SAFER STRONGER DONCASTER PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Mary'

Date of murder – June 2020

OVERVIEW REPORT

Chair Carol Ellwood-Clarke
Author Carol Ellwood-Clarke and Sara Wallwork

CONTENTS

1. INTRODUCTION

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

1.2 This report of a domestic homicide review (DHR) examines how agencies responded to, and supported, Mary, a resident of Doncaster, prior to her murder in June 2020.

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 DHR's 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 Mary had been in a relationship with a male for around six years, which ended during the summer of 2019. They had a child together, Toni.

1.6 Mary began a new relationship with John towards the end of 2019 and the relationship was described as "fast moving". They were separated at the time of the incident.

1.7 John was known to South Yorkshire Police (SYP) as a perpetrator of domestic abuse.

1.8 On 5 June 2020, Police and ambulance attended an incident at the home address of John. Officers found Mary deceased. John was arrested on suspicion of murder later that day and was subsequently charged with Mary's murder.

1.9 A Home Office post mortem determined the cause of Mary's death as –

1a Severe Blunt Force Head and Facial Injuries.

1.10 On 22 November 2020 John was found dead in his prison cell in HMP Leeds. He had hanged himself.

[1] Home Office Guidance Domestic Homicide Reviews December 2016

1.11 The case of Mary's murder was heard in Sheffield Crown Court on 30 November 2020. Judge Thomas presided over the case with Mary's family and John's family present. The court were satisfied that John was deceased and the file was closed based on the evidence. The indictments have no legal effect now and the case was formally concluded. The prosecution did refer to John having publicly acknowledged he was responsible for causing Mary's death on 10 June 2020 and 13 November 2020.

2. TIMESCALES

2.1 On 11 June 2020 Safer Stronger Doncaster Partnership (SSDP) determined the death of Mary met the criteria for a domestic homicide review.

2.2 The first meeting of the review panel took place on 5 August 2020. This and subsequent panel meetings were held virtually during the Covid-19 pandemic and contact was maintained with the panel via email and telephone calls. In total the panel met seven times. The criminal trial prevented contact with the family, until matters were concluded.

2.3 The DHR covers the period from 1 September 2019 (prior to the commencement of the relationship) to early June 2020.

2.4 The domestic homicide review was presented to SSDP on 30 July 2021 and concluded on 29 September 2021 when it was sent to the Home Office.

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 and perpetrator, and family members, which were agreed with Mary's family.

3.3 This table shows the age and ethnicity of Mary, John, Toni and Colin. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Mary	Victim	26	White British female
John	Offender	45	White British male
Toni	Mary's child	Primary school age	White British
Colin	Father of Toni		White British male

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 5 August 2020. These were shared with the family who were invited to comment on them.

4.2 The DHR panel set the period of review from 1 September 2019, through to 5 June 2020.

The purpose of a DHR is to:[2]

a] 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;

b] 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;

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d] 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;

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

N.B. This DHR is not a review in accordance with the requirements of NHS Serious Incident Framework[3].

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Mary as a victim of domestic abuse and what was the response?

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

[3] https://improvement.nhs.uk/resources/serious-incident-framework/

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

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

4. Did actions or risk management plans fit with the assessment and decisions made?

5. When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

6. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were these followed in this case? Has the review identified any gaps in these policies and procedures?

7. Were there any issues in relation to capacity or resources in your agency that effected its ability to provide services to Mary, Toni and/or John, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

8. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Mary, Toni and/or John?

9. What learning has emerged for your agency?

10. Are there any examples of outstanding or innovative practice arising from this case?

11. Does the learning in this review appear in other domestic homicide reviews commissioned by Safer Stronger Doncaster Partnership?

5. METHOD

5.1 SYP notified SSDP on 8 June 2020 of the death of Mary and that the case potentially met the criteria for a domestic homicide review. A screening meeting held on 11 June 2020 determined the criteria had been met for a DHR to be undertaken.

5.2 On date 20 July 2020, Carol Ellwood-Clarke was appointed as the Independent Chair with Sara Wallwork Independent author supporting the Chair.

5.3 The first meeting of the DHR 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 Individual Management Review (IMR)[4] Authors to assist in the completion of the written reports.

5.4 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. Prior to any interviews taking place agreement was obtained from the Senior Investigating Officer from the Police due to the ongoing criminal investigation.

5.6 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.

5.7 The DHR Chair liaised with the panel members to identify family members or friends to help inform the DHR process. During the Covid-19 pandemic the Chair informed the family of the progress on the DHR via letter which was delivered by the Police FLO[5] and through emails and telephone calls. The Chair also provided updates to the Victim Support Homicide Service who was supporting the family during the criminal investigation. The family provided valuable information which has been included within the report.

5.8 There was no opportunity to involve John in the review as he took his own life whilst on remand in prison custody awaiting criminal trial.

[4] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review
[5] Family Liaison Officer

5.9 HM Coroner for Doncaster invited the Author of the review to attend the inquest into Mary's death and information obtained has contributed to the review.

5.10 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. Mary's family attended a panel meeting at the end of March 2021 and contributed to the review. The draft report was shared with Mary's family who were invited to make any additional contributions or corrections.

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

6.1 The Chair wrote to Mary's mother and Mary's previous long-term partner and father of Toni. SYP FLO delivered the letters and the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Domestic Abuse (AAFDA)[6], additionally the terms of reference for the review were included.

6.2 In early February 2021, the Chair and Author spoke with Mary's mother and previous long-term partner via telephone and on-line teams' meetings. Details of the DHR process were discussed including the terms of reference who were invited to make any suggestions as they felt necessary.

6.3 The family were supported during the review process by a caseworker from the Victim Support Homicide Service.

6.4 No contact was made with John prior to his death.

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

7. CONTRIBUTORS TO THE REVIEW

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

Agency	IMR	Chronology	Report
Army	✓	✓	
Army Welfare Service	✓	✓	
DBTHT			✓
DCASC- Doncaster Community Adult Social Care	✓	✓	
DCST -Doncaster Children's Services	✓	✓	
Doncaster Clinical Commissioning Group - GP	✓	✓	
Doncaster IDVA service	✓	✓	
School 1	✓	✓	
RDaSH- Rotherham, Doncaster and South Humber NHS Foundation Trust	✓	✓	
South Yorkshire Police	✓	✓	
Yorkshire Ambulance Service (YAS)		✓	

7.2 The IMR's 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.

7.3 Mental health services in Doncaster are commissioned by the Clinical Commission Group and Rotherham Doncaster and South Humber NHS Foundation Trust provide a single point of access service for all referrals.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members

Name	**Job Title**	**Organisation**
Helen Allen	Team leader- Safeguarding Adults	Safeguarding Adult Hub Doncaster Adult Social care
Ian Boldy	Head of Individual Placements & Designated Nurse Safeguarding Adults	CCG Doncaster
Charlie Cottam	Lead Professional – Safeguarding Adults	Rotherham, Doncaster and South Humber NHS Foundation Trust
Kelly Cousins*[7]	Safeguarding lead	School 1
Carol Ellwood-Clarke	Chair of the DHR panel	Independent
Kim Goddard	Lead Professional- Safeguarding Adults	Rotherham, Doncaster and South Humber NHS Foundation Trust
Jayne Grice	Head of Service	Doncaster Children's Services Trust
Andrea Hamshaw	Workforce Development Officer	Doncaster Council
Susan Halliday	Named Nurse Safeguarding Children	Rotherham, Doncaster and South Humber NHS Foundation Trust
Susan Horton	Domestic Abuse Caseworker Team Leader	Doncaster Domestic Abuse Hub
Julie Jablonski*	Housing Safeguarding Partnership Manager	St Leger Homes
Pat Johnson	Lead Professional for Safeguarding Adults	Doncaster Bassetlaw Teaching Hospitals
Annette Keogh	Area Personal Support Officer (Domestic Abuse Lead)	Army Welfare Service
Dr Suzanne Kirby	General Practitioner	NHS Doncaster

[7]* Indicates these individuals attended the initial panel meeting only

Cal Lacy*	IDVA	Doncaster Domestic Abuse Services
Jane Mundin*	Public Health Improvement Officer, Substance Misuse	Doncaster Metropolitan Borough Council
Hazel O'Neill	Named Professional for Safeguarding	Yorkshire Ambulance Service
Andrew Miller	Detective Sergeant	South Yorkshire Police
Andrea Parkinson	Services Manager	Riverside Domestic Abuse Services
Vesta Ryng	Managing Director	Phoenix Women's Aid
Anna Sedgwick*	T/Detective Inspector	South Yorkshire Police
Debbie Secker	Principal	School 1
Luke Shepherd*	Head of Probation Delivery Unit	South Yorkshire Community Rehabilitation Company
Tim Staniforth	Domestic Abuse and Sexual Abuse Theme Manager	Doncaster Metropolitan Borough Council
Andy Sutherland	Second in Command, 8 Rifles	8 Rifles Army
Gary Thompson	Case Review and Policy Officer	South Yorkshire Police
Sara Wallwork	Author and support to chair	Independent
Ben Wood*	Senior Investigating Officer	South Yorkshire Police

8.2 The Chair of SSDP was satisfied that the Panel Chair and author were 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 seven times and the circumstances of Mary's homicide were considered in detail with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic panel meetings met virtually. Outside of the meetings the Chair's queries were answered promptly via email or telephone call 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. In this case the Chair and the Author were separate persons

9.2 The Chair, Carol Ellwood-Clarke was supported in the review by Sara Wallwork. Both are independent practitioners who between them have served over 60 years in British policing, (not in South Yorkshire) with additional expertise in safeguarding and vulnerability. They were the authors of the report and judged by the chair of SSDP to have the experience necessary to conduct an independent and thorough enquiry.

9.3 Between them they have undertaken the following types of reviews: 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.

9.4 Neither practitioner has worked for any agency providing information to the review. Carol Ellwood-Clarke has completed one previous DHR in 2019 and is currently an Independent Chair for another DHR, for Safer Stronger Doncaster Partnership which commenced late 2019.

10. PARALLEL REVIEWS

10.1 HM Coroner for Doncaster opened and adjourned an inquest. The Chair notified Her Majesty's Coroner on 5 August 2020 that a DHR was being undertaken. The inquest concluded on 8 March 2021, with HM Coroner reaching a conclusion of unlawful killing.

10.2 SYP completed a criminal investigation and prepared a case for the Crown Prosecution Service (CPS) and Court.

10.3 SYP referred themselves to the Independent Office for Police Conduct[8] (IOPC) following the murder of Mary. This investigation was suspended during the conduct of the criminal investigation at the request of the SIO.

The Chair informed the IOPC that a DHR was being undertaken. The IOPC investigation concluded in May 2021. The investigation did not identify any learning[9].

10.4 The case did not meet the criteria for a mental health investigation, as John had not been in receipt of specialist mental health service provision at the time of Mary's murder. Further information is contained at 11.4 and 11.5 regarding a referral for John in 2018 for Cognitive Behavioural Therapy and contact with mental health services.

10.5 Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) reported the incident on the Strategic Executive Information System (StEIS)[10].

10.6 The Army undertook a learning review following Mary's murder and provided the DHR with a copy of their report to inform the review process.

10.7 The review is not aware of any other investigations that have taken place since Mary's murder.

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[8]https://www.policeconduct.gov.uk/
Every time someone has direct or indirect contact with the police when, or shortly before, they are seriously injured or died the police force involved must refer the matter to the Independent Office for Police Conduct (IOPC).

[9] https://www.policeconduct.gov.uk/recommendations/police-response-welfare-concerns-preceding-murder-woman-%E2%80%93-south-yorkshire-police-may

[10] https://improvement.nhs.uk/resources/steis/
This system facilitates the reporting of Serious Incidents and the monitoring of investigations between NHS providers and commissioners.

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[11]

11.3 Mary and John were both known to adult mental health services. In 2018, John's GP made a referral for Cognitive Behaviour Therapy[12] in relation to low irritability and episodes of anger. Records show that John did not respond to the 'opt in' letter for this intervention.

11.4 In May 2020, John had contact with mental health services following him having taken an overdose of medication. Mental health professionals from RDaSH did attend the medical wards at the Doncaster Royal Infirmary to meet with John. A full needs assessment was not completed at this time.

11.5 Mary became known to mental health services in September 2019 after taking an overdose and being admitted to hospital. She engaged with the Home Treatment Team (HTT)[13] and the Improving Access to Psychological Therapies (IAPT)[14] team until the spring of 2020. Mary was prescribed medication by her GP for night terrors she was experiencing in March 2020.

11.6 There is nothing in agency records that indicated that Mary or John lacked capacity[15] in accordance with Mental Capacity Act 2005. Professionals applied the principle of Section 1 Care Act 2005:

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

[12] https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/

[13] https://www.rdash.nhs.uk/about-the-home-treatment-service-rotherham-services/ The Home Treatment service is staffed by medics, community mental health workers, social workers, and support workers. The home treatment service provides short-term intervention for people who require additional support in the management of their mental health needs.

[14] https://iapt.rdash.nhs.uk/

[15] The Mental Capacity Act 2005 established the following principles;

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.7 In completing this review the DHR panel also took account of the definitions of 'mental health'[16] and 'mental ill health'[17] which were referred to within agency contacts.

11.8 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. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.9 Domestic homicide, and domestic abuse in particular, are predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018 the Office of National Statistics homicide report stated:

Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

[16] https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[17] https://everymind.org.au/mental-health/understanding-mental-health/what-is-mental-illness

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

11.10 Term 8 of the report provides statistical data.

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
- Safer Stronger Doncaster Partnership
- All agencies that contributed to the review
- South Yorkshire Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND INFORMATION [THE FACTS]

13.1 Mary lived with her child Toni. Mary had separated from the father of Toni during 2019. Mary met John towards the end of 2019, and they began a relationship.

13.2 Mary became known to mental health services in September 2019, after taking an overdose and being admitted to hospital. Mary engaged with the HTT and the IAPT team until spring of 2020. During this period Mary also had contact with her Army supervisory team and two separate referrals were made to the Army Welfare Service (AWS), September 2019 and May 2020. The AWS is a non-statutory service.[18]

13.3 SYP received two calls concerning domestic abuse in which John was the perpetrator and Mary was the victim. The first of these was on 4 May 2020, following Mary's disclosure at school of an incident two days earlier. Toni also disclosed to school staff incidents of domestic abuse between their mother and John. This matter was reported to Children's Social Care and the Police.

13.4 The Police visited Mary and she informed them that John had assaulted her and threatened 'to blow her head off'. John fled the address with a shotgun he recovered from the bedroom. John was the holder of a firearms certificate. A Domestic Abuse, Stalking and Honour Based Violence Risk Identification model risk assessment (DASH)[19] was completed, and the risk level was identified as High Risk. During this contact Mary disclosed a previous incident of domestic abuse with John.

13.5 Mary left her home address, supported by the Army and stayed at a hotel out of the area for 24 hours. SYP recovered John's firearms. John was arrested on 5 May 2020 when he attended at the Police station to recover his firearms. John was interviewed by the police and released on bail with conditions.

13.6 On 6 May 2020, the Police gave a disclosure to Mary under the Right to Know, Domestic Violence Disclosure Scheme (DVDs)[20], also known as 'Clare's Law', due to John's history of domestic abuse.

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[18] The difference between a statutory and a non-statutory service is that a statutory service is required by law, funded by and have legislations in place set by government.
[19] DASH- The Domestic Abuse, Stalking and Honour Based Violence Risk Identification model. It was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).
[20] Clare's Law, or the Domestic Violence Disclosure Scheme (DVDS), is designed to provide victims with information that may protect themselves for an abusive situation.

13.7 The case was referred to the Multi Agency Risk Assessment Conference (MARAC)[21]. Mary was supported by an Independent Domestic Violence Advocate (IDVA)[22] and they provided her with a safety plan. This included target hardening at her home. The case was scheduled for MARAC on 20 May 2020.

13.8 On 6 May, Mary informed her Army Welfare Worker (AWW) that John had sent her flowers and chocolates. This activity was evidence of John's continued controlling behaviour[23]. The AWW reported this to the Police via email. This is covered later in the report.

13.9 On 15 May 2020, SYP received a call was from Mary's grandmother who stated that Mary had gone to John's address after receiving messages on Snapchat[24] from him saying he was going to kill himself. YAS and SYP attended John's house and he was taken to hospital having taken an overdose. A referral was made to Adult Social Care in respect of John. John was arrested for the breach of bail once deemed fit by the hospital.

13.10 On 17 May 2020, John was charged with Section 39 assault[25] and breach of bail and remanded to court by SYP. John appeared at Magistrates court and was released on conditional bail.

13.11 Towards the end of May 2020, Mary contacted SYP requesting to withdraw her statement in relation to the assault earlier that month. On the day of Mary's murder, she had provided a retraction statement to SYP. Later that day Mary went to John's address and shortly before midnight YAS and SYP responded to a report of a seriously injured female at the address. Mary was discovered with serious injuries and appeared to be deceased. Enquiries by the police during the homicide investigation established that Mary went to John's address following contact via text messages.

13.12 John attended a local police station and admitted to the murder of Mary. John was arrested and later charged with Mary's murder.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

[21] MARAC Multi agency risk assessment conference.

[22] https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

[23] See Appendix B

[24] Snapchat lets you easily talk with friends, view Live Stories from around the world, and explore news in Discover.

[25] https://www.cps.gov.uk/legal-guidance/offences-against-person-incorporating-charging-standard

14. CHRONOLOGY

14.1 Background

Mary
Mary was a bright child and described by her family as everyone's friend, a people's person who would not tolerate aggression. Mary maintained a small friendship group throughout her school life with whom she remained friends with after school. Mary's mother described her as her best friend. Mary had wanted to join the Army from the age of 10, signing up when she was 15 years and 10 months. Mary enlisted into the Army at 16, and although she initially struggled being away from home, she soon settled into Army life. When Mary was 18, she went to Afghanistan. Her family described how Mary had found herself in the Army. Mary met Colin in the Army. When Mary discovered she was pregnant with Toni, she voluntarily discharged herself from the service as she did not want to bring Toni up in Army life. After leaving the Army, her family stated that she could not cope with civilian life and returned as an Army reservist as she needed to be back in that environment. Mary started body building and set up her own business as a personal trainer. Mary was well liked throughout Doncaster. During Easter 2020 Mary collected over 100 Easter eggs which she distributed to local care home staff during the Covid-19 pandemic. After six years Mary and Colin's relationship ended but they remained on friendly terms. Mary was a good mother to Toni, taking Toni with her whenever she could. Toni adored Mary. Colin described Mary as a beautiful woman and a great mother.

John
John died by hanging on 22 November 2020 whilst in HMP Leeds. John was known to have been a bouncer working on pub doors in Doncaster. Mary's family believed he had used illegal drugs.

Relationship between Mary and John
Mary and John's relationship began towards the end of September 2019 after John contacted Mary via social media. Mary's family felt that the age gap between them was in part linked to Mary looking for a father figure. The family described the relationship as 'fast moving'. The family provided the Chair and Author information about their relationship that in hindsight raised concerns and they recognised as controlling, but at the time they did not recognise as concerning. This included John mirroring activities that Mary had previously undertaken with Colin. In one example, Colin had planned to take Mary to Amsterdam; however, this did not happen, but John booked the same trip taking Mary. John also took Mary to Edinburgh and made the same trips and visits whilst there, that Colin had done previously with Mary whilst in the Army. John booked a holiday to Paradise Island, a resort that Colin had previously taken Mary and Toni to. In November 2019, on Remembrance Day parade John turned up with Mary and Toni as Colin marched with his reservist troops. When Mary had a car accident in December 2019, John moved Mary and Toni into his house and encouraged Mary to stop working, going out and in effect he was isolating her. On one occasion in the early hours of the morning, Mary was thrown out of John's address when he accused her of cheating on him. The Inquest into Mary's death provided information that on New Year's Eve 2019, John surprised Mary with a marriage proposal and bought her a ring that he said cost £8,000. Mary later told her mother that she felt pressured to accept the proposal. In January 2020, at a family gathering of Mary's relatives, John made Mary leave the party due to photographs being shown at the function of Colin and Mary when they were still together. Colin provided additional information of controlling behaviour which included installation of cameras and a listening device in Mary' home. The family felt that John's attempt to take his own life on 15 May 2020, which was the day before Mary's birthday, was timed to deliberately ruin her birthday. Colin stated that Mary had confided in him in May 2020, that there was a build-up of problems in the relationship, with John shouting, screaming, causing her mental strain as well as the physical assault and threats that had been reported to the Police.

15. OVERVIEW

15.1 Introduction

15.1.1 This section of the report summarises what information was known to the agencies and professionals involved with Mary and John. The structure adopts a chronological approach in which each issue of significance is described, and the input of each agency considered. The events are cross referenced to the events table contained within Appendix C. Detailed analysis of the contacts appears at section 15.

15.2 Events predating the timescale of the DHR

15.2.1 Between 2004 and 2011 SYP recorded three separate crime reports relating to assaults committed by John during domestic abuse incidents with two different previous female partners.

15.2.2 In 2004 John held a knife to his own throat and threatened he would harm himself if his female partner left. John then unlawfully imprisoned the victim and sexually assaulted her. John cut his own wrists when disturbed by Police. John was arrested, interviewed, and later warned about his conduct. This is understood to be a police decision and the crime was filed as detected. SYP have no further information available in relation to this incident and it predates the rigor of proactive audits in line with National Crime Recording Standards (NCRS)[26].

15.2.3 In 2005 during an argument, John physically assaulted his female partner over a two-hour period by punching her in the face, arms and torso and grabbing her around the neck. John was arrested and bailed with conditions pending a CPS decision. The CPS decision was for No further Action and the case was finalised.

15.2.4 In 2011 John physically assaulted a female from whom he had recently separated by striking her in the face and verbally abusing her. The victim did not want to give evidence or support a prosecution. The investigation was finalised, and the crime was filed as No Further Action. It is understood that John was not arrested on this occasion and that the outcome was a police decision.

None of these incidents resulted in a criminal conviction.

15.2.5 In November 2018, John was referred by his GP for Cognitive Behaviour Therapy. The referral stated that John had low grade irritability to many

26 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940262/count-general-nov-2020.pdf

things with occasional episodes of anger. The referral was directed to the IAPT team and records show that John did not respond to an 'opt in' letter that was sent to him by the service. John was subsequently discharged on 14 December 2018.

15.3 Events within the timescale of the DHR

Events during 2019

15.3.1 In early Sept 2019, Mary was admitted to hospital following an overdose of 'Clenbuterol'[27]. Mary indicated to medical doctors in the Emergency Department that she wasn't suicidal. Mary was referred to the Hospital Psychiatric Liaison Team who assessed her as being suicidal and low mood. A follow up with HTT was arranged as they deemed, she was at risk of self-harm.

15.3.2 The HTT visited Mary at her mother's home within days of hospital discharge to monitor her risk of self-harm. Mary said she felt guilty that she had contemplated taking her own life. During this visit there were no immediate risks identified, although Mary was still feeling suicidal and unable to cite any protective factors. Mary agreed to be referred to IAPT for treatment and support and at this point, mid-September the intervention of the HTT ended. The Community Mental Health Team wrote to Mary's GP to alert them of Mary's overdose and management via the HTT caseload and referral to IAPT for counselling. The letter referenced Mary having a past medical history of post-natal depression

15.3.3 The Army included Mary in their Vulnerability Risk Management register following a risk conference on 9 September 2019 and a referral was made to the Army Medical Services for mental health support.

15.3.4 Mary was seen at the Army Medical Centre, York. This was in response to the overdose and inclusion on the Vulnerability Risk Management register, and a decision was made by the medical board for her to be downgraded to 'Medically Non-Deployable' (MND)[28]. As Mary was a reservist solider, medical treatment was deferred to the NHS with the medical board making a referral to the NHS. Reservist primary and secondary health needs are

[27] Clenbuterol is a Class C drug (BNF) and is used for weight loss and body building.
[28] Medically Not Deployable (MND): Personnel medically fit for duty with major employment limitations. MND personnel are not fit to deploy on Operations but may be deployable on UK based exercises.

primarily the responsibility of NHS, unless they are mobilised or on certain types of Full Time Reserve Contracts.

15.3.5 During the initial appointment with IAPT on 29 September 2019, Mary made several disclosures of traumatic life events, that were negatively affecting her mental health and causing anxiety. Mary said she was suffering from recurring nightmares and post-traumatic stress disorder following experiences in the Army. There were no current risks of harm identified upon assessment and a Patient Health Questionnaire 9 (PHQ9)[29]; 11 Generalised Anxiety Disorder 7 (GAD7)[30]; 16 was documented.

15.3.6 During the second IAPT appointment, on 1 October 2019, Mary's overall anxiety had reduced. The score for GAD7 had decreased significantly and scores on PHQ9 had increased slightly. Mary reported she was still not able to sleep, having nightmares, then feeling tired because of no sleep. No immediate risks were recorded.

15.3.7 In December 2019, Mary was involved in a road traffic accident and was seen at the Emergency department of Pinderfields Hospital Wakefield. There was no-one else in the car with Mary at the time of the accident.

15.3.8 In November 2019, John was prescribed testosterone gel by his GP. John's repeat medication of Atorvastatin[31] and Lansoprazole[32] for the management of cholesterol had not been requested regularly. The GP practice intended to remove John from the patient list at the end of November after he was abusive towards a GP. However, due to an error John wasn't taken off the system. In May 2020, John registered at a new GP practice.

15.3.9 Towards the end of 2019, Mary started a relationship with John.

Events during 2020

15.3.10 During an IAPT appointment on 29 January, Mary said, "I don't have an issue now I talk". Her nightmares were continuing but she had developed coping mechanisms. No immediate risks were recorded. At the following week's appointment, Mary said she had stopped drinking alcohol and her mood had improved. Support continued and techniques around dealing with trauma were discussed. Mary said she had a new partner. It is understood but not documented that the new partner was John.

[29] PHQ9 Depression assessment tool: score 11 = moderate severity.
[30] GAD7 is an anxiety assessment tool score 7 = moderate
[31] https://bnf.nice.org.uk/drug/atorvastatin.html#Search?q=Atorvastatin
[32] https://bnf.nice.org.uk/drug/atorvastatin.html#Search?q=Lansoprazole

15.3.11 On 26 February, Mary disclosed at her IAPT appointment that she had attempted to self-harm and had superficial cuts on her wrist. Mary said she was distressed as Toni was staying with her ex-partner (Colin) for the first time in a while. During this appointment, a timeline of significant life events was talked through, and Mary was able to reflect on these. Mary made a comment that she was in a new relationship that started in October 2019 and that "I want to be loved".

15.3.12 At the beginning of March, during an IAPT appointment Mary said she was making an Army service complaint due to her experiences in her regular Army service. The DHR were informed that this was investigated by the Army, the outcome of this is not relevant for the DHR.

15.3.13 Mary cancelled an IAPT appointment scheduled for 11 March. No reason was given for the cancellation. The IAPT practitioner attempted to contact Mary and an alternative appointment was subsequently arranged for 25 March. This appointment was re-scheduled to an on-line consultation on 1 April due to the Covid-19 pandemic. During this consultation Mary spoke about night terrors and said she was taking prescribed medication Amitriptyline 10mg[33]. Mary said she was managing well with the lockdown and another appointment was made for 8 April.

15.3.14 In total, Mary attended eight appointments with the IAPT service. The impact of the Covid-19 restrictions meant that all appointments post 23 March 2019 were conducted virtually, on-line.

15.3.15 In March, Mary was referred into the Army Welfare Service by her Army supervisor. This followed home visits by Mary's chain of command to ensure support was available to her. Mary was aware and in favour of the referral. She was allocated a worker at the end of March 2020. From the referral, the AWS obtained Mary's background and the issue Mary needed support with.

15.3.16 Towards the end of March, Mary had three separate consultations with the GP.

17 March- Mary telephoned the GP's practice and reported a flare up of low mood and anxiety to the practice nurse. This was shared with the GP who telephoned Mary to discuss her symptoms. Mary stated that the Army doctor recommended a different antidepressant 'sertraline'. The GP had prescribed Amitriptyline tablets due to the worry about worsening risk of

[33] https://www.nhs.uk/medicines/amitriptyline-for-depression/

self-harm with sertraline. Mary told the GP that she was more anxious, and therapy was making it worse.

24 March- Mary was unwell with tonsillitis and had a video consultation with her GP.

27 March- Mary's GP conducted a telephone review of Mary's anxiety depression and the medication. Mary was advised to continue with the Amitriptyline and a further appointment in two weeks.

15.3.17 At the beginning of April the AWS had initial contact with Mary via the telephone. Mary said she could not speak at that time and asked for a later call. Thereafter, the AWS tried without success for two weeks to contact Mary. An email was sent to Mary outlining that the case would be closed if there was no response within a seven-day period. The case was subsequently closed when no response was received from Mary.

15.3.18 Mary did not attend the IAPT on-line appointment on 8 April and a message was left for Mary to contact IAPT by the end of the week. There is no record of Mary returning this contact.

3 and 4 May 2020

15.3.19 On 3 May, Mary disclosed an incident of domestic abuse to her Army supervisor. The incident had occurred the night before, John was the perpetrator. Mary was advised to report the matter to the police.

15.3.20 On 4 May 2020, SYP received two calls from Toni's school concerning domestic abuse in which John was the perpetrator and Mary was the victim. The first of these followed Mary's disclosure that she had been having issues with her ex-partner, John, over the previous days. Toni had been present at the time of the incidents. Mary disclosed that John had attended her address with a shotgun. The second call followed Toni's disclosure, that the previous day (3 May 2020), John and their mother had been arguing. Toni had hidden on the sofa under a cushion.

15.3.21 The Multi Agency Access Point (MAAP)[34], following the referral from school led to an immediate allocation of a social worker from Children's social care. Mary and Toni were seen face to face by the allocated social worker that day. Mary disclosed to Children's social care that John had thrown a frying pan at her, pushed her over and hit her three times in the face. He then threatened to blow Mary's and her child's heads off, he had then gone and fetched a shotgun which Mary was not aware that it was in the

[34] MAAP- Multi Agency Access Point

property at the time. SYP were informed of the further disclosures that Mary had made.

15.3.22 SYP attended Mary's home address in the evening on 4 May 2020 and Mary disclosed a second incident that occurred on 2 May 2020. Mary and John had argued, and it became heated. John shouted threats toward Mary, and he threatened to 'blow her head off', he then proceeded to get his shotgun from the bedroom, run downstairs and drive away in his van with the firearm. This incident had not been reported to SYP at the time of it occurring.

15.3.23 A DASH risk assessment and MARAC referral was completed by Doncaster Children's Services and assessed as 'High'. A joint visit with police and Children's services took place at Mary's home and safety measures were discussed. Mary agreed to leave the home with Toni and the Army supported and offered alternative temporary accommodation out of the area.

15.3.24 Mary was referred to the AWS by her Army regiment supervisor, with her consent, for a second time and was provided support initially via her unit welfare officer and subsequently also by an Army welfare worker. The AWS checked that the police and Children's Social Care were already aware.

15.3.25 Mary and Toni were supported by the Army to reside away from the family home for one night in hotel accommodation. The option of the Army Reserve Centre was discounted as an insecure location as Mary would have been in a camper van with Toni and their 'grandparents'[35] at the centre when John's whereabouts were unknown at the time. Accommodation was not routinely available to Reservist soldiers on the basis that unlike Regular soldiers they reside in the community. Mary chose to return home with support from her ex-partner (Colin).

5 May 2020

15.3.26 Both school and children's services contacted Mary by telephone, and she confirmed that she would be returning to her home address later that day. Mary informed the Social Worker Colin would stay with them for safety.

[35] Mary's family informed the DHR panel that the couple Mary referred to as 'grandparents' were not related to her.

15.3.27 The IDVA service were informed by SYP Domestic Abuse Risk Assessment Team (DARA) of a High-risk domestic abuse referral for Mary. The DARA team have responsibility for assessing the appropriate level of risk after reviewing the attending officer's initial assessment, having completed the DASH questions and grading the risk as standard, medium or high. In addition to information obtained by the attending officer DARA staff have full access to SYP systems to gather further information to allow a more thorough assessment of the risk. An introductory telephone call was made by the IDVA, and it was confirmed to Mary that the case would be discussed at MARAC. A risk assessment was completed, including discussions in relation to safety planning. John was still at liberty and the police were actively looking for him to arrest. Mary shared information with the IDVA that John had access to another gun, and that he could be hiding it in her loft. This was shared with the SYP offender management team who assisted with enquiries.

15.3.28 The social worker expressed concerns to the IDVA for Mary and Toni to return home whilst John was still outstanding. The IDVA completed a home visit and provided practical control measures at the property. A referral for a home assessment was also made to South Yorkshire Fire and Rescue (SYFR). A Right to Know application was authorised and disclosure was given on 6 May 2020. The Army Welfare Worker (AWW) tried to contact Mary via the telephone but after several attempts they emailed her offering support.

15.3.29 John attended at a local police station and asked to have his shotguns returned, he was arrested for the domestic abuse incident on 2 May 2020. John was interviewed and released on police bail with two conditions;

1) Not to go to Sprotborough;

2) Not to contact Mary and two other individuals, both for reasons of preventing further offences.

<u>6 May 2020</u>

15.3.30 The AWW telephoned Mary. Mary gave her verbal consent for the AWW to approach other agencies to ascertain if a DASH was completed and for other details to be shared to save Mary repeating the information. During this conversation Mary disclosed to the AWW that John had sent her flowers and chocolates. Arrangements were made for a further call. Mary stated she was overwhelmed telling her story to so many agencies. The AWW agreed to offer Mary some space and to call again on 11 May 2020.

15.3.31 The AWW emailed SYP requesting a copy of the DASH risk assessment and that John had breached his bail. The AWW was requested by SYP to complete a Data Protection Form in order to receive the DASH.

7 May 2020 onwards

15.3.32 On 7 May, the social worker from DCST and AWW discussed Mary's case and agreed that the AWW would remain involved to support Mary. AWS practitioners routinely use the Safe and Together framework[36] to understand, assess and manage cases involving survivors who are enduring abuse from perpetrators of domestic abuse.

15.3.33 On 11 May, the Social Worker visited Mary and Toni to complete a child and family assessment. Direct work was completed with Toni. The IDVA and AWW contacted Mary by telephone but she stated she did not want to speak as a friend had recently died and she did not feel able to talk.

15.3.34 On 13 May, both the IDVA and AWW telephoned Mary, but as there was no reply, a voicemail message was left asking for a call back from Mary.

15.3.35 On 14 May, the IDVA spoke to Mary via telephone. Mary said she was feeling much better and that she had heard from friends that John had been posting upsetting comments on Facebook, which she was trying to ignore. Mary spoke about John being on bail with conditions. Mary confirmed her ex-partner was no longer living at her house and that the SYFR assessment had been completed on her home. Mary was advised to contact the police if John turned up. The AWW spoke with Mary on the telephone and completed an AWS assessment with the information gained. This is covered later in Section 15.

15 May 2020

15.3.36 A 999 call was made to SYP by a family member of Mary's, concerned for her safety after John had contacted Mary stating that if she did not attend his address, he would end his life. John was found in the address by Mary having taken an overdose. Mary found letters that John had written to friends and family stating that he was going to take his own life. This was the day before Mary's birthday.

[36] The Safe & Together™ Model is an internationally recognised suite of tools and interventions designed to support safeguarding and domestic violence interventions.

15.3.37 Both YAS and SYP responded to the incident. John was taken to hospital following an 'ASHICE' call[37] from the ambulance service. John was very unwell and unresponsive on attendance by YAS and his responsiveness continued to fluctuate. John was admitted as an inpatient on the Medical Unit. John was referred to the mental health team and reviewed whilst on the ward. No evidence of any mental illness was found, and the team were satisfied for him to be discharged once medically fit.

15.3.38 Police officers remained at the hospital with John until he was fit for discharge at which point, he was arrested for breach of bail. John was charged with an offence of Section 39 assault and breach of bail, on the advice of CPS. SYP submitted a referral into Adult Social Care.

15.3.39 On 16 May, Adult Social Care reviewed the safeguarding referral for John. This was assessed by health care professionals and crisis team who concluded that John's risk showed no evidence of any care or support needs and that the safeguarding adults' thresholds were not met. This information was shared with the hospitals integrated discharge team and with children's services. John's GP had no record of this incident as an adult safeguarding letter was not received by the GP. The hospital discharge letter was shared with the GP; however, it went to John's previous practice that he left in November 2019.

15.3.40 The MARAC was held on 20 May. Information sharing took place which included the breach of bail when John attempted to take his own life on 15 May and previous threats to take his own life when Mary had tried to end their relationship on previous occasions. Children's social care and Police also shared information outlining the ongoing support for Mary, the actions that had already been taken and updating the MARAC that John had been charged with assault and breach of bail. RDaSH were represented by the 0-19 services. Army and AWS representatives were not invited to the meeting.

15.3.41 Mary was updated on the MARAC the following day by the IDVA. At this time Mary stated that everything was ok and that a court hearing was due on 31 July at Doncaster Magistrates court. The court process was discussed with Mary, and she stated that she was willing to attend court with the IDVA support.

[37] An ASHICE call is made to pre-alert the department to a seriously unwell patient's attendance. This kind of pre-alert is known as ASHICE. This is an acronym Age, Sex, History, Injuries/Illness, Condition, Estimate time of Arrival used to pass the important details of a critically ill patient over to the receiving hospital to ensure that they have all the appropriate equipment and staff assembled and prepared.

15.3.42 On 21 May, the child and family assessment was completed. The outcome was no further action to be taken as the case was to be stepped down with continued support from AWS. However, the AWS file did not reflect this understanding. It was also noted that Mary had IDVA and police ongoing involvement.

15.3.43 Towards the end of May and into early June, AWS were unable to make contact with Mary. Daily telephone calls and voicemail messages were left asking for Mary to call back. On 3 June, due to the concerns about lack of engagement a planned home visit was agreed with Mary. Army supervisors visited Mary's home address at a pre-arranged time, however, Mary was not at home. Mary telephoned later that day and apologised for missing the meeting and stated she had missed the appointment due to them calling at a different time to what had been arranged. Mary stated that she was ok and there were no concerns.

15.3.44 Mary contacted SYP on 29 May and left a voicemail message with the police officer dealing with her case, saying that she wished to retract her statement. The officer made attempts to call Mary back but did not make contact until 5 June. During this telephone call Mary was described as seeming bubbly and happy making a comment that she wanted to move on with things and that she felt due to her mental health, she would not be able to give evidence in court. Mary signed and returned a retraction statement that had been emailed to her by the Police Officer.

15.3.45 At 23.33 hours YAS attended at John's address and found Mary deceased. Around the same time, John attended a local Police Station and admitted to the murder of Mary. John was arrested, interviewed and charged with Mary's murder.

16. ANALYSIS USING THE TERMS OF REFERENCE

16.1 Term 1

What indicators of domestic abuse did your agency have that could have identified Mary as a victim of domestic abuse and what was the response?

16.1.1 In early September 2019, Mary attended hospital after taking an overdose of tablets. Mary's initial explanation for the incident was that she was "trying to lose weight" and that she did not intend to end her life. Mary indicated that she had taken too many tablets by mistake. Mary was admitted onto an acute medical ward and this incident was explored in a FACE assessment (Functional Analysis of Care Environment risk assessment) by the mental health team whilst Mary was at hospital. The detailed assessment by the mental health team stated that Mary intended to harm herself and they explored this further and continued to monitor her risk for self-harm.

16.1.2 The panel felt that further elements of a recent relationship breakup and stressors were not explored, and any domestic abuse risk should have been considered, during the following brief intervention of the HTT. Assessments with regards to mental health need to include domestic abuse as individual issues cannot be treated in isolation. Professionals undertaking assessments need to understand whether domestic abuse is a concern that is interfering with mental health recovery. The panel agreed that exploring domestic abuse further may have given a better insight to Mary's situation rather than the superficiality in the information available. This has been identified by the IMR Author for RDaSH and a relevant recommendation made.

16.1.3 During the IAPT appointments the interventions and assessments considered the relationship between Mary and her ex-partner (Toni's father). These assessments did not identify domestic abuse. The panel established that direct questions had not been asked to identify domestic abuse and determined that practitioners should try to ask questions to explore domestic abuse, if safe to do so.

16.1.4 During the IAPT appointment on 26 February 2020, the assessment completed indicated that Mary was "having a bad week". She had attempted to self-harm and had superficial cuts on her wrist. During the exploration of Mary's situation, she stated that she felt angry and distressed as her child was staying with her ex-partner for a few days for the first time in a while. Mary also spoke about being in a new relationship since October 2019 and made a comment "I want to be loved". There is no

evidence in the IAPT notes of the new partner's details. In Mary's case it is evident in her IAPT notes that she spoke of a new relationship, however the assessments did not document any reconsideration in relation to safeguarding and domestic abuse. The panel felt Mary's new partners details should have been obtained and the relationship explored further.

16.1.5 On 3 May 2020, Mary made a direct disclosure to her Army supervisor, that there had been an incident of domestic abuse the previous night with John. Mary described John as being an ex-partner at this time. This was the first indication the Army had of Mary being a victim of domestic abuse. The appropriate support was given to Mary and a referral was made to the AWS. Mary was advised by the Army to report the incident to the police. The panel now know that Mary did not make a report to the police that day. The decision making around this is covered in term 3.

16.1.6 The panel determined that the Army should have reported the matter to the Police, ideally with Mary's consent. The panel also determined that a referral to Children Social Care should have been made due to the safeguarding concerns for Mary's child. In addition, a referral to the domestic abuse service with Mary's consent could have also been considered by the Army. The IMR author for the AWS highlighted that the MOD has a process of ongoing review of its policies and the AWS has already sought to include lessons identified through this DHR process into the current policy update of tri-service (Army, Navy and RAF) policy on domestic abuse. The panel has made a relevant recommendation [Recommendation 6]

16.1.7 On 4 May 2020, Mary disclosed to a member of teaching staff at her child's school that she had been having issues with John over the last few days. She said that Toni had been present at the time and that Mary thought she should speak to school about it. Mary stated that John had come to the house with a firearm. During these disclosures Mary referred to John as being her ex-partner. Later that morning disclosures were also made to school by Toni, which provided information that Mary had been verbally abused and physically assaulted by John and that Toni had witnessed the abuse and felt scared.

16.1.8 This was the first indication the school had that Mary was a victim of domestic abuse. Immediate action was taken, and the school safeguarding policy and procedures were followed in terms of sharing information with the appropriate agencies and working alongside agencies.

16.1.9 Children's Social Care had no prior knowledge of domestic abuse until the referral from the school. A DASH risk assessment was completed with Mary which resulted in a referral to MARAC and IDVA. Safety planning occurred which involved Mary and Toni staying away from home on the night of 4 May 2020. The involvement of the AWW was known to children's services and it was understood by the Social Worker, that the AWW would be involved with Mary and follow the Safe and Together framework around domestic abuse. DCST completed a child and family assessment to consider any additional safeguarding or support needs for Toni and Mary. The outcome of the assessment was for no further action, due to Mary stating that the relationship with John had ended, appropriate services being in place and no other concerns being identified. The panel learnt that the AWS were not made aware of the rationale for Children's Social Care closing their case.

16.1.10 DCST had no information that would have identified John as a perpetrator of domestic abuse. Information was not shared by the Police of John's previous history. The Social Worker did not speak with John as part of the Child and Family Assessment. The IMR Author from DCST has identified learning in relation to the involvement of ex-partners whilst undertaking assessments and has made a relevant recommendation.

16.1.11 SYP police had no previous record of any domestic abuse incidents involving Mary prior to the events of early May 2020. Officers attended at Mary's home address and gathered evidence to support a criminal investigation including taking photographs of her injuries, obtaining a detailed witness statement, and also completing a DASH risk assessment. This was later risk assessed by specialists in the DARA team as 'high risk'. SYP assisted Mary to a new temporary location and safeguarding measures were put in place. John was targeted for a priority arrest with an immediate response arrest package.

16.1.12 John had a history of being a domestic abuse perpetrator. This information was known to the Police. The panel has seen evidence that SYP considered this information when responding to the decision in relation to disclosure to Mary under the DVDS, right to know. This point is covered further in Term 2.

16.1.13 Mary had consented to be referred to the AWS on 4 May 2020 and information was confirmed by Mary over a series of three telephone contacts to inform an assessment. During contact the AWW wanted to complete a DASH risk assessment with Mary, however, Mary stated that this had already been completed by the police. Mary gave her permission for a copy of the DASH to be sought from the police. The panel agreed the best practice would have been for the Army to have considered a DASH at the point Mary made the initial disclosure of domestic abuse on 3 May. The Army referred Mary to the AWS as they believed the service to be more specialist in their understanding of domestic abuse and therefore the appropriate service to complete a DASH. When the referral was received by the AWS, two DASH assessments had already been completed; one by SYP and one by DCST. As DASH is a dynamic assessment the panel determined that the AWS should have completed a further DASH which would have allowed for any new information or changes in risk being identified. The person-centred rationale for the AWS not completing a further DASH was acknowledged and discussed by the panel; including the very close timescale of existing DASH assessments being completed within a two-day period and the wishes of Mary. However, the panel determined that a DASH would have highlighted the AWS involvement and been a link with MARAC and the IDVA. This is to be incorporated in the AWS policy.

16.1.14 The AWW identified that Mary was feeling overwhelmed at her situation and the involvement with various agencies. The email correspondence to the police requesting a copy of the DASH also ensured that the police were aware that AWS were working with Mary. The AWW made no direct contact with MARAC as other statutory agencies were aware of their involvement. The AWW assumed that MARAC would be held and AWS would have been invited via the MARAC coordinator. The panel learnt that although several statutory agencies were aware of the involvement Mary had with the AWS and Army, this did not lead to them being invited to the MARAC. The panel agreed that the Army and the AWS should have been invited to the MARAC meeting and be included within the Community Safety Partnership Agreement. The DHR panel have identified this as learning and made a relevant recommendation. [Recommendation 1]

16.1.15 During DHR panel meetings the panel heard the Army describe themselves as a hidden community, who are often overlooked during safeguarding incidents involving service personnel. It was established that this was a nationwide concern across The Armed Forces and the panel have made a relevant recommendation. [Recommendation 3]

16.1.16 On 6 May 2020, Mary received flowers and chocolates from John. Mary informed the AWW about the flowers and chocolates and the AWW sent an email to the Police with this information, recognising controlling and coercive behaviour. A request for a copy of the completed DASH was also included in the email. The panel considered whether sending an email was the most appropriate form of communication, given the delays in the SYP returning the DASH to the AWW. The panel agreed that a telephone call to the Police would have been the most appropriate response. During contact with Colin, he informed the Chair and Author that Mary had also reported receiving the flowers and chocolates to the police. SYP made enquiries in relation to this and confirmed that John had ordered and paid for the items before his arrest and subsequent bail conditions. There was no breach of bail conditions. The panel felt that this was an act of controlling and coercive behaviour by John.

16.1.17 Since September 2020, SYP have commenced an online portal facility to report incidents and crime. The portal is constantly monitored, and incidents are created and telephone call backs undertaken where necessary. The panel agreed that online reporting would be a suitable way of reporting breaches of bail where there is no immediate risk to the victim. The IMR author for SYP has identified this as an area of learning and have made a relevant recommendation.

16.1.18 The Police requested that the AWS completed a Data Protection Act (DPA)[38] form to receive a copy of the DASH, this created a delay in information sharing. The panel agreed that this was not required as Mary had consented for information to be shared when the DASH was completed. AWS provided the DPA form to SYP on 18 May 20, resulting in the DASH being shared by SYP with AWS on 1 June 2020. No further explanation was provided to the panel by SYP to account for the delay.

16.1.19 On 15 May 2020, during YAS response to the attempted taking of his own life, Mary disclosed to the clinicians attending that John was subject of bail conditions restricting contact with her. The clinician's priority was to transport John to hospital due to his medical state. There was no opportunity to discuss this further with Mary and no follow up took place. The panel felt this was a missed opportunity to engage with Mary and share information with other agencies. YAS have identified this as learning.

[38] The Data Protection Act 2018 (DPA) includes exemptions which allow personal data to be disclosed to law enforcement agencies without the consent of the individual who is the subject of the data, and regardless of the purpose for which the data were originally gathered.

16.1.20 Mary's continued engagement with the AWS and IDVA became fragmented and at the end of May/beginning of June. Every agency working with Mary recorded difficulty in contacting her at this time. The panel learnt that Mary had informed the AWS that she had previously been prevented from seeking help by John. This could have also been a factor impacting Mary's engagement with other services. The AWS have identified learning around routinely creating a plan for victims of domestic abuse, to include, when and how contact will be undertaken and how to check out wellbeing where there is pressure to disengage. The panel agreed that a plan is a useful tool and for consideration of this to be undertaken by the best placed professional working with Mary, so that it can be agreed and shared amongst professionals to avoid overwhelming victims with multiple requests.

16.1.21 The GP was not aware that Mary had been the victim of domestic abuse. The panel heard that a notification to the GP following the disclosure of domestic abuse could have triggered a discussion in the practice safeguarding meetings or with the practice safeguarding lead and this may lead to more proactive interventions for both Mary and Toni. It could also lead to an alert on records that would ensure the information was used in future risk assessments and management.

16.2 Term 2

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

16.2.1 The panel heard from SYP that John was a perpetrator of domestic abuse with two previous female partners between 2004 and 2011. Agencies learnt about John's domestic abuse history during the MARAC in May 2020. The recognised pattern of John as a perpetrator of domestic abuse behaviour resulted in the DVDS disclosure.

16.2.2 The information was not shared with DCST to inform their Child and Family Assessment. The DHR were informed that John had been a significant part of Toni's life, having been seen daily taking and collecting Toni from school. The DHR panel agreed that John's past history should have been shared prior to the MARAC. [Recommendation 1]

16.2.3 A DARA team member completed the risk assessment requests and the decision made for the DVDS was authorised by an Inspector. The panel heard no evidence that a multi-agency forum or agency information contributed to the decision making nor the form of words agreed for the DVDS.

16.2.4 National DVDS Guidance[39] provides the operational framework for the scheme –

'The first step is the decision to disclose the information. Once that decision is made because it is judged that there is a risk to harm presented by the perpetrator, there follows a series of considerations;

a) what will be disclosed?

The guidance states a multi-agency forum will consider the specific wording of a disclosure that contains sufficient information to allow the recipient to make an informed choice with regard to their relationship or contact with the perpetrator.

The disclosure must be accompanied by a robust safety plan tailored to the needs of "A" and based on all relevant information, which identifies the service provision and the agency leads who will deliver on-going support to "A"

b) who should the disclosure be made to

The disclosure should be provided to the person(s) best placed to safeguard A. Whilst it is envisaged that the majority of disclosures will be made to A, it may not be appropriate to do so in all instances. The judgement of who to disclose to will be determined following the information gathered as part of this Disclosure Scheme process and subsequent risk assessments.

c) how the disclosure will be made

The disclosure will be delivered by the police; however, the multi-agency forum will consider whether there are other agencies that should also be involved in the delivery, based on the information at hand. It is good practice to consider joint-agency approach to the disclosure provision.

It is strongly recommended that the disclosure should be made in person. In line with safeguarding procedures, it is essential that the disclosure takes place at a safe time and location to meet the specific needs of A'.

16.2.5 The DHR panel were provided with a copy of the DVDS. The DVDS did not include details around the timescales, methodology, including details of the alleged assaults in relation to John's history as a domestic abuse perpetrator. From reviewing the DVDS, it did inform Mary that John had committed assaults against previous partners and that there was a pattern of abuse that put her at risk. The panel agreed that details of previous incidents outlining the seriousness of the crimes alleged, would have

39 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

provided an opportunity for Mary to make an informed choice about her relationship with John.

16.2.6 There was no evidence of a documented safety plan on the DVDS provided to the DHR Panel. It was not documented what was shared to other agencies nor which agency was to deliver on-going support to Mary. The judgement to disclose to Mary was determined following the information gathered as part of this Disclosure Scheme process. It is not known to the panel what subsequent risk assessments, if any, were undertaken to reach this decision. The disclosure to Mary was made in person at her home address. It was delivered by two police officers and the panel heard no information that a multi-agency forum considered other agencies to be involved in the delivery. It is good practice to consider joint-agency approach to the disclosure provision. The panel have made a relevant recommendation. (Recommendation 4)

16.2.7 SYP dealt with domestic abuse in May 2020, where John had shown physical aggression towards Mary and made threats to kill her and went to fetch a shotgun, that he owned, as he left the property. John was not holding a firearm when he made the threats to Mary. Mary did not make a direct report to the police. The panel learnt that Mary was visited by the police following the disclosure she had made at school and it was during this initial contact that Mary made the second complaint. Both incidents were indicators of domestic abuse as defined with the cross-Government definition. See Appendix A. The panel heard that a shotgun had been used to threaten Mary during the first domestic abuse incident and that this was an overt demonstration of controlling and coercive behaviour by the use of a firearm. John was a registered firearm certificate holder. His licence was granted on 5 August 2016 and would have been valid until 4 August 2021. The panel felt that possession and use of firearms should escalate risk where domestic abuse is known and recognised the associated risk to professionals too.

16.2.8 Home Office guidance[40] provides the operational framework in relation to medical involvement in firearms licencing. The guidance does not mandate the requirement of medical involvement, however several police forces in England and Wales have departed from the guidance, including SYP[41]. There are relevant medical conditions which applicants for a firearm or shotgun certificate are required to declare on the application form. As part of the application process the police may ask some applicants to obtain and pay for a medical report to assist with their consideration of medical suitability.

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40 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/518193/Guidance_on_Firearms_Licensing_Law_April_2016_v20.pdf

41 https://basc.org.uk/med/

In John's case, SYP made enquires with Field Road Surgery and a GP provided a supportive letter dated 17 June 2016.The panel heard that there was no record in John's GP notes of the SYP enquiry. The CCG IMR author outlined the advice issued at the time to GPs, from the Doncaster Local Medical Committee and it was not advised to add flags to patients records due to the imprecise nature of flags, absence of reliable software and the lack of clear protocol for removal. The panel learnt there is ongoing work with the Home Office to address this.

16.2.9 Statistics on firearm and shotgun certificates issued by police forces in England and Wales under the Firearms Act 1968 (as amended)[42] show that in the year ending 31 March 2020, 586,351 people held a firearm and/or a shotgun certificate, a 0.8% decrease since the previous year. There were 7,962 new applications for firearm certificates, of which 97% were granted and 3% were refused. 18,857 new applications for shotgun certificates, of which 97% were granted and 3% were refused. In the same period 371 firearms certificates were revoked, a decrease of 1% (-5) compared with the previous year and 0.2% of the total firearm certificates on issue. 1,141 shotgun certificates were revoked, an increase of 2% (+25) compared with the previous year and 0.2% of the total shotgun certificates on issue.

16.2.10 The panel heard that the initial police response was to ensure that Mary had support and gather evidence to support the criminal investigation. The information relating to threats to kill and physical assaults provided by Mary and the fact the John had access to firearms informed the DASH risk assessment, which was assessed as high risk. The panel heard that immediate safety measures were taken with Mary and her family supported with alternative accommodation out of the area offered by the Army. The panel felt that was an appropriate response in addressing immediate safeguarding needs.

16.2.11 SYP informed the review that there is a good working relationship between Firearms Licensing Department and Domestic Abuse Risk Assessment Team. Within Firearms Licensing during the application processes, including renewals of Firearms certificates, where it is identified that there is a history of violence or other areas of risk, procedures are in place for contact with the relevant department, including domestic abuse and safeguarding to share information. Within the Domestic Abuse Risk Assessment Team where it is identified that a person involved in an incident is a Firearm Licence holder the case is referred to the Firearms Licensing Department for consideration of further action, including revocation of Firearms.

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42 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903213/statistics-firearm-shotgun-certificates-england-wales-2019-2020-hosb1820.pdf

16.2.12 The panel felt that there was some multi-agency awareness of the threat's John presented to Mary and individual agencies were working to support her, however there was little evidence of frequent sharing of updates collectively to understand what the situation was like for Mary. The panel determined that arguably agencies had "lost sight" of John as they focussed their efforts to help Mary. The panel have identified this as learning and made a relevant recommendation. [Recommendation 5]

16.2.13 The panel felt that the prompt arrest of John was positive. Following John's arrest and interview his release on police bail with conditions was the only option available, whilst a prosecution file of evidence was being compiled for the CPS to consider appropriate criminal charges. The panel heard that Mary's case was classed as an 'Orange' case, which meant that the investigating officers had 72 hours to submit the prosecution file and thereafter the CPS to respond with their decision within 28 days.

16.2.14 The releasing of John into the community with bail conditions after his arrest was a concern for some panel members. The panel heard from SYP that a Domestic Violence Protection Notice (DVPN)[43] was not appropriate in these circumstances as John had been released on bail conditions which were seen as appropriate safeguarding measures; whereas the use of a DVPN could have provided Mary with additional support and time to consider her situation, giving her a 28-day period to take appropriate action.

16.2.15 The panel saw evidence of bail conditions to mitigate the risk of further offences and a support package around Mary provided by IDVA, AWS and Children's Social Care. Mary was supported by an IDVA, who from 5 May 2020 to 4 June 2020 contacted Mary on six occasions. A home visit was undertaken with physical control measures completed and safety planning discussed. There were also a further two contact attempts.

16.2.16 John's attempt to take his own life, on 15 May 2020, was a clear example of controlling and coercive behaviour intended to provoke Mary to resume contact in breach of his bail conditions. This was the day before Mary's birthday. John was arrested for a breach of bail and for Section 39 assault upon discharge from hospital. SYP presented evidence to the CPS who determined that John be charged with Section 39 assault and breach of bail. The panel have had sight of the MG3 form that was submitted to the CPS and decision making. No charges were made in relation to the threats to kill.

[43] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

16.2.17 SYP made a referral to Adult Social Care following John's overdose. A decision was reached that the referral did not meet safeguarding adult's thresholds and the information was shared with DCST and the hospital integrated discharge team. At this time there was an ongoing Child and Family Assessment and a criminal investigation. The panel questioned whether an effective multi agency response took place and felt that there was a missed opportunity to convene a professional's meeting to share information and see the wider pattern of controlling and coercive behaviour by John. The panel agreed that good safeguarding practice would have been to communicate with John's GP and ascertain whether there was any information to assist in the decision making. The panel heard that neither John's previous GP practice, nor his new one, received an Adult Safeguarding referral. A discharge letter from hospital was received at the new GP practice but correspondence from the mental health crisis team who had seen John at hospital was not received. The panel have been informed that a practice review of its removal process is currently taking place.

16.2.18 The panel also learnt that the IDVA had liaised with SYP Integrated offender Management unit (IOM) to establish whether John was known to them on their cohort of offenders. John was not part of the IOM Cohort. The panel considered it may have been appropriate for John to be proactively managed by SYP given his high-risk status and bail conditions. SYP have identified this as an area of learning.

16.2.19 The panel learnt, from information Mary provided to the AWS, that John had been a perpetrator of domestic abuse towards her prior to the report on 5 May 2020. John had possession of weapons and ammunition, sending unwanted gifts and was refusing to accept Mary's wishes to end the relationship. These are recognised controlling and coercive behaviours as defined by the Serious Crime Act 2015. See Appendix B. As a perpetrator John used a wide range of tactics against Mary, these included –

- emotional abuse
- physical abuse
- threats to kill
- threats to take his own life
- threats to identify Mary as a bad parent
- spreading lies about her mental health
- isolating her from her family and friends
- preventing her from seeking help

16.2.20 The panel heard that John was referred to the Single Point of Access for Cognitive Behavioural Therapy (CBT). The referral originated from his GP at the time and stated – 'he has always had a low-grade irritability to many things with occasional episodes of anger'. The GP suggested that the 'simple anger management' would not be conducive to him and he believed CBT may help modify his behaviour. The referral appeared to have been directed for IAPT intervention and was transferred following review by a senior member of the clinical team. An 'opt in' letter was sent to John on 29 November 2018 requesting he contact IAPT to make an appointment within 14 days of the letter. There is no documented evidence within John's clinical records that he made contact with IAPT and he was subsequently discharged from their service on 14 December 2018.

16.2.21 Case summaries for Mary's MARAC were circulated on 7 May, eight working days before the meeting was held. The expectation on receipt of the case summaries is that agencies research information held, and risk management action is taken as soon as possible rather than waiting for the MARAC to be held. The panel heard that DBTH and RDaSH could have placed a flag on Mary, John's and Toni's records at the point when they received the case summaries, however this was not done until the MARAC was held. The IMR author's for DBTHT and RDaSH identified learning and have made a relevant recommendation. The MARAC process within DBTHT and RDASH have been reviewed and records are now flagged at the point of receiving the case summaries, rather than after attendance at MARAC. (This is addressed in Term 3) RDaSH are reviewing MARAC processes.

16.2.22 MARAC case summaries and invitations are sent to a core list of agencies which includes Children and Adults social care, IDVA, Police and health. When other services are involved, they are invited on a case-by-case basis In Mary's case, the MARAC coordinator was not made aware of the involvement of the Army nor the AWS and they were not sent case summaries nor invited to the meeting. The panel heard that GP attendance at MARAC is unrealistic due to resources. However, following discussions between the CCG and MARAC, now the IDVA will be the liaison contact for GP's and for MARAC and will ensure the relevant information is shared for MARAC. The IMR author for Doncaster CCG identified this as learning and has made a relevant recommendation.

16.2.23 The panel heard how John had become involved in taking Toni to and from school and it was noted by school that it was only ever either Mary or John who collected Toni, they were never seen together at school. This was not unusual in the circumstances as due to the pandemic; school had directed parents and carers to only have one person dropping off and picking up to minimise transmission on site. Toni seemed happy around John with no concerns until the disclosure was made.

16.2.24 The panel heard that Mary had also disclosed to her Social Worker, behaviours from John that included physical aggression, threats, emotional abuse and controlling behaviours. The panel learnt that due to Mary confirming the relationship with John had ended that he was not considered in the assessment. The panel felt that there was an over optimism for the safety of Mary and her child with the knowledge that the relationship had ended. The panel recognised missed opportunities to see the continued risks with John and his pattern of controlling and coercive behaviour. This the panel felt was applicable across all professional agencies.

16.2.25 The panel heard that the assessments conducted by the IDVA also gave clear indication of coercive and controlling behaviour from John.

16.2.26 Information gathered during the homicide investigation and during the review identified that Mary was frightened of John and that his behaviour towards her was coercive and controlling. John would text Mary to see where she was and how long she would be, he made threats to take his own life if she didn't go to him and isolated her from going to appointments when she was trying to get help. Mary disclosed that she had missed appointments due to John's behaviour.

16.2.27 The family informed the review of John's behaviour which they state that looking back since her murder was clear evidence that he was isolating Mary and controlling her movements. These incidents are captured in Section 14.

16.3 Term 3

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

16.3.1 Following Mary's admission as an inpatient on the Acute Medical Unit at the Doncaster Royal Infirmary in September 2019, the panel heard that an initial FACE risk assessment completed at the time of the first assessment at the Doncaster Royal Infirmary indicated that there was 'no apparent risk of abuse or exploitation by others' and scored '0' on this category of risk. Within the categories of 'personal circumstances indicative of risk', the sub-categories of abuse, neglect, victimisation by others (adults or children including domestic violence), and domestic abuse, are both categorised as 'no' for historical risks or current risks. This was the appropriate assessment to complete at that time and the panel appreciated that this was based on self-reporting by Mary.

16.3.2 The panel learnt that Mary had continuing support from the HTT following discharge from DRI. The GP received a letter which stated Mary was discharged from the HTT on 17 September 2019. Mary had been referred to IAPT services on 11 September 2019. She was seen for an initial assessment on 20 September 2019, identifying trauma related symptoms which required additional treatment through Cognitive Behaviour Therapy (CBT). On 1 October 2019 the therapist followed up to complete the Impact of Events Scale Questionnaire which is a recognised measure for trauma and to collect further information. The case was discussed on 7 October 2019 and agreed that Mary would need to be placed on a waiting list for high-intensity CBT.

16.3.3 There was a wait of approximately three months for this and Mary was placed on a waiting list. The panel discussed whether this was a normal waiting time and learnt that although monitored internally within the service there is no current national monitoring of waiting times for second 'waits', i.e., Mary was seen quickly by IAPT for the initial assessment and then stepped up for the high-intensity CBT treatment which she then commenced. RDaSH confirmed to the panel current waiting times (as of November 2020) were around 14 to 16 weeks for CBT.

16.3.4 The panel were informed that the nature of CBT often means that individuals may have initial contacts closer together with later ones being spaced out to allow individuals to undertake 'homework' based tasks. Mary commenced CBT treatment on 29 January 2020 (her first session for assessment; session 1 the following week). The panel felt that Mary's mental health needs appear to have been met through this service and there was no negative impact on her treatment due to waiting times which were within the recommended time periods that the Trust had set as a target.

16.3.5 Following her treatment, it is evident that Mary was working on symptoms associated with Post-Traumatic Stress Disorder. The panel heard that the Team Manager had clinically reviewed Mary's notes, there were no significant concerns raised or noted related to elements of risk which would have prompted a different response.

16.3.6 The panel heard that Mary cancelled one IAPT appointment on 11 March 2020 and the reason for this is unknown. A message was left with the therapist by IAPT admin to call Mary back to rearrange the appointment. This was rearranged to 1 April, which meant there was a three-week gap between appointments which Mary was agreeable to and the therapist believed to be acceptable.

16.3.7 The panel heard that on 17 March 2020, Mary telephoned the GP and stated that she was feeling worse and becoming more anxious. Mary was concerned that therapy was making her situation worse and she did not feel she was improving. The panel determined that it would have been beneficial had various clinicians been able to directly share important information regarding her mental health. In Mary's case this could have been between the Army Doctor, GP and IAPT. This may have taken some pressure off Mary as she was finding it difficult with several agencies being involved and it seemed as if the only communication between these agencies was via Mary.

16.3.8 Mary's last contact with primary care was on 27 March when she reported having night terrors. Mary was started with CBT. The panel felt that there may have been opportunity to explore the 'night terror' comment further. This contact was a telephone consultation, and it was noted previously in Mary's records that her partner may answer the mobile phone, therefore it may not have been safe to routinely enquire about domestic abuse with presentation of anxiety and depression. An assumption may have been made that it related to Mary's army experiences as these symptoms were reported in September 2019. The panel heard that GPs are encouraged to recognise the importance of professional curiosity in relation to domestic abuse where indicators such as mental health issues are present. In Mary's case there is no documented evidence that this was explored with Mary.

16.3.9 Following Covid-19 restrictions on 23 March 2020, IAPT appointments were conducted via telephone rather than face to face. Mary did not attend a telephone appointment on 8 April. At the time of Mary's non-attendance, a 'did not attend' (DNA) policy was not in place. The therapist attempted telephone contact and left a telephone message. Mary did not respond. Mary's case then remained 'open' and she was not discharged from the service. This was a recording oversight and normal practice would be to give the patient sufficient time to respond to messages prior to the case being closed to IAPT. The panel learnt the Trust policies on individuals disengaging with services was reviewed and there is now one new DNA policy and procedure in place [44] which incorporates management of adults and also safeguarding children, in respect of where adults have caring responsibilities. The review of the policy was planned prior to the learning from this DHR and was in line with the Trust focus on a think family approach to safeguarding children and adults.

[44] https://www.rdash.nhs.uk/wp-content/uploads/2020/11/Disengagement-Policy-v1.pdf

16.3.10 Following Mary's disclosure of domestic abuse, the school undertook a risk assessment with Mary by telephone, ensuring that John would not be coming onto school grounds at the end of the day to collect her child. The panel learnt that this risk assessment was discussed with police and there was an agreement that if John did come onto school grounds the police would be rang immediately. This was deemed appropriate in the circumstances. The school received updates from Mary that John had been arrested and was released on bail. The panel learnt that the police did not update the school with John's bail conditions.

16.3.11 DCST completed a DASH and Child and Family Assessment, the latter, in line with the statutory responsibility for local authorities under Section 47 Children Act 1989[45]. The purpose of a Child and Family Assessment is to gather sufficient information about the child and family to understand its needs and make decisions about: The nature and impact of the concerns or needs described in the referral and what intervention or support is necessary; Whether the child meets the criteria for ongoing services as a 'Child in Need'.

16.3.12 The panel learnt that the social worker with responsibility for the assessment with Mary and the AWS, were aware of each other's contact and there were professional discussions in relation to continuing assessment and support. The outcome of the Children and family's assessment was no further action for DCST. This decision was based on the information available, the support in place and no evidence to suggest the relationship between Mary and John had not ended. The Social Worker updated the AWS on 19 May confirming the case would be closed following their assessment as there were no risks identified to Toni. Mary was identified as a protective factor; school were also supporting and there were control measures in the family home. This was deemed an appropriate outcome for DCST. The panel learnt that the DCST case would have closed at this point anyway and closure was not due to the ongoing AWS support. The social worker did not make it clear to the AWS that they were expected to continue as lead support for Mary. If Mary had not been supported by the AWS, DCST would have signposted Mary to other domestic abuse services at the point of closing their case. The panel felt the information between the DCST and AWS could have been communicated more clearly.

16.3.13 The AWS have identified learning for its staff around challenging other agencies who appear to be overly optimistic and assume safety is achieved for a survivor of domestic abuse when they and the perpetrator have separated. This is a difficult but necessary task for AWS as a non-statutory agency.

[45] https://www.legislation.gov.uk/ukpga/1989/41/section/47

16.3.14 The panel also recognised that the apparent over optimism for Mary's situation due to the relationship with John "ended", as identified previously in the report, may have influenced the decision for John not to be included in the Children and family assessment.

16.3.15 Research tells us that the point of separation in a relationship increases risk of harm to victims. The Femicide Census released in November 2020, revealed that 1,425 women were killed by men between 2009 and 2018. In 62 % of cases, the relationship between the perpetrator and the victim was that of current or ex-spouse or intimate partner being 888 of 1,425 cases. Women who had recently left an abusive partner were most at risk. Of those who were killed by a current or ex-spouse/partner, 378 (43%) had separated or taken steps to separate and 89% of these were killed within the first year and 38% within the first month of having separated/taken steps to separate. This highlights the fact that leaving is often a risk factor for escalated violence and that just because a woman leaves – or has left – a perpetrator does not mean she is free of the danger[46].

16.3.16 The initial AWS contact with Mary established that DASH RIC had already been completed by the Police. The panel heard that the decision made by AWW was to seek a copy of this rather than complete again with Mary. The AWW assumed that the Police had referred the case to MARAC. Learning has been identified by AWS around the MARAC processes.

16.3.17 The panel recognised that this was also an opportunity for AWW to link in with IDVA although the AWW indicated that Mary was unclear about who else was involved and what their role was, making it slightly more cumbersome for AWW to seek out the IDVA. The panel felt that it would be helpful for all agencies to be aware of each other's involvement and that this would have assisted in supporting Mary.

16.3.18 The AWS assessments presented an opportunity for an AWW to use best practice knowledge and tools to analyse information provided by survivors of abuse and to seek to understand the perpetrator pattern and its direct and indirect impacts on Mary and Toni, and the overall family functioning. The panel heard that the Safe and Together Mapping tool provides a framework for this domestic abuse informed practice, including identifying what is not yet known. However, in Mary's case the Mapping Tool was not used as Mary had identified that she did not want domestic abuse to be the focus of the work with the agency.

[46] https://www.femicidecensus.org/reports/

16.3.19 The AWW did gather and record pertinent information and the record was professional and clear, recording in detail many aspects of John's abusive behaviour. The panel heard that by balancing the wishes of Mary and based on disjointed initial contacts, the AWW completed the assessment, knowing Mary was entitled to see it. AWW intended to use the mapping tool/aide memoire in future work with Mary. The panel learnt that the analysis did not fully link the information given by Mary about John's behavioural choices and the risks which needed to be understood in the context of domestic abuse research findings. It did not mention that John had previously prevented Mary from accessing support and that he had threatened her with a shotgun. Overall, the risk identified as being to her emotional well-being. The Mapping tool would have allowed the AWW to clearly analyse and articulate the risks. This has been identified as a learning point for the AWS.

16.3.20 The panel heard that once a copy of the DASH was received by AWW, it was added to Mary's case file and no further action was taken. The panel heard that the AWW indicated that Mary was considered to be at the highest risk already and the DASH did not alter this view. The panel heard that best practice would have seen the information contained in the DASH used to revisit and re-analyse the initial AWS assessment and possibly seek additional clarity on safety planning for Mary and her child.

16.3.21 The panel heard that on 2 June 2020, with the AWW's realisation that Mary was no longer engaging with AWS, led the AWW to contact Mary's Army Unit supervisor. It became apparent that Mary had not responded to several telephone calls and emails since 14 May 2020. This action from AWW was responsive and logical and importantly based on Mary's past record of good contact with her Army Unit, and therefore had some chance of success. The panel learnt that in addition to this response, best practice would have included AWS revisiting the statement Mary had made previously about John preventing her from seeking help. In turn this may have prompted an escalation of the shared concerns to MARAC (though acknowledging that AWS had not at this stage been informed if a MARAC had been convened).

16.3.22 SYP officers and DCST completed separate DASH assessments which assessed Mary as 'high risk'. The police removed John's firearms in recognition of the risk and appropriate referrals were also made to DCST, IVDA and MARAC. The decision to invoke the DVDS, was appropriate. This has been addressed in Term 2.

16.3.23 SYP informed the panel that all high-risk domestic abuse incidents are dealt with by Specialist Protecting Vulnerable Persons domestic abuse team. A Detective Sergeant allocates the investigation, sets investigation plans, complete reviews and oversee enquiries whilst the suspect is in custody, including reviewing the investigation prior to any bail decision. The panel learnt that due to the lack of previous convictions for John, no record of him offending on bail or failing to surrender to bail and no previous convictions between John and Mary there was no realistic prospect of achieving a remand in custody. Where officers are not seeking a remand in custody CPS will only provide advice on charging on the Full Code Test (all evidence must have been obtained and sent to them). Statements from Mary's friend and Mary's child (potentially an Achieving Best Evidence[47] account) were still to be obtained so this was not a realistic prospect during the 24-hour custody time limit for John, hence he was granted conditional bail. When John breached his bail conditions officers had grounds to request a remand in custody and so were able to approach CPS for charging advice whilst he was still in custody. In these instances, advice can be provided as long as the Threshold Test has been met (there may be outstanding evidence to be obtained however there is sufficient to show the suspect has committed the offence).

A copy of the subsequent CPS decision has been seen by the panel. The below paragraph from the reviewing lawyers' comments has been shared:

'I have considered the relevant charges; the suspect has injuries to her face which are consistent with s.39 Common Assault by Beating. I do not authorise a charge of Threats to Kill. This is a very difficult offence to prove and there is no evidence that the suspect made a direct threat to kill the complainant intending her to believe the threat'.

16.3.24 The MARAC was chaired by the IDVA services manager and assessments and information in relation to Mary's case were presented by SYP and DCST. There was no representation from the CCG GP, Army or AWS. The panel agreed this was a missed opportunity to accurately share all available information. The panel identified that disclosure to primary care or at least notification of MARAC to Mary and John's GP would have provided a point of contact for more detailed information as needed and alert them of the domestic abuse. The panel have identified this as learning and made a relevant recommendation. [Recommendation 1]

47 https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

16.3.25 In early March 2021, a Multi-agency Tasking and Co-ordination process (MATAC) commenced within South Yorkshire to respond to serial perpetrators of domestic abuse. This approach seeks to embed behaviour change in repeat perpetrators of domestic abuse via a multi-agency approach and management, using a 'green route' to seek engagement to reduce offending and risk and to proactively prosecute and disperse perpetrators who refuse to engage via a 'red route'. The MATAC has been successfully piloted in other areas of the country following funding from the Home Office.

16.3.26 The panel heard there is work ongoing in relation to information sharing and pathways between services within the Safer Stronger Doncaster Partnership and beyond. Process mapping and other interagency activity has been and continues to be reviewed to improve efficiency and streamline activity. This work is taking place internally within Doncaster Metropolitan Borough Council and external partners in relation to domestic abuse. The work is focussed on the whole family approach to seek to provide appropriate and timely interventions for all individuals affected by domestic abuse. This work has not happened as a result of Mary's murder, it was planned as part of a wide-ranging review of partnership working and will be a component of further multi-agency collaboration as the borough moves through 2021 and beyond.

16.3.27 The decision by Adult Social Care in relation to the referral from the Police, in May 2020 that the safeguarding adult's thresholds had not been met, the panel felt that was a missed opportunity to consider a professional's meeting to fully understand the wider safeguarding concerns.

16.3.28 The panel felt that all agencies had made good use of their internal assessment frameworks and procedures initially and all had documented accurately the risk to Mary. It was noticeable to the panel that there were challenges with ongoing multi-agency working during the Covid-19 pandemic. There appeared to be little evidence of convening a professionals' meeting after MARAC to assess developments and reassess potential risks. In Mary's case the over optimism on the separation as a factor to reduce risk and the difficulties for face to face contact the panel felt that this may have impacted on multi-agency working.

16.4 Term 4

Did actions or risk management plans fit with the assessment and decisions made?

16.4.1 At the time of Mary's overdose (Sept 2019) a full needs assessment and FACE risk assessment was completed. This is standard practice when an individual is assessed by the Hospital Liaison Team in the Emergency Department. The panel heard that decision to admit Mary onto the caseload of the HTT seemed proportionate at the time with clear plans for appropriate interventions identified.

16.4.2 The panel considered, with the added value of hindsight and reflective practice, that as Mary was technically open to IAPT service provision at the time of her murder, there was a missed opportunity to recognise this within the MARAC conference. In addition, the GP had been involved with Mary for her mental health in March 2020. Further information may have been helpful to the management outcome from MARAC. The panel determined that if that had occurred then the risk-related information could have been passed to the clinician who had last had contact with Mary thus prompting an attempt to engage with her, prior to her murder.

16.4.3 The Vulnerability Risk Management plans completed to support Mary by the Army recognised her vulnerability after her overdose and after the disclosure of domestic abuse. The opportunity to refresh and adapt to dynamic changes in Mary's situation was namely based on information provided by her. The panel heard that 8 Rifles did not have any real visibility of the police investigation against John nor of the subsequent proceedings being 'dropped' and therefore missed an opportunity to identify and respond to a significant material change in the situation which may have required a further review of the Vulnerability Risk management plan. The Panel felt that the civilian Police and wider agencies needed to be more open and proactive in sharing information with the Ministry Of Defence.

16.4.4 School demonstrated that an appropriate risk assessment was put in place whilst John was at large following Mary's disclosure. The focus was on keeping pupils and staff safe by way of keeping everyone inside as a precautionary measure should John have turned up on school grounds. Following John's release on bail, staff at the school remained vigilant in terms of checking he was not trying to access the school site.

16.4.5 Mary was supported by DCST and safety planning was considered as part of the assessment that was completed. Mary had Great grandparents who were part of the safety planning as was Toni's father. Toni was attending school which provided further safety. The panel heard that as the relationship with John had ended, Mary was supporting police prosecution and there were no concerns in relation to the care provided to Toni from Mary the involvement from DCST ended on 21 May 2020. This has been addressed in Term 3.

16.4.6 The assessments by SYP in relation to the DASH and a further specialist risk assessment, which resulted in the DVDS have been addressed in Term 3.

16.4.7 The risk John posed with firearms was realised and these were removed on the day of Mary's disclosure by officers from SYP. John's firearms license was temporarily revoked. A review of John's appropriateness to hold a firearms license was also initiated. The panel considered whether SYP could have followed the Threat to Life Protocol (TTL) in Mary's case. The TTL protocol considers the real and immediate threat of harm or injury to a person and involves the police assessing risks, giving people subject of a threat warning called 'Osman warning' and those believed to be causing the threat also receive a warning called 'disruption notice' also known commonly as a 'Reverse Osman'. The panel heard that as Mary was already aware of the threat to her and John had been arrested and was subject of bail conditions that the immediacy of the threat was in the past and other measures were in place to manage the risk posed by John, SYP decided the TTL protocol was not necessary in this case.

16.5 Term 5

When and in what way were the subjects' wishes and feelings ascertained and considered? Were the subjects' informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

16.5.1 It is evident that Mary participated within the mental health assessment and contributed to the process. A 'crisis plan' was devised accordingly and in collaboration with her at the time of her admission onto the HTT caseload. The breakdown of her relationship was one stressor that had been identified at the point of the assessment. Later during her interventions with IAPT it was identified that she had experienced trauma in her personal life none of which were linked to domestic abuse. The panel have considered these as part of the overall information and analysis for the DHR.

16.5.2 Following hospital discharge in September 2019, the panel heard that Mary made an informed choice to be supported by Army medical services. Mary reported to her GP that she had discussed her symptoms of low mood and anxiety with an Army doctor. The review established that Mary later contacted her GP (March/April 2020) in relation to depression and anxiety and was supported with treatment and monitoring of her mental health.

16.5.3 Mary had established friendships and respectful chain of command relationships within her Army regiment and it was clear to the panel that Mary's feelings were sought at all times. As seen in the analysis in Term 1 her wishes around involving the police and subsequently being referred into the AWS were considered.

16.5.4 The panel acknowledged that all agencies involved with Mary had at times been unable to contact her. This was attributed to other things going on in Mary's life, including the ongoing efforts she was already making to keep herself and her child safe and a recent bereavement. The AWW was appropriately responsive and flexible to Mary's needs and requests to move or cancel appointments. The AWW continued to make efforts to contact Mary when engagement changed, and when the AWW was not receiving a response from her.

16.5.5 Mary expressed confusion regarding agencies roles. The AWW responded by acknowledging how she felt and with Mary's consent agreed to contact the other agencies for updates in order that Mary did not have to 'retell her story'. The panel determined that this was good practice and agreed that a multi-agency approach would have been better to seek and maintain engagement with Mary. [Recommendation 1]

16.5.6 The IDVA considered Mary's wishes and feelings throughout the process of their working relationship. It is clear and apparent from the case notes that Mary was allowed to express her own opinions and was able to make her own choices. The IDVA made decisions with Mary and a referral was made to South Yorkshire Fire and Rescue Service for a fire safe risk assessment to be carried out at Mary's home address. Mary was also advised around possible Refuge for alternative accommodation but Mary had been accommodated out of area via the Army.

16.5.7 There was openness and transparency with Mary about the obligation to involve statutory services, once child protection concerns were evident by the school. In this case, Mary's wishes and feelings were rightly overridden to ensure the safety of herself and her child. In undertaking this action, the school followed the procedures as set out in the Safeguarding and Child Protection Policy[48].

16.5.8 The Social Worker obtained Mary's wishes during the completion of the Child and Family Assessment, this included safety planning and Mary's willingness to engage with AWS around domestic abuse. During the completion of the Child and Family Assessment Mary provided information about herself and her relationship with John. The outcome of the assessment was explored as well as reiterating Mary's engagement with AWS and police. It was known to DCST that Mary had also already received support from IDVA service. The panel heard that as there was no ongoing relationship with John and he was not the father of Toni, there was no exploration within the contacts whether John's view of the relationship was the same as Mary's. The panel agreed that this was a missed opportunity. DCST have identified this as learning and made a relevant recommendation. [See Term 3 and 4]

[48] https://www.richmond.doncaster.sch.uk/serve_file/705997

16.5.9 SYP throughout their contact with Mary, considered her wishes and feelings, initially establishing that she wished to support a criminal prosecution and ensuring her safety with the support of temporary move in accommodation and bail conditions placed on John. Mary's consent was obtained on the DASH risk assessment which allowed for sharing of information to other agencies and services. [See Term 2, 3 and 4]

16.5.10 The panel learnt that on the DCST DASH risk assessment Mary had expressed a view that there may have been a chance of reconciliation with John if he were to seek and receive the appropriate help. However, the panel heard no evidence of professionals asking Mary directly what her views were on the likelihood of reconciliation with John following the DASH being completed. It is clear that there was an over optimism on the risks to Mary being minimised as the relationship had ended.

16.5.11 Mary's wishes to withdraw her support for a criminal prosecution were accepted by SYP and it is documented that during the statement obtained from Mary she referred to the assault on her as a 'minor incident'. The panel felt that this minimisation by Mary was concerning and it would have been beneficial to explore her wishes in this instance more carefully to ensure that she was not under any duress or subject of controlling and coercive behaviours from John to withdraw the statement. Colin informed the DHR Chair and Author that he had been with Mary when she telephoned the Police to ask to withdraw her statement. Colin was not with Mary when the statement was taken.

16.5.12 A copy of Mary's statement was made available to the panel and in addition to the Criminal Justice Act section 9[49] paragraph at the start of the statement it is documented that Mary provided the statement under her own free will and not under duress. The panel considered Mary's capacity at the time of providing this statement to SYP and acknowledged that she may have been minimising the risk due to feeling frightened and still experiencing indirect fear of John's passive control and coercion. The panel heard that the statement was emailed to Mary to read and sign and felt that whilst the email went to an email address that it cannot be confirmed who returned it with the electronic signature. The panel also established that SYP practice of obtaining retraction statements in domestic abuse cases by specialist domestic abuse trained officer was not consistent across all SYP areas. SYP have recognised an opportunity to review and revise the procedural instruction.

[49] Criminal Justice Act 1967 section 9

16.5.13 The panel felt the use of the word "retraction" was misleading as Mary was withdrawing her support to continue with the ongoing criminal prosecution, rather than stating that her witness testimony was inaccurate and that the events had not occurred. The fact that the statement was taken over the telephone left the panel wondering how fully Mary's request to withdraw her support for a prosecution was explored with Mary. There was no face-to-face contact with Mary and no contact with other agencies to discuss the request. It was a single agency decision and a missed opportunity for multi-agency engagement. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 4]

16.5.14 The panel recognised the benefits of having an IDVA involved in the process of withdrawal of support, ensuring that elements of coercion or duress can be properly assessed, and maximum support provided to victims of domestic abuse. The panel also felt that consideration of mental health opinion about Mary's capacity to make a decision to withdraw support for prosecution could have been considered. The panel recognised that support should be timely, responsive and would be intensive in terms of availability and time. There were 4.5 established IDVA roles in Doncaster who support high risk cases of domestic abuse. The panel have made a recommendation to the Community Safety Partnership in relation to service provision and capacity within the IDVA service. [Recommendation 4] There are now 6.5 established posts in response to the growing demand to the service during 2020/21.

16.6 Term 6

Did the agencies have policies and procedures for Domestic Abuse and Safeguarding and were these followed in this case? Has the review identified any gaps in these policies and procedures?

16.6.1 The DHR panel have been informed that agencies involved in the review had in place policies and procedures for domestic abuse and safeguarding These policies detail the expectations of staff, enabling victims to talk about their experiences, assessing the risk to victims and children, safety planning and providing support and information and signposting to specialist domestic abuse services. All agencies recognised that the incidents amounted to domestic abuse and therefore policies and procedures were followed.

16.6.2 RDaSH have reviewed their non-attendance policy. The review was already planned prior to the learning from this DHR. [See Term 3]

16.6.3 SYP recognised an opportunity to revise the procedural instruction in relation to obtaining retraction statements from victims, to ensure the statements are taken face to face, using domestic abuse trained officers for domestic abuse cases and with supervisory oversight.

16.6.4 The panel determined that there is a need for a review in relation to information sharing and agencies contribution to MARAC. This has been addressed within Term 1, 3 and 7. [Recommendation 2]

16.7 Term 7

Were there any issues in relation to capacity or resources in your agency that effected its ability to provide services to Mary, Toni and/or John, or on its ability to work effectively with other agencies? NB Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

16.7.1 There were no significant issues identified in relation to capacity or service delivery in relation to adult mental health. The panel heard that the timescale from Mary's discharge from the HTT to accessing IAPT services experienced a wait of approximately three months and was within the acceptable time limits. [See Term 3]

16.7.2 Mary's appointment date with IAPT in late March 2020 was re-arranged from a face-to-face appointment to a telephone consultation due to the practice changes as a direct result of the Covid -19 pandemic. The panel heard that this did not appear to have any significant impact on actual service delivery from IAPT.

16.7.3 There were some restrictions on the availability of primary care to do face to face assessments due to the Covid-19 pandemic, but this did not impact on the ability to access a GP or practice nurse, and the panel have seen evidence that Mary was offered telephone consultations on the same day when she contacted the practice for advice.

16.7.4 There were minimal staff working in the school at the time of the incident in May 2020, due to the Covid-19 pandemic; however, the school ensured that there was always someone responsible for safeguarding on the premises. This was evidently effective with the school acting appropriately and responding to the disclosure in May.

16.7.5 The work undertaken by the Multi Agency Access Point (MAAP) following referral led to an immediate allocation of a social worker. There was no negative impact on the timeliness and thoroughness of the support and advice provided to Mary in relation to safety planning.

16.7.6 All of Mary's contact with the AWS occurred between April and June 2020, during the period of Covid-19 pandemic. AWS staff were working from home and undertaking contact over the phone or using Microsoft teams rather than face to face contact. Normally the worker would have been physically co-located with their supervisor which provides overt supervision. At this time, like many agencies, AWS was working to revised priorities and dealing only with cases identified as holding risk. In Mary's case services were prioritised as a high-risk case and actual delivery of service continued effectively.

16.7.7 SYP experienced an overall increased demand for policing services during the Covid-19 pandemic. At this time SYP procedure required that all reports of domestic abuse were to be dealt with in person. During this period officers were given best practice guidance on how to take statements by telephone where this was appropriate. In Mary's case the panel were informed that this instruction had been incorrectly interpreted by an Officer, which resulted in Mary's retraction statement being obtained via telephone and email. Following the murder of Mary, SYP issued a reminder to all officers that DASH risk assessments and domestic abuse victim statements must be conducted in person and not over the telephone and that Covid-19 safety policies and social distancing were to be adhered to. The DHR panel have had access to the briefing notice issued by SYP. This has already been analysed in term 3 and 4.

16.7.8 There was a significant rise in referrals to IDVA service at this time, with increased reporting of domestic abuse to police, and this coupled together with staff sickness, directly related to Covid-19, impacted on how the service operated. The team had to adapt to work remotely and this necessitated working with clients by telephone with minimal face to face or home visits being possible. The panel heard that there were capacity issues with staff members being expected to take on more cases than normal. However, the assessment of support provided to Mary the panel felt was not unduly affected.

16.7.9 Referrals into MARAC increased with MARAC meetings being held every two weeks. On the day of Mary's MARAC, a total of 47 cases were heard. Mary's case was listed at number 43. Soon after this MARAC, a strategic decision was made that there should be a limit of 30 cases heard at MARAC. It is recognised that this figure is over the recommended Safelives guidance to limit cases to 15[50]. The panel were informed that the high level of MARAC caseloads had been identified approximately a year earlier, when it had been agreed to consult with partner agencies in terms of

[50] https://safelives.org.uk/sites/default/files/resources/Guidance%20for%20Maracs%20-%20High%20Volume%20NB.pdf
https://safelives.org.uk/node/521
https://safelives.org.uk/practice-support/resources-marac-meetings/latest-marac-data

frequency of meetings and case numbers to be heard. Due to a change in personnel, and then the impact of Covid-19 pandemic, this did not progress until May 2020. The panel concluded that the MARAC and associated policies should be reviewed, as case numbers are likely to continue to increase. [Recommendation 2] The panel were informed that following a further review MARAC meetings are now held over 1.5 days, hearing a maximum of 45 cases over this period. The content of MARAC decision making and working effectively with other agencies has already been covered in the analysis in Term 2, 3, 4.

16.7.10 YAS were unable to permit Mary to travel in the ambulance when they responded to John's overdose, due to restrictions during the Covid-19 pandemic. The panel heard that had this occurred there may have been more opportunity for the crew to provide signposting advice to Mary.

16.7.11 With all agencies working differently and remotely due to the pandemic, there were pockets of organisations that did effectively deliver a joined-up approach resulting in Mary gaining valuable support. It was more problematic to secure consistent face-to-face contact due to the climate and more of the contact was virtual and over the telephone. The panel acknowledged that nationally, just under a quarter of services (22%) reported seeing an increase in demand during the Covid-19 pandemic[51].

16.8 Term 8

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues when completing assessments and providing services to Mary, Toni and/or John?

16.8.1 Section 11 of this report sets out the issues of equality and diversity and considers whether either Mary or John should be treated as having a disability. Consequently, that information is not repeated here. Mary and John had contact with agencies in relation to their mental health and at the time of Mary's murder she was an open case with a specialist mental health practitioner. [See Term 3]

16.8.2 The DHR panel learnt that there were no known issues in relation to racial, cultural, linguistic, faith or diversity when completing assessments and providing services to Mary, Toni and John.

[51] https://safelives.org.uk/news-views/domestic-abuse-and-covid-19

16.8.3 Research acknowledges that women are more likely to experience domestic abuse then men[52]. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2017)[53]. Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

16.8.4 ` Mental illness and domestic homicide: A population-based descriptive study 2013' [54] [55] focused on all convicted adult domestic homicide perpetrators in England and Wales between 1997 and 2008. The study identified that 20% of intimate partner homicide perpetrators and 34% of adult family homicide perpetrators in England and Wales had symptoms of mental illness at the time of offense, higher than had been reported amongst perpetrators of other types of homicide. When comparing the sociodemographic characteristics of adult family homicide perpetrators with and without symptoms of mental illness at the time of offence, the study identified no differences in respect to sex, age, racial-ethnic minority status, marital status, or living arrangement. Perpetrators with symptoms of mental illness were, however, less likely to be employed.

16.9 Term 9

What learning has emerged for your agency?

16.9.1 Agency learning is identified with Section 17.1 of this report.

16.10 Term 10

Are there any examples of outstanding or innovative practice arising from this case?

16.10.1 Whilst not outstanding or innovative practice per se, the speed of the response following the initial disclosure of domestic abuse by Mary demonstrated by school, DCST, IDVA, AWS and SYP the panel determined was positive.

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[52] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/

[53] Office of National Statistics

[54] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201200484

[55] Dr. Oram and Prof. Howard are affiliated with the Department of Health Service and Population Research at the Institute of Psychiatry, King's College London, PO31 David Goldberg Centre, De Crespigny Park, London SE5 8AF, United Kingdom (e-mail: sian.oram@kcl.ac.uk). Dr. Flynn, Prof. Shaw, and Prof. Appleby are with the Centre for Mental Health and Risk, University of Manchester, Manchester, United Kingdom.

16.10.2 The panel recognised that working from home and using telephone contacts to maintain support for Mary was a positive effort in the circumstances of the Covid-19 pandemic. However, the review identified that this was not without its challenges and impacted on engagement with Mary and with multi-agency working. [See Term 7]

16.11 Term 11

Does the learning in this review appear in other domestic homicide reviews commissioned by Safer Stronger Doncaster Partnership?

16.11.1 MARAC services and development of the process to improving communication between agencies has appeared in other reviews[56], including updating MARAC policy and procedure.

16.11.2 Domestic abuse training and awareness raising in relation to domestic abuse has featured in previous reviews. Raising the awareness of all agencies of the increased risk when a person leaves the perpetrator and the importance of referral to a specialist domestic abuse service at this time to help keep them safe.

16.11.3 Domestic abuse training for Primary Care staff has featured in previous reviews. Raising awareness of domestic abuse and importance of professional curiosity and routinely enquiring about domestic abuse. During the Primary Care training in 2013 all GPs who attended were advised to Ask, Assess and Act in cases of Domestic Abuse and to routinely enquire where possible regarding Domestic Abuse. This was also emphasised in September 2020 at the Doncaster GP training for Children's safeguarding. A domestic abuse training package has been delivered to GPs in Doncaster in 2021.

[56] DHR01/11 and DHR02/11

17. CONCLUSIONS

17.1.1 Mary was killed by her ex-partner John, during a violent attack at his home address. John was charged with Mary's murder and whilst awaiting trial he was found dead in his prison cell.

17.1.2 In September 2019, Mary became known to mental health professionals due to her overdose. Over the following months, Mary was seen by mental health professionals in relation to this and further traumatic life events not related to domestic abuse. At the same time, Mary was supported by the Army medical services.

17.1.3 At the beginning of May 2020, Mary experienced domestic abuse perpetrated by John, which manifested in physical assault and threats to kill her and her child with a firearm. The fear and desperation that Mary felt was captured within the DASH risk assessments completed by professionals. The DASH captured the escalation, controlling behaviours, isolation and fear experienced by Mary. Her situation was assessed as high risk and the case was referred to MARAC.

17.1.4 The review identified the importance of communication between different agencies, especially in relation to significant events which could impact on risk assessments and potential ongoing actions to support Mary. The concern at the difficulty in contact and engagement with Mary was raised with professionals in silo. The lack of contact was seen by professionals as being related to Mary having support via other sources and the wider context of controlling and coercive domestic abuse was not recognised collectively by professionals. At no stage did professionals reconvene after the MARAC meeting to reassess Mary's situation.

17.1.5 The review identified that there was a positive significance placed on the fact that Mary and John were separated. Professionals appeared to be over optimistic that the separation lowered the risks to Mary.

17.1.6 The review identified that the lack of face-to-face contacts with Mary, due to the Covid-19 pandemic, limited the opportunities to identify dynamic risk changes in Mary's situation.

17.1.7 The review identified the importance of accurate recording keeping and recording of decisions between agencies, including which professionals have made those decisions and the rationale as to how those decisions were reached.

17.1.8 The learning from the review has been captured into relevant recommendations which will be progressed through Safer Stronger Doncaster Partnership. The DHR Chair has maintained regular contact with Mary's mother and Colin who have contributed to the review process throughout and provided valuable and relevant information to assist the DHR panel.

17.1.9 The DHR Panel are grateful for Mary's family's contributions and acknowledged their views during their attendance at a panel meeting in March 2021. Mary's family asked questions of the Panel, listened to the learning identified and were appreciative of the review. Mary's family were seeking outcomes which were not within the scope of a DHR. The DHR Chair provided support and signposted Mary's family to address the issues raised with the appropriate organisations.

18. LEARNING IDENTIFIED

18.1 Agencies learning (taken directly from their IMRs)

Army Welfare Service

- Victim engagement plan.
- Review MARAC SOI including proactive engagement with MARAC even when DASH is not completed by AWS.
- Continued roll out of Safe and Together training.
- Review training on impact of diversity on service users.

Doncaster Children's Services Trust

- Engagement with perpetrators during child and family assessments.

Doncaster Clinical Commissioning Group - GP

- Record keeping on routine enquiry for patients who present with domestic abuse indicators.
- Consideration of protocol and reference guide for domestic abuse in Doncaster that can be used in practice by primary care staff.
- Training on domestic abuse and learning from DHR's. To be facilitated through the GP Target training session (planned for 2021)

IDVA

- Refresher training and continued professional development for IDVA's.
- Contact with GP's to be part of the IDVA toolkit.
- MARAC to be reviewed operationally.
- GP contact information to be standing item at MARAC.
- MARAC Information Sharing Agreement to be refreshed.
- All Armed Forces to be included in Information Sharing Agreement.
- IDVA Process Guide amended and refreshed, including contacting GP's.

- DMBC DA training already delivered across multi-agency workforce.

Rotherham, Doncaster, and South Humber NHS Foundation Trust

- Awareness of policy relating to disclosures of historical abuse and record keeping on decision making, treatment pathways or referrals.
- Professional curiosity regarding new relationships should be demonstrated during clinical contacts.
- All staff to handover pertinent information between health agencies
- Awareness of policy for patients who do not engage or miss appointments.
- To check whether cases are 'open' when discussed at MARAC.

School 1

- Information sharing training.

South Yorkshire Police

- Use of retraction statements by telephone. (Immediately rectified)
- Safeguarding following retractions statements, including review of consideration of evidence led prosecution.
- Proactive monitoring of domestic abuse perpetrators.

Yorkshire Ambulance Service

- Awareness of high-risk features of abuse and access to evidence-based tools to support assessment.
- Pathways to support victims and escalate concerns in making onward referrals.
- Review the referral process, risk assessment tool (DASH) and referral to MARAC.
- Training and learning material on recognition of and response to domestic abuse.
- Review 'Domestic Abuse: Management Guidance'.

N.B. All above are reflected in YAS Safeguarding Team work plan with a completion date of July 2021.

18.2 The Domestic Homicide Review Panel's Learning (Arising from Panel discussions)

18.2.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at paragraph 17.1. 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
Professionals need to ensure that when engaging with individuals, they consider the wider context and proactively seek out information to identify domestic abuse and have clear information sharing pathways to enable effective multi-agency working and avoid working in silos
Lesson
Embedded and effective information sharing pathways, will support professionals in gaining a better insight to an individual's situation. Ongoing multi agency information sharing will prevent working in isolation.

Learning 2 [Panel recommendation 2]
Narrative
The MARAC process identified Mary as a high-risk victim of domestic abuse. In Mary's case several agencies had contact with her, and many contributed to the support and management of her as a high-risk victim. Greater clarity of agencies involvement with Mary would have ensured all agencies were represented at MARAC. While several professionals were involved it is not clear which, if any agency or professional held lead responsibility for managing Mary's case. A full review of the MARAC will explore the areas identified from this DHR.
Lesson
MARAC relies on the sharing of all available information. A clear MARAC process provides the framework for chairing meetings, case numbers and will support the early identification of a lead professional and agency for a high-risk domestic abuse case. It helps ensure structure and accountability is maintained in the process and also ensures effective information sharing and communication.

Learning 3 [Panel recommendation 3]
Narrative
Information about a person's experience of domestic abuse is often held within services and organisations that may not be the traditional and statutory agencies. In Mary's case this was the Army and the AWS. In order to ensure MARAC action plans are robust all information available must be sought
Lesson
By considering the victim's experience and understanding opportunities to identify wider information available relating to domestic abuse, professionals will maximise obtaining the information available. The Armed Forces should be considered as a source of information.

Learning 4 [Panel recommendation 4]
Narrative
People who are experiencing domestic abuse, seeking help during key decisions and times of crisis, need to know what options are available and specifically when considering withdrawing from the criminal justice process should be supported and understand options available. This should be a multi -agency decision and effective service delivery benefits from co-location and can include help and support from non-statutory agencies. Face to face contact is vital with professionals with the specialist skills. In Mary's case the DVDS disclosure and the obtaining of the withdrawal statement.
Lesson
By having a multi-agency approach to the process of withdrawal of support for a criminal prosecution, others as well as specialist police officers can ensure that elements of coercion or duress can be properly assessed, and maximum support provided to victims. Joint decision making and a multi-agency approach to DVDS would provide the necessary support to victims.

Learning 5 [Panel recommendation 5]
Narrative
An over optimism that the risk level to Mary reduced due to the ending of the relationship with John, left the focus on John's risk as static. Separation is a known risk factor in domestic abuse and further dynamic risk assessments could have been considered.
Lesson
By recognising key material changes in ongoing high-risk domestic abuse cases, ongoing risk can be assessed. It is important that the perpetrator of domestic abuse remains visible to agencies and professionals throughout and to consider proactive opportunities with high-risk perpetrators of domestic abuse.

19. RECOMMENDATIONS

19.1 Panel Recommendations

Number	Recommendation
1	That all agencies provide assurance and evidence to Safer Stronger Doncaster Partnership that information sharing pathways have been embedded and multi-agency information sharing of updates continue throughout interventions to prevent working in isolation.
2	That Safer Stronger Doncaster Partnership review the MARAC protocol in terms of communication, agency involvement, case numbers, frequency of meetings, identification of a lead professional and monitoring of action plans, including consideration of shared IT case management system
3	That all MARAC's should invite relevant Armed Services to be involved in information sharing and the MARAC process where the subject of the MARAC is known to be involved in the Armed Services.
4	That Safer Stronger Doncaster Partnership reviews the multi-agency response to victim engagement during DVDS and criminal investigations.
5	That all agencies consider how to ensure the perpetrator of domestic abuse remains visible throughout and consider proactive opportunities with high-risk perpetrators of domestic abuse.
6	That the Armed Services provide assurance and evidence to the Safer Stronger Doncaster Partnership that the learning disseminated in the Tri-service Domestic Abuse policy is embedded across the Armed services.

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[57]

- 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;

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

- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children 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.

Events Table	
Date	**Event – Pre ToR**
2016	John had a series of Orthopaedic Outpatient appointments for a knee problem, which started in 2016.
29.05.18	Mary attended hospital emergency department following which she was referred to Ophthalmology
Jan 2019	Mary did not attend ophthalmology out-patients' appointments
24.06.19	Mary attended the emergency department with a foot injury. Mary left without being seen. Mary returned to hospital the following day and a closed fracture was identified in her foot. This was treated and Mary was discharged.
July - August 2019	Mary attended at the GPs for routine health issues.
	Events within ToR
04.09.19	Mary presented at hospital emergency department having taken an overdose. Admitted to the Acute Medical Unit. Seen by the mental health liaison team and referral to the Home Treatment Team and discharged following day.
05.09.19	GP received discharge from hospital.
06.09.19	RDaSH Multi-disciplinary team meeting held and plan to refer Mary to IAPT and Home treatment team to visit.
06.09.19	Mary contacted school and asked that school not allow (CP) to pick Toni up due to separation of parents.
06.09.19	HTT conduct a home visit to Mary.
08.09.19	HTT visited Mary. Mary confirmed she had an appointment for the Army medical officer and counselling referral.
09.09.19	Mary contacted school and confirmed CP had moved out of the area.
09.09.19	Mary entered onto the Vulnerability Risk Management register by Army reserve unit. Formal referral to Army Medical Services and Welfare for mental health treatment
09.09.19	Mary seen by a Dr at Army Medical Centre, York.
10.09.19	HTT visit to Mary. Mary requested less frequent appointments (once a week). Mary agreed to referral to IAPT rather than counselling through the Army.
11.09.19	Opt in letter for IAPT sent to Mary.
11.09.19	Mary was seen at Medical Centre York. Downgraded to Medically Non-Deployable (MND) and referred to the NHS
16.09.19	Confirmation of appointment for Mary with IAPT 20/9/19 10.45am
17.09.19	GP Mental Health and Community Mental Health Services involvement review with Mary

17.09.19	HTT Discharged and Mary due to start psychological therapies with the IAPT team 20/9/19. Discharge letter sent to GP
19.09.19	SMS reminder sent to Mary regarding appointment on 20.09.19
20.09.19	Mary's IAPT initial appointment. Moderate symptoms with low mood and severe symptoms of anxiety. Problems in her relationship. Other traumatic life events disclosed. Therapist recommended Treatment; to step up for CBT therapy for trauma symptoms. No immediate risks or safeguarding concerns identified.
30.09.19	Mary was sent a text confirmation of IAPT appointment for 1/10/19
01.10.19	Mary's second IAPT appointment. Mary reported her anxiety had reduced. She had completed psycho-education on anxiety. There was no active risk identified following the risk assessment completed.
28.10.19	Text reminder sent to Mary for the IAPT appointment on 29.01.20
06.11.19	Mary contacted the GP for routine health matter which resulted in a referral to hospital.
13.11.19	John was prescribed testosterone gel by his GP
15.11.19	John was removed from his GP practice list due to threatening the GP
04.12.19	Mary was seen in accident and emergency department following a road traffic collision (RTC). Mary was not seriously injured.
05.12.19	Mary had a one to one with Army unit welfare officer, who was aware of the recent RTC. They were aware of previous engagement with Mental Health agencies. Mary stated that the NHS Mental Health Crisis Team had discharged her.
11.12.19	The GP Spoke with Mary following recent x-ray with patient. Appointment with GP agreed for following day
12.12.19	The GP referred Mary to a specialist clinic. A 2-week referral booked for Monday 30 December 2019(Jasmine centre)
30.12.19	Mary attended at the Out-patient's department following referral from the GP. Treatment given and discharged from clinic.
09.01.20	Mary was seen at the Medical Centre in York where she was medical board upgraded to Medically Limited Deployable (MLD).
30.01.20	Mary had her 3rd IAPT appointment. She stated that she had a new partner however no details are obtained. Following assessment Mary's mood was described as OK and no immediate risk or safeguarding concerns were recorded.
05.02.20	Mary had her 4th IAPT appointment. Risk assessments completed. Mary reported, she had stopped drinking alcohol, her mood had improved. No immediate risks or concerns. Next appointment 12/2/20
12.02.20	Mary had her 5th IAPT appointment. Risk assessments completed. Mary reported a good week.
26.02.20	Mary had her 6th IAPT appointment. Risk assessment completed. Mary spoke about having a bad week. Attempted to self-harm and had superficial cuts on her wrist. Therapist explained that she had signs and symptoms of trauma. Mary decided, she would like to continue with therapy. No immediate risks identified.

March 2020	John was admitted as a day case and underwent an Orthopaedic procedure for knee problem which first presented in 2016. He then attended a series of physiotherapy follow up appointments.
04.03.20	Mary had her 7th IAPT appointment. Mary reported that she had made an Army service complaint. Treatment continued with a focus on trauma.
11.03.20	Mary telephoned and cancelled the IAPT appointment scheduled that day. No reason was given by Mary. The IAPT telephoned Mary back and left a message for Mary to contact IAPT after getting no reply.
17.03.20	Mary telephoned practice with flare up low mood anxiety to practice nurse then GP telephoned her also to discuss her symptoms. Mary told the GP that she was more anxious and therapy she believed was making it worse. Mary was advised to try amitriptyline.
17.03.20	Text message to Mary confirming her IAPT appointment on 25/3/20
17.03.20	Army Sergeant raised a concern regarding Mary's welfare. She stated that she was suffering from nightmares and waking up in cold sweats An appointment was made for Mary to attend York Medical Centre. Mary was downgraded to Medically Non-Deployable (MND). A formal re-referral to NHS for continuation of mental health treatment was made
17.03.20	Mary was contacted by Army sergeant to check on the GP appointment and she informed him that she had an appointment with her NHS GP at 1750hrs that day.
19.03.20	Mary contacted School and shared information in relation to contact with CP and informed of ongoing court proceedings.
19.03.20	Mary received a welfare visit from the Army
19.03.20	The Army submitted a referral to AWS requesting support for AS. This referral was with Mary's consent. Her ongoing mental health treatment had brought to light historic issues that were additional traumas. These were subsequently raised as two historic Service Complaints.
20.03.20	Mary received a telephone call from RDaSH who advised of having to rearrange her appointment 25/3/20 and moving to telephone work for the foreseeable future. Rebooked for 1/4/20 (Telephone consultations commenced due to COVID-19.
23.03.20	National Lockdown due to Covid-19 global pandemic.
24.03.20	Mary had a video consultation with GP due to tonsillitis.
27.03.20	GP practice sent SMS text message sent to Mary stating ready to start the consultation via video. Anxiety review conducted. Advised to continue with medication. Follow up in 2 weeks.
31.03.20	Mary Case file allocated in AWS. There is a slight delay in allocation due to staffing/capacity issues.
01.04.20	Mary's 8th IAPT appointment. Mary disclosed she had experienced night terrors 2 weeks ago and had commenced medication from her GP. The next appointment was arranged for 8.4.20. No immediate risks identified.
02.04.20	AWS gathered background on Mary's situation from the unit welfare officer.

03.04.20	AWS made a telephone call to Mary. Mary was unable to speak and she asked for a call back at 1400 hours. The AWS called back at 1400 hours but the call was not answered.
06.04.20	AWS made two telephone calls and sent an email to Mary. After no response from Mary, an email was sent to which gave 7 days to respond. If no contact from was received from Mary the case would close. It is routine to send an email to encourage contact and give cut-off date. The service would still be available to AS if she wished.
08.04.20	Mary's 9th IAPT appointment was scheduled. Mary did not attend this 'working from home' appointment. A message was left for Mary to contact IAPT by the end of the week. Mary did not respond.
15.04.20	AWS informed Mary's unit welfare officer that due to lack of engagement from Mary her referral would be closed.
29.04.20	Health visitor involvement with Toni ended as the child was now not under 5 years.
03.05.20	Toni- Notification of attendance at the Emergency Department with a finger injury (accompanied by grandmother) Discharged to orthopaedics. Discharge letter to GP
03.05.20	Mary informed Army sergeant that during the previous night she had been subjected to domestic abuse by her ex-partner John. A home visit took place. The incident was reported through the Army chain of command. There is a report of Domestic Abuse incident on Mary's army record. She was advised to involve the police.
04.05.20	Mary made a disclosure of domestic abuse to school. School followed safeguarding policy and procedure and referred the matter to children's social care and the police. Later that morning Toni also disclosed to school witnessing domestic abuse and feeing scared of John.
04.05.20	Referral accepted by children's services and determined that a Child & Family Assessment was required. Mary was spoken to by MAAP Social Worker as part of the referral. A DASH risk assessment completed and the assessment was High risk. A joint visit is made at Mary's home address by social care and police. During the visit Mary confirms there were two separate incidents of domestic abuse.
04.05.20	Police make attempts to arrest John and all firearms are seized from John's address. John attended the police station to request firearms back and was arrested. John was interviewed and bailed with conditions pending CPS decision. John's Firearms certificate was surrendered.
04.05.20	The allocated social worker visited Mary and at the end of the visit a police officer arrived and informed them that John had been arrested. Later that date the police contacted the emergency social services team (ESST) to update that John would likely be bailed with conditions. The ESST discussed the risk of her being at home. Later that evening Mary agrees to move out of the area with her family to ensure their safety.

04.05.20	Mary and her family are safeguarded at Army Barracks out of the area, whilst John was outstanding. Mary was referred by the Army to the AWS. The AWS received the referral and direction was given for immediate allocation of a welfare worker.
05.05.20	MARAC referral shared by children's services. Social Worker telephoned Mary and she stated she was returning home and that her ex-partner, CP would stay with them for safety.
05.05.20	A DARA team member completed the risk assessment requests for DVDS consideration in Mary's case.
05.05.20	IDVA service received a High-risk DA referral from SYP DARA team for Mary. The allocated IDVA made an introductory telephone call to Mary and informed Mary that her case would be discussed at MARAC. A risk assessment was completed and safety discussed. Children's social care, social worker telephoned the IDVA Team Manager and stated she was concerned that Mary and her family was returning to the family home whilst John was still outstanding. The IDVA stated that they were visiting the address and there were control measures to be put in place to target harden the address. A fire risk assessment was also requested.
05.05.20	Mary was allocated an AWW by the AWS. The AWW made an unsuccessful attempt to call Mary and an email was sent offering support.
06.05.20	School was asked for a report to aid the social care assessment ongoing for Toni.
06.05.20	Police gave a DVDS disclosure to Mary
06.05.20	Mary had a very brief telephone conversation with the AWS as she stated she was expecting another call. Mary subsequently advised, the AWW that she was overwhelmed telling her story to so many agencies. AWW agreed to offer Mary some space and to call again on 11 May 20. Mary gave verbal consent to the AWW to approach other agencies to ascertain if a DASH was completed. Mary disclosed to the AWW that John had sent her flowers and chocolates, which was a breach of his bail conditions. This information was emailed to police along with the request for a copy of the DASH.
07.05.20	AWS had a telephone conversation with the allocated Social Worker. It was confirmed that the case file was still in assessment phase. It was confirmed that the case had been referred to MARAC
07.05.20	There was a discussion between the DCST social worker and the Army Welfare Officer and it was agreed that the AWS would provide support to AS using the Safe and Together framework
11.05.20	DCST social Worker visited Mary and Toni. Direct work was completed with Toni and Mary was spoken to as part of the Children and family assessment.
11.05.20	AWS sent a follow up email to police requesting the DASH
11.05.20	IDVA made contact with Mary. Due to the bereavement of a friend Mary did not wish to talk
13.05.20	AWS telephoned Mary and the call went straight to voicemail

13.05.20	IDVA telephoned Mary and the call went to voicemail. A message was left asking for Mary to contact
14.05.20	IDVA telephoned Mary and Mary said she was feeling much better. Mary stated that John was posting upsetting comments on social media. Mary was advised to contact the police if John turned up at her address.
14.05.20	AWS completed an assessment with Mary. The information to inform this was gathered over three telephone calls. The AWW did not send assessment to Mary because there was no confirmation that the email was safe from John.
15.05.20	John contacted Mary threatening to end his life if she did not attend. A member of Mary's family telephoned emergency services concerned for Mary's safety. Mary attended John's address and found John had taken an overdose. Police officers and YAS attended. John was admitted to hospital. Upon being medically fit John was arrested for breach of bail conditions on 16th May.
15.05.20	AWS responded to the police request to submit a data protection form, before a copy of the DASH would be shared.
16.05.20	Following John's attempt to take his own life SYP made a referral Adult at risk (AAR)
18.05.20	AWS chased up Mary and she returned the competed DPA forms which had been requested to be returned by SYP.
19.05.20	AWS had a telephone conversation with CSC and the decision had been made to close their case.
19.05.20	AWS-returned the DPA forms to SYP.
19.05.20 & 20.05.20	IDVA -MARAC research form completed then case presented at MARAC the following day.
20.05.20	MARAC meeting held and Mary's case was discussed.
21.05.20	IDVA telephoned Mary to update her from the MARAC. Mary did not answer and a message was left on voicemail. Mary returned the call to the IDVA and she informed that the trial was set for 31 July 2020 at Doncaster Magistrates' court. Support was offered for this and Mary said she would attend. Mary was advised to contact the police if John contacted her.
21.05.20	The Children and Family assessment on Toni was completed. Outcome was no further action from DCST. The case was step down to the AWS for on-going support.
26.05.20	AWS telephoned Mary. The call went straight to voicemail and a message was left asking for Mary to contact AWS.
27.05.20	AWS telephoned Mary. The call went straight to voicemail and a message was left asking for Mary to contact AWS. A subsequent email also sent to Mary asking for her to make contact.
28.05.20	AWS sent a letter of support to Mary encouraging her to make contact
01.06.20	Army reserve unit telephoned Mary and also sent a text message. A voicemail message was left. Mary did not respond to either.
01.06.20	AWS received response back from SYP with a copy of the DASH which confirmed the High-risk assessment.

02.06.20	AWS telephoned Mary and it went straight to voicemail. A message was left asking for Mary to contact AWS
02.06.20	The GP conducted a review of Mary's medical notes.
03.06.20	AWS tried unsuccessfully to contact Mary several times. A decision was taken following consultation with senior Army personnel to conduct a home visit to check on Mary's wellbeing.
04.06.20	IDVA telephoned Mary. There was no reply. It was intended to call next week.
04.06.20	Army reserve unit sergeant visited Mary's home address at the pre-arranged time, however found Mary was not at the house. Later the same day Mary telephoned her sergeant and apologised for missing their meeting. Mary assured him that everything was ok and that she had missed the AWS appointments due to them calling at a different time to what had been arranged.
05.06.20	AWS to continue to try and contact Mary and to continue to liaise with other agencies.
05.06.20	SYP obtained a retraction statement from Mary after she had left a message for the investigating officer to contact her. This statement was taken over the telephone.
Early June 20	YAS received a call from a friend of John who stated there was a seriously injured female at John's address. YAS contacted SYP who were first to arrive. Mary was located deceased. A criminal investigation commenced.
Early June 20	SYP contact DCST Social Worker. DCST informed of Mary's murder. Child & Family Assessment required. Social care informed that Toni was safe.

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 assurance and evidence to Safer Stronger Doncaster Partnership that information sharing pathways have been embedded and multi-agency information sharing of updates continue throughout interventions to prevent working in isolation.	Local	All agencies to review Information Sharing Pathways. Further work is to follow with the Probation Service	Doncaster Metropolitan Borough Council. TS.	Supported by Colleagues from Policy Insight and Change, Review of Process mapping across services, DMBC, DCST, SYP, Riverside. Work to continue. DA Service Dashboard development and sharing of information with Localities is ongoing. Localities Central DA Task and finish group established. Chaired by TS. Will be expanded to all localities. MODUS/Paloma workshop held on 24.09	December 2021 Revised to June 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**
					exploring referral pathways into the DA Service and potential access to MODUS for partner agencies.		
2	That Safer Stronger Doncaster Partnership review the MARAC protocol in terms of communication, agency involvement, case numbers, frequency of meetings, identification of a lead professional and monitoring of action plans, including consideration of shared IT case management system	Local	Review of MARAC Protocol. Action plans to be monitored as part of IDVA case management reviews. IT system sharing is to	Doncaster Metropolitan Borough Council. TS.	Review of Protocol. Review undertaken and Protocol being refreshed in preparation for presentation to the Doncaster Domestic Abuse Strategic Board. Briefing of MARAC chairs. Briefing of MARAC Steering Group.	August 2022 November 2021 February 2022	MARAC Chairs Briefed. February 2022. Steering Group Briefed February 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**
			be explored. During 2022.		MARAC Steering Group to review and report back to SSDP. Task and Finish Group established to complete this work. Independent MARAC Review process commissioned. Scheduled to take place in the summer and autumn of 2022.	August 2022 December 2022	
3	That all MARAC's should invite relevant Armed Services to be involved in information sharing and the MARAC process where the subject of the MARAC is known to be involved in the Armed Services.	Local and regional.	Embedded locally and to be shared regionally.	Doncaster IDVA service MARAC administration. TS.	DMBC DA service staff have been briefed re the requirement. Information saved in the IDVA process guide. Information to be embedded in MARAC	July 2021 October 2021. November 2021.	July 2021. Embedded and contact to be made by IDVAs in applicable cases.

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**
					protocol as part of the review. South Yorkshire partners briefed (2nd December 2021)	 December 2021.	
4	That Safer Stronger Doncaster Partnership reviews the multi-agency response to victim engagement during DVDS and criminal investigations.	Local and regional.	Multi Agency Review via DA and SA Theme Group.	Doncaster Metropolitan Borough Council. TS and SYP.	To be discussed at DA and SA Theme Group November 2021. Numbers of DVDS applications and disclosures is part of the performance framework for the domestic abuse partnership. Standing item on the agenda of the Doncaster Domestic Abuse Strategic Board meeting.	November 2021.	March 2022.This has been incorporated into the Domestic Abuse Performance Management Framework for the partnership. Monitoring the DVDS process will continue as part of the Framework.

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**
5	That all agencies consider how to ensure the perpetrator of domestic abuse remains visible throughout and consider proactive opportunities with high-risk perpetrators of domestic abuse.	Local and regional.	All Agencies	Doncaster Metropolitan Borough Council. Tim Staniforth DA and SA Theme Lead.	Multi Agency Review has been undertaken to look at Serial Perpetrators and their relationships. A second serial perpetrator workshop took place in September 2021. 10 serial perpetrators were fully reviewed which identified 64 victims associated with those perpetrators and 88 children. A report was produced and shared with the DA Strategic Board in October with suggestions for the future management of serial perpetrators in Doncaster.	November 2021.	November 2021. Multi Agency Serial Perpetrator Group meeting established. Core members are South Yorkshire Police, Probation Service, Childrens Social Care. Doncaster Council Domestic Abuse Service. March 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**
					MATAC Meetings sit monthly to discuss DA perpetrators also. MATAC/MARAC Coordinators are being recruited by SYP to provide a SPOC within the Police service. A new Serial Perpetrator Worker Post to be established within DMBC to perform multi agency working from with the DA service. .		SYP MARAC/ MATAC team recruited and established. Consistent support across both MARAC and MATAC by the same staff members from SYP.
6	That the Armed Services provide assurance and evidence to the Safer Stronger Doncaster Partnership that the learning disseminated in	National	Defence Global safeguarding team are reviewing and rewriting	Army	Tri Service policy already exists. National military Policy is now being affected by the learning from the review.	October 2021 Work is continuing.	To be confirmed.

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**
	the Tri-service Domestic Abuse policy is embedded across the Armed services		the DA policy document.		Defence Global safeguarding team are reviewing and rewriting the DA policy document.	Work is continuing.	To be confirmed.

Army Welfare Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	AWS staff to routinely create a plan with DA victims about when/how to check on well-being if 'pressure to disengage' is part of perpetrators pattern of control.	Amend DA SOI	Guidance added. Add guidance to DA SOI. AWS Senior Mgt group to reinforce guidance with practitioners.		AK	End June 2021
2	In cases where a DASH RIC has been completed recently by another agency and AWS hold significant information,	Amend MARAC SOI	Guidance added to MARAC SOI AWS Senior Mgt group to reinforce guidance with		AK	End June 2021

Army Welfare Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	; the AWW they MUST proactively contact the MARAC. This is critical even if AWW has not completed a DASH RIC.		practitioners.			
3	AWS to revisit the training plan to include competence around DA risk 'flags', particularly at point of separation. This specialist training on DA and stalking should focus on the Domestic Homicide training by Dr Jane Monkton-Smith and Laura Richards. Specifically, this needs to increase awareness/management guidance on cases characterised by threats to kill, the ending of an intimate relationship, previous threats to take his own life by the perpetrator and a sense that the perpetrator is	Staff to be provided additional specialist training on stalking and Domestic Homicide Timeline.	Training planned by Aurora New Dawn for 2020 to be revisited.		AK	End June 2021

Army Welfare Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	losing control which collide to indicate a high risk of homicide.					
4	AWS to ensure diversity issues are addressed with service users and articulated in case files.	Amend DA and MARAC SOI	AWS Senior Mgt group to reinforce guidance with practitioners.		AK	End June 2021
5	AWS to offer additional guidance/consultation in teams where staff are not S&T trained. This will avoid the risk associated with over-optimism when mapping full range of concerns in assessments.	Ensure specialist advice available to practitioners and supervisors	AWS Safe and Together instructors (SMEs) assigned to AWS teams as 'consultants' in complex DA cases. Aurora New Dawn also utilised as consultant in highest risk DA cases		AK	July 2021
6	AWS S&T training planned to recommence in Jan 21. 8 x 4-day Domestic Violence Informed Practice Training planned.	Continue training plan	Training re- commenced Feb 2021. All AWS PS staff mandated to attend.	All staff trained by end Oct 2021	AK	February 2021

Doncaster Children Services Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	DCST will improve practice around how we respond to and work with perpetrators of domestic abuse.	Develop a practitioner toolkit for assessing and working with domestic abuse on a whole family approach Develop guidance for practitioners on assessing and working with perpetrators of domestic abuse Training to be delivered to all relevant staff on the use of the toolkit and	The toolkit is written and was signed off internally on 12.05.21. It is to be launched on 1st June This will be completed, including sign off, by 28th May '21 and launched on 1st June alongside the toolkit Training dates are set for June and July '21. Attendance will be monitored and	Practitioners will have the skills and confidence to work whole family in relation to domestic abuse. There will be a focus on the work with perpetrators in order to reduce the risk of future harm to all victims of domestic abuse (adults and children)	JG	12 May 2021

Doncaster Children Services Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		the guidance in practice Develop an audit framework in relation to domestic abuse in order to evidence the impact of the above on practice	further dates arranged			

Doncaster Clinical Commissioning Group - GP						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Primary Care Training Update on Domestic Abuse to include the professional curiosity and risk assessment on	GP Training planned	Slide Presentation Target%20Presentation%20on%20Domes	Programme of GP training commenced May 2021 First Session on 12/5/21 next planned for 26/5/21	IB lead officer for all actions for CCG	June 2021

Doncaster Clinical Commissioning Group - GP						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	separation with actions for primary care.					
2	Improved communication between agencies. For example, protocol for MARAC and Children's Trust information-sharing with primary care related to domestic abuse.	Meeting between IB and TS to discuss feedback from MARAC	Examples of communication to GPs	Planned information from MARAC via IDVAs to GP's	IB	September 2021
3	To consider producing a primary care protocol and reference guide.	Dr Kirby to produce draft guidance	Guidance document  SK%20Domestic%20Abuse%20Guidance%	Guidance shared with Primary Care at Training and document e-mailed to all GP	IB	June 2021

Independent Domestic Violence Advocate						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Refresher training and continued professional development for IDVA's.	Training provision accessed and delivered.	Training portfolios for staff.	Continual professional development for IDVAs and DACs. DMBC DA Training available for all staff.	TS	Continual. June 2021.
2	Independent Domestic	Details	GPs details shared	Improved information	TS	June 2021

Independent Domestic Violence Advocate						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	Violence Advocates share details regarding cases being discussed at MARAC with clients GP's	obtained during safety planning meetings.	at MARAC. GPs surgeries informed that the case has been discussed at MARAC.	sharing regarding High Risk victims of DA. GPs alerted to potential risk to patients.		
3	MARAC review working group set up. (ongoing) Links into Recommendation 6.	To review capacity across services to support MARAC	Meetings held quarterly. Work owned by the Doncaster MARAC Steering Group.	Improved information sharing across agencies. Non high risk repeats are not automatically referred into the next MARAC meeting. Cases triaged by SYP and IDVA service.	TS	November 2021.
4	IDVA Chair training being facilitated with Safelives on behalf of SYP.	Work to identify dates is underway	Training to be delivered by Safelives	All Doncaster MARAC chairs have the same accredited Chair Training	TS/ KC (SYP DA Coordinator)	November 2021
5	IDVA Process Guide is being amended and refreshed.	Updated guide delivered to staff	IDVA process is updated	Consistent updated practice from staff	TS/CL	October 2021
6	Partnership working with SYP re management of cases referred to MARAC.	Work is ongoing to look at how repeat	Consistent Management of repeat referrals	Less non High-risk cases sent to MARAC.	TS/ KC (SYP DA Coordinator)	November 2021

Independent Domestic Violence Advocate						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	Ongoing and is a countywide initiative.	referrals are managed. Pilot Scheme commenced at the end of July 2021.		Non high risk repeats are not automatically referred into the next MARAC meeting.		
7	MARAC steering group to be reinstated.	Next Meeting scheduled for 08.12.21	Meetings scheduled quarterly.	Inclusion of all agencies involved in MARAC. Improved information sharing in MARAC.	TS	23 June 2021.

School 1						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Refresher training for School 1and explicit training for trust schools regarding what information can/cannot be shared before the police have confirmed the death of a person in the community.	*Discussions with School 1 staff to explain the reasons as to why information about the case could not be	* All trust school safeguarding Leads awareness of processes when dealing with a death in the community. *Trust school access Dash & MARAC training	*Schools know not to share information internally or externally until directed by the Police.	KC – Executive Safeguarding Lead for the Rose learning Trust of schools of which School 1 is a part	28 September 2020

School 1						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		provided prior to police confirmation of Mary's death. *Kelly Cousins to speak with CEO of the trust to raise this as a key action for all trust schools. *Kelly Cousins to arrange Safeguarding Network for trust schools in which this is addressed as an agenda item.				

School 1						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		* Trust Network to be set for the 28th of September. * Delivery of training to Trust schools safeguarding leads to disseminate to own schools. *Promotion of Training for MARAC & DASH to support Information sharing procedures				

Rotherham, Doncaster and South Humber NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Awareness of policy relating to disclosures of historical abuse and record keeping on decision making, treatment pathways or referrals	Raising profile of appropriate guidance relating to disclosures of non-recent abuse. Re-emphasising the need for clear recording and defensible decision making with all RDaSH staff	7-minute briefing to be developed and disseminated to all RDaSH staff. Minutes of Care Group Quality meetings highlighting the need / reminder regarding defensible decision making. Dissemination though safeguarding supervision forums. Inclusion in safeguarding training	Improved and wider knowledge and understanding of processes relating to non-recent / historical disclosures of abuse. Improvement of standards of documentation	Safeguarding Team	Doncaster Care Group – 1/12/21 Childrens – 4/5/2022 Rotherham – discussed 14/4/22 North Lincs – discussed 21/4/22
2	Professional curiosity regarding new relationships should be demonstrated during clinical contacts	Raised awareness of the need of	7-minute briefing developed reflecting the use of professional curiosity and the	Improved practice and recording of patient relationships and evidence	Safeguarding team	30/3/22 – Shared on intranet front page

Rotherham, Doncaster and South Humber NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		professionals to utilise professional curiosity.	need for 'checking and challenging'	of engaging in professionally curious practice.		31/3/22 – shared via daily communications
3	Reminder for all staff to handover pertinent information between health agencies.	All staff to be reminded of the need to handover relevant information where there are two health agencies working.	Discussion through Care Group Quality meetings across the Trust.	Improvement in practice and documentation.	Individual Care Groups (Associate Nurse Director	Doncaster Care Group – 5/4/22 Childrens – discussed 6/4/22 Rotherham – discussed 14/4/22 North Lincs – discussed 14/4/22
4	Awareness of policy for patients who do not	Point for learning to be	Provision of daily communication e-mail	All staff will be reminded of the	Daily communications	30/3/22 – Shared on intranet front

Rotherham, Doncaster and South Humber NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	engage or miss appointments.	disseminated Trust wide. Awareness of policy to be highlighted using Trust communications	highlighting this.	need to follow and utilise policy and procedure appropriately.		page 31/3/22 – shared via daily communications
5	To check whether cases are 'open' when discussed at MARAC.	RDaSH are currently reviewing MARAC processes.	Cases as recorded as at MARAC up receipt of case summary document.	Cases are "flagged" as High Risk DA MARAC cases.	Safeguarding	Confirmation of process received 4/5/22

South Yorkshire Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	SYP should seek to explore the use of technology (such as GPS Tagging) to support Police bail conditions and restrictions. The tag would allow for opportunities to manage more effectively any	S - SYP should seek to explore the use of technology (such as GPS Tagging) to support Police bail	SYP Policy Pi15.10 – Electronic Tagging and Monitoring. Power-Point presentation given by previous force	At this time the trial and implementation of EM and Tagging in this manner is only in place for volume offences such as burglary and theft/shoplifting. Other forces have implemented trials for use in DA cases but data is not	Current Force lead for Electronic Monitoring Case Review and Policy Officer - PVP P&G	As at 31/03/2022 this work and it's implementation is still ongoing.

South Yorkshire Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	contact a perpetrator may have with a victim following a DV incident where alcohol was a contributing factor. This 'Tagging' would be voluntary and could not be enforced. This area should continue to be explored as a work in progress for the future.	conditions and restrictions. M – Introduce Electronic Tagging and Monitoring (EM) Policy. Training and information given to all SYP Officers in the Implementation of the use of EM. A – SYP Policy Pi15.10 – Electronic Tagging and Monitoring agreed	lead – DCI Leach starting 2019. D/Sup Cowley Head of PVP – P&G in process of writing a Senior Command Team paper on application of EM for perpetrators of DA/DV.	yet returned from this, however with a force lead in place this could be considered by SYP in due course depending on analysis of results from trials and is being explored for potential use in the future. Update on 05/07/2022 from SYP. SYP has purchased 40 of the electronic "Buddy" Tags and 10 issued to each of the Districts. Funding of over £100,000 has been secured from the Force for the monitoring and servicing of the Tags. Although these are still used by perpetrators of DA/DV who wish to change behaviour, so on a		

South Yorkshire Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		28/10/2019 and cascaded to all Staff and Officers by Intranet. Training for officers by presentation to be given at refresher training by force lead. R – Provide the training and procedural instruction to explain the occasions where electronic tagging and		voluntary basis. Recent change to national DA policy, recognised the use of EM and reduction in DA offences, so it is being looked at and hopefully subject to change to become court enforced so mandatory.		

Yorkshire Ambulance Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Review the referral process for domestic abuse and scope the potential to use the Domestic Abuse, Stalking, Harassment and Honour-Based Violence (DASH) risk assessment tool to drive quality practice and provide a referral mechanism to the Multi-agency Risk Assessment Conference (MARAC) process. Develop training and learning material to support staff around recognition of and response to domestic abuse and the referral options, to improve staff knowledge and confidence in supporting victims. (Moved from Key Actions column)	Agree with trust clinical directorate scoping of proposa Raise awareness of risk assessment and referral at National Ambulance Safeguarding Group (NASaG) Training package to be identified.	Task and Finish group formed. Opinion provided to NASaG for review of Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance on DA ESR compatible training package	Policy will be robust and offer clarity on the trust's response to victims and perpetrators of domestic abuse including the use of risk assessment and referral pathways. Open discussion at national level on improvement of response to domestic abuse victims and perpetrators Staff will be released to complete as part of role specific statutory and	HO HO HO/CH	Expected end date 12/2022 For discussion at Association of Ambulance Chief Executives (AACE) 05/2022 12/2022

Yorkshire Ambulance Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		480 training hours allocated to Domestic Abuse training in 2022/23	identified to be user tested and rolled out.	mandatory training. Training to be assigned to ESR profile by identified role and compliance to be monitored by line management with trust oversight by Head of Safeguarding and the Non-Clinical PGB.		
		Bright Sky app to be installed on all trust issue smartphones.	App added to the standard install list prior to issue of smartphones and publicised through trust-wide communications	Frontline staff have access to information and can search for local services to signpost patients to services that will better meet their needs	HO	Complete 09/2021
		Ongoing audit and monitoring of volume and	Audit data available to multi-agency partners for assurance	Audit evidences improvement in recognition of, and response to victims and	HO	To commence 04/2023 following roll out of

Yorkshire Ambulance Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		quality of referrals.	purposes. Learning identified and disseminated. This will be evidenced by audit of the quality and volume of referrals in respect of domestic abuse. (Original Action plan information.)	appropriate referrals made. Consistent risk assessing, reporting and processing of DA incidents.	These recommendations are reflected in the YAS Safeguarding Team work plan as a priority action. with a planned completion date of July 2021	training and process. To be confirmed.