North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of 'Dianne'

September 2018

Report Author: Mike Cane

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Contents

Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This Domestic Homicide Review was commissioned by the North Yorkshire Community Safety Partnership on 29th October 2018 following notification of the facts by North Yorkshire Police.
'Dianne' was killed in September 2018. Dianne is the victim's real name and will be used throughout this review. It is unusual to use a victim's name, but this is not without precedent. Dianne's family feel strongly that they would like her to be remembered and made a specific request to use her real name.

1.1.2 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the North Yorkshire Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and tackling organised crime. He has extensive experience both as an author and panel member for Domestic Homicide Reviews and is a former member of Teesside's Safeguarding Vulnerable Adult Board, the Domestic Abuse Strategic Partnerships and the Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across Teesside for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

1.1.3 This overview report will examine life 'through the eyes of the victim.' The purpose of the review is not to judge 'Dianne' but to better understand her circumstances, so we may appreciate how or why she made certain decisions. It is also important to understand the involvement of several agencies in this case, to examine the professional's perspective within that context and to avoid hindsight bias. This will ensure that any learning is captured and acted upon.

1.1.4 The death of any person in these circumstances is a tragedy and the family are still coming to terms with their loss. Dianne's family have been consulted during the review process and their views are reflected in this document. The overview report author is grateful for their contribution and the information obtained during these discussions. The family are of course still grieving, and we extend our deepest condolences to them for their tragic loss.

1.1.5 The following agencies / organisations / voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) have been requested and supplied. Following careful

consideration by the Review Chair and Panel, it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author. The following organisations were required to produce an Individual Management Review:

1.1.6

- North Yorkshire Police
- NHS Scarborough and Ryedale Clinical Commissioning Group (victim's and perpetrator's GP)
- Independent Domestic Abuse Service (IDAS)
- Scarborough Borough Council (Customer First, Housing and Community Impact teams)
- North Yorkshire County Council Health and Adult Services.

1.2 The Review Panel

1.2.1 The Chair of the Review Panel is Mr Steven Hume, Community Safety and Security Manager with Stockton-On-Tees Borough Council. Steven is independent of the organisations and agencies contributing to the review. He had no prior knowledge or contact with the victim, the perpetrator or their wider families. Steven brings his experience as a Community Safety Manager but maintains his complete independence in this matter.

1.2.2 The Domestic Homicide Review panel is comprised of the following people:

- Steven Hume – Community Safety and Security Manager, Stockton-on-Tees Borough Council and appointed Independent Chair
- Odette Robson – Head of Safer Communities, North Yorkshire County Council
- Detective Superintendent Allan Harder –North Yorkshire Police
- Olwen Fisher- Designated Professional Adult Safeguarding, NHS Scarborough and Ryedale CCG
- Christine Appleyard- Head of Practice, Personalisation and Safeguarding, North Yorkshire County Council Health and Adult Services

- Chris Davies – Head of client services IDAS (Independent Domestic Abuse Services) North Yorkshire and York
- Shan Thistleton, Senior Audit Officer, Scarborough Borough Council
- Nicola Cowley, Named Nurse for Safeguarding Adults, York Teaching Hospital NHS Foundation Trust.
- Mike Cane – Independent Author and Safeguarding Consultant

1.3 Reason for conducting the review

1.3.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself."

1.3.2 For this review, the term domestic abuse is in accordance with the agreed cross-government definition of domestic abuse:

"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 family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*
- *Coercive control*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim."

1.3.3 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

1.4 Purpose of the review

1.4.1 The North Yorkshire Community Safety Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

1.4.2 The statutory guidance states the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- To establish whether the events leading up to the homicide could have been predicted or prevented.

1.5 Timescales

1.5.1 Following the decision to conduct a review, an Independent Chair and Author were appointed. The first Domestic Homicide Review Panel was convened on 30th

November 2018 where terms of reference were agreed. The review made good progress in reviewing the circumstances of the case. There were no significant delays and the final overview report was presented to the North Yorkshire Community Safety Partnership on 6th September 2019.

1.5.2 A comprehensive action plan was drafted and then the documents forwarded to the Home Office. There was a significant delay (over nine months) in the Home Office Quality Assurance Panel meeting to review the report. Part of this delay can be attributed to the Covid 19 pandemic. This has delayed publication. However, in the interim, the North Yorkshire Community Safety Partnership has progressed the identified learning through their action plan.

1.6 Confidentiality

1.6.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

1.6.2 The subject of this review is the victim; 'Dianne'. This is her real name. On the date of her death she was 70 years old.

1.6.3 The perpetrator is identified as the pseudonym 'Margaret'. She is the long-term partner of Dianne and was 65 years old at the time of the murder.

1.6.4 Any relevant addresses will be referred to only in general terms to protect the anonymity of those involved.

1.6.5 It is standard practice to protect the identities of individuals involved in a DHR by using pseudonyms within the overview report. However, Dianne's family have specifically requested that her real name is used throughout the document. Dianne's experiences will be used to improve services for vulnerable people at risk of harm. The Domestic Homicide Review panel carefully considered whether to use Dianne's name and considered the following factors:

- The stipulations set out within the national statutory guidance for the conduct of DHRs
- The impact on Dianne's family, friends and professionals who were involved with Dianne in the lead up to her death
- The potential identification of the perpetrator

- The potential for Dianne to be identified, regardless of whether the report was anonymised
- There have been previous DHRs published using a victim's real name for good reason (i.e. a precedent had been set).

When considering these factors, the panel noted the statutory guidance states:

" The benefits of involving family, friends and other support networks include….(g) Enabling families to choose, if they wish, to use a pseudonym for the victim to be used in the report. Choosing a name rather than using initials, letters or numbers, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports outline where families have declined the use of a pseudonym."

The panel discussions also included that the murder took place in a very small community on the East Coast of North Yorkshire where the victim and perpetrator were well known within that community. The murder and subsequent trial were reported in the local media.

1.6.6 The victim Dianne and the perpetrator Margaret were both British nationals. They had been together for over 30 years. It is unclear how long this was as 'friends' but it is confirmed that for a significant period of their relationship they were intimate partners. They had lived in several parts of the UK, including Buckinghamshire and Leeds before settling in North Yorkshire about six or seven years ago. They moved into the current property approximately three years ago.

1.7 Terms of Reference

1.7.1 The following terms of reference were agreed by the Review panel with regards to the murder of Dianne:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for domestic abuse, stalking and harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of the victim and perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally

accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

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

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

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options / choices to make informed decisions? Were they signposted to other agencies?

- Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Were senior managers of the agencies and professionals involved at the appropriate points?

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- Did any staff make use of available training?

- Did any restructuring during the period under review have any impact on the quality of service delivered?

- How accessible were services for the victim and perpetrator?

1.8 Parallel Reviews

1.8.1 The inquest was opened and adjourned during the criminal trial process.

1.8.2 There were no other parallel reviews applicable to this case.

Section 2: The Facts

2.1 Case specific background

2.1.1 The victim, Dianne, was born in 1948 and was 70 years old at the time of her death. She had several jobs including working as a nurse, a care worker, a bookkeeper and running a public house. She had lived with Margaret for around 30 years. Dianne has an adult daughter from an earlier relationship. It is unclear how Dianne and Margaret first met but it was probably through mutual friends in the Leeds area. They became friends and later were intimate partners. In recent years, Dianne had become frailer and more immobile due to an operation that had not gone well.

2.1.2 The perpetrator, Margaret, was born in 1953 and was 65 years old at the time of the murder. She has previously worked as a cleaning supervisor, running a public house and as a bus driver. She had two adult children from an earlier relationship. Margaret has a conviction in 1992 for an assault on Dianne's adult daughter. This was for assault occasioning actual bodily harm and occurred when the couple lived in Milton Keynes. Margaret was given a conditional discharge and ordered to pay compensation and a fine.

2.1.3 Both Margaret and Dianne received a police 'caution' in 2005 for an assault in a car park in West Yorkshire. There are no further details available relating to this incident. Dianne's daughter recalls it was related to another motorist obstructing her mum's car.

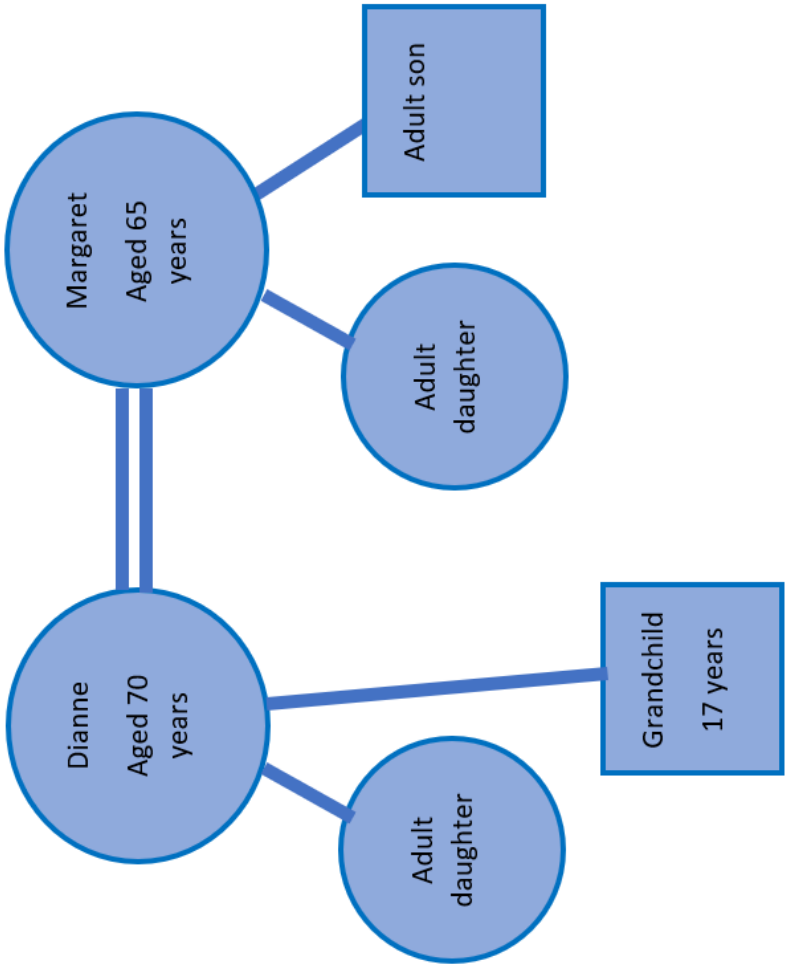
2.1.4 Dianne reported several incidents of domestic abuse perpetrated by Margaret over many years. In addition to the assault in Milton Keynes in 1992, there were further incidents reported during their stay in North Yorkshire from 2012. We also know that Dianne spent some time in a women's refuge in Scarborough in May 2009. Unfortunately, the records relating to her stay have been destroyed so we cannot confirm the circumstances that led to her staying there for one week. (North Yorkshire Police did not have any involvement with the couple at that time).There was also an incident where an allegation was made by Margaret that she had been assaulted and threatened by Dianne.

2.1.5 Several agencies had contact with Dianne and Margaret. This was within the context of an abusive relationship. Although their case was never listed at MARAC (the Multi-Agency Risk Assessment Conference which manages the highest risk cases of domestic abuse), they were assessed, and interventions took place. They were also discussed at other multi-agency settings (e.g. the 'Community Impact Tasking meeting').

2.1.6 Both Dianne and Margaret suffered from poor health and were regular attendees to their GP practice and to other medical services. In January 2017, Dianne underwent a procedure which involved an operation on her left leg. This was a *femoro-popliteal bypass (Surgery that reverts the hardening of arteries).* The operation had complications which meant a deterioration in her health and thus more reliance on her partner, Margaret.

2.1.7 On 2nd September 2018 a '999' call was received by North Yorkshire Police. Margaret stated she believed she had killed her partner, Dianne. Officers attended the couple's home address and found Dianne's body. Margaret was arrested and charged with Dianne's murder. A post-mortem examination gave the cause of Dianne's death as manual strangulation. She also had bruising to her head, face and neck plus other bruising on her arms and torso.

2.1.8 On 8th April 2019 Margaret appeared at Leeds Crown Court. She denied murder and admitted manslaughter by diminished responsibility, which prosecutors at Leeds Crown Court accepted. Margaret appeared back in court on the 9th April 2019, when her sentence was adjourned for probation and psychiatric reports. On the 3rd May 2019, Margaret was sentenced to eight years imprisonment.


Margaret
Aged 65
years
Adult son
Adult
daughter
Dianne
Aged 70
years
Grandchild
17 years
Adult
daughter

2.3 The Individual Management Reviews

2.3.1 There were five Individual Management Reviews completed as part of the Domestic Homicide Review. In addition, there were supplementary reports from other agencies who had minimal contact with Dianne or Margaret, plus reports giving some historical perspective.

2.3.2 NORTH YORKSHIRE POLICE

- The first contact with North Yorkshire Police was on 1st January 2012. At 10.43pm; Dianne used the '999' system to report she had been assaulted by Margaret at their home address. Dianne had left the property and rang police from a neighbour's house. When officers arrived, they noted Dianne's head injury and obtained a written statement from her. Margaret had left and could not be immediately located. Dianne's statement included details that Margaret had grabbed her by the throat, pushed her to the floor, climbed on top of her and banged her head on the floor three times. Margaret then grabbed her by the throat again and made threats to kill her. Dianne believed these threats. The incident was assessed by the attending officer as 'medium risk' using the approved risk assessment (DASH) method. Dianne's injuries were photographed. Attempts to trace Margaret during the night were unsuccessful.
- At 9.00am the following morning, an officer visited Dianne who now stated she no longer wanted any police involvement and did not want Margaret arresting for the assault. Margaret attended a police station that afternoon for a voluntary interview. She denied the assault and told officers that Dianne had been violent towards her and that she had restrained her. Margaret did not wish to make any counter allegations against Dianne. Police took no further action in relation to any criminal matters.
- This incident was reviewed by a specialist Domestic Abuse Officer on 6th January. This member of staff reviewed the risk assessment and reduced it to a 'standard risk.' They decided there was no defined victim or perpetrator in this case. There was also supplementary information available relating to a relationship history of 22 years where Dianne stated Margaret had assaulted her on five previous occasions; the last time being ten years ago when they lived in Buckinghamshire. The assessment and action will be subject to further comment in the analysis section of this overview report.
- The next contact with North Yorkshire Police was six weeks later on 15th February 2012. Dianne reported Margaret had 'chased her around the pub and threatened her' earlier that afternoon. There had been an argument relating to use and location of a car. Dianne told police she did not believe Margaret would carry out the threats and also that she did not feel at immediate risk as she did not believe Margaret would return to the pub.

- An officer attended the home address that evening and spoke with Dianne and Margaret. They stated they had recently separated, and both were 'taking this badly.' They stated they no longer lived together and did not intend to resume their relationship. The officer determined that no offences had been disclosed. A risk assessment was completed, and the incident was assessed as 'standard' risk using the recognised DASH model. It is not clear from the documentation whether Dianne and Margaret were spoken to separately by the police officer. The incident was reviewed 22 days later by a specialist Domestic Abuse Officer. The 'standard' risk assessment was ratified, and a marker added to police systems to reflect this. The DASH assessment report differed significantly from the previous incident six weeks earlier. Further comment will be made on this in the analysis section of this overview report.
- On 28th February (two weeks after the incident in the public house) Dianne attended the police station to report that Margaret had fraudulently insured her car on Dianne's insurance policy. A police officer obtained a statement from Dianne and began enquiries. However, on 12th March Dianne contacted police to withdraw the allegation made against Margaret. The officer dealing with the case spoke with Dianne who confirmed to the officer that she and Margaret had resumed their relationship and so no offences had taken place. No further action was taken by police. There had clearly been some form of disagreement and the relationship had resumed but the officer did not complete a domestic abuse risk assessment. This meant there were no further interventions by specialist officers.
- On 8th March 2012, Dianne rang police reporting she had been harassed by Margaret over the previous three weeks and she believed Margaret had put a screw in her car tyre. She also stated Margaret had been following her and sending her abusive messages. An officer spoke with both Dianne and Margaret and a statement was taken the same day from Dianne. In addition, a crime scene investigator swabbed what appeared to be blood near the wheel of the car. The officer took no action in relation to the harassment allegations. This included not submitting a domestic abuse risk assessment. Therefore, there were no follow-up actions. A few days later, Dianne contacted police to withdraw the allegation about the car tyre. No further action was then taken in relation to criminal damage or harassment. This incident suggested an escalation in behaviour, including stalking. Further comment will be made in the analysis section relating to this missed opportunity.
- There were no further incidents between Dianne and Margaret reported to North Yorkshire Police for over five years. The next incident reported to police was on 9th June 2017. Margaret rang North Yorkshire Police Control Room at 2.07am to report Dianne had threatened her with a rolling pin and assaulted her. Margaret told police it was not the first time she had been assaulted. During this incident, Margaret described how they had argued in relation to a missing bank card which she believed Dianne had taken from her. She said she had taken Dianne's mobile phone and tablet in retaliation. Margaret stated Dianne had banged on her bedroom door with a rolling pin. Margaret removed this from her, and Dianne had assaulted her on the bed by grabbing her leg and punching her to the face and chest. Small bruises were

later photographed on Margaret's chest and arm. Dianne was arrested and interviewed. She denied the allegation of assault and stated it was a difficult relationship and that Margaret was a bully. Dianne said she had tried to end the relationship several times, but that Margaret convinced her to return home. She told police she wanted to 'break free from her.' Dianne did admit banging on the door with the rolling pin but denied assaulting Margaret. She was released from custody later that day as officers assessed the evidential threshold for a prosecution had not been met. The incident was assessed by a Domestic Abuse Officer who agreed with the attending officer's assessment that this was a 'standard' risk domestic abuse incident.

- A full year elapsed before the next incident was reported to North Yorkshire Police. On 6th June 2018 Dianne rang '999' to report Margaret being aggressive – shouting and swearing at her and that she was afraid. She confirmed that no physical assault had taken place. A police officer attended the address and spoke with Dianne and Margaret separately. There appeared to have been an altercation over possession of some car keys. The officer described Dianne as being heavily under the influence of alcohol and particularly difficult to deal with. The DASH risk assessment was completed which assessed the incident as 'standard' risk.
- There was a further call from Dianne to North Yorkshire Police a week later on 14th June, but this appears to be a request for advice about the car keys linked to the earlier incident.
- Although not attended as specific incidents, North Yorkshire Police did attend several 'Community Impact Team tasking meetings' relating to Margaret and Dianne. These are multi-agency forums and will be considered separately to the North Yorkshire Police IMR.
- On 2nd September 2018, North Yorkshire Police received a '999' call from a female stating she believed she had killed her partner. Officers attended an address and Dianne was found dead at the scene. Margaret was arrested at the premises and was later charged with Dianne's murder.

2.3.3 NHS SCARBOROUGH AND RYEDALE CLINICAL COMMISSIONING GROUP (GP PRACTICE FOR VICTIM AND PERPETRATOR).

As Dianne and Margaret shared the same GP Practice, separate IMRs have been submitted to focus on each and their own involvement and contact.

GP – DIANNE

- Dianne was a regular attendee at her GP surgery. The GP record shows Margaret as Dianne's partner and next of kin. During the period of this review, Dianne had around 70 contacts with the surgery (appointments or reviews).

- On 6th January 2012 Dianne had an appointment with her GP. She stated she had been beaten by her female partner a few days earlier. She also disclosed this was not the first time and that it had happened four times over the past 20 years. The notes state that police had been informed and that Dianne had dropped the charges. However, Dianne had taken time to reconsider and now intended to approach the police and file charges. The doctor noted some old, healing bruises to Dianne's upper back, right jaw and both forearms. Although there are some elements that demonstrate the GP has looked at mitigation of risk (e.g. Dianne has a supportive daughter, she and Margaret are no longer living together, and she is cancelling a planned holiday) there was no formal recognised risk assessment undertaken.

- Dianne attended the GP surgery a couple of weeks later on 23rd January. She reported that she did not go to the police after her last appointment. She was also going on holiday with Margaret as they would not be able to claim back the payment. She did tell the GP that she had separated from her partner. The GP continued Dianne with a course of anti-depressants, which had started two months earlier, following the death of Dianne's dogs and her low mood symptoms. Although the updated information was Dianne had not been back to the police and she was going on holiday with Margaret, there was still no formal risk assessment undertaken nor any referral to other support agencies.

- A month later, on 24th February Dianne re-attended her GP surgery. She had returned from holiday. She was feeling low but not suicidal. She stated she had not seen her ex-partner since the holiday. Further anti-depressants were prescribed.

- Dianne attended over 60 other appointments or received District Nursing home visits between February 2012 and July 2018. None of these related to domestic abuse. The appointments were for a variety of medical issues which will not be reviewed in further detail during this report in order to respect Dianne's privacy.

- On 18th July 2018 Dianne attended her GP and reported she was suffering stress at home. She had split from her partner of 30 years. She was anxious; not eating or sleeping. Dianne was prescribed diazepam. There is no record of domestic abuse being discussed and there does not appear to have been considerations of alternatives to medication (i.e. counselling).

- On 2nd August, the surgery tried to contact Dianne. Initially there was no reply but then Dianne called back. She requested a further prescription of diazepam. She reported low mood but not as bad as it had been. She stated she 'starts trembling but not like a panic attack.' She also reported she was going to stay at her daughter's in Leeds for two weeks.

- On 29th August 2018 Dianne had an appointment with her GP and reported she lives with her female partner who had previously been physically abusive and who took her disabled badge and used it. Also, that her partner had taken the car off her and used Dianne's credit card to make payments. The GP confirmed there were no children involved. Dianne was 'not deemed to be a vulnerable person.' Dianne was struggling to sleep and takes one diazepam most days. She stated she had been trying to leave her partner for the last four months, but she convinced her to come back. Dianne reported she was trying to get the council to help her to move house. As well as considering medication, the GP advised Dianne to speak to IDAS (Independent Domestic Abuse Service) and Citizen's Advice. A review was set for four weeks later. There was no recognised risk assessment carried out by the GP in relation to the domestic abuse (physical, verbal and financial abuse) disclosed by Dianne in relation to Margaret. This was the last contact with the GP surgery. Dianne was murdered four days later.

<u>GP – MARGARET</u>

- Margaret was registered at the same GP practice as Dianne. She was a frequent attendee and had over 60 appointments or consultations with her GP during the timeframe of this review. Margaret had first registered at the practice in March 2011. Margaret had no next of kin or children recorded in her GP records. This contrasts with Dianne's records at the same GP practice which had Margaret noted as Dianne's next of kin from 2012.

- Although outside the scope and timeframe of this review it is worthy of note that in Margaret's GP records there is a reference to a disclosure relating to an 'Adverse Childhood Experience' (ACE) when Margaret presented as 'tearful over her mother's death and has angry memories of her father.' Margaret was referred to counselling.

- During a telephone consultation on 1st March 2012, Margaret was discussing some side effects of her medication (sore throat) but then also disclosed she had recently had a break-up from her partner and was not sleeping. This discussion was followed up with an appointment at the GP practice the following week (9th March). Margaret gave further details that she had been with her female partner for 20 years. There were multiple reasons for the break-up. On 1st January she had drank a lot. They had an argument and police had been called.

- Margaret stated she had poor sleep since this incident and the GP records she was drinking '14 pints a day' to help her sleep. The notes do not specifically state 'alcohol' but this is a reasonable assumption to make when considering the context of the disclosure. She reported reduced appetite and low mood. Margaret was tearful during the appointment. She expressed some suicidal thoughts of 'jumping off a cliff' but did not think she would do this. She stated she had children 'down south.' There does not appear to have been a recognition this was a domestic abuse

incident. No formal risk assessment was completed and there is nothing recorded regarding any referrals linked to alcohol abuse. A review was planned for two weeks' time.

- On 22nd March, Margaret attended another appointment with her GP as planned. Much of the appointment was to discuss medical issues that are not relevant to this review. During the consultation, Margaret stated that she and her ex-partner were now talking, and she thought they might get back together. She also reported she had reduced her alcohol intake to four pints per day.

- There were several further (non-related) GP appointments over the following months. On 3rd July 2012 during a telephone consultation, Margaret was very tearful. She reported waking early on a morning and having poor appetite. She would not state why she was unhappy. She said she felt suicidal but did not think she would act on these feelings. She told the GP she was going to the pub and then home to her partner. The GP notes record the doctor tried to discuss management of Margaret's issues, but she was not interested. The notes conclude stating 'Review tomorrow.'

- The review appointment took place the next day (4th July) as planned. Margaret stated she felt better than yesterday but was not willing to discuss the cause of her low mood. She said she drinks six pints a day which sometimes improves her mood. She did not feel suicidal. After discussions with her GP, Margaret agreed to a prescription of anti-depressants, counselling and a referral to mental health services. The notes record 'Review in two weeks' but there is no record of this taking place. This may have been due to waiting for updated mental health information.

- On 3rd August 2012, the GP practice received a letter from the Tees, Esk and Wear Valley NHS Mental Health Trust. The letter related to an 'Adverse Childhood Experience' (ACE) in Margaret's life. These experiences were still affecting her.

- Margaret had around another 50 appointments or consultations over the following six years. None of these related to domestic abuse. Three appointments (3rd July 2013, 26th August 2014 and 20th October 2017) mention excessive alcohol consumption when Margaret disclosed drinking between 10 and 15 pints of alcohol per week. She was given weight loss advice but declined an offer for interventions to deal with excessive alcohol consumption. By her 2017 appointment it was noted some abnormality of the liver function due to fatty liver disease.

2.3.4 SCARBOROUGH BOROUGH COUNCIL

There were three separate functions within Scarborough Borough Council considered as part of this Domestic Homicide Review. Each of these departments had contact with the victim. None had any contact with the perpetrator:

1. CUSTOMER FIRST.
   This team provides a first point of contact between the Council and the public. Contact can be made via the telephone to the call centre or by visiting the 'Customer First' centre based at the Town Hall in Scarborough. The advisors within this team record initial information from the caller to enable them to sign post to the correct service or person within the Council.
2. THE HOUSING TEAM.
   This team provides the resources to enable the Local Authority to discharge its' statutory responsibilities relating to the prevention of homelessness in addition to other housing functions. The team provided two distinct services at the point when they were accessed by Dianne. These are the Housing Options team and the Homeless Prevention team.
3. THE COMMUNITY IMPACT TEAM.
   This multi-agency team is co-located at the Town Hall in Scarborough. The team's focus is on reducing crime and anti-social behaviour. This includes managing high risk 'vulnerability' issues which require a multi-agency response. (This team will be reviewed within the section on 'multi-agency forums and processes').

- Dianne first contacted the 'Customer First' team when she attended Scarborough Town Hall in person, on 31st May 2018. She asked for assistance with re-housing. The records show this request was made due to the breakdown of the relationship with her friend. Dianne and her friend held a joint tenancy in their current property. An initial triage assessment was then completed that same day by a Homeless Prevention Officer. Dianne reported that her friendship with Margaret had broken down. As well as the joint tenancy they also had a joint financial interest in several items including a car and 'white' goods. Dianne reported to staff that Margaret had been violent with her in the past. The notes add 'but there was no indication that there was any threat of physical violence at this time.' It is unclear how this assessment was reached. Dianne stated she would have liked to stay in her current property as sole tenant but appreciated this was not financially possible at that time. Dianne also disclosed that Margaret had been taking money from her bank accounts. Dianne was expecting a large compensation payment from the NHS due to a problematic operation on her leg. She was concerned Margaret would demand some of this money if her claim was successful. The relationship of the couple at this point is described as 'friends.' The Officer confirmed they were joint tenants and checked the Housing Benefits system when discussing Dianne's financial position. The benefit application and payments supported that Dianne was receiving Housing Benefit in her own right for 50% of the rent.

Dianne was offered a full housing needs assessment which was booked for the following day.

- On 1st June 2018, Dianne attended the Town Hall for a housing needs assessment with one of the Housing Options officers. A full assessment was completed in line with Council protocols. Throughout the meeting, Dianne is referred to as Margaret's 'ex-partner.' The officer recorded that Dianne was suffering harassment from her ex-partner at their home, was a victim of domestic abuse and that Margaret had cleared Dianne's bank account. There does appear to be some contradictory information recorded. When answering the question 'incidents of violence', the officer noted 'no.' But the document also showed that Dianne had reported Margaret had been violent to her in the past. Dianne was assessed as being under threat of homelessness, could not afford to stay in her current property and could not continue to live with Margaret. The Housing Options Officer therefore assessed the Council had a statutory Homelessness Prevention duty towards Dianne. During the meeting, temporary accommodation was discussed but Dianne stated she was happy to remain in the current property until such time that an alternative property could be found. In addition to Dianne's wishes, it is also worthy to note that temporary accommodation is only available in the Scarborough area and it cannot cater for pets (Dianne told the Housing Options Officer she would not consider any accommodation that would not allow her to take her two cats and her dog). Dianne also stated she only wanted to consider properties in the Filey area. This, together with Dianne's physical needs meant there was a very limited stock of housing likely to become available. Social housing was agreed as the most appropriate route to accommodate Dianne's requirements.

- Following the meeting on 1st June, the Homelessness Prevention Officer submitted a referral to the Community Impact Team (CIT). Included in the referral were the identified issues of a breakdown in the relationship between Dianne and Margaret, that Margaret had been taking money from Dianne's bank account and that Dianne wanted to find accommodation on her own. Also included was information that Dianne expected to receive a significant sum in compensation from the NHS regarding an operation which had not gone well. The report also stated Margaret and Dianne were long term friends and that Margaret had been violent to Dianne in the past. It is not clear why the Housing Options Officer recorded Dianne and Margaret as 'ex-partners' during the full housing needs assessment but the Homelessness Prevention Officer as 'long term friends' on the referral to the CIT.

- After the full housing needs assessment, the Homelessness Prevention Officer facilitated the activation of a social housing application for Dianne. A warden assessment was also arranged as was a health and welfare assessment in order to support Dianne's need for a specific type of accommodation (either a bungalow or ground floor flat with warden control). The activation was 'live' from 25th June and Dianne was placed in the 'silver' band category. This was based on her identified

welfare needs and was not the highest band which is 'gold.' To achieve a 'gold' banding would include issues such as fleeing violence. Further comment will be made on this during the analysis section of this overview report.

- On 6th June, Dianne attended the Town Hall in Scarborough to say that she was desperate to move as the situation had worsened. She also expressed concerns that due to her age she did not use the internet and was worried this would affect her ability to find suitable accommodation. Therefore, the Homelessness Prevention Officer agreed to ensure suitable properties were assessed every week when they were published, and any appropriate bids would be placed on Dianne's behalf. This is positive in terms of assisting Dianne in her re housing but there is no record of any professional exploring why Dianne was suddenly desperate to move and how the situation had worsened.

- On 8th June Dianne called the Housing team in a distressed state. Margaret had received an e-mail from 'Beyond Housing' *(*formerly 'Yorkshire Coast Homes') stating that Margaret had been stealing money from Dianne. Margaret had threatened to sue Dianne for slander unless the wording was changed. After further investigation, staff identified that Dianne's e-mail had not been updated during the reactivation of a previously closed housing application. (The previous application had been in joint names and used Margaret's e-mail address). This error had an impact at least in increasing tension between Margaret and Dianne. Evidence of this is shown by the 999 call to police which Dianne had made on the evening of 6th June (see North Yorkshire Police IMR) that Margaret had been aggressive – shouting and swearing at her. Margaret's e-mail address was removed from the application.

- There were other omissions and errors in addition to retaining Margaret's e-mail address on the housing application. There are several entries on notes made during Dianne's housing application that she suspected Margaret was interfering with her mail (and she was not receiving all her expected letters). The Council was asked to send all Dianne's mail to a friend's address. However, this was not updated on the housing application system as a contact address. Letters continued to be sent to Dianne and Margaret's address. (As part of this DHR, Dianne's daughter informed the independent author that her mother had told her she found letters in the bottom of her wardrobe. They had been ripped up and were still unopened).

- On 2nd July 2018 during a telephone conversation, Dianne confirmed with housing staff that she did not want to move to Scarborough. She would only consider her local area.
  Dianne did say that the situation between her and Margaret was better and improving. They were on speaking terms, but Dianne still wanted to obtain her own accommodation. As no notice had been served on their current property, she could afford to take her time and wait until a suitable property became available. Housing records confirm that no application for re housing was ever made by Margaret.

- Dianne's homelessness duty was regularly reviewed by a Housing Options Officer. Records show that Dianne's application was checked on the Choice Based Letting system on 30th July, 14th August, 17th August and 24th August for suitable available properties. None were available throughout that time in the Filey area. During a telephone call on 14th August, Dianne informed the Homelessness Prevention Officer that she was staying temporarily with her daughter in Leeds. She reported she had also been in contact with 'AGE UK' who had been helping her with the completion of a 'Personal Independence Payment' application.

- On 29th August, Dianne called the Homeless Prevention Officer to confirm she had returned home following the stay at her daughter's in Leeds. Dianne reported she was still suffering the same emotional abuse from Margaret and asked if the Council would be able to provide her with financial assistance through the bond scheme to see if she could find a private let. She also stated she was seeing her doctor that afternoon as she was having trouble sleeping. Dianne did stress to the Homeless Prevention Officer that she did not feel in any physical danger by remaining in her current property. This was the last direct contact between the Housing team and Dianne.

- On 30th August (three days before her murder), the 'Choice based letting' system was checked and a suitable property for Dianne was available. A bid on the property was placed on Dianne's behalf. Her application on the property would have competed with other applicants. We do not know if Dianne would have been allocated this property. However, Dianne's bid was placed at 46 out of 103 applicants so it is highly unlikely she would have been successful.

2.3.5 <u>THE INDEPENDENT DOMESTIC ABUSE SERVICE (IDAS).</u>

IDAS is a 3rd sector organisation providing a range of domestic abuse services across the North Yorkshire area. IDAS had a total of four contacts with Dianne during the period of this review.

- An initial domestic abuse referral was forwarded to IDAS from North Yorkshire Police on 15th June 2018. The incident had been assessed by the police as a 'standard risk' incident using the nationally recognised DASH risk assessment tool. A member of IDAS staff had made contact with Dianne four working days later. Although it is normal practice for an IDAS worker to complete their own DASH risk assessment in each case, this does not appear to have taken place. During the telephone call, it was established that Dianne was staying temporarily with her daughter. Discussions with Dianne included housing needs, health concerns and emotional support. It is standard practice that '*when a victim is reluctant to engage'* a follow-up call will be made which gives an opportunity for a full assessment. The Help Line telephone number was sent to Dianne by text message.

- The Hub worker arranged a follow-up call two weeks later, and this was made on 5th July. The records indicate that Dianne's priority was her re-housing. The notes do not record whether the option of a refuge was discussed. However, the records do state that Dianne was aware that properties were available, but she wanted to stay in the local area. Therefore, it is not likely that refuge was a choice Dianne would have made. Again, there is no record of a DASH risk assessment being completed. After Dianne was advised to call the Help Line or Hub worker if she needed help, the case was closed and the referrer (North Yorkshire Police) advised of the outcome.

- When the Hub worker returned from a period of leave on 19th July, she found two texts from Dianne. These had been sent on 17th and 18th July. The worker telephoned Dianne who said she was experiencing poor mental health. She told the Hub worker she was in contact with her GP and had been prescribed medication plus she was receiving support from AGE UK regarding a benefits claim.

- Dianne made a further call to the Help Line on 30th August. Dianne's concerns were around Margaret's misuse of her 'blue' (disability) badge and of Margaret's reaction when Dianne challenged her about this, together with associated mobility issues and her re-housing. The IDAS worker asked Dianne if she had ever been in a relationship with Margaret. Dianne replied 'no' and was adamant they were friends who lived together. The outreach worker also enquired if she had ever called the police previously in relation to any issues with Margaret and Dianne replied she had not. As part of this review, the worker was interviewed. She stated she had checked IDAS systems for previous incidents but could find no trace of Dianne or Margaret. There are some issues with the 'CMS' recording system used by IDAS and attempts are now ongoing to have these resolved. The outreach worker gave Dianne safety advice including to dial '999' if she felt threatened and to consider a lock for her bedroom door. The worker considered a DASH risk assessment but decided against this as Dianne was adamant, she and Margaret were not in a relationship. Instead, the IDAS worker made a referral to 'Safeguarding' (Health and Adult Services). Dianne consented to the referral.

2.3.6 HEALTH AND ADULT SERVICES (HAS) NORTH YORKSHIRE COUNTY COUNCIL.

- North Yorkshire County Council Health and Adult Services (HAS) had only brief contact with Dianne. They first received a referral on 30th August 2018 which was only three days before Dianne's death.

- A safeguarding concern was raised verbally by an outreach worker from the Independent Domestic Abuse Service (IDAS) on the afternoon of Thursday 30th August. The concerns for Dianne were listed as physical, emotional/psychological,

financial/material and domestic abuse by Margaret who IDAS stated was Dianne's friend. It was agreed the IDAS worker would also send an electronic 'safeguarding concern form.' The verbal account was inputted straight away onto HAS systems by a Customer Services Advisor and stated that Dianne had mobility problems and had become reliant on her friend Margaret. The report also included that they had a joint tenancy on their property and that Dianne stated Margaret drank large amounts of alcohol, returned home under the influence of alcohol and made threats to commit suicide. The report also referenced that it was believed there had been previous attempts at suicide. The IDAS worker's report was that Dianne was reliant on Margaret to transport her. Dianne had a 'blue' disabled badge but was no longer able to drive herself. Margaret was apparently using the 'blue badge' even when Dianne was not in the car. When Dianne had challenged Margaret about this, Margaret had parked the car a long way from their home which caused Dianne distress. She felt she had to be kind to Margaret or there would be consequences. The report also included that they lived in a village. Dianne relied on Margaret to give her a lift to the bus station but now Margaret would not take her. In relation to violence, the IDAS outreach worker stated Dianne used the phrase "She wouldn't dare hit me now" and made reference to a large sum of money Dianne was expecting relating to an operation which had not gone well. Dianne had been advised to put a lock on her bedroom door, have a way to get out of the house, contact the Housing Options team and call the police if there were further problems.

- The full written safeguarding concern form was received from IDAS that same day. The concerns listed included psychological, financial/material and domestic abuse. It did not include the category of 'physical abuse' which had been given verbally. There was also differing information between the verbal account and the written safeguarding form; on the verbal account it stated the person alleged to have caused harm was not aware of the referral but on the written form a box is ticked as 'yes' in answer to a set question on if the person alleged to have caused harm is aware**.** The form also confirmed that Dianne had stated she was not in a relationship with Margaret.

- The following day (Friday 31st August), a Safeguarding Enquiry Officer from the Care and Support team rang Dianne and had a lengthy discussion about the issues. They completed a 'Safeguarding Adults Risk Assessment' (SARA). The officer recorded it was clear that Dianne was aware of the risks in her situation at home and could clearly describe them. The Enquiry Officer described Dianne as an intelligent lady who was willing to talk and engage with services. The officer identified several key issues which had been recorded during the referral from IDAS the previous day. These included that Dianne had some care and support needs linked to an operation that had gone wrong. This affected her mobility and she was now more reliant on Margaret who she had lived with for 30 years. Margaret's heavy drinking was also discussed with Dianne describing Margaret as 'coming home legless.' Dianne also told the officer that since her retirement Margaret's behaviour had changed. Dianne

believed Margaret was depressed but that Margaret would not acknowledge this or discuss it.

- In terms of escalation, Dianne described that the relationship had now broken down and that Margaret was being very controlling. This included the threat of violence, financial abuse and psychological pressure. Further details were fully discussed linked to the issues on the referral form regarding the blue badge misuse and using Dianne's bank account and credit cards. Margaret's threats to kill herself were causing Dianne a lot of anxiety and sleeplessness. The physical violence was further discussed. Although Dianne stated this was now under control, she also told the enquiry officer that 'Margaret had her up against the wall the other day but did not touch her.' Dianne stated there had been police involvement in the past when Margaret had assaulted her but not recently. During discussions with the IMR author, the enquiry officer stated Dianne gave the impression she was not concerned about Margaret physically abusing her but was more focussed on the risk of financial and psychological abuse together with Margaret's controlling behaviour.

- Dianne told the enquiry officer she wanted to extricate herself from the relationship and had applied for a housing transfer and been allocated a 'silver' band rating. The officer advised Dianne to return to the Housing department and request a 'gold' banding due to domestic abuse. Dianne replied that she already knew this was an option. She found the idea of moving distressing as she had lived in her home for several years. Dianne expressed her concerns about Margaret's reaction once she knew she was leaving.

- The officer explored support options. They recorded Dianne had good support from her daughter who lived in Leeds. However, Dianne was determined she did not want to move to any temporary accommodation and wanted to wait until a suitable property became available. Dianne stated "I can't run away. I have to deal with this." At no point did Dianne give the enquiry officer any impression that she was at risk of any imminent physical danger. The enquiry officer did not believe Dianne needed to be taken to a place of safety.

- The SARA risk assessment considered nine domains. These were assessed ranging from 'moderate' risk (vulnerability, domestic abuse, physical abuse, financial abuse) through to 'high' risk (risk of repeated abuse and impact of abuse of people at risk of harm).The enquiry officer informed Dianne that the case would be passed to the Locality Team and that a member of that team would contact her to arrange to meet Dianne. The officer reported Dianne was pleased with the offer of support.

- Dianne was asked the nature of her relationship with Margaret. Dianne was adamant they were just friends. They lived together for convenience and companionship. On the initial safeguarding contact form, it had been recorded Margaret was possibly an ex-partner of Dianne's.

- At 3.50pm on Friday 31st August, the Safeguarding Coordinator from the Care and Support team rang their colleague in the Locality team. They were informed a SARA had been completed and that further investigation was now required. The coordinator stated it was not urgent but asked that a member of the Locality team make contact on Monday (3rd September). Health and Adult Services is not a 7 day service and operates Monday to Friday. Dianne was killed on Sunday 2nd September before the home visit could be arranged.

2.3.7 AGE UK

- AGE UK are an Independent charity. They are registered locally as 'AGE UK Scarborough and District'. Their aim is to relieve poverty and hardship for any person over 50 years of age. Their small team includes experienced 'link workers' who maintain contact with clients and liaise with other local statutory and non-statutory services.

- Due to the size of the organisation, it was not appropriate to request an IMR from AGE UK. Instead, a brief chronology was provided, and this was supplemented by a personal visit to AGE UK (Scarborough) by the appointed Independent Author from the Domestic Homicide Review.

- On 21st June 2018, Dianne self-referred into the AGE UK service. She then attended a 'drop-in' session at Filey. On 26th June, she disclosed her current situation and the link worker advised Dianne to telephone '999' if she ever felt at risk. The worker also ensured that Dianne was aware of specialist services such as IDAS. Dianne confirmed she had been in recent contact with IDAS. In particular, Dianne told the AGE UK worker there had not been any physical violence from Margaret.

- The link worker carried out a home visit with Dianne on 17th July 2018. Part of this work also included the link worker contacting the Housing team to ensure they had the full facts of Dianne's case. During that home visit, Margaret arrived home but did not speak to the link worker or even appear to acknowledge her presence. Although the worker could not state there was particular tension, she observed that Dianne was 'petite and thin' and Margaret was a much larger lady.

- A second home visit was conducted on 3rd August 2018. Dianne was given advice over her benefit payments and other money issues. The last contact with Dianne was a brief telephone call on 8th August relating to finances. There was no suggestion of any deterioration within the relationship.

2.4 Multi-agency forums and processes

- Neither Dianne nor Margaret were ever discussed at MARAC (the Multi-Agency Risk Assessment Conference). This is the forum for all agencies to discuss the highest risk cases of domestic abuse and put plans in place to protect victims. This lack of involvement with MARAC could be for a number of reasons that will be explored within the analysis of this overview report.

- Neither party were discussed at MAPPA (Multi Agency Public Protection Arrangements) which is the statutory format to discuss such cases. Clearly neither Dianne nor Margaret met the criteria as a 'violent offender' under the MAPPA guidance.

- However, they were discussed several times at the 'Community Impact Team' (CIT) tasking meeting. This forum meets across the Borough of Scarborough and several agencies are represented. The aim of the meeting is to: (a) Tackle crime and disorder (b) tackle anti-social behaviour (c) tackle alcohol and substance misuse and (d) protect vulnerable people.
  The meeting convenes every two weeks and any agency can nominate an individual, family or group of people to be discussed. With the consent of Dianne, the Homeless Prevention Officer referred Dianne and Margaret to the CIT on 1st June 2018 following the initial triage interview on 31st May 2018 using the generic risk matrix template. The 'screening' scored the risk as 65 which is within the high risk category and so the case was forwarded to the CIT tasking meeting.

- Dianne and Margaret were discussed at the CIT tasking meeting on four occasions. These were 5th June, 19th June, 3rd July and finally on 17th July 2018 when the case was closed.
  The concerns for Dianne and Margaret were listed as a tenancy dispute between two long term friends. On 5th June, an action was for the Homeless Prevention Officer to speak with the safeguarding manager to confirm the status of the relationship to ensure the correct support was offered. On 19th June, the Homeless Prevention Officer was to offer mediation to the couple as they were not identified as 'partners.' On 3rd July, the same mediation action was to be confirmed once it was carried out. The case was finally closed on 17th July after information was received that the situation had improved, and the services of the CIT were no longer required.

Section 3: Family involvement and analysis

3.1 Family Involvement

3.1.1 Dianne's family took part in this review. Their help was invaluable in providing an insight into Dianne's life. Clearly, they are still grieving but wanted to provide a picture of Dianne as a mother and grandmother.

3.1.2 The family were notified of the Domestic Homicide Review process by the police Family Liaison Officer following a request by the panel. The Independent Author then met with the family twice (in May and July 2019) and discussed the review's findings and learning. The family were supported during these meetings by an appointed advocate.

3.1.3 Dianne has an adult daughter and a 17 year old grandchild. Dianne's daughter describes her mum as generous and with a big heart. She loved her family. She remembers that even after eating a big Sunday dinner, Dianne would still be off to make sandwiches – 'always cut in triangles and never in squares.'

3.1.4 Dianne's daughter was aware of Margaret's temper and had experienced this at first hand. She states the mood in her mum's home as 'like treading on eggshells' when Margaret was around. On one occasion in 1992 Dianne's daughter was assaulted by Margaret. It was a sustained attack by Margaret and Dianne's daughter (then aged 20 years) suffered a broken nose and required hospital treatment for her concussion.

3.1.5 Dianne's daughter describes Margaret as a 'bully' and very manipulative.

3.1.6 Margaret and Dianne moved around the country with different jobs. They had met in Leeds through a mutual friend. They bought a public house in Buckinghamshire, but the business did not go well and eventually they moved back to Yorkshire. They initially used a caravan on the East Coast for short holidays. They liked the area so much that they began renting a bungalow together.

3.1.7 Dianne became frailer after an operation went badly. She relied on Margaret, but Dianne's daughter believes Margaret took advantage of this change in circumstances and in particular believes Margaret was wanting a 'share' of any financial compensation.

3.1.8 Her mum used a phrase when describing several incidents involving Margaret. She would say "She cornered me." Dianne's daughter is sure what her mum meant is that Margaret had assaulted her.

3.1.9 Dianne's daughter visited her mum on Friday 31st August. They spent a lovely afternoon and evening together, chatting and having a drink. Her daughter recalls her mum texted her to come over. When she arrived, she thought her mum was 'A bit down.' They went out together and called at the newsagents and the pet shop. It was a really hot afternoon and they visited a couple of pubs and sat in the beer

garden. Dianne's daughter fondly remembers her mum had never had a 'pink gin' and so her daughter bought her one. They ordered a taxi back to Dianne's house and her daughter stayed the night to keep her company. (Margaret had stayed in Leeds that night). Dianne's daughter left the following morning. She did not see her mum again.

3.1.10 Dianne's daughter does not believe there was any sexual element to her mum's relationship with Margaret. She knows they became close friends and went on to be companions even after they had fallen out many times. She never saw them kiss or even hold hands. She believes it was an intimate partnership but would never describe it as a 'loving' relationship as Margaret was such a bully. Looking back, she recalls her mum was always covered in bruises.

3.1.11 Dianne's daughter sent her mum a 'What's App' message on the Sunday evening (only a few hours before her death). It read:

Dear beautiful you, yes you have within you the strength to get through even the darkest of days ….Don't let anyone steal your sparkle, keep your chin up and know that things are going to get better ….oh yes they will ….Take it one step at a time … ….and keep believing in your dreams …always.

3.2 Analysis

3.2.1 Dianne and Margaret had known each other for at least 30 years. They met as friends but over time their friendship developed into them becoming intimate partners. They lived together at various addresses as a couple. There is evidence that after altercations or abusive incidents they were no longer a 'couple' but did still live together for reasons of both companionship and for practical reasons (for example in sharing household bills). During enquiries carried out as part of this Domestic Homicide Review the relationship 'status' between Dianne and Margaret became very important as that 'categorisation' often led to subsequent issues with identification, referrals, routing of services and interventions.

3.2.2 This analysis will focus on the terms of reference set by the Domestic Homicide Review panel to help to understand the activities, considerations and interventions of the many agencies involved in this case. It will also examine how the dynamics of the relationship changed once Dianne became more reliant upon direct assistance from Margaret.

3.2.3 By the number of Individual Management Reviews (IMRs) from a variety of agencies it is clear there was a lot of contact with the couple. This included a long history of domestic abuse incidents dating back over several decades. However, there were also lengthy periods (spanning several years) where no such domestic

abuse was reported. (Dianne's daughter believes this may have been during periods when her mum and Margaret lived apart during the week due to work commitments).The frequency and scope of agency involvement increased in the last few months of Dianne's life due to her increasing frailty and need for support services. The purpose of this Domestic Homicide Review is not about apportioning blame but is to look for any missed opportunities, anything that could have been done differently, any themes that are emerging and ultimately to what lessons can be learned from Dianne's tragic death.

TERMS OF REFERENCE

The terms of reference were agreed at the initial Domestic Homicide Review Panel on 30th November 2018:

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

3.2.4 There are extensive indications that demonstrate agencies were sensitive to the needs of the victim and perpetrator. Some shortcomings are also apparent:

3.2.5 For example, North Yorkshire Police attended a domestic abuse incident on 1st January 2012. This was the first time North Yorkshire Police had contact with the victim (though there had been separate earlier contacts with other police forces elsewhere in the UK). The attending officer completed a nationally recognised risk assessment (DASH model) which identified the victim, Dianne, at 'medium risk.' The definition of medium risk is:

'*There are identifiable indicators of risk of serious harm. Offender likely to cause serious harm if change in circumstances i.e. failure to take medication, relationship breakdown, substance misuse, if bailed after court appearance.'*

The account of the incident given by Dianne to the police included allegations of a sustained assault resulting in a head injury, 'grabbed by the throat', Margaret making threats to kill her (and Dianne believing she would carry out this threat) and a long history of violence in the relationship. With such disclosure this could have been assessed as 'high risk' (i.e. a risk of significant harm). However, the 'medium risk' assessment was made after a detailed risk assessment by the attending police officer. But when the incident was reviewed by a specially trained 'Domestic Abuse Officer' (DAO), the risk level was downgraded to a 'standard risk.' This was not, and never could be, the correct risk assessment in those circumstances. There are

several identified indicators of harm. In addition, by the time of this review by the DAO, Dianne had withdrawn her allegation and it was clear the relationship was to continue. This change in relationship status negated some of the mitigating factors made during the initial 'medium risk' assessment in that now, the couple were to continue to live together. The perpetrator, Margaret, had been interviewed under caution but had denied the incident and made counter allegations against Dianne. This appears to be the basis for the DAO downgrading the incident and for no further offers of support or referrals to other agencies with the DAO citing 'no defined victim or perpetrator and therefore no referrals were required at this time.' It is common for there to be counter allegations within incidents of domestic abuse, but such complexities do not mean agencies cannot identify victims and offenders and it should not mean there are no referrals to other support services. The incorrect risk assessment left Dianne at risk of further harm and meant that there was no referral to other multi-agency forums such as MARAC (the Multi-Agency Risk Assessment Conference which exchanges information across organisations and develops plans to protect the highest risk victims of domestic abuse).

3.2.6 In other agencies, the lack of identification of Dianne and Margaret as a couple meant the agency did not route concerns through established channels to tackle domestic abuse. For example, within Scarborough Borough Council, initial records clearly state they were long term friends, and this was supported by their benefit claim history. However, other notes within the same team describe Margaret as Dianne's 'ex-partner.' It should be noted that staff did ask Dianne the nature of her relationship, but with contradictory records stating both that they were friends and 'ex-partners' this could have been explored further. Several organisations (e.g. the police) already had information that Dianne and Margaret were in fact a 'couple' and had lived together for many years as 'intimate partners.' We must also recognise that the actual services on offer from Scarborough Borough Council relating to their core services on re-housing were not affected by the lack of clarity over the nature of the relationship. Dianne received a good level of service in this regard. However, the additional 'wrap around' services relating to domestic abuse were not offered as the intimate relationship was not fully explored.

3.2.7 A similar issue occurred with the Independent Domestic Abuse Service (IDAS). The police had made a referral to IDAS following a domestic abuse incident in June 2018. This was followed up when IDAS made telephone contact with Dianne. Dianne stated her priority was re-housing. There are no records to indicate if IDAS offered Dianne refuge accommodation but related notes suggested she wanted to remain in the local area so refuge would not have been an option. Dianne did not require further support and the case was closed at IDAS on 5th July 2018. However, when Dianne made a further call to the IDAS Help Line on 30th August (relating to Margaret's alleged misuse of her 'Blue' disabled badge), the IDAS worker asked the nature of their relationship. In particular the worker asked if they had ever been in

a relationship. Dianne replied 'no.' and this is recorded in the IDAS notes. But this is only two months after North Yorkshire Police had made a referral and this clearly showed Dianne and Margaret were in an intimate relationship. Other such checks could have been made with the victim's GP. It is to the credit of the IDAS worker that they still made a referral to other services regarding Dianne's 'vulnerability' (in this case to Health and Adult Services). But the lack of further action to confirm the true nature of the relationship meant that other opportunities were missed.

Did the agency have policies and procedures linked to risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used?

3.2.8 The incorrect risk assessment by North Yorkshire Police from the incident reported on 1st January 2012 had already been considered. There is a comprehensive Force policy in place which covers all aspects of domestic abuse including risk identification, assessment and risk management for victims and perpetrators. The procedures were not always followed in future incidents. On 15th February 2012, Dianne contacted the Force Control Room reporting Margaret had threatened her in a nearby public house. Officers attended promptly and Dianne was given advice. On the face of it, the risk assessment carried out by the attending officer was correct in that it reflected the circumstances described by Dianne (the DASH model of risk assessment is 'victim–led' and is reliant on accurate responses being provided by the victim). However, the 'score' of only 2 / 27 risks identified may well have been the responses Dianne gave, but these answers to the officer's questions did not match the answers Dianne gave at the incident only six weeks earlier. Although the previous incident responses may not have been known at that time by the attending officer, they would have been known to the Domestic Abuse Officer who reviewed the incident later. The review was not carried out in a timely manner (it was completed 22 days after the actual incident). Examples such as the question"Was previous violence used?" had completely contradictory answers on the two separate referral forms. The DAO did not discuss these inconsistencies with Dianne which a good risk assessment process should have picked up. This was an opportunity to consider a referral to the MARAC meeting as officers now had access to information from previous incidents. This did not take place.

3.2.9 The North Yorkshire Police response to a later incident reported on 6th June 2018 was much more positive. The assessment of standard risk reflected the 'score' but also matched that there was no physical violence involved. The risk assessment was thoroughly completed with additional comments recorded by the attending officer – an indication they spent some time listening to the concerns of the victim. The subsequent review by the DAO also suggests a comprehensive re-assessment and

ensured Dianne was referred on to other organisations that could help her; in this case to the Citizen's Advice Bureau.

3.2.10 The Independent Domestic Abuse Service (IDAS) has formal policies in place relating to domestic abuse and clearly this is the core business of this organisation. The referral had been received from the police in June 2018 and entered on to their case management system. However, IDAS policy is for each worker to complete their own DASH assessment for all referrals *wherever possible*. There is no record of such an assessment on the case management system nor any notes to suggest one was completed during the telephone call with Dianne. Although Dianne did not want to engage further, there was still an opportunity to complete a limited DASH risk assessment during the call.

3.2.11 There were missed opportunities for identification of domestic abuse at the GP practice. In March 2012, Margaret described a situation to her GP regarding a break-up in her 20 year relationship with her female partner. She told the doctor that police had been called to their home following a verbal argument, but this does not appear to have been recognised by the GP as domestic abuse. When Margaret re-attended later that month, she mentioned to the doctor that she is back on 'speaking terms' with her ex-partner and that she thinks they may get back together. As domestic abuse was not identified in the earlier disclosure, then there was no assessment of the potential increase in risk if the relationship had resumed.

3.2.12 The same incident was disclosed by Dianne to her GP (at the same GP practice but a different doctor). This GP had access to further information as Dianne described the physical assault that had taken place by her partner and was presenting at the surgery with her injuries. However, this was also not documented as domestic abuse and no recognised risk assessment process took place. There were safeguarding policies and procedures in place with the GPs in 2012 and these included a need for evidence based risk factors; in particular domestic abuse.

3.2.13 Scarborough Borough Council has a 'safeguarding policy' but not a specific domestic abuse policy. There is no reference to the DASH risk assessment within the safeguarding policy. The Council's 'Community Impact team' does use a 'risk matrix'. This has been disseminated following internal training sessions, but it does not relate specifically to domestic abuse and there are no formal procedures in place that map out the referral process available for staff with concerns.

3.2.14 North Yorkshire Health and Adult Services do not have separate policies and procedures for domestic abuse. However, the 'Safeguarding Adults, West and North Yorkshire and York Multi Agency Policy and Procedure (2015)' does include reference to domestic abuse. Although the 2015 policy did not refer specifically to the DASH risk assessment, this is being included in the planned operational guidance due for issue in October 2019. In the contact with Dianne in August 2018,

the Health and Adult Services team did complete a comprehensive risk assessment using the SARA model (Safeguarding Adults Risk Assessment). This assessment will be reviewed later in this overview report.

Did the agency comply with domestic violence and abuse protocols ,including 'information sharing protocols'?

3.2.15 The Scarborough Borough Council safeguarding policy does not have a reference directly to domestic abuse protocols.

3.2.16 As already highlighted, HAS and the GP practice have specific domestic abuse protocols within their wider ranging safeguarding policy.

3.2.17 IDAS protocols were not followed during their first referral to Dianne. However, it should be acknowledged that their services are in great demand and this particular incident was assessed as 'standard' risk by the referrer (in this case North Yorkshire Police). They responded by way of contact to the victim (Dianne) in four days and not the three days which is the timeframe within their agreed protocol. This is a minor issue and not worthy of negative comment for the reasons stated.

3.2.18 IDAS did not follow their own protocols when they missed an opportunity to complete a DASH risk assessment relating to the same incident. Even though Dianne was reluctant to engage, the assessment could still have been carried out. Dianne left text messages for the IDAS worker to contact her. There was a slight delay as the worker was on leave. The protocol is that workers provide clients with a work mobile number and are advised that they are not always available due to their working patterns. Clients are also given the Helpline number for contact that requires a faster response. The text messages only delayed the response by a few days and Dianne did know she had the option of the Helpline number if she needed it.

3.2.19 In some instances, North Yorkshire Police did not comply with their domestic abuse protocols. Following the incident in January 2012 there was no contact with the victim. As a standard risk incident this is compliant with the Force protocol. However, the risk assessment itself was incorrect and this meant that subsequent actions were influenced by this initial (incorrect) decision.

3.2.20 On two other occasions, North Yorkshire Police did not submit a 'Form 253' (the domestic abuse recording form that both assesses the risk and records/updates Force systems about the incident). The protocol is clear that in all such incidents, a form must be submitted. On 28th February 2012, Dianne had attended the police station to report Margaret fraudulently insuring her car. A statement was obtained.

There were clearly underlying issues, but the officer does not seem to have recognised this as financial abuse in what was clearly an acrimonious relationship. The investigation itself was sound, but the non-compliance with submitting a 'form 253' meant the domestic abuse team were not informed of the incident (this particular incident occurred only two weeks after the previous one reported to police and would have given an indication of the ongoing tension in the relationship).

3.2.21 On 8th March 2012, Dianne rang the police to report harassment by Margaret over the previous weeks (including sending abusive messages) and that she suspected Margaret of putting a screw in her car tyre. From the documents relating to the case , it is clear a thorough investigation was carried out and this included obtaining a witness statement from Dianne and obtaining swabs of blood found on the car. But even though the officer notes they are in an 'acrimonious split' they do not submit a 'form 253' to inform colleagues of the domestic abuse incident. This is particularly concerning as we know this is one of several reported incidents within a short space of time, that harassment is a sign of escalation in the risk and that the Force Control Room had already 'coded' this incident as domestic related.

3.2.22 It should be noted that although these incidents described did not comply with Force protocols that require submission of a report / risk assessment at every domestic abuse incident, they did take place over six years ago. At subsequent (2017 and 2018) incidents attended by North Yorkshire Police a 'form 253' was submitted on each occasion.

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

3.2.23 North Yorkshire Health and Adult Services' (HAS) only contact with Dianne was via the telephone. They had limited involvement. However, all information gathered during the Domestic Homicide Review process suggests that they conducted a thorough and balanced assessment with Dianne. Plans were in place for a subsequent home visit but tragically Dianne was killed before this could be arranged. Further analysis will follow regarding the HAS risk management plans and decision-making.

3.2.24 For Scarborough Borough Council, a key decision made related to the housing application 'banding' for Dianne. However, the decision must be based on the 'Choice Based Letting' framework which is in place across North Yorkshire. She was awarded a 'silver' banding. This is a medium priority. For many domestic abuse cases a 'gold' (high) banding is given. However, in Dianne's case she had

specifically requested a housing move near to her existing home. She did not want to move to Scarborough which would have offered a greater choice. In addition, Dianne had several pets and she wanted a property which would take pets. Finally, her medical needs were also considered, and this too placed a further restriction on the choice of accommodation. Dianne's wishes were taken into account and there is clear evidence that the officers in the Housing service listened to Dianne's wishes and this informed the assessment that was made. Although a 'gold' band might have meant a quicker housing move, this would almost certainly have been to a property that either did not meet Dianne's needs or was in an area where she did not want to reside. Even when the first bid was placed on a property on Dianne's behalf in August 2018, there were several people with a gold banding who were ahead of Dianne on the priority listing.

Crucially, Dianne insisted that she was willing to wait at her current home, which she shared with Margaret, until a suitable property was available. She did not feel in danger and there was nothing revealed within the housing needs assessment that suggested to officers that Dianne was at imminent risk of significant harm.

3.2.25 Dianne presented at her GP surgery on several occasions and disclosed she was suffering domestic abuse. The medical notes do not show any formal (e.g. DASH) risk assessment conducted, but there is evidence within the records that the GP was considering the incident and any mitigating factors in place (for example in 2012 when the physical assault is discussed, and that Dianne has reported to police but dropped the charges). The records note that they no longer live together, and that Dianne had cancelled a planned holiday with Margaret. Subsequent notes show that she was now intending to go on holiday with Margaret but on her return, there is a review by the GP which confirms they are now separated.

3.2.26 There were opportunities for assessment and decision-making relating to Dianne and Margaret through the 'Community Impact Tasking' meeting (CIT). This is a multi-agency forum which meets fortnightly within the Scarborough Borough Council area. However, there appears to be a lack of understanding by partner organisations of their roles and responsibilities. Any agency can nominate a case for discussion. Dianne and Margaret's case was discussed on four occasions on 5th and 19th June and on 3rd and 17th July.

3.2.27 The initial referral to the CIT was made by a Homeless Prevention Officer using the standard risk matrix template. The 'screening' tool gave a 'score' of 65 which indicated a 'high' risk and so met the threshold for discussion at the CIT meeting. The main reason for the referral was given as a tenancy dispute. Crucially, the nature of Dianne and Margaret's relationship was recorded as 'long term friends.' This was the information given by Dianne herself when she first spoke with the Housing team. However, elsewhere on their housing documentation they are recorded as 'ex-partners.' The relationship should have been explored and if necessary, Dianne challenged with other agency records which correctly recorded them as partners / ex-partners.

3.2.28 In particular, the role of the police at the CIT meeting fell below expected standards. A police officer attended the meeting to represent North Yorkshire Police. The officer had access to police systems which showed clearly on many occasions that in fact Dianne and Margaret were intimate partners and had been so for 30 years. The information also showed a history of violence and physical assaults. The officer did not present this information to the meeting. As part of this Domestic Homicide Review, the officer was interviewed, and it appears they did not fully understand their role at the meeting. They were not briefed on information sharing protocols. In addition to not providing information to the meeting from the police recording systems, they also failed to update police systems after they returned from the meeting. Therefore, there was no record for any member of North Yorkshire Police (i.e. Domestic Abuse Officers or Force Control Room staff) to interrogate their systems and note that Dianne and Margaret had been discussed at the CIT meeting. This lack of information sharing prevented other potential actions and interventions.

3.2.29 After information was provided via Dianne that the 'situation had improved', the case was closed to the CIT. We know that Dianne had contacted the police at least twice in June 2018 regarding threats and disputes with Margaret, and that she maintained contact with the Housing Team and also had made contact with IDAS. The premature closure of the case at the CIT meeting was a missed opportunity to either explore further actions within the CIT membership or to refer to another forum (e.g. the MARAC).

Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided?

3.2.30 Following a referral from IDAS, North Yorkshire Health and Adult Services (HAS) inputted the details of the case into Dianne's client record system. The concerns noted included physical abuse, emotional/psychological abuse, financial abuse and domestic abuse. The perpetrator was shown as Margaret who was recorded as Dianne's 'friend.' There was a timely response and within 24 hours the HAS team had made contact with Dianne on the telephone.

3.2.31 HAS completed the SARA (Safeguarding Adults Risk Assessment) and discussed details of the incidents with Dianne. She disclosed an operation which had gone badly and that this had restricted her mobility. This in turn had made her more reliant on Margaret. She also told the HAS Safeguarding Enquiry Officer that Margaret now drank heavily and was depressed. Dianne told the officer there had been physical violence by Margaret in the past but that this was 'now under control.' However, the notes also state that 'Margaret had her up against the wall the other day but did not touch her.' She also said there had been police involvement in the past but not recently. Dianne had already applied for a housing

move and she wanted support to extricate herself from the relationship. Dianne also told the officer she had support from her daughter who lived in Leeds.

3.2.32 Subsequent planning by HAS took into account the disclosures made: There was previous physical violence, current threats of physical violence, mobility problems (and hence increased reliance on Margaret), potential alcohol abuse and elements of controlling behaviour (in the form of either parking Dianne's car some distance away so she couldn't get to it or by veiled threats of suicide by Margaret). These were deliberate tactics employed by the perpetrator to control the victim.

3.2.33 Dianne was already accessing several services (including Housing, Age UK, her GP and IDAS). By contacting HAS, Dianne was asking for that 'blanket of support' to enable her to achieve her house move and move on from Margaret in a managed way. The Safeguarding Enquiry Officer made assessments based on the initial referral from IDAS and from their subsequent conversation on the telephone with Dianne. They assessed several categories within the SARA as 'moderate' risk. These included 'vulnerability of the adult' and 'the extent of the abuse'. They assessed other categories as 'high' risk. These included 'pattern of abuse', 'risk of repeated abuse', impact of abuse', and 'actions of the person alleged to have caused harm'.

3.2.34 The planning needed to match the assessed risks identified under the SARA model. The Enquiry Officer noted the negative factors included her increased reliance on Margaret and that she could not easily physically protect herself. To mitigate these, it was noted Dianne was able to raise her concerns with others (both family and professionals). Above all, Dianne had told the Safeguarding Enquiry Officer that she was very aware of the risks in her situation and was able to describe them. The Enquiry Officer describes Dianne as an 'intelligent lady who was willing to talk and engage with services.' The officer informed Dianne she was recommending the case was transferred to the Locality team and that a member of that team would be in touch to arrange to meet with Dianne. By this point in the assessment it was 3.50pm on a Friday afternoon. The HAS team is a Monday to Friday service. Arrangements were made for the Locality team to take up the case on the Monday morning. Tragically, Dianne was murdered on the Sunday.

3.2.35 The risk management plan from HAS did fit with the assessment made after full involvement with Dianne. Although there were indicators of physical abuse and this included some contradictions (e.g. 'no recent physical violence' versus a disclosure that Margaret had 'pinned' Dianne against the wall in the previous days), there was nothing directly that suggested Dianne was at risk of imminent harm. The Safeguarding Enquiry Officer listened carefully to Dianne. Dianne wanted to plan the house move and to extricate herself from reliance on Margaret, but she wanted to do this in a planned and coordinated way. If there were a 7 day HAS service, then a home visit may have been carried out sooner but that is purely speculation. In any event, the home visit was unlikely to have altered Dianne's wishes.

3.2.36 Similarly to Health and Adult Services, the Housing team at Scarborough Borough Council needed to match their risk management plans with the assessments made. The team confirmed their Homelessness Prevention duty towards Dianne. The assessment had included the risks as disclosed by Dianne. Although there is an indication within the notes that Dianne and Margaret may have been in a relationship this was never fully pursued, and they remained recorded as friends as this is what Dianne said of their relationship status. In addition to the housing needs, the team did complete the risk matrix template and forwarded this (with Dianne's consent) to the Community Impact Tasking meeting. But in a similar way to the HAS team, the Housing team correctly assessed Dianne had full mental capacity to make her own decisions and she wanted to wait until a suitable property was available.

3.2.37 There were errors made by the Housing team when they did not update Dianne's contact details resulting in e-mails about her disclosures being read by her partner, Margaret. Nor did they re-route Dianne's mail deliveries to a friend's address as requested. This did not help an already tense situation. It was a mistake which staff have acknowledged. Once Dianne contacted the team, they amended her e-mail and postal contact immediately.

When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options / choices to make informed decisions? Were they signposted to other agencies?

3.2.38 There is a lot of evidence that shows Dianne's feelings and wishes were ascertained. She was given options on how to proceed.

3.2.39 Both the Housing team and Health and Adult Services discussed Dianne's housing requirements. She made her own decisions on how she wanted to progress the move (in a managed way). She accepted there would be delays in finding a new property but made clear to professionals this is how she wanted to proceed.

3.2.40 Although IDAS could have checked further to establish the true nature of the relationship between Margaret and Dianne, they did still listen to Dianne and complied with her wishes by making a referral on to HAS.

3.2.41 North Yorkshire Police had involvement over a longer period of time than HAS, Housing or IDAS. In the majority of the incidents reported to North Yorkshire Police, Dianne's wishes, and feelings were ascertained and she was informed of options / choices, (e.g. when she was assaulted by Margaret in January 2012 and Dianne

asked to drop the charges against Margaret). In a minority of incidents Dianne's voice may not have been fully heard, (e.g. in June 2018 when she re contacted police regarding access to her car keys. An officer had told her that Margaret should hold the keys as she was the registered keeper of the car, yet it was Dianne who had paid for the vehicle). But Dianne was also informed by police officers regarding other options available to her, linked to using a private solicitor or the Citizen's Advice Bureau.

Has the victim disclosed to any practitioners and was the response appropriate? Was this information recorded and shared where appropriate?

3.2.42 Dianne disclosed the assault on her, perpetrated by Margaret, to her GP. The GP did not use a recognised risk assessment nor did they 'code' the incident as domestic abuse. The details were recorded, and this information was used during a subsequent review by the GP two weeks later. However, none of this information was shared with other agencies.

3.2.43 Dianne disclosed to HAS that Margaret had been violent to her in the past but told staff this was 'now under control.' HAS were also told by Dianne that Margaret 'had her up against the wall the other day' which contradicts the notion of the physical violence being 'under control.' However, the response from HAS staff was appropriate as it was Dianne herself who was clear that her focus was on the house move and the financial abuse together with Margaret's controlling behaviours.

3.2.44 In terms of responding to emergency and ongoing incidents, North Yorkshire Police listened to Dianne's disclosures and reacted appropriately to the presenting circumstances. However, they did not share valuable information when the opportunity arose (i.e. the multi-agency CIT meetings).

3.2.45 The IDAS worker took full details of Dianne's disclosure. The initial response was appropriate in terms of advice given but not in relation to risk assessment as there is no documentary evidence that the IDAS worker completed their own (DASH) risk assessment. The subsequent response was delayed when Dianne texted the IDAS staff mobile telephone when the worker was on holiday, rather than telephoning the Helpline. However, this complied with IDAS protocols: the direct mobile number gives a more personal response to clients. Dianne knew she had the option of the Helpline but was happy to leave a text message in this instance.

Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were there any other protected characteristics relevant in this case?

3.2.46 The protected characteristics applicable to Dianne were her physical vulnerability (which could be interpreted as a disability) and possibly her sexual orientation (i.e. if she was in a same-sex relationship with Margaret). Dianne's daughter believes there never was any 'sexual' element to her mother's relationship with Margaret but does know that Margaret asked her mum to marry her more than once. Her mum declined the proposals.

3.2.47 Each IMR author has reviewed individual incidents and interviewed staff within their agency when necessary. There are no identified circumstances when Dianne was treated less favourably due to any sexual orientation.

3.2.48 The police are an emergency service and as such responded to real-time incidents. Dianne disclosed the nature of her relationship with Margaret to attending officers. Dianne was dealt with respectfully and correctly and in no way any differently to any other victim. Reported incidents and crimes were investigated.

3.2.49 Dianne's GP was also fully aware of the nature of Dianne's relationship and again was treated completely professionally and in no way any differently to other patients.

3.2.50 It was more challenging for other professionals involved in this case (IDAS, HAS, Scarborough Borough Council or AGE UK) as Dianne did not disclose the true context of her relationship with Margaret. Staff did not 'tip toe' around the subject and indeed there is ample evidence that staff asked Dianne to clarify if she and Margaret were 'friends' or 'intimate partners.' Dianne insisted they were just friends. This did affect some subsequent actions (i.e. whether the case was progressed via a 'domestic abuse' route such as MARAC or an alternative 'vulnerability' route such as CIT or SARA). There were opportunities for staff to challenge Dianne regarding her disclosure and they could have checked details with other agencies (such as the police). However, this challenge needed to be balanced with treating Dianne with respect and acknowledging she was a vulnerable victim.

3.2.51 In regard to Dianne's age or physical frailty, this was recognised by agencies. Many assessments by Housing, AGE UK, HAS and IDAS refer to her age, size and her operation, which had gone badly wrong, leaving her more dependent upon Margaret. These assessments were clearly reflected in the plans for her continued care and re-housing. On each occasion, the physical disability of Dianne was noted but importantly, professionals also noted Dianne had full mental capacity and they respected her wishes on how she would like matters to progress.

3.2.52 Dianne's GP was aware of her frailty and also of other issues she disclosed relating to her depression. This was noted by her doctor as low mood and poor sleep. Her alcohol consumption appears high (at 14 units per week). NHS guidance is men and women are advised not to drink more than 14 units per week on a regular basis. The GP recorded she was tearful but had no ideas of self-harm. Medical notes from 2012, 2014 and 2018 all refer to medication which was prescribed to help Dianne. The only reference to offering considering counselling was shown during an appointment on 29th May 2012 but Dianne is shown as 'not keen' on this option.

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

3.2.53 Some agencies were involved with Dianne and Margaret over many years. Most were involved over a fairly limited time. The case did not reach a stage where it required intervention or review from senior managers. It was never taken to a MARAC as it was not assessed as 'high risk'. The level of 'repeat' incidents did not suggest such an escalation was required. From Housing, the regular reviews are documented which ultimately led to an offer to bid for suitable accommodation. For HAS, the full response was planned for the following week but sadly Dianne was killed before this could be implemented. For IDAS, the disclosure by Dianne of being 'friends' with Margaret and not in an intimate relationship meant that the most appropriate route to protect her (i.e. to HAS) was followed.

Are there lessons to be learned from this case relating to the way in which an agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

3.2.54 In relation to victims, the lessons learned are already shown within the analysis and are listed within the findings and recommendations of this report. Dianne was treated as an individual and tailored plans put together to help her. This illustrates that professionals were 'viewing life through the victim's eyes.'

3.2.55 In relation to perpetrators, Margaret was never categorised as a 'violent offender' under the MAPPA guidance (Multi- Agency Public Protection Arrangements) and this was the correct decision. Margaret had a high alcohol consumption, and this is confirmed in her GP records which shows, at times, Margaret was drinking 14 pints per day. The GP did try to discuss management of this with Margaret, but she declined to seek further help. IDAS, HAS, AGE UK and the Housing team did not

have any contact with Margaret. The CIT could have considered a referral to alcohol support services but as had already been discussed, the CIT were not provided with the full information available.

3.2.55 A key element of learning from this case is around how the perpetrator was managed. On several occasions Margaret and Dianne were not identified as intimate partners and this subsequently affected the multi-agency response.

Did staff make use of available training?

3.2.56 Professionals across agencies did access relevant training. However, there are opportunities for this training to be enhanced and agencies could put more checks in place to ensure their evolving workforce is trained in up to date initiatives.

Did any restructuring during the period under review have any impact on the service provided?

3.2.57 Restructuring of teams did not have any impact on the management or progression of this case.

How accessible were services for the victim and perpetrator?

3.2.59 Dianne and Margaret can both be described as 'regular attendees' to their GP practice. Both had multiple health concerns, and this is reflected in the volume of their attendances

3.2.60 Most services are not 'seven day' services. I.e. the Housing team, Health and Adult Services and AGE UK provide a Monday to Friday service. This can impact on the ability for victims or perpetrators to access services. However, all organisations have limited resources which have been reduced in recent years. It is not a realistic proposition at present to suggest services in these areas could be expanded.

3.2.61 There is evidence to illustrate services were adapted to suit the needs of the victim. Dianne was isolated in a rural community and also struggled with use of the internet. Both the Housing team at Scarborough Borough Council and the staff at AGE UK put measures in place to solve this by making bids for properties on Dianne's behalf. This ensured she had equality of opportunity with others.

3.3 National and Local Perspective

3.3.1 The Crime Survey of England and Wales gives data on the levels of domestic abuse within society. For the year to March 2018 there were 2.0 million adults who experienced domestic abuse (6 in every 100 people). This equates to 7.5% of women and 4.3% of men. Nationally, the police recorded 599,549 offences linked to domestic abuse.

3.3.2 The Home Office homicide index also provides further data. For the year to March 2018, 33% of all female victims of homicide (a total of 63 women) were killed by their current or former partner. This figure of domestic homicide is the lowest for forty years. The downward trend began after the introduction of statutory Domestic Homicide Reviews. However, we should also be mindful that this is still 63 victims and 63 grieving families.

3.3.3 North Yorkshire Police recorded 5,647 offences within the county in the year to March 2018 that were within the category of domestic abuse. This is a huge 52% increase on the previous year (and way above the national trend). However, much of this increase can be attributed to better recording processes and could be seen as a positive step so that victims of domestic abuse are identified at an early stage and therefore receive the right services.

3.3.4 Since the introduction of legislation mandating Domestic Homicide Reviews there have been two previous domestic homicides within North Yorkshire (in 2013 and in 2018). The first Domestic Homicide Review (in 2013) was commissioned by Scarborough Community Safety Partnership (CSP). At that time, each District had its own local community safety partnership arrangements. Since 2014, a county wide CSP has existed; known as the North Yorkshire Community Safety Partnership. The second Domestic Homicide Review occurred in May 2018 and that review is currently progressing, with identified learning being implemented as part of a multi-agency action plan.

Section 4: Equality and Diversity

4.1.1 The protected characteristics named under the Equality Act 2010 are age, gender, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

4.1.2 The characteristics relevant to this review are age, disability and sexual orientation.

4.1.3 Dianne was elderly (70 years old at the time of her death). This was acted on by agencies and Dianne received support from 'Age UK.' Her age is identified a as a factor in the abuse. She had become more reliant on her abuser. However, it did not affect the service received from professionals.

4.1.4 Dianne suffered physically following an operation which had not gone well. Again, this characteristic (disability) made her more reliant on her abuser. This affected the power dynamics of the relationship and this learning is highlighted in the report.

4.1.5 The couple were almost certainly in a same sex relationship. This was not known to Dianne's family. Dianne did disclose their relationship to some agencies (notably during an emergency incident) but the exact nature of the relationship was not known to most professionals. However, this was a choice for Dianne. Practitioners were professional and did ask probing questions for clarification. But there were incidents not progressed through a domestic abuse forum as the relationship was never fully understood.

Section 5: Conclusions and recommendations

5.1 Conclusions

5.1.1 Dianne and Margaret had been in an intimate relationship for 30 years. There had been reports of domestic abuse as far back as 1992.

5.1.2 During the time frame agreed for this review, there was only one incident that could have been assessed as 'high risk.' (In January 2012 when Margaret repeatedly struck Dianne, held her by the throat and threatened to kill her). The incorrect review and downgrading of this incident to a 'standard' risk prevented the case from progressing to the Multi-Agency Risk Assessment Conference (MARAC). This meant that any multi-agency plan to intervene and protect Dianne was not developed. However, this incident was over six years before Dianne's death. There was significant agency involvement in the years that followed.

5.1.3 For reasons which are still unclear, Dianne chose not to disclose the nature of her relationship with Margaret to all professionals who were supporting her. Dianne

and Margaret were intimate partners over several decades, yet Dianne continued to describe them as 'friends.' Agencies did seek clarification on this, yet Dianne maintained they were not intimate partners. We can only speculate on Dianne's actions. She may not have wanted to discuss her sexual orientation, she may have been concerned about any effect to their benefit payments or she may simply have wanted to keep her private life private. Whatever the reason(s), because not all agencies understood or recognised this was an intimate relationship, Dianne was not considered as a victim of domestic abuse within any multi-agency forum.

5.1.4 The dynamics of Dianne and Margaret's relationship had changed in recent years. Due partly to her age (Dianne was 70 years old when she died) and also because of an operation that had gone badly wrong, Dianne became physically weaker and much more reliant on assistance from Margaret. This changed the power balance within the relationship and meant that Margaret could exercise much greater control over Dianne.

5.1.5 The Community Impact Team (CIT) tasking meeting did present an opportunity for a multi-agency intervention. However, through a lack of practitioner's knowledge of processes, poor briefing of attendees and a lack of confidence in Information Sharing Protocols, this opportunity was missed.

5.1.6 It is a sad fact that in the days before her death, Dianne had the opportunity to make a bid on a suitable property that had become available. Simultaneously, an appointment was pending for a home visit by a professional from the Health and Adult Services team. This forthcoming meeting would have taken a full holistic assessment of Dianne's needs and vulnerabilities. She was killed before she knew if her property bid was successful and before her imminent meeting with Health and Adult Services.

5.1.7 Although becoming increasingly frail, Dianne is described by several professionals as an intelligent lady who knew what she wanted to do and how she wanted to achieve her goal of leaving her relationship with Margaret and to be able to live independently on her own. She was aware of the risks within the relationship but believed she could manage these risks while waiting to move on her own terms. Dianne's daughter believes her mum was afraid of Margaret but had no real options. She knows her mum couldn't have dealt with the isolation of living in Scarborough and so wanted to wait for the right property to become available.

5.1.8 Although there was a long history of abuse, no reported domestic abuse incidents were assessed as 'high risk.' (We do not know which incident led to Dianne's stay in Scarborough refuge in 2009). Although there was a history of domestic abuse, there were also long periods (spanning several years) where no domestic abuse was reported to any agency or professional.

5.2 Recommendations

5.2.1 **Recommendation 1:**

All agencies within the North Yorkshire Community Safety Partnership should review their risk assessment training arrangements for domestic abuse cases. The training should ensure staff are confident in making risk assessments based on victim responses, known facts and professional judgement. All training must include a review of the relationship history and any changes in the circumstances of the victim and perpetrator.

5.2.2 **Recommendation 2:**

All front line staff should receive training in the early identification and recording of domestic abuse. Such training should include the importance of enquiring routinely and sensitively about a person's experience in private and exploring intimate relationships / partners or ex-partners, same-sex relationships and wider family structures. It is vital that domestic abuse is identified by practitioners at an early stage if the right specialist services are to be offered to victims and perpetrators; and that the physical and psychological factors experienced as a result of violence and abuse are recognised and appropriately supported by practitioners involved in ongoing general health and care services. The training should include recognition of psychological abuse, economic abuse, harassment and coercive control.

5.2.3 **Recommendation 3:**

The North Yorkshire Community Safety Partnership should conduct a review of the arrangements for its Community Impact Team/ Community Safety Hubs multi-agency meetings. This review to include governance arrangements and a particular focus on the aims and objectives of the Community Impact Team/ Community Safety Hub. Any review to ensure delegates are aware of their responsibilities in relation to preparation, interrogation of their systems, contribution at multi-agency meetings and post meeting responsibilities.

5.2.4 **Recommendation 4:**

All agencies involved in protecting the vulnerable should work together to confirm the most appropriate organisation is working with a vulnerable victim/patient /client /service user. This requires a full understanding of different risk assessment methods and confidence in Information Sharing Protocols.

5.2.5 **Recommendation 5:**

The Community Safety Partnership, Safeguarding Adults Board and Safeguarding Children Partnership should map out structures and governance arrangements to reduce duplication, build a mutual understanding and get the right services to vulnerable people. This process should include an illustration of referral pathways.

5.2.6 **Recommendation 6:**

The North Yorkshire Community Safety Partnership should review its Information Sharing Protocols (ISPs) so that staff are confident in making lawful and proportionate requests for inter-agency information to help protect the vulnerable. Any revised Information Sharing Protocol to be circulated as widely as possible.

References:

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

'Working together to safeguard children' (HM Government 2015, revised 2018)

'Advice for victims and professionals' (Paladin national stalking advocacy service)

MAPPA guidance (Ministry of Justice 2012)