Sunderland Partnership

Domestic Homicide Review

Adult Elizabeth

Stephen Cullen
Report Author

Final Version

SUNDERLAND DHR 6

1. This Domestic Homicide Review (DHR) has been commissioned by the Safer Sunderland Safety Partnership.

2. For the purposes of this report, Elizabeth is a pseudonym used for the victim in this case. Sean is a pseudonym for the perpetrator in this case. Pamela is a pseudonym used for the primary family contact.

3. The Independent Reviewer is Stephen Cullen.

GLOSSARY

4.	**AAFDA**	Advocacy After Fatal Domestic Abuse
5.	**ACN**	Adult Concern Notification
6.	**ACPO.**	Association Chief Police Officers
7.	**A & E**	Accident and Emergency
8.	**AFV**	Adult Family Violence
9.	**CAADA.**	Co-Ordinated Action Against Domestic Abuse
10.	**CAP**	Child and Adult Protection
11.	**CCG**	Clinical Commissioning Group
12.	**CPS**	Crown Prosecution Service
13.	**COPD**	Chronic Obstructive Pulmonary Disease
14.	**DA**	Domestic Abuse
15.	**DASH**	Domestic Abuse, Stalking and Honour-Based Abuse
16.	**DHR**	Domestic Homicide Review
17.	**DHR**	Panel Domestic Homicide Review Panel
18.	**DS.**	Detective Sergeant
19.	**DV**	Domestic Violence
20.	**DVN**	Domestic Violence Notification
21.	**DVPN/O**	Domestic Violence Protection Notice/Order
22.	**DVO**	Domestic Violence Officer
23.	**DWP**	Department for Work and Pensions
24.	**ED**	Emergency Department
25.	**GP**	General Practitioner
26.	**IDVA**	Independent Domestic Violence Adviser
27.	**IMR**	Individual Management Review
28.	**IOM**	Integrated Offender Management
29.	**IPV**	Intimate Partner Violence
30.	**IRIS**	Identification and Referral to Improve Safety
31.	**MARAC**	Multi Agency Risk Assessment Conference
32.	**MASH**	Multi Agency Safeguarding Hub
33.	**NDM**	National Decision Making Model
34.	**NFA**	No Further Action
35.	**NHS**	National Health Service
36.	**NICE**	National Institute for Health and Care Excellence
37.	**NPCC**	National Police Chief's Council
38.	**NPT**	Neighbourhood Policing Team
39.	**NPS**	National Probation Service
40.	**NPT**	Neighbourhood Policing Team
41.	**OPD.**	Out Patient Department
42.	**PCC**	Police and Crime Commissioner
43.	**RARA.**	Remove, Avoid, Reduce, Accept

44. **RIC** Risk Indicator Checklist
45. **RCGP** Royal College of General Practitioners
46. **SSP** Safer Sunderland Partnership
47. **THRIVE** Threat, Harm, Risk, Investigation, Vulnerability, Engagement
48. **WWiN** Wearside Women in Need

FOREWORD BY Pamela (Elizabeth's 'niece')

"My aunty Elizabeth..... our Elizabeth was my queen ... her life is personal to me and her and no-one else cos they didn't give a jot xxx"

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80. NOTE OF CONDOLENCE AND GRATITUDE

81. As the author of this Domestic Homicide Review (DHR), I offer my sincere condolences to the family and friends of Elizabeth for their loss.

82. To lose Elizabeth, at a relatively young age, having been murdered is a tragedy.

83. For anyone to commit murder, and then suicide, in the circumstances her son Sean did is shocking.

84. Pamela adopted the role as key point of contact for Elizabeth's family. Pamela's mother was Elizabeth's cousin. Elizabeth had been born out of wedlock, so she was effectively brought up like a sister to Pamela's mother. Pamela always referred to Elizabeth as her Aunty.

85. Pamela describes Elizabeth, who was 15 years older than her, as the 'older sister she never had'.

86. Pamela describes her relationship with Elizabeth as 'close', although they saw less of each other in more recent times.

87. Pamela is understandably very distressed at what happened to Elizabeth. Her experience has been a painful one.

88. Pamela has been very supportive and helpful throughout the DHR, for which I am grateful.

89. It is also important to acknowledge the courageous actions of Elizabeth's work colleagues, who were sufficiently concerned around her welfare to repeatedly try and contact Elizabeth when she failed to attend work, and ultimately called the Police.

90. My appreciation is also extended to the Professionals of the Agencies who also co-operated fully with this DHR, as well as the Community Safety Lead from the Safer Sunderland Partnership, who provided unstinting and supportive professional co-ordination and support.

EXECUTIVE SUMMARY

INTRODUCTION

This Domestic Homicide Review (DHR) examines agency responses and support given to Adult Elizabeth, up to the point of her death.

The key purpose for undertaking a DHR 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.

BACKGROUND INFORMATION (THE FACTS)

The circumstances leading up to this DHR being undertaken are detailed as follows:

The Safer Sunderland Partnership (SSP) received information from Northumbria Police in February 2020 of a homicide and suicide they had attended in Sunderland in the same month.

A summary of the Police notification to the Safer Sunderland Partnership received in February 2020 is detailed as follows:

The victim Elizabeth, and her son, the perpetrator, Sean, lived together, in Sunderland.

Northumbria Police had recorded a number of domestic violence and abuse incidents by Sean towards Elizabeth from as far back as 1997 to February 2020.

Elizabeth was last at work for the local Charity in early February 2020 and was then due to attend work a week later, but she never arrived. The Charity Staff had spoken to Elizabeth by telephone during the week.

Concerned Elizabeth had not attended work, over the following days, staff at the Charity made a number of efforts to contact her by telephone, but only ever received an answer from Sean; who claimed his mother was ill. Sean was abusive towards the Charity Staff on the telephone.

103. Neighbours describe hearing, and or seeing, Elizabeth during the period she was absent from work, but cannot be precise when this was. One witness reported hearing Elizabeth and Sean rowing during the early hours on the morning.

104. A concerned Member of Staff from the Charity called at Elizabeth's home address in late February 2020 but got no answer. On looking through the living room curtains she saw Sean, motionless on the sofa. As a result of this she contacted her office, who, in turn contacted the Police.

105. Upon Police attendance, entry was forced, and Elizabeth and Sean were both found, deceased, within the living room. Elizabeth was on the floor beside the sofa with a number of, what appeared to be, stab wounds. Sean was naked on the sofa, with no obvious injuries.

106. A post-mortem of Elizabeth and Sean took place shortly afterwards. Elizabeth had nine stab wounds, the fatal two being to her jugular.

107. Elizabeth had been dead for some time, up to possibility a week. Elizabeth died due to stab wounds to her neck.

108. Toxicology In relation to Elizabeth showed:

- Blood alcohol 312mg/100ml.
- Nicotine and its metabolite and caffeine detected in blood.
- No other drugs collected.

109. The Ethanol concentration was described as sufficient to impair cognitive and motor functionality.

110. The conclusion was Elizabeth was unlawfully killed.

111. Sean had no injuries consistent with assault.

112. Toxicology in relation to Sean showed:

- Blood codeine 2774 mg/ml.
- Blood free morphine 9 ng/ml.
- Blood total morphine 11 ng/ml.
- Blood paracetamol 537 mg/l.

113. The blood Paracetamol level was described as grossly elevated and within the quoted lethal range. The blood Codeine level was described as within the quoted

lethal range. Some Codeine is converted in the body into Morphine. There were no other identifiable drugs. The vitreous biochemistry results were unremarkable.

114. The conclusion was Sean died as a result of a Codeine overdose.

115. **HM CORONER**

116. An inquest into the deaths of both Elizabeth and Sean was held by HM Coroner in March 2020.

117. The Assistant Coroner described the relationship between the mother and son as 'problematic', adding, the son was 'very controlling' and was both emotionally, and sometimes physically, abusive.

118. The Assistant Coroner continued 'It seems clear she (Elizabeth) was a very independent, proud mother but that, effectively, this has ultimately led to her death because she obviously had difficulties with Sean.'

119. She said Elizabeth's 'mother's instinct' must have made it 'doubly difficult to effectively walk away from the situation'.

120. The conclusion was Elizabeth was unlawfully killed.

121. The Coroner arrived at the conclusion Sean died as a result of a Codeine overdose.

122. HM Coroners enquires are now complete.

123. **TERMS OF REFERENCE**

124. The Terms of Reference for this DHR are detailed as follows:

125. **1. To consider the impact of decisions made in relation to Elizabeth on her overall wellbeing; and whether any potential impact was recognised and whether she was supported.**

126. **2. To consider Elizabeth's death in light of national/local suicide prevention strategies. What were the quality of risk assessments and risk management plans in response to known incidents?**

127. **3. To consider whether any risks were identified assessed at the appropriate level?**

128. **4. To consider whether the MARAC process implemented in line with local policy and procedures? (Please include appropriate policies and procedures).**

129. **5. To consider whether there is any evidence Elizabeth and Sean were offered assistance to address alcohol related issues, and if they were, what were the outcomes?**

130. **6. What were the quality of risk assessments and risk management plans in response to known incidents? Were the risks to Elizabeth appropriately assessed at the correct level of risk? Were static factors present in all risk assessments?**

131. **7. If so, for Elizabeth, did this result in appropriate needs assessment and safety planning actions and what was the evidence of this?**

132. **8. If the process was not implemented in line with local policy, procedure, and guidance, what were the reasons for this?**

133. **9. Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew Elizabeth was experiencing domestic abuse?**

134. **10. Was appropriate use made of available civil and statutory tools and powers: including but not limited to Civil Orders, Domestic Violence Protection Notices (DVPNs), Domestic Violence Protection Orders (DVPOs), Domestic Violence Disclosure Scheme (Clare's Law) etc?**

135. **11. Where services and protection planning could not be delivered due to non-engagement of Elizabeth, were the reasons for non-engagement explored and what efforts were made to encourage engagement?**

136. **12. Were the correct referral pathways (including but not limited to MARAC) implemented in line with local policy, procedure, and guidance?**

137. **13. How effective was Inter-Agency working and interagency information sharing around addressing the risks that Sean posed to Elizabeth?**

138. **14. Did Elizabeth's' workplace have any cause for concern that Elizabeth may be at risk from domestic abuse by her son?**

- **If so, did this result in any routine or selective enquiry, safety planning and/or risk management actions and what was the evidence of this?**
- **If not, what were the reasons for this?**

- **Did 'Elizabeth's' workplace have a domestic abuse workplace policy? If so, how were staff made aware of these policies.**

139. **15. Subject to Family, Friends, Neighbours, and Work Colleagues of Elizabeth wanting to participate in the review, did they have any cause for concern that Elizabeth may be at risk from domestic abuse by her son? If so, were they aware of support services and how to seek advice and support?**

140. **SCOPE**

141. The timeframe of this DHR is from 14th September 2016 until when the murder / suicide was reported to Police.

142. There is an extensive history between Elizabeth and Sean, with Police records dating back to 1997.

143. The incidents recorded by Northumbria Police between 1997 and 2015 which are out of scope are detailed further in this DHR. Whilst the history has been taken into account, the partnership felt it was disproportionate to examine events over such a protracted period of time.

144. 2016 is significant as this was when a MARAC meeting took place where Elizabeth and Sean were subject of professional discussion.

145. Whilst recognising the long history of violence and abuse by Sean towards Elizabeth, this timeframe was considered to be a proportionate period of time for review.

146. **CONCLUSION**

147. It is clear Elizabeth had a difficult life. She suffered the loss of her husband at a relatively young age and was left to bring Sean up alone.

148. Sean presented challenges to his mother from a young age. Over many years he was violent and abusive towards Elizabeth.

149. It would appear over time Sean's mental health deteriorated, and his misuse of alcohol increased, resulting in extreme violence and abusive behaviour in turn causing his mother significant distress and harm.

150. It would appear Elizabeth's health and well-being deteriorated, and she became increasingly isolated from family and friends. Elizabeth appeared to use alcohol as a coping mechanism.

151. The presentation is dichotomous at all levels; Elizabeth presented as fearful but protective of Sean, at risk and at times posing a risk to herself and others through alcohol misuse, help seeking but declining help for herself in the pursuance of help for her son; which may have engaged her in an effective support plan and managed the risk.

152. Elizabeth's and Sean's contact with Agencies and Professionals was inconsistent over time.

153. There is some limited evidence of Elizabeth engaging with Agencies. However, on other on other occasions she elected not to. This is understandable given her desire to protect her son from the criminal justice system.

154. There were some missed opportunities from Agencies involved with Elizabeth to utilise a higher degree of professional curiosity to help enquire about, challenge and elicit pertinent information to identify underlying risk issues she may have been experiencing in terms of domestic abuse. In most interactions with Elizabeth, Professionals focused their efforts on her presenting need, and further enquiry could have been undertaken to consider possible indicators of abuse and the interplay between multiple presenting factors (e.g., injuries, depression and anxiety, alcohol use etc).

155. With a small number of exceptions, the presenting information appears to have been accepted at face value by Professionals without any evidence of them trying to clarify, or confirm, if said action had taken place.

156. As a consequence, there were missed opportunities to signpost Elizabeth (and Sean) to relevant Support Services.

157. It is clear a number of Agencies did not have a full awareness, or understanding, of the inter-family violence taking place between Elizabeth and Sean.

158. The escalation of risk was not consistently identified by Agencies. As a consequence, information was not always shared and the opportunity for multi-agency working was not optimised.

159. Professionals, even when acting as part of a joint team, need to be aware of the necessity to make appropriate referrals to allow consideration of further actions and notifications to be made to other parties.

160. The importance of Agencies communicating internally and with each other, ensuring they 'join the dots' and make multi-agency decisions on the most accurate, timely and complete information, cannot be overstated.

161. Had the concerns been viewed holistically there was information, either known or available, which should have given rise to a view significant harm was at least likely.

162. A better understanding of the circumstances which Elizabeth and Sean were living in may have prompted Agencies to adopt a more coherent response.

163. In undertaking this review there were some examples of good practice including the IDVA referring the case to MARAC and the victim follow up WWiN. Further, Northumbria Police attended all of the reported incidents during the scoping period and one occasion submitted a DASH risk assessment. On another occasion, they submitted an Adult Concern Notification.

164. However, whilst taking into account the complex circumstances and the lack of engagement by Elizabeth, I would suggest professional practice was on a number of occasions reactive, rather than a proactive holistic response to the risks presented by Sean towards Elizabeth.

165. It could be viewed Elizabeth was effectively left to manage Sean on her own, when, due to her own vulnerabilities, she was not in a position to do so.

166. This DHR has identified a range of learning opportunities for Agencies and Professionals in supporting vulnerable people who are subject of adult family violence.

167. The learning includes recognising domestic abuse involving a mother and son, the importance of multi-agency working, information sharing, professional curiosity, risk assessments, and the signposting specialist alcohol and drug support.

168. There are a number of strategic considerations which the Partnership are invited to consider:

- Do services or procedures need to be more focussed on engagement with people?

- Are there discussions with people, about the outcomes they want, embedded in key processes at the beginning, middle and end of the process, so the service and procedures drive engagement with people?

- How are Agencies addressing workforce development issues required to ensure people are skilled, and competent, in having difficult conversations with individuals at risk of harm or abuse?

- Are Professionals equipped to work with families, and networks, to negotiate outcomes and seek resolution?

- Do professionals have skills, knowledge, and permission to use the full range of legal and social work interventions needed?

169. A DHR triggered by a murder is by nature a reactive activity.

170. A standard question to consider as part of any DHR is whether or not the person's death could have been avoided had Agencies done more.

171. Whilst the review acknowledges there are some examples of good practice, it has also highlighted there were some missed opportunities to support and safeguard Elizabeth. That is not to say, the murder would have been prevented, but more professional curiosity, better information sharing, and enhanced multi-agency working may have helped to reduce the risk.

172. The murder of Elizabeth by her own son is a real tragedy for the family. There are lessons to be learned from these sad events. These lessons which may help avoid similar distress for others in the future.

173. The findings of this DHR provides an opportunity for Agencies individually, and collectively, to consider their response in light of the learning and recommendations, in order to make the future safer for others.

174. A critique of DHR's over time will identify, despite the commitment of Agencies and Professionals to safeguard the most vulnerable, much of the learning in this review are repeated themes.

175. Creating transformational and sustainable change is a significant challenge for Community Safety Partnerships. The relevant learning and recommendations from this DHR should be disseminated and monitored to support this change.

176. **LESSONS TO BE LEARNED**

177. **RECOMMENDATIONS / LEARNING**

178. **Learning Recommendation 1**

179. **Where a victim elects not to support a prosecution Northumbria Police should specifically record how and why the victim was feeling at the time, whether the decision not to support the prosecution was influenced by fear**

of the perpetrator and / or for other reasons together with any protective support offered to the victim.

180. **Learning Recommendation 2**

181. **Professionals within the MASH should ensure sufficient weight is placed on any history between the victim and perpetrator of domestic abuse, together with the account provided by the attending Police officers when undertaking the screening – triage process. This will ensure all of the potential risks have been considered before closing a case with no further action.**

182. **Recommendation / Learning 3**

183. **Where a victim of domestic abuse is presenting to different agencies at different times intoxicated, with injuries, and appears reluctant to accept support, partners should come together to share information, identify 'clear' ownership, and collectively agree the way forward.**

184. **Recommendation / Learning 4**

185. **All Agencies to disseminate to Professionals the Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) guidance, as part of their professional development strategies. Specific recommendations which are relevant to this DHR are detailed as follows:**

186. **a) It is imperative that risk is seen as dynamic, fluid and is regularly reassessed at 'critical points' within each case.**

187. **b) Agencies should always refer to the MARAC based on professional judgement when information is limited, and the victim / survivor is perceived to minimising the risks/is unable or too fearful to disclose the full extent of the abuse.**

188. **c) Professionals should bear in mind that often friends and family or 'informal networks' hold vital information around the level of risk.**

189. **d) Links between health services are crucial in ensuring a holistic overview of patterns in appointments, walks-ins, and emergency attendances rather than them being viewed in isolation.**

190. **e) Some consideration should be given to including the screening of perpetrators within mental health services and establish referral pathways.**

191. **f) All staff should receive training on identifying; risk assessing and safely responding to domestic abuse.**

192. **g) All staff should be expected to enquire about DVA.**

193. **h) Improved awareness and training around risk identification, management, and access to support for AFV with a particular emphasis on access to mental health services.**

194. **i) Improved information sharing between health professionals, GP's, hospitals, and substance misuse services in order to promote co-working pathways and holistic responses to AFV.**

195. **Recommendation / Learning 5**

196. **All Agencies should continue to build upon the training to date and support Professionals around identifying and supporting victims who may be subject of coercive control.**

197. **Recommendation / Learning 6**

198. **The Safer Sunderland Partnership should ensure an all age multi-agency suicide prevention plan is in place. Agencies should ensure training and guidance is provided to Professionals around preventing suicide.**

199. **Recommendation / Learning 7**

200. **Northumbria Police should promote the Force Adults at Risk Policy and Procedure and train and support officers to identify and support victims who require safeguarding.**

201. **Recommendation / Learning 8**

202. **All Agencies should consider routinely submitting a DASH and / or an ACN risk assessment where domestic violence or abuse be identified or suspected, including inter-family violence.**

203. **Recommendation / Learning 9**

204. **Northumbria Police Neighbourhood Policing Teams should give further consideration to conducting further in-depth research in order to understand the victim and perpetrator, and their complex issues and consider a problem-solving approach in complex cases such as this.**

205. **Recommendation / Learning 10**

206. **Where a number of incidents are reported within a short time frame, Northumbria Police and Partner Agencies should ensure any review process specifically examines whether risk is escalating, and interventions are required.**

207. **Recommendation / Learning 11**

208. **All Agencies should give consideration to reviewing MARAC cases where the victim has disengaged, or never engaged, where there is potential for escalating risk.**

209. **Recommendation / Learning 12**

210. **The Safer Sunderland Partnership should give consideration to the MARAC demand and the capacity of agencies to manage high risk domestic abuse referrals.**

211. **Recommendation / Learning 13**

212. **SCCG should ensure that any referral to MARAC should be followed up with further exploration of the issues and the offer of safeguarding support for the victim of domestic abuse.**

213. **Recommendation / Learning 14**

214. **SCCG should ensure that any frequent attendance at A&E for a similar complaint should be treated as a 'red flag' inviting further exploration and engagement with other agencies around potential domestic abuse.**

215. **Recommendation / Learning 15**

216. **STSFT and SCCG should routinely use professional curiosity where a person frequently presents with injury that may have been as a result of domestic violence or abuse.**

217. **Recommendation / Learning 16**

218. **All Agencies should look to implement mechanisms to routinely capture and share information on why victims decline access to Support Services.**

219. **Recommendation / Learning 17**

220. **All Agencies should promote and provide specific training on co-working pathways to domestic abuse.**

221. **Recommendation / Learning 18**

222. **The Safer Sunderland Partnership should promote 'Practical Guidance for Line Managers, Human Resources and Employee Assistance Programmes'.**

223. **Recommendation / Learning 19**

224. **As part of the ongoing campaign to support victims of domestic abuse, the Safer Sunderland Partnership should specifically raise awareness about the importance of third-party reporting.**

225. **INTRODUCTION**

226. This Domestic Homicide Review (DHR) examines agency responses and support given to Adult Elizabeth, prior to the point of her death in February 2020

227. The key purpose for undertaking a DHR 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.

228. **TIMESCALES**

- The Home Office were notified on 1st April 2020 the Safer Sunderland Partnership would be commissioning a DHR.

- The DHR was initially delayed due to the Covid pandemic.

- On 17th May 2021 I was appointed as Independent Reviewer.

- On 28th July 2021 a multi-agency meeting was held to consider the scoping reports submitted by relevant Agencies alongside the Terms of Reference for this review.

- Further professional conversations took place between the Independent Reviewer and Professionals in seeking further relevant information and addressing points of clarity.

- On 1st February 2022 a Draft Version 1 of this DHR was submitted to the Safer Sunderland Partnership.

- Following feedback, on the 11th April 2022 a Draft Version 2 of this DHR was submitted to the Safer Sunderland Partnership.

- Following further feedback, on the 26th June 2022 a Final Version 3 of this DHR was submitted to the Safer Sunderland Partnership.

- The Sunderland Safer Sunderland Partnership submitted the Final Version of this DHR to the Home Office DHR Quality Assurance Panel on the 4th October 2022.

- The Home Office DHR Quality Assurance Panel reviewed this DHR on the 23rd March 2023.

- On the 15th May 2023 the Safer Sunderland Partnership received feedback from the Home Office DHR Quality Assurance Panel.

- Following this feedback, the Independent Reviewer made the necessary amendments and submitted Version 4 of this DHR to the Safer Sunderland Partnership on the 10th June 2023.

- On the 22nd November 2023 the Safer Sunderland Partnership received further feedback from the Home Office DHR Quality Assurance Panel.

- Following this feedback, the Independent Reviewer made the necessary amendments and submitted Version 5 of this DHR to the Safer Sunderland Partnership on the 8th December 2023.

CONFIDENTIALITY

229. The findings of each review are confidential. The Information is available only to the family, participating Agencies and Professionals.

230. Pseudonyms have been agreed with Pamela and used in the report to protect the identity of the individuals involved.

TERMS OF REFERENCE

231. The Terms of Reference for this DHR are detailed as follows:

1. **To consider the impact of decisions made in relation to Elizabeth on her overall wellbeing; and whether any potential impact was recognised and whether she was supported.**

2. **To consider Elizabeth's death in light of national/local suicide prevention strategies. What were the quality of risk assessments and risk management plans in response to known incidents?**

3. **To consider whether any risks were identified assessed at the appropriate level?**

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9. **Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew Elizabeth was experiencing domestic abuse?**

10. **Was appropriate use made of available civil and statutory tools and powers: including but not limited to Civil Orders, Domestic Violence Protection Notices (DVPNs), Domestic Violence Protection Orders (DVPOs), Domestic Violence Disclosure Scheme (Clare's Law) etc?**

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14. **Did Elizabeth's' workplace have any cause for concern that Elizabeth may be at risk from domestic abuse by her son?**

- **If so, did this result in any routine or selective enquiry, safety planning and/or risk management actions and what was the evidence of this?**
- **If not, what were the reasons for this?**
- **Did Elizabeth's workplace have a domestic abuse workplace policy? If so, how were staff made aware of these policies.**

15. **Subject to Family, Friends, Neighbours, and Work Colleagues of Elizabeth wanting to participate in the review, did they have any cause for concern that Elizabeth may be at risk from domestic abuse by her son? If so, were they aware of support services and how to seek advice and support?**

SCOPE

232. The timeframe of this DHR is from 14th September 2016 until when the murder / suicide was reported to Police in February 2020.

233. There is an extensive history between Elizabeth and Sean, with Police records dating back to 1997.

234. The incidents recorded by Northumbria Police between 1997 and 2015 which are out of scope are detailed further in this DHR. Whilst the history has been taken into

account, it was felt disproportionate to examine events over such a protracted period of time.

235. 2016 is significant as this was when a MARAC meeting took place where Elizabeth and Sean were subject of professional discussion.

236. Whilst recognising the long history of violence and abuse between Elizabeth and Sean, this timeframe was considered to be a proportionate period of time for review.

METHODOLOGY

237. This DHR is commissioned by Safer Sunderland Partnership in response to the deaths of Elizabeth and Sean which were reported in February 2020.

238. The review is commissioned in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

239. The review follows the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

240. The Criteria for a Domestic Homicide Review (DHR) is detailed within the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

241. The Chair of the Safer Sunderland Partnership appointed me to undertake the role of Independent Chair and Reviewer for the purposes of this DHR. I am neither employed by, nor otherwise directly associated with, any of the Statutory or Voluntary Agencies involved in the review.

242. The key purpose for undertaking a DHR 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.

243. In addition to Agency involvement, this DHR will also examine the past, to identify any relevant background or trail of abuse before the homicide, whether support was accessed with Agencies and 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 for those at risk of domestic abuse and violence.

244. Further, the purpose of this DHR is to:

- Establish the facts leading up to the incident in February 2020 resulting in Elizabeth's murder and Sean's suicide, and whether there are any lessons to be learned from the case about the way in which local Professionals and Agencies worked together to safeguard Elizabeth.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

- Additionally, establish whether Agencies have appropriate policies and procedures to respond to domestic abuse and to recommend changes as a result of the review process.

- Adopt a strengths-based approach and highlight any good practice.

- Contribute to a better understanding of domestic violence and abuse.

Hindsight Bias and Outcome Bias

245. Care has been taken to avoid hindsight bias and outcome bias.

246. Hindsight bias is when actions which could have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming Staff and Professionals closest in time to the incident.

247. Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident which leads to no harm; even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair.

248. This report acknowledges hindsight is difficult to eliminate, but everything possible has been done to limit it.

249. A tendency towards hindsight bias can be reduced by ensuring the DHR focuses on how things were perceived at the time, with the rationale for decisions, actions, or inactions at the time.

Limitations / Parameters of the DHR

250. There are some limitations or parameters around this DHR.

- The main focus of the DHR is on learning, this creates the framework through which it is presented i.e., the DHR is not an investigation nor something which seeks to attribute blame.
- Reviewing the deaths of Elizabeth and Sean, and the events leading up to their deaths, is challenging for all concerned. All parties may not agree with all aspects of the Independent Reviewer's assessment.
- The Independent Reviewer may not have communicated with every Family Member, Friend or Professional who may have contributed to the DHR.
- The Independent Reviewer was provided with information as requested throughout. However, given the scale and complexity of the issues there may be key material which has not been brought to the attention of the Independent Reviewer.
- Therefore, not every issue or incident experience by Elizabeth and Sean is the subject of reflection, but a sufficient amount of insight was gathered to arrive at some informed findings.
- Pamela has been the only point contact identified for the family in support of this DHR. Although Pamela has been very helpful, she stated that she had seen Elizabeth a lot less frequently over recent times so understandably there are some limitations to the amount of insight she could provide.
- Pamela disclosed that Sean had been aggressive towards her in the past and this may have affected Elizabeth's reduced contact with Pamela over time.
- Elizabeth was described as a private person who understandably was reluctant to share what was happening at home with family, friends, and work colleagues.
- It would also appear that whilst Elizabeth had a routine which included work, she was to a degree socially isolated.
- Given that this DHR has explored the history from 2016 until February 2020, access to all the information and recall may have been affected given the passage of time.

Involvement of Family, Friends, Work Colleagues, Neighbours and the Wider Community

251. The quality and accuracy of the review is likely to be significantly enhanced by family, friends, and wider community involvement. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder.

252. The involvement of family, friends and others is both necessary and complex, as they can have important information about the nature and extent of the abuse which may not have been shared with agencies.

253. The benefits of involving family, friends and other support networks include:

a) Assisting the victim's family with the healing process, which links in with Ministry of Justice objectives of supporting victims of crime to cope, and recover, for as long as they need after the homicide.

b) Giving family members the opportunity to meet the Review Panel if they wish and be given the opportunity to influence the scope, content, and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased, helping the process to focus on the victim's and perpetrator's perspectives rather than just Agency views.

c) Helping families satisfy the, often expressed, need to contribute to the prevention of other domestic homicides.

d) Enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the victim, and/or perpetrator, in order to see the homicide through the eyes of the victim, and/or perpetrator. This approach can help the panel understand the decisions and choices the victim and/or perpetrator made.

e) Obtaining relevant information held by Family members, Friends and Colleagues which is not recorded in official records. Although witness statements and evidence given in Court can be useful sources of information for the review; separate and substantive interaction with Families and Friends may reveal different information to set out in official documents. Families should be able to provide factual information, as well as testimony to the emotional effect of the homicide. The Review Panel should also be aware of the risk of ascribing a 'hierarchy of testimony', regarding the weight they give to Statutory Sector, Voluntary Sector, and Family Friends and contributions.

f) Revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) Enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report.

254. The Safer Sunderland Partnership Chair and Independent Reviewer have sought to 'reach out' and engage with Elizabeth's family.

255. In doing so, the particular sensitivities arising out of a situation, where a son has murdered his mother, were fully considered.

- In seeking to involve Elizabeth's family in the review process, the SSP Chair and Independent Reviewer have sought to take into account who the family may wish to have involved, as Lead Members and to identify other people they think relevant to the review process. Pamela was identified as the only point of contact for the family.

- Pamela was given the opportunity to meet with the Chair and Independent Reviewer to share her insight into the lives of Elizabeth and Sean. Pamela was provided with the relevant Home Office DHR leaflet and offered the opportunity to contact the Chair and Independent Reviewer at any stage of the review.

- The review agreed a communication strategy which kept Pamela informed throughout the process. Pamela was contacted in person, on the telephone and in writing throughout the DHR. The review has sought to be sensitive to her wishes, any need for support, and any existing arrangements already in place to do this.

- Pamela was offered the opportunity to present the foreword of this DHR (see above).

- It is evident that Pamela has found the loss of Elizabeth a painful experience.

256. CONTRIBUTORS TO THE REVIEW

257. The following Agencies were identified and contributed to the DHR:

- Northumbria Police (NP)– the Police Force responsible for the geographic area covering Sunderland.

- South Tyneside and Sunderland NHS Foundation Trust (STSFT) – the Health Trust responsible for the geographic area covering Sunderland.

- Sunderland Clinical Commissioning Group (CCG) – the statutory Health body responsible for the planning and buying of local NHS care and services to meet the needs of the local community.

- Wearside Women in Need, commissioned by Sunderland City Council, responsible for delivering specialist domestic abuse support services within Sunderland, including support for high-risk victims.

- A local charitable organisation where the victim Elizabeth was employed since 1995.

258. **REVIEW PANEL MEMBERS**

LAVERTON, Stephen	Strategic Manager Community Safety & Safeguarding (Prevent Lead) Sunderland City Council
HUDSON, Shelley	Detective Chief Inspector Northumbria Police
PROCTOR, Wendy (NHS SUNDERLAND CCG)	Safeguarding Nurse Sunderland Clinical Commissioning Group
FARROW-TAIT, Maria (NHS SUNDERLAND CCG)	Safeguarding Nurse Sunderland Clinical Commissioning Group
ROGERSON, Becky MBE	Director of Wearside Women in Need (WWIN) Specialist Abuse Service
DAWSON, Tracy (SOUTH TYNESIDE & SUNDERLAND NHS FOUNDATION TRUST)	Named Nurse Safeguarding Adults. South Tyneside and Sunderland NHS Foundation Trust
ANAND, Chandra (NHS COUNTY DURHAM CCG)	GP Safeguarding Lead
DUFFY, Sheona	Team Manager. Safeguarding and Public Protection, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

AUTHOR OF THE DHR REPORT

259. The Independent Reviewer is a recently retired Chief Police Officer who served with Avon and Somerset Constabulary and West Mercia Police and has no previous connection with the Sunderland Community Safety Partnership.

260. The Author is a former Head of Public Protection and Senior Investigating Officer.

261. The Independent Reviewer is also an Independent Scrutineer for a Child Safeguarding Partnership and an Associate with Safe Lives, a national charity supporting partners to reduce Domestic Abuse.

262. The Independent Reviewer has carried out other DHR's on behalf of other Partnerships.

263. The Independent Reviewer, therefore, has the required knowledge and understanding to undertake this DHR.

264. **DIRECTIONS TO AGENCIES / INDEPENPENDENT REVIEWER**

265. Agencies were directed:

266. To provide a narrative description of any significant episodes involving Elizabeth prior to the highlighting the relevance of the incident.

267. To draw up a chronology of the involvement in the life of Elizabeth to determine where further information is necessary. Where this is the case, Individual Management Reviews or Summary Reports were required by relevant agencies.

268. To produce IMRs or Summary Reports for the period commencing 14th September 2016 to the date of Elizabeth's death.

269. To invite responses from any other relevant Agencies, Groups or Individuals identified through the process of the review.

270. To seek the involvement of Family, Neighbours, and Friends of Elizabeth, to provide a robust analysis of the events and to understand Elizabeth's life.

271. As the Independent Reviewer I was then directed to produce a report summarising the chronology of events, including the actions of involved agencies; analyse and comment on the actions taken and make any required recommendations regarding safeguarding individuals where domestic abuse is a feature.

PARALLEL REVIEWS

272. It should be noted DHRs are not inquiries into how the victim died, or who is culpable. This is a matter for the Coroner and Criminal Courts.

273. However, the review was cognisant of parallel reviews, and consultation was undertaken with HM Coroner.

274. An inquest into the deaths of both Elizabeth and Sean was held by HM Coroner in early March 2020.

275. The Assistant Coroner described the relationship between the mother and son as 'problematic', adding, the son was 'very controlling' and was both emotionally, and sometimes physically, abusive.

276. The Assistant Coroner continued 'It seems clear she (Elizabeth) was a very independent, proud mother but that, effectively, this has ultimately led to her death because she obviously had difficulties with Sean.'

277. She said Elizabeth's 'mother's instinct' must have made it 'doubly difficult to effectively walk away from the situation'.

278. The conclusion was Elizabeth was unlawfully killed.

279. The Coroner arrived at the conclusion Sean died as a result of a Codeine overdose.

280. HM Coroners enquires are now complete.

281. There are no other reviews being undertaken by any other Agency.

282. EQUALITY AND DIVERSITY [1]

1 The Equality Act 2010 legally protects people from discrimination in society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations.

In summary, those subject to the general equality duty must have due regard to the need to:

The Equality Act 2010 defines the following characteristics are protected characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

283. Elizabeth was female and aged 68 years of age at the time of her death. Sean was a male and aged 44 years of age at the time of his death. Both Elizabeth and Sean were of White British origin and English was their first language.

284. It is reported (although uncorroborated) Elizabeth had relationships with a man and women throughout her life.

285. Sean suffered with a mental health disability. However, historically he declined support from Professionals. It is recorded that Sean had suicidal ideation. Elizabeth commented on Sean's deteriorating mental health to a number of Professionals over time. Sean was unreliable in taking his prescribed medication. Elizabeth also disclosed to Police that Sean had autism although she stated this had never been formally diagnosed.

286. As part of this DHR consideration has been given to Elizabeth's gender and sexual orientation, as well as Sean's mental health disability.

287. There is no evidence to suggest Elizabeth or Sean were discriminated against or treated unlawfully as a result of their protected characteristics.

288. DISSEMINATION

289. After Home Office approval, this report will be published on the Safer Sunderland Partnership (SSP) pages of the City of Sunderland website. Copies will also be disseminated to all Chief Officers of the SSP member organisations and to the Northumbria Police and Crime Commissioner.

290. BACKGROUND INFORMATION (THE FACTS)

291. The circumstances leading up to this DHR being undertaken are detailed as follows:

292. The Safer Sunderland Partnership (SSP) received information from Northumbria Police in February 2020 of a homicide and suicide they had attended in Sunderland in the same month.

293. A summary of the Police notification to the Safer Sunderland Partnership received in February 2020 is detailed as follows:

294. The victim Elizabeth, and her son, the perpetrator, Sean, lived together, in Sunderland.

295. Northumbria Police had recorded a number of domestic violence and abuse incidents by Sean towards Elizabeth from as far back as 1997 to February 2020.

296. Elizabeth was last at work for the local Charity in early February 2020 and was then due to attend work a week later, but she never arrived. The Charity Staff had spoken to Elizabeth by telephone during the week.

297. Concerned Elizabeth had not attended work, over the following days, staff at the Charity made a number of efforts to contact her by telephone, but only ever received an answer from Sean; who claimed his mother was ill. Sean was abusive towards the Charity Staff on the telephone.

298. Neighbours describe hearing, and or seeing Elizabeth during the period she was absent from work but cannot be precise when this was. One witness reported hearing Elizabeth and Sean rowing in the early hours.

299. A concerned Member of Staff from the Charity called at Elizabeth's home address in late February 2020 but got no answer. On looking through the living room curtains she saw Sean, motionless on the sofa. As a result of this she contacted her office, who, in turn contacted the Police.

300. Upon Police attendance, entry was forced, and Elizabeth and Sean were both found, deceased, within the living room. Elizabeth was on the floor beside the sofa with a number of, what appeared to be, stab wounds. Sean was naked on the sofa, with no obvious injuries.

301. A post-mortem of Elizabeth and Sean took place shortly afterwards. Elizabeth had nine stab wounds, the fatal two being to her jugular.

302. Elizabeth had been dead for some time, up to possibility a week. Elizabeth died due to stab wounds to her neck.

303. Toxicology In relation to Elizabeth showed:

- Blood alcohol 312mg/100ml.
- Nicotine and its metabolite and caffeine detected in blood.
- No other drugs collected.

304. The Ethanol concentration was described as sufficient to impair cognitive and motor functionality.

305. The conclusion was Elizabeth was unlawfully killed.

306. Sean had no injuries consistent with assault.

307. Toxicology in relation to Sean showed:

- Blood codeine 2774 mg/ml.
- Blood free morphine 9 ng/ml.
- Blood total morphine 11 ng/ml.
- Blood paracetamol 537 mg/l.

308. The blood Paracetamol level was described as grossly elevated and within the quoted lethal range. The blood Codeine level was described as within the quoted lethal range. Some Codeine is converted in the body into Morphine. There were no other identifiable drugs. The vitreous biochemistry results were unremarkable.

309. The conclusion was Sean died as a result of a Codeine overdose.

Matricide

310. Matricide (from Latin matricidia “mother killer”) is the act of killing one’s own mother.

Family

	Name	**Age**	**Relationship**	**Ethnic Origin**
Victim	Elizabeth	68	Mother	White European
Perpetrator	Sean	44	Son	White European

Elizabeth Personal History

311. Elizabeth was born in Manchester then travelled back to family home in the North East in 1952.

312. Elizabeth and George had a child, Sean in the mid 1970s.

313. Sadly, when Sean was an infant, George passed away, leaving Elizabeth to bring up Sean on her own.

314. Elizabeth remained in the private family home with her adult son Sean until their deaths.

315. Elizabeth was reported to be close to her mother, who died in 1990.

316. Elizabeth once told a friend she had two great loves in her life, one an unidentified female, who she had a relationship before she married who died, and the second was her husband, George.

317. Elizabeth had volunteered at a local Children's Charity on a part time basis since 1995. Elizabeth was a caring person and enjoyed her work.

318. Elizabeth enjoyed socialising with friends and colleagues from the Charity, having regular breakfast with them.

319. Elizabeth's colleagues at work described her as 'friendly' but 'feisty'. Whilst she was a long-standing employee, she was described as somewhat unreliable with frequent absences from work. This is commented upon later in this review.

320. Elizabeth was described as being 'houseproud', however in more recent years, friends noted a significant deterioration in the cleanliness and condition of her home.

321. Elizabeth loved her garden and neighbours would often see her outdoors. However, there were also number of reports of disputes with near neighbours, resulting in Police attendance. Sean and Elizabeth stated to Police the neighbours called them as they were trying to get the council to move them.

322. Elizabeth is described as a private person who was reluctant to disclose what may have been happening with Sean 'behind closed doors'.

323. Elizabeth did speak to WWiN about a friend who 'works in the Police'; Elizabeth was very worried her friend might find out about the incidents and sought assurance information would not be shared, as she actively protected her privacy. Elizabeth also spoke of two Nephews who were Police Officers, but made it clear she did not want family to know what was happening within her home. Elizabeth maintained a level of secrecy about her home life which perhaps only neighbours, colleagues or Police saw. When the Police were involved on different occasions both Elizabeth and Sean were highly intoxicated.

324. It is felt Elizabeth became more isolated over time; family and friends visited less and less due to Sean's behaviour. Her contact with Pamela reduced over time. Friends and Relatives who did attend her address were sometimes kept outdoors. It is felt Elizabeth was embarrassed about Sean and his behaviour.

325. Elizabeth was also described as a smoker and a heavy drinker. Elizabeth would drink in Public Houses and at home. On a number of occasions, when Police attended the home address, Elizabeth was reported to be intoxicated.

326. Elizabeth had a history of vertigo. On a number of occasions when presenting with injuries at hospital or work, Elizabeth would say they were as a result of her horizontal imbalance.

327. When Elizabeth passed away, the Chronicle reported tributes flooded in through social media for a 'lovely woman'.

Sean Personal History

328. Northumbria Police have records detailing that they arrested Sean on 11 separate occasions between 1997 and 2015 for a range of offences including assault, criminal damage and drunk and disorderly and to prevent a breach of the peace. The vast majority of these incidents involved Sean carrying out domestic abuse in the home towards Elizabeth. Sean received a range of sanctions including community orders and fines, and on a number of occasions no further action was taken. Sean was observed by police officers to be intoxicated when they attended a number of these incidents.

329. In 2013 Sean was convicted of assault against Elizabeth and sentenced to 6 weeks imprisonment. As he had failed to comply with the requirement of the community order imposed on 11th December 2012, the order was revoked, and he was committed to prison for 12 weeks giving an overall sentence of 18 weeks.

330. Sean lived in the family home, with his mother in Sunderland, for the majority of his life. Sean did move out 'on a couple of occasions' for short periods of time, but always returned home. Sean would reportedly make threats to kill himself if asked to leave the family home.

331. As stated, Sean's father, George, died when Sean was an infant. Sean did not appear to have any adult male role model in his life.

332. There is no evidence of Sean having a relationship with anyone.

333. Sean was described as 'very intelligent'. He attended private school on a scholarship and continued his studies after his father passed away. However, Sean was bullied by other children who teased him, calling him 'charity boy'. Sean ran away and may have self-harmed as a teenager, resulting in a scar to his wrist.

334. When assessed by a Health Professional whilst in Police custody on 30th April 2015, Sean stated he had not had suicidal thoughts for ‘around 20 years’. However, there is evidence to suggest Sean threatened to kill himself as he got older, when he was asked to stay away, or leave, the family home by his mother.

335. Sean attended University but ‘dropped out’ of his course.

336. Elizabeth stated Sean had autism to Police, although this was never clinically diagnosed. It was also reported Sean had epilepsy.

337. Sean was described by a number of people as obnoxious and rude, and would challenge authority, believing he had a superior intellect. He was described as having a ‘posh’ accent and an overbearing manner.

338. Sean was unemployed for long periods during his life, although there was a suggestion, he may have been employed by a book shop at some stage.

339. Sean was described as a reclusive alcoholic, who was not seen outside of the house for protracted periods of time. Sean would often stay awake all night, and sleep throughout the day.

340. Sean had poor hygiene. He would rarely wash, change his clothes, and smelt of body odour.

341. Sean is also described as being extremely untidy. Elizabeth reported Sean hated detergents or any cleaning materials or activity. The overall living conditions in the family home were described as unhygienic, with evidence of damage to furniture and a pungent smell. It is reported Sean would keep bottles full of urine in the house, rather than use the toilet.

342. Sean was described as having an unhealthy fixation with Adolf Hitler, the occult and was a ‘goth’ when he was a young man. There is an uncorroborated suggestion Sean may have killed a cat at some stage.

343. When his father passed away, Sean sought to adopt the position as ‘man of the house’, although it appears he may have been financially dependent on Elizabeth, given his limited employment history.

344. Within Elizabeth’s historical clinical notes, it is recorded, when discussing Sean, Elizabeth stated ‘he sometimes thinks he’s my husband’.

345. Sean would be very demanding of his mother. For example, it is reported he would insist she should purchase vodka for him on a frequent basis. Sean was very

particular about his food and would often lose his temper over minor household issues.

346. Elizabeth commented on Sean's deteriorating mental health to a number of Professionals over time. It appears Sean could not be relied upon to take his medication.

347. However, Sean's involvement with mental health services sits outside the scope / timeframe of this DHR. Having been arrested in 2012, 2013 he declined further mental health support and in 2015 was encouraged to register with a GP for support.

348. Mental health issues are a common feature of the majority of perpetrators of Adult Family Violence (AFV), including depression, self-harm, psychosis, and paranoid schizophrenia. The most frequent risk factors for perpetrators of AFV, are mental health issues, alcohol or substance misuse and previous criminality. Several review reports have also noted perpetrators of AFV commonly displayed patterns of threatening behaviour towards women, and also committed some other form of violence against women. It is of note Pamela reported historically Sean was threatening towards her.

349. **Events Outside Scope of Review**

350. Based on records provided by Northumbria Police

351. **December 1997**

352. Call received from Elizabeth reporting Sean had broken some windows at the address and was threatening to cause further damage. Officers attended and Sean was arrested for criminal damage. Elizabeth refused to make a complaint; therefore, Sean was released NFA. This was not 'crimed' as per policy in force at that time.

353. **May 2002**

354. Incomplete 999 call received. A female asked for police then cleared the line. On attendance Elizabeth was found to be intoxicated and appeared to have bruising/swelling to her face. Sean was arrested on suspicion of S.47 assault. In interview he disclosed that they had argued, and Elizabeth had lunged at him, so he raised his hands to fend her off and struck her face. When officers spoke to Elizabeth the following morning, she refused to make any complaint. As such Sean was released NFA. No crime report was raised as there was no evidence of criminal intent. A 10-point DV update was added to the log.

355. **March 2003**

356. Elizabeth reported that during an argument with Sean, he had shot her in the face with an air rifle. Her nose was bleeding as a result. As Sean was still in the premises a firearms authority was granted. There were no firearms warnings attached to the address or to Sean. Armed officers attended. Elizabeth was

spoken to by phone and was able to leave the address to the ambulance. Sean then came out to speak to officers. He was unarmed and compliant and was arrested. Firearms officers recovered the weapon from inside the house. Officers attended hospital where Elizabeth was being treated. It was believed that she would be detained overnight, and the pellet would be removed the following day. A 10-point DV update was added to the log. Sean was arrested and subsequently charged with S.18 assault. He appeared at Newcastle Crown Court on 05/08/03. He was found not guilty for wounding with intent and unlawful wounding and found guilty of assault OABH receiving 80 hours community punishment and 12 hours community rehabilitation.

357. **October 2005**

358. Sean was arrested for drunk and disorderly after being stopped in the street by officers. He was subsequently charged with the offence. In court he was fined £75 and ordered to pay £50 costs.

359. **October 2005**

360. Anonymous call received reporting possibly 4 persons fighting in a flat. On attendance this was established to be an argument between tenant and landlord. Elizabeth was subsequently arrested for breach of the peace and later common law released. No offences were disclosed.

361. **October 2006**

362. Anonymous call received reporting Sean was causing a disturbance at his mother's address. On attendance this was a verbal altercation between Elizabeth and Sean. No offences were disclosed.

363. **September 2006**

364. Elizabeth reported that Sean had locked her out of the house. She was only wearing her nightwear. On attendance it transpired that both were intoxicated. While Elizabeth had been smoking in the garden Sean had locked the door preventing her from getting back in. Sean only came to the door when he was informed that Elizabeth had given officers permission to force entry. He then refused to leave and was therefore arrested to prevent a breach of the peace. He was subsequently common law released.

365. **January 2007**

366. Call received from a member of the public reporting a male banging on doors and climbing on cars. On attendance the male was identified as Sean who began to shout and swear at officers. He was arrested and subsequently charged with drunk and disorderly. In court he was fined £100 and ordered to pay £50 costs.

367. **May 2008**

368. Elizabeth called reporting problems with Sean. A male could be heard shouting in the background. On attendance both parties were intoxicated. It transpired that Elizabeth had been locked out by Sean as she was intoxicated. She then smashed a window, climbed in to the house and assaulted Sean by hitting him in the face with a dinner plate.

369. **October 2010**

370. Elizabeth reported problems with Sean. She stated that he had been drinking and had locked her out of the house. On attendance both were intoxicated. Elizabeth was assessed as standard risk.

371. **March 2011**

372. Elizabeth called police wanting Sean removed from the premises. On police attendance both were intoxicated, and they had had a verbal argument. Elizabeth had been making chips and had cut her thumb. There was no record of an ambulance being required. Sean was arrested to prevent a breach of the peace. He was later common law released. A DVN was raised for Elizabeth.

373. **November 2011**

374. Elizabeth reported that Sean was making threats towards her, and she wanted him removed. On police arrival both parties were heavily intoxicated, and it was established that a verbal altercation had taken place. Sean was not capable of finding anywhere else to stay and was subsequently arrested to prevent a breach of the peace. He was later common law released. Elizabeth was assessed as standard risk.

375. **November 2012**

376. Elizabeth reported that Sean had assaulted her, and he was still in the house. She reported they had both been drinking alcohol and she had an injury to her face but refused an ambulance. On attendance officers requested an ambulance as Elizabeth had an injury to her eye and Sean was arrested for assault. It was established that there had been an argument over vodka and Sean had punched her twice in the face causing extensive swelling and bruising to her right eye and a small cut to her temple. Sean also had a cut to his nose. Sean was arrested and in interview he admitted the offence. He was subsequently charged and attended court on 11/12/12 when a community order was made.

377. A restraining order was not made as Elizabeth did not participate in the prosecution and did not want a restraining order. Elizabeth was assessed as medium risk and passed to the NBM for further contact. She was contacted on 26/11/12. She stated that she was “perfectly fine” and had received a visit from the officer involved in the incident. She did not require a referral.

378. **February 2013**

379. Elizabeth reported that Sean was intoxicated and had punched her about the head and face. An ambulance was declined. On attending both parties were intoxicated, and Sean was arrested for assault. In interview Sean stated that he had been drinking heavily and could not remember anything due to his intoxication but agreed it would be wrong to hit his mother. Sean was subsequently charged with common assault by beating / battery. In court the following day he pleaded guilty and was sentenced to 6 weeks in prison for the assault. As he had failed to comply with the requirement of the community order imposed on 11/12/12, the order was revoked, and he was committed to prison for 12 weeks giving an overall sentence of 18 weeks.

380. Elizabeth was assessed as a medium risk and passed to NBM for management. On 18/02/13 Elizabeth was spoken to at length, and she refused any further police assistance. She was advised to contact police should she need any further help.

381. **April 2013**
382. Elizabeth reported that Sean had recently come out of prison, and he was at the address and being a “little bit aggressive”. She was concerned things could escalate. On attendance Sean was intoxicated; however, Elizabeth declined to expand on what had happened. Sean was arrested for breach of the peace and later common law released.
383. A DVN was raised for Elizabeth.
384. Elizabeth was assessed as medium risk and passed to NBM. A referral was declined.
385. Elizabeth was re-visited on 29/04/13. Sean was present in the house. Elizabeth stated that he was on his last chance and if there were any further incidents, she would seek an injunction against him. She declined any assistance. Sean was spoken to and given suitable advice regarding his behaviour.

386. **April 2015**
387. Elizabeth reported that Sean was becoming aggressive. She stated that both had been drinking. On attendance both were intoxicated. The living room floor was described as covered in empty beer and vodka bottles. Sean was very vocal, refusing to calm down and was therefore arrested for breach of the peace. He was subsequently common law released. A DVN was raised for Elizabeth.
388. Elizabeth was assessed as standard risk. Attempts were made to contact Elizabeth on 01/05/15 and 02/05/15 with no reply. She was spoken to on 03/05/15 and advised re: Turning Point and Crisis. She was attempting to get Sean help around his alcohol and mental health issues. She stated that she was happy for him to remain in the home, although she was finding it harder to cope. She stated she would encourage Sean to engage with other agencies and had NPT details.

389. **April 2015**
390. Elizabeth reported that Sean was becoming aggressive. She stated that both had been drinking. On attendance both were intoxicated. The living room floor was described as covered in empty beer and vodka bottles.
391. She was spoken to on 03/05/15 and advised re: Turning Point and Crisis. She was attempting to get Sean help around his alcohol and mental health issues. She stated that she was happy for him to remain in the home.

CHRONOLOGY (From July 2016)

392. For ease of reading, chronologies have been broken down by each Agency involved in this DHR:

393. **Northumbria Police**

394. **30th July 2016**

395. An IDVA attended the home address of Elizabeth & Sean following a silent 999 call coming into the Police. The WWiN IDVA was on shift with the Police DV Car and

picked this up for a visit as there was a Domestic Violence marker on the property due to previous incidents at the address. The IDVA was sufficiently concerned and referred to WWiN Outreach for a full assessment.

396. **23rd August 2016**

397. A MARAC referral was received for Elizabeth from WWIN. This followed the silent 999 call coming into the Police.

398. It was reported Elizabeth was assaulted 6 weeks prior by Sean and she had concerns about his mental health. A Domestic Abuse Officer (DVO) was allocated for safety planning. It was agreed contact would be made with the Referrer prior to contact being made with the victim. It was noted the perpetrator (Sean) resided with the victim & could potentially answer if contact was made.

399. **24th August 2016**

400. The DVO spoke to Elizabeth who declined all safety planning.

401. Elizabeth disclosed:

- She feels like she is walking on ‘egg shells’.
- Elizabeth disclosed Sean has previously been physically violent towards her.
- Elizabeth stated, ‘around ten years ago’, Sean had shot her in the face with an air rifle as a result of his deteriorating mental health. Elizabeth stated the historical incident with the air rifle went to Court. Elizabeth also reported six weeks previously, Sean had grabbed her around the throat.
- Elizabeth stated Sean was emotionally controlling & made threats to kill himself if asked to leave the family home.
- Elizabeth disclosed Sean has also caused damage to the address and states he has an obsession with Hitler.
- Elizabeth feels Sean's mental health was again deteriorating.

402. The DVO signposted Elizabeth to WWIN and explained the MARAC process. The DVO ‘crimed’ the other disclosed assault as per National Crime Recording Standards. Elizabeth’s case was referred to MARAC.

403. As part of the information provided to the MARAC on the 14/09/2016 a disclosure was made in relation to an assault; this was correctly recorded in line with the above procedure as per crime number 077032J/16. However, Elizabeth did not provide a statement to the Police and would not support a prosecution citing intimidation and/or reprisals for this decision. There isn’t any record as to any specifics or

measures taken to negate Elizabeth's concerns. The crime was closed as undetected.

404. There are a number of benefits for the Police to record accurately at the time why a victim may not wish to support a prosecution, as well as any measures taken to provide reassurance. An accurate record illustrates how and why the victim was feeling at the time, whether a decision not to support a prosecution was influenced by fear of the perpetrator and / or for other reasons and can be helpful in the future should further incidents occur and / or the victim reconsider their decision. Accurate record keeping also allows for all agencies to be held accountable for the level of support offered to the victim and any action taken against the perpetrator.

405. **Learning Recommendation 1**

406. **Where a victim elects not to support a prosecution Northumbria Police should specifically record how and why the victim was feeling at the time, whether the decision not to support the prosecution was influenced by fear of the perpetrator and / or for other reasons together with any protective support offered to the victim.**

14th September 2016

407. Elizabeth was discussed at MARAC (Case no: A/274/16) following the referral from WWiN.

408. Information was supplied via handwritten answers to the following questions by Sean's GP practice and shared at the MARAC meeting:

409. Has domestic violence been identified previously?

410. 'Nothing on GP records, registered with us since December 2013 not seen by any GP since'.

411. Information on key risk indicators e.g., Mental health problems, drug and alcohol use, non-engagement with agencies previous violence etc?

412. 'Not on any medication, has epilepsy? in active problems but not on any medication regularly, alcohol intake documented 20/01/15 30 units'.

413. The following actions were agreed:

Actions Agreed	Responsible Agency	Update

Flag system for Elizabeth re: her alcohol use and consider a referral to appropriate services.	Health	Letter to GP to flag records re alcohol misuse
Try to recontact victim and encourage to a referral for her son (perpetrator) to mental health services. Update victim of MARAC.	WWIN	Completed

414. In addition, WWIN took away an action to explore a referral to mental health services for Sean.

27th May 2017

FWIN 1015
Crime No 061020E/17 Public Order Distress

415. The next-door neighbour reported Elizabeth was shouting out of her window at her and some friends, who were sitting in her garden, threatening to kill them. The neighbour reported ongoing issues with Elizabeth. The caller was advised to go inside and lock her doors. On attendance Elizabeth was found to be intoxicated. It transpired the caller had recently installed new security lights which Elizabeth and Sean found too bright. Elizabeth had heard the caller and her friends talking about the lights which resulted in a 'heated debate' between them, resulting in Elizabeth making a 'drunken rant' which included the threats. Elizabeth could not actually remember what she said, and the caller agreed the threat was not perceived immediate or real. Advice was given to all parties.

25th August 2019

FWIN 1070
ACN A014018/19

416. The next-door neighbour reported further problems - Elizabeth had been shouting out of her window saying she was going to set fire to the neighbour's house. The neighbour reported they had been having a barbeque and Elizabeth had been shouting at them and the children who were present. No officers were available that evening and as nothing was currently going on arrangements were made to

visit the following day. Officers spoke to both parties and no offences were disclosed. Advice was given in relation to mediation.

417. **A summary of the Police Officer's report is detailed below:**

418. 'Attended with reference to neighbour complaint, Elizabeth would not let me into the address, and I had to speak with her in the back garden. Alcohol could be smelt on her, and her eyes were a yellow colour, and she was very shaky. Whilst speaking with her the back door burst open and Sean immediately became aggressive towards myself stating if I think all men are domestic violence offenders then I'm wrong. He was shirtless and sweating profusely; Elizabeth then shouted at him to go inside and forced the door closed. I tried to speak with Elizabeth regarding the domestic comments and Sean in general, but she just kept stating she was ok, she states he has autism, but this has not been diagnosed by a medical professional. I am unsure if he ever leaves the house and Elizabeth and Sean seem to spend a lot of time together. When the door opened there was an awful smell from within. I have concerns there is more than Elizabeth would like to admit going on within the address, her and her sons relationship appears quite explosive and upon returning to the station and conducting checks there is a history of domestic violence between the pair'.

419. The Police Officer submitted an Adult Concern Notification (ACN).

420. Triage was completed with the Safeguarding Officer and the MASH supervisor, and the decision was made no further action was required at that time. In support of this review, the current MASH supervisor was asked around the rationale for this decision commented as follows:

421. 'We have hundreds of adult concerns discussed each month, so it is unlikely the two reps in the meeting would remember the conversation re this case.

422. The morning triage looks at the circumstances of each Police adult concern, both Adult Services and Police will look at what is historically on their systems (e.g., is there an escalation in seriousness or frequency of concerns) and make a decision if there is any role for Adult Social Care. If an adult is open to ASC it would be automatically forwarded for info of the case worker.

423. Looking at the circumstances it seems straight forward to me there was no role for them at this time in these circumstances. This is because:

- Elizabeth clearly not open to Adult Services or we would have sent the concern to the case worker
- This was first adult concern for Elizabeth since 2012

- The call was nothing to do with son, it came from neighbour complaining about Elizabeth making threats to them. (NFA by attending officer)'

424. There is clearly significant demand with finite resources within the MASH. There is an established screening - triage process which seeks to identify and manage threat, risk, and harm. Experienced professionals are expected to assess risk and make difficult decisions, sometimes with missing or ambiguous information. There will inevitably be an element of subjectivity in the decision making.

425. Whilst the points made by the current MASH supervisor are valid, it is not clear whether the following information was fully taken into consideration when the decision was made that no further action should be taken.

- There was a long history of violence, including the use of a weapon, between Elizabeth and Sean
- There was a referral to MARAC in 2016
- The Officer who submitted the ACN had described the relationship between Elizabeth and Sean as 'explosive'. The officer had raised a concern Sean may be suffering abuse but may be reluctant to disclose.

426. The Independent Reviewer cannot definitely state that the decision to take no further action was incorrect in the circumstances and the MASH supervisor has offered the rationale as to why this decision was made. However, greater weight may have been placed on the significant history of domestic abuse by Sean towards Elizabeth and the description of the relationship between them by the officer who attended the incident.

427. **Recommendation/Learning 2**

Professionals within the MASH should ensure sufficient weight is placed on any history between the victim and perpetrator of domestic abuse, together with the account provided by the attending Police officers when undertaking the screening – triage process. This will ensure all of the potential risks have been considered before closing a case with no further action.

31st October 2019

FWIN 775 311019

428. A neighbour had contacted police reporting Sean and Elizabeth were shouting and swearing at each other and could hear items being thrown around and stated this was a regular occurrence.

429. Police attended the address and spoke with Elizabeth and Sean, who both stated they had raised their voices. Sean had overcooked a burrito which he had placed within the microwave instead of cooking it in the oven. This has caused him to become annoyed and in frustration started shouting. Elizabeth has raised her voice in return. Supportive measures were discussed with Elizabeth, but she declined all help stating she had managed her son's behaviour since he was 5 years old. The attending officers concluded this incident was not a domestic situation therefore no DV HRN was appended.

14th November 2019

FWIN 688 14/11/19
DVN D032560/19

430. A neighbour reported a male and female shouting from Elizabeth's address. On attendance both parties were spoken to separately. Both denied any domestic incident, stating Sean had been watching TV with the sound turned up loud. Elizabeth had shouted downstairs to ask him to turn it down, but he could not as they had lost the remote. They stated they were in dispute with the neighbour. They both confirmed no argument had taken place. It was recorded Sean had autism. Advice was given regarding the noise and the neighbour was asked to report any future incidents.

431. It appears the officer(s) recognised the risk of domestic abuse, and a DASH assessment was raised for Elizabeth. The officer(s) assessed the risk as 'standard' with 2 specific risk indicators ticked:

- Suspected mental / alcohol / drugs.
- Abuser previous criminal history.

432. The DASH was triaged and assessed as 'standard' within the MASH and allocated to the local Neighbourhood Policing team supervisor for review. All 'standard' and 'medium risk' victims are managed by the local Neighbourhood Policing Teams.

433. **February 2020**

434. **FWIN 230**
435. **CRIME NO 025796P/20. Murder and Suicide**

436. A concern for the welfare of Elizabeth was reported by a colleague, who works for a local charity. The caller stated a volunteer, Elizabeth has not been seen by staff for around two weeks. It was reported that in early February 2020 was the last date she was seen; and she is not answering her contact number. Colleagues had

attended her address for the last few days, and they have spoken to her son, Sean who states he has not seen her for a few days, but he always presented as intoxicated when spoken too by staff as he is an alcoholic.

- The caller stated Elizabeth suffered from mental health issues. The caller did not have much information on this but stated Elizabeth can be temperamental.
- The caller stated around ten years ago Elizabeth was shot with an air rifle by her son, Sean.
- The caller stated staff were last at address this morning when Sean was seen through the window lay asleep on the settee with a bottle of vodka and he refused to answer the door. - the caller stated a friend of Elizabeth, was still at the address and the caller stated she would advise her to wait and await the arrival of the Police.

437. In late February 2020 Police arrived at Elizabeth's home address and duly forced entry. Elizabeth and Sean were found deceased at the scene.

438. In summary, during the time period of this review (14th September 2016 to February 2020), prior to the murder and suicide, Northumbria Police had recorded and attended 5 reported incidents in relation to Elizabeth and Sean. The first of these resulted in a MARAC referral, two other incidents resulted in referrals to the MASH, via a DASH assessment, and an ACN.

439. **South Tyneside and Sunderland NHS Foundation Trust**

1st May 2018

440. Elizabeth attended Sunderland Royal Hospital (SRH) Emergency Department (ED) with a history of back/rib pain. Elizabeth informed staff she had been gardening the previous week and had fallen onto the patio wall. Safeguarding questions were asked and Elizabeth's response was "yes", to her ability to assess, and "No" to all the remaining questions.

3rd June 2018

441. Elizabeth attended SRH ED with an injury to her right thumb, sustained when renewing a toilet seat using a hammer. Elizabeth was triaged and streamlined to Pallion Health Centre, a sub-contracted service of STSFT. It is detailed in the discharge letter, to Elizabeth's General Practitioner (GP), she said "No" to any safeguarding questions.

4th July 2018

442. Elizabeth attended SRH ED with a history of vertical and horizontal imbalance. Elizabeth stated she had bent over to pick an item up and fell over and hit her head and injured her left ring finger. Staples to her head were required. Safeguarding questions were asked, and Elizabeth answered “No” to all questions.

25th October 2018

443. Elizabeth attended SRH ED with a laceration to her finger. Elizabeth provided a plausible reason for the laceration, she stated she was chopping onions the previous evening and she had partially amputated her fingertip; therefore, no further professional probing was considered necessary.

444. Elizabeth was triaged and streamlined to Pallion Health Centre, a sub-contracted service of STSFT. It is detailed in the discharge letter, to Elizabeth’s General Practitioner (GP), Elizabeth had said “No” to any safeguarding questions.

445. **6th February 2020**

446. Elizabeth attended Sunderland Eye Infirmary (SEI) ED with blurred vision. A primary diagnosis of dry eye syndrome was recorded. Safeguarding questions were asked, and Elizabeth answered “No” to all questions.

Historical engagements with South Tyneside and Sunderland NHS Foundation Trust

447. Whilst the scoping period of this review starts on 14th September 2016 it is felt important to highlight significant incidents involving Elizabeth, recorded by South Tyneside and Sunderland NHS Foundation Trust.

South Tyneside and Sunderland NHS Foundation Trust

448. In the period from 8th November 1983 to the 14th September 2016 Elizabeth had several engagements with the SRH. A number of these are detailed attendances to SRH ED.

26th September 1991

449. Elizabeth attended SRH ED with a facial injury which she stated she sustained when a gate blew against her in the wind. It is detailed in hospital records Elizabeth’s son was 16 years old and she was happy for him to remain at home overnight. No other family detailed. No safeguarding concerns detailed.

27th March 2003

450. Elizabeth attended SRH ED where it was detailed during an argument with her son Elizabeth was shot with an air rifle at close range by Sean. The pellet resulted in an entry wound to the left-hand side of the bridge of her nose. Police were aware of the incident. A disclosure was made by Elizabeth stating the injury was caused by her son.

1st December 2003

451. Elizabeth attended SRH Outpatient Department (OPD) with a history of fluctuations in balance. Elizabeth stated she had been under a lot of stress at home. It is detailed Elizabeth also had a broken ankle. It was not possible to determine where the fracture was diagnosed and managed. No safeguarding concerns were disclosed.

24th June 2005

452. Elizabeth attended SRH ED with a history of a fall while in Scotland two weeks previous. Rib fractures and a right sided pneumothorax (collapsed lung) were diagnosed.

25th November 2012

453. Elizabeth attended SRH ED with Police with facial injuries whose origins she could not recall. A haematoma and laceration to right eye were treated.

30th September 2014

454. It is detailed in a copy of a chest x-ray report to Elizabeth's General Practitioner (GP) Elizabeth had longstanding pleural changes at the right base associated with multiple healed rib fractures.

455. It is significant no safeguarding disclosures were disclosed in any of the above incidents with one exception. The only disclosure made was on the 27th March 2003 in relation to the injury being sustained by Elizabeth's son Sean following his use of an air weapon.

456. With the exception of the incident in 2003, Elizabeth consistently stated "No" to safeguarding questions when asked by medical professionals.

457. It should be noted however current safeguarding questions were initially implemented in 2015.

458. At all Elizabeth's presentations, she always provided an explanation for the injuries she sustained, and the injuries matched her explanation.

459. Given the passage of time of time, the range of injuries presented by Elizabeth, the explanations provided and her response to safeguarding questions, it would have been challenging for medical professionals to identify a clear pattern without further information from Elizabeth and / or other Agencies.

460. **Sunderland Clinical Commissioning Group (CCG)**

461. Elizabeth was a patient at a Sunderland Practice for most of her adult life and was last seen by her own GP in 2015. However, she was seen on several occasion in 2019 and once in February 2020 which was her last contact with the Practice before her death in 2020.

462. There is no disclosed domestic abuse at the Practice by Elizabeth during her consultations, however there was a MARAC request in September 2016, as Elizabeth was referred via WWIN for a MARAC. The MARAC form was completed by the Practice but there was nothing further heard from MARAC.

463. There is no recent history of mental health issues or concerns, no involvement with IAPT. The only mention of depression is in 1992 on a summarised note (on old records).

464. The Practice has no recorded history of alcohol or drug misuse for Elizabeth.

465. It is recorded that Elizabeth lived with her son which was mentioned in one of her consultations. There was no record in the notes of any issues with her son.

466. **Consultations within timeframe of DHR.**

467. **23rd July 2019.**

468. Elizabeth was last seen in the Practice for her hypertension annual review. At the time she smoked 10 cigarettes a day albeit was considering stopping smoking again (having tried previously multiple times). Elizabeth's alcohol consumption was recorded as 12 units/week. Bloods including LFTs were normal, and initiation of statin was agreed as her QRISK2 was 11%.

469. Elizabeth was seen by the Domestic Violence Lead Nurse at this appointment on the 23rd of July 2019 during her consultation and no concerns were disclosed.

470. **5th August 2019**

471. Elizabeth was telephoned on the 5/08/2019 to arrange her repeat bloods post statin initiation but failed to attend her blood test appointment in 11/2019 (2 letters sent).

472. **3rd July 2019**

473. Elizabeth was seen by a GP for an exacerbation of her COPD.

474. **2nd August 2018**

475. Elizabeth was seen by a GP for an exacerbation of her COPD requiring antibiotics and steroids.

476. **April/May/June 2018**

477. During April, May and June 2018, Elizabeth was seen by the Practice Nurse for smoking cessation.

478. It is recorded that Elizabeth was seen on the 06/02/2019 at the Sunderland Eye Infirmary for a stye condition and no concerns were raised at that point either.

479. It is also recorded that Elizabeth attended the Emergency Department 3 times in 2018 with hand injury and laceration.

480. Elizabeth attended the Practice infrequently over the last few years of her life usually either for exacerbations of her COPD or for her smoking cessation.

481. Elizabeth was not a frequent attendee of the Practice and only attended when she had an exacerbation of her physical health conditions or after being recalled for her annual review.

482. Elizabeth had no other relevant history, no involvement with DWP, nor requests for sick notes or medical assessments. She had no learning disability, and no advanced care planning was required.

Wearside Women in Need (WWiN) Domestic Abuse Service Sunderland

30th July 2016

483. An IDVA attended the home address of Elizabeth & Sean following a silent 999 call coming into the Police. The WWiN IDVA was on shift with the Police DV Car and picked this up for a visit as there was a DV marker on the property.

484. The IDVA was sufficiently concerned and referred to WWiN Outreach for a full assessment.

8th August 2016

485. Following numerous attempts to follow up, an appointment was made for Elizabeth. A risk assessment was completed scoring 15, thus meeting the MARAC threshold. The following risk factors were identified relating to Sean:

- Previous (historic) violence including shooting Elizabeth in the face with an air rifle and other physical assaults – the gun was reported to have been removed.
- Elizabeth reported Sean shouting, exhibiting unpredictable behaviour, and had a fear of further violence.
- Sean reported to have grabbed Elizabeth round the neck a few weeks prior to this incident.
- Reports of binge drinking by Sean (no disclosure of own alcohol use)
- Sean's long-term depression and threats of suicide
- Reclusive behaviour, Sean reported to never leave the house, has no friends or social life.
- Elizabeth stated Sean is obsessed with Hitler.
- Elizabeth described herself as 'walking on eggshells' as Sean has numerous other obsessional behaviours, for example, he hated detergents or any cleaning materials or activity.

486. WWiN referred Elizabeth to MARAC as an urgent high-risk case and followed up with safety planning, including contact numbers for a Well-Being Clinic and the Crisis Team and offers of further support; all of which were declined by Elizabeth. Close liaison also took place with Northumbria Police, who also offered protective measures, but these were also declined. The MARAC actions for WWiN referred to previously were primarily focussed on engaging with Elizabeth.

487. WWiN continued to offer a service to Elizabeth for three months after the initial report; however, all support was declined. The case was then moved 'on file' as a non-active MARAC case. This means the case is only re-activated if a further referral is received.

488. WWiN close cases after a period on non-engagement if all efforts to engage have failed and/or the client declines support; as they can only support and hold cases for 'voluntary clients'. If a further Police report is received the case would be re-

activated and WWiN would seek to engage. However, the 3-month period is the 'cut off' to avoid having cases open which they are not actively working on.

489. In this case, no further referral was received, and no further action taken.

Local Charity

490. As stated, Elizabeth worked at a local charity, from 1995. Elizabeth was described as a caring person who enjoyed her job.

491. Elizabeth's colleagues at work described her as 'friendly' but 'feisty'. However, whilst she was a long-standing employee she was described as somewhat unreliable with frequent absences from work.

492. The lead person at the Charity stated she had been very close to Elizabeth and had supported her on a number of occasions to seek further support in the care of her son, and management of his behaviours. She referenced a number of incidents where she had encouraged Elizabeth to talk to the Police about what was happening in the home, but Elizabeth refused saying 'he is my only son'.

493. A long-standing colleague of Elizabeth reported she would often see her with bruising to her face, black eyes, or cuts to her hand. The colleague reports Elizabeth would tell her the bruising was the result of falls when she suffered vertigo, when she fell over by accident or as a result of her mascara smudging. The colleague reported she was sceptical of Elizabeth's explanations for all her accidental injuries, and suspected her son, Sean may have caused the injuries.

494. Colleagues at the Charity describe Elizabeth as quite a private person who didn't talk about her family life openly. They also formed the impression Elizabeth may have suffered with a drink problem, as they would often smell alcohol on her breath, and her eyes were often red and bloodshot. Elizabeth would not turn up at the Charity drunk. It just appeared she was suffering the after-effects of drinking.

OVERVIEW

495. Police attended Elizabeth's and Sean's home address on a number of occasions within the DHR timeframe prior to the murder and suicide.

496. It is of note three of these calls were during a three-month period between August and November 2019.

497. It is significant no safeguarding disclosures were disclosed by Elizabeth in any of the above incidents.

498. Elizabeth also attended hospital on a number of occasions during the scoping period.

499. It is of note four of these attendances were during a five-month period between May and October 2018.

500. It is significant no safeguarding disclosures were disclosed by Elizabeth in any of the above incidents.

501. The only contact Elizabeth had with Wearside Women in Need (WWiN) Domestic Abuse Service Sunderland was as part of the MARAC referral in 2016.

502. The local charity where Elizabeth worked report that between April 2018 and September of 2018, Elizabeth did not come into the office. She told her colleagues she had been unwell.

503. It is of note this absence coincides with Elizabeth attending hospital on four occasions during a five-month period between May and October 2018.

ANALYSIS

504. In undertaking the analysis, I have placed due consideration to the duty of positive action.

505. The Human Rights Act 1998 places positive obligations on police officers to take reasonable action, which is within their powers, to safeguard the following rights of victims and children:

- Right to life (Article 2 ECHR).
- Right not to be subjected to torture or inhuman or degrading treatment (Article 3, ECHR).
- Right to and respect for private and family life (Article 8, ECHR).

506. The requirement for positive action in domestic abuse cases incurs obligations at every stage of the Police response. These obligations extend from initial deployment to the response of the first Officer on the scene, through the whole process of investigation and the protection and care of victims. Action taken at all stages of the Police response should ensure the effective protection of victims, while allowing the Criminal Justice System to hold the offender to account.

507. In terms of broader partnership responsibilities Sunderland City Council on behalf of the Community Safety Partnership both then and now Commission Wearside

Women in Need (WWiN) to provide accessible community-based services across Sunderland to anyone at risk of or suffering abuse aged 18 or over. They offer a 24-hour number for advice and support for vulnerable victims.

508. I will now address the specific Terms of Reference.

509. **1. Consider the impact of decisions made in relation to Elizabeth on her overall wellbeing; and whether any potential impact was recognised and whether she was supported.**

510. It is clear Elizabeth had a very difficult life. Upon losing her husband she was left to bring Sean up alone.

511. Sean presented challenges to his mother from a relatively young age.

512. There is recorded evidence with Northumbria Police, over at least 23 years, of conflict and abuse between Elizabeth and Sean; on a number of occasions resulting in violence, and ultimately their deaths. The Police have 17 reports of domestic violence and abuse within this extended period.

513. It would appear, over time, Sean's mental health deteriorated, and his misuse of alcohol increased; resulting in extreme violent and abusive behaviour, which caused his mother significant distress and harm.

514. It would appear Elizabeth's health and well-being deteriorated, and she became increasingly isolated from family and friends. Elizabeth appeared to use alcohol as a coping mechanism.

515. Over many years, with a small number of exceptions, Elizabeth elected not to disclose the violence and abuse she was suffering at the hands of her son to Professionals. This is despite been asked by Police and Health Professionals, on a number of occasions, as to whether there were any safeguarding concerns.

516. It is of note, that Police were called to Elizabeth and Sean's home address by neighbours, as opposed to Elizabeth asking for help. When Police attended, Elizabeth and Sean were reluctant to engage with the officers.

517. When exploring the reasons why Elizabeth may have been reluctant to report what was happening to Professionals it is important to recognise that she brought Sean up as a single mother and was naturally protective of him.

518. Elizabeth may have believed or hoped that the abuse would reduce or end over time. In fact, the situation deteriorated over time.

519. Conversely, given the protracted nature of the abuse by Sean, sadly, Elizabeth may have accepted the situation as her ‘norm’ over time.

520. Elizabeth clearly loved her son and was clearly very concerned about Sean’s deteriorating mental health. As the Coroner stated her ‘mother’s instinct’ was to protect her son.

521. Elizabeth would understandably not have wanted her son to be prosecuted via the criminal justice process.

522. Elizabeth may have feared retaliation from Sean if she had elected to report what was happening to Professionals or family and friends. It is clear that many victims can be afraid of the consequences if they report abuse, particularly in the immediate period after they have found the courage to make a disclosure. It is of note that Sean had shot Elizabeth with an air rifle in the past so naturally she would be concerned about her safety.

523. It would also appear that over time Elizabeth became more socially isolated. For example, her contact with Pamela with whom she was previously close reduced in the period prior to her death.

524. Elizabeth was a private person, and it appears over time she was also reluctant to share what was happening to her with family and friends. This reduced the opportunity to share her concerns and seek support.

525. Elizabeth may have been reluctant to disclose the abuse she was suffering from Sean as she felt a degree of embarrassment and therefore chose to give different explanation for her injuries when asked by Police, Health Professionals, or work colleagues.

526. It may also have been the case that Elizabeth may have had a perception that the response by Agencies was unsatisfactory which in turn may have made her more reluctant to seek support. For example, her interaction with the Police when they were called to her address were not always positive.

527. The situation clearly impacted on Elizabeth over time. There is evidence of increased social isolation, more absences from work, taking less care of her home, and increased alcohol use.

528. The presentation is dichotomous at all levels; Elizabeth presented as fearful but protective of Sean, both at risk and, at times, posing a risk to herself and others through alcohol misuse; help seeking, but declining help for herself in the

pursuance of help for her son; which may have engaged her in an effective support plan and managed the risk.

529. Sean had significant challenges but declined Professional Support and when Police were called to the family home, he was reluctant to make any disclosures.

530. Sean became increasingly isolated which reduced the opportunities for Professionals to engage with him.

531. Sean's involvement with health professionals reduced over time. He was reported to be unreliable in taking his medication. In turn, he became increasingly reliant on alcohol.

532. When exploring the reasons why Sean's mental health needs were not addressed, it is important to recognise Sean presented challenges to his mother from a relatively young age. His complex needs were potentially evident as a young person.

533. Sean's involvement with mental health services sits outside the scope / timeframe of this DHR. However, when arrested in 2012, 2013 he declined mental health support and in 2015 was encouraged to register with a GP for support.

534. Statistically men are less likely to seek help for mental health difficulties. Sean may have felt it more beneficial to ignore the problem or simply be unprepared to accept he had mental health issues.

535. Sean may have feared judgement, change, the unknown or what they may discover in therapy.

536. Sean may have doubted the efficacy of mental health treatment: he may have been sceptical as to whether treatment would work or have certain misguided viewpoints. He may have felt a sense of stigma in engaging with mental health services.

537. Given Sean's reduced involvement with Professionals he may not have had a full understanding of the support available to him and how it may have helped him.

538. From an Agency perspective any support around mental health requires the consent and co-operation of the person in need. Sean consistently declined help over time which proved a challenge for Professionals to advance help and support. Given he was socially isolated, aside from his mother, Sean did not have anyone to advocate on his behalf.

539. This context, and the complexities of the relationship between Elizabeth and Sean, in line with many adult inter-family violent cases, presented significant challenges for Agencies.

540. Working and supporting vulnerable people in such circumstances can result in Professionals feeling they are stuck between a ‘rock and a hard place’. On the one hand they are seeking to adopt the principles of making safeguarding personal and respect the wishes of the victim, whilst at the same time, will naturally wish to intervene, where they observe or suspect harm.

541. These circumstances can result in conflict between core professional values of rights to self-determination and a duty of care. Professionals can feel the rights of an individual are in direct conflict with the broader duty of care. Where exactly the boundaries fall between an individual's unwillingness to accept support, and professional responsibility to intervene, can be challenging.

542. So, accepting the threshold for professional intervention is not always clear or understood. When should Professionals act? It is suggested five key areas of harm should be considered when assessing whether harm is being caused:

- the impact on physical health
- the impact on emotional well-being
- the impact on social functioning
- the impact on environment and
- the impact on other people

543. All are all strong indicators to inform any risk assessment and intervention.

544. Designating a pattern of behaviour, as a safeguarding issue, does not in itself make vulnerable individuals safe. However, if Professionals and Agencies are professionally curious, and share their safeguarding concerns, there is a strong likelihood positive intervention will follow.

545. This invites a question around multi-agency working and information sharing in this case.

546. Multi-Agency working is challenging, but critical. It is recognised there is always a raft of competing demands on Agencies. However, effective multi-agency working can provide an enhanced response and protection to individuals with multiple and complex needs.

547. It appears Agencies may have engaged with Elizabeth in isolation, as opposed to recognising the interdependencies, the importance of information sharing and the

added value of coming together to support Elizabeth. It appears when Professionals sought to engage with Elizabeth, this was often with limited understanding of what information and support other Agencies may hold, and what support they may or may not have been providing.

548. Professionals, even when acting as part of a joint team, need to be aware of the necessity to make appropriate referrals to allow consideration of further actions and notifications to be notifications to be made to other parties.

549. By working together, agencies can use their strengths and individual specialised skills to the best advantage, enabling the victim to access support through a multi-agency framework.

550. It is acknowledged that the issues in this case were not straightforward with the victim presenting different accounts to different agencies at different times, therefore 'joining the dots' was challenging.

551. However, had the concerns been viewed holistically there was information, either known or available, which should have given rise to the view Elizabeth was at risk of significant harm.

552. Given the complexities of the situation, and associated risk, I would suggest there would have been significant benefits in calling for Partners to come together in order to share information, identify clear 'ownership' and collectively agree a way forward. Adult family violence cannot be addressed by a Single Agency alone, and it is only by working together the level of risk can be properly assessed, and a layer of support interventions put in place.

Recommendation / Learning 3

Where a victim of domestic abuse is presenting to different agencies at different times intoxicated, with injuries, and appears reluctant to accept support, partners should come together to share information, identify 'clear' ownership, and collectively agree the way forward.

553. **2. Consider Elizabeth's death in light of national/local suicide prevention strategies. What were the quality of risk assessments and risk management plans in response to known incidents?**

554. **Definition of Domestic Abuse** [2]

2 The shared National Police Chiefs' Council (NPCC) and government definition of Domestic Abuse is; 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16, or over, who are, or have been, intimate Partners or are Family Members regardless of gender and sexuality. This can encompass but is not limited to the following types of abuse: * psychological * physical * sexual * financial * emotional
Family members include Mother, Father, Son, Daughter, Sister, Brother, Grandparents, and In-laws.'
Government strategy recognises tackling domestic abuse is a cross-departmental and multi-agency responsibility.

555. A whole system family and agency approach should be adopted. No Single Agency can tackle domestic abuse on their own and it needs to be seen as everyone's business.

556. Victims and survivors should be at the heart of any domestic abuse strategy. It is also critical Agencies challenge and disrupt perpetrator behaviour.

557. Safe Lives, a national Domestic Abuse support charity has developed a national strategy entitled 'The Whole Picture'.[3]

558. Tackling domestic abuse as a key priority for the Safer Sunderland Partnership.

559. The Safer Sunderland Partnership delivers activity around:

560. 'Providing treatment, or support or rehabilitation to those who have been a victim and to those who need help to break the cycle of offending and substance misuse. This is about supporting victims to live safely (e.g. outreach work and supported accommodation such as DV refuges) and safety planning for high risk DV victims via the MARAC; as well as managing offenders in such a way (IOM) as to prevent further re-offending and ensuring there is swift and effective treatment for substance misuse'.

561. Whilst the majority of domestic homicides will involve Intimate Partners, the national definition of domestic abuse is deliberately broad, to include cases such as this one.

562. Homicides and suicide involving a mother and son are thankfully very rare.

563. There can be clear differences in Intimate Partner Violence (IPV) and Adult Family Violence (AFV).

564. Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) states 'While both forms of violence are gendered, there are clear differences in the

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[3] Safe Lives 'The whole picture' aims to end domestic abuse for good. The outcomes of this strategy are:

- act before someone is harmed.
- identify and stop harmful behaviours.
- increase safety of those at risk.
- support people to live the lives they want after harm occurs.

dynamics and motivations underpinning Intimate Partner Violence (IPV) and Adult Family Violence (AFV)'.

565. The analysis goes on to say 'Adult Family Violence (AFV) thus falls within this definition and the remit of its associated legislative instruments, Governmental Policy, and Professional Guidance and Practice. It has been recognised, however, there is a dearth of research into AFV.'

566. The report goes on to say, 'the lack of research means most of the existing practice guidance and tools in responding to domestic abuse are geared towards intimate partner violence (IPV) and potentially unsuitable for dealing with AFV'.

567. The report by Sharp-Jeffs and Kelly, (2016) highlights 'the most frequent risk factors for perpetrators of Adult Family Violence, to emerge from this analysis are mental health issues, alcohol or substance misuse and previous criminality. Several review reports have also noted perpetrators of Adult Family Violence displayed patterns of threatening behaviour towards women and had also committed some other form of violence against women'.

568. Alcohol misuse, mental health, and violence and threatening behaviour towards Elizabeth are clearly evident in this case.

569. Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) was instrumental in highlighting some distinctive features of homicide committed by family members.

570. 'Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 114 were Adult Family homicides (28% of all domestic homicides) (Office for National Statistics, 2018b). It is therefore safe to say at least a quarter of domestic homicides involve Family Members and thus deserve much more attention'.

571. Some key features relating to dynamics and risk factors have consistently emerged from Adult Family Homicides and are particularly relevant in this case:

572. **1. Gender**

573. Similar to IPV, AFV is gendered both in terms of victimisation and perpetration, albeit with a more pronounced gender split in the latter (at least 90% of perpetrators of Adult Family homicides are men). Mothers and Sisters continue to be the main victims of fatal violence from their Sons and Brothers.

574. When we explore the situation between Elizabeth and Sean this follows the trend that the vast majority of domestic abuse perpetrators are men, and the vast majority

of victims are women. Whilst AFV by a son towards his mother is less common that intimate partner violence there are lot of commonalities around the abuse. It is of note that Elizabeth disclosed that given Sean's father passed away he sought to adopt the position of 'man of the house'.

575. **2. Mental Health Issues**

576. Mental health issues are the most common feature of the majority of perpetrators of AFV, including depression, self-harm, psychosis, and paranoid schizophrenia.

577. It is clear that Sean was suffering with his mental health and was unreliable in taking his medication. There is evidence that Sean was depressed and isolated. Sean had declined mental health support when arrested in 2012 and 2013.

578. When assessed by a Health Professional whilst in Police custody on 30th April 2015, Sean stated he had not had suicidal thoughts for 'around 20 years'. However, there is evidence to suggest Sean threatened to kill himself as he got older, when he was asked to stay away, or leave, the family home by his mother.

579. Whilst Elizabeth believed her son had autism, there is no record that Sean was formally assessed and diagnosed.

580. **3. Substance Misuse Issues**

581. Drug and alcohol issues are a common feature of the majority of perpetrators of AFV.

582. It is clear that Sean was misusing alcohol, over time. He insisted on his mother purchasing vodka for him on a frequent basis. When the Police attended the home address Sean was observed to be intoxicated.

583. 4. **Caring Relationships and Responsibilities**

584. Linked to the 2 issues above, caring relationships and responsibilities are salient, featuring in the vast majority of AFV cases. They manifest themselves in a number of different ways:

- Victims are parents (principally mothers) caring for mentally unwell or substance dependent adult children (principally sons), mostly in an informal capacity.
- Victims are elderly, vulnerable parents with care and support needs who are being cared for by their adult children.
- Victims and perpetrators are adult children involved in the care of a vulnerable parent. Thus, although the vulnerable parent is not the direct

victim of AFV, issues relating to caring responsibilities are a crucial feature in the background of the family relationship.

585. We cannot therefore ignore the strong relationship between the gendered dynamics of AFV and the wider cultural context of gender expectations surrounding caring roles and responsibilities.

586. When we explore the relationship between Elizabeth and Sean it is clear that Elizabeth loved and cared for her son from birth.

587. Elizabeth tried to support Sean with his mental health from a relatively young age as a single mother.

588. Elizabeth tried to manage Sean's misuse of alcohol, but it appears that she was coerced into purchasing vodka for him on a frequent basis.

589. Elizabeth provided a home for Sean into adulthood, and it appears that he was financially dependent upon her, given his lack of employment.

590. Given the limited engagement with Professionals it could be said that Elizabeth adopted the role of 'informal carer' for Sean, despite his abusive behaviour towards his mother.

591. **5. Instability, Dependence, and Social Isolation**

592. Research into Adult Family Homicides has shown a high degree of instability in the lives of those who committed the murders:

- inability to sustain employment due to mental health and associated issues.
- lack of stable, long-term relationships.
- high degree of transience due to lack of housing options.
- or difficulties in sustaining independent living.
- breakdown of intimate relationships; work-related stress etc.

593. This in turn increased their financial and emotional dependence on their parents and other Family Members, which was evident in the fact most of the adult children were living with their parents. Social isolation was an additional poignant feature in the lives of perpetrators.

594. Despite his intelligence, Sean had limited employment during his adulthood.

595. Sean resided with his mother for the majority of his life and indicated he would self-harm if he was directed to leave the home address. It appears that Sean was financially dependent on his mother.

596. There is no evidence that Sean had any personal relationship with anyone. He was described as reclusive and was isolated from society.

597. **6. Lack of a Clearly Defined 'primary' victim**

598. Abusive behaviours most often take place within a wider context of Family violence, with the perpetrator offending against other Family Members and Siblings in particular, as well as displaying patterns of threatening behaviour towards Intimate Partners. Therefore, risk needs to be considered for all Family Members living in the home. As an example, responding to an incident involving two Brothers or a Brother and a Sister, Officers should always take into account other Family Members, especially if elderly or vulnerable Parents are present. Inversely, it is quite common for Parents to be relied on to provide bail addresses for perpetrators of IPV. Their safety and any risk concerns (such as mental health, substance misuse, and history of criminality) should be fully considered.

599. Elizabeth and Sean lived at the property alone, so there is no record of him offending against other family members.

600. It is of note however that Pamela disclosed that Sean had been aggressive with her in the past.

601. **7. Absence of 'visible' high risk and lack of engagement**

602. Due to complex Family relationships, caring responsibilities, and perceived support needs of the perpetrators, as well as lack of suitable options, Family Members affected by abusive behaviours are often less likely to engage in support with Police, Prosecution, or IDVA. They are more likely to minimise their safety concerns and less able to formally articulate their experience as 'abuse'. This could in turn reinforce assumptions made by key Professionals, such as Police and CPS, about their level of risk, thereby increasing victims' isolation and barriers to their help-seeking and access to support.

603. Elizabeth may have been reluctant to report what was happening to Professionals and minimised what was happening to her. Elizabeth was naturally protective of Sean.

604. Elizabeth may have believed or hoped that the abuse would reduce or end over time. In fact, the situation deteriorated over time.

605. Conversely, given the protracted nature of the abuse by Sean, sadly, Elizabeth may have accepted the situation as her 'norm' over time.

606. Elizabeth was clearly concerned about Sean's deteriorating mental health.

607. Elizabeth would understandably not have wanted her son to be prosecuted via the criminal justice process.

608. This may in turn have resulted in an inconsistent response by Police and other Professionals around the level of risk and support required. Whilst there are examples of good practice, there were also opportunities missed.

609. It may also have been the case that Elizabeth may have had a perception that the response by Agencies was unsatisfactory which in turn may have made her more reluctant to seek support. For example, her interaction with the Police when they were called to her address were not always positive.

610. The situation clearly impacted on Elizabeth over time. There is evidence of increased social isolation, more absences from work, taking less care of her home, and increased alcohol use.

611. Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) summarises the risk factors that need to be identified in family violence cases:

- Family – complex and intergenerational.
- Caring for someone/being cared for by somebody linked to mental health, suicidality, depression.
- Suicide and homicidal thoughts.
- History of perpetrator – previous violence against women, pattern of previous criminality, antisocial behaviour.
- Sense of entitlement, including to financial resources.
- Addiction issues.
- Social isolation of victim.

612. The report offers the following guidance to professionals in seeking to reduce risk of harm:

1. Never equate victim(s)' lack of engagement with an absence of risk

2. Consider all the key risk factors mentioned above (mental health, substance misuse, caring relationships, history of violence towards partners and other family members, and various aspects of instability) when assessing risk

3. Look beyond the 'primary' victim in the incident for risk to other family members, especially if there is a vulnerable adult in the family

4. Always consider risk and safety when bailing perpetrators of IPV to their parents' address

5. Always offer the support of an IDVA

6. Always consider an Adult Safeguarding referral and provide information on mental health and substance misuse support.

Recommendation / Learning 4

613. **All agencies to disseminate to Professionals the Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) guidance, as part of their professional development strategies. Specific recommendations which are relevant to this DHR is detailed as follows:**

614. **a) It is imperative that risk is seen as dynamic, fluid and is regularly reassessed at 'critical points' within each case.**

615. **b) Agencies should always refer to the MARAC based on professional judgement when information is limited, and the victim / survivor is perceived to minimising the risks/is unable or too fearful to disclose the full extent of the abuse.**

616. **c) Professionals should bear in mind that often friends and family or 'informal networks' hold vital information around the level of risk.**

617. **d) Links between health services are crucial in ensuring a holistic overview of patterns in appointments, walks-ins, and emergency attendances rather than them being viewed in isolation.**

618. **e) Some consideration should be given to including the screening of perpetrators within mental health services and establish referral pathways.**

619. **f) All staff should receive training on identifying; risk assessing and safely responding to domestic abuse.**

620. **g) All staff should be expected to enquire about DVA.**

621. **h) Improved awareness and training around risk identification, management, and access to support for AFV with a particular emphasis on access to mental health services.**

622. **i) Improved information sharing between health professionals, GP's, hospitals, and substance misuse services in order to promote co-working pathways and holistic responses to AFV.**

623. The Domestic Homicide Project (the Project), based in the Vulnerability Knowledge and Practice Programme (VKPP), was established by National Police Chiefs' Council and the College of Policing, and provides further relevant research and guidance. The Project was created in May 2020 through Home Office funding to collect, review, and share quick-time learning from all police-recorded domestic homicides and suspected suicides of individuals with a known history of domestic abuse victimisation during the Covid19 pandemic.

624. Key findings from the research which are relevant to this DHR include.

625. Where older victims were killed by their partners, it was also common for the suspect to die by suicide. 54% of IPH homicide-suicides involved victims (and suspects) aged 65 or older.

626. Older victims of IPH often had serious physical and/or mental health needs. In these cases, suspects were commonly caregivers for the victims.

627. Suspects of AFH deaths involving older victims often had a history of substance misuse and/or mental ill health. In these cases, victims were commonly caregivers for the suspects.

628. A key aspect of the relationship between Elizabeth and Sean was the level of coercive control Sean exhibited towards his mother over time. There was clear evidence of Sean of seeking to disorientate Elizabeth with his abusive and extreme behaviour.

629. Coercive control is defined by the Government as follows:

630. 'Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse is used to harm, punish, or frighten their victim.

631. 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.

632. The types of coercive control being used will differ from victim to victim & perpetrators will often use a combination of tactics, taking advantage of any weakness or insecurities to manipulate, intimidate, isolate & humiliate.

633. Being subjected to coercive control reduces a person's ability to make decisions & limits their independence & can create co-dependency, which makes it very hard for them to break away'.

634. Coercive & controlling behaviour is one of the strongest indicators of risk. But it can be missed as the focus is on the severity of single incidents, rather than considering the pattern of behaviour.

635. A growing body of evidence highlights levels of coercive control in a relationship may be a stronger predictor for domestic homicide than a history of incidents of physical violence. This highlights an urgent need for greater awareness and understanding (by professionals and the wider public) of the warning signs and risks associated with coercive and controlling behaviours.

Recommendation / Learning 5

636. **All agencies should continue to build upon training to date and support Professionals around identifying and supporting victims who may be subject of coercive control.**

637. **<u>Suicide</u>**

638. Within the 'Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives', dated 27th March 2021, the then Minister for Suicide Prevention stated:

639. 'Each and every suicide is a tragedy, which causes devastating and permanent impacts on Families, Friends, and broader communities. It is estimated that annually 800,000 people across the world die by suicide, with 5,316 people sadly taking their life in England in 2019. It is of the utmost importance that we do all we can to reduce this number as far as possible, so fewer people die by suicide.'

640. 'That is why we are doing all we can to ensure that support is available to all who need it. Within the long-term plan for the NHS, we reaffirmed the NHS's commitment to make suicide prevention a priority over the next decade, implementing a new Safety Improvement Programme across all mental health trusts, and setting out important measures to improve crisis care services. We have ensured that every local area has a robust all-age Multi-Agency Suicide Prevention Plan in place, and I am grateful to local councils for their continued dedication on suicide prevention and to prevent and mitigate some of the most pressing impacts of COVID-19 on their local communities' mental health and wellbeing.'

641. The Minister continued:

642. ‘But funding alone will not deliver what we need. We also need a cross-system, collective approach to suicide prevention, with a single agreed strategy will drive progress across all sectors of national government, local government, and the voluntary sector, to reduce suicides.’

643. ‘It is vital the data and evidence we have is timely and accurate, and work is proceeding at pace to embed a national, real-time suicide surveillance system that will provide us with the tools to identify and implement targeted support to reduce suicide numbers. Whilst high-quality, timely data is crucial, we will also ensure we do not lose sight of the value of personal experiences, local intelligence, information and evidence from our delivery and voluntary partners’.

Recommendation / Learning 6

644. **The Safer Sunderland Partnership should ensure an all-age Multi-Agency Suicide Prevention Plan is in place. Agencies should ensure training and guidance is provided to professionals around preventing suicide.**

645. Within a blog entitled ‘Tackling the root causes of suicide’ by Ruth Sutherland, the Samaritans Chief Executive dated 1st August 2018, she stated:

646. ‘The latest UK suicide figures show that on average just under 6,000 people take their own lives every year. Three-quarters of them are men.

647. Suicide is the leading cause of death for men under 50.

648. Why so many men? Again, the research, including Samaritans’ Men and Suicide report, shows how complex the issue is. In the report, men talk about relationships breaking down, separation from children, job loss, addiction, lack of close friendships, loneliness and being unable to open up’.

649. Research will indicate mental health is closely aligned to risk of suicide.

650. From the post mortems it appears Sean murdered Elizabeth a number of days prior to taking his own life. Given his state of mind and his death, Professionals can only speculate what went through Sean’s mind when he murdered his mother and later died by suicide. The murder may have been committed when both parties were intoxicated and it is difficult to say what impact this may have had, given both parties were alcohol dependent.

651. There was an element of concealment by Sean from Elizabeth’s work colleagues. Having committed the murder Sean may have felt extreme guilt or may have been

frightened of the consequences of what he had done. Sean may also have recognised how dependant he was on his mother and be concerned how he would cope without her support. Equally Sean may not have felt any remorse at all.

652. In a research piece ‘Why Men Kill Their Mothers Psychologists by Alexis Linkletter (2016) he offers the view matricide is fuelled by a combination of hatred and sexual desire.

653. ‘There are two primary theories behind why sons murder their mothers. Sigmund Freud, who spent a great deal of his research ruminating on the relationships between parents and children, claimed a son who murders his mother is defending against incestuous impulses.

654. Other experts—like Dr Kathleen Heide, a Criminology Professor at the University of South Florida who has written four books on parricide (‘the killing of a parent or other near relative’)—believe sons are more often reclaiming control. In her book Understanding Parricide, Heide suggests ‘men who commit matricide often reported feeling their mothers were either ambivalent toward them or excessively domineering. These men were frequently described as considering the act of killing their mothers as a way to maintain their masculinity or as protection against extreme emotions triggered by their mothers' behaviour.’

655. Psychiatrist Fredric Wertham, one of the first Doctors to take an in-depth look at parricide, blended the two theories. In his 1954 book, Seduction of the Innocent, he wrote ‘many matricides committed with excessive force occur in the bedroom and are precipitated by trivial reasons. These crimes represent the son's unconscious hatred for his mother, superimposed on sexual desire for her.’

656. In placing the academic research into context, it is important to note there is no suggestion of Sean committing any sexual offences against Elizabeth.

657. Within a research piece ‘Parricide: A Comparative Study of Matricide Versus Patricide by Dominique Bourget, Pierre Gagné and Mary-Eve Labelle Journal of the American Academy of Psychiatry and the Law Online September 2007, offered a view of the characteristics of perpetrators:

658. ‘The ages of the offenders ranged from 14 to 58 years, with a mean age of 31.4. Seventy percent (17/24) of perpetrators who committed matricide had a psychotic motive (i.e., delusional thinking) compared with 63.9 percent (23/36) of those who committed patricide. The difference between psychotic motive and sex of the victim is not statistically significant. Only 2 (8.3%) of the 24 who killed their mothers had no psychotic motive, while 11.1 percent (4/36) of those who killed their fathers had no psychotic motive. A motive was unknown for five of the matricides (20.9%) and

for nine (25%) of the patricides. For both matricide and patricide offenders, the most common Axis I diagnosis was schizophrenia or other psychosis (54.2% for matricides; 46% for patricides), followed by depression (16.7% for matricides; 13.9% for patricides) and intoxication (4.2% for matricides; 5.6% for patricides). Substance abuse other than acute intoxication was found in one (2.8%) case of patricide. It is interesting to note 8.3 percent (2/24) of matricide and 5.6 percent (2/36) of patricide perpetrators were found not to have an Axis I mental disorder.'

659. When we explore how this research relates to the relationship between Sean and Elizabeth it is clear that a number of factors were evident.

660. When we examine 'Tackling the root causes of suicide' by Ruth Sutherland Sean's long-term unemployment, alcohol addiction, lack of any close friendships and apparent inability to open up to Professionals or Family are clearly evident in this case.

661. When we review the work of Dr Kathleen Heide there is evidence of Sean seeking to control his mother with abusive behaviour. It is of note that Elizabeth disclosed that Sean sought to adopt a position as 'man of the house'.

662. Looking at the research 'Parricide: A Comparative Study of Matricide Versus Patricide' there is evidence that Sean suffered from depression, was misusing alcohol and observed by Professionals to be intoxicated when they attended the home address.

663. There is evidence of Sean self-harming as a younger person resulting in a scar to his wrist. When assessed by a Health Professional whilst in Police Custody on the 30th April 2015 Sean stated he had not had suicidal thoughts for 'around 20 years'.

664. However, there is evidence to suggest Sean threatened to kill himself as he got older, when he was asked to stay away or leave the family home.

665. Sean had mental health issues which appeared to be deteriorating over time.

666. Given Sean had such limited contact with Agencies and did not seek Professional support over a protracted period of time, an informed assessment of the risk of suicide, by Sean, was never carried out.

667. There was no indication in health or Police records to indicate Sean was a suicide risk prior to his death.

668. However, Sean ultimately died by suicide having murdered his mother.

669. **2. (continued). What were the quality of risk assessments and risk management plans in response to known incidents?**

670. In simple terms, risk is the possibility of something bad happening. It is the chance, or possibility, a person may be adversely affected if exposed to harm.

671. It is recognised risk cannot ever be completely eliminated, but it can be managed.

672. I will explore the quality of risk assessments and risk management plans in response to known incidents, in the case of Elizabeth and Sean, by Northumbria Police.

673. A summary of the Police response is detailed as follows:

674. On the 27th May 2017 the next-door Neighbour reported Elizabeth was shouting out of her window at her and some friends, who were sitting in her garden, threatening to kill them. Upon attendance advice was given to all parties. The attending Officer(s) concluded this incident was not a domestic situation, therefore no DV HRN was appended.

675. On the 25th August 2019 the next-door Neighbour reported further problems; Elizabeth had been shouting out of her window and said she was going to set fire to the Neighbour's house. Advice was provided to Elizabeth and an Adult Concern Notification (ACN) was submitted for triage. The adult triage process was completed by a Safeguarding Officer and a MASH supervisor, resulting in a decision of no further action required at that time. The ACN was closed.

676. On 31st October 2019 a Neighbour contacted Police, reporting Sean and Elizabeth were shouting and swearing at each other, and they could hear items being thrown around, and stated this was a regular occurrence. Advice was provided to Elizabeth. The attending Officer(s) concluded this incident was not a domestic situation therefore no DV HRN was appended.

677. On 14th November 2019 a Neighbour reported a male and female shouting from Elizabeth's address. Advice was provided to Elizabeth and Sean and a DASH was raised due to the past domestic history, with 2 risk indicators ticked. The Officer viewed the risk as 'standard'.

678. When exploring the incidents at the home address Northumbria Police attended within the scoping period, it is likely the Officers who attended this incident would have based any decision making, at each incident, in relative isolation; due to the time that had elapsed between contacts, and different Officers attending at different times. Given Agencies often deal with specific incidents, supervising or investigating stand-alone crimes, there is a risk of seeing victim or perpetrator through a single lens, without considering the broader context.

679. That said, Officers should always check records, or be made aware of the history between the people involved, and their involvement with the Police and if possible, other Agencies. If the Officers attending the different incidents checked the Police records, it was evident on each of the occasions they attended, there was a long-extended history of domestic abuse between Elizabeth and Sean; including a very violent incident involving a weapon in 2003. Whilst this is an historical incident and context, levels of vulnerability and risk can change over time; the volatile history between Elizabeth and Sean is highly significant in terms of assessing risk.

680. Within research entitled 'Men Who Murder Their Families: What the Research Tells Us by Bernie Auchter' NIJ Journal / Issue No. 266 (2010), Gelles, Professor and Dean of the School of Social Policy & Practice at the University of Pennsylvania, said '90 percent of the time the best predictor of domestic violence is past behaviour'.

681. There was a long history of domestic violence and abuse by Sean towards Elizabeth, with a repeated pattern of behaviour. Albeit this was frequently denied or minimised by Elizabeth.

682. It is recognised when Officers attended the home address, Elizabeth and Sean were reluctant to co-operate, on occasions provided ambiguous or conflicting information and consistently declined any offer of professional support.

683. However, whilst taking all of this into account, there would appear to be inconsistencies in the approach Northumbria Police took to each incident.

684. On 27th May 2017 it appears the incident was reported to the Officer(s) as a neighbour related dispute, and this is how it presented when the officer(s) attended Elizabeth's and Sean's home address. On this occasion the officers did not consider the incident was a domestic abuse incident, and advice was given.

685. However, given Elizabeth was intoxicated on 27th May 2017 the Officers may have considered submitting an ACN to signpost her for Specialist Alcohol Support.

686. To their credit, with regard to the incident on 25th August 2019 the Officer(s) recognised Elizabeth was an adult at risk and submitted an ACN to the MASH for triage.

687. With regard to the incident on 31st October 2019 this was initially reported to the Officers as a domestic abuse incident. However, when the Officer(s) attended they stated in their Professional judgement this was not a domestic abuse incident and, in their opinion, a DASH was not required.

688. Again, the Officers may have considered submitting an ACN to signpost Elizabeth Specialist Support in managing Sean's mental health. It is recorded, however, Elizabeth stated no supportive measures were required; and therefore, it is unknown whether she would have consented to such support in any case.

689. It is positive on 14th November 2019 it appears the Officer(s) recognised the risk of domestic abuse, and a DASH was raised for Elizabeth.

690. Given different officers will have attended each time and the information presented may have been incomplete or unambiguous it is understandable that the Police officers arrived at the decisions that they did at the time. However, upon reflection, the three incidents within a relatively short period were potentially an indicator of escalating risk and required further review and assessment. Sean had been observed acting in an aggressive way, neighbours reported raised voices on a number of occasions, and Elizabeth and Sean had been seen in an intoxicated state, all of which potentially required further exploration. Whether this would have resulted in a referral to MARAC is another question as the criteria is high.

691. As stated, Police officers and other first line responders are faced with challenging high risk situations and are required to make rational decisions that will protect victims and the wider public 'in the moment'. Many responders may be inexperienced or lack specialist knowledge around domestic abuse. This in turn can lead to an inconsistency in approach. In this case, there were some indicators, as detailed above, which aligned to the historical abuse suffered by Elizabeth from Sean required more exploration.

692. It can also be the case that when Police officers and other front line responders repeatedly attend either similar types of situations including domestic abuse cases or neighbour disputes, there may be an element of over optimism and the incident it is viewed as the latest in a pattern of similar incidents over time. This can be even more so when officers are regularly sent to the same address and / or the victim elects not to engage. This in turn can lead to some complacency and belief that the risk may not be as high as it actually is.

693. These knowledge and experience gaps can and has been closed with ongoing domestic abuse training which promotes a victim focus, professional curiosity, recognising coercive control, taking positive action, and the use of body worn video.

694. **Domestic Abuse**

695. The Northumbria Police Domestic Abuse Risk Assessment guidance is clear. Risk is defined as follows:

696. **Standard risk**
Current evidence does not indicate likelihood of serious harm

697. **Medium risk**
There are identifiable factors of risk of serious harm. The offender has the potential to cause serious harm, but is unlikely to do so unless there is a change of circumstances

698. **High risk**
There are identifiable indicators of risk of serious harm or death. The potential event could happen at any time and the impact would be serious.

699. **Serious Harm (Home Office 2002 & OASys definition)** is defined as follows:

700. 'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

701. **DASH**

702. In order to assess risk, officers are directed to use The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model.[4]

703. The model was further developed from the SPECSS+ model in London by the ACPO Violence Adviser who worked in partnership with Safe Lives, formerly known as CAADA.

704. 'The First Time, Right Time' approach underpins the DASH assessment, as these are some of the most dangerous cases where women are more likely to be killed. The DASH checklist is a tried and tested way to assess risk. DASH is a lifeline to victims. It is based on research about the indicators of high-risk domestic abuse.

705. Police Officers are directed to a risk assessment using a DASH checklist, even when the victim(s) may be uncooperative and reluctant to engage.

706. The purpose of the DASH risk checklist is to give a consistent tool for Practitioners, who work with adult victims of domestic abuse, to help them identify those who are

4 DASH 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).

DASH was a pioneering and a significant step forward in keeping victims safe, turning a reactive 'it's just a domestic' into a proactive 'you must ask' questions approach. This also meant for the first time all Police Services, and a large number of Partner Agencies across the UK, started to use a common checklist for identifying, assessing, and managing risk.

at high risk of harm; and which cases should be referred to a MARAC meeting so Agencies may manage the risk. DASH applies to all victims of domestic violence.

707. When completing the DASH risk assessment, it is very important Officers ask all of the questions on the checklist at every incident. In doing so, Officers should consider:

- Who is at risk?
- The context of the behaviour
- How the risk factors interact with each other
- The victim's perception of risk

708. Officers should explain to the victim(s) the completion of the risk assessment allows the Police and Partner Agencies to have a clearer picture of what is happening in the relationship, and to understand the level of risk which the victim is being subjected to, this also assists in the identification of any coercive control offences.

709. Ideally, the form should reflect the victims perspective of risk and be as comprehensive as possible.

710. The DASH assessment contains 27 questions covering key risk factors. These questions are wide ranging and inclusive of gender, race, age, and other protected characteristics.

711. Some of the key questions within the DASH assessment are detailed as follows:

1. Has the current incident resulted in injury?
2. Are you very frightened?
3. What are you afraid of? Is it further injury or violence?
4. Do you feel isolated from friends / friends?
5. Are you feeling depressed or having suicidal thoughts?
6. Have you separated or tried to separate from the perpetrator?
10. Is the abuse happening more often?
11. Is the abuse getting worse?
12. Does the perpetrator try to control everything you do and/or are they are excessively jealous? In terms of the relationship, are you being 'policed at home'?
21. Have problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?

712. When examining the relationship between Elizabeth and Sean, if the incidents had been viewed as domestic abuse and a DASH had been completed on each occasion; an affirmative response could have applied to all of these questions

contained with the DASH assessment. Each of these questions were potentially all evident in this case.

713. On the DASH form there are 9 risk indicators which are ‘static’ in a relationship these are:

11. Has the abuser ever hurt the children/dependants?
12. Has the abuser ever threatened to hurt or kill the children/dependants?
16. Has the abuser ever used weapons or objects to hurt you?
17. Has the abuser ever threatened to kill you or someone else and you believed them?
18. Has the abuser ever attempted to strangle / choke / suffocate / drown you?
22. Has the abuser ever mistreated an animal or the family pet?
25. Has the abuser ever threatened or attempted suicide?
26. Has the abuser ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children?
27. Do you know if the abuser has ever been in trouble with the Police or has a criminal history?

714. Static risk factors are those that will not change. When examining the relationship between Elizabeth and Sean, with the exception of questions 11 and 12, an affirmative response could have applied to all of these questions. They were all potentially all evident in this case.

715. As stated, static risk factors are those factors which once present should remain present on all subsequent DASH risk assessments if the victim/perpetrator remain the same. Therefore, in this case, if the incidents had been viewed from a domestic abuse context, static risk factors should have been considered in each of the incidents the police attended.

716. Specifically, the perpetrator’s previous criminal history, and history of violent behaviour, was not consistently identified as key risk factors. The aforementioned research indicates past behaviour is often a predictor of future behaviour, and it is essential Professionals use such information to consider the presenting risk.

717. Northumbria Police completed a DASH on one of the four occasions they attended the home address prior to the murder / suicide. This is primarily because the incidents either presented as a neighbour dispute or the Officer(s) did not in their Professional judgement consider the incidents to be domestic abuse.

718. Whilst Elizabeth was reluctant to engage with police officer(s) and respond to the question set within the DASH, important information, such as the fact Sean had

previously used a weapon and had attempted to choke Elizabeth, was known to Northumbria police and Partner Agencies.

719. Once the DASH report form has been completed a domestic abuse computerised record must be completed by officers before the termination of duty. The computer will generate a risk level based on the DASH matrix and escalation and frequency of previous incidents - the risk to victim will be graded as High, Medium, or Standard.

720. When officers(s) use DASH to assess risk, they are directed to follow the guidance detailed below:

HIGH	14 or more ticks, OR Professional judgement, OR Repeat MARAC victim* Honour Based Abuse, Forced Marriage, Female Genital Mutilation
MEDIUM	8-13 ticks, OR 4 incidents or more in 4-month period, OR Professional judgement
STANDARD	Incidents falling outside of the above

721. Officers are encouraged to use their professional judgement and have the option to escalate a victim to medium or high risk but cannot downgrade a risk level.

722. With the exception of one of the incidents the Police attended during the scoping period, officers did not appear to identify domestic abuse or consider it necessary to submit a DASH for Elizabeth; meaning any opportunity to undertake further risk assessment, refer to Partner Agencies or secure additional support was not taken forward. An ACN was submitted in one of the incidents for the MASH to triage.

723. Within their own learning, Northumbria Police recognise static risk factors must be seen as a constant throughout the DASH risk assessment. This will enable Officers and Professionals from other Agencies to be as informed as possible when assessing risk. An example from this case is the 'previous choke or strangle' reference. Once this had been identified this information should always have been present in any subsequent DASH.

724. The current Northumbria Police system requires the officer completing the DASH to research previous incidents, and then to manually enter the identified risk factors based on the victims answers. This can mean these 'static risk factors' can be missed, and do not therefore contribute to the overall risk assessment. The current Northumbria Police computer system is due for replacement (work currently ongoing) and therefore a computer fix for this is deemed unrealistic. Northumbria Police are also awaiting the College of Policing's new DASH model which would also make any work and changes to the current system redundant.

725. **Adults at Risk**

726. The priorities of Northumbria Police in responding to an adult at risk of harm and/or abuse are as follows:

- To take positive action to protect adults who are at risk from harm or abuse.

- To work with Partnership Agencies to prevent, identify and investigate the treatment of harm and abuse of adults at risk.

- To take the lead in all criminal investigations involving the harm or abuse of adults at risk.

- To contribute to the safeguarding of adults at risk by timely and effective intervention.

- To foster a "whole team" approach which places the person led, and outcome focused engagement of individuals, and their needs before the needs, or processes of the system, and the requirements of individual organisations or Agencies.

727. There are often interdependences between domestic abuse and adults at risk. A core policing responsibility is identifying and managing perpetrators who choose to target others who are vulnerable and at risk.

728. Through this further risk identification officers are then able to look at what available options can be put in place in order to improve the safety of the victim.

729. In assessing and recording risk, officers are directed to consider a DASH assessment alongside giving consideration to submitting an ACN for adults at risk.

730. When the officers attended the four incidents within the scoping period, on more than one occasion they recorded Elizabeth as intoxicated, the living conditions as

unhygienic and Sean acting aggressively. Officers also recorded Sean as having autism, although this was not clinically diagnosed.

731. The Northumbria Police Adults at Risk Policy and Procedure is clear. It recognises the Police have a crucial role to play in the safety and protection of vulnerable adults at risk of harm and abuse.

732. Within the Adults at Risk Policy and Procedure it states the safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the LA is meeting any of those needs).
- is experiencing, or at risk of, abuse or neglect.
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

733. If the above is met, the Local Authority (and Partner Agencies) must make enquiries to enable it to decide whether any action should be taken in the case, and if so, what and by whom.

734. In supporting adults at risk, the policy and procedures reaffirm the importance of 'making safeguarding personal' - Any adult safeguarding incident response, referral, or investigation should be person led, and outcome focussed. This is to ensure equality of service provision and Police response to all adults at risk, regardless of their race, gender, class, culture, disability, sexuality, age, or religion/belief.

735. The policy also states 'How staff record information is vital as it will be shared with colleagues, other Agencies and possibly further. One mistake can have devastating consequences and waste valuable time, effort, or resources'.

736. The purpose of an ACN is to notify both the Child and Adult Protection (CAP) DS within Northumbria Police, and Adult Services of the concern or identified risk. Once an initial assessment of the risk is identified by the Multi-Agency Safeguarding Hub (MASH), the ACN will be referred to the CAP DS for allocation of criminal investigation where relevant and/or subject to a safeguarding meeting within the MASH.

737. Any Officer, dealing with an incident where an adult is identified as being at risk of abuse or neglect, should consider any risks to the adult and submit an ACN outlining the concerns for the adult. This will allow information to be shared with the LA and determine the most appropriate action to be taken to safeguard the person(s) at risk.

738. The information submitted on an ACN should be accurate, adequate, and relevant. All ACNs should be completed before the reporting officer terminates duty.

739. There is deliberately no threshold guidance for when to submit an ACN, merely the submitting Officer's assessment of risk, in particular risk of abuse or neglect.

740. Based on the information provided, with one exception, Officers did not consider it necessary to submit a ACN for Elizabeth or Sean meaning there wasn't any referral for Support Services.

741. Given Elizabeth was intoxicated on the 27th May 2017 the Officers may have considered submitting an ACN to signpost her for Specialist Alcohol Support.

742. On the 31st October 2019 the Officers may have considered submitting an ACN to signpost Elizabeth to Specialist Support in managing Sean's mental health. It is recorded, however, Elizabeth stated no supportive measures were required and therefore it is unknown whether she would have consented to such support.

743. Where Officer(s) elected not to submit an ACN it limited the opportunity to undertake further risk assessment, refer to Partner Agencies, or secure additional support, was not taken forward.

744. There is an important distinction to be made between risk identification and risk assessment. While risk identification involves knowledge and use of the checklist and identification of risk factors, risk assessment requires more in-depth knowledge and is an on-going, sustained process.

745. It is essential such risk factors are recorded accurately for future assessments. It is imperative risk is seen as dynamic, fluid and is regularly reassessed at 'critical points' within each case. Police Officers are expected to use their professional judgement when information is limited, and the victim is perceived to be minimising the risks or unable or too fearful to disclose the full extent of the abuse.

Recommendation / Learning 7

746. **Northumbria Police should promote the Force Adults at Risk Policy and Procedure and train and support officers to identify and support victims who require safeguarding.**

Recommendation / Learning 8

747. **All agencies should routinely consider submitting a DASH and / or ACN risk assessment where domestic violence or abuse be identified or suspected, including inter family violence.**

748. **3. Were any risks identified assessed at the appropriate level?**

749. Northumbria Police manage risk via established risk assess models and professional judgement.

750. The following risk assessment models are used by Police forces extensively across the UK:

751. **The National Decision-Making Model (NDM)[5]**

752. **The THRIVE Model (THRIVE) [6]**

753. Alongside these established models, officers are also encouraged to use their discretion and use their experience and knowledge to protect victims from further harm.

754. **DASH**

755. As per the previous narrative, DASH is the key model in assessing risk where domestic violence and abuse is evident.

756. As stated, there would appear to be inconsistencies in the approach Northumbria Police took to each incident.

757. It is positive that by applying the NDM and THRIVE, Northumbria Police directed Officer(s) should attend Elizabeth and Sean's home address, in each of the four incidents reported to them, prior to the murder / suicide. For example, before Officers attended the incident on 14th November 2019, the Police identified domestic violence, deregistered MARAC, violent and firearms markers against Elizabeth's address in support of the deployment. This would indicate there was the appropriate identification of risk during the initial handling of the calls into the Police control room.

5 The National Decision-Making Model (NDM) is a dynamic decision-making model which can be applied to a whole range of incidents, including domestic abuse and violence.

6 The THRIVE model (threat, harm, risk, investigation, vulnerability, and engagement) is designed so Police Officers and Staff can assess risk and decision making in a consistent way.

758. Based on the information provided, with one exception, the Officer(s) did not view the incidents as domestic abuse and/or consider there was a necessity to submit a DASH.

759. Further, with one exception, Officers did not consider it necessary to submit a ACN for Elizabeth or Sean.

760. Where Officer(s) elected not to submit either a DASH or ACN it limited the opportunity to undertake further risk assessment, refer to Partner Agencies, or secure additional support, was not taken forward.

761. To their credit, with regard to the incident on the 25th August 2019 Officer(s) recognised Elizabeth was an adult at risk, and submitted an ACN to the MASH for triage.

762. Adult Triage was completed with the Safeguarding Officer and the MASH Supervisor, and the decision taken was 'no further action required' at the time. The case was closed with no further action.

763. The current MASH Manager has offered the following rationale for closing the ACN:

- Elizabeth clearly not open to Adult Services, or we would have sent the concern to the Case Worker
- This was first adult concern for Elizabeth since 2012
- The call was nothing to do with son, it came from neighbour complaining about Elizabeth making threats to them. (NFA by attending officer).'

764. Whilst it is recognised the MASH has significant demand and has a well-established triage system in place, greater consideration could have been given to the violent and abuse history between Elizabeth and Sean, and the MARAC referral in 2016 in particular. Whilst the initial call was around a neighbour dispute, the Officer who attended the incident, was sufficiently concerned from what he saw and heard, for the safety of Elizabeth. Indeed, the Officer described the relationship between Elizabeth and Sean as 'explosive'.

765. The Independent Reviewer cannot definitely state that the decision to take no further action was incorrect in the circumstances and the MASH supervisor has offered the rationale as to why this decision was made. However, greater weight may have been placed on the history of domestic abuse by Sean towards Elizabeth and the description of the relationship between them by the officer who attended the incident.

766. On 14th November 2019 it appears the Officer(s) recognised the domestic abuse, and a DASH was raised for Elizabeth. The Officer assessed the risk as standard, having outlined two risk indictors:

- Suspected mental / alcohol / drugs.
- Abuser previous criminal history.

767. As there were only two risk indicators, and there had been no reported domestic violence incidents reported since the 23rd August 2016, the Officer assessment is not unreasonable and in any event was subject of further assessment once submitted.

768. In domestic abuse incidents where the victim is assessed as standard risk, it is the responsibility of the first Responding Officer to initiate safety planning and set out options for the victim, even when this may be followed up by a Specialist Officer.

769. The safety plan should:

- Reduce the risk of further harm.
- Reflect management of the risks identified through the DASH risk assessment form.
- Be bespoke to the needs of the victim.
- Build upon existing coping strategies, encouraging the victim to increase their own safety.
- Consider risks to others: children / new partner / family members.
- Be dynamic and subject to review at any trigger point.

770. The plan should be recorded and follow the RARA model:

- Remove the risk.
- Avoid the risk.
- Reduce the risk.
- Accept the risk.

771. The Attending Officer on this occasion recorded the following information following the RARA model:

- Remove: 3rd party report no arrest made. Both parties deny any offences have occurred. They state there is an ongoing neighbour dispute where Neighbours call in all noise as they are trying to get them removed.
- Avoid: Advice given re noise and to report any future incidents.

- Reduce: Safeguarding advice given, telephone number taken and checked it is correct on in case of silent 999 calls.
- Accept: New DASH submitted. Standard risk.

772. When a domestic incident is identified as standard or medium risk, MASH Professionals will ordinarily allocate the case to the local Neighbourhood Policing Team Supervisor for review.

773. Professionals within the MASH will queue standard risk victims to the NPT Supervisor, with responsibility for the Neighbourhood Policing Sector in which the victim resides. The purpose for doing this is to allow the NPT Supervisor to decide whether it is appropriate for further intervention, given the holistic understanding of the broader issues which may exist, with regard to the family of individuals concerned.

774. The NPT Supervisor should manage the queue and look at each incident as soon as practicable. This is not a review of how the incident has been dealt with, or a risk assessment. If the NPT Inspector determines further intervention is required, an appropriate entry should be made on the record. If one is not required there is no need to record anything. This part of the process recognises the wealth of knowledge and understanding NPTs have in relation to their local communities and provides a framework for a flexible approach to be adopted, with regard to standard risk victims of domestic abuse.

775. The Neighbourhood Policing Team (NPT) is responsible for:

- Ensuring every standard risk victim will be reviewed by a Neighbourhood Policing Team Sergeant.
- Conducting the safety planning for medium risk victims of domestic abuse (except where the victim is downgraded from high if a plan has already been completed by Safeguarding Staff).
- In order to complete safety planning for medium risk victims, NPT Officers should conduct further in-depth research in order to understand the victim and their complex issues and apply a problem-solving approach.
- If research highlights any concerns which impacts upon the risk to the victim, the Officer should consider through professional judgement whether the victim should be raised to high risk. If so, the Officer will need to notify the MASH Supervisor to ensure records are updated.
- Safety Plan all standard/medium victims when the perpetrator is due to be subject of a prison release.

776. In this case the Neighbourhood Supervisor in their professional judgement decided no further action was required.

777. The demand on neighbourhood Policing resources is acknowledged and it is recognised there are only finite resources.

778. Whilst at this stage the assessment was standard, as opposed to medium, I would suggest some further consideration could have been given to conducting further in-depth research in order to understand the victim and perpetrator, and their complex issues and consider a problem-solving approach.

Recommendation / Learning 9

779. **Northumbria Police Neighbourhood Policing Teams should give further consideration to conducting further in-depth research in order to understand the victim and perpetrator, and their complex issues and consider a problem-solving approach in complex cases such as this.**

780. **4. Was the MARAC process implemented in line with local policy and procedures? (Please include appropriate policies and procedures).**

781. There are six local authority areas across Northumbria. Each MARAC is chaired by a Police Detective Inspector. All high risk domestic abuse incidents are heard at MARAC.

782. MARAC is primarily informed by Police (and Partner Agencies) completing a DASH assessment, alongside professional judgement.

783. The risk assessment process has the following objectives:

- To gather detailed and relevant information from victims, which can be shared with other Agencies.
- To identify those who will need more intensive support in order to save life and prevent further harm.
- To make Agencies aware of the most dangerous offenders.

784. The referral on the 23rd August 2016 was in line with the requirements of a MARAC referral and a Safelives risk assessment had been completed. This assessment included the following identified risks:

- Victim frightened.
- Afraid of further violence/Injury.
- Depressed / suicidal thoughts.
- Abuse happening more often.
- Abuse getting worse.

- Jealous / Controlling.
- Weapons.
- Threats to kill.
- Previous strangle/choke.
- Suspected financial problem.
- Suspected mental/alcohol/drugs.
- Suspected threat/attempt suicide.
- Abuser previous criminal history.

785. The risk was raised by the Referrer to high risk using professional judgement with the following justification:

- Report of physical assault including being shot with an air rifle ten years ago and grabbed by the throat six weeks ago.
- Perpetrator's mental health is thought to be deteriorating.
- Perpetrator has caused damage to the address.

786. The assessment was completed on the same day and entered into the Northumbria Police system and heard at MARAC on the 14th September 2016. The risk assessment for this referral was appropriate, based on the Safelives risk indicators, and the use of the Referrer's professional judgement. It is to the credit of the Referrer they used their professional judgement to recognise, and escalate, the risk and ensure appropriate support from Agencies.

787. This was the only occasion Elizabeth was classified as high risk and referred to MARAC.

788. There were opportunities to potentially refer Elizabeth to MARAC following the other incidents Northumbria Police attended during the scoping period.

789. However, these incidents were either viewed as Neighbour disputes or the Officer(s) did not consider it necessary to submit DASH.

790. On another occasion, an ACN was submitted identifying Elizabeth as an adult of concern.

791. With regard to the incident on the 14th November 2019, the Officer on this occasion identified Elizabeth as victim, and Sean as perpetrator; and places the incident into context on the DASH detailing they have drawn on the previous domestic history, to inform their decision.

792. The incident was classified as standard risk and following further assessment the case was not referred to MARAC.

793. Whilst Elizabeth did not engage with WWiN, when her case was heard at MARAC in 2016, it is possible if any of these other incidents had been classified as high risk and referred to MARAC, Elizabeth may have engaged, and more support could have been put in place.

794. **MARAC Repeat Incidents**

795. Safelives define a MARAC repeat incident as:

796. 'Any instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC'.

797. The individual act of abuse does not need to be 'criminal', violent or threatening but should be viewed within the context of a pattern of coercive and controlling behaviour.

798. These events could be disclosed to any Service or Agency including, but not exclusive to, Health Care Practitioners (including Mental Health), Domestic Abuse Specialists, Police, Substance Misuse Services, Housing Providers etc'.

799. MASH staff will apply quality assurance to Northumbria Police MARAC repeat incidents to decide which cases meet the Northumbria MARAC threshold. MARAC repeat cases, which meet the threshold, will be raised to high risk and returned to MARAC.

800. Given the only referral to MARAC involving Elizabeth was in September 2016, the incident on the 27th May 2017 would have been within the twelve-month time period, if it had been identified as a domestic incident.

801. With regard to the incidents on the 14th August 2019, 31st October 2019 and the 14th November 2019, all were well outside of the timeframe from the previous MARAC referral, but were all within a three-month time period of each other. This could have been identified as escalating risk.

802. It would appear that the case was not referred back to MARAC after 2016 due to the fact that when Police attended the incidents at the home address, they did not classify the situation as high risk. The attending officers took the view that the incidents were neighbour disputes and / or the risk that Sean presented to Elizabeth was classified as standard.

803. When Elizabeth engaged with other Agencies, Elizabeth did not disclose domestic abuse and therefore the case was not referred to MARAC.

804. The incident within the twelve month timeframe from the original MARAC referral on the 27th May 2017 was following a dispute between Elizabeth and her neighbour and was not viewed as a domestic abuse incident. Police gave advice to all parties and no further action was taken. In these circumstances it is understandable why a DASH risk assessment was not carried out or a referral made to MARAC. However, given Elizabeth was intoxicated on 27th May 2017 the Officers may have considered submitting an ACN to signpost her for Specialist Alcohol Support.

805. With regard to the three incidents where police were called to the home address between the 14th August 2019 and the 14th November 2019 all were called in by neighbours with concerns around what may be happening within Elizabeth and Sean's home. The Police adopted a different approach each time. They gave advice on one occasion, submitted an Adult at Risk notification on another occasion and completed a DASH risk assessment on the third occasion.

806. Given different officers will have attended each time and the information presented may have been incomplete or unambiguous it is understandable that the Police officers arrived at the decisions that they did at the time. However, upon reflection, the three incidents within a relatively short period were potentially an indicator of escalating risk and required further review and assessment. Sean had been observed acting in an aggressive way, neighbours reported raised voices on a number of occasions, and Elizabeth and Sean had been seen in an intoxicated state, all of which potentially required further exploration.

807. As stated, every high risk domestic abuse incident is heard at MARAC.

808. In addition, every standard and medium domestic abuse incident that has been in MARAC in the previous 12 months is reviewed by a Decision Maker to ensure the risk level is accurate. The Decision Maker being authorised to move the risk to high if so deemed.

809. Likewise, Northumbria Police has set a threshold of 'four' domestic abuse incidents in any rolling 'four' month period should be subject of a similar review.

810. In this case, Police were called to three separate incidents at the home address between the 14th August 2019 and the 14th November 2019 but three different responses were adopted, with only one incident resulting in the completion of a DASH assessment. Therefore, no MARAC referral was considered. Taking into account the current policy even if a DASH had been submitted on each occasion it is unlikely that the risk would have been escalated to high and a referral made to MARAC at that time.

811. A broader more holistic approach may be required, with discretion to refer a case to MARAC where risk is considered to be escalating within a concentrated period of time, even where DASH assessments have not been completed.

Recommendation / Learning 10

812. **Where a number of incidents are reported within a short time frame, Northumbria Police and Partner Agencies should ensure any review process specifically examines whether risk is escalating, and interventions are required.**

813. It is recognised there is significant demand on Agencies with finite resources. However, in terms of victims who have previously been classified as high-risk cases but have disengaged or never engaged; a review process may be beneficial, both internally by Single Agencies and through the Partnership to share any new information and opportunities to engage, and support, victims who may have 'gone off the radar'. For example, in this case, the neighbour complaints could have provoked consideration for multi-agency discussions thus re-igniting this case and reviewing the potential escalation in risk. Whilst fully recognising the context in which Agencies are operating, there are potentially lessons for all Agencies in terms of 'sitting' on high-risk cases and waiting for an opportunity to re-engage via another referral.

Recommendation / Learning 11

814. **All Agencies should give consideration to reviewing MARAC cases where the victim has disengaged or never engaged where there is potential for escalating risk.**

815. In terms of other learning around MARAC, Sunderland CCG will say although there was no information sent back to the Practice from the MARAC in September 2016, they could have actively pursued feedback from although this should have been received from MARAC as per protocol.

816. As well as exploring whether a case should be referred to MARAC, it is also important to consider the quality and depth of discussion at MARAC. There is a growing concern around rising demand, and the capacity for Professionals, to manage high risk cases effectively. As part of this DHR, some Agencies have raised concerns the volume of cases going into MARAC in Sunderland, can result in a quick presentation of the incident and a brief history, which can limit the quality of the discussions and the depth of risk assessment.

817. This concern is also shared in other areas. The Standing Together report (2021) 'What does good' look like? Pan London MARAC Review' report offered the following view:

818. 'It is fair to conclude that most MARACs had seen an increase in volume in 2020 when compared with 2019 with an average 20% increase. From the sample, 88% of MARACs were seeing over the recommended volume of cases. In terms of referring Agencies, most 13 Copyright © 2021 Standing Together Against Domestic Abuse. All rights reserved. MARACs had Police as the top referring Agency in 2020 accounting for 9% to 46% of all referrals. In 2020, the remaining MARACs had IDVAs as the top referring Agency accounting for 31% to 47% of referrals. This was a slight increase on 2019, whereby IDVAs accounted for 31% of all referrals into MARAC. Other top Referrers were noted to be Children's Services (CSC), the voluntary sector and other (MARAC transfers and non-core Agencies). Some Boroughs had increased frequency of MARAC meetings during the pandemic to cope with the demand whereas others noted the length of the meeting increasing with some continuing late into the evening or split across two days which had an impact on resourcing for the Coordinators, Chairs, and Partners'.

819. Given these concerns, the Partnership should give consideration to the MARAC demand, and the capacity of Agencies to manage high risk domestic abuse referrals.

820. **Recommendation / Learning 12**

821. **The Safer Sunderland Partnership should give consideration to the MARAC demand and the capacity of agencies to manage high risk domestic abuse referrals.**

5. Is there any evidence Elizabeth and Sean were offered assistance to address alcohol related issues, and if they were, what was the outcomes?

822. Alcohol misuse clearly played a significant role in Elizabeth's and Sean's life. Elizabeth was described as a 'heavy drinker' and was intoxicated on a number of occasions where the Police attended her home address. Colleagues at the Charity also report Elizabeth often smelt of drink and had glazed eyes.

823. Sean was described as a reclusive alcoholic who asked his mother to purchase vodka for him on a frequent basis.

824. It is clear, in the majority of cases reported to police, alcohol was a key factor in the abuse taking place between Elizabeth and Sean.

825. There have been a number of DHRs within the Northumbria Police area where alcohol has been an identified major factor involved in domestic related incidents.

826. There can be an issue around domestic abuse victims accessing services when they are heavily abusing alcohol, and likewise offenders accessing alcohol services whilst perpetrating domestic abuse. In any case all alcohol intervention requires the positive engagement of both parties.

827. In considering this question, Northumbria Police have put forward a proposal the Home Office should be asked to consider a statutory provision for compliance, with alcohol treatment, when there is an established link to domestic abuse, to run in conjunction with DVPNs/DVPOs.

828. Northumbria Police propose the statutory provision should be considered in cases such as this one, where:

- Alcohol is an ever-present factor in the majority of incidents.
- Ongoing interventions are having no impact.
- Criminal law is not effective (through lack of engagement). Incidents were escalating.
- Where there is significant impact on Police resources.
- There is significant impact on the Community, based on hearsay statements, taken as part of the Civil Injunction Investigation.

829. Presently this type of behaviour is dealt with by means of Civil Injunction (which any Agency can apply for) Sections 1 to 21 of the Anti-Social Behaviour, Crime and Policing Act 2014; applied for as it does not require a criminal conviction and is based on a lower standard of proof, balance of probabilities as opposed to beyond reasonable doubt.

830. Northumbria Police will say this has previously been recognised as a national recommendation in previous DHRs. I understand a response is awaited from the Home Office.

831. Although the recovery from long term alcohol abuse cannot be achieved by the Police alone, a problem-solving approach has been embedded within Northumbria Police.

832. Northumbria Police procedure states in relation to referrals to Support Services:

833. ‘It is imperative all officers fully explain and positively promote the importance of Support Services to each victim and actively seek their consent to a referral. These Agencies provide specialist, emotional and practical support to victims of domestic

abuse, and will review each victim's individual circumstances to ensure the appropriate support is given and where necessary refer on to further specialist support services if appropriate'.

834. When the Police attended the incident on the 27th May 2017 Elizabeth was described as intoxicated.

835. When the Police attended the incident on the 25th August 2018 Elizabeth was described as 'smelling of alcohol'.

836. Whilst Elizabeth was not willing to engage, both of these incidents potentially provided Police with an opportunity to consider making a CAN, and offering Elizabeth Professional Support around her alcohol misuse.

837. It is evident alcohol is known to lower inhibitions and can increase the severity of violence.

838. The aforementioned Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) report details clear links between adult family violence, mental health, and drugs.

839. 'Analysis of Metropolitan Police data on domestic violence homicides in 2008-09 found that all six of the perpetrators who had killed family members (mother or father) were either suffering from mental health problems and/or were under the influence of drugs and/or alcohol (cited by Neville & Sanders-McDonagh 2014)'.

840. Scott (2015) highlights 'there is a strong association between harmful levels of alcohol use and perpetration and victimisation, and that alcohol may exacerbate abusive behaviour in a relationship where it already exists.'

841. Within the MARAC meeting in 2016 one of the key actions was to flag 'the system' for Elizabeth regarding her alcohol use and consider a referral to appropriate services. Health agreed to send a letter to Elizabeth's GP to flag records regarding her alcohol misuse.

842. A review of the records has identified there does not appear to any referral made to substance abuse services. This represents a missed opportunity to support Elizabeth with her alcohol misuse.

843. On the 29th January 2012 Sean was seen by a Mental Health Professional whilst in Police custody, having assaulted his Mother. Clinical records indicate Sean accepted a referral to Turning Point as he recognised his level of alcohol use was getting worse. It has not been possible given the passage of time and a change in

specialist support to establish if Sean engaged in any programme of specialist support.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

844. **6. What were the quality of risk assessments and risk management plans in response to known incidents? Were the risks to 'Elizabeth' appropriately assessed at the correct level of risk? Were static factors present in all risk assessments?**

845. South Tyneside and Sunderland NHS Foundation Trust (STSFT) will say during the time frame of this DHR, it was routine to ask a series of safeguarding questions to establish if patients feel safe. These questions continue to be asked to date.

846. Given the protracted history between Elizabeth and Sean, it should be noted these safeguarding questions may not have been asked prior to the time frame of this DHR.

847. The safeguarding questions are asked when a patient attends Sunderland Royal Hospital (SRH) Emergency Department (ED) are as follows:

- Able to assess?
- Do you have any children or caring responsibilities?
- Any historical safeguarding concerns or alerts?
- Any safeguarding concerns with this attendance?
- Do you have concerns about your safety at home?
- Any actions to be taken?

848. All Elizabeth's attendances between 2018 and 2020 were at Sunderland Royal Hospital (SRH) Emergency Department (ED), with the exception of the last attendance, which was to the Sunderland Eye Infirmary (SEI). No disclosures were made on any of the five occasions she attended hospital.

849. STSFT will say on each occasion Elizabeth attended hospital, they followed appropriate policies and procedures and asked safeguarding questions in order to encourage a disclosure.

850. Sean was not known to STSFT during the timeframe of this DHR.

851. Historical medical records from the 24th May 2007 detail Sean presenting to hospital with a complaint of mental health, and hallucinations. The diagnosis was personality disorder However, Sean left without treatment.

852. It is clear Elizabeth was reluctant to disclose the violence and abuse she was suffering at the hands of Sean to Health Professionals.

853. Elizabeth always attended hospital, as opposed to been treated at home. This presented an additional challenge for Professionals to obtain a complete picture of the victim's life in her own household. A Professional visiting Elizabeth's home would have been in a better position to observe and share information of any risk presented by Sean to Elizabeth within the home environment.

854. Elizabeth's explanation of how she received her injuries were always consistent with the injuries she presented with. Elizabeth was always seen alone and asked the safeguarding questions to encourage a disclosure. Elizabeth did not raise any safeguarding concerns when attending ED.

855. In accordance with RCGP, IRIS, CAADA (Safe Lives) and NICE guidance, Health Professionals should probe around potential abuse where a patient has presented with repeated 'accidental' injuries, alcohol dependence, and a history of depression, anxiety, or failure to cope and social withdrawal.

856. **Sunderland CCG**

857. It is of note that Sunderland CCG had consistent involvement in Elizabeth's health care as required and made a determined attempt to reach full diagnosis for her chronic health conditions. Elizabeth clearly felt able to discuss her health concerns and was also supported for smoking cessation.

858. SCCG will say that having been alerted to the fact that Elizabeth had been referred to MARAC there missed opportunities to discuss the referral further during the subsequent appointments that Elizabeth attended at the Practice.

859. There was also opportunity for both WWiN and the Practice to discuss the issues which led to the referral in the first place. There is no information in the notes or correspondence which gave reference as to why the referral was made and who the issue was in relation to.

860. This was a missed opportunity by the Practice to explore the issue of the referral with Elizabeth and check if she required any additional support. Although nothing was fed back from the MARAC any referral indicates a serious risk of domestic abuse and this could have been explored further to understand what had happened and what safeguarding measures could be put in place.

861. The three attendances at A&E by Elizabeth in 2018 for hand injury and lacerations were a red flag and could have been further explored at the Practice when

Elizabeth attended. Conversations should have been had with Elizabeth as to why she had attended A&E so frequently with injuries.

862. Elizabeth was seen 3 times by the Practice Nurse in 2018 and all these appointments potentially represented opportunities for further exploration around the nature of the injuries and the associated risk.

863. Alternatively, an appointment could have been sent to Elizabeth to discuss the attendances with the Domestic Violence lead as frequent attendance at A&E for a similar complaint is considered to be a red flag for domestic abuse concerns. A further referral to WWiN could also have been discussed.

864. There was also missed opportunity in 2016 and 2018 for agencies to discuss and respond to statutory referrals and A&E attendance.

865. Sunderland CCG have reflected upon how little was actually known about Elizabeth and her life. Apart from some identified health issues there is no real picture of her life at home, her relationship with her son or any rationale for the referral to MARAC and her attendance with injury at A&E. There doesn't appear to be, at any point, an attempt to explore any social issues with Elizabeth.

866. Because of the lack of information and communication regarding the victim Elizabeth and what appears to be issues of potential domestic abuse then risk areas were never identified or explored in the practice by either direct or routine questions. There was no risk identified in the notes and no alerts as to Domestic Abuse.

867. **Recommendation / Learning 13**

868. **SCCG should ensure that any referral to MARAC should be followed up with further exploration of the issues and the offer of safeguarding support for the victim of domestic abuse.**

869. **Recommendation / Learning 14**

870. **SCCG should ensure that any frequent attendance at A&E for a similar complaint should be treated as a 'red flag' inviting further exploration and engagement with other agencies around potential domestic abuse.**

871. STSFT and SCCG both acknowledge that more professional curiosity shown by staff.

872. Professional curiosity is a combination of creating a safe space, looking, listening, asking the ‘second question’ and not accepting things at face value.

873. Reflection and triangulating information and professional opinion is also key to protecting vulnerable people from harm.

874. Professional curiosity, or respectful uncertainty, is particularly important when working with victims who are displaying signs of vulnerability but are consistently stating they have no safeguarding concerns and are reluctant to engage.

875. There is a continuum of behaviours from victims, with full co-operation at one end of the scale, and a clear reluctance to engage at the other. Many vulnerable victims seek to ‘show their best side’ or ‘save face’ which means Professionals have to rely upon limited information, guidance, experience, and judgement to ‘see beyond the obvious’.

876. The following principles may help front line Professionals support vulnerable victims who are reluctant to disclose harm more effectively:

- Vulnerable adults can be reluctant to readily disclosure violence or abuse, this means Professionals have to be able to spot the signs and create a suitably safe and trusting listening environment.
- Developing and maintaining an open stance of professional curiosity supports Professionals to consider the possibility of maltreatment, and to challenge and explore issues while maintaining an objective and supportive approach.
- Professionals should focus on the needs, voice and ‘lived experience’ of the victim.
- Professionals focus on any change in the family dynamic and the impact this will have on the life and well-being of victim – this is a more reliable measure than the agreement of the victim in the professionals plan.
- There is some evidence an empathetic approach by Professionals may result in an increased level of trust and a more open family response leading to greater disclosure by victims.
- There are examples of Professionals focusing on offenders behaviours and not their underlying vulnerabilities.
- Professionals and Managers need to be curious, to be sceptical, to think critically and systematically but to act compassionately.
- Professionals should question their own assumptions about how families function and guard against over optimism.
- Professionals should recognise how their own feelings (for example tiredness, feeling rushed or illness) might impact on their view of a vulnerable adult or family on a given day.

- Professionals should demonstrate a willingness to have less than 'comfortable' interactions with families when this is necessary.
- Professionals should address any professional anxiety about how hostile, or resistant, families might react to being asked direct or difficult questions.
- Professionals should remain open minded and expect the unexpected
- Professionals should appreciate respectful scepticism and challenge are healthy – it is ok to question what you are told.
- Professionals should understand the impact of coercive control on the behaviour and responses of family members.
- Professionals should understand the cumulative impact on vulnerable adults of multiple, or combined, risk factors, e.g. domestic abuse, drug/alcohol misuse, parental mental health (previously referred to as 'toxic mix').
- Professionals should ensure practice is reflective and ensure they have access to good quality supervision.

Recommendation / Learning 15

877. **STSFT and SCCG should routinely use professional curiosity where a person frequently presents with injury that may have been as a result of domestic violence or abuse.**

7. If so, for 'Elizabeth', did this result in appropriate needs assessment and safety planning actions and what was the evidence of this?

878. Given no disclosures were made by Elizabeth, no needs assessments or safety planning was carried out by STSFT or SCCG which may have reduced risk.

8. If the process was not implemented in line with local policy, procedure, and guidance, what were the reasons for this?

879. As stated, within the scope of this DHR, Elizabeth attended hospital on five occasions. These attendances detailed injuries where Elizabeth provided an explanation, which was medically acceptable. Elizabeth did not disclose any concerns in relation to her safety at home, therefore no further enquiry was instigated.

880. From 2016, SRH have had a Hospital Independent Domestic Violence Advocate (IDVA) in post. The post holder is employed by Wearside Women in Need (WWiN) and has an honorary contract with STSFT. An IDVA referral system was introduced as part of the implementation process. As Elizabeth did not disclose any concerns in relation to her safety at home, an IDVA referral was not made during the time frame of this review.

881. STSFT patient's electronic records are flagged if patients are open to MARAC as a victim and as a perpetrator.

882. Elizabeth was not flagged as being open to MARAC. STSFT did not attend MARAC at that time Elizabeth was referred into the process. STSFT only retain flags for 12 months unless the person is open to MARAC again within the 12-month period.

883. Learning for SCCG is detailed above as per Recommendations 14,15 and 16.

884. In short, any referral to MARAC should be followed up, attendances at A & E with a similar complaint should provide a 'red flag' and professional curiosity should be used routinely.

9. Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew 'Elizabeth' was experiencing domestic abuse?

885. STSFT have a Safeguarding Adult Policy which includes domestic abuse.

886. Alongside the policy there is guidance; Identifying and Responding to a Patient Disclosure of Domestic Abuse Guidelines. Appendix 2 details the following: Routine or Selective Enquiry - Enabling Victim Disclosures and making Safe Enquiries. This section advises staff to follow the principles of safe routine enquiry, meaning staff should routinely ask their patients 'if they feel safe', while always ensuring any discussions are conducted in a safe and confidential one to one environment, with no Family Members or Carer's present.

887. It appears evident on all Elizabeth's attendances at hospital she attended alone. When patients are triaged in ED they are reviewed alone, unless collateral information is required from a Family Member, Friend, or Carer. There were no reasons to doubt Elizabeth's capacity.

888. Safeguarding questions were asked on all of the occasions and Elizabeth did not disclose any concerns in relation to her safety at home; and the historical account Elizabeth provided, in relation to how she sustained her injuries, was consistent to the injury presented.

889. Most Agencies, including STSFT, work with an approach of selective enquiry where questions about domestic abuse are asked. This approach recognises in cases where abuse may be hidden, a lack of routine enquiry can potentially result in missed opportunities for disclosure.

10. Was appropriate use made of available civil and statutory tools and powers: including but not limited to Civil Orders, Domestic Violence Protection Notices (DVPNs), Domestic Violence Protection Orders (DVPOs), Domestic Violence Disclosure Scheme (Clare's Law) etc?

890. DVPOs and other civil options present Agencies with a window of opportunity in order to maximise engagement with victims. They can create a 'safe space' for the victim as well as ensuring the risk posed by the perpetrator can be monitored. It is also recognised this can be a high-risk period of time for vulnerable victims, as preparators may feel they are losing control of the situation.

891. Partner Agencies can work better together, during the window of separation a DVPO, and other civil options, provide to engage with, and signpost, victims to specialist services.

892. As no disclosures of domestic abuse were made to STSFT staff during the time frame of this report, no statutory tools and powers were considered.

893. It is not known definitively whether Elizabeth explored any civil options, although given her long term protection of Sean, this is unlikely.

11. Where services and protection planning could not be delivered due to non-engagement of Elizabeth, were the reasons for non-engagement explored and what efforts were made to encourage engagement?

894. Elizabeth was consistently reluctant to engage with Professionals and explain what was happening within her home.

895. The benefit of professional curiosity is outlined previously within this review.

896. The rationale for Elizabeth declining referrals to services and/or not wanting to engage was not routinely collected by Partner Agencies involved in the review.

897. It can be challenging for Professionals to obtain this information, given the victim may be reluctant to offer any explanation. However, it is important Professionals use their experience, and judgement, and document any reasons as to why they think the victim may not be prepared to accept support.

898. The primary reason why Elizabeth's did not wish to engage with services appears to be to protect her son, but further information may have and identified if these were any other potential barriers for Elizabeth.

899. **Recommendation / Learning 16**

900. **All Agencies should look to implement mechanisms to routinely capture and share information on why victims decline access to Support Services.**

12. Were the correct referral pathways (including but not limited to MARAC) implemented in line with local policy, procedure, and guidance?

901. As commented on previously, Agencies considered the situation as standard risk and therefore there were no referrals to MARAC.

902. Opportunities to raise an ACN and refer Elizabeth for either Specialist Support around her alcohol abuse, or managing Sean's mental health, were not taken.

903. Given the lack of disclosures from Elizabeth and limited professional curiosity, STSFT did not make any referrals.

13. How effective was Inter-Agency working and interagency information sharing around addressing the risks that 'Sean' posed to 'Elizabeth'?

904. Government strategy recognises tackling domestic abuse is a cross-departmental and multi-agency responsibility.

905. A whole system Family and Agency approach should be adopted. No single Agency can tackle domestic abuse on their own and domestic abuse needs to be seen as everyone's business.

906. When Elizabeth was referred to MARAC, which took place on the 14th September 2016 there was clear evidence of interagency working and information sharing. This resulted in actions for Agencies to try and engage with Elizabeth and provide support.

907. When examining the other incidents within the DHR timeframe it appears when Police attended Elizabeth's home address on 27th May 2017 and the 31st October 2019 any consideration around interagency working was limited.

908. When Police attended on 25th August 2019 an ACN was raised and forwarded to MASH. However, the case was closed without any reference to other agencies.

909. When Police attended on 14th November 2019 a DASH was submitted. However, this was graded as standard risk and therefore there was no engagement with other Agencies.

910. STSFT did not make any other referrals to any other agencies. However, it is acknowledged that STSFT had not been in receipt of any disclosure from Elizabeth. Her expressed health needs were being met by STSFT.

911. Sunderland CCG will acknowledge a routine enquiry following the A&E attendees could have highlighted any concerns and offered an opportunity for a safe discussion as to what was happening at home.

912. The CCG also accept there could have been better inter agency working and communication between MARAC and the Practice and also more communication between WWiN and the Practice regarding any risk areas or concerns.

913. The CCG will suggest that the implications for services are, that closer involvement with voluntary and statutory sector are a positive and constructive way to sensitively deal with potential victims of domestic abuse.

914. Routine enquiry and direct enquiry should always be considered when red flags are evident i.e., MARAC referral or frequent attendee at A&E. This can be facilitated by specific training in practices for domestic abuse and specialist supervision for practice staff from domestic abuse leads.

915. The current Domestic Abuse Health advocate project facilitates training currently in 16 Sunderland practices and supports GP with routine enquiries, direct enquiries, referral to MARAC and also referral to early intervention services (WWIN). This is a positive programme.

916. We know information sharing, in line with the rules of consent and confidentiality, is essential to ensuring Agencies have access to relevant information, at the point of contact with victim and/or perpetrator, to be able to adequately support and protect. Risk is fluid and dynamic which means things can change very quickly; and without access to timely and accurately recorded information there is a risk Agencies do not see the full scope of the domestic abuse situation.

917. Sunderland's Multi-Agency MARAC procedure, Sunderland's Safeguarding Adults Multi-Agency policy and procedures, and the Safer Sunderland Partnership Information Sharing Protocol and guidance, would have been sufficient to prompt and allow for the sharing of relevant information across Agencies in this case.

918. However, there was limited information sharing across Agencies noted in this case.

919. The limited multi-agency working reduced opportunities for further informed assessment and greater consideration of the risk posed by Sean to Elizabeth.

Recommendation / Learning 17

920. **All Agencies should promote and provide specific training on co-working pathways to domestic abuse.**

14. Did Elizabeth's' workplace have any cause for concern that Elizabeth may be at risk from domestic abuse by her son?

921. **If so, did this result in any routine or selective enquiry, safety planning and/or risk management actions and what was the evidence of this?**

922. **If not, what were the reasons for this?**

923. **Did 'Elizabeth's' workplace have a domestic abuse workplace policy? If so, how were staff made aware of these policies.**

924. As stated, Elizabeth volunteered at a local Charity.

925. Elizabeth had volunteered at a local children's Charity on a part time basis since 1995. Elizabeth was a caring person and enjoyed her work.

926. Elizabeth enjoyed socialising with Friends and Colleagues from the Charity, having regular breakfast with them.

927. Elizabeth's Colleagues at work described her as 'friendly' but 'feisty'. Whilst she was a long-standing employee she was described as somewhat unreliable with frequent absences from work.

928. The Lead Person at the Charity stated she had been very close to Elizabeth and had supported her on a number of occasions to seek further support in the care of her son and management of his behaviours. She referenced a number of incidents where she had encouraged Elizabeth to talk to the Police about the situation at home, but Elizabeth refused saying 'he is my only son'.

929. A long-standing Colleague of Elizabeth reported she would often see her with bruising to her face, black eyes, or cuts to her hand. The Colleague reports Elizabeth would tell her the bruising was the result of falls when she suffered vertigo, when she fell over by accident or as a result of her mascara smudging. The Colleague reported she was sceptical of Elizabeth's explanations for all her accidental injuries and suspected her son, Sean might have caused the injuries.

930. Colleagues at the Charity describe Elizabeth as quite a private person who didn't talk about her family life openly. They also formed the impression Elizabeth may

have suffered with a drink problem, as they would often smell alcohol on her breath and her eyes were often red and bloodshot. Elizabeth would not turn up at the Charity drunk. It just appeared she was suffering the after-effects of drinking.

931. The Charity report between April 2018 and September of 2018, Elizabeth did not come into the Office. She told her Colleagues she had been unwell.

932. It is not unusual for Friends and Colleagues to reflect upon behaviours they had come to be regard as a 'normal', were in retrospect identified as concerning.

933. It is of note this coincides with Elizabeth attending hospital on 4 occasions during a 5-month period between May and October 2018.

934. The Department of Health and Safelives have published a 'Practical guidance for line managers, Human Resources and Employee Assistance Programmes'.

935. The document offers the following guidance to employers:

1. **Recognise the Signs:**

   Signs an Employee might be experiencing domestic abuse include:

   - Unexplained injuries
   - Decreased productivity
   - Frequent lateness or absence. Changes in behaviour

   These behaviours could reflect a range of issues and at the same time, potentially lead to disciplinary procedures. It is therefore important to establish what is behind them.

2. **Respond:**

   Understand it can be difficult for Employees to make a disclosure of domestic abuse, and your support is important:

   - Do be sensitive/non-judgemental/ practical/supportive/discrete.
   - Do prioritise safety over work efficiency.
   - Do allocate some private time and space to listen.
   - Do not seek proof of abuse.

   This guidance refers principally to women, but it applies equally to men. Research shows women are more likely to suffer more serious injury and ongoing assaults than men.

3. **Record:**

- Any written record, including any agreed workplace adjustments, should be held outside of official Employee records and stored securely.
- Disclosures should not impact on the Employee's work record, provided their performance is maintained as agreed.
- Any decision to disclose without consent (if a Colleague is at serious risk of injury or death) should be documented.
- All incidents of violence, threatening behaviour or breaches of security in the
  workplace should be recorded and retained for evidence purposes if required
- The record must be clear, accurate and include dates, times, locations, and any witnesses. Any breaches of orders, for example, non-molestation orders should also be noted

936. The Charity did not have a Domestic Abuse Workplace Policy in place at the time Elizabeth worked there. However, it is clear the Charity Lead was supportive of Elizabeth and did her best to try and encourage Elizabeth to seek Professional Support. It is also important to note all staff at the Charity had undertaken Safeguarding & DV training on offer from the Local Authority.

937. **Recommendation / Learning 18**

938. **The Safer Sunderland Partnership should promote 'Practical guidance for line managers, Human Resources and Employee Assistance Programmes'.**

15. Subject to Family, Friends, Neighbours, and Work Colleagues of 'Elizabeth' wanting to participate in the review, did they have any cause for concern 'Elizabeth' may be at risk from domestic abuse by her son? If so, were they aware of support services and how to seek advice and support?

939. Pamela is the primary point of contact for the family. Pamela was close to Elizabeth for many years, and Elizabeth would confide in her.

940. However, prior to her death, Pamela had far less contact with Elizabeth, and it is felt she became more isolated from her Family.

941. Elizabeth did socialise with Friends and Colleagues from work, but they describe her as a private person who was reluctant to disclose what may be happening at home.

942. Elizabeth had resided in the family home for many years, so presumably would have been well known to her Neighbours.

943. However, during the time frame of this DHR there is evidence of conflict with near Neighbours, with the police attending on a number of occasions.

944. One of the near Neighbours stated to Police 'In my opinion they (Elizabeth and Sean) had an argumentative relationship, and I could often hear them shouting at each other through the walls. When they do shout, I can tell there is a male and female voice and at times, if the voices are loud enough, I can make out what they are saying'.

945. Sean and Elizabeth stated to Police the Neighbours will have called as they were trying to get the council to move them.

946. Whilst it is accepted the Neighbours who called the Police, on different occasions, may have been primarily concerned with resolving any conflict, and the level of interaction Police had with Neighbours is not clear; their attendance may have presented opportunities to explore information Neighbours could potentially provide around Elizabeth's safety in her home.

947. I understand the partnership are planning to undertake a public awareness campaign with the support of WWiN.

948. The Sharp-Jeffs and Kelly, Standing Together Against Domestic Violence 2016 report specifically highlights the importance of raising awareness of third-party reporting of domestic abuse.

Recommendation / Learning 19.

949. **As part of the ongoing campaign to support victims of domestic abuse, the Safer Sunderland Partnership should specifically raise awareness about the importance of third-party reporting.**

950. **EFFECTIVE PRACTICE**

951. This DHR adopts a strengths-based approach and has identified the following effective practice. This was consistent with the partnership approach in wanting to recognise positive practice where it was appropriate to do so.

952. On the 30th July 2016 an IDVA attended the home address following a report Elizabeth was assaulted 6 weeks prior by Sean and Elizabeth had concerns about his mental health. The IDVA was sufficiently concerned to refer the case to WWiN

Outreach for a full assessment. The IDVA could have written off the case without further investigation and it is to their credit they used their professional judgement to identify this as a high risk case and escalate accordingly.

953. WWiN subsequently referred Elizabeth to MARAC as an urgent high-risk case. When Elizabeth was referred to MARAC, which took place on the 14th September 2016, there was clear evidence of interagency working and information sharing. This resulted in actions for Agencies to try to engage with Elizabeth and provide support.

954. WWiN followed up with safety planning, including telephone numbers for a Well-Being Clinic and the Crisis Team and offers of further support; close liaison was also evident with the Police and protective measures were offered. Despite the fact Elizabeth declined support, this represents effective practice.

955. It is positive by applying the NDM and THRIVE, Northumbria Police directed Officer(s) should attend Elizabeth and Sean's home address to each of the incidents reported to them within the scoping period. This would indicate there was the appropriate identification of risk during the initial handling of the calls.

956. On the 25th August 2019 it is credit to the Officer(s) who attended the incident, as despite the reluctance of Elizabeth to disclose anything, they were sufficiently concerned to submit an ACN to the MASH for triage and review.

957. On the 14th November 2019 it is credit to the Officer(s) who attended the incident, as despite the reluctance of Elizabeth to disclose anything they were sufficiently concerned to submit a DASH to the MASH for triage and review.

958. It is clear the Charity Lead was supportive and tried to encourage Elizabeth to seek professional support.

959. It is also important to acknowledge the courageous actions of Elizabeth's Work Colleagues who were sufficiently concerned around her welfare to repeatedly try and contact Elizabeth when she failed to attend work, and ultimately called the Police.

960. Sunderland CCG had consistent involvement in Elizabeth's health care as required and made a determined attempt to reach full diagnosis for her chronic health conditions. Elizabeth clearly felt able to discuss her health concerns and was also supported for smoking cessation.

961. There was no referrals made to other agencies as STSFT had not been in receipt of any disclosure. Her expressed health needs were being met by STSFT.

IMPROVEMENT ACTIVITY

The following improvement activity undertaken during the scoping period has been identified by the agencies involved in this DHR.

Northumbria Police

Northumbria Police are an organisation of learning and make continual improvements in their response to domestic abuse. Since 2016 they have committed to a series of training and initiatives as detailed as follows:

Raising Investigation Standards (RIS) 4 part programme addressing the response to, and investigation of domestic abuse 2018
DA Civil and Family proceedings x 3 2019
DA Investigation Procedure Changes 2020
Stalking and Harassment series of webinars 2017
Through the Eyes of a Child video 2018/9
Implementation of DA Tool Kit 2018
DVPN/O Awareness raising 2019
SPO Implementation 2020
Implementation of Domestic Abuse champions 2021
In 2022 Northumbria Police have planned further training including wider vulnerability training, coercive control, stalking & harassment refresher training and the implementation of CPV

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

From 2016 STSFT have continued to strive towards continually improving Domestic Abuse Support Services. This includes the employment of Hospital IDVA and DAHA, engagement with MARAC process and involvement with Sunderland Domestic Violence Partnership (SDVP) and Domestic Abuse Partnership Group.

The following guidelines were also produced during this timeframe:

- Identifying and Responding to a Patient Disclosure of Domestic Abuse Guidelines 2018

- Employee Domestic Abuse Guidelines 2018

STSFT staff are encouraged to attend both internal and external training in relation to domestic abuse. All levels of Safeguarding mandatory training also include a

section relating to domestic abuse as per the Intercollegiate Document adults (2018) and Children (2019).

980. STSFT also engages in national campaigns such as the White Ribbon campaign, this includes awareness raising posters and leaflets and work closely with partner agencies to support community related campaigns, media publication.

981. STSFT Safeguarding Adults team work collaboratively with STSFT Safeguarding Children's team and DAHA, which and are all co-located. This close Team working enables a 'Think Family' approach, which in turn can highlight domestic abuse and ensure appropriate support is facilitated.

982. The Safeguarding Team liaise with Domestic Abuse Support Services such as Wearside Women in Need, Impact Family Services and Harbour. WWiN had only two IDVA's responding to the whole of Sunderland; they now have a Team of eleven Outreach staff covering the work. These services are part of a national network of providers working together to ensure safe spaces for families in need.

983. The Safeguarding Team, IDVA and DAHA attend daily (Monday to Friday) 'ED huddle' in order to support staff who are in receipt of a disclosure of domestic abuse. The Team also provides advice, support, and supervision to all STSFT staff.

984. The DA employee guidance and the DAHA both provide the Trust with additional support, not just for patients but for staff who may be a victim of DA. The DAHA links in with Human Resources and Occupational health in relation to cases whereby DA is a feature. The DAHA attends MARAC and if any cases are related to staff either as a victim of perpetrator these are raise with HR.

985. **Sunderland Clinical Commissioning Group (CCG)**

986. The CCG is currently funding and supporting the Domestic Abuse health advocate project which promotes DA training in practices, domestic abuse champions and also supports practice staff with referrals and routine enquiry. This project is recognised as instrumental to achieving positive outcomes for DV victims and needs to be in place for all surgeries.

987. There is currently a business plan in CCG to request further funding to achieve roll out to all surgeries by March 2022. This is being monitored by a rolling audit plan and outcomes reports from WWIN.

988. These actions should bring about increased referrals and routine enquiries in GP practices across Sunderland and promote domestic abuse advice, training, and support for practice staff. This could then lead to safer outcomes and early identification of domestic abuse in more cases.

989. **Wearside Women in Need (WWiN) Domestic Abuse Service Sunderland**

990. WWiN will say Elizabeth was in effect given the responsibility of managing the perpetrator's behaviour which she was clearly unable to do. Sean appears to have had significant needs of his own which were highlighted by Elizabeth and remained unaddressed. The Multi-Agency approach needs to clearly state the actions being taken to manage the known needs and risk perpetrators pose.

991. WWiN recognise Neighbours may well have had a better understanding of the seriousness and frequency of events; and may be in a position to help Professionals understand the full picture and assess the risk.

992. However, there is no pathway for this information to be shared within the risk management process. WWiN are in the process of developing a Family, Friends and Community response to domestic abuse and would welcome the opportunity to discuss ideas/options to take forward through this scheme.

993. There are lessons for WWiN in terms of 'sitting' on high-risk cases and waiting for an opportunity to re-engage (via another referral); though at the time of this incident, WWiN had only two IDVA's responding to the whole of Sunderland, they now have a team of eleven Outreach Staff covering work.

994. WWiN also now have a community-based perpetrator programme, which was not available during the scoping period which can respond to non-court mandated / non-statutory duty cases.

995. **CONCLUSION**

996. It is clear Elizabeth had a difficult life. She suffered the loss of her husband at a relatively young age and was left to bring Sean up alone.

997. Sean presented challenges to his mother from a young age. Over many years he was violent and abusive towards Elizabeth.

998. It would appear over time Sean's mental health deteriorated, and his misuse of alcohol increased, resulting in extreme violence and abusive behaviour in turn causing his mother significant distress and harm.

999. It would appear Elizabeth's health and well-being deteriorated, and she became increasingly isolated from family and friends. Elizabeth appeared to use alcohol as a coping mechanism.

1000. The presentation is dichotomous at all levels; Elizabeth presented as fearful but protective of Sean, at risk and at times posing a risk to herself and others through

alcohol misuse, help seeking but declining help for herself in the pursuance of help for her son; which may have engaged her in an effective support plan and managed the risk.

1001. Elizabeth's and Sean's contact with Agencies and Professionals was inconsistent over time.

1002. There is some limited evidence of Elizabeth engaging with Agencies. However, on other on other occasions she elected not to. This is understandable given her desire to protect her son from the criminal justice system.

1003. There were some missed opportunities from Agencies involved with Elizabeth to utilise a higher degree of professional curiosity to help enquire about, challenge and elicit pertinent information to identify underlying risk issues she may have been experiencing in terms of domestic abuse. In most interactions with Elizabeth, Professionals focused their efforts on her presenting need, and further enquiry could have been undertaken to consider possible indicators of abuse and the interplay between multiple presenting factors (e.g. injuries, depression and anxiety, alcohol use etc).

1004. With a small number of exceptions, the presenting information appears to have been accepted at face value by Professionals without any evidence of them trying to clarify, or confirm, if said action had taken place.

1005. As a consequence, there were missed opportunities to signpost Elizabeth (and Sean) to relevant Support Services.

1006. It is clear a number of Agencies did not have a full awareness, or understanding, of the inter-family violence taking place between Elizabeth and Sean.

1007. The escalation of risk was not consistently identified by Agencies. As a consequence, information was not always shared and the opportunity for multi-agency working was not optimised.

1008. Professionals, even when acting as part of a joint team, need to be aware of the necessity to make appropriate referrals to allow consideration of further actions and notifications to be made to other parties.

1009. The importance of Agencies communicating internally and with each other, ensuring they 'join the dots' and make multi-agency decisions on the most accurate, timely and complete information, cannot be overstated.

1010. Had the concerns been viewed holistically there was information, either known or available, which should have given rise to a view significant harm was at least likely.

1011. A better understanding of the circumstances which Elizabeth and Sean were living in may have prompted Agencies to adopt a more coherent response.

1012. In undertaking this review there were some examples of good practice including the IDVA referring the case to MARAC and the victim follow up from WWiN. Further, Northumbria Police attended all of the reported incidents during the scoping period and one occasion submitted a DASH risk assessment. On another occasion, they submitted an Adult Concern Notification.

1013. However, whilst taking into account the complex circumstances and the lack of engagement by Elizabeth, I would suggest professional practice was on a number of occasions reactive, rather than a proactive holistic response to the risks presented by Sean towards Elizabeth.

1014. It could be viewed Elizabeth was effectively left to manage Sean on her own, when, due to her own vulnerabilities, she was not in a position to do so.

1015. This DHR has identified a range of learning opportunities for Agencies and Professionals in supporting vulnerable people who are subject of adult family violence.

1016. The learning includes recognising domestic abuse involving a mother and son, the importance of multi-agency working, information sharing, professional curiosity, risk assessments, and the signposting specialist alcohol and drug support.

1017. There are a number of strategic considerations which the Partnership are invited to consider:

- Do services or procedures need to be more focussed on engagement with people?

- Are there discussions with people, about the outcomes they want, embedded in key processes at the beginning, middle and end of the process, so the service and procedures drive engagement with people?

- How are Agencies addressing workforce development issues required to ensure people are skilled, and competent, in having difficult conversations with individuals at risk of harm or abuse?

- Are Professionals equipped to work with families, and networks, to negotiate outcomes and seek resolution?

- Do professionals have skills, knowledge, and permission to use the full range of legal and social work interventions needed?

1018. A DHR triggered by a murder is by nature a reactive activity.

1019. A standard question to consider as part of any DHR is whether or not the person's death could have been avoided had Agencies done more.

1020. Whilst the review acknowledges there are some examples of good practice, it has also highlighted there were some missed opportunities to support and safeguard Elizabeth. That is not to say, the murder would have been prevented, but more professional curiosity, better information sharing, and enhanced multi-agency working may have helped to reduce the risk.

1021. The murder of Elizabeth by her own son is a real tragedy for the family. There are lessons to be learned from these sad events. These lessons which may help avoid similar distress for others in the future.

1022. The findings of this DHR provides an opportunity for Agencies individually, and collectively, to consider their response in light of the learning and recommendations, in order to make the future safer for others.

1023. A critique of DHR's over time will identify, despite the commitment of Agencies and Professionals to safeguard the most vulnerable, much of the learning in this review are repeated themes.

1024. Creating transformational and sustainable change is a significant challenge for Community Safety Partnerships. The relevant learning and recommendations from this DHR should be disseminated and monitored to support this change.

1025. **LESSONS TO BE LEARNED**

1026. **RECOMMENDATIONS / LEARNING**

1027. **Learning Recommendation 1**

1028. **Where a victim elects not to support a prosecution Northumbria Police should specifically record how and why the victim was feeling at the time, whether the decision not to support the prosecution was influenced by fear of the perpetrator and / or for other reasons together with any protective support offered to the victim.**

1029. **Learning Recommendation 2**

1030. **Professionals within the MASH should ensure sufficient weight is placed on any history between the victim and perpetrator of domestic abuse, together with the account provided by the attending Police officers when undertaking the screening – triage process. This will ensure all of the potential risks have been considered before closing a case with no further action.**

1031. **Recommendation / Learning 3**

All Agencies should recognise the importance of Multi-Agency working and follow agreed protocols around information sharing in order to assess and inform risk.

1032. **Recommendation / Learning 4**

1033. **All Agencies to disseminate to Professionals the Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) guidance, as part of their professional development strategies.**

1034. **Recommendation / Learning 5**

1035. **All Agencies should continue to build upon the training to date and support Professionals around identifying and supporting victims who may be subject of coercive control.**

1036. **Recommendation / Learning 6**

1037. **The Safer Sunderland Partnership should ensure an all age multi-agency suicide prevention plan is in place. Agencies should ensure training and guidance is provided to Professionals around preventing suicide.**

1038. **Recommendation / Learning 7**

1039. **All, All Professionals, who are likely to come into contact with victims and perpetrators, should be trained in carrying out risk identification and assessment.**

1040. **Recommendation / Learning 8**

1041. **All Agencies should consider routinely submitting a DASH and / or an ACN risk assessment where domestic violence or abuse be identified or suspected, including inter-family violence.**

1042. **Recommendation / Learning 9**

1043. **MASH Professionals should ensure the history between victim and perpetrator are fully considered in assessing risk and making a referral.**

1044. **Recommendation / Learning 10**

1045. **Northumbria Police Neighbourhood Policing Teams should give further consideration to conducting further in-depth research in order to understand the victim and perpetrator, and their complex issues and consider a problem-solving approach in complex cases such as this.**

1046. **Recommendation / Learning 11**

1047. **Where a number of incidents are reported within a short time frame, Northumbria Police and Partner Agencies should ensure any review process specifically examines whether risk is escalating, and interventions are required.**

1048. **Recommendation / Learning 12**

1049. **All Agencies should give consideration to reviewing MARAC cases where the victim has disengaged, or never engaged, where there is potential for escalating risk.**

1050. **Recommendation / Learning 13**

1051. **The Safer Sunderland Partnership should give consideration to the MARAC demand and the capacity of agencies to manage high risk domestic abuse referrals.**

1052. **Recommendation / Learning 14**

1053. **ICB should ensure that any referral to MARAC should be followed up with further exploration of the issues and the offer of safeguarding support for the victim of domestic abuse.**

1054. **Recommendation / Learning 15**

1055. **ICB should ensure that any frequent attendance at A&E for a similar complaint should be treated as a 'red flag' inviting further exploration and engagement with other agencies around potential domestic abuse.**

1056. **Recommendation / Learning 16**

1057. **STSFT and ICB should routinely use professional curiosity where a person frequently presents with injury that may have been as a result of domestic violence or abuse.**

1058. **Recommendation / Learning 17**

1059. **All Agencies should give consideration to building upon the training to date and improve awareness and understand around the importance of Multi-Agency information sharing in order to promote co-working pathways and holistic responses to domestic abuse.**

1060. **Recommendation / Learning 18**

1061. **As part of the ongoing campaign to support victims of domestic abuse, the Safer Sunderland Partnership should specifically raise awareness about the importance of third-party reporting.**

1062. **SINGLE AGENCY LESSONS TO BE LEARNED**

1063. Single agency learning.

1064. The following learning has been identified by each of the agencies involved in this DHR.

1065. **Northumbria Police**

- Northumbria Police recognise static risk factors must be seen as a constant throughout the DASH risk assessment. This will enable Officers and Professionals from other Agencies to be as informed as possible when assessing risk. Static risk factors are those factors that, once present, should remain present on all subsequent DASH risk assessments, if the victim/perpetrator remain the same. An example of this is 'previous choke or strangle' - once this has been identified this information should always be present in any subsequent DASH. The current Northumbria Police system requires the Officer completing the DASH to research previous incidents, and

then to manually enter the identified risk factors based on the victims answers. This can mean these 'static risk factors' can be missed, and do not, therefore, contribute to the overall risk assessment. The current Northumbria Police computer system is due for replacement (work currently ongoing) and therefore a computer fix for this is deemed unrealistic. Police are also awaiting the College of Policing's new DASH model which would also make any work and changes to the current system redundant.

- Home Office to be asked to consider a statutory provision for compliance with alcohol treatment - When there is an established link to domestic abuse, and the following points were present to run in conjunction with DVPNs/DVPOs:

    - Alcohol was an ever present in the majority of incidents
    - Ongoing interventions were having no impact
    - Criminal law was not effective (through lack of engagement). Incidents were escalating
    - Significant impact on police resources
    - Significant impact on the Community based on hearsay statements. Taken as part of the Civil Injunction Investigation

1066. Presently this type of behaviour is dealt with by means of Civil Injunction (which any Agency can apply for) Sections 1 to 21 of the Anti-social Behaviour, Crime and Policing Act 2014, applied for as it does not require a criminal conviction and is based on a lower standard of proof, balance of probabilities as opposed to beyond reasonable doubt.

1067. This has previously been recognised as a national recommendation in previous DHRs. A response is awaited.

1068. There have been a number of DHRs within the Northumbria Police area where alcohol has been an identified major factor involved in domestic related incidents.

1069. **South Tyneside and Sunderland NHS Foundation Trust (STSFT)**

1070. As a result of this DHR, an audit of STSFT compliance to the Safeguarding Adult Policy will be undertaken. This will seek to provide some reassurance vulnerable victims are appropriately identified and supported.

1071. **Wearside Women in Need (WWiN) Domestic Abuse Service Sunderland**

1072. WWiN have identified the following missed opportunities during this DHR:

- No comprehensive assessment of family history
- No actions to manage the perpetrator instigated
- No follow through after 3 months
- No MARAC review system in place for this case as no further reports.
- Elizabeth declined all support but had attended an assessment, which suggests there was an opportunity to work with her. The reasons were explored with Elizabeth who stated she couldn't "see him on the street" and Elizabeth asking for help for Sean, not for herself - a Safeguarding Adults referral could have been made?
- Alcohol related Neighbour disputes at the address could have been shared and/or brought the case back to MARAC or WWiN for further exploration
- Workplace not explored as not detailed in WWiN's records (may not have been in place at that time).
- WWiN will review their policy on non-engaging MARAC cases and will seek a pathway back to the MARAC for Partnership support. WWiN will also request the information sharing agreement for high-risk cases, subject to MARAC, be a more recognised pathway to enable a comprehensive assessment to be undertaken. The current model appears reliant on Police information only which leaves the responsibility (outside of the meeting) between Police and WWiN.

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THE END