	28.02.21 15.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			monkey specific to group supervision. Any concerns highlighted in group supervision will be shared with the referrer.			
7	Programme Coordinator for Freedom to sit on and report to MARAC	Programme Coordinator to be invited to MARAC	Cath Prest has emailed the MARAC coordinator requesting inclusion in the meetings. Following attendance Cath Prest will feedback to Freedom Programme facilitators any concerns or changes in risk for them to take appropriate action to address this.	Regular information sharing takes place with MARAC as appropriate and women are flagged on appropriate systems	MARAC Chair Julie Topley	

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
8	Domestic abuse training for all staff	Team managers to ensure all staff have up to date Domestic abuse training	Tracey Hill has met Louise Walker to discuss a training strategy for improving capacity and quality of provision.	All staff at early help and social care level are able to recognise and respond appropriately to signs of domestic abuse	Louise Walker Cath Prest Tracey Hill	30.06.21

Redcar & Cleveland Borough Council – School Inclusion						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Schools should consider sharing the decision to submit a SAFER referral to schools of siblings.	To promote schools to consider sharing the decision to submit a SAFER referral to schools of siblings.	Referral training workshops	Improve information sharing to further develop a culture of vigilance to safeguard children and young people.	June Craven	15/07/21 Ongoing throughout future training workshops

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	To revise the safeguarding supervision practice guidance to include trigger points to seek supervision	Safeguarding Lead to revise the supervision guidelines to incorporate trigger points whereby staff are expected to seek supervision		When a victim of domestic abuse enters a new relationship safeguarding supervision will occur to determine assessment and analysis of new relationship. When a staff member is having difficulty screening for DA, safeguarding supervision will be sought to determine next steps and analyse any risk factors.	Safeguarding Lead Nurse	End of Jan 2021
2	That all health visiting and school nursing staff utilise every opportunity to screen for domestic violence. Claire's Law Disclosures are utilised when necessary, information is sought routinely regarding significant males in the child's life and all staff	The Safeguarding Lead Nurse will develop a new practice guidance on how staff work with families where there is a history of		There will be a significant increase in the screening for domestic abuse and rescreening will take place routinely. Staff will use a written screening tool where necessary and when staff have difficulty completing DA screening they will seek safeguarding	Safeguarding Lead Nurse	End of Jan 2021

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	utilise every opportunity to explore parental/caregiver's relationships.	violence, this will include standardising when/if to apply for Claire's Law Disclosures; assessment of males, when and how to screen for domestic abuse and when and how to explore adult relationships.		supervision and also explore other means to see the individual on their own. Staff will gather more information about significant males which in turn will enable an effective risk analysis. Staff will routinely explore adult relationships in the hope that any indictors of domestic abuse are exposed.		
3	All staff will be familiar with the national learnings from safeguarding practice reviews where domestic abuse was a feature	Domestic Abuse prompt sheet will be printed and laminated to A5 diary size. It will act as an aide		Staff learn from safeguarding practice review recommendations	Safeguarding Lead Nurse	End of Jan 2021

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		memoire for all staff in how to recognise and assess domestic violence				
4	All of the Health Visiting and School Nursing workforce are aware of the new and revised practice guidance and that assurance is gained that the guidance is being followed.	Mandatory training will be provided to all staff inclusive of students. This training will be based on learnings from this and other recent safeguarding practice reviews in addition to introducing the new practice guidance. It will also form	Dates have been published for staff to book on to training throughout Feb 2021	That all staff follow the new and revised practice guidance	Safeguarding Lead Nurse	March 2021

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		part of the safeguarding induction of new staff. There will also be an audit of records to ensure that the guidance is being adhered to.	Commencing Aug 2021			Sept 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	In additional to the GP safeguarding lead, practices will be advised to nominate administrative safeguarding lead that will support the GP safeguarding lead.	Share best practice with GP practices to: a. Practices to appoint administrative safeguarding lead.	This has been standard advice from the CCG since 2016. It will be reminded to practice representatives at the next CCG GP	Safeguarding practice will be embedded within all roles with the GP practice	TBC	June 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		b. GP & administrative lead to hold regular sharing information meetings and cascade key information to all GP practice staff	training session in June 2021			
2	Practices will be advised that their audit policies should include a specific safeguarding record keeping audit to review if safeguarding concerns have been identified, recorded and acted upon and / or review the quality of safeguarding referrals	Share best practice with GP practices to: a. Include safeguarding record keeping audit within GP practice audit policy. b. Provide evidence of lessons learnt and appropriate	This has been standard advice from the CCG since 2016. It will be reminded to practice representatives at the next CCG GP training session in June 2021	Practices are able to demonstrate review of records and appropriate actions related to safeguarding correspondence and practices.	TBC	September 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		actions to address any gaps in practice.				
3	General Practices will be advised to implement a Child Not Brought (CNB) Policy.	CCG to disseminate a best practice CNB policy.	CCG to disseminate a best practice CNB policy.	Practices are able to demonstrate compliance with the follow up of any child that has not been brought to an appointment.	Dr John Bye	March 2021
4	General Practices are routinely invited to contribute to statutory safeguarding meetings (including Strategy Meetings) and included in the distribution list	The CCG safeguarding team will work with the Local Authority to ensure there is a consistent and robust process in place.	Work around communication and information sharing between GPs and Social Care was started in 2019 and is subject to on-going review and quality improvement work.	GP's are able to demonstrate participation in the statutory safeguarding meetings.	TBC	June 2021
5	The CCG will continue to deliver locality specific safeguarding training for practices which emphasises the	CCG will continue to provide an annual safeguarding	This work continues to be delivered on a quarterly basis.	GP practices are able to demonstrate continued safeguarding practice learning for all appropriate staff.	TBC	March 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	importance of 'Think Family' and the use of professional curiosity.	training programme.				