North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of 'Julie'

March 2018

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Contents

Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This overview report has been commissioned by the North Yorkshire Community Safety Partnership following the homicide of 'Julie' that occurred on or before 5th March 2018. Julie is a pseudonym and will be used throughout this review to protect the victim's identity and maintain confidentiality.

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 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 'Julie' 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. Julie's family have been consulted during the review process and their views are reflected in this document. The Overview 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

- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- York Teaching Hospital NHS Foundation Trust
- NHS Vale of York Clinical Commissioning Group (victim's GP)
- Yorkshire Ambulance Service
- North Yorkshire Police
- West Yorkshire Police
- Independent Domestic Abuse Service (IDAS)
- National Probation Service
- Leeds Clinical Commissioning Group (perpetrator's GP)

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
- Jacqui Hourigan – Nurse Consultant, Safeguarding Children and Vulnerable Adults, Primary Care, Scarborough & Ryedale CCG
- Christine Pearson- Designated Nurse, Safeguarding Adults Scarborough & Ryedale CCG and Vale of York CCG

- Claire Lindsay – Adult Safeguarding Manager, North Yorkshire County Council
- Sarah Hill – CEO IDAS (Independent Domestic Abuse Services) North Yorkshire and York
- Louise Johnson – Head of Area, National Probation Service
- Suzy Sweeting – Partnerships Manager, Selby District Council
- Gill Marchant – Head of Safeguarding and Designated Nurse, Leeds CCG
- Beverley Geary - Chief Nurse, York Teaching Hospitals NHS Trust
- Nikki Gibson - Head of Safeguarding, Yorkshire Ambulance Service NHS Trust
- John Needham - Deputy Head of Safeguarding, Leeds and York Partnership 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 Terms of Reference

1.5.1 The following terms of reference were agreed by the Review panel with regards to the homicide of Julie:

- 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?

- Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

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

- Was information recorded and shared where 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 other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

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

- 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?

1.6 The subjects of the review

1.6.1 The subject of this review is the victim; the pseudonym 'Julie' will be used throughout the review. On the date of her death she was 51 years old.

1.6.2 The perpetrator is identified as the pseudonym 'Marcus'. He is the ex-husband of Julie and was 49 years old at the time of the homicide.

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

1.7 Confidentiality

1.7.1 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.

1.7.2 To protect the identity of the victim and their family the pseudonyms identified in 1.6 above will be used when referring to the victim, perpetrator and other key individuals.

1.7.3 The victim Julie and the perpetrator Marcus were both British nationals. Although they spent lengthy periods abroad, they were mainly resident in the UK.

1.8 Background

1.8.1 The Crime Survey of England and Wales gives data on the levels of domestic abuse within society. For the year to March 2017 there were 1.9 million adults who experienced domestic abuse (6 in every 100 people). This equates to 7.5% of women and 4.3% of men. The police recorded 488,049 offences linked to domestic abuse.

1.8.2 The Home Office homicide index also provides further data. For the three years April 2013 – March 2016 there were 454 domestic homicides recorded in England and Wales. 70% of victims were women.

1.8.3 Within North Yorkshire, the Community Safety Partnership provides information via the 'North Yorkshire and City of York Domestic Abuse Overview strategy 2014-2018.' There were 10,111 incidents of domestic abuse reported within the county during 2013-2014. Within North Yorkshire, 30% of assaults are domestic abuse related. Since the introduction of legislation mandating Domestic Homicide Reviews there has been one previous domestic homicide within North Yorkshire (in 2013). That Domestic Homicide Review was commissioned by Scarborough Community Safety Partnership. At the time each District had its own local community safety partnership

arrangements. Since 2014, a county wide community safety partnership has existed; known as the North Yorkshire Community Safety Partnership.

Section 2: The Facts

2.1 Case specific background

2.1.1 The victim, Julie, was born in 1966 and was 51 years old at the time of her death. Although she was divorced from Marcus, the couple continued to stay in touch with each other. Marcus lived only a short distance from Julie. Julie was a freelance beauty therapist and a part time self-employed property developer. She first met Marcus in 2010. Julie has an adult daughter from an earlier marriage.

2.1.2 The perpetrator, Marcus, was born in 1968 and was 49 years old at the time of the homicide. He is a self-employed builder and property developer. His first wife had died from cancer in 2008. He has two adult sons from his first marriage. He had two previous convictions for violence. The first was in 1995 and followed an attack on the male friend of a former partner of Marcus. The second was in 2014 and related to a serious assault upon Julie. Information has also been discovered since Julie's death of Marcus perpetrating significant domestic abuse to his former fiancée.

2.1.3 Julie reported domestic abuse to the police which she suffered at the hands of Marcus. The first occasion was on 21st August 2013 when she reported an assault that had occurred four days earlier while the couple were on holiday in Greece. Upon returning to the UK, Julie reported that Marcus and she had argued. During the argument he grabbed her by the throat with both hands and squeezed tightly shouting "I'm going to kill you." Julie pleaded for him to let her go. He threatened to throw her from the balcony. Eventually he calmed down and released his grip. Julie collected her belongings and passport and made her way to the airport to fly straight home. Marcus remained in Greece. Julie reported the incident to the police and an investigation was carried out. However, the relationship continued.

2.1.4 The next incident of domestic abuse that Julie reported to police was on 28th June 2014. She telephoned '999' to report she had just been strangled by her husband, Marcus. He had left their home address but was traced by officers shortly afterwards and arrested. He was charged with assault occasioning actual bodily harm and threats to kill and was subsequently remanded in custody awaiting trial. Following several suicide attempts Marcus was transferred to a secure hospital. In October 2014 he pleaded guilty at York Crown Court and was sentenced to be detained on a Hospital Order (section 37 Mental Health Act). However, following his release in February 2015 he and Julie resumed their relationship.

2.1.5 Julie and Marcus met in 2010 and married on 12th May 2014. They were divorced on 26th August 2015, but they did remain in close contact with each other.

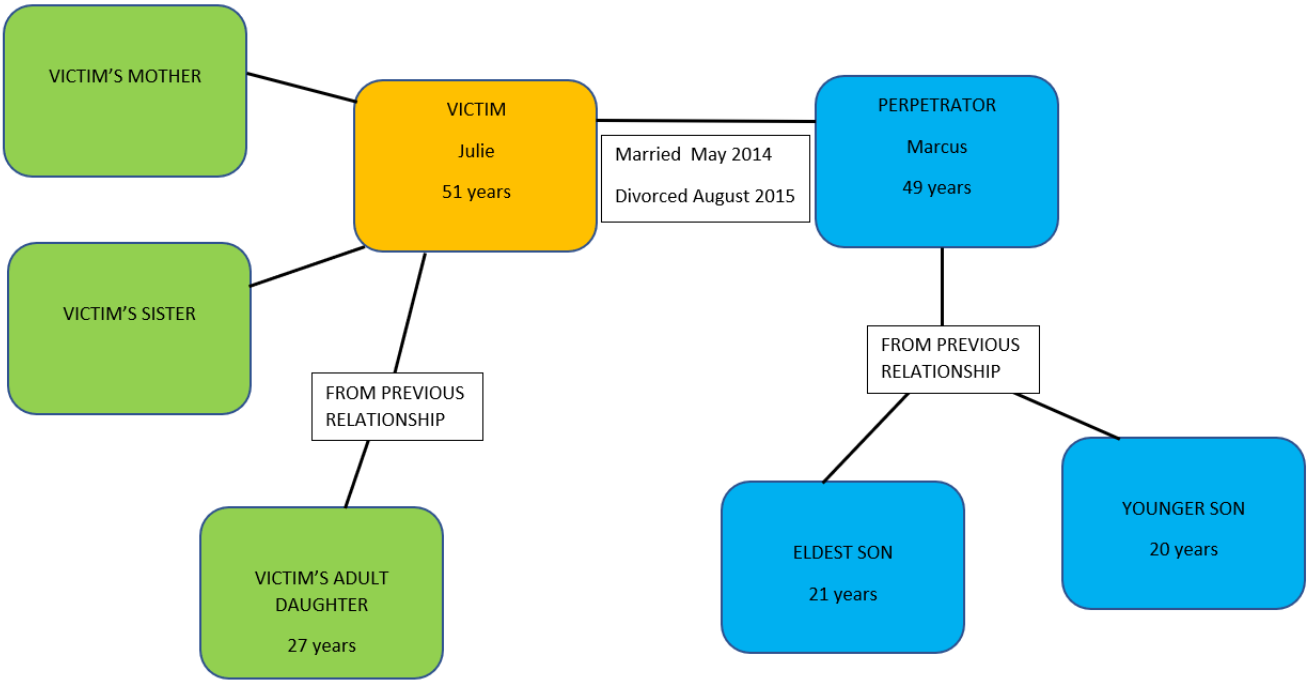
2.1.6 Several agencies had contact with Julie and Marcus. This included their case being listed at four separate MARAC meetings (Multi Agency Risk Assessment Conferences) which is the recognised national process to manage the highest risk cases of domestic abuse.

2.1.7 On 5th March 2018 a '999' call was received by police in Cumbria. Marcus stated he had killed his ex-partner, Julie. He gave further information about where her body was located. Shortly afterwards, officers from North Yorkshire Police found Julie's body at her home address. Marcus was charged with Julie's murder on 6th March 2018. A post mortem examination gave the cause of Julie's death as strangulation. The post mortem also showed bruising to Julie's face. Although a fall could not be ruled out, the Home Office pathologist believed the most likely cause of the bruising was from an assault.

2.1.8 On 24th September 2018 Marcus appeared at Leeds Crown Court. He pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility. His plea was accepted by the prosecution following submission of a psychiatrist's report by the Defence. On 12th November 2018, Marcus was sentenced to life imprisonment with a minimum tariff of 10 years. He will be detained in a secure hospital until his treatment is completed and then serve the remainder of his sentence in HM prisons.

2.1.9 All grounds for discrimination or "protected characteristics" in the Equality Act 2010 i.e. age, disability, race, marriage, religion/belief have been considered. These had no bearing on any agency involvement.

2.2 Genogram


VICTIM'S MOTHER
VICTIM
Julie
51 years
Married May 2014
Divorced August 2015
PERPETRATOR
Marcus
49 years
VICTIM'S SISTER
FROM PREVIOUS RELATIONSHIP
FROM PREVIOUS RELATIONSHIP
VICTIM'S ADULT DAUGHTER
27 years
ELDEST SON
21 years
YOUNGER SON
20 years

2.3 The Individual Management Reviews

2.3.1 Nine agencies have provided Individual Management Reviews and chronologies. These reports have closely examined the actions of their respective agency and provide detailed accounts of each agencies' contacts with Julie and Marcus. The IMR authors were not involved in this case and have no line management responsibilities relating to the staff involved with Julie and Marcus. Each author was briefed on the terms of reference and asked to consider these as they gathered facts and analysed their organisation's actions. The summary of each agency's Individual Management Review is provided:

2.3.2 <u>WEST YORKSHIRE POLICE</u>

- At the time of her death, Julie was not living in West Yorkshire and West Yorkshire Police had no direct involvement at that time with Julie or Marcus.

- Julie had no previous police convictions. Marcus was recorded on the Police National Computer (PNC) with a conviction for assault relating to an incident in 1994. Although the assault conviction did not relate to a partner or family member, the circumstances were that Marcus assaulted a male friend of his former partner.

- On 21st August 2013 Julie reported an assault to West Yorkshire Police. The incident had occurred a few days before while Julie and Marcus were on holiday in Zante, Greece. Marcus's 15-year-old son had also been present. They had been on holiday for over a month and Zante is also the home of Marcus's father. Marcus owns property on Zante.

- In her statement provided to officers from West Yorkshire Police, Julie described her relationship with Marcus as 'up and down.' During an argument Julie said Marcus 'flipped.' He grabbed her by the throat and with both hands squeezed very tightly. As Marcus shouted "I'm going to kill you here and now" Julie couldn't breathe and felt dizzy. Marcus's nails dug into her neck and she could hear herself gurgling. When Marcus released his grip, Julie ran across the room, but Marcus pinned her to a table. He threatened to throw her over a balcony. Julie pleaded for him to let her go. Eventually Marcus did release her. They chatted briefly. Marcus asked Julie if she was going to the police and that he 'couldn't take this sort of crap.' Julie believed this meant he would take his own life. As Julie was packing to go back to the UK, Marcus told her if she said anything to his family then he would 'be visiting your mum when I get back.'

- Marcus's actions and comments during this incident suggest the significant degree of control he was trying to exercise over Julie.

- Julie visited her GP. She had scratches, swelling and internal bruising to her neck and she had a sore throat. In addition, she suffered bruising to her leg.

- In compliance with their own policies and procedures, West Yorkshire Police completed a risk assessment. They used a nationally recognised 'DASH' risk assessment tool. This tool indicates (by a scoring system or by professional judgement) the assessed level of risk to the victim (i.e. Julie). The police officer assessed this case as 'high risk.' (the highest level of risk of harm). The risk assessment was subsequently reviewed by a specialist officer from West Yorkshire Police's Safeguarding Unit. This officer reduced the level of risk to 'medium' and sent this revised risk decision to her supervisor. The decision to reduce the assessed level of risk was ratified by the police supervising officer. The supervisor does document the reasons for their decision. These include that the subject lived away from the victim and was currently wanted by police, there were no children involved and that the victim's details had been passed to 'Victim Support.' They also documented this was the first recorded domestic violence incident and that the victim had only received one text from the perpetrator in the previous weeks.

- The Independent author has reviewed the actions and decision-making of West Yorkshire Police during this episode and believes this to be a missed opportunity for intervention. Full details within the 'analysis' section of the overview report will highlight the number of factors which suggest Julie was in fact at risk of significant harm with both physical violence and controlling behaviour evident throughout this episode. The reduction in risk level from high risk to medium risk prevented this case from passing to the Multi Agency Risk Assessment Conference (MARAC) which would have generated a full multi agency response to this case.

- West Yorkshire Police continued with their investigation into the incident in Zante. The investigating officer was a local Leeds District Officer, not a specialist domestic abuse investigator. This officer rang Marcus who stated he would not be back from Greece for several weeks. The officer had called at Marcus's home address to find his 15-year-old son there alone. He told police that he lived there with his 17-year-old brother and his dad. He said his dad was out at work. The police officer rang Marcus's number. Marcus said he was still in Greece and would be home in a few weeks though he wasn't sure exactly when. The officer questioned who was taking care of his 15-year-old son. Marcus indicated his mother looked after her grandsons while he was away. The officer called at Marcus's mother's home. She told police she tried to go and visit them daily. The officer confirmed the house was clean and tidy and that the fridge was well stocked. The 15-year-old was in tears when the officer arrived but would not say why. The officer raised the issue with their supervisor. However, the supervisor deemed that so long as the grandmother continued to look after the grandsons then the child care was to be left with the family. No referral was made to Children's Social Care, which is not in line with expected safeguarding practice and further comment will be made within the 'analysis' section of this overview report. Although the

responding officer carried out further checks by noting conditions within the home and contacting the grandmother, there were a number of concerning factors apparent: that the boys had been left living alone for several weeks (though accepted with visits from their grandmother), the father could not be sure exactly when he was returning from Greece, that police were seeking to trace the father for a particularly violent assault on his new partner and that the 15 year old may have witnessed the domestic abuse in Greece.

- When Marcus returned to the UK he was interviewed about the matter. However, before he returned Julie contacted the police. She stated she did not wish to pursue the complaint and wanted to retract her statement. She had spoken with Marcus and he said he will go and get some help. The officer explained to Julie that Marcus still needed to be interviewed about the matter. Marcus attended the police station as a voluntary attendee on 7th September 2013. He was not arrested as there is no specific power of arrest for an assault occasioning actual bodily harm when the offence took place in Greece. He denied the allegation. The crime was then filed as 'no crime.' It is not clear why the crime was recorded as 'no crime' as the offence took place abroad but was reported to West Yorkshire Police in the UK. It was a crime and should have been recorded as such. This would have been the correct course of action to comply with the Home Office counting rules. This is a missed opportunity**.** Further comment will be made within the 'analysis' section of this overview report relating to evidential thresholds, the severity of the violence, the on -going risks within this domestic abuse case and the potential views of the Crown Prosecution Service (CPS) in taking this matter forward (in liaison with their counterparts in Greece) irrespective of Julie's wishes.

- West Yorkshire Police had no further involvement with Julie or Marcus for a further ten months. On 2nd July 2014 they received information from colleagues in a neighbouring force; North Yorkshire Police, of a domestic incident that had taken place between Julie and Marcus at their home address. The reason for passing the information from North Yorkshire to West Yorkshire was that Julie was staying at her mother's address within the West Yorkshire area. Upon receiving the information, West Yorkshire Police created a 'marker' on the address which would highlight the matter to any attending officers. This is good practice between North Yorkshire and West Yorkshire Police and was effective at managing the on-going risks to Julie and her mother.

- Two months later, on 12th September 2014 West Yorkshire Police received further information when they were notified Marcus was now a hospital detainee within their area at the Newsam Centre Leeds. He had been transferred there from HMP Lincoln.

- On 12th February 2015, West Yorkshire Police received further information directly from the Newsam Centre in Leeds. The information related to Marcus's planned discharge into the community. There was a delay in the sending of this information to

the police which placed Julie and her family at risk. This information is covered at length in the Leeds and York Partnership NHS Trust IMR and so no further comment will be made here. On receipt of the information, West Yorkshire Police put measures in place to ensure the welfare of Julie and her family. This was important as the information suggested that Julie and Marcus were still seeing each other regularly. Marcus was living in the West Yorkshire Police area and Julie would often stay at her mother's which was also in the West Yorkshire area.

- There was no further involvement from West Yorkshire Police with Julie or Marcus for a further eleven months. On 20th January 2016, they received information from colleagues in North Yorkshire Police that although Julie herself was living in North Yorkshire, Marcus had made threats to Julie's mother who lived in West Yorkshire. Officers carried out a welfare check with Julie's mother, aged 71 years. She was given advice and reassured around her own safety and security. This was the last involvement from West Yorkshire Police prior to Julie's death.

2.3.3 YORKSHIRE AMBULANCE SERVICE

- Between June 2014 and March 2018, there were a total of 11 calls or contacts between Julie and Marcus and the Yorkshire Ambulance Service. Six of these contacts were in June 2014. The first on 9th June was Julie reporting that Marcus had taken an intentional overdose. He was drowsy and wouldn't let her take him to the hospital. The attending ambulance crew found him alert. He had taken citalopram and antihistamines. He told the crew his intention was to end his life. Julie told them she thought he had a breakdown that morning. The ambulance service notes also recorded that Julie and Marcus had returned from Thailand (where they had been on honeymoon) the previous day. Marcus was taken by ambulance to the Emergency department at York Hospital for further assessment.

- The next three calls in June relate to both Julie and Marcus seeking medical advice about the earlier overdose or medical needs related to their trip to Thailand. Possible malaria was mentioned, and both were referred to their GP.

- On 28th June 2014, ambulances were called to attend both an industrial estate and Julie's home address. Marcus was at the industrial estate. He had been drinking and there were empty paracetamol and codeine packets in his car. The crew assessed he may have taken an intentional overdose, but Marcus refused to attend hospital. The crew deemed he had the mental capacity to make that decision. However, Marcus was placed under arrest by police officers at the scene and placed in a police car. The ambulance followed the police vehicle to the hospital. At the same time, the ambulance crew who attended Julie's home documented she told them Marcus had strangled her until she lost consciousness. They could see red marks on her neck and documented she was anxious and had problems swallowing. Eventually, Julie agreed

to go to hospital. The crew documented they were planning to submit a safeguarding referral for Julie, but no record can be found of this. This is a missed opportunity to highlight Julie's vulnerability. Further comment will be made within the analysis section of this overview report relating to systems and procedures.

- There is no further Yorkshire Ambulance Service involvement with Julie or Marcus for over two and a half years. On 16th January 2017 Julie called '999' to say she had fallen downstairs. During the call, she indicated she was not alone but did not say who was with her. She had bruising to her right thigh, right forearm and pain in her back. She was taken by ambulance to York Hospital Emergency department. The documentation shows Marcus was going to follow the ambulance. We do not know if this was a genuine fall downstairs or whether the reason was more sinister. We can only speculate but we do know Julie did not suffer from any condition that would increase her risk of falls. With the previous history of domestic abuse, it is reasonable to believe this may have been a domestic assault. Victims of domestic abuse are not 'flagged' on Yorkshire Ambulance Service systems. A 'flag' may have given the attending crew an indication to ask the patient more probing questions. (Though this call was to a different address to earlier incidents). If this had been done, then perhaps Julie may have disclosed the assault and interventions could have been put in place to protect her. The incident therefore has to be regarded as a missed opportunity. Further comment will be made as part of the multi-agency recommendations for this review.

- There were three further calls to the Yorkshire Ambulance Service either from or relating to Julie and Marcus, but none are relevant to this review.

- The final call to Yorkshire Ambulance Service was from the police on 5th March 2018. The crew found Julie laid on the sofa of her home. They noted the marks on her neck and could find no sign of life. They pronounced life extinct and left Julie's body in the care of the police.

2.3.4 <u>Independent Domestic Abuse Service (IDAS)</u>

- The Independent Domestic Abuse Service (IDAS) provides an IDVA (Independent Domestic Abuse Advocate) to support victims through the criminal Justice process and also deploys 'Outreach' support within the community or at home. IDAS were contacted following the serious assault in June 2014 and provided support to Julie. The member of IDAS staff assessed Julie and agreed a support plan with her. The IDVA used the DASH model of risk assessment which 'scored' 18. This is a high figure and assesses the victim at high risk of significant harm. There were two questions on the assessment tool which were not answered so we can see the actual 'score' may have been even higher. As the case was deemed 'high risk' it was referred to the MARAC (the Multi Agency Risk Assessment Conference which would discuss Julie's case and

prepare a safety plan involving all relevant agencies). Julie did not consent to the referral. However, the IDVA followed agreed protocols linked to risk management and information sharing and so took the decision to refer to the MARAC anyway. This is good practice and is sometimes necessary if agencies are to proactively manage a victim who may not feel able to ask for further interventions at that time.

- Subsequent involvement with Julie was for IDAS staff to carry out a holistic assessment of Julie's life and her needs in relation to housing, finance, health, safety and support. Julie was also signposted to her GP. Julie expressed she felt safe as Marcus was in custody, but she agreed to continued telephone contact. From 24th September 2014 Julie decided she did not want further support and her wishes were respected.

- Although much of the work from IDAS was thorough and holistic there are several sets of notes missing from files. At that time, IDAS did not have electronic recording systems in place. Poor record keeping will be commented on in the analysis section of this overview report.

- There was no further contact between IDAS and Julie including when her case was heard at MARAC in 2017. These protocols will also be scrutinised further within the analysis.

2.3.5 NATIONAL PROBATION SERVICE

- The victim, Julie is of good character and has no criminal convictions. Therefore, she has never had any contact with the National Probation Service.

- In relation to Marcus, the National Probation Service did log his appearance at York Magistrates Court in June 2014 and subsequently his appearance at York Crown Court in July 2014. However, there was no requirement for a pre-sentence report as Marcus received a section 37 Mental Health Act Hospital Order. There was no statutory supervision by the probation service and the lead agency for a hospital order is Health.

- All other involvement from the National Probation Service relates to their involvement in the MARAC meetings or in the screening process for MAPPA (Multi Agency Public Protection Arrangements).

2.3.6 YORK CCG (Victim's GP surgery)

- Julie first registered with her GP practice on 10th October 2012. It is worthy of note that Marcus was not registered at the same GP practice. There was 'nothing of note' within Julie's earlier records transferred from her former GP.
- Over the six years Julie was registered as a patient with the practice, she had 60 contacts or appointments with doctors or nurses at the surgery. The IMR author notes

this is not an unusual or excessive figure. Most of the reasons for her attendance are medical but not relevant to domestic abuse and so Julie's privacy will be respected and no further comment on those visits made.

- The first appointment that is connected to this Domestic Homicide Review is on 21st August 2013. Julie informed her GP that her partner had attempted to strangle her whilst they were on holiday in Greece. Julie thought she was going to pass out. Her partner had also threatened to kill her and to harm her mother if she told anyone about it. The doctor noted her voice was hoarse and she had pain to the right side of her neck. There are some positives to this attendance in that Julie is referred to the ENT (ear, nose and throat) specialists for an assessment of her injuries and the notes state 'IDAS number given.' However, there was no evidence of any formal risk assessment taking place. To anyone, this would sound a particularly serious incident. The medical notes state 'Julie is planning to report to the police' but the GP could have done more to confirm this had been done. This lack of a recognised risk assessment meant there was no referral to MARAC. Such an assessment could also have potentially identified if children or young people were present during the incident which would have required a safeguarding response through a child protection referral. Further comment on this will be made in the analysis section of the overview report.

- On 9th September 2013 Julie saw the GP as she was struggling to come to terms with what had happened. She was in touch with police and was away from danger. The GP recommended counselling sessions. Of note Julie stated to her doctor that she still loved Marcus. This is important to note as this is during a one on one private conversation with no other compulsions linked to the criminal justice process or witness statements. Clearly Julie is expressing she still has strong feelings for Marcus.

- On 28th June 2014 the surgery received notification from the Accident and Emergency department at Leeds Teaching Hospital after Julie had attended following an assault.

- Two days later on 30th June 2014 Julie attended the surgery for an appointment and disclosed her partner had assaulted her over the weekend. He had strangled her in the bathroom and she had woken up after 'blacking out.' She said her partner had been arrested. She had pain in the neck and visible bruising. Although the doctor documented the injuries and suggested contacting the police, again there was no formal risk assessment carried out. This was the second strangulation episode known to the surgery. The file was coded as 'domestic abuse,' which is good practice and allows future practitioners to be aware of the history, but nothing further was done to assess the risk or contact other agencies. Some of this is mitigated two days later when on 2nd July North Yorkshire Police sent the request for Julie's medical records. However, even if the GP surgery believed the police would now deal with the risk assessment, the fact is that victims may give a different account to different agencies. This is especially so when it could be argued a patient is more likely to give a full

account to their GP rather than to the police (who, by the nature of their role, may take action against the victim's partner).

- On 29th August 2014 Julie attended and stated she was depressed in her mood. Her husband had tried to hang himself in prison. The GP discussed counselling support and medication. Julie did not want medication at this time but did accept a referral to counselling.

- Subsequent records indicate that Julie had 14 appointments with a counsellor, arranged via the GP, between September and December 2014. The counsellor was interviewed as part of this Domestic Homicide Review. The counselling notes do not add anything of further value to this process.

- Julie accessed further counselling sessions provided via the GP practice between November 2015 and February 2016. Notes state she is experiencing less distressing 'flashbacks.' She had an appointment with her GP on 3rd December 2015. She confirmed she is still seeing the counsellor. She wasn't sure if her condition had given her a physical symptom, but she stated she now felt okay. She would consider PTSD or IAPT to stop the flashbacks of her ex-husband assaulting her. The GP advised against having two therapies at once.

- On 27th April 2017 Julie attended for an appointment suffering from chest pains. She relayed there were significant stresses being in a relationship with someone with a psychotic personality. He had attempted to strangle her and there had been 'minor' attacks. The police were involved. He had made multiple attempts to kill himself. Julie stated she still has a 'relationship of sorts' with him but she needs to end the relationship for her health. Her partner is in Greece at present. He is not taking the relationship split well and wants to keep in touch. The GP noted she has had counselling and had support from the police and domestic abuse services.

- Julie returned to the surgery two weeks later, on 11th May. She was feeling reassured and had no physical symptoms now though she still felt 'jittery' at times. The doctor discussed being clear on her relationship with her partner. She said he was in Greece and she now has reduced contact with him. She would like to split amicably but does not know how he would react. The doctor discussed thinking about her safety when he returns to the UK.

- Julie attended eight more appointments at her GP surgery prior to her death. None appear to relate to domestic abuse and none of the notes discuss domestic abuse.

- Finally, it is useful to remember that Julie's surgery is a large busy GP practice. Although Julie attended for 60 appointments or telephone follow- ups, she had contact with at least 20 different health professionals during these appointments or

conversations. This illustrates the importance of good record keeping and accurate coding of issues, so that when a patient attends, the health professional can make an informed assessment even if they personally had not met the patient before. The records and coding at this practice are considered robust and accurate by the IMR author.

2.3.7 NORTH YORKSHIRE POLICE

- On 28th June 2014 Julie rang '999' and informed North Yorkshire Police that she had just been strangled by her husband Marcus. He had left the house and threatened suicide. Marcus was traced and arrested. He stated he had taken a quantity of pills and so was detained under the Mental Health Act and taken to York District Hospital. The attending officer assessed this case as 'high risk' (as per the national DASH model) and so the investigation was passed to the 'Protecting Vulnerable Persons Unit' for their specialist officers to continue with the enquiry. Julie provided a written statement which included details that Marcus had told her early in their relationship how he had been physically violent, including using strangulation, towards others. Julie's statement also included the previous incident when she had suffered the strangulation at the hands of Marcus in Greece in 2013.

- Julie also made comment in her statement that she and Marcus had become engaged in December 2013. Of note she stated to the police that Marcus had asked her a few times, but she finally agreed to the engagement as she believed it may stop his paranoia about her seeing other people. They had married in May 2014, but Julie said she felt under pressure to agree to the marriage as she found Marcus paranoid and controlling.

- During the honeymoon in Thailand his jealous behaviour had escalated. On one occasion he grabbed her by the neck and pushed her down on the bed. This caused her lip to swell and bleed. Marcus put a pillow over her head and threatened to 'finish her off.' Julie bit his hand and he released her. She told officers she had intended to leave him when they returned to the UK. When they did return Marcus had sought psychiatric help. However, on 28th June, she did tell him she would leave him, and he grabbed her throat, pushed her to the floor and threatened to kill her. She lost consciousness. When she came around, she had trouble breathing. Marcus had left, and Julie telephoned the police.

- Julie was visited by a specialist 'Domestic Abuse Officer' from North Yorkshire Police. This is good practice so that a holistic assessment can be made. Unfortunately, the visit was only by the police. Protocols are in place for 'joint visits' with a professional from IDAS (Independent Domestic Abuse Service) but it is believed there was no member of staff available. A thorough investigation was carried out and Marcus was charged with an 'assault occasioning actual bodily harm' and threats to kill. He was

remanded in custody. Julie was kept updated and she was safe while he was in custody. Marcus subsequently received a six-month hospital order. Julie was pleased with this and expressed to professionals that she wanted him to receive treatment.

- North Yorkshire Police referred the case to the Multi Agency Risk Assessment Conference (MARAC) with Julie's consent, where the case was listed on 25th July 2014. This facilitated further information exchange and outlined actions which were designed to protect Julie. This provided on-going safety assessments. This whole incident, from initial call, prompt action, through to effective investigation by specialist officers, charges and remand in custody and finally to MARAC for a multi-agency plan was dealt with well by North Yorkshire Police.

- On 12th February 2015 North Yorkshire Police were informed by colleagues in West Yorkshire Police that Marcus had been given leave from hospital. North Yorkshire Police then contacted Julie (who resided in North Yorkshire) and learned that in fact Marcus was already at Julie's address. He left before officers attended. When they arrived, the police convinced Julie to stay at her mother's house for her own safety.

- On 24th February 2015 the hospital informed a Domestic Abuse Officer in North Yorkshire Police that they had given permission for Marcus to attend the Lake District with Julie. The Domestic Abuse Officer conferred with their supervisor. The decision was made not to intervene. The rationale was that Julie was with Marcus, she was fully aware of the risks and that to intervene or contact Julie on the telephone may increase Marcus's paranoia and thus increase the risk to Julie.

- The case was listed again at MARAC on 5th March 2015. A Domestic Abuse Officer had contacted Julie who stated the relationship was over and that Marcus had taken the news well. There were no specific actions set at this MARAC, but all agencies were given the opportunity to exchange up to date information about the couple and their relationship.

- Five months later, on 19th August 2015, North Yorkshire Police received information from the NHS that the relationship between Julie and Marcus had resumed. It does not appear that any action was taken with this updated information. This is a missed opportunity for intervention. Professionals knew the severity of the incident that Marcus had been previously detained for on a hospital order. They also were aware of his previous strangulation attacks in Greece and in Thailand. The resuming of the relationship should have triggered a more positive response. Julie may have chosen to resume the relationship, but an assessment may have given an indication of levels of control etc.

- On 30th August 2015 Julie's sister contacted North Yorkshire Police. She stated Julie and Marcus were now divorced but Marcus was not happy about it. Officers spoke

with Julie who confirmed Marcus had driven by the house. Her sister was staying at the house with her. The message on police systems suggests Julie would contact the Domestic Abuse Officer in the morning. Although the initial actions (i.e. Julie has her sister with her) were proportionate at that time it is poor practice for the specialist officer not to proactively contact the victim. The onus should be on the professional agency not on the victim. This is especially so as Marcus had a history of significant violence to Julie and was now exhibiting signs of stalking. The message was never passed to the Domestic Abuse Officer from the Control Room. It also appears that at that time there was no proactive checking by the Domestic Abuse Officers of the running '24-hour log' which would have highlighted a domestic abuse case. This was a missed opportunity for an early intervention with a potential stalking case.

- On 5th November 2015 North Yorkshire Police visited Julie's home address**.** Julie confirmed that although now divorced she had been seeing Marcus on a regular basis. The officers noticed she was still wearing a wedding ring and there were photographs of the couple around the house. Julie told them that she hoped to fully resume the relationship. Although they had a couple of arguments Marcus had not been violent. Julie insisted that she was aware of the danger signs and she knew how to safeguard herself if matters escalated and she knew who to call. Julie declined an offer to refer to IDAS. The officers did tell her that the case would again be listed at MARAC due to their concerns for her. This is good practice. Although Julie did not want further help the correct action was to take this case back to MARAC where information from all professionals could be shared and the police were proactive in doing so.

- On 6th November 2015, a Domestic Abuse Officer at North Yorkshire Police was contacted by the Forensic Outreach Team. Julie had apparently telephoned them with concerns that she believed Marcus was recording their telephone calls. She had expressly asked that the team did not inform the police. The officers had only visited Julie the day before and so decided not to contact Julie. She had received up to date safeguarding advice and any contact now would potentially create mistrust between Julie and the Forensic Outreach Team and thus prevent Julie from engaging with them in future. This appears to be a sound decision. The decision paid dividends as the following day Julie did in fact report the matter to North Yorkshire Police on the advice of the Forensic Outreach Team. She also told officers she was going away for a few days to make a clean break from Marcus. There does not appear to be a recognition by officers of stalking taking place. This will be subject of further comment in the analysis section of this overview report.

- On 20th November 2015 Julie and Marcus's case was again listed at the MARAC. Information shared at the meeting included Julie telling Forensic Outreach that Marcus's mental health was deteriorating, and he was becoming increasingly paranoid. He was not taking his medication and turning up at Julie's house unannounced. The MARAC acknowledged that professionals were struggling to find answers on how best to safeguard Julie. The 'on / off' nature of the relationship was

creating difficulties around making an informed assessment. This will be subject to further comment in the analysis section of this overview report. Information shared also suggested that both Julie and Marcus believed they were each recording each other's telephone calls. One action was to update Julie and police checked her telephone and gave advice around 'Spyware.' The location device on the telephone was switched off. An alarm was considered but all professionals acknowledged this was irrelevant while Julie was inviting Marcus into the property. Julie refused a referral to IDAS. This may have been a missed opportunity and will be subject to further comment in the analysis section of this overview report.

- Three days later, on 23rd November Julie rang North Yorkshire Police to say that for the last few nights she had received a text from Marcus stating 'Good night' when she turned her lights out. She was concerned he may be watching the house. Julie did not require a visit but wanted the call logged. No further action was taken by officers in the Force Control Room. This is poor practice**.** With the earlier incidents of driving by the house and of allegedly recording telephone calls this was yet a further extension of stalking behaviour. In addition, police systems already had entries relating to previous strangulation incidents from Marcus to Julie. Stalking is recognised as high risk, extremely dangerous and obsessive behaviour. Irrespective of Julie's wishes this should have warranted further intervention. Further comment will be made in the analysis section of this overview report.

- Two months later, on 22nd January 2016 Julie reported to North Yorkshire Police that Marcus was demanding a necklace back from her and that he sounded agitated. She briefly mentioned she was moving to France and Marcus did not know. She was also concerned that as Marcus lives in West Yorkshire, she was worried he may go to the address of her mother. North Yorkshire Police took positive action. Even though Julie did not want an officer to attend one did so. She was given safeguarding advice. A message was sent to West Yorkshire Police to check on the welfare of Julie's mother. This was completed. A Domestic Abuse Officer reviewed the DASH risk assessment. There was a low 'score' (standard risk) but the officer correctly used professional judgement to re assess the incident as high risk due to the previous incidents including the strangulations. The case was therefore listed at MARAC. Julie confirmed that she changed the locks to her property.

- A full year elapsed before further contact between Julie and North Yorkshire Police. On 2nd January 2017 Julie rang North Yorkshire Police. She reported Marcus had turned up at her house and was asking for some property. He was stopping her from leaving and refusing to give her house key back. When officers attended, Julie had left but they did speak to her on the telephone. The couple were again trying to 'make a go' of the relationship. Julie stated no threats had been made. Following submission of the DASH domestic abuse risk assessment (assessed as 'medium risk') a Domestic Abuse Officer made contact with Julie the next day. By that time Julie had decided to

separate from Marcus. Julie was reassured she did the right thing in telephoning police. The officer also gave Julie safeguarding advice.

- It was eight months later, in September 2017, when Julie next contacted North Yorkshire Police. She said Marcus had stayed overnight but the following morning had become aggressive when she asked him to leave. He made threats with his fist towards her and took her car keys to stop her from leaving. Officers attended, and Marcus was arrested for common assault and criminal damage to the property. Julie provided officers with a witness statement. The statement included details that Marcus was living with Julie and was contributing to the rent until the house he had purchased was ready. Prior to this Marcus had been living in Greece for six months. They had been getting along well since his return. However, Julie had decided that she did not wish to remain with him on a permanent full-time basis. He had not taken this news well. As well as raising his fist he had blocked her car on the drive, so she could not leave. A DASH risk assessment was carried out. Julie did not consent to an IDAS referral. Julie did state she was considering taking out an injunction. Following his arrest Marcus was bailed with conditions not to have any contact with Julie. There was an opportunity to consider a Domestic Violence Protection Notice. However, in this case Marcus was on bail with conditions and so the use of a DVPN in those circumstances would not have been appropriate. This was a high-risk case due to the history of incidents between this couple. The assault was a threat with a fist. There was no other corroborating evidence in terms of CCTV or witnesses in nearby houses. The case progression manager decided to take no further action. Even though this was a high-risk incident the case must pass an evidential threshold and this case simply did not do so. Of more concern is the lack of follow-up action. The local Domestic Abuse officer was not informed and therefore did not contact Julie. This was exacerbated by Julie herself ringing the police to say she was not happy with their decision. She asked to discuss the matter with the officer dealing with the case. North Yorkshire records indicate an e mail was sent to this officer to contact Julie. However, the officer updated the log that they have been unable to do so due to workload. This is poor practice towards a high-risk victim. Further comment will be made in the analysis section of this overview report.

- The above case was listed at MARAC on 13th October 2017. Actions for the police were to contact Julie to check on her welfare and to obtain any relevant information from her GP and Tees Esk and Wear Valley Mental Health Trust. Julie informed the Domestic Abuse Officer that Marcus had not been to the property since the incident. Again, Julie declined a referral to IDAS. There have been some shortcomings identified in the MARAC actions which will be commented on later.

- On 6th February 2018 Marcus attended York police station. He told officers that his first wife died on 8th February several years earlier, and that at this time of year Julie gets jealous of his deceased wife and starts arguments. He further stated that he has been seeing a counsellor, that his behaviour is under control and he is now in a ‘better

place.' He said she is lovely to him when other people are around but gets nasty when they are alone. The reason for his visit was he wanted to speak to an officer about a property dispute. No officers were available, so he attended an appointment at Selby police station the following day. The officer did complete a DASH form and no offences were disclosed. Marcus said he did not want Julie informed as it may make the current situation worse. Although the case was reviewed by a Domestic Abuse Officer, they did not make contact with Marcus. This is not in compliance with Force policy. This states all victims (which in this case Marcus had been recorded as the victim) should be contacted by a Domestic Abuse Officer. Although it is accepted that the original officer may have given all the correct advice, this case (due to its violent history) should have warranted a further intervention from a Domestic Abuse Officer. We do not know if Marcus would have given further information, but it is a missed opportunity. Given Marcus's mental health background he may well not have felt he had been listened to.

- This was the last contact with North Yorkshire police prior to Julie's death.

2.3.8 <u>YORK TEACHING HOSPITALS NHS TRUST</u>

- There were five different contacts between Julie, Marcus and York Teaching Hospital NHS Trust during the period of this review. One of these is an unrelated medical matter but the other four incidences are worthy of note.

- The first episode was on 21st August 2013. Julie appears to have been referred on to the hospital after consulting her GP. The documentation from the Senior House Officer records that" Went away to Greece for 6 weeks, had an argument and partner had MS and depression, strangled her from front with hands only. Squeezing tightly. Nearly lost consciousness but no loss of consciousness. Felt dizzy at time." Julie was referred on to the Ear Nose and Throat clinic which addressed her immediate medical needs. But the only other comment is "Patient states she will inform police." This places a significant onus on the victim. In particular, the clinician has described a particularly violent assault but there is no suggestion of any risk assessment being carried out. A similar process occurred when Julie arrived in the ENT department. The nature of her attack and injuries are well documented but there is no mention of the risk to her from her partner. This will be subject to further comment in the analysis section of this overview report.

- On 9th June 2014 Marcus presented at York Hospital Emergency department following an overdose of citalopram. The notes state he had returned from a 'fractious holiday' in Thailand with his wife yesterday. "Has been in low mood for some time. No previous attempts. Has appointment to see psychiatrist next week. Reviewed by GP this afternoon – given script for citalopram. Took overdose. Told his wife subsequently. Plan – admit medically. Will seek psychiatric review. Children aged 17 and 18 years in employment." Further entries the following day make mention of

psychiatric review and that Marcus was "reluctant to leave hospital as he felt he still had problems. He agrees he is at low risk of any further self-harm but that he has serious anger management problems." There is no entry relating to potential child protection concerns even though the notes describe a suicide attempt and there is a 17-year-old in the family home. (In fact, Marcus's sons were 18 years and 16 years old at this point). This is poor practice. Further comment will be made in the analysis section of this overview report in relation to both the lack of recognition of child protection referrals and the issue around control relating to telling Julie about his overdose.

- On 28th June 2014 (less than three weeks since the earlier overdose) Marcus again attended York Hospital. He has taken a further overdose 'following a domestic incident with wife.' Medical notes add 'Discharged back to police after toxicology under section 136.' No mention is made about any risk assessment but as police were clearly involved and the assessment is 'victim led' it would not be reasonable to expect more from hospital staff at that time. However, once again there is no mention of any child protection issues even though the 17-year-old (in reality 16 year old) is documented and this is Marcus's second overdose in a short period of time plus the domestic assault incident for which he has been arrested.

- The fourth episode occurred on 16th January 2017 when Julie attended York Emergency department, brought in by ambulance following a 'fall downstairs' She was discharged after x-ray. Despite hospital records showing a serious domestic abuse incident (strangulation) in 2013 and another mention of a domestic abuse incident recorded against Marcus in 2014 there is no mention of any suspicions relating to the cause of this fall. It is true that on this January 2017 attendance Julie attended under her married name but there was no cross reference to her earlier patient surname. Further comments will be made in relation to this in the analysis section of this overview report.

2.3.9 LEEDS AND YORK PARTNERSHIP NHS TRUST

- The Leeds and York Partnership NHS Foundation Trust (LYPFT) was the mental health care provider for Marcus between 2nd September 2014 and 1st July 2016. He was discharged from the service on 1st July 2016 after which he went to live in Greece. There was no further involvement from this date of discharge which was some 20 months prior to Julie's death.

- Marcus first came to the attention of LYPFT in 2014 following two failed suicide attempts in HMP Lincoln. At that time Marcus was on remand in custody following his assault on Julie. The notes at his gatekeeping assessment gives Marcus's account of what had happened to lead to his arrest and charge: "My wife was a bit off hand and

told me she was going to her mum's. I just flipped, I got hold of her around the neck and was squeezing her neck, I was in a rage, her face went red and I let go, she gasped for air, I blew into her face and she came around straight away, I said I am sorry, she said 'I've had a bad day at work." Marcus went on to tell the medical staff that they went for a walk. She walked outside and told him to drive and he drove. When he drove, he said "I'm going to kill myself, I'm not going to harm you." The LYPFT report adds that Julie had said she had noticed him behaving oddly and that she did not feel safe. She decided to leave the house to stay with her mother and went to tell him she was leaving. It was at that time he put his hands around her neck.

- Marcus reported to staff that preceding this incident he had persistent suicidal thoughts following his return from their honeymoon in Thailand. (Marcus does not seem to mention his attack on Julie in Thailand). He said he first made an attempt on his life on 9th June 2014 when he overdosed on tablets and then again later that same month. When he was held on remand on 22nd July 2014 he cut deep into his wrists, resulting in significant blood loss which required surgery. On his return from hospital he was placed on constant observations due to his risk of suicide. These observations had been reduced as prison staff perceived his mood to be improving. Then on 30th July he was found hanging in his cell. Medical staff attempted to resuscitate him until there were signs of life. He was then taken to Lincoln Hospital and placed on life support. At that time, it was thought he would not recover. However, after several days he regained consciousness and he was taken back to prison. Further comment will be made on these numerous suicide attempts in the analysis section of this overview report.

- On 12th August 2014, Marcus was assessed at HMP Lincoln and a recommendation was made for his transfer to low secure services due to the ongoing risk of self-harm. Marcus was admitted to inpatient services at the Newsam Centre in Leeds on 2nd September 2014 under section 48 / 49 Mental Health Act 1983.

- At the time of his admission there was a restraining order in place in respect of his wife Julie. However, LYPFT notes suggest that while in prison Julie had attempted to visit and contact him. While detained at the Newsam Centre, Marcus and Julie were often in touch on the telephone and Marcus had to be advised by staff that he could not have contact with Julie as per the conditions of the restraining order. However, they remained in contact. There appears to be a lack of communication between LYPFT and other agencies here. The restraining order is a legal document but there is no evidence that the police or courts were contacted with this information about repeated breaches of the order. This will be commented on during the analysis section of this overview report.

- Marcus appeared at court on 2nd December 2014 and was sentenced to a section 37 Hospital Order without restriction. Under the Mental Health Act 1983 guiding

principles *a Hospital Order, with or without restrictions, diverts the offender from a custodial sentence to a hospital for treatment. There is no limit to the time a Hospital Order is in force so that the period of detention will be determined by the need for treatment in hospital. A patient being removed from such a section is granted by the responsible clinician but support of the removal of the section would be a multidisciplinary decision.*

- When Marcus received the hospital order, the restraining order was lifted. Marcus and Julie were then noted by staff to have resumed their relationship. Initially, contact between them was supervised, and gradually this supervision was removed, leading to periods of unescorted overnight leave being granted from 20th January 2015. There is no evidence that other agencies involved in the safeguarding and protection of Julie were consulted on this decision. This is poor practice and placed Julie at further risk of harm.

- Julie had several contacts with the multidisciplinary team (MDT) at the Newsam Centre. This included some 1:1 sessions with psychology services to look at Marcus's risks of relapse, self-harm and violence and she was also involved in collaborative risk assessment with the team. This is good practice by LYPFT. Clearly the staff are using a holistic approach and considering not only Marcus's treatment but also the impact on the victim Julie. By involving Julie in the psychology work and risk assessment she is no doubt having to confront the risks she faces if the relationship continues. This will be commented on later in the analysis section of this overview report.

- Staff noted that both Marcus and Julie struggled to come to terms with the index offence. On numerous occasions they reported the relationship was over only for it to be rekindled the following week. This is a common theme identified by many professionals as a barrier in the safety planning process. Staff also noted there were discrepancies in the information Julie was providing to the police and to ward staff.

- Marcus had several week-long leave periods during February and March 2015 in preparation for his discharge on 10th March 2015. From that date, he was discharged from his Section 37 Hospital Order and became an informal patient remaining under the care of his inpatient consultant but was now actually an outpatient being supported by the Forensic Outreach Team in Leeds. Although their records show a MAPPA referral was considered by LYPFT, this referral was not made. Nor is there any reference in the notes to the views being sought of other professionals, i.e. police or those involved in the MARAC process. LYPFT did e mail West Yorkshire Police that Marcus would be discharged the following month, (together with a request for North Yorkshire Police contact details or for the e mail to be forwarded to North Yorkshire Police, as this was where Julie resided). When reviewing the MARAC minutes, it is also apparent that there was no attendance by any professional from LYPFT. As it is his imminent release which is the issue, this lack of attendance is a concern. By not

working with other professionals, Julie was placed at further risk of harm. Further comment will be added in the analysis section of this overview report.

- There are notes that indicate a child protection referral was considered by LYPFT. In fact, LYPFT did telephone Leeds Children's Social Care and discussed the case with a social worker, but there is no record of a written referral being sent regarding any potential risks to Marcus's sons. Leeds Social Care have no record of the conversation; therefore, correct referral processes were not followed by either agency.

- Marcus's Community Psychiatric Nurse (CPN) met with Julie on 29th April 2015. Julie was given information to enable her to identify early warning signs and risk, along with crisis contact to assist in supporting Marcus. Julie did not raise any concerns about her relationship with Marcus during the meeting.

- Further notes from LYPFT indicate the relationship deteriorated to the point of Julie filing for divorce. In June 2015 Marcus stated they had separated, and he was planning to move to Greece. However, by the following week, Marcus reported that the relationship was 'back on' and they intended to move to Greece together. Throughout this period there is no evidence of either depressive or psychotic symptoms.

- At this time, Marcus began to express his dissatisfaction with his antidepressant medication. He was advised by professionals to continue taking it at the prescribed dose, but he later disclosed he had reduced the dose against the medical advice but that he was feeling better for it. Marcus was also encountering several practical, social and financial problems. This presented in low mood and increased risk of suicide. He accepted increased contact from the LYPFT team along with practical support to address the contributing factors.

- Also, Marcus commented to staff that Julie's family believed that he was attempting to build a mitigating circumstance case to kill her. There is nothing further in the notes to indicate that this information was shared with other professionals involved in managing the risk to Julie. This is poor communication and will be commented on further in the analysis section of this overview report.

- Marcus's new CPN looked for further support in managing the risk as consideration was being made for discharge. The team's opinion was that he no longer required the support of secondary services. The CPN made contact with Leeds MARAC who directed them to North Yorkshire. (MARAC protocols being the case is managed where the victim resides). Following this, the CPN was advised that a MARAC was held in March 2015, but they were informed by Julie that she was not pursuing the relationship nor in contact with him so did not require their support.

- Some of Marcus's practical issues were resolved and so his mood improved. He and Julie were offered psychological intervention in respect of their relationship. During a psychology appointment in September 2015 Julie stated she wished to have some 'time out' from the relationship, to which Marcus agreed. They were offered further appointments to look at various strategies, but they did not attend. As a result of their non-attendance they were discharged from the caseload. They had also been given advice to contact 'Relate' to address their relationship difficulties. This is poor practice. All evidence suggests that an organisation such as 'Relate' is about reconciling differences / disputes. It should not be adopted in domestic abuse cases and particularly not in such cases as Marcus and Julie where there was a history of significant violence together with other issues such as suicide attempts.

- The CPN updated the MARAC coordinator around the dynamics of the relationship. Information passed from Julie to North Yorkshire Police at this time was that she did not require their support and she was able to manage the risks herself. (see North Yorkshire Police proactive home visit by specialist officers on 5th November 2015). The CPN also updated police that Marcus was recording Julie's telephone calls. (This information is confirmed in the MARAC minutes on 20.11.17.). Further comment will be made within the 'MARAC' section of this report.

- In the following months, Marcus continued to report fluctuations in the relationship, but no mental instability or evidence of psychosis was reported. He disclosed he had stopped taking his antidepressant medication. A team discussion followed, and it was agreed he was not detainable under the Mental Health Act and had capacity in relation to his treatment. Marcus continued to be offered contact with his CPN, psychological interventions and outpatients' appointments with his consultant. The MDT agreed there was nothing else that could be done to manage his risk to Julie.

- On 1st March 2016, Marcus sent a message to his CPN to inform her he was in Greece and would be staying for some time. His father was ill. He appeared to have travelled with Julie and his two sons who were by now young adults. Marcus saw his CPN on his return to the UK at the end of March 2016. He told her he was well and did not need the support of mental health services any longer. Although he agreed to further support, he missed his next appointment. He was next seen on 20th April 2016 at his home address. The notes state that he had sold his furniture in preparation for returning to Greece.

- Marcus did not attend his discharge CPA (Care Programme Approach) meeting but he was given a copy of the care plan at his last meeting. His CPN met with his GP to discuss his care plan and risk history and the GP was agreeable to Marcus's transfer of care. The CPN also made the locality Community Mental Health Team aware should Marcus be referred to them in future by his GP. This is good practice. The CPN was ensuring a continuous process was in place to ensure other health professionals were briefed on Marcus's history, his needs and the risks to Julie.

- Marcus was discharged from LYPFT mental health services to the care of his GP on 1st July 2016. There was no further contact with him from that date.

2.3.10 LEEDS CCG (Perpetrator's GP surgery)

- Marcus was registered with a GP practice in Leeds; of note this is a different GP practice to Julie.

- The GP surgery is a large city practice. Marcus was seen by 15 different GPs during the period of this review. Health professionals advise this is not an unusual figure with a city practice and over an extended period.

- Marcus had a diagnosis of relapsing, remitting multiple sclerosis (MS) prior to the timeframe of the review. Many of his attendances were for medical needs which were not directly relevant to this Domestic Homicide Review. Therefore, his privacy will be respected, and comments only made in relation to attendances relating to his mental health or relationship with Julie.

- On 14th January 2014, Marcus had a telephone conversation with his GP. He was having problems trusting women, insecure behavioural problems, women in his family going with other men since childhood and issues affecting personal relationships. He was advised to make an appointment with a view to making a referral to 'Improving Access to Psychological Therapies (IAPT) or to the Community Mental Health Team. He did not make an appointment.

- On 9th June 2014, Marcus had an appointment with a GP and he expressed his need to see a psychiatrist. Marcus relayed to the doctor that he had just returned from honeymoon. His previous wife had died five years earlier from cancer and he met his new partner two years ago. He has two sons aged 16 and 18 years who he states do not live with him or his new wife. The GP completed a Patient Health Questionnaire (known as a PHQ 9). The 'score' was 25/27. PHQ 9 is a patient questionnaire and is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression. The GP recorded that it was a 'difficult' consultation with Marcus wanting immediate action. Marcus had already decided he wanted to make a private appointment with a psychiatrist in Harrogate, which the GP wrote a letter for. Marcus was also given the details of the IAPT service and the STOP (Start Treating Others Positively) project. He was also prescribed citalopram. Marcus does not appear to have mentioned the assault on Julie while they were on holiday.

- On the same day as his appointment Marcus took an intentional overdose with the citalopram prescribed by the GP. The discharge letter from York Teaching Hospital was

sent to the GP practice. He was seen by a GP a few days later (though not the same GP he had seen on 9th June who prescribed the citalopram in the first place). Marcus had been seen by a psychiatrist and was not suicidal now. He stated he regretted his actions. He admitted he had a lot of issues relating to anger and on two occasions had put his hands around his wife's throat. He knows that he can be controlling and is not sure if his wife is pressing charges after the recent incident, but she has moved out for now and is staying at her mother's. There is no mention of any risk assessment by the GP. They have been informed that Marcus has twice assaulted his partner by putting his hands around her throat. However, risk assessment models within domestic abuse are victim based and Marcus's GP was not the same practice as the victim. This will be commented on further in the analysis section of this overview report. Also of concern is that Marcus has revealed two domestic assaults and the doctor is aware of at least one suicide attempt. Marcus has said he has two sons and one is only 16 years of age but there is no record in Marcus's medical notes of any consideration of child protection issues. His comments to the GP may have suggested they lived elsewhere but with the GP practice also knowing that the boy's mother had died five years earlier there is an expectation that at least some more information gathering was required to make an assessment of whether this warranted a child protection referral.

- On 24th June 2014 Marcus had an appointment with a GP regarding possible malaria following a recent trip to Thailand. He also discussed anxiety and depression with low mood and poor sleeping. He had seen a psychiatrist in Harrogate and was awaiting psychological support. The GP prescribed mirtazapine.

- Marcus's mother had a telephone conversation with the GP on 8th August 2014 to report that Marcus had been taken into custody back in July. He had tried to hang himself and was on suicide watch. She stated he had been married a few months and there is a lot of trauma in the relationship. He had made three suicide attempts in recent months. The GP advised that they would see Marcus after he was released but that the preferred option would be for services to be arranged prior to his release. Although the GP asked Marcus's mother to ask the prison psychiatrist to send written information to the GP, there is no evidence this was ever received.

- On 19th August 2014 an 'aunt' made contact with the GP (on this occasion it was the same GP who has spoken on the telephone to Marcus's mother). The aunt reported Marcus remained in prison and had made two attempts on his life. The aunt stated his solicitor was requesting the GP provided a referral to a psychiatrist. It was explained that this could not be done while Marcus remained under the care of the prison health services.

- There is a letter in the GP records indicating a GP was invited to a CPA meeting on the mental health ward on 10th November 2014. This is good practice in order to share all information about Marcus's condition and treatment. Unfortunately, no one was available from the GP practice to attend the meeting. However, the ward did send a

copy of the agreed CPA care plan after the meeting. The GP was again invited to a meeting on the mental health ward on 30th December 2014 but again had to offer apologies as no one was available to attend.

- Marcus had a couple of appointments with his GP in February 2015, but these were nor relevant to this review.

- On 4th March 2015, the GP was invited to the discharge CPA meeting for Marcus by the mental health team. It is unclear if the GP attended the meeting, but the GP did receive a discharge summary dated 18th March 2015. The letter indicated Marcus had been an in patient under section 48/49 of the Mental Health Act after being transferred from prison following three suicide attempts. It was noted that one attempt took place following the index offence of trying to strangle his wife and then two further attempts while he was held on remand. The GP practice sent a letter to Marcus dated 25th March 2015 inviting him to make an appointment to review his medication and symptoms. The medication review took place during an appointment on 16th April 2015. Marcus reported he was enjoying life, was back to work and had good support at home. He had no paranoid psychosis or thoughts of self-harm now. The plan was to continue with the current medication.

- On 2nd June Marcus had a telephone conversation with the GP. He reported he had been away and had lost his medication. Marcus wanted the same brand of medication as he feels swapping brands causes him some issues.

- The GP surgery received a letter dated 30th June 2015 from a consultant psychiatrist. Although there were no actions for the GP, the information in the letter included that the relationship between Marcus and his wife remains 'tumultuous' with frequent quarrelling and exchange of insults. Marcus finds the experience humiliating and despite physical aggression from his wife he has not retaliated.

- There are seven further appointments or telephone conversations relating to Marcus between 30th October 2015 and 14th April 2016. These relate to medication, dizziness and generally feeling unwell. Marcus believes it is due to his medication, but the Community Mental Health Team do not agree. On one occasion the consultant forensic psychiatrist notes Marcus has stopped his medication against medical advice. The letter from the psychiatrist also states they are planning to discharge Marcus into the care of his GP.

- The GP spoke with the mental health worker on 1st and 22nd June 2016 and wanted to discuss with the consultant psychiatrist. The consultation between the GP and the CPN took place on 1st July 2016. Marcus did not attend as he was in Greece. He was there with Julie and there was no set date for their return. The notes from this consultation include that 'symptoms are now well controlled, no overt depression, has stopped all

medication against medical advice. Has not fully engaged with the service but has had therapy.' The GP sent a letter to Marcus to attend for a review dated 8th July 2016.

- There is then a gap of over a year with no contact from Marcus to his GP.

- On 23rd August 2017 Marcus attended a GP appointment. He reported stress and relationship issues but not to the level of a few years ago. He reported no suicidal thoughts or self-harm, does not feel depressed but did request support. The GP recorded they had a long conversation and information about the IAPT service was given. The GP also noted a history of relapsing MS and Marcus had previously been under the care of neurology. The GP re-referred to neurology for review.

- There were only two further appointments with Marcus in December 2017 and January 2018, but these are not relevant to the Domestic Homicide Review.

2.4 Multi Agency forums and processes

2.4.1 There were two multi agency processes involved in considerations and actions relating to the domestic abuse in Julie and Marcus's relationship. These were the Multi Agency Public Protection Arrangements (MAPPA) and the Multi Agency Risk Assessment Conference (MARAC). Both forums are specifically listed in the Domestic Homicide Review's terms of reference and so each will be considered here.

2.4.2 <u>Multi Agency Risk Assessment Conference (MARAC)</u>

- The MARAC process was established nationally over a decade ago with all areas now operating this system to manage the risk in the highest risk cases of domestic abuse. There are four MARACs operating across the North Yorkshire Community Safety Partnership based on the localities of District Authorities within North Yorkshire. Initially they were chaired by the Independent Domestic Abuse Service (IDAS) but this function passed to the police several years ago. North Yorkshire Police employs the MARAC Chair and the MARAC Coordinator, but all agencies involved in protecting vulnerable victims are involved in the process.

- Julie and Marcus's case was heard at the MARAC on four separate occasions. The first time was on 25th July 2014. This followed the serious assault (strangulation) in North Yorkshire. The other three MARACs were on 5th March 2015, 20th November 2015 and 13th November 2017. At each meeting, information was shared, and actions set. The minutes record these actions. The function of MARAC will be considered during the analysis section of this overview report.

2.4.3 Multi Agency Public Protection Arrangements (MAPPA)

- MAPPA is a statutory process used to manage sex offenders and violent offenders. A key difference with MARAC is that it is offender focused rather than victim focused (though of course both processes will consider the impact on all elements of the relationship). The MAPPA process also has a duty to consider risks to the public.

- There are three MAPPA categories and three management levels. MAPPA categories 1 and 2 are determined by conviction and sentence. Category 1 are Registered Sex Offenders. Category 2 includes violent offenders (those convicted of a relevant offence under schedule 15 of the Criminal Justice act 2003 and who receive a term of imprisonment of 12 months or more or are placed on a hospital order (with or without restrictions). Category 3 is known as 'other dangerous offenders' who pose a risk of serious harm to the public, but do not meet the criteria of category 1 or 2 yet which requires active multi-agency management. The three levels of management within MAPPA are determined by the level of resource that would be required to manage the offender.

- On 18th February 2015 a MAPPA category 3, level 2 referral was submitted by an officer within North Yorkshire Police. It was received by the screening officer in the MAPPA unit two days later. On 24th February 2015 a joint screening took place by two of the three 'Responsible Authorities' designated under MAPPA (in this case the police and the National Probation Service). The decision was for no further action from MAPPA in this case and the decision was sent back to the referring officer in North Yorkshire Police the following day.

- Marcus had been convicted on 2nd December 2014 and dealt with by a s.37 Hospital Order without restrictions. The offence was 'Actual Bodily Harm' and the circumstances within the referral mentioned two previous occasions when Marcus had tried to strangle his partner.

- The referring officer within North Yorkshire Police was also the investigating officer for the incident of strangulation in June 2014. Police had been informed of Marcus's imminent discharge but in fact he had already been released on extended leave. This had taken place before any risk assessment by the police. The MAPPA referral stated, 'there were serious concerns for Julie and that multi agency management would add value by ensuring the actual risk posed by Marcus could be assessed and all relevant agencies could implement the appropriate work needed, in particular to safeguard people.' The referral also stated that a MARAC meeting had taken place on 25th July 2014 and that there were no child protection concerns. Agencies suggested to be involved were police, IDAS and the Newsam Centre (where Marcus had been detained on the hospital order).

- The rationale to reject the referral under category 3 was recorded as 'the subject had been subject to a hospital order, but this no longer remained in place. The case was primarily concerned with domestic abuse and the risk to Julie. The Domestic Abuse Officer remained involved.' The screening officers also noted that Julie remained in fear of Marcus and that the only agencies involved in the case were those working to protect Julie. Their rationale includes that no agency was working with Marcus. In fact, this is not correct. Even though leaving hospital, Marcus was not formally discharged from the order until 2016 and so his Forensic psychiatrist, CPN and GP were involved for some time after this referral. (though there were no MOJ restrictions attached to his s.37 or community treatment order). The screening decision also refers the case back to MARAC. Further comment will be made on this decision in the analysis section of this overview report.

Section 3: Analysis

3.1 Family involvement

3.1.1 Julie's family were contacted during the Domestic Homicide Review process and expressed their wish to be involved in the review. Discussions and meetings took place between the Independent Chair and Author and Julie's mother, her sister and her adult daughter.

3.1.2 The family describe Julie as a confident, outgoing and independent person. She loved the outdoors and being active and enjoyed holidays in the Lake District. She had been married before but did not have any problems with her previous husbands. When they divorced the splits were amicable.

3.1.3 Julie met Marcus in 2010 when he was doing some work for a mutual friend. They were friends for a while, and it did not become a 'serious' relationship for about a year.

3.1.4 They describe Marcus's behaviour as changing fairly quickly. He would comment if he believed Julie's top was too low or her skirt too short. When they were out, the family began to notice Julie would look constantly at Marcus just in case he thought she was looking at other men. They found Marcus controlling and manipulative.

3.1.5 Julie had renovated houses in the past and Marcus had also worked on such projects. They did some work together on properties that Marcus owned in Greece. However, Julie was very comfortable financially and had no reliance on Marcus. In fact, the opposite was true, and the family believe Marcus eventually owed Julie several thousand pounds. This was never reported to any agency as 'financial abuse'. There could be many reasons behind this. We know Julie felt affection for Marcus and often tried to support him.

3.1.6 When they learned of the first strangulation incident, they warned Julie that he would kill her. However, Julie's mother, daughter and sister all say that Julie had deep feelings for Marcus and wanted to help him. In particular they firmly believe he repeatedly used the threat of suicide to keep control of her. They think she felt she had to stay in touch with him to stop him harming himself. Julie did tell her family that Marcus had told her he had been violent to his previous partners. They also believe he was manipulative and recall how he sent Julie a birthday card from prison (against the terms of his restraining order). This really shook Julie and she told her family that Marcus must love her. To the family's frustration Julie seemed to blame herself for getting Marcus into trouble.

3.1.7 The family also recall the incident of Julie 'falling' downstairs. They know Marcus was present at the time and believe he was probably responsible as Julie told her daughter and her sister not to tell her mum about the 'fall.'

3.1.8 It was a shock to Julie's family when she married Marcus in 2014. They believed it was because she felt sorry for him and that she may have believed she could deal with his paranoia if they were married. The circumstances of the wedding day were also unusual.

3.1.9 The family describe how Julie loved parties and family gatherings and could see no reason why she would have a quiet registry office wedding and not tell anyone. They believe all of this – no family present at the ceremony and then travelling straight to Thailand on honeymoon – was Marcus's idea.

3.1.10 Julie's family believe more should have been done by agencies to obtain orders or injunctions to keep Marcus away from Julie. She was clearly a victim of domestic abuse and so the onus should not have been with her. In particular, they believe that staff at the secure hospital where Marcus was detained should have been more forthright in telling Julie to end the relationship rather than advise her on how to 'manage' him. They also believe he was released from the Hospital Order far too quickly.

3.1.11 The family are distraught at their loss. Julie was the matriarchal figure who pulled the family together. They comment that Marcus has "taken every bit of happiness out of this family. She was the force within the family that held the family together." Julie's sister remembers during their childhood and when they were adults how Julie was always looking out for her. "She pulled me up if I was going down. She never let me sink."

3.1.12 Julie's family are now being supported by an advocate from the AAFDA charity.

3.2 Analysis

3.2.1 Julie and Marcus met in 2010. They married in May 2014 and divorced in August 2015. However, they remained in contact from the time they first met through to Julie's death. Their relationship is described by the couple themselves, the family and by professionals involved as 'on and off.' The frequency of this ending the relationship, sometimes spending time apart and then resuming the relationship was a factor in making it a challenge for professionals involved to manage, assess and intervene.

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 the nature of the relationship between Julie and Marcus, the decisions that they took as individuals and more importantly *why* they made those decisions.

3.2.3 The number and depth of the Individual Management Reviews (IMRs) from a variety of agencies indicates there was a great deal of contact from professionals

with both Julie and Marcus. These were not isolated individuals. 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 the Julie's tragic death.

3.2.4 The first known contact with any organisation in relation to domestic abuse was in August 2013 when Julie returned from holiday in Greece and reported a serious domestic assault on her by Marcus. This is the first episode of strangulation. Strangulation is repeated in other episodes in Thailand and in the UK. This first reported episode was prolonged and was accompanied by threats to kill Julie, to throw her from the balcony of their accommodation and threats to harm Julie's mother. We know from future discussions Julie had with her GP and counsellor that this incident affected her deeply. She was clearly afraid and reported having 'flashbacks.' West Yorkshire Police took the incident seriously and action was taken. However, some of the response was not as effective as it should have been. With Marcus still overseas, West Yorkshire Police began their enquiry, obtained a witness statement from Julie and conducted an initial risk assessment. The risk assessment was categorised as 'high' under the nationally recognised 'DASH' risk assessment tool. This means the victim (Julie) was identified as 'at risk of significant harm.' Unfortunately, when the risk assessment was reviewed by a specialist officer the category was reduced to 'medium.' This was ratified by the specialist officer's supervisor. Although the officer documents their rationale for doing so - and lists several protective factors such as the perpetrator being overseas, there being no children involved (which was incorrect), there being no history of domestic abuse and Julie being referred to victim support – the evidence suggests this was the wrong decision. This was a serious incident of strangulation and threats to kill. There were also several elements of control by Marcus which aggravated the situation. This was a missed opportunity. If the assessment had remained as 'high risk' the case would have proceeded to the MARAC and measures put in place to intervene and protect Julie. In addition, after a brief period, Julie decided she did not want to proceed with a criminal prosecution. There are many reasons why a victim of domestic abuse does not wish to pursue action through the criminal justice system. In some cases, once they have reported the incident and they feel safe they simply do not want further involvement. Some may think the relationship may get better. Some may rely on their partner financially, sometimes couples want to stay together for the sake of their children, in others they simply do not want to get their partner into trouble with the authorities. We can only speculate on the reason Julie wanted to withdraw the allegation. We should not judge her for this. But simply because a victim does not wish to proceed does not mean action should automatically be discontinued. This was clearly a high-risk case. Marcus was still going to return to the UK at some point. He was interviewed by police upon his return home. He denied the offence. But with Julie's witness statement, the GP records and photographs of her injuries,

it is likely the case would have met the 'evidential threshold' for police to approach the Crown Prosecution Service (CPS) for a decision. Once the evidential test is met, the second stage would be for a CPS lawyer to consider the 'public interest test.' We cannot second guess the decision of the lawyer, but it seems unlikely such a vicious and sustained assault would not meet the public interest test. (There are clear protocols on jurisdiction which would involve the CPS liaising with their counterparts in Greece regarding any prosecution). After Marcus's denial, the matter was recorded as 'no crime' and there was no further involvement from the police.

Recommendation 1: All front-line professionals who may encounter domestic abuse situations should receive training in risk assessment using the recognised 'DASH' model.

Recommendation 2: The Community Safety Partnership to ensure there are protocols in place between the police and Crown Prosecution Service to ensure any high-risk case of domestic abuse that meets the evidential threshold is not discontinued without good reason. That rationale of the decision about the prosecution case, together with a plan to protect the victim should be recorded.

3.2.5 Another theme which emerges from this initial contact in August 2013 is that of child protection. On that occasion, it was West Yorkshire Police who called at Marcus's home when they were trying to trace him. They were met by a 15-year-old boy (Marcus's son) who initially said his father was working. In fact, Marcus had been in Greece for many weeks. The boy became upset. The officer checked with the boy's grandmother who popped round regularly. The boy's 17-year-old brother also lived there. The officer did check the home conditions and recorded the house was clean and there was plenty of food available. But something must not have felt right as the officer sought advice from their supervisor. The supervisor confirmed the grandmother was in regular contact and then police took no further action. They did not submit a referral to Children's Social Care either under the category of child protection (section 47 Children Act 1989) or as a 'child in need' (section 17 Children Act 1989). This was a 15-year-old, who was not looked after full time by an adult and whose father the police were seeking for a serious domestic related assault on his new partner.

3.2.6 There were further lapses in child protection concerns by other agencies: In later episodes (when the son was still between 15 and 17 years) the information about serious domestic abuse (strangulation) was discussed by Julie's GP and (to a lesser extent) Marcus's GP. This was also the case at York Teaching Hospital when during Marcus's attendance for an overdose they documented he lived with a 17 year old (though the boy was actually only 16 years). Doctors documented the young person and the domestic abuse or suicide attempt but did not make any referral to Children's Social Care (or at least document their reasoning for not doing so). When Marcus was being considered for release as an in-patient being detained on the Hospital Order for strangling and threatening to kill Julie, the notes state Marcus was 'returning to live with Julie and his two sons'. The younger son was still

17 years old at the time (16 years when Marcus was sentenced). LYPFT staff did telephone Leeds Children's Social Care to discuss the case but this was not followed up with a written referral in relation to what was a very serious violent domestic incident (when an earlier strangulation incident possibly occurred in the presence of the boy when he was 15 years old). Plus of course, by the nature of his care within the hospital order, Marcus had mental health needs following several suicide attempts.

Recommendation 3: All front line professionals should receive appropriate training to recognise Child Protection situations. The training should include (a) Putting the child at the centre of their thinking irrespective of the reason they are involved. (b) An appreciation of the different levels of child welfare concerns ('Child Protection' and 'Child in Need').

3.2.7 There was an incident when systems and processes could have worked more effectively to protect Julie. The Yorkshire Ambulance Service attended a call in June 2014 when Marcus had taken an overdose and Julie was injured following an incident of strangulation. The notes relating to Julie indicate that the crew were to submit a safeguarding referral. No referral was ever completed. There should be checks and balances put in place to ensure that busy emergency crews submit the necessary referrals prior to finishing their tour of duty. The system or process should include being unable to finalise the closure of the incident without a report being submitted or a supervisor checking submission.

Recommendation 4: All agencies review their processes for closure of incidents involving vulnerable people. This system to include checks and balances to ensure any necessary safeguarding referrals are submitted.

3.2.8 There was some good work carried out by the Independent Domestic Abuse Service (IDAS) following the serious assault on Julie in 2014. Even though Julie did not consent to take the case forward to MARAC, the IDVA used their professional judgement (and confidence in local Information Sharing Protocols) to take the case to the MARAC without consent. This ensured all professionals were able to discuss the case and formulate a more holistic safety plan. In subsequent episodes that were reported Julie repeatedly insisted she did not want a referral made to IDAS. Her wishes were respected but this may have been a missed opportunity. On some occasions telephone contact was attempted but not always successful. There are also incidences listed of Domestic Abuse Officers from North Yorkshire Police trying telephone contact. On some occasions this is shown as due to lack of capacity of the team. In addition, for a very practical reason during a MARAC in November 2017 the MARAC Chair directs that contact is done in person as it is believed Julie's telephone calls may be being recorded by Marcus. There are many advantages to establishing face to face contact with high risk victims rather than use of the telephone. Professionals can build more effective relationships and trust. Likewise, just because a high-risk victim does not consent to a referral to IDAS, it should be

for professionals to make the informed consideration on the merit of direct contact in such cases.

Recommendation 5: In high risk cases of domestic abuse, professionals within a support role should consider the benefits of making direct face to face contact with the victim rather than on the telephone. This should not be discontinued simply because the victim does not consent. Ideally this would be a joint home visit with IDAS and a police DAO, ensuring the victim is aware of all services available while simultaneously ensuring safety of staff.

3.2.9 There are several incidences described in a number of IMRs of staff in different roles not identifying high risk domestic abuse and not making the necessary interventions to safeguard Julie. Her GP practice records a serious episode of strangulation but does not evidence any notion of conducting a formal risk assessment or linked referral. This is repeated at the York Teaching Hospital where clinicians in both the Emergency department and at the Ear Nose and Throat unit note the circumstances of a serious domestic related assault but then do not make an assessment of the risk to Julie. They deal very well with her medical needs (both physical and emotional) but do not assess the on-going risk from her relationship. During discussions at panel meetings it is apparent that some of the concerns (particularly from health professionals) is around sharing of information when they do not have the patient's consent. This is perfectly understandable, and there is a difficult balance between maintaining the trust and confidence of a patient and protecting them from harm.

3.2.10 There is an incident of Julie 'falling down the stairs' in January 2017. She is attended to at home by the ambulance crew and then taken to York Teaching Hospital for further treatment. Julie does not disclose domestic abuse but there is no record of any professional asking sensitively if this may be a factor. Julie did not suffer from any condition that would increase her risk from falls. Although we must recognise the hindsight, we do now know of Marcus's violence towards a previous partner which included 'dragging her downstairs.' We also know that Marcus was present during the incident where Julie allegedly fell (while he was on temporary leave from his in-patient hospital order). This incident raises two issues: First is the recognition of potential domestic abuse. Second, both organisations had previous dealings with Julie and Marcus. They had recorded incidents of previous serious domestic abuse. This should have alerted staff to what they may be dealing with and thus safeguard Julie more effectively. Feedback at a panel meeting was that Julie had changed her surname after marrying Marcus. However, she still had the same date of birth and records could be cross referenced to include both names.

Recommendation 6: The Community Safety Partnership should satisfy itself that adequate training programmes are delivered which highlight to professionals:

(a) The recognition of domestic abuse and its complexities, 'push-pull' factors and pressure on victims

(b) Local procedures in place such as DASH risk assessments, the MARAC process, DVPN and DVDS provisions.

(c) The ECHR competing articles that both protect the confidentiality of victims / patients but also recognise the duty on all professionals to 'protect life.' Specifically, this should include balancing the requirements of Article 2 ('the right to life.') and Article 8 ('the right to a private and family life.')

Recommendation 7: The Community Safety Partnership should review its Information Sharing Protocol for information exchange between professionals who are working in the field of domestic abuse and other areas of safeguarding. The revised ISP to be clear on the need for balance between confidentiality and protecting vulnerable people from significant harm and thus give professionals confidence in making referrals in challenging circumstances. Any new protocols to be compliant with the GDPR.

Recommendation 8: All agencies involved in protecting the vulnerable should have a 'flagging' system in place to ensure their systems alert attending professionals of previous domestic abuse linked to a victim, perpetrator or address.

Recommendation 9: Agencies should cross reference their patients / clients with married names / change of name / other aliases to ensure opportunities for identification of vulnerable people are not missed.

3.2.11 Communication both within and between agencies is a common and recurring feature in the case involving Julie and Marcus. Much of the communication is very effective. In some instances, it could have been better: When Marcus was initially transferred from prison to the Newsam centre (following several suicide attempts) he was still subject to a restraining order not to have contact with Julie. Staff were aware that Marcus and Julie were in frequent contact on the telephone. Staff tried to manage this situation and advised Marcus he was not allowed to contact Julie. However, there is no evidence that staff alerted the police. This was a legal order and the breaches could have been put back before the courts in an attempt to set boundaries and create some space in the relationship. Likewise, when Marcus was allowed temporary leave from his stay as an in-patient, the staff from LYPFT did not consult with the police in good time. This did not allow the police an opportunity to consider any risks or express any objections to this course of action. This included an instance when Marcus accompanied Julie on a short holiday to the Lake District. When considering the previous domestic abuse incidents that took place in Greece and in Thailand this omission placed Julie at risk of harm. That risk could have been reduced by more effective communication.

3.2.12 On another occasion, a referral was made by the police to MAPPA to assess Marcus for inclusion as a MAPPA nominal. The decision-making around the referral was communicated back to the referring officer but did not include telling the officer they could have objected to that decision. The referring police officer had not submitted a MAPPA referral previously. It may not have altered the decision, but better effective communication could have explored other alternatives. The same referring officer (from North Yorkshire Police) also encountered difficulties when trying to obtain information about Marcus from Leeds and York Partnership NHS Foundation Trust. This was an officer from a statutory agency trying to gather information about Marcus from Marcus's main care provider at that time so that she could complete a MAPPA referral. Marcus was due to be discharged from LYPFT on the Hospital Order and the MAPPA process was a logical step in exploring the options on how to best manage him. However, the LYPFT staff told the police officer they did not feel at liberty to disclose personal information about their patient. This is disappointing as the agency with the most information about Marcus were LYPT themselves. They are a recognised 'Duty to Cooperate' agency and under MAPPA national guidance they were the most appropriate agency to have referred to MAPPA in the first place. The whole MAPPA process does not seem to have been fully considered by LYPFT. The 'blocker' in communication could have been the officer not clarifying why she wanted the information or in the hospital not appreciating the value of providing it. Either way, these examples add further justification in making 'Recommendation 7' (ISP) above.

Recommendation 10: The Community Safety Partnership should encourage and measure the training of staff within both the 'Responsible Authorities' (RAs) and the 'Duty to Cooperate' (DTC) agencies on the new MAPPA E Learning package.

3.2.13 When noting these 'missed opportunities' in terms of communication it is also worth remembering some very effective communication channels between agencies. One example is between North Yorkshire and West Yorkshire Police when Julie and her family were safeguarded in relation to Marcus. Information was received by one Force and it was identified there were also risks to others in a separate police Force area. This was acted on quickly to ensure all those involved were protected. Another example was in the Leeds and York Partnership NHS Foundation Trust. Their multi-disciplinary team involved Julie in discussions about the continued management and assessment of Marcus. This both empowered Julie and gave her a sense that she had meaningful involvement but also meant information was gathered about the wider environmental factors that may assist in Marcus's rehabilitation. There is further good practice in communication shown when the Community Psychiatric Nurse met Julie after Marcus's release as an in-patient and by her briefing Marcus's GP when Marcus was eventually discharged

from his Hospital Order. However, it should also be noted that the family believe it was Julie who instigated the meeting with the CPN.

3.2.14 Julie and Marcus's case was listed at the MARAC on four occasions. A lot of the work within MARAC is well thought out and minutes show that options are considered with actions set to safeguard Julie. However, there are improvements that need to be made to improve the effectiveness of the MARAC process. One set of MARAC minutes (in 2014) were missing for some time and were only traced late into this review process. Poor record keeping does not assist future safety planning. Further analysis of the other sets of minutes show that information exchange is clearly recorded, and actions set. However, in some instances those actions are not followed up to ensure compliance. (e.g. on 13.10.17 the NHS were e mailed for further information but there is no check that this new information was ever received and incorporated into future planning). Good engagement within a MARAC clearly starts with good attendance. The minutes on one MARAC shows eleven persons attending from several organisations. This should be the minimum expectancy. At another MARAC (5.3.15) there are nine persons present but four of these are from the police and two from the probation service (NPS and CRC). There does not appear to be any representation from any health organisation (GP, acute hospital services or mental health services) nor anyone from Children's Social Care. On another MARAC on 13th October 2017, there are only 7 people present at the meeting. Some staff also reported to IMR authors that their workload was significant, though it is unclear if this is due to MARAC actions or their regular work alongside the MARAC.

Recommendation 11: The Community Safety Partnership should carry out a review of the MARAC operating procedures within North Yorkshire. Where practices are working well staff should be recognised. The frequency of MARAC meetings should be considered together with the administrative support available to support the Chair, ensuring actions are completed in a timely manner and accurately recorded. The CSP should provide visible governance to encourage regular attendance by all agencies with reporting back to the CSP on annual attendance levels. Above all, the CSP should provide leadership to demonstrate to agencies that ALL organisations should be fully committed to this partnership process.

3.2.15 From the outset of this Domestic Homicide Review the panel have tried to look at life through the eyes of the victim. Julie was an intelligent, professional woman. She was financially independent and had no overt vulnerabilities linked to any issues such as mental health, drug or alcohol misuse. When we consider Julie's decision-making around her relationship with Marcus, this is not to judge her but to look at any factors that affected those decisions.

3.2.16 The first report to any agency of Julie suffering domestic abuse was in August 2013 while she was on holiday in Greece with Marcus. This was a particularly serious

incident involving strangulation and threats to kill. He had his hands so tight around her throat she had felt dizziness and could hear herself gurgling. This must have been a terrifying experience and Julie left Greece soon afterwards, returned to the UK and reported the incident to police. Marcus was interviewed about the assault, but Julie did not feel she could go through with a prosecution and withdrew her statement. This is not uncommon in domestic abuse cases. The data from the CPS shows that the level of attrition in relation to domestic abuse crimes is far higher than in 'other' offences. People choose to remain with their partner for a whole variety of reasons. For this instance, we can see from her GP records that Julie expresses she still loves Marcus. But there is also a number of 'controlling' elements to this which are being exercised by Marcus; the threats to harm her (throw her from the balcony), the threats to harm Julie's mother and the veiled threats of his suicide. Whatever, the reasons, Julie remains in her relationship with Marcus.

3.2.17 In June 2014, following another serious violence incidence of strangulation, Marcus was arrested. This time Julie provided a full statement and Marcus was charged with offences and remanded in custody. It is not certain, but there is some suggestion that Julie tried to make contact with Marcus while he was in prison. What did happen in prison was Marcus made four determined attempts at suicide. He took two separate overdoses, made deep cuts to his wrists and finally was found hanging in his cell. It was only by swift intervention and transfer to hospital that Marcus survived. Marcus was then transferred from prison to a hospital under section 48 / 49 of the Mental Health Act 1983. Here, during his assessment, staff report Julie frequently telephoning Marcus in contravention of a restraining order imposed by the courts. There seems little doubt that Julie was very concerned about Marcus and his mental state. But we should be mindful that this may be more than just sympathy. Marcus (by four determined suicide attempts – which is what he threatened to do the year before)- is exercising significant control over Julie. During a meeting with the Independent author of this review, Julie's family described how she was 'heartbroken' when Marcus was in a coma. She expressed to her family how it was clear Marcus needed her. There is no doubt that Marcus's suicide attempts were a major factor is why the relationship continued.

3.2.18 We also know from Julie's conversations with her GP and subsequent referral to a counsellor that she was struggling to come to terms with what Marcus did to her and reported 'flashbacks' which could be interpreted as PTSD.

3.2.19 In December 2014 when Marcus was sentenced to a section 37 Hospital Order the Restraining Order was cancelled. Julie then began to visit Marcus in the secure facility. Staff gave her safety advice but within two months of sentencing Marcus was on home leave and he and Julie spend time together. When Marcus was eventually discharged in March 2015 he moved in with Julie. The 'on/off' nature of the relationship is noted by professionals. Julie expressed to some professionals that she wants to leave Marcus but is worried about how he may react. This could

be an element of fear for her own safety, fear for her mother's safety or fear for Marcus and what he might do to himself. Whatever the reasons there is never a clean break of the relationship. Even when they divorced, they remained in frequent contact.

3.2.20 When Julie told Marcus it is over; he escalated his behaviour to stalking. This was not recognised by the police. He starts when he drove past her house. Then there are allegations he recorded her telephone calls (and counter allegations by him that she is recording his calls), then she received texts saying 'Good night' when she turned the lights out at night. On another occasion, he took her keys. All of this suggests obsessive behaviour by Marcus. Ultimately, Marcus moved from Leeds to an address in the same road in the same village as Julie.

Recommendation 12: All professionals working directly with victims should receive training in stalking and harassment and particularly around identification, risk assessment and safety planning.

3.2.21 The introduction of the Domestic Violence Disclosure Scheme (DVDS) may have provided an opportunity to warn Julie by formal notification of Marcus's violence towards a former partner. However, only one incident was ever reported to the police and even then, it was an assault on the male friend who was with his ex-partner. The ex-partner refused to press charges or attend court. Only the male provided a statement about the assault on him. Therefore, there were no convictions relating to domestic abuse recorded against Marcus on the PNC (Police National Computer).The full extent of his abusive relationship with the ex-partner was only given to police during the investigation following Julie's death. The woman would still not provide a witness statement but did verbally confirm to police that during the 1980s and 1990s she was engaged to be married to Marcus. Marcus regularly exercised controlling behaviour, jealousy, threats of violence and physical violence. This included her being dragged downstairs, kicked and punched to the head, face and body, held by the throat and false imprisonment. Although not reported to the police, the woman had to take time off work to hide bruises, black eyes, a broken thumb and dislodged teeth. Of course, we cannot know what the level of unreported domestic abuse there was perpetrated by Marcus on Julie. Even though no formal disclosure under the scheme was ever made, there is no doubt that Julie knew from her own experiences of Marcus's propensity for extreme violence and threats. She also mentioned in her statement made to North Yorkshire Police in June 2014 (following a strangulation incident) that Marcus had told her he had assaulted previous partners, including strangulation. However, this does not negate the need for authorities to consider making such a disclosure under the Domestic Violence Disclosure Scheme. (Knowledge and understanding of the DVDS could be incorporated into training within 'Recommendation 6').

Recommendation 13: This Domestic Homicide Review has included information and participation across two Community Safety Partnerships -North Yorkshire as coordinators and Leeds (where the perpetrator resided during periods of this review). It is good practice to share all learning and recommendations with colleagues within the 'Safer Leeds' Partnership.

3.2.22 TERMS OF REFERENCE

The terms of reference were agreed at the initial Domestic Homicide Review Panel on 8th June 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?'**
  There were some shortcomings in identification and subsequently what to do as a consequence of this omission. These have been documented in the report. However, there is still evidence of proactive action by several agencies and actions are taken to safeguard Julie. Likewise, there is extensive content relating to the care and treatment of Marcus by a variety of organisations and professionals.

- **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?**
  Again, the shortfalls have been addressed and recommendations made.

- **Did the agency comply with domestic violence abuse protocols ,including 'information sharing protocols'?**
  The improvements in protocols, training, governance and partnership working are also made in the recommendations and particularly around Information Sharing protocols.

- **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.**
  These have been highlighted throughout the overview report and where these fell short, the incident or issue has been highlighted and recommendations made.

- **Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided?**
  There are many examples, both single agency and through multi-agency forums such as MARAC that show robust plans were made. Any shortcomings have been identified and acted upon.

- **Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders in place?**
  A lot of information was known about Marcus through his assessment during his treatment under the Hospital Order. The information about his serious violence to a former partner was known to Julie but not to professionals until after Julie's death. He was considered but rejected as a MAPPA nominal. He was subject to a Restraining Order prior to the sentencing on a Hospital Order.

- **Has the victim disclosed to any practitioners and was the response appropriate? Was this information recorded shared where appropriate?**
  When a disclosure was made by Julie this was acted upon. There were some shortcomings in recording and sharing of information which have been highlighted during the review and are subject to recommendations.

- **Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families?**
  There were no cultural, religious or linguistic barriers identified. There was an issue relating to a long-term illness (MS) of the perpetrator, but this was identified by the appropriate agency and does not appear to have impacted upon this case.

- **'Were senior managers of the agencies and professionals involved at the appropriate points?**
  There are several examples of the involvement of consultants, psychiatrists, senior practice GPs and MARAC Chairs intervening at the appropriate points.

- **Was the domestic homicide the only one that had been committed in the area for a number of years?**
  This was the first domestic homicide within the North Yorkshire Community Safety Partnership area for five years. Since the statutory guidance was introduced, there has been only one previous domestic homicide in the county in 2013. That review is published on the CSP web site.

- **Are there ways of working effectively that could be passed on to other organisations or individuals?**
  Several of the recommendations relate to training and development. This will be most effectively delivered within a multi-agency setting.

- **Did staff make use of available training?**
  Staff have accessed available training. The training itself has improved since the timeframe of the review and this is documented by many agencies involved in the review. Further training is part of the recommendations within the overview report. All training should be delivered on a development cycle to ensure newly appointed front line staff are incorporated.

- **Did any restructuring during the period under review have any impact on the service provided?**
  There has been re-structuring (e.g. with police taking over responsibility for chairing and administrating MARACs from IDAS) but this was not to the detriment of services provided.

- **How accessible were services for the victim and perpetrator?** Both Julie and Marcus accessed a variety of services available. These included, support, enforcement, medical, psychological and multi-agency forums.

- **Are there lessons to be learned from this case relating to the way in which agencies work to safeguard victims and their welfare?** This is mirrored in paragraph 1.4 and is a core purpose of the review: "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."

- **When and in what way were the victim's wishes and feelings ascertained and considered? Was the victim informed of options or choices to make informed decisions? How accessible were services to the victim and perpetrator?**

  This final 'term of reference' is crucial to understanding 'life through Julie's eyes' and will be considered in detail in the 'conclusion' section of the overview report.

3.2.23 EMERGING THEMES AND LESSONS LEARNED

- Communication: Although there were many examples of effective communication, several episodes involve poor communication between agencies.

- Record Keeping: The review found some instances of records being missing. In other examples, the notes were too brief. This became important if (for example) an agency employed many professionals and so a different practitioner saw the victim or perpetrator at their next contact. Notes from earlier interventions are vital in helping give context to colleagues.

- Risk identification and risk assessment: This is vital if the victim is to be protected from harm.

- Child Protection: This was a theme cutting across several agencies. Professionals involved in domestic abuse cases must be aware of the link to child protection concerns.

- Awareness of domestic abuse: Abuse was not always recognised as such.

- Systems and processes: Some systems require improved checks and balances to ensure planned actions are carried out.

- Information Sharing Protocols: This is vital if staff involved in domestic abuse cases are to have confidence when passing information about high risk victims to other organisations to ensure they are safeguarded from harm.

- Engagement with MARAC: The Multi-Agency Risk Assessment Conference is a joint forum and not the responsibility of one agency. All professionals working in the field of domestic abuse should fully engage in this recognised process.

- Stalking: Stalking is an indication of obsession. By its very nature it is 'high risk'. Staff did not always recognise the signs of stalking in this case.

- Lack of training: As well as issues already listed such as awareness of abuse, child protection and risk assessment, training is also required to update on new developments such as DVDS, DVPN or coercive control. The training needs of organisations should be continuously reviewed due to staff turnover.

Section 4: Conclusion and recommendations

4.1 Conclusions

4.1.1 This is a tragic case. Julie was an intelligent and professional woman who was killed by her ex-husband. Her relatives describe her as the 'matriarch' of their family and her loss has been devastating. Julie suffered significant domestic abuse from Marcus. Although she attempted to end the relationship on several occasions, the pair repeatedly resumed their relationship.

4.1.2 We have explored and speculated with the information available to reach the most objective conclusions. We will never have the full answer why the relationship continued so long after the incidences of serious violence by strangulation and threats to kill. We know there were at least three previous episodes of strangulation perpetrated upon Julie by Marcus before he finally killed her by strangulation.

4.1.3 We know about the love and affection in the relationship, we know about the arguments, the relationship ending and then resuming. We also know about the control exercised by Marcus upon Julie ranging from extreme violence, to threats against her family to his own attempts at suicide. Julie was also aware Marcus had lost his previous wife to cancer. We can never be certain whether the reasons Julie stayed in the relationship were fear, affection, sympathy or a mixture of all three.

4.1.4 This Domestic Homicide Review has considered the actions of a variety of agencies and professionals working with Julie and Marcus. Lessons have been learned and documented. These will form the basis of recommendations to improve delivery of local services, prevent domestic homicides and better protect to all victims of domestic abuse.

4.1.5 This crucial element within the terms of reference relates to Julie herself. **'When, and in what way, were the victim's wishes and feelings ascertained and considered?' Was the victim informed of options or choices to make informed decisions? How accessible were the services for the victim and perpetrator?'**

In response to this, there is a great deal of evidence to show that Julie was listened to. The police took positive action following the traumatic and serious violence episodes. Julie was interviewed and assessed by an experienced Independent Domestic Violence Advocate from IDAS. There was an incident (when a threat and assault by Marcus was discontinued against Julie's wishes) when she did not receive the correct level of service required. The decision to discontinue the case was the right one. However, Julie did ask for the officer to contact her about this. The officer received an e mail about Julie's request but did not get in touch with her, citing 'workload.' However, there are many incidences of officers proactively getting in touch with Julie, including specialist Domestic Abuse Officers to outline

the risks and her options. When Marcus was detained under the hospital order, the staff at Leeds and York Partnership NHS Foundation Trust involved her in the planning around his eventual discharge. On several occasions at the MARAC meeting, an action was for a specialist Domestic Abuse Officer to personally update Julie on agreed actions. The services available to Julie were visible and accessible.

4.1.6 Marcus was Julie's fourth husband. The three former husbands were contacted during the police investigation and the Domestic Homicide Review. They describe 'amicable' splits and at least one remained on good terms with Julie. There are no reports to police or other agencies of domestic abuse perpetrated towards Julie by any of her former husbands.

4.1.7 Marcus was violent to Julie and the reported incidents of domestic abuse were serious and life threatening. For a variety of reasons which have been explored and evaluated Julie remained in the relationship. She did tell family and professionals she intended to break away gently to not increase Marcus's paranoia. When considering the nature of the previous strangulations, the homicide may well have been predicted and this was ultimately how Marcus killed Julie. We cannot say with any certainty that the homicide could have been prevented. This review has identified some missed opportunities where a more effective intervention could have taken place. But these missed opportunities should be balanced against some of the positive actions taken by agencies to protect Julie. These actions included advice to leave such a violent partner. Her family also pleaded with her to end the relationship as they had such concerns for her safety. For reasons which have been considered and documented within this review, Julie did not feel able to make a complete break from this destructive relationship.

4.2 Recommendations: Overview Report Author

Recommendation 1: All front-line professionals who may encounter domestic abuse situations should receive training in risk assessment using the recognised 'DASH' model.

Recommendation 2: The Community Safety Partnership to ensure there are protocols in place between the police and Crown Prosecution Service to ensure any high-risk case of domestic abuse that meets the evidential threshold is not discontinued without good reason. That rationale of the decision together with a plan to protect the victim is in place should be recorded.

Recommendation 3: All professionals should receive appropriate training to recognise Child Protection situations. The training should include (a) Putting the child at the centre of their thinking irrespective of the reason they are involved. (b) An appreciation of the different levels of child welfare concerns ('Child Protection' and 'Child in Need').

Recommendation 4: All agencies review their processes for closure of incidents involving vulnerable people. This system to include checks and balances to ensure any necessary safeguarding referrals are submitted.

Recommendation 5: In high risk cases of domestic abuse, professionals within a support role should consider the benefits of making direct face to face contact with the victim rather than on the telephone. This should not be discontinued simply because the victim does not consent. Ideally this would be a joint home visit with IDAS and a police DAO, ensuring the victim is aware of all services available while simultaneously ensuring safety of staff.

Recommendation 6: The Community Safety Partnership should satisfy itself that adequate training programmes are delivered which highlight to professionals:

(a) The recognition of domestic abuse and its complexities, 'push-pull' factors and pressure on victims

(b) Local procedures in place such as DASH risk assessments, the MARAC process, DVPN and DVDS provisions.

(c) The ECHR competing articles that both protect the confidentiality of victims / patients but also recognise the duty on all professionals to 'protect life.' Specifically, this should include balancing the requirements of Article 2 ('the right to life.') and Article 8 ('the right to a private and family life.')

Recommendation 7: The Community Safety Partnership should review its Information Sharing Protocol for information exchange between professionals who are working in the field of domestic abuse and other areas of safeguarding. The revised ISP to be clear on the need for balance between confidentiality and protecting vulnerable people from significant harm and thus give professionals confidence in making referrals in challenging circumstances.

Recommendation 8: All agencies involved in protecting the vulnerable should have a 'flagging' system in place to ensure their systems alert attending professionals of previous domestic abuse linked to a victim, perpetrator or address.

Recommendation 9: Agencies should cross reference their patients / clients with married names / change of name / other aliases to ensure opportunities for identification of vulnerable people are not missed.

Recommendation 10: The Community Safety Partnership should encourage and measure the training of staff within both the 'Responsible Authorities' (RAs) and the 'Duty to Cooperate' (DTC) agencies on the new MAPPA E Learning package.

Recommendation 11: The Community Safety Partnership should carry out a review of the MARAC operating procedures within North Yorkshire. Where practices are working well staff should be recognised. The frequency of MARAC meetings should be considered together with the administrative support available to support the Chair ensuring actions are completed in a timely manner and accurately recorded. The CSP should provide visible governance to encourage regular attendance by all agencies with reporting back to the CSP on annual attendance levels. Above all, the CSP should provide leadership to demonstrate to agencies that ALL organisations should be fully committed to this partnership process.

Recommendation 12: All professionals working directly with victims should receive training in stalking and harassment and particularly around identification, risk assessment and safety planning.

Recommendation 13: This Domestic Homicide Review has included information and participation across two Community Safety Partnerships -North Yorkshire as coordinators and Leeds (where the perpetrator resided during periods of the review). It is good practice to share all learning and recommendations with colleagues within the 'Safer Leeds' Partnership.

4.3 Recommendations: Single Agency IMR authors:

4.3.1 Most single agency recommendations are incorporated into the Overview Report recommendations to be adopted by all agencies involved in the Domestic Homicide Review. There are some additional specific recommendations made by the IMR author relating to their own agency:

Leeds and York Partnership NHS Foundation Trust

No additional recommendations

York Teaching Hospital

No additional recommendations

Julie's GP surgery

GP Practice staff should routinely record names of partners and link to clinical records to enable a clear understanding of who potentially poses a risk to the patient.

Yorkshire Ambulance Service

No additional recommendations

North Yorkshire Police

- The Force Control Room make Domestic Abuse Officers (DAOs) aware of all incidents involving high risk victims. This will afford the DAO the opportunity to review the incident and make a further risk assessment.

- Ensure that during 'Daily Management meetings', consideration is given for the serving of Domestic Violence Protection Notices / Domestic Violence Protection Orders (DVPNs / DVPOs) for offenders in custody when no further action is being proposed. A breach of a DVPO carries a power of arrest and consideration of a custodial sanction.

- North Yorkshire Police should review the decision to appoint only police staff to the role of DAO. The IMR author believes a more blended mix of experiences would give a more comprehensive service to victims.

West Yorkshire Police

No additional recommendations

IDAS

No additional recommendations

National Probation Service

No additional recommendations

Leeds CCG

The CCG to provide GP practices across the city with a template safeguarding policy which encompasses the most up to date information and resources. This will standardise practice and promote an understanding of safeguarding, including domestic abuse.

4.3.2 These sets of recommendations will be incorporated into 'SMART' action plan with leadership and scrutiny provided by the North Yorkshire Community Safety Partnership.

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 multi-agency response to children living with domestic abuse.' (Joint publication: HMICFRS, HM Inspectorate of Probation, Ofsted, Care Quality Commission 2017)

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

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

'The knowledge hub – resources for identifying the risk victims face; resources for MARAC meetings' (Safe Lives – registered domestic abuse charity).

MAPPA guidance (Ministry of Justice 2012)