Sunderland Partnership

Safer Sunderland Partnership

DOMESTIC HOMICIDE REVIEW

FINAL OVERVIEW REPORT

Adult 5 – Michelle

(Month/Year of Homicide: September 2018)

Independent Chair – Richard Corkhill

Independent Author – Adam Lindridge

Report Completion Date:

April 2020

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FOREWORD – INDEPENDENT CHAIR

Safer Sunderland Partnership and the Domestic Homicide Review Panel (DHR) would like to express their condolences to Michelle's family and friends for their sad loss. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future.

As Independent Chair of the DHR Panel, I would like to thank all agencies involved, including Michelle's family, Advocacy After Fatal Domestic Abuse (AAFDA) and the many specialist partners that contributed to the process in an open and transparent manner. I would also like to formally acknowledge the support provided by Safer Sunderland Partnership in co-ordinating the DHR Panel process as well as the efforts of the author, Adam Lindridge, for his work on producing the Overview Report.

The DHR examines responses and support provided by partners to Michelle, a resident of Sunderland, prior to her death. Michelle was murdered at her home address in September 2018 by the perpetrator, her estranged husband, who subsequently took his own life. We know from Michelle's family she was a strong and independent person, who would live life to the full, and was someone who would go out of her way to help anyone.

We know Michelle experienced domestic abuse and had reported numerous incidents to Northumbria Police over several years. Protective measures (such as Domestic Violence Protection Orders) were used to help control the behaviour of the perpetrator – and Michelle also took proactive and positive steps herself to try and put an end to the abuse she was experiencing. There are however some missed opportunities, through our interactions with Michelle, to have utilised a better degree of professional curiosity to help us to elicit further information about her home life that would have put agencies in a better position to be able to assess the perpetrator's risk of harm.

There is also a tendency from agencies to rely too heavily on victim engagement with support services – and we need to do more to re-focus the spotlight towards tackling the behaviours of perpetrators. In addition, the case highlights the need for stronger Workplace Domestic Abuse Policies to encourage disclosures alongside an improved understanding of how the language and terminology used by partners can impact on our response to domestic abuse.

We have evidenced, through this DHR process, that there continues to be lessons that can be learned by agencies to further protect and safeguard victims of domestic abuse – and I am hopeful that, through implementation of the recommendations, partners will be in a better position to respond in future.

Richard Corkhill
Independent Chair – Michelle – DHR Panel

FOREWORD – MICHELLE'S FAMILY

The Domestic Homicide Review Panel invited Michelle's family to provide a foreword for the Final Overview Report. This narrative helps the reader to understand, in short, how Michelle was regarded by her family and how she impacted on their lives prior to her homicide.

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Michelle was the fifth child of six wonderful children that myself and her late father were privileged to have. To Michelle, her family, from the very young ones through to the eldest, were everything; her love for us was unconditional, she would care and protect us with her life to which she sadly did.

Michelle showed her caring side from a young girl, from an injured bird to a stray kitten by bringing them home, and she would have loved to own a horse. As an adult, she loved her 2 dogs; first Roxy and then Buster, and was distraught when they died, and cried buckets, especially for Roxy.

To her many friends, Michelle was a joy to be with always leaving a part of herself with everyone she met, and her loyalty to them unflinching. She was a social butterfly.

In Michelle's work, people weren't just a number they were a person and she treated them with respect. She had dreams and inspirations, she should have years ahead of her to achieve her goals, but her life was brutally cut short.

Michelle was always on the side of the vulnerable, needy and the underdog, wanting to make a difference and, little did we realise, she was the most vulnerable of all which she hid too well with her beautiful smile.

There wasn't a cowardly bone in Michelle's body, she was straight to the point, but if made mistakes would say so, and apologise. She faced her problems never shying away from them.

Michelle was taken away from us in the most brutal, cruel and cowardly way, which has left her family and many many friends devastated. The chain has been broken, she will always be the missing link.

Sleep peacefully our beautiful, precious Michelle, in our hearts and thoughts you will forever remain. Till we meet again.

Your broken-hearted mother and family.

SECTION ONE:

1 INTRODUCTION

1.1 This Domestic Homicide Review (DHR) examines the responses and support provided by agencies to Michelle, a resident of Sunderland, prior to her death. In addition to agency involvement, the DHR will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed in the community and whether there were barriers to accessing support. By taking a holistic approach, the DHR will seek to identify appropriate solutions to make the future safer.

1.2 Northumbria Police confirmed Michelle died September 2018 at the hands of her estranged husband who subsequently took his own life and was found at the same address. The review considered agency contact and involvement with Michelle and the perpetrator from 12/01/14 – 20/09/2018. The period covers early incidents of domestic abuse reported to Northumbria Police by Michelle until the homicide incident in September 2018[1].

1.3 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened in the lead up to the homicide to help identify what needs to change to help reduce the risk of similar tragedies occurring in the future.

1.4 The DHR will highlight learning points for partners to consider along with several recommendations for agencies to implement to help prevent what happened to Michelle from happening to others.

2 TIMESCALES

2.1 Safer Sunderland Partnership received formal notification of Michelle's death from Northumbria Police on the 21st September 2018 and agreed the circumstances reached the criteria[2] to undertake a statutory Domestic Homicide Review – and subsequently informed the Home Office. An information scoping exercise was carried out by the Safer Sunderland Partnership in October 2018 and, following this, a decision to appoint an Independent Chair and Author was undertaken.

2.2 The first Panel meeting took place on the 30th November 2018 and the Final Overview Report was completed in early November 2019. It was presented to the Safer Sunderland Partnership (Community Safety Partnership) for approval in December 2019 and was subsequently submitted to the Home Office DHR Quality Assurance Panel for endorsement thereafter.

[1] There was a single domestic abuse incident reported by Michelle earlier than the time period identified and related to a verbal argument which had taken place with the perpetrator on 01/01/2011. There were no apparent domestic abuse incidents or concerns identified for three-years starting January 2014; hence, the truncated review period.

[2] The criteria in the statutory guidance under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004: (1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 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, held with a view to identifying the lessons to be learnt from the death.

2.3 It was not possible to complete the DHR within the six-month timescale (as set out within Home Office Domestic Homicide Review guidance). A draft copy of the IOPC (Independent Office for Police Conduct) report was provided to the Independent Chair on the 11th June 2019 which raised additional issues for the DHR Panel to consider.

3 CONFIDENTIALITY

3.1 It is standard practice to protect the identities of individuals involved in a DHR by using pseudonyms. Individuals will be named throughout the Final Overview Report as follows:

Classification	Name	Age	Ethnicity
Victim	'Michelle'	Age at the time of her death: 49	White British
Perpetrator	'Perpetrator'	Age at the time of the homicide: 53	White British

3.2 It is worth noting that Michelle's family, via their appointed advocate, requested for her real name be included as part of the published documents. The DHR Panel considered these wishes but felt publishing Michelle's real identity, may ultimately compromise the anonymity of other people included/involved in the review process, including friends of Michelle's, and the perpetrator's family. For this reason, the Panel recommended to the Safer Sunderland Partnership that a pseudonym be used. This recommendation was shared with Michelle's family, who strongly disagreed with the decision – and were subsequently invited, via their appointed advocate, to submit a short statement to the Safer Sunderland Partnership setting out their reasons and rationale for why Michelle should be named.

4 TERMS OF REFERENCE

4.1 The statutory guidance states the purpose of a DHR is to:

- establish what lessons could be learnt from domestic homicides regarding the way in which local professionals and organisations work individually, and together, to safeguard victims.

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

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

- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a

coordinated multi-agency approach to ensure domestic abuse is identified and responded to effectively at the earliest opportunity.

- contribute to a better understanding of the nature of domestic violence and abuse and to highlight good practice.

4.2 The finalised Terms of Reference for Michelle's DHR were:

(a) What were the quality of risk assessments and risk management plans in response to known incidents? Were the risks to Michelle appropriately assessed at the correct level of risk? Were static factors present in all risk assessments?

(b) Were appropriate managers, agencies and professionals involved at the appropriate points and concerns about risks escalated in a timely and appropriate manner?

(c) There was an occasion when the perpetrator called Northumbria Police and was identified as the victim of domestic abuse. Did agencies have a clear understanding of who committed the violence in the relationship and did this impact on the risk assessments and risk management plans?

(d) With specific regard to domestic abuse, did the portrayal of Michelle's alcohol use and mental health by the perpetrator affect decisions made by organisations regarding her risk of domestic abuse?

(e) Was there any evidence that Michelle was experiencing coercive control from the perpetrator and is there any evidence that this impacted on her seeking help or prevented her from contacting services?

(f) Was the perpetrator's known history of violent behaviour (including but not limited to domestic violence) and use of weapons given sufficient weighting in police risk assessments?

(g) Were the correct referral pathways (including but not limited to MARAC) implemented in line with local policy, procedure and guidance?
- If so, for Michelle, did this result in appropriate needs assessment and safety planning actions and what was the evidence of this?
- If so, for the perpetrator, did this result in appropriate actions being taken to address his abuse towards Michelle and what was the evidence of this?
- If the process was not implemented in line with local policy, procedure and guidance, what were the reasons for this?

(h) Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew Michelle was experiencing domestic abuse?

(i) Was appropriate use made of available civil/statutory tools and powers including but not limited to: Civil Orders, Domestic Violence Protection

Notices (DVPNs), Domestic Violence Protection Orders (DVPOs) and Domestic Violence Disclosure Scheme (Clare's Law)?

(j) Where services and protection planning could not be delivered due to non-engagement[3] of Michelle, were the reasons for non-engagement explored and what efforts were made to encourage engagement?

(k) How effective was interagency working and interagency information sharing around addressing the risk the perpetrator posed to Michelle?

(l) Michelle was a repeat victim of domestic abuse in this relationship and in previous relationship(s). The perpetrator was a repeat perpetrator of domestic abuse in this relationship and previous relationship(s). Was either Michelle and/or the perpetrator offered any form of assistance or intervention to address domestic abuse (including programmes for perpetrators or victims?). If so, what were the outcomes?

(m) Did Michelle or the perpetrator's workplace have any cause for concern that Michelle may be at risk from domestic abuse by her husband?
- If so, did this result in any routine or selective enquiry, safety planning and/or risk management actions and what was the evidence of this?
- If not, what were the reasons for this?
- Did Michelle and the perpetrator's workplace have domestic abuse workplace policies? If so, how were staff made aware of these policies; and were these policies applied?

(n) Did family, friends, neighbours and work colleagues have any cause for concern Michelle may be at risk from domestic abuse? If so, were they aware of support services and how to seek advice and support?

5 METHODOLOGY

5.1 All agencies were contacted and asked to secure their respective files and to provide a chronology of their involvement with Michelle and/or the perpetrator – which was subsequently combined into a single narrative chronology and shared with the DHR Panel for scrutiny.

5.2 Timescales used for the chronologies were:
- For both Michelle and the perpetrator, a period spanning from the 12th January 2014 through to the 20th September 2018 to consider any relevant history in the lead up to Michelle's homicide. The period covers the early incidents of domestic abuse reported to Northumbria Police by Michelle through until the date of her homicide in September 2018.

[3] A learning point from this DHR has been the use of language; it is not about the 'non-engagement' of people who use the services but how easy is it for people to access services and how person-centred the services are. Terminology such as 'non-engagement' can appear victim blaming. SSP will take steps to ensure future DHR Terms of Reference refrain from using this type of terminology (and consider questions that place a greater onus on services and why they were unable to engage with the person).

- Agencies were also encouraged to review historical information (prior to the 12th January 2014) and to include any noteworthy events linked to domestic abuse and/or information that may be pertinent to the case.

5.3 At the first Panel, the Terms of Reference were discussed/drafted and those agencies that were required to provide Individual Management Reviews[4] (IMR) were identified. IMRs were requested from five agencies who had been in contact with either Michelle and/or the perpetrator and, where appropriate, staff were subsequently interviewed. The Police Officers involved in the case could not be contacted or interviewed as part of the process due to their involvement with the Independent Office for Police Conduct[5]. Authors of IMRs were independent of case management and not directly involved with the case.

5.4 The Independent Author accessed some of the homicide investigation witness statements provided by Northumbria Police and these were used to help further strengthen chronologies and develop a fuller picture of Michelle and the perpetrator's experiences in the lead up to the homicide. These proved a useful insight into the lives of Michelle and the perpetrator and helped supplement information provided by family members.

5.5 Following the initial scoping meeting held in October 2018, there were a total of five DHR Panel meetings, starting in November 2018 through to August 2019 (30/11/18; 21/02/19; 29/04/19; 11/07/19 and 28/08/19). The DHR Panel were responsible for reviewing all IMRs, critiquing drafts of the Overview Report and Action Plan and providing scrutiny functions before submission to Safer Sunderland Partnership for approval.

6 INVOLVEMENT OF FAMILY AND FRIENDS

Michelle – the victim

6.1 With the assistance from the Family Liaison Officer (FLO) from Northumbria Police, Michelle's family were initially contacted by the Independent Chair who arranged a meeting in February 2019 to outline the DHR process. An offer of advocacy was provided by Advocacy After Fatal Domestic Abuse (AAFDA) and was taken up by the family.

6.2 There was a regular dialogue between the Independent Chair, Michelle's family and their advocate (by either telephone, email and/or face-to-face) throughout the DHR process to ensure family members and interested parties were kept appropriately informed.

[4] Individual Management Reviews (IMRs) are completed by those organisations that were involved with the victim and/or the perpetrator prior to the homicide. IMRs allow agencies to look openly and critically at both individual and organisational practice to ascertain whether changes could be made to help protect future victims of domestic abuse. IMRs are comprehensive written documents provided by agencies in response to the Terms of Reference set out by the DHR Panel and provide recommendations that the organisation intends to implement as a result of the homicide. Further information on the contents of IMR contents and templates used can be found in the national DHR Home Office Guidance published in December 2016: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[5] This is an investigation which is an automatic referral where there is a death after police contact – and is standard operating practice. Due to contact with Northumbria Police shortly before her murder, Michelle's case was investigated by the Independent Office for Police Conduct (IOPC).

6.3 The Independent Chair and Independent Author met with Michelle's family face to face and comprehensive notes were made and shared for agreement:

- February 2019: Michelle's mother, brother and sister along with their advocate. The Terms of Reference were also shared, and Michelle's family were invited to include any additional questions or concerns of their own – but did not have anything further to add.

6.4 In September 2019, Michelle's family and their advocate were provided with copies of the draft Overview Report to seek their views and thoughts prior to completion and submission to the Safer Sunderland Board and the Home Office DHR Quality Assurance Panel. The family had an opportunity to review the report privately and provided comments via their appointed advocate. Contributions provided by Michelle's family have been invaluable to informing the review and have allowed the DHR Panel to gain a tangible understanding and appreciation of Michelle's life. We would like to thank them for their time and for sharing personal stories and anecdotes with the Panel about Michelle.

6.5 One of Michelle's closest friends (who was also a work colleague and someone she confided in around the domestic abuse she was experiencing at the hands of the perpetrator) was contacted by her employer, on behalf of the Independent Chair, but decided she did not wish to contribute and/or be involved with the review.

Perpetrator

6.6 Home Office guidance stipulates that DHR Panels should consider approaching the family of the perpetrator who may also have relevant information to offer. The Panel agreed the insights of the perpetrator's family would be useful to help to strengthen the information held by agencies. Discussions took place with Michelle's family to inform them the perpetrator's family would be contacted to be involved in the review process.

6.7 An invitation was subsequently sent to the perpetrator's family which was accepted – and the Independent Chair and an experienced DHR Panel Member met with his brother in May 2019. Comprehensive notes were made and shared with family members for agreement.

7 CONTRIBUTORS TO THE REVIEW

7.1 Five organisations had been involved with and/or held information regarding Michelle or the perpetrator prior to the homicide and suicide. Detailed chronologies and Individual Management Reviews (IMRs) were requested from the following organisations:

- **Northumbria Police** – the Police Force responsible for the geographic area covering Sunderland.

- **VictimsFirst Northumbria** – a local charitable organisation, commissioned by Northumbria Police and Crime Commissioner, providing emotional and

practical support to victims of crime (including standard and medium risk victims of domestic abuse).

- **Wearside Women in Need (WWiN)** – a local charitable organisation, commissioned by Sunderland City Council, responsible for delivering specialist domestic abuse support services within Sunderland, including support for high-risk victims.

- **Sunderland Care and Support Limited** – a local authority trading company established by Sunderland City Council, which is responsible for delivering a range of social care, health and support services to residents across the city of Sunderland and in the region.

- **Sunderland Clinical Commissioning Group** – organisations set up by the Health and Social Care Act 2012 to commission the delivery of hospital and community NHS services in local areas for which they are responsible.

7.2 Assurance was sought from organisations that IMR authors had no contact with Michelle or the perpetrator and had no management responsibility for those officers directly involved with the case. None of the members of the DHR Panel had any previous responsibility for delivery or direct management of services which had had contact with Michelle, the homicide perpetrator or members of the immediate family. In the interest of transparency, the DHR Panel member for Northumbria Police disclosed that, as a senior ranking officer, she is ultimately responsible for the management of the officers involved in the case and would also be contributing to the IMR process. The Panel felt this was not a significant conflict of interest and permitted future involvement.

7.3 Information previously identified as part of the scoping exercise from North East Ambulance Service, National Probation Service, South Tyneside & Sunderland NHS Foundation Trust (City Hospital Sunderland) and Gentoo (the Registered Social Landlord) was also used. A short document was also requested from a health and social care charity (an organisation where Michelle worked in the months prior to her homicide). It was agreed by the DHR Panel that full IMRs were not required from these agencies due to limited involvement/interaction with either Michelle and/or the perpetrator.

8 REVIEW PANEL MEMBERS

8.1 The core membership of the DHR Panel was as follows:

Panel Representative	Role and Agency
Barry, Martin	Team Manager, Adult Social Care Sunderland City Council
Begbie, Sandra	Business Manager Sunderland Care and Support Ltd
Corkhill, Richard	Independent Chair

Dawson, Tracy	Named Nurse Safeguarding Adults South Tyneside & Sunderland NHS Foundation Trust
Douglass, Stuart	Lead for Community Safety and Safeguarding Sunderland City Council
Kilgallon, Jim	Safeguarding Adults Adviser North East Ambulance Service
Lindridge, Adam	Independent Report Author
Lister, Julie	Operations Manager Gentoo
O'Neill, Karin	Head of South of Tyne NPS National Probation Service
Parker, Ruth	Chief Executive Victims First Northumbria
Paulsen, Amy	Strategic Safeguarding Specialist Sunderland City Council
Rogerson, Becky	Acting Director Wearside Women in Need
Sampson, Aelfwynn	Detective Chief Inspector – Safeguarding Northumbria Police
Scott, Richard	Designated Nurse Safeguarding Adults Sunderland Clinical Commissioning Group
Smith, Julie	Associate Lead for Community Safety Sunderland City Council

8.2 There were five DHR Panel meetings held, starting in November 2018 through to August 2019. Some agencies did not attend every Panel, as they were not directly involved with the case, but they were provided with copies of the draft Overview Reports and DHR Panel minutes and would submit their comments via Community Safety staff within Safer Sunderland Partnership. The Panel included specialist organisations and experts in domestic abuse and victim support (i.e. WWiN and Victims First Northumbria, both charitable organisations)

<u>Independent Chair – Richard Corkhill</u>

8.3 **The Chair is independent of, and has no current connection with, any agencies in the Sunderland area or Safer Sunderland Partnership.** Richard Corkhill has over 30 years operational and senior management experience in social care and supported housing sectors. The latter included senior and strategic management of outreach and accommodation-based services for women and children who had experienced domestic abuse. He has been a self-employed Consultant since 2004 and is based in the North East of England. Since 2012, he has acted as Independent DHR Chair and/or Author for 15 DHRs. Richard has successfully completed on-line Home Office training for DHR Chairs/Authors. He regularly attends training, conferences and seminars, in order to maintain and update his knowledge of current research and practice on domestic abuse. Crucially, this includes events involving families affected by domestic abuse and domestic homicide. He has also acted as Chair and Author for Safeguarding Adults Reviews (SARs) and other similar multi-agency review processes, including combined SARs/DHRs. He is fully independent

and has never been employed by any of the organisations which were involved with Michelle or the perpetrator.

Independent Author – Adam Lindridge

8.4 **The Author is independent of, and has no connection with, any agencies in the Sunderland area or Safer Sunderland Partnership.** Adam is the Community Safety Business Manager for Gateshead Council and has been working in the field of Community Safety for more than 10 years. He is responsible for strategy and policy development for a range of Community Safety themes. He has knowledge and understanding of the domestic abuse agenda and has previously line managed the Gateshead Independent Domestic Violence Adviser Team. He completed online training for DHRs, attended several conferences and events and has shadowed several DHRs in recent years to support his development and learning. In addition, he has previously been involved as a Panel member and IMR author for a high-profile DHR in a neighbouring local authority. In the interests of disclosure, Adam has previously worked as an Intelligence Analyst for Northumbria Police (which included analytical work for homicide investigations between 2006-09).

9 PARALLEL REVIEWS

9.1 As per standard operating processes, Northumbria Police referred the case to the Independent Office for Police Conduct (IOPC) due to their involvement with Michelle leading up to her homicide – and a parallel review was subsequently carried out.

9.2 A draft of the IOPC Investigation Report was sent to the Independent Chair in June 2019 and focused on investigating the nature and extent to Northumbria Police's contact with Michelle. This included assessing the response provided to a disclosure of rape and multiple assaults, an assessment of risk relating to Michelle from the perpetrator and the effectiveness of actions taken by Northumbria Police in relation to the planning and implementation of actions to safeguard Michelle. The IOPC investigation identified no evidence to suggest that Northumbria Police may have caused/contributed to Michelle's death. The Police Officers involved have correctly followed policies and made appropriate decisions which were in line with Northumbria Police policies. The Independent Chair maintained regular contact with the nominated IOPC representative throughout the process and was provided with routine updates.

9.3 The Independent Chair contacted Sunderland's Coroner on several occasions to provide updates and maintained contact throughout the DHR process. A copy of the draft Overview Report was shared with the Coroner's Office in early July 2019. Whilst there was no criminal trial, the Coroner held a pre-inquest hearing in July 2019 and separate inquests into Michelle and the perpetrator's deaths were concluded in late August 2019. The Coroner issued a Regulation 28 Report to Prevent Future Deaths, addressed to the Secretary of State for Home Office (see Appendix 1). This related to his concerns around preventing unlawful deaths in relation to the issue of protection of domestic abuse victims whilst a perpetrator is released under investigation and not subject to bail

conditions or any other restrictions. The response from the Home Secretary is attached as Appendix 2.

10 EQUALITY AND DIVERSITY

10.1 Equality of opportunity and diversity is vital to ensure a fair, just and democratic society. To achieve full equality in practice, it has long been recognised that different groups may require different treatment because they are differently situated. Under the Equality Act 2010, it is illegal to discriminate against anyone on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. The Panel considered the protected characteristics and found no evidence of Michelle having been subject to discrimination and/or any barriers to accessing services.

10.2 However, it should be noted that domestic-related homicide, especially intimate partner homicide, is a gendered crime, and means the protected characteristic of 'sex' is directly relevant to this DHR. We know women are disproportionately affected and that men are disproportionately perpetrators of domestic homicide. The Global Study on Homicide carried out by United Nations Office on Drugs and Crime in 2013 reported that women make up 70% of victims and men 95% of offenders. It is a global issue. It is mentioned within the Istanbul Convention, which has been ratified by most countries, and is designed to reduce violence perpetrated against women and girls. The importance of promoting learning from DHRs is also included as part of the Government 'Ending Violence Against Women and Girls Strategy 2016 – 2020'.

10.3 Murder followed by the suicide of the perpetrator, as in this case, follows a very similar unbalanced gendered split. A report published in 2018 by the Violence Policy Centre in America[6], which reviewed all murder-suicide cases over a six-month period, showed offences of this nature were committed overwhelmingly by male perpetrators and were most prevalent between two intimate partners, of which 96% of victims were females. Michelle's homicide follows a pattern common in female intimate partner homicide cases. Women are significantly more likely to be seriously harmed or killed in situations of intimate partner violence and this should inform risk assessment/safety planning. Therefore, there is learning to consider in the way that agencies respond to female victims.

10.4 In terms of marriage – we could not find any issues of discrimination; however, prior to the homicide, Michelle had separated from the perpetrator and had started divorce proceedings – and means the protected characteristic of 'marriage' is relevant to the review. The Crime Survey for England and Wales published in November 2018 show that divorced women were more likely to be victims of domestic abuse than those who were married, civil partnered, cohabiting or single. Findings from 2016 Office of National Statistics (ONS) report on intimate personal violence and partner abuse highlights women who had separated from their partner had the highest prevalence of any domestic

[6] American Roulette: Violence Policy Centre – 2018 (http://vpc.org/studies/amroul2018.pdf)

abuse in the last year (19.8%) compared with other marital status groups (such as married or civil partnered 3.6%) or cohabiting (6.6%)).

10.5 Although it was never described as a disability, we know that Michelle suffered from Kienbocks Disease in her wrist, which impacted on her ability to work. We do not know if this condition was a factor in relation to the domestic abuse Michelle experienced (e.g. deliberate targeting of wrist by the perpetrator) and/or whether this 'disability' impacted on her ability to access services. Based on information provided to the Panel, it is unlikely that it was a significant issue.

10.6 This is the 3rd of 5 DHRs carried out in Sunderland which involves a murder-suicide type incident. The Panel reviewed the findings of the previous DHRs to ascertain if there were any similarities, but no obvious parallels could be made. The circumstances and conditions of each DHR were found to be very different and we were unable to draw any meaningful patterns or learning points relevant to this DHR. It demonstrates however that suicide, and the threat of suicide, remains a significant risk (in terms of domestic abuse) and illustrates the critical importance of raising awareness of how suicidal persons need to be considered as potentially homicidal (in the context of domestic abuse).

10.7 The Panel also considered, and did not identify, any specific cultural aspects in relation to the case (including race and religion).

11 DISSEMINATION

11.1 Once approved by the Safer Sunderland Partnership and Home Office Quality Assurance Panel, the Overview Report, Action Plan and any other supporting documentation will be disseminated to the Chief Executive (or equivalent) for all partners and services represented on the DHR Panel. In addition, copies will be shared with Safer Sunderland Partnership, the elected Police and Crime Commissioner for Northumbria and the Sunderland Coroner's Office.

11.2 A copy of the report was sent to Michelle's family to seek views and comments prior to completion – and where relevant, the report has been updated to reflect any issues raised. As details of the IOPC Investigation Report have been used to supplement the DHR process, a copy of the draft was submitted to the IOPC for comment prior to its publication. In addition, other contributors to the review, including Michelle's friends and colleagues, will be signposted to the final DHR upon publication.

11.3 Following satisfactory approval from the Home Office Quality Assurance Panel, the Overview Report will be published on the Safer Sunderland Partnership website (https://www.sunderland.gov.uk/domestic-violence) in accordance with national Home Office Guidance.

SECTION TWO:

12 BACKGROUND INFORMATION

12.1 The victim, Michelle, lived in a privately-owned two-bedroom house in Sunderland. She shared the property with, her recently estranged husband (the perpetrator), and had resided at the address for 18 years prior to her homicide. The couple had been in a relationship for approximately 15 years, after being introduced by a mutual friend in early 2005. The perpetrator had co-habited at Michelle's property from 2008, and in 2010, the couple had married and took on joint-ownership of the property. The couple had no children together and no other person lived at the address.

Michelle – the victim

12.2 Michelle was born, and raised, in Sunderland. At the time of the homicide, she was 49 years of age – and had five siblings. She is described by her family as caring, loving and kind-hearted, who 'would do anything for anyone'. She cared deeply about supporting her family and would routinely look after and undertake caring duties for her father. Michelle's family proudly recollect how she would 'make a positive impact on people's lives' and shared how she was a popular and friendly character – with many close friends and acquaintances. There is no evidence to suggest Michelle was isolated from her friends and family. She is described as always being 'the life and soul of the party' – someone who 'lived life to the full' and who would 'regularly go out of her way to make you smile and be happy'. Wearside Women in Need, through their brief interactions with Michelle, described her as 'independent, strong-willed and resilient'. Michelle often worked long hours, at an organisation providing care and support; but, would still readily make time for her family and friends. We know from GP records Michelle had disclosed issues around low mood and depression as well as being a victim of domestic abuse in a previous intimate relationship. In addition, she had Kienbocks Disease in her right-wrist, which is caused when a bone in the hand loses blood supply leading to pain and loss of range of hand movements.

12.3 Michelle described the perpetrator to her family as someone who was insecure and jealous, something, which she felt had become increasingly worse over the last couple of years. She put his actions down to excessive alcohol use – and stated he would often falsely accuse her of having an affair. Michelle reported to friends the relationship had become a lot more volatile, and violent, particularly after the death of his mother in 2016. Although Michelle had a good family support network, she was described as a private person and had kept to herself, a lot of the abuse the perpetrator was perpetrating against her. The family were aware of some problems in the marital relationship, but Michelle rarely disclosed domestic abuse, and collectively, all family members stated they 'didn't really know the extent of what she was going through'.

Perpetrator

12.4 Similar to Michelle, the perpetrator was born and raised in Sunderland and was one of five siblings. At the time of his death, the perpetrator was 53 years old and working as a self-employed bricklayer. He had previously married and was a father to three children (across two previous relationships). His family dynamics were multifaceted and complex. His father committed suicide in

2016, following the death of his mother, and his older brother passed away in 2018. His younger brother stated the perpetrator had an on-off relationship with his family with limited involvement and interaction with his father and children. Family accounts state his father perpetrated both physical and emotional abuse towards his mother, over a long period, and these acts were regularly witnessed by the perpetrator and his siblings. His brother described abuse towards his mother, by his father, as 'really bad'.

12.5 From 1979 through to 2010, we know the perpetrator was convicted of several offences ranging from assault, possession of a firearm (air weapon), burglary and criminal damage – and, in 1983, following a conviction for assault, he was sentenced to 3 months imprisonment at Medomsley, a youth detention centre. The Police National Computer does not have details of the victim recorded – so we are unable to ascertain if the conviction for assault was domestic abuse-related (although discussions with the perpetrator's brother did not give the impression it was domestic). There have been several convictions relating to physical and sexual abuse of young prisoners (during the period in which the perpetrator was incarcerated[7]) at Medomsley. He was due to be visited by Durham Constabulary the day after Michelle's homicide (as part of the trial preparation process and provide a Victim Personal Statement which details how the impact of the abuse, he experienced in Medomsley, had affected him). There are also several domestic abuse incidents reported against the perpetrator from one of his ex-partners (disclosed post-homicide) and included similar allegations of violence and abuse.

12.6 The perpetrator's older brother described him as someone who was a 'fantastic lad who was always smiling and happy'. He is characterised as quite a private person, who 'wouldn't really tell anyone about problems he was having' and 'someone who would never have sought help with his own issues'. He felt it was the perpetrator who took 'the brunt of the blame' and was 'always the one who had to leave [the home] regardless of who was at fault'. He felt 'some of the domestic abuse was not always all down to the perpetrator but split fifty-fifty [between him and Michelle]' and 'alcohol/cannabis consumption' was a primary reason for the escalating domestic abuse between the couple.

<u>Background to Homicide Incident</u>

12.7 Michelle experienced domestic abuse, perpetrated by her estranged husband, for several years with numerous incidents reported to Northumbria Police prior to the homicide. Michelle was murdered at her home address in Sunderland, after she returned from work on Wednesday 19th September 2018, and the perpetrator went on to take his own life.

12.8 At the time of the homicide, the couple had separated, and the perpetrator was temporarily residing at a friend's property located about a mile and a half away from their shared privately-owned residence and was subject to a non-molestation order.

[7] 'Operation Seabrook' is the criminal investigation by Durham Constabulary into allegations of sexual and physical abuse perpetrated by staff against detainees at Medomsley Detention Centre near Consett, County Durham. It was launched in 2013 and is investigating historical incidents that occurred, principally in the 1970s and 1980s.

12.9 At approximate 20:30hrs on Thursday 20th September 2018, Michelle's sister-in-law contacted Northumbria Police to report her concerns. The log states that Michelle had not turned up to care for her father which was completely out of character. Moreover, members of Michelle's family stated they had not spoken to her since the previous day and her neighbour also reported not having seen her since the evening of Tuesday 18th September 2018.

12.10 In response to the call from Michelle's sister-in-law, Northumbria Police attend Michelle's address at 21:05hrs and subsequently forced entry to the address and located Michelle and the perpetrator deceased within the property. The latter was found hanging from a loft hatch and Michelle was found in the bedroom of the property – with the Post Mortem indicating she had died from Cardiorespiratory Arrest caused through strangulation. The Coroner's Inquest reported Michelle was unlawfully killed and the cause of her death was Strangulation and Blunt Force Head Injury'

12.11 A separate incident was reported to Northumbria Police by the perpetrator's friend at 19:20hrs on Thursday 20th September 2018 which reported him missing. The perpetrator had left his friend's house at approximately 18:45hrs on Wednesday 19th September 2018 and had not returned.

13 CHRONOLOGY OVERVIEW

13.1 This section summarises the information known regarding Michelle and the perpetrator prior to the homicide.

- Michelle was born, and raised, in Sunderland and had lived in the local area her entire life. She is described as a normal, healthy woman who was caring, loving and kind-hearted and was someone who gave a tremendous amount of time to help look after and support her close-knit family. She worked for a local support agency and had several close friends and acquaintances.

- The perpetrator was from the Sunderland area and had been in a relationship with Michelle for 15 years prior to her homicide, having been introduced via a mutual friend. He is described as a man who could be 'hot-headed' [volatile] and was quite a private person – someone who would not readily share or seek help in relation to any problems/issues he was facing. At the time of his death, the perpetrator was 53 years old and was a self-employed brick layer. He had previously married and was a father to 3 children (by 2 ex-partners).

- Our evidence shows Michelle was a victim of domestic abuse in a previous relationship and the perpetrator also perpetrated abuse towards some previous ex-partners. Michelle disclosed to her GP that violence was perpetrated towards her by an ex-partner (prior to her relationship with the perpetrator); and that he also held historic convictions for assault against an ex-partner. In addition, there was evidence of domestic abuse manifesting itself within the perpetrator's family along with recent family bereavements (which included the suicide of his father and death of his brother).

- Evidence shows Michelle experienced domestic abuse, perpetrated by her estranged husband, for several years with nine separate domestic abuse incidents reported to Northumbria Police from 2014 through to her homicide.

- The first reported domestic abuse incident took place in January 2014, and was recorded as a verbal altercation, which took place after the perpetrator became jealous over Michelle's past. Both parties were recorded as intoxicated and Michelle contacted Northumbria Police to seek support. The last incident was reported in September 2018 and related to a disclosure of rape by Michelle against the perpetrator – which was later retracted (by Michelle).

- We know that Michelle took proactive steps to help protect and keep herself safe – seeking legal protection through a non-molestation order. This was served on the perpetrator on the 18th September 2018 and, less than 24 hours later, on the 19th September 2018, Michelle was murdered by the perpetrator, who went on to take his own life. At this stage, Northumbria Police were not aware of any form of non-molestation order.

- The non-molestation order had purportedly been 'a shock' to the perpetrator and he was 'quite angry' with Michelle about it. Witness statements obtained from Northumbria Police from the perpetrator's friends show in the week/days leading up to the non-molestation order being served, and around the time he had been accused of raping Michelle, he was reporting suicidal thoughts – and had been 'talked down from throwing himself off a bridge' by a close friend. The incident and/or concerns were not reported to Emergency Services.

- Michelle was described as independent, strong and resilient by agencies who were involved/engaged with her. She disclosed to WWiN her concerns of 'being frightened of what could happen if he [the perpetrator] lost everything' and within a statement in relation to the non-molestation order she described examples of the perpetrator being violent, controlling and jealous as well as verbally degrading towards her. She said she was terrified of the perpetrator, the abuse was ongoing and that it had affected her mental health, making her constantly feel drained and anxious.

- Although Michelle's family were aware of some of the problems emanating between the couple, they were not aware of the full extent of the domestic abuse she was experiencing – with domestic abuse never fully disclosed by Michelle. Similarly, the perpetrator's family were also not aware of the full scope of the abuse in the relationship. There was no evidence to suggest Michelle was being isolated from her friends and family by the perpetrator.

- Witness statements taken from friends and work colleagues post-homicide describe quite a volatile and turbulent relationship between the couple, with regular arguments and aggression directed towards Michelle from the perpetrator, often fueled by high levels of alcohol consumption. There were also several examples of Michelle disclosing quite controlling behaviour

from the perpetrator. Statements also showed signs that Michelle minimized some of the abuse she was experiencing and implied she was in control of the situation and was seeking to end the relationship. Although concerned, no one appeared to regard the behaviors and actions of the perpetrator as domestic abuse and/or fully understood the true extent of the abuse that Michelle experienced.

13.2 There were **five** organisations that had been involved with Michelle and/or the perpetrator prior to or following the homicide: Northumbria Police, VictimsFirst Northumbria, Wearside Women in Need, Sunderland Care and Support Limited and NHS Sunderland Clinical Commissioning Group.

<u>Northumbria Police</u>

- There were 9 domestic abuse incidents reported to Northumbria Police in relation to Michelle and the perpetrator spanning almost a five-year period, starting in early January 2014 through to the last incident in late September 2018. Michelle was a repeat victim of domestic abuse and is recorded as a victim for all but one incident.
- There is a clear escalation in the volume and severity of incidents from 2017 – which culminates in a disclosure of sexual assault in September 2018.
- Incident logs from Northumbria Police regularly identify alcohol/intoxication as a factor within the relationship. In most of the incidents, alcohol was found to be a presenting issue – with either Michelle, the perpetrator and/or both reported as having consumed excessive amounts.
- Two Domestic Violence Protection Notices/Orders are issued – March 2017 and August 2017 – and on both occasions, the perpetrator complied with the requirement conditions (which included not to contact Michelle directly or indirectly or returning to their home for 28 days).
- On the 7th September 2018, Michelle discloses multiple assaults and disclosed rape which she later retracts. During disclosure, Michelle states 'she is having domestic violence issues with the perpetrator and was terrified to go home'. At this time, Wearside Women in Need interact with Michelle who states she is committed to seeking legal advice to end the relationship.
- Following the rape disclosure, and based on professional judgement, Michelle is assessed 'high risk' by Northumbria Police and is subsequently referred to Multi-Agency Risk Assessment Conference (MARAC).
- Michelle's referral was not discussed at MARAC (as the homicide had occurred before the fortnightly meeting was scheduled to take place).
- The perpetrator is arrested and interviewed in relation to rape. He is subsequently Released Under Investigation and is not subject to bail conditions. In terms of his ability to access the property, Northumbria Police had no legal basis to make the perpetrator surrender his keys.

<u>VictimsFirst Northumbria (VFN)</u>

- Of the 9 incidents reported to Northumbria Police, VFN received 3 x referrals – all in relation to Michelle. All 3 x referrals were received in early 2017 – starting January, the second in March and, the third in April.

- As Michelle was recorded as standard/medium risk, her consent to a VFN referral is required. Michelle did not wish to seek specialist support for the other 6 incidents and did not consent for her details to be passed to VFN.
- For the 3 occasions, where Michelle did consent to a VFN referral, attempts were made to contact her via telephone. She was spoken to once, after the first incident, by a Case Co-ordinator but chose not to engage with services at that time[8]. VFN failed to contact Michelle in relation to the second incident, and closed the case, after 3 unsuccessful telephone call attempts.
- No contact at all was attempted for the third incident, after information on Northumbria Police system stated Michelle was 'already being supported by WWiN', the local specialist domestic abuse service in Sunderland.

Wearside Women in Need (WWiN)

- WWiN first had contact, and engaged, with Michelle at Southwick Police Station in September 2018 when she had disclosed the assault and rape.
- WWiN provided Michelle with appropriate advice, support and guidance – and arranged to see her at their offices two days later.
- WWiN completed a further Risk Indicator Checklist and identified Michelle as medium risk. WWiN carried out an assessment of need in the context of several protective measures having been put in place already by Michelle, which included a change of locks and Non-Molestation Order.
- Michelle was offered support in relation to refuge accommodation and access to the Freedom Programme but chose to turn these offers down due to her work commitments and caring responsibilities.
- WWiN offered telephone support on a fortnightly basis and support through the Court process (if, and when, the case progressed to the Criminal Court) and/or through the Civil route if the Injunction was contested.
- WWiN also offered support to gain information from Northumbria Police to establish any progression on the criminal complaint.

Sunderland Care and Support Service Ltd

- Michelle's employer became aware of domestic abuse in the relationship in 2014 – after Michelle took a period of sickness – whereby the presenting issue was initially recorded as 'domestic violence'.
- However, the reason for her absence was not passed onto Michelle's line manager and therefore was not acted upon under the Workplace Domestic Abuse Policy.
- There was no evidence of any discussion taking place regarding the incident; nor is there any record of how this absence type was decided upon.
- There is a potential missed opportunity for her employer to engage Michelle in a meaningful dialogue about her home life and any domestic abuse she was experiencing within her relationship.

NHS Sunderland Clinical Commissioning Group

- Michelle was in regular contact with her GP practice – having 34 contacts in the timescale of the review, which included 1 contact with Minor Injuries Unit. 25 of the 34 were telephone consultations and 9 face-to-face.

[8] Victims of domestic abuse will often choose not to take up offers of help and support and this can be for a variety of reasons (e.g. not being ready to discuss their abuse, a fear of reprisals, feeling that things will get better etc.).

- It is apparent Michelle sought out support from health professionals on repeated occasions for chronic concerns, as well as stress and anxiety. Historically, although outside of the timescale of the review, it is evident that Michelle had experienced issues with self-esteem and self-confidence – and incidents of domestic abuse perpetrated against her by ex-partners.
- It remains uncertain as to whether Michelle presented regularly at the GP to seek support; however, there are occasions where further professional curiosity and challenge may have elicited information about her home life.
- Routine enquiry around domestic abuse may have facilitated her to discuss issues and potentially access support.

14 DETAILED CHRONOLOGY

14.1 This is a combined narrative of events leading up to Michelle's death and is based on the information provided from: Individual Management Reviews submitted as part of the DHR, interviews and testimonies from Michelle's family and friends and information gleaned from any witness statements from the investigation carried out by Northumbria Police.

Caveat: the language used throughout the Detailed Chronology section is that which is recorded in records supplied by partners agencies and taken from interviews held with Michelle and the perpetrator's family members. It is not the language the Panel would necessarily use to describe incidents and events as we feel that some of the language used could be interpreted as victim blaming.

< 2005 **Relevant Information Outside of Review Timescales**

Background Information – Michelle

From 1980 to 2002, there are 144 appointments, written correspondence and GP attendances for Michelle in relation to a wide range of issues, including anxiety, depression and abdominal pain. Information shows Michelle also had attended her GP relating to facial/head injuries, but no detail is recorded about the mode of the injury, except for one disclosure in 1995 regarding an assault by a partner 8 years prior (circa 1987). Michelle first disclosed issues around low mood/depression in May 2001 and this continues to be an ongoing issue recorded throughout GP records. In September 2004, Michelle is referred to a psychiatrist, and as part of these discussions, where she disclosures domestic abuse perpetrated towards her in two previous relationships (prior to her relationship with the perpetrator). In addition, through interviews with Michelle's family, it was reported her mother had also been a victim of domestic abuse, at the hands of Michelle's father.

Background Information – Perpetrator

From 1979 through to 2010, we know the perpetrator was convicted of several offences ranging from assault, possession of a firearm (air weapon), burglary and criminal damage – and, in 1984, following a conviction for wounding with intent, the perpetrator was remanded in a local youth detention centre for four-months. In addition, there are

several domestic abuse incidents disclosed by one of his ex-partner's (post homicide) against the perpetrator, which include allegations of violence and abuse perpetrated by him – brief details have been included at the end of the Detailed Chronology.

Since 1964, The perpetrator attended the GP 64 times in relation to lower back pain, headaches, anxiety and low mood/depression. In May 1996, the perpetrator had presented at the GP twice due to anxiety following his wife's (alleged) adultery (wife prior to Michelle) which included a discussion about a court injunction and the perpetrator being 'unable to see his family'.

In October 1996, GP records detail correspondence from City Hospitals Sunderland highlighting an overdose 'suicide attempt' by the perpetrator and a suicide letter was found. Further correspondence highlighted the perpetrator's problems 'began five months ago [June 1996] when his wife was having an affair'. He had 'assaulted her after an argument' and was 'awaiting sentencing for actual bodily harm' which had increased his suicidal thoughts. The perpetrator was seen by his GP again in March 2003 whereby he stated he had fallen out 'with his ex' and, a similar discussion was held again in May 2006.

< 2010

Michelle and the perpetrator were introduced by a mutual friend in early 2005 and started a relationship. The perpetrator initially co-habited at Michelle's property from 2008, and in 2010, they married. Michelle commenced work with Sunderland City Council in June 2010 – and was employed as a Support Worker within the Community Reablement Service. In early December 2013, Sunderland Care and Support Ltd, a company established by Sunderland City Council, responsible for delivering social care, health and support services was formed, and Michelle was TUPE transferred into this organisation.

Jan 2011

On the 1st January 2011, Northumbria Police received a call from a female asking for police assistance; however, the line was cleared before being able to be connected. On ring back, the female was identified as Michelle. According to the Northumbria Police IMR, she did not sound distressed and stated she had been in a verbal argument with her husband, the perpetrator. Both parties were intoxicated after attending a party at her brother's address – and upon returning home, an argument had ensued, started by the perpetrator, due to his alleged jealousy about Michelle's past relationships. The perpetrator left the property and went to his mother's address – no offences were disclosed by Michelle. Michelle requested no Victim Care Bureau[9] contact in relation to incident. A Domestic Abuse, Stalking and Honour based Abuse (DASH) Risk Indicator Checklist was completed and recorded Michelle as 'standard risk'. One risk indicator was highlighted:

- Jealous / controlling.

[9] The Victim Care Bureau was responsible for providing victim support functions across Northumbria – and pre-dated VictimsFirst Northumbria which was established in 2015. The VCB provided practical advice, support and guidance to victims of crime in Northumbria (including victims of domestic abuse).

May 2012 From May 2012 through to July 2013, the perpetrator presented at his GP on six separate occasions suffering from low mood – and was subsequently prescribed with anti-depressants.

Jan 2014 On the 12th January 2014, Michelle called Northumbria Police reporting that the perpetrator had assaulted her and caused criminal damage. The perpetrator could be heard shouting in the background. Police attended and recorded both parties as being intoxicated. Michelle requested the perpetrator be removed from the property. The back-door window was smashed, which the perpetrator admitted to, saying that he was locked out of the house. Michelle had swelling/bruising to her eye; however, she refused to disclose how she came about the injury. The perpetrator was arrested on suspicion of Assault Occasioning Actual Bodily Harm, which he denied, stating Michelle had fallen due to her intoxication. Michelle made no allegations and the perpetrator was released No Further Action (NFA'd). Michelle requested no Victim Care Bureau contact in relation to incident and the case was subsequently closed. A DASH Risk Indicator Checklist was completed, and Michelle was recorded as 'standard risk'. Three risk indicators were highlighted:

- Incident resulted in injury
- Abuser hurt anyone else
- Abuser previous criminal history.

Mar 2014 On the 18th March 2014 in a face-to-face consultation with her GP, Michelle presented as upset stating she was experiencing a lot of stress due to her husband being 'falsely accused of something' which had triggered Irritable Bowel Syndrome. It is not documented as to whether further information was explored in relation to Michelle's current situation. Two days later, Michelle had a telephone consultation with her GP. She continued to feel 'very stressed by recent events' and requested anti-depressants (which she was prescribed) but did not want a referral for counselling services. In May 2014, Michelle presented to her GP recording she was 'tired all the time'. There were no further details or documentation about this consultation.

June 2014 On the 16th June 2014, the perpetrator had a face to face consultation with his GP reporting low mood and stated that his anxiety was 'getting worse again'. GP clearly documented information in relation to his social circumstances at the time indicating 'he lived with his wife', was 'happy with no problems' and that he was had 'no financial concerns or suicidal thoughts'. At this appointment, anti-depressants were recommenced.

July 2014 On the 15th July 2014, face-to-face GP consultation with the perpetrator for a 30-day review of his anti-depressants. It is documented he had started to feel better with the medication and was 'happy at home and at work'. At the appointment, the perpetrator discloses to the GP he was 'drinking every night but had reduced this to a Friday and Saturday'. Advice was provided to reduce alcohol intake and to continue medication.

Aug 2014 On the 16th August 2014, Michelle presented in the Minor Injuries Unit (MIU). Michelle stated that she had been involved in a car accident the previous evening – the car was stationary, and she was hit by another car. Michelle reported no police or paramedics were called to the scene and was discharged with no further follow up as no concerning injuries. Almost a week later, on the 22nd August 2014, Michelle had a telephone consultation with her GP in relation to 'soft tissue injuries'. Michelle stated she was 'hit with something at work' – and was seeking a fit note. It is interesting to note that the mode of injury stated by Michelle is different in the telephone consultation to what was stated in MIU.

Aug 2014 On the 18th August 2014, there was a face-to-face GP consultation with the perpetrator for a 30-day review of his anti-depressants. Records indicated that he was 'fine with medications and to continue on repeats.

Sept 2014 Between September 2014 and December 2015, Michelle had several telephone consultations with GP in relation to issues surrounding the Kienbocks Disease affecting her wrist. Michelle underwent surgery on her wrist on the 26th November 2014 – and several fit notes were issued by the GP through to August 2015.

July 2015 On the 7th July 2015, Michelle presented at the GP, following an initial telephone consultation, suffering from 'blurring of vision and knee pain'. This was the first face-to-face contact between Michelle and a GP since September 2014.

Correspondence in GP records between August to November 2015 from Orthopaedics states, Michelle 'fell over two weeks ago sustaining a finger fracture which was 'swollen' but had full range of movements.

Oct 2015 Michelle and the perpetrator went on holiday to Mexico. Michelle's family recall an incident whereby Michelle had phoned her mother after two days and said, 'if there was a flight home, she'd have come home after 2 days'. When asked why: Michelle said, 'it's him' (referring to the perpetrator) …all he is concerned about is drink [alcohol] and he had left Michelle to her own devices, he would stay out all night and she'd find him in lobby/reception area drunk/crashed out the next day. Michelle's sister in-law (who was also on the holiday) said she should stay with them, but the perpetrator would shout abuse at her from across the hotel; he wasn't bothered/concerned about Michelle's feelings or wellbeing.

Conversely, the perpetrator's brother held differing views around the version of events. He disclosed, during interviews for this review, that Michelle and the perpetrator had smoked cannabis throughout the holiday and held a view that the consumption of cannabis was a significant influencing factor in the conflict. He described responsibility for the conflict as being 'very much fifty-fifty', as opposed to it all stemming from the perpetrator.

Shortly after returning from holiday, Michelle told her mam she wanted to end the marriage – the abuse in Mexico 'had sickened her' – but said she would have to 'put her house affairs in order' and 'work out mortgage payments' before progressing with anything. Michelle arranged to see a financial adviser at her bank to enquire how much it would be 'to pay the perpetrator off' (i.e. to buy out the perpetrator's share of equity in the property). Her family recall it was going to cost around £9k and Michelle didn't have funds to offer him – and so had investigated the possibility of taking out a bridging loan with the bank. Michelle did eventually offer him £9k but the perpetrator wouldn't take it, saying 'you're not getting rid of me that easy'. At this point, Michelle felt as though she was in a trapped situation.

According to Michelle's family, around this time, the perpetrator kept pestering her saying, 'he would change' and Michelle 'genuinely wanted to save her marriage' and was 'always willing to give the perpetrator yet another chance to change'.

Dec 2015

On the 29th December 2015, Michelle called Northumbria Police and reported the perpetrator has assaulted her – whereby he had punched her in the face causing reddening to the cheek, grabbed her hair and pulled her to the floor and kicked her to the body causing bruising to her right arm. According to the Police IMR, Michelle had stated she had been out drinking with family the previous night and that the perpetrator had started an argument with her brother. When they got home, Michelle had slept on the settee to prevent further arguments from occurring before the assault took place. Michelle had left the property and was at a neighbouring property waiting for Police arrival.

On Police arrival, it stated Michelle sounded intoxicated and was slurring her words – and as well as disclosure of assault, Michelle also stated that the perpetrator had taken the home phone from her and smashed it when she attempted to call the police. He was arrested on suspicion of assault and criminal damage. He admitted to arresting officers that he had smashed both the house phone and Michelle's mobile phone – but denied assaulting Michelle. He stated Michelle had jumped on his back and scratched his face, so he had 'flung her off'. The perpetrator was subsequently charged with common assault and criminal damage. Michelle did not consent to a referral to VictimsFirst Northumbria. A DASH Risk Indicator Checklist was completed, and Michelle was recorded as 'standard risk'. Two risk indicators were highlighted:

- Incident resulted in injury
- Afraid of further violence / injury

Michelle was allocated to Sunderland NPT (Neighbourhood Policing Team) for contact. After several unsuccessful attempts to engage, contact was made with Michelle on the 7th January 2016. A safe telephone number was established and added to Michelle's nominal record. A referral to WWiN (Wearside Women in Need), the local specialist domestic abuse agency, was declined.

On the 12th January 2016, Michelle was recorded as being absent from work, with records indicating the absence was due to 'domestic violence'. Michelle's family stated this absence could have been around the time when the perpetrator purportedly threw a chest of drawers down the stairs at Michelle causing her to sustain a bruised eye and sore wrist. The reason for Michelle's absence is not passed onto her line manager; and there was no record of any further discussion/record of this absence.

Feb 2016 On the 1st February 2016, Durham Constabulary requested health records from the perpetrator's GP in relation to 'Operation Seabrook'. In enquiries, where the allegation is non-recent, Police will seek evidence of contemporaneous disclosures by victims to third parties and is considered a routine line of enquiry. We now know the perpetrator had made a complaint of historical physical abuse whilst in custody at Medomsley and, the day after the homicide, he had been scheduled to meet with Durham Constabulary to discuss his involvement, as a prosecution witness in criminal proceedings.

Mar 2016 On the 15th March 2016, Michelle held a telephone consultation with her GP complaining about 'knee pain' and an x-ray was requested. No disclosures were made about any issues linked with domestic abuse or problems with her partner.

The perpetrator appeared in court on the 17th March 2016 in relation to an incident with Michelle on the 29th December 2015. The assault charge was discontinued, and he was given a six-month conditional discharge for criminal damage and ordered to pay costs.

Jun 2016 Michelle left employment at Sunderland Care and Support Limited on the 30th June 2016 on a voluntary severance deal.

Jul 2016 On the 21st July 2016, Michelle held a telephone consultation with her GP complaining about 'wrist pain'. Records indicated Michelle may need further surgery in due course and was issued a fit note until the 20th August 2016.

Aug 2016 According to GP records, on the 13th August 2016, a request was made to GP from the perpetrator to release information to help with a housing application. A review of local housing provider records show that no application was made by the perpetrator (with the last recorded contact from the perpetrator in 1999).

On the 30th August 2016, a further telephone consultation was undertaken with Michelle by her GP. Michelle stated that she was 'fed up of her wrist condition – especially in relation to job implications'. Records indicated that the GP suggested counselling support, which Michelle was interested in taking up, and she was also restarted on anti-depressants. A further fit note was provided to Michelle through until the 30th November 2016.

Nov 2016 From the 4th November 2016 through to the 15th December 2016, there were several documents from the Job Centre in relation to Michelle 'no longer being able to claim for employment and support allowances. Her GP agreed a letter of appeal would be written and sent. In addition, a report from Rheumatology highlighted concerns about Michelle in relation to employment and finances.

Dec 2016 On the 19th December 2016, Michelle had a telephone consultation with her GP. Michelle requested anti-depressants but indicated she was not taking them as prescribed. GP advised Michelle to take the medication regularly and a note was placed on the system to follow up in December 2017. A fit note was issued through until the 27 February 2017. There was no documentation around any probing of her emotional wellbeing or the impact on her employment/finances.

Jan 2017 In the early hours of the morning on the 2nd January 2017, Northumbria Police were contacted by the perpetrator reporting that Michelle had returned home extremely intoxicated and had scratched his face. On Police attendance, it was established Michelle was intoxicated and the couple had argued about their relationship. The perpetrator wanted Michelle removed from the premises. When asked about a couple of small scratches on his face, he would not disclose how they had come about, or wanted to make any allegation of assault. Michelle was taken to a friend's address for the night. A Risk Indicator Checklist was completed, and the perpetrator is recorded as 'standard risk'. Four risk indicators were highlighted:

- Afraid of further violence / injury
- Separation
- Suspected financial problem
- Suspected mental / alcohol / drugs

He was allocated to Sunderland NPT. Contact was made, and the incident was discussed. A safe number was established and was added to his nominal record. The perpetrator reported support was already in place regarding Michelle's depression and they were attempting to work things out. All further support was declined.

Later that same day, Michelle contacted Northumbria Police reporting the perpetrator had removed a safe from the house which contained her £5,000 severance pay. There was nothing to suggest he had gained access to the safe as Michelle was the only person who knew the code. Michelle felt that he had taken the safe as they were 'going through marital difficulties and he was making a point he was entitled to cash from the divorce'. Michelle thought he might try to access the money to buy alcohol. No crime was made; however, it was recorded that the perpetrator was controlling and a heavy drinker. Michelle stated she was waiting at the house as she believed he would return and was advised to call back if there were any subsequent issues. A DASH Risk Indicator

Checklist was completed, and Michelle was recorded as 'standard risk'. Three risk indicators were highlighted:

- Separation
- Jealous / controlling
- Suspected mental / alcohol / drugs

Later the same day, Michelle contacted Northumbria Police reporting the perpetrator had returned, and she was scared. He was intoxicated, and she was 'unsure what he would do'. Police attended the address, and he was subsequently arrested for Breach of the Peace. The same officers attended both incidents and this was considered a continuation of the same incident – and as such no separate DVN[10] was raised. Michelle was spoken to at length and disclosed a medical issue had resulted in her having to leave employment, which had resulted in some financial pressures and arguments. Although they were separated, they were living in the same house, and she intended to speak to a solicitor regarding a divorce and injunction the following day. In addition, the log stated Michelle was seeing her GP for her depression and was aware of agencies that can help. Michelle agreed for a referral to be made to VFN (VictimsFirst Northumbria) for support and an automated DV Tandem Notification was created and sent[11].

The case was subsequently allocated to a VFN Case Co-ordinator on the 4th January 2017 who attempted contact, via telephone, on the 5th January 2017. This was unsuccessful, and the number rang through to Michelle's voicemail. A second attempt was made on the 1st February 2017 and contact with Michelle was established. According to the VFN IMR, Michelle stated everything was okay and she did not need support. The case was subsequently closed on the VFN case management system. No update was added to Northumbria Police IT system to make them aware of this contact and that Michelle had declined any support.

Feb 2017

A letter from Rheumatology on the 8th February 2017 stated 'although investigations have taken place for a diagnosis in Michelle's *left* hand for Kienbocks Disease, the problems ongoing are in relation to her right hand'. It was therefore unknown as to why Michelle was experiencing pain in her left hand; however, there is no evidence to suggest any enquiry about domestic abuse was carried out.

On the 27th February 2017, there was an assumed telephone consultation between Michelle and her GP, and a further fit note issued for Kienbocks Disease (lasting until 29th May 2017). There was uncertainty as to whether there was any conversation with Michelle or whether a fit note was issued without consultation (as there isn't any further documentation).

[10] Domestic Violence Notification (DVN)

[11] A DV Tandem is an automatically generated email to VictimsFirst Northumbria, once a Police Officer has completed a DASH Risk Assessment, whereby the victim consents to support. The DV Tandem includes details of the incident and a copy of the DASH Risk Assessment.

Mar 2017 On the 9th March 2017, Michelle called Northumbria Police to report the perpetrator assaulted her twice. The first incident took place 4 days prior on the 5th March 2017, where he pushed her to the ground causing bruising to her left arm, and the second incident had taken place that day, whereby he had poked Michelle in the face and was making threats to cause damage. On the call, a male could be heard shouting in the background. Michelle wanted the perpetrator removed from the property. Police attended, and he was arrested for assault. Michelle was not willing to make a statement and did not support a prosecution. Advice was sought from the CPS for a victimless prosecution, but CPS would not charge. A Domestic Violence Protection Notice was applied for and granted by a Northumbria Police Superintendent, due to the violence, and was issued prior to the perpetrator's release from custody. A subsequent Order was granted at North Tyneside Magistrates Court on 10th March 2017, which forbade the perpetrator from contacting Michelle or returning to their home address for 28 days [12].

In interview, he stated Michelle had been intoxicated, shouting and swearing and denied assaulting her. He disclosed they had been in a verbal argument over money. He was subsequently released No Further Action and the crime was closed as undetected – evidential difficulties. A DASH Risk Indicator Checklist was completed, and Michelle was recorded as 'standard risk'. Five risk indicators were highlighted:

- Incident resulted in injury
- Afraid of further violence / injury
- Separation
- Suspected mental / alcohol / drugs
- Abuser previous criminal history.

Michelle agreed to a referral to VictimsFirst Northumbria (VFN) for support and an automated DV Tandem Notification was created and sent. The following information was included as part of Victims Needs Assessment: 'victim states she is in a volatile relationship with her husband, who has issues with alcohol. Victim currently has medical issues with her hand which means at this time she is unable to work'.

Michelle was contacted by Sunderland NPT on the 10th March 2017. She stated the domestic abuse had been long running and she was now finally wanting to end the relationship and seek a divorce. She did not want to support a formal prosecution and had contact details to assist with a non-molestation order. Michelle was also provided details for WWiN for further support and was updated regarding the DVPN/O.

[12] Domestic Violence Protection Orders (DVPOs) and Domestic Violence Protection Notices (DVPNs) were rolled out across all 43 police forces in England Wales from 8 March 2014. DVPOs are civil orders which enable police to put in place short-term protective measures, in the immediate aftermath of a domestic violence incident, where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions. A DVPN is an emergency non-molestation and eviction notice which can be issued by police, when attending to a domestic abuse incident, giving the victim immediate support. Within 48 hours of the DVPN being served on the perpetrator, an application must be made by Police to a Magistrates' Court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days.

The case was allocated to a VictimsFirst Northumbria Co-ordinator on the 10th March 2017. There were three unsuccessful attempts made by VFN to contact Michelle, via telephone, over the next fortnight, with each phone call ringing out and going directly through to Voicemail. Following unsuccessful calls, the Co-ordinator subsequently closed Michelle's case and updated the relevant VFN case management system and Northumbria Police.

Apr 2017 The DVPO expired on the 7th April 2017 – and the perpetrator complied with the requirement conditions.

On the 8th April 2017, Michelle contacted Northumbria Police reporting the perpetrator had returned after the DVPO had expired. She believed the separation would have done him some good; however, he had been drinking, was intoxicated and was being verbally abusive towards her. She stated she was scared to remain in the house and feared that he may assault her and so had left and was currently at her a friend's house. She wanted the perpetrator removed from the property. On Police arrival, he had already left the premises. No offences were disclosed, and Michelle was provided with advice regarding her safety. A DASH Risk Indicator Checklist was completed, and Michelle was recorded as 'standard risk'. Six risk indicators were highlighted:

- Victim frightened
- Afraid of further violence / injury
- Separation
- Abuse happening more often
- Jealous / controlling
- Suspected mental health/ alcohol / drugs

Michelle agreed to a referral to VictimsFirst Northumbria (VFN) for support and an automated DV Tandem Notification was created/sent.

Michelle was contacted on the 9th April 2017 by Sunderland NPT. Police logs record Michelle was 'already supported by WWIN' and was in contact with her own solicitor and did not require any further signposting.

The case was allocated to VictimsFirst Northumbria Co-ordinator on the 10th April 2017. Upon reviewing Northumbria Police system, and noting information above, the Co-ordinator did not attempt contact with Michelle. The Co-ordinator updated the internal VFN case management system and Northumbria Police system stating the case would be closed pending further contact as support was already in place.

Aug 2017 Michelle underwent a cosmetic eye procedure on the 14th August 2017 and on the 21st August 2017, she had a telephone consultation with her GP and a fit note was issued (through until the 28th August 2017). The GP documented further context, stating that Michelle had started her new job.

On the 27th August 2017, Michelle called Northumbria Police reporting the perpetrator had tried to strangle her. Michelle sounded distressed and stated she had marks on her neck. It was recorded both parties had been drinking. On Police arrival, the perpetrator was arrested for common assault. Michelle refused to provide a statement, assist the police investigation, support a DVPO and had no visible injuries. Michelle provided Northumbria Police with a house key to be handed to the perpetrator on his release. In interview, he denied assaulting Michelle stating she had punched him, and he had pushed her away.

A DVPN was served on the perpetrator due to violence being reported and was deemed necessary 'as they [Michelle and the perpetrator] appear to be caught in a repeating cycle of domestic incidents that are violent'. An DVPO was subsequently granted at South Tyneside Magistrates Court on the 29th August 2017 and prohibited the perpetrator from contacting Michelle or entering the street where they lived. Michelle did not consent to a referral to VictimsFirst Northumbria. A DASH Risk Indicator Checklist was completed, and Michelle remained 'standard risk'. Two risk indicators were highlighted:

- Separation
- Suspected mental health/ alcohol / drugs

Michelle was contacted by Sunderland NPT on the 31st August 2017 – and she stated she had no contact with the perpetrator since the incident. She was offered and declined any further support from WWiN and was advised to contact police or partner agencies if she required any support in the future.

On the 29th August 2017, an email was sent from Northumbria Police Criminal Justice Unit Admin Mailbox to the Central Referral Unit providing details of the perpetrator's DVPO conditions.

Sept 2017 On the 25th September 2017, the DVPO against the perpetrator outlined above expired – and he complied with the required conditions.

Oct 2017 On the 5th October 2017, the SCCG Safeguarding Lead Nurse informed the GP practice that a DVPO was in place for Michelle. The notification of the DVPO had not been received into the CCG Safeguarding Inbox until the 21st September 2017, despite it being served on the 29th August 2017. This meant by the time the GP was made aware the DVPO had already expired. There was no evidence that the DVPO was saved within Michelle's GP records.

Jan 2018 On the 30th January 2018, there was a face-to-face consultation with Michelle and her GP relating to minor health concerns which were not significant; however, this was the first face-to-face encounter with Michelle since the notification of the DVPO had been received.

Feb 2018 On the 19th February 2018 – Michelle had a telephone consultation with her GP who stated she had sustained a back injury last week painting

the ceiling and had twisted a muscle. GP subsequently issued a fit note through to the 26th February 2018.

Jun 2018

Michelle called Northumbria Police on the 10th June 2018 reporting ongoing domestic abuse with the perpetrator. She stated that she was 'terrified' of him, he was threatening her and making accusations. He had been physically violent towards her in the past. She reported that he was not currently at the address. She stated the previous evening she had stayed with a friend as she was too scared to return home after he had been out drinking. There had been a verbal argument and he was so intoxicated she was scared that there would be violence if she did not leave. Michelle disclosed that she had received a lot of abusive voicemails from him making threats towards her. It was not recorded if Michelle was asked to provide her phone or whether these messages were listened to by the Officer. Michelle stated that his behaviour had been escalating over the past few weeks and that he was continuously mentally abusing her. She was unsure where he was and was advised to lock doors until police attended. Michelle stated she had changed the locks on the property and did not want the perpetrator at, or anywhere near, the address and was to attend a solicitors' the next week to start divorce proceedings. Michelle did not consent to a referral to VictimsFirst Northumbria and did not support a prosecution. He was interviewed, and no further action was taken by Northumbria Police. A DASH Risk Indicator Checklist was completed, and Michelle remained 'standard' risk. Four risk indicators were highlighted:

- Victim frightened
- Isolation
- Separation
- Suspected mental health/ alcohol / drugs

Michelle was contacted by Sunderland NPT on the 14th June 2018 and she declined all support offered stating, a friend was helping them sort the problems within the marriage. The perpetrator was back living at the address and the range of support options available were highlighted.

Jul 2018

Michelle started a new job on the 3rd July 2018. She was employed as a Support Worker and her duties consisted of providing personal and social support to clients with Learning Difficulties. Michelle had joined the organisation via a recommendation from her friend, who also worked at the service, and was described as a well-liked individual. From information provided, we know that Michelle had made her line manager aware that she was going through divorce proceedings; and was requesting time off to attend appointments – and was offered practical support. In addition, Michelle had spoken to some of her colleagues around her relationship with the perpetrator; however, nothing was brought to line management attention to give any cause for concern around her welfare, so no risk management strategies were put in place.

In a disclosure to Northumbria Police, made on the 7th September 2018, Michelle stated that around the weekend of the 15th July 2018, there

had been an argument between herself and the perpetrator which had lasted all evening. Michelle decided to sleep on the settee to prevent the argument escalating further. At approximately 03:00hrs, he had come downstairs. He was intoxicated and verbally aggressive, shouting at her to go to bed. Michelle stated that she agreed to this to keep things calm. When they were in bed, the perpetrator kept trying to kiss her and initiate sex. Michelle felt she had no choice, and felt she was pressured into it, as the only way to stop the situation from getting worse. Michelle was scared and vulnerable. The perpetrator attempted, and succeeded, in initiating sexual intercourse even though Michelle was in fear of violence.

Aug 2018 In a disclosure, made in September 2018, Michelle said she had been to a pub on the 26th August 2018, and the perpetrator had won a large sum of money on a bandit. There had been a row and he had grabbed her by the throat, pushing her against a wall and shouting at her. Michelle stated he let her go and she left the pub, calling a taxi to get home. Later that night, when the perpetrator returned home, he had assaulted her again by pulling her out of bed by her hair and right wrist, causing severe pain and injury. The MO (modius operandi)[13] also includes that he grabbed her throat again when they returned home. Since the assault, Michelle said she had 'told the perpetrator she was fed up of his behaviour and wanted a divorce'.

07-Sept-18 During late evening on the 7th September 2018, Michelle attended Southwick Police Station requesting 'to speak to a female [Police] Officer regarding domestic abuse she was having with her husband'. Michelle disclosed she had been the victim of multiple assaults and rape by the perpetrator. She stated she was 'terrified to go home' as 'she knew he was tanked up' and 'was afraid of what he might do'. Michelle also stated he has been very threatening towards her that evening after he had seen Facebook pictures, where she did not appear to be wearing her wedding ring. In addition, he had been texting and calling her making threats.

While at Southwick Police Station, Michelle was introduced to a Support Officer from Wearside Women in Need (WWiN), the specialist domestic abuse service covering the Sunderland locality.

The WWiN IMR detailed that Michelle made a number of disclosures of 'incidents' including a sexual assault. Michelle made it clear to Northumbria Police that she did not want to pursue a complaint of rape but did want the allegation of assault at the pub [which took place in August 2018] to be investigated and was requesting Northumbria Police seek to obtain CCTV evidence.

The WWiN Support Officer took the view it was not appropriate to complete a DASH Risk Indicator Checklist at that time as Michelle had

[13] A modus operandi (often shortened to M.O) is someone's habits of working, particularly in the context of criminal investigations. It is a Latin phrase, approximately translated as 'mode of operating'

attended specifically to pursue her previous complaint with the Police. She did however assess Michelle's situation as serious, based on the information shared and the level of distress displayed. She provided Michelle with safety planning advice and discussed Michelle's options and protective measures available such as home safety, changing daily routine, non-molestation orders and access to refuge accommodation. At this stage, Michelle did not believe she needed or wanted refuge as she had already put several plans into action and wanted to stay in her own home. Michelle stated her husband was not living at the address, that she did not feel at immediate risk of harm in her home and she had already arranged an appointment with solicitors to seek legal protection via a non-molestation order.

08-Sept-18 Michelle provided officers with a key to the property to aid in the arrest of the perpetrator and, at 01:00hrs on the 8th September 2018, he was arrested at their home address on suspicion of assault and rape.

At 05:41hrs, a Crime Reference Report was created for the rape offence. The report described the details of the offence as "Michelle states she and the perpetrator had verbal argument and she has then decided to go downstairs and sleep there instead of possibly escalating the situation. The perpetrator has come downstairs and wanted Michelle to come back to bed upstairs. Once upstairs Michelle has laid facing away from the perpetrator and because she is in fear of violence from the perpetrator when he has initiated sexual intercourse, she has been unable to stop him". A DASH Risk Indicator Checklist was completed for Michelle and she was recorded as medium risk. However, due to the disclosure of rape, the Police Officer used professional judgement and manually override this, and graded Michelle as being at high risk of serious harm. Seven risk indicators were highlighted:

- Incident resulted in injury
- Victim frightened
- Separation
- Jealous / controlling
- Previous strangle / choke
- Sexual nature / harm
- Suspected mental / alcohol / drugs

Police records stated Michelle and the perpetrator were 'in the middle of marriage break up and are currently in a dispute over their property. Michelle states he is drinking on a regular basis and is becoming very violent'.

The case was picked up by Northumbria Police Rape Investigation Team. The investigation was allocated to a Detective Sergeant and the following notes were added to the crime report outlining the investigation plan to be undertaken: "Michelle reported to the police that she was suffering domestic abuse and had been raped by her husband. I note there is domestic history between the two and I am aware from the perpetrator's convictions that he is physically violent. I advise officers

every effort must be made to secure evidence to corroborate at least part of Michelle's account. This would be CCTV footage from one of the reported assaults on 26 August. Michelle was quite adamant that footage would show her being assaulted, before she left to go home. Safeguarding is of paramount importance given the allegation of chronic domestic abuse. They are married and live together, with a mortgage. Every effort should be made to minimise the risk to Michelle. The allegation of assault should be investigated expeditiously and in the interest of protecting a vulnerable person, seek charge advice/remand in custody".

An investigation subsequently took place which included viewing CCTV and interviewing those present at the time of the alleged assault. Images showed body language suggesting the couple were arguing – however, there was no evidence of the perpetrator assaulting Michelle. In addition, accounts from employees at the pub described Michelle and the perpetrator as 'regular customers' who were 'often argumentative'.

There were several texts recovered; albeit deemed by Northumbria Police to be not threatening. In one, Michelle sends to the perpetrator: "the first sign of violence from you, I will not hesitate to call the Police. And I will let them know, you forced me in to sex, like you did the other week, when you forced me in to bed, when I never wanted to because I fear you". This is followed by another text from Michelle that reads, "I have no money, you gave me nothing for months. I pay the bills and my bank show that". He responded with: "Fuck off, you stupid woman".

The perpetrator is interviewed, and he denied the allegations of assault and rape. At 16:30hrs, after interviewing the perpetrator, Northumbria Police attended Michelle's address to discuss the next steps in the investigation. When they arrived, Michelle stated she wanted to retract the rape element of the case saying that she had consented to sex and was not forced. Coercive control was explained to Michelle; however, she still stated she had not been raped but was still keen to go ahead with the assault element of the case. Michelle requested a DVPO and it was explained that this option was not available to her as it did not fit the criteria (i.e. did not appear to be any immediate threat[14]). Michelle informed Officers that she had sought legal advice but would not answer questions about what legal advice she had received.

The perpetrator was subsequently Released Under Investigation. At the time of his release, he was unaware that Michelle had retracted her allegation of rape. The perpetrator was not subject to bail or any bail

[14] Guidance states a DVPO should be considered when 'there are reasonable grounds for believing the subject has been violent or has threatened violence towards the victim or associated person *on this occasion*". There is no evidence of 'recent' violence (both the rape and assault occurred some weeks before disclosure), text messages reviewed 'do not show any threats of violence' and CCTV viewed of the pub also does not corroborate evidence.

conditions[15] (as there was no corroborated evidence to support this requirement). He is escorted by Officers to his home address to collect some belongings and his car. He was asked if he was prepared to hand over his house keys, but he refused, stating the house was half his. As the perpetrator was the joint owner of the property with Michelle, there was no legal basis for Northumbria Police to force him to hand over his keys. He collected his belongings and left in his own vehicle. Michelle was informed that he had been unwilling to give up his keys and was advised to seek legal advice. Michelle stated she already had a solicitor's appointment lined up and was given some general advice about keeping safe. This included keeping the doors locked, leaving the keys in the door while she was in and to call 999, if the perpetrator turned up at the house.

Within the IOPC Report, the Police Officer escorting the perpetrator describes his "demeanour throughout as calm…and whilst he appeared annoyed at the situation, he was not angry or aggressive, he didn't make any threats towards Michelle or anyone else and [the police officer] was not concerned that he posed any threat to Michelle at this time".

09-Sept-18 On the 9th September 2018, the perpetrator contacted Northumbria Police to report Michelle had purportedly thrown a brick at his car door the previous weekend when she could not get in to the house. He stated Michelle had told him she had caused the damage, but he did not consent to a referral to VictimsFirst Northumbria.

10-Sept-18 On the 10th September 2018, the WWiN Support Officer made a follow-up call to Michelle to check how she was, and whether there had been any further problems. Michelle did not disclose any further matters of concern but did agree for a referral into the WWiN Outreach Team. A referral was made – and the WWiN Outreach IDVA[16] subsequently contacted Michelle by telephone later that day to arrange an appointment. During this conversation, Michelle stated that 'this time she had "had enough" and "was finished with her husband". Emergency safety measures were reiterated, and Michelle was given further advice around other civil protective measures. An appointment was made to attend WWiN's office on the 18th September 2018.

11-Sept-18 On the 11th September 2018, Michelle attended an appointment with a local solicitor's firm in relation to seeking legal protection.

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[15] For clarity – the process for granting an initial period of bail starts with the Inspector considering any representation from either the detained person or their legal representative. The Inspector then needs to decide if they believe the use of bail and any conditions being imposed is necessary and proportionate – and is fixed at 28 days. There is no rationale recorded on Police custody system and officers spoken to by the IOPC 'can't recall there being any specific conversation about the decision to RUI'.

[16] An Independent Domestic Violence Advisor (IDVA) is an individual who has been accredited to support people who have been assaulted or abused by their partner or a family member. The purpose of the IDVA is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. They can explain the criminal justice process, attend court and provide support on a range of things such as the emotional impacts of domestic abuse, housing and legal matters.

12-Sept-18 On the morning of the 12th September 2018, Michelle was referred into Sunderland MARAC (Multi-Agency Risk Assessment Conference) by Northumbria Police because of rape allegation made five days prior[17].

Later, on the 12th September 2018, the perpetrator called Northumbria Police to advise them he was inside their home address. He stated that 'it is his home as well [as Michelle's] and he has every right to be there' and told the Call Handler 'he was not on bail and the police have advised him he had every right to be in the house'. He goes on to say he thought 'there would be trouble when Michelle finished work and got home'. The Call Handler advised him to seek legal advice as it was civil matter.

Once the call had ended, the log was reviewed, and notes added to the incident log referencing the previous DVPOs from 2017 and a request for someone to call Michelle to let her know about the perpetrator being at the address (as she was at high risk of domestic violence).

Michelle was subsequently contacted but already knew the perpetrator was at the address. She stated she was not happy about it and was advised by Police that 'if, when she returns home from work at 21:00hrs, he is still at the property, to park at the end of the road, not to enter, and call the Police'.

13-Sept-18 On the 13th September 2018 at 15:00hrs, Michelle contacted Northumbria Police to say, 'she wanted her house back'. She had stayed with a friend, on the night of the 12th September 2018, as the perpetrator had been staying at their home, but that she now 'wanted to get back in'. She also stated that he was continuing to contact her via her mobile.

Later that day, Michelle attended Southwick Police Station to have her phone contents downloaded, which did not find anything to corroborate Michelle's allegations. Michelle goes on to say the perpetrator was 'at home and she wanted him removed so that she could go and get some clothing'. Northumbria Police subsequently agree to go to the property with Michelle and to ask the perpetrator to leave. He was advised to stay away [from Michelle] until the investigation was complete, and he agreed to go and stay at his friend's house. The Officer escorted the perpetrator to his friend's house and, at Michelle's request, informed him that the rape allegation against him had been retracted, but that the investigation into the assault was ongoing. He was warned if current behaviour continued, he risked arrest.

17-Sept-18 On the 17th September 2018, a Non-Molestation Order was obtained by Michelle via her solicitor – which were the first legal actions taken that were not police-led. The order prohibited the perpetrator from contacting

[17] A Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. In Northumbria, MARACs are scheduled to take place across each Local Authority area every fortnight.

Michelle either himself or through a third party by any means, verbally, electronically or via social media unless through a solicitor or family mediator. It also forbade him from attending the home address. The Non-Molestation Order was for a six-month period and would expire on 17 March 2019.

Several unsuccessful attempts were made to serve the Non-Molestation Order on the perpetrator on the 17th September 2018. Michelle was informed and told it would be served the following day.

18-Sept-18 Michelle attended an appointment at WWiN on 18th September 2018. A DASH Risk Identification Checklist was completed and, based on the information received from the victim and information from the attendance at Southwick Police Station, ten risk indicators were highlighted – meaning Michelle was classified 'medium risk':

- Frightened
- Frightened – further violence
- Separated
- Abuse happening more often
- Abuse getting worse
- Weapons
- Strangulation
- Hurt someone else
- Threatened/attempted suicide
- Perpetrator has criminal history

There were comments recorded on the DASH about the perpetrator which provided added context (and these were based on what Michelle disclosed to the WWiN Officer at the time of completion) and related to: allegation of strangulation in a public place, reference to a previous custodial sentence for an assault on a previous partner[18] and threats/attempts of suicide. Michelle stated she was 'frightened of what the possibilities of what could happen if he feels he is losing everything' as well as referring to 'this is the first time I [Michelle] have seriously sought legal advice about separating [from the perpetrator]. In addition, Michelle self-identified as having a 'strong family network and good friend' and that she 'feels strong, resilient and independent'. The assessment was conducted in the context of several protective measures having already been put in place by Michelle, including a change of locks and the Non-Molestation Order.

Michelle informed WWIN that she had retracted the rape allegation and 'was not looking for a divorce at this stage, just some time away from the perpetrator to see if he could work through his drinking'.

Michelle was offered a place on the Freedom Programme (a support group that was running at the time in Sunderland) but declined due to

[18] This relates to offence in 1996. The MO of the incident is recorded: 'during a domestic dispute the perpetrator punches the victim causing injury'; however, there is no victim name logged.

her work commitments and care responsibilities. The WWiN Outreach IDVA also attempted to contact Northumbria Police via 101 non-emergency contact number for an update on the assault allegation – but unfortunately, the system was experiencing problems and there was no reply and updates had to be sought later.

On the 18th September at 17:30hrs, the perpetrator was served with the Non-Molestation Order at his friend's home address. A copy is subsequently posted to Northumbria Police.

19-Sept-18 ***Homicide*** Michelle was murdered by the perpetrator at home in Sunderland during early evening on Wednesday 19th September 2018.

20-Sept-18 On the 20th September 2018, the GP was informed that Michelle was to be discussed at MARAC. Health, along with all other partners, were sent an agenda and case list which detailed all high-risk victims and perpetrators to be discussed. No information in relation to the incident that generated the referral into MARAC is shared before the actual MARAC in line with local Information Sharing Protocols. The information request was completed by Michelle's GP and stated that 'Michelle does not have any mental health, drug and alcohol misuse or previous abuse'.

At 20:27hrs on the 20th September 2018, Michelle's sister-in-law had contacted Northumbria Police to report her concerns. The log outlined Michelle had not turned up to care for her disabled father which was completely out of character. Her family had been to her house to find her car parked outside and mobile ringing inside the house. Moreover, Michelle's family had not spoken to or seen her since the previous day and her neighbour had reported not having seen her since the evening of Tuesday 18th September 2018. The call was 08:38 minutes long. In response, Northumbria Police attend at 21:05hrs and forced entry into the address, whereby they found both Michelle and the perpetrator, deceased within the property. The latter was found hanging from the loft hatch and Michelle was found in the bedroom with Post Mortem results indicating she had died from strangulation.

A separate incident had been reported to Northumbria Police, by a friend of the perpetrator's, at 19:20hrs on Thursday 20th September 2018 which reported him missing. He purportedly left his friend's house at around 18:45hrs on Wednesday 19th September 2018 and had not returned or been heard from.

26-Sept-18 Michelle's case was scheduled to be discussed at Sunderland MARAC on the 26th September 2018 (because of the rape disclosure on the 7th September 2018).

Witness Statements

14.2 Information taken from witness statements, provided as part of the homicide investigation, provided a useful insight into the home life and experiences of Michelle and the perpetrator. **It is important to stress that this information was not known to agencies, prior to, or at the time of, the homicide occurring**; however, it helps to demonstrate a clear pattern of abuse and conflict building within their relationship. The information was not interspersed throughout the Chronology, as a lot of material contained indeterminate dates and times; nor, did the Panel want to include some information as it was felt it could prove identifiable – and instead, have provided generic observations here.

<u>Non-Molestation Order Statement</u>

- Within the witness statement that Michelle made as part of her application for the Non-Molestation Order against the perpetrator in September 2018, she described several examples of physical violence, controlling and coercive behaviour and jealousy as well as numerous illustrations of the perpetrator being verbally degrading towards her.
- She stated the perpetrator had been violent and controlling since the very beginning of relationship, consistently accuses her of having affairs and liking other men and became obsessed. She said he would 'badger [her]' for days or months and that she felt there was nothing she could do to try and reassure him. She went on to say the situation significantly affected her mental health and she constantly felt drained, mentally and physically, and had become a very anxious person.
- Michelle refers to an incident in 2014, where the perpetrator punched her in the face, causing a black eye and, although Northumbria Police were called and attended, she stated that she felt too frightened to press charges. She also purported, through several examples, to have been punched, kicked, pulled by the hair and grabbed by the throat so she could not breathe. She went on to say she was terrified of the perpetrator, that the abuse and harassment was happening more often – including numerous text messages, call and voicemails being left, often quite degrading, and that she was starting to become 'extremely concerned as to what he will do next'.

<u>Statement(s) from family, friends, neighbours and colleagues (post homicide)</u>

- Witness statements highlighted similar concerns with many describing the couple as having quite a volatile and turbulent relationship, often alcohol-fueled arguments which were aggressive in nature taking place. Michelle disclosed several incidents of controlling/abusive behaviour, perpetrated by the perpetrator towards her, to others including examples where he had cut up her leather coats, chewed her wedding rings into pieces as well as threatening to kick her out of the house. Whilst, in some cases, there were signs of Michelle minimizing the abuse experienced, implying she was in control of the situation and occasionally blaming herself for some of the perpetrator's actions.
- There were signs, particularly towards the end of the relationship, where Michelle was starting to become fearful of the perpetrator's behaviour and actions – she was committed to ending the relationship and seeking legal support and advice, which we know she had commenced. Although the witness statements showed that she had confided in some family, friends

and colleagues regarding some of the domestic abuse she was experiencing, the full extent and severity was not widely known to all. We know persons are often aware of or suspect something is happening but, do not necessarily feel able to (or know how to) get involved to help the situation.

Allegations obtained from previous partners (post-homicide)

- Following the perpetrator's suicide, information came to light from one of his previous partners, which involved allegations of violence and abuse. An ex-partner contacted Northumbria Police, as part of homicide investigation, and provided a statement detailing the relationship with the perpetrator and included allegations of violence and abuse.
- The circumstances mirrored similar situations to those faced by Michelle. The victim stated he would become quite jealous and would regularly argue and assault her. His behaviour escalated and he became unpredictable. The victim was terrified of upsetting him and felt it became impossible to avoid confrontation and arguments. Violence and abuse became a regular occurrence and it was alleged he would initiate sexual activity against her will. The victim felt it was a situation they could not control due to his violent and aggressive nature.

SECTION THREE:

15 LIST OF KEY FINDINGS

Key Finding 1: there was evidence Michelle was a victim of domestic abuse and that conflict was present within the relationship **(page 46)**

Key Finding 2: the level of risk to Michelle escalated quickly following her decision to seek formal legal support **(page 48)**

Key Finding 3: there was a history of witnessing/perpetrating domestic abuse **(page 50)**

Key Finding 4: Michelle sought appropriate advice, guidance and support in relation to the domestic abuse that she was experiencing **(page 52)**

Key Finding 5: Domestic Violence Protection Orders (DVPOs) presents agencies with a window of opportunity to try and maximise engagement with victims **(page 53)**

Key Finding 6: There continued to be overreliance on Michelle engaging with services with a lesser focus on addressing the perpetrator's behaviour **(page 54)**

Key Finding 7: Strong workplace policies are important in supporting and encouraging victims to report abuse **(page 55)**

Key Finding 8: Professional curiosity is critical to eliciting an improved understanding of risk and family life / relationships **(page 58)**

Key Finding 9: The timely sharing of information across partner agencies is essential to help develop a full picture of abuse **(page 61)**

Key Finding 10: The importance of agencies using the constructive language and terminology when referring to victims of domestic abuse **(page 62)**

Key Finding 11: Ensuring victims are safe and secure in their own home is important **(page 63)**

Key Finding 12: Risk Indicator Checklists did not account for or document static risk factors **(page 64)**

Key Finding 13: Michelle's family, friends, work colleagues and neighbours were, to a greater or lesser extent, aware of the domestic abuse she was experiencing from the perpetrator **(page 68)**

Key Finding 14: IOPC confirmed assessment of risk the perpetrator posed towards Michelle was appropriate/proportionately handled by Northumbria Police **(page 69)**

Key Finding 15: Agencies offering services to victims/perpetrators of domestic abuse should be in regular communication to ensure effective safety planning **(page 70)**

Key Finding 16 – Agencies do not routinely record the reasons why victims choose not to engage with specialist support **(page 71)**

16 ANALYSIS

16.1 The Chronology attempts to provide an overview of Michelle's life leading up to the homicide and, through interviews with her family and friends, tries to capture her thoughts, feelings and emotions. The Analysis section builds upon this and highlights some of the key learning points and good practice identified as part of the DHR. It also addresses the questions outlined within the DHR Terms of Reference set out in the earlier stages of the report.

Key Finding 1

There was evidence Michelle was a victim of domestic abuse and that conflict was present within the relationship.

1 Michelle was a repeat victim. She was, in all but one incident, recorded by Northumbria Police as a victim of domestic abuse (perpetrated by the perpetrator) on 8 separate incidents (including a disclosure of rape). On one occasion, the perpetrator was reported as a victim.

2 There were several accounts from Michelle that she was starting to 'feel scared' and 'terrified' of the perpetrator's actions in the lead up the murder, including a 'fear of violence'. There were two incidents whereby a DVPN/O was used to prevent further escalation and he was also charged with a domestic abuse assault and a criminal damage. Michelle disclosed to Northumbria Police she felt the perpetrator's 'behaviour was getting worse' and claims that he was 'continuously mentally abusing her'. She stated she had received a lot of abusive texts and voicemails and the perpetrator would regularly make false accusations she was having an affair. In the weeks prior to her murder, Michelle disclosed to Northumbria Police that 'she was having domestic violence issues with the perpetrator and was terrified to go home' and described to WWiN a fear of being "frightened of what could happen if the perpetrator was to lose everything". Michelle's family thought she would have felt 'trapped' by the situation but continued to give him 'chance after chance to change'.

3 Michelle did not see herself as being controlled by her husband; however, there are indications that she recognised the abusive behaviour and had started to take proactive steps to keep safe. Witness statements show in the weeks leading up to her homicide, Michelle disclosed concerns to some family members and friends about the perpetrator's behaviour and stated she feared for her life. Michelle had also expressed concerns to WWiN regarding her husband's drinking and stated she 'wanted a complete separation to see if she can see a change in his drinking and attitude' [towards her] and was fully committed to seeking legal advice and pursuing a criminal prosecution. It could be argued the rape experienced by Michelle is the ultimate form of power and control by the perpetrator and that the resolute actions undertaken by Michelle to end the relationship may have triggered a desperate last act from the perpetrator who knew he had lost her.

4 Alcohol consumption appeared to be a consistent factor within the case. In all but one reported incident, either Michelle, the perpetrator and/or both were recorded by Northumbria Police as intoxicated. We know alcohol can be a compounding factor and, although not a cause of abuse, its consumption was frequently identified as a contributing factor that often led to escalated conflict between the couple. Furthermore, there is a broad evidence base which shows alcohol use significantly increases the occurrence and severity of intimate partner violence. Yet, there was no evidence from the toxicology reports to suggest that either Michelle or the perpetrator had alcohol within their system at the time of the homicide/suicide. Although alcohol appeared to be a significant influencing factor in previous domestic abuse incidents – it did not play an influencing role in the homicide. We know alcohol use affects cognitive and physical functions and exacerbate financial difficulties or other stressors. We must also be mindful consumption of alcohol can also be a method of coping or self-medicating; giving victims a means to 'escape the abuse they are experiencing or masking'. Despite the number of occurrences involving alcohol, neither Michelle or the perpetrator were known to drug and alcohol services in Sunderland at that time and there is no evidence of they ever agreeing to such referrals.

5 Disagreements over money appears to be an identified factor within several of the domestic abuse incidents reported by the couple; however, there is not enough evidence to show if financial control was strongly evident within the relationship. The perpetrator accused Michelle of taking money from his wallet, conflicting views in relation to a safe which contained Michelle's severance pay – which only Michelle had access to – but was taken by the perpetrator as well as suggestions from Michelle (via text messages in the lead up to her homicide) that the perpetrator was withholding funds to pay for household bills. We know both Michelle and the perpetrator were employed. There were also indications that Michelle had explored financial options and bridging loans with her bank.

6 Interviews with Michelle's family highlighted examples of the perpetrator appearing to be the main protagonist in the relationship. It was clear that family and friends were aware of the domestic abuse but to different extents. The perpetrator's actions in Mexico, the chewing-up of Michelle wedding ring[19], the violent altercation with Michelle's brother, slashing of coats and the physical violence indicate examples of a level of volatility and anger. However, discussions with the perpetrator's brother offer a differing account. He felt it was the perpetrator who took 'the brunt of the blame' and was 'always the one who had to leave [the home] regardless of who was at fault'. He stated 'some of the domestic abuse situations were not always all down to the perpetrator but split fifty-fifty [between him and Michelle].

7 Witness statements obtained by Northumbria Police indicated Michelle and the perpetrator as 'argumentative' and a couple who often had 'regular verbal altercations and disagreements'. In addition, they were also described as individuals who 'gave as good as they got'. It could be argued some of the

[19] The examples provided here are sourced from witness statements and from family accounts but have not been referenced within the Detailed Chronology section (as they could not be attributed to a specific date) but provide examples of the coercive control that Michelle experienced.

incidents were situational couple violence, which involves a relationship dynamic "in which conflict can occasionally get 'out of hand' and is usually provoked by a situation or incident when emotions get out of control and escalate; it is not necessarily an attempt at power or control over the other partner. Slapping, pushing, throwing items and kicking are examples of common situational couple violence – and we know alcohol is often involved. It can be initiated by either partner, male or female, and is often reciprocal – which would tie in with some accounts.

8 In several reports to Northumbria Police, the perpetrator denied and minimised his behaviour and held Michelle responsible for provoking the situation (e.g. on several occasions, he stated any injuries were down to Michelle's 'drinking'). Denying responsibility or arguing that the victim's actions provoked the attack is another rationalisation the perpetrator's uses to justify his behaviour.

Key Finding 2

The level of risk escalated quickly following Michelle's decision to seek formal legal support

9 There are numerous accounts of Michelle stating that she wanted to end the relationship with the perpetrator and was intending to seek legal advice on the options that were available; albeit, she did not appear ready to progress with this action and did not access any form of legal support until the weeks leading to her murder. We need to be mindful of the various stages that victims will typically follow before taking steps to end an abusive relationship[20].

10 The risks to Michelle accelerated over a very short period following disclosures made in September 2018 pertaining to the assault and disclosure of rape. At this point, Michelle had decided to finally end her relationship with the perpetrator – and felt confident enough, for the first time, to subsequently seek necessary legal advice to obtain a Non-Molestation Order to curb the perpetrator's behaviour (and is potentially because Northumbria Police had advised a DVPO could not be pursued). It was the first formal step towards the potential end of the relationship.

[20] The first 'pre-contemplative' stage is characterised by victims minimising abuse, defending abuser and thinking they're at fault; which is followed by which is followed by a contemplative stage where is victim has a growing awareness of problems and is starting to recognise that what there are experiencing is abuse. We know Michelle was cognisant of problems emanating within their relationship and had also made tentative disclosures to close friends and family about the perpetrator's behaviour towards her. We found some examples where Michelle had started to think about her future and what her life could look like free from the relationship with the perpetrator. However, there are usually some apprehensions and anxieties from victims at this point, and it is often the lengthiest stage for victims to overcome, as they struggle to come to terms with the reality of their situation. The third stage, 'preparation', is where the victim is committed to taking necessary action, usually within the next month, to end the relationship; and involves seeking out advice and support to help them prepare for the final stage. We know Michelle had taken some preparatory steps and had sought legal advice, guidance from WWiN and was exploring options regarding her home (e.g. use of an Occupancy Order) and was at the point of ending her relationship with the perpetrator. Most professionals want to move a victim to leave their abuser often before they're ready to make that commitment and it risks them being set-up to fail. We need to be cognisant, as professionals, we are supporting clients at a pace that suits them and victim-led.

11 It is often assumed that a victim choosing to separate from an abusive partner will reduce the risk of further harm. However, evidence indicates that the risk of further violence and harm increases at the point at which a victim leaves the perpetrator. We know that victims who attempt to end a violent relationship are strongly linked to intimate partner homicide – and is the most dangerous time for victims.

12 The Non-Molestation Order was served less than one day prior to the homicide and was the first serious action taken by Michelle. Witness statements show that the perpetrator was 'really angry' with Michelle, after he was served with the order, and it was potentially this step, designed to protect Michelle, which may have triggered a significant escalation and a desperate last act from the perpetrator, who knew he had finally lost her. There is no indication those who witnessed 'anger' as a result of him being served a non-molestation order considered it important enough to report their concerns about his behaviour to Police.

13 Michelle expressed to WWiN that she was feeling 'frightened' particularly around 'the possibilities of what could happen if the perpetrator 'felt he was losing everything' - indicating she felt the situation had escalated with the perpetrator and stated that it was the first time she had seriously considered taking legal advice. Information contained within the statement Michelle provided for the Non-Molestation Order also highlighted that she was 'terrified' and outlined a significant number of examples of abusive behaviour perpetrated towards her. Despite this, both Michelle and agencies did not necessarily expect the risk from the perpetrator to escalate at the speed at which they did.

14 Michelle self-identified to WWiN as independent and resilient; and often kept a lot of domestic abuse she was facing to herself; similarly, the perpetrator was also known to keep issues private from his own family. Yet, during this time period, the perpetrator expressed to a friend increased feelings of suicidal thoughts (following Michelle's disclosure of rape). Partner agencies did not know this information at the time – but in hindsight, it is a significant behaviour change and, although there were no threats towards Michelle, a person perpetrating domestic abuse who is suicidal should also be considered homicidal, and threats to commit suicide remain a significant escalating factor in domestic homicide.

15 We know the perpetrator had previously attempted to strangle Michelle, had a history of similar patterns of abuse against an ex-partner and had demonstrated signs of jealousy (in terms of Michelle's past relationships), which are important when identifying and assessing risk and are associated with serious violence and homicide. In addition, we know persons reporting domestic sexual assault are, as a result, at potentially increased risk of more serious injury from their abuser longer-term.

16 Despite being warned to stay away from Michelle, as per the Non-Molestation Order, the perpetrator went on to ignore the potential consequences and failed to comply with the requirements, which is yet another indicator of increasing escalated risk. Finally, we know the perpetrator's alcohol use and suicide

threat, although not the cause of the abuse, brings an added dimension and risk of further harm.

17 By considering temporal sequencing, such as models published by Monckton-Smith (2019), which set out the various progression stages relationships will go through prior to a homicide, we can start to draw similarities with Michelle and the perpetrator's relationship. There was a pre-relationship history of domestic abuse perpetrated by the perpetrator, the couple developed a serious relationship quite quickly, there were clear signs he was dominating Michelle and made her feel frightened through the abuse he perpetrated, there was a significant trigger to threaten his control (through the use of the non-molestation order to prohibit further contact with Michelle), there were examples of escalation during the separation period (through the use of numerous texts, calls and voicemail) and there was also a potential change in his thinking (e.g. his threats of suicide and low mood; angry with non-molestation order). Based on this model, there was an elevated risk to Michelle of homicide and the perpetrator's level of dangerousness could have been regarded as high.

Key Finding 3

There was a history of witnessing and perpetrating domestic abuse.

18 We know from records that the perpetrator spent some time in a local youth detention centre which has since seen several former staff members convicted over the historical physical and sexual abuse of young prisoners. Medomsley, which closed in 1988, was built in 1960 to house offenders and at any one time held about 70 young men, aged from 17 to 21, who were detained for relatively minor crimes. The convictions were part of Operation Seabrook, which was launched by Durham Constabulary in 2013 to explore allegations of abuse perpetrated by staff against detainees. Operation Seabrook investigated incidents which happened over many years, principally the 1970s and 1980s, and remains one of the largest investigations of its kind in the UK. By March 2019, Durham Constabulary stated 1,676 men had come forward and reported allegations of abuse, while detained at Medomsley, and prosecutors have described "an atmosphere of fear and violence [being used to control] throughout the institution". The perpetrator was due to be visited by Durham Constabulary the day after Michelle's homicide (as part of the trial preparation process and provide a Victim Personal Statement which details how the impact of the abuse, he experienced in Medomsley, has affected him).

19 There is a wealth of information available detailing the life course impacts of witnessing or experiencing domestic violence on children and young people. Evidence shows situations where a child experiences some form of abuse (either directly or witnessing) can lead to very serious psychological trauma with possible long-term effects, affecting not only the wellbeing during or shortly after the abuse, but also affecting an ability to build/maintain healthy relationships in later adult life. Clark County Prosecuting Attorney (2012) estimates 'one of every three abused children becomes an adult abuser or victim'; whilst Brown

and Bzostek (2003) evidenced males exposed to abuse as children are much more likely to engage in domestic violence as adults.
The Royal College of Psychiatrists (2014) state "children who have witnessed violence and abuse are more likely to become involved in a violent and abusive relationship themselves".

20 Aggression witnessed as a child can play a great part in the relationship building as an adult and must not be overlooked. We must be mindful of the environment and possible abuse that the perpetrator may have been subjected to and/or witnessed growing up, may have been relived in the months and days leading up to the homicide, particularly as he was due to give evidence several weeks after his death (with a trial scheduled for 5th November 2018).

21 We must consider the long-term impact of institutional abuse of children and young people in custodial settings and how this may manifest in adult life. This is certainly not to say that the abuse suffered justifies the perpetrator's actions or behaviours towards Michelle, but it is a potential important influencing factor. In addition, we know the perpetrator had witnessed domestic abuse within his own childhood. The recent death of his mother, the suicide of the perpetrator's father and death of his brother may have also negatively impacted. Domestic abuse is often explained in terms of a 'cycle of violence' which argues that people who grow up in violent families will repeat the patterns in adult relationships; men as perpetrators and women as victims. Some research indicates men who witness domestic abuse as children may be at greater risk of being violent as adults. However, there are many men who grow up in violent families who don't go on to become abusers and, conversely, there are those men who are violent to a partner who come from families with no history of domestic abuse. Abusers learn to be violent from the society within which they grow up. Family is not the only formative influence on behaviour; the unequal power men have is reflected in legal, social and economic inequalities in society – and this inequality means that men have more power than women – and some will exploit that power to gain control in their relationships.

22 Similarly, interviews with Michelle's family also suggest that domestic abuse was a factor within her own household. A recent survey carried out by Hestia in May 2019 suggested children who witnessed and/or experienced domestic abuse: up to 59% experienced anxiety/depression in adult life, 55% reported having trust issues in future relationships, and almost 34% reported having self-medicated with alcohol or substance misuse. These all relate to both Michelle and the perpetrator and we need to acknowledge how the potential domestic abuse experienced in their respective childhoods may influence their awareness and understanding of (un)healthy relationships in later life.

23 As part of the investigation into Michelle's murder, one of the perpetrator's former partners provided statements detailing their previous involvement. Information within the statements suggests the perpetrator had exhibited similar behaviours within his past relationships, a lot of which bore similar hallmarks to the issues experienced by Michelle. Comparing the details of Michelle's case against the experiences of one of his ex-partners, it becomes clear the perpetrator utilised similar transferable tactics; and illustrates how perpetrators

often repeat tested behaviours in successive relationships and highlights the importance of recording as much information as possible about historical actions to help assess current and future risk. We know that past behaviour is often a predictor of future behaviour and it is essential that we use this information to better protect victims from future abuse.

Key Finding 4

Michelle sought appropriate advice, guidance and support in relation to the domestic abuse that she was experiencing

24 Michelle sought advice, guidance and support from agencies in the weeks leading up to her murder, which included access to and engagement with WWiN (the local domestic abuse service), appointments with local solicitors to seek advice around a Non-Molestation Order and dialogue with Northumbria Police in relation to the disclosure of multiple assaults and rape.

25 We know of the previous 9 incidents that Michelle reported to Northumbria Police in relation to domestic abuse – on only 3 occasions, did she consent to a referral to VictimsFirst Northumbria. As Michelle was only identified as standard risk, she was not appropriate for a referral into specialist domestic abuse services, until the final disclosure in September 2018. Consent must be provided from the victim to be referred into support services for non-high-risk domestic abuse cases. However, WWiN, the specialist domestic abuse service, does accepts self-referrals from victims at any risk level.

26 We know Michelle did not wish to seek support for the other 6 incidents and did not consent for her details to be passed to VFN. At the time, partner agencies did not collect rationale for victims not wanting to access their services; and, as such, we are unable to ascertain the reasons for not being able to engage with and discuss benefits of accessing support services at those times. It would be prudent to suggest that Michelle was either not ready to act at that point in time and/or that the services offered were not suitable to meet her needs. If a victim does not consent or does not wish to take up an offer of support, there is limited action which can be undertaken – and potentially leaves victims isolated and without appropriate safeguards in place. Collecting data on why victims do not want to or are not ready to engage could help services to tailor their support packages to help improve how victims needs and wishes are better matched.

27 SafeLives (2015) 'Getting it right the first time' evidenced 85% of persons who experienced domestic abuse sought help from professionals an average of five times before they received effective help to stop the abuse – this applies to Michelle. Each contact represented a chance for both Michelle to disclose and/or for agencies to enquire about her home life – these potential opportunities for early intervention were missed. Agencies need to be ready and able to support victims regardless of where they present. For example, if routine enquiry had been in place with Michelle's GP, this may have been an opportunity for her to receive advice and support; similarly, contact with

Northumbria Police, VictimsFirst Northumbria and/or her place of work should have been able to spot the signs, enquire about domestic abuse and respond appropriately in a victim-led manner.

28 Michelle had recognised something had changed within the relationship and that she needed to act; sadly, this case escalated faster than agencies were able to respond; and whilst unable to engage Michelle in support previously, we know she did ultimately engage when the support offer met her needs (and/or she was ready to act). We therefore need to consider the importance of how the offer of support is made and introduced to victims. Services should be tailored and offer support that is more victim-led, asking what they need and what measures can be undertaken to help encourage victims to successfully engage. Services should not be a homogenous package which signposts victims to support; instead, it should reflect all needs, not just safety.

Key Finding 5

A Domestic Violence Protection Order (DVPO) presents agencies with a window of opportunity to try and maximise engagement with victims of domestic abuse.

29 Following the first DVPO issued in March 2017, Michelle accepted a referral to VFN for support, however – the service was unsuccessful in their attempts to contact Michelle via telephone and subsequently closed the case. In August 2017, following the second DVPO, Michelle did not consent to a referral to VFN. This meant that on both occasions, there was a potential 28-day window provided by the serving of the DVPO, where the perpetrator was prohibited to contact Michelle, and services were unable to speak with her. This was a potential missed opportunity for agencies to be able to proactively intervene and support Michelle. It must be recognised that victims who call the police are often calling when they feel the behaviour is of greatest concern to them — and are effectively seeking agency help to prevent and stop the abuse. The DVPO created 'space' for Michelle (away from the perpetrator) to consider her options, and support services should maximise this time in terms of trying to engage victims and assess their needs.

30 Greater consideration should be given to how partner agencies can work better together, during the window of separation that a DVPO provides, to help maximise our ability as a partnership to engage with and signpost victims to specialist services. A good practice response would be to hold a meeting between the victim and specialist support services before the application of a DVPO is submitted. This would enable a full explanation of its purpose and the support available during the 28-day period. As the DVPO is considered at a time when the victim is actively seeking help (i.e. calls to Police) this may provide a window of opportunity to engage with services, provide insight into the options and choices available and enhance safety through a tailored safety plan. Where available, target hardening measures such as a Sanctuary

Scheme may also be discussed and implemented providing additional home security for the victim and, most importantly, leave the victim 'feeling safer'.

Key Finding 6

There continued to be an overreliance on Michelle engaging with support services with a lesser focus on addressing the perpetrator's behaviour.

31 There continued to be a repeated overreliance on Michelle having to engage with specialist support services to address concerns around domestic abuse with a much lesser focus on tackling the behaviour of the perpetrator.

32 We must recognise that any report of domestic abuse to the Police is an 'action' by the victim – and is an opportunity not only to put plans in place to safeguard the victim, but to also assess the perpetrator's risk of harm, based on his history and current situation and to use this information to inform safety planning. We tend to rely too heavily on the victim engaging with services and subsequently our actions/resources are therefore targeted defensively around protecting the victim rather than proactively targeting the perpetrator.

33 We should aim to take more robust engagement and intervention with domestic abuse perpetrators to reduce risk and harm to the victim; and, more importantly, to help shift the focus towards holding perpetrators to account (but in a way that does not escalate the potential for further risk to the victim). There tends to be an overemphasis on singular incidents of physical violence rather than recognition of a wider pattern of abuse and control within the relationship with an underlying assumption that separation or removal of the perpetrator automatically reduces risk.

34 There are instances in which DVPN/Os were used to provide protection for Michelle; but there are missed opportunities for partner agencies to consider interventions for the perpetrator to try and positively address his underlying behaviour and abuse. Although attendance at a Domestic Abuse Perpetrator Programme cannot be mandated, efforts could have potentially been made to engage the perpetrator during this window of separation. Sunderland has the BIG Programme[21] – which is a voluntary domestic abuse perpetrators programme for men aged 18 and over – and provides group programmes and one-to-one assessments, which have been designed to help perpetrators to stop using abusive behaviour towards an intimate partner or ex-partner. There is no evidence the perpetrator was considered for or offered this programme.

[21] Men wishing to attend a Domestic Abuse Perpetrator Programme must satisfy: (1) be 18 years or over; (2) agree voluntarily to attend the programme; and (3) recognise their behaviour has been abusive towards their current or ex-partner. A client will be deemed unsuitable and excluded from attending if: (a) severe/chronic mental health or psychiatric illness; (b) recent convictions for firearms possession/use; (c) outstanding criminal justice matters; (d) convictions for sexual abuse; (e) extensive criminal record of violence; or (f) chaotic substance abuse dependency.

35 We know that a sole focus on the victim does not significantly reduce domestic abuse in the long term. The end of a relationship is unlikely to mean an end to perpetration of domestic abuse – with many abusers going on to continue to re-offend against new partners or continue to abuse original partner in other ways (Hester & Westmarland, 2006). We cannot afford to ignore actions designed to tackle perpetrators. We know Sunderland is a pilot area for 'Change that Lasts' which focuses on professionals, communities and services delivering early effective intervention and the right response first time. Other pilot localities are currently expanding the model to working with perpetrators[22] – and this might present a further opportunity for Sunderland to consider in relation to placing a greater spotlight on perpetrator behaviour.

36 Domestic Abuse Protection Orders, outlined in the Domestic Abuse Bill announced in January 2019, proposed restrictions being placed on the actions of offenders (including positive requirements). The use of positive requirements to address offending behaviour could prove to be an added protective factor for future domestic abuse victims; albeit, we must be mindful that to be successful, the perpetrator must be suitably motivated for an intervention and be ready to change their behaviour. However, if we don't routinely ask perpetrators, we will not be afforded this opportunity to be able to affect any form of change.

Key Finding 7

Strong workplace policies are important to supporting and encouraging victims to report abuse.

37 Employers have a responsibility to provide staff with safe working environments and we know that for some staff the workplace can be the only safe-haven from domestic abuse. Evidence collected by the Home Office in 2009 estimated up to a fifth of victims of domestic abuse had taken a month or more off work in the previous year due to the abuse[23]. It is critical therefore to have strong workplace policies to be able to adequately protect and support employees and encourage reports of abuse.

38 In January 2014, Michelle took a 9-day period of absence from work, which was recorded on her Personal Staff Record as a 'domestic violence' incident. Michelle had reported her sickness absence to a duty call handler and her employer was unable to provide any further evidence or details on the circumstances of the absence; yet, we understand, from discussions with Michelle's family, the absence was potentially due to injuries sustained when 'the perpetrator threw a chest of drawers down the stairs at Michelle causing her to suffer from a bruised eye and sore wrist'.

[22] Early Intervention Response to Perpetrators of Domestic Abuse: via the Home Office Transformation Fund was submitted jointly by OPCC Lincolnshire, Lincolnshire Police and OPCC Sussex, WAFE and Respect with support from Lincolnshire County Council, Brighton & Hove City Council and East Sussex County Council.
[23] Domestic violence, sexual assault and stalking: Findings from British Crime Survey (S Walby and J Allen, 2009)

39 The review showed Michelle's employer did have a Domestic Violence Policy and an Absence Management Policy in place at the time of Michelle's absence. These are discussed as part of the induction process for all new employees and are disseminated to line managers. The Policy provides details of how employees will be supported to return to work through a range of supportive measures, and where abuse is identified, reasonable adjustments and risk assessment would be also be identified and implemented. This includes providing employees with advice and guidance including signposting to support agencies.

40 If the initial reason for Michelle's absence had been appropriately shared, then upon her return to work following the absence, there would have been an opportunity for her line manager to enquire about domestic violence; and to potentially provide an additional layer of support for Michelle. There are no records to evidence if any follow-up action was taken by Michelle's employer in relation to domestic abuse; nor could we ascertain if a Return to Work Interview was completed. Without any records, which should have been in place as per the Absence Management Policy, there is no proof to be able to demonstrate if the domestic abuse was recognised, responded to, whether Michelle was provided with support and/or if she was offered a referral or signposted to help.

41 Further enquiries have shown a different reason for absence recorded on Michelle's payroll record – which recorded the absence as 'Personal Reasons'. Michelle's employer could not provide any further clarity or evidence to suggest why the reason for absence had been altered (other than to indicate that Michelle may have 'changed the reason for her absence when she returned to work'). It could be 'domestic violence' was not recorded on payroll system for confidential reasons; but, regardless of this, at the very least, Michelle's line manager should have been made aware the absence was linked with potential domestic abuse. Michelle left employment with the organisation in 2016 and the agency has since been restructured – which could account for some of the missing records and a lack of information relating to her absence. Despite the lack of evidence, we need to recognise the initial disclosure by Michelle was a significant missed opportunity for her line management to potentially engage her in a meaningful conversation around domestic abuse and to record this appropriately. As a result of the DHR, the organisation has reviewed and re-launched its Domestic Abuse Workplace Policy and previously amended their Absence Management Policy to ensure employees contact their line manager to inform of the absence and to identify the reasons behind their non-attendance. This allows line managers to be aware of the reasons for absence of their staff member from the outset (and helps flag up to management any potential disclosures of domestic abuse).

42 Michelle's most recent employer, who she had started working for in the month prior to her death, did not have a formal Domestic Abuse Policy in place. There were no disclosures from Michelle to her line management, whilst she was at work; however, there is evidence that she did informally discuss some aspects of the perpetrator's behaviour with her peers, but the conversations did not necessarily raise any significant concerns with her colleagues for them to warrant seeking advice from management. If a Domestic Abuse Policy had

been in place, it could be argued that it may have triggered her colleagues to think differently about what was being discussed and potentially to refer to a structured process of how to raise any concerns with their employer. The organisation has since implemented a Domestic Abuse Policy.

43 It is well recognised that victims find disclosures of domestic abuse difficult; and it is less likely an employee will approach their manager in the first instance, or that they will disclose to people at work about the abuse they are experiencing. Evidence from Hestia (2019) shows that nearly 90 per cent of victims never tell their employer, up to 70 per cent of organisations do not know how to respond to domestic abuse disclosures with only around 5 per cent of businesses having a formal domestic abuse policy in place for staff to access and seek support.

44 However, with one third of a working adult's life spent in work, employers are in a unique position to create a supportive workplace culture that encourages the identification of domestic abuse and offer appropriate and confidential support to help victims to be able to deal with their situation far more effectively.

45 Organisations across the City need to ensure they are acting appropriately to disclosures of domestic abuse from their employees. Despite comprehensive policies, Michelle's case highlights the importance of staff being routinely able to identify, respond to and record abuse at the earliest possible opportunity and to act accordingly. Line managers are at the heart of tackling domestic abuse in the workplace and should be provided with the necessary tools to recognise the signs, however ostensibly small, and play an active role in its prevention. Greater management training, supportive workplace cultures and improved awareness of the ways in which domestic abuse may manifest itself (through staff absence) is critical to ensuring organisations are in a stronger position to protect their employees at work.

46 Some examples include: Northumbria Domestic Abuse Workplace Champions Scheme which is designed to be able to support victims both practically and emotionally. The project was proactively rolled out across private employers and public-sector organisations in Sunderland and is regarded as best practice. We know that Michelle's employer was not part of the scheme at the time of her disclosure – and it may well have provided Michelle with another outlet, other than her line manager, to seek advice whilst at work. Similarly, Trusted Professional[24] as part of the Change That Lasts pilot is also being rolled out in Sunderland, which aims to train professionals to recognise the strengths and resilience of survivors and to respond in a needs-led, strength-based way. In addition, a new national programme "Everyone's Business" led by Hestia was

[24] Trusted Professional brings the Change That Lasts values and working practices to professionals in services who are already in contact with and trusted by survivors. The Trusted Professional intervention encourages systems change within organisations and amongst individual practitioners. A series of training and professional development days are supported by policy changes, reflective practice and service user focus groups to change both the culture and practice of organisations. Building on the trusting relationship already established with survivors, the training focuses on the non-physical, coercive and controlling signs of domestic abuse so that these are not missed when a survivor is in contact with a Trusted Professional. The intervention aims to change the systemic response to abuse by training professionals to recognise the strengths and resilience of survivors and to respond in a needs-led, strength-based way, using the Space for Action concept.

launched in 2019 and offers support and training for employers to change the way they deal with domestic abuse at work.

47 A review of the chronology highlights Michelle had a significantly high number of absences from work due to Kienbocks Disease in her wrist. According to the IMR provided by her employer, Michelle had 'several opportunities to disclose domestic violence whilst at work and received regular supervisions, return to work interviews and appointments at Occupational Health in relation to her underlying medical condition'. Yet, this suggests the onus was on Michelle to disclose concerns. Throughout her absences, there is no indication or evidence to suggest whether Michelle's employer actively enquired about the possibility of domestic abuse as a contributing factor for her time off work. In hindsight, given the potential 'domestic violence' absence in early 2014, further dialogue and follow up would have been useful.

48 We know enquiries about domestic abuse from employers, if done sensitively and correctly, show that the workplace can be a significant source of support to victims. Employers have an increased legal responsibility to employees who disclose that they may be at risk of harm from domestic abuse and the recording issues and lack of enquiries following absence was a missed opportunity for Michelle's employer to engage in meaningful conversation about potential domestic abuse concerns. Workplace Domestic Abuse Policies need to include advice and guidance on how to ask about domestic abuse and be accompanied by regular training opportunities to equip line managers with an increased ability and awareness of how respond positively and proactively to potential disclosures.

Key Finding 8

Professional curiosity is critical to eliciting a better understanding of risk.

49 There were several missed opportunities from agencies involved with Michelle to utilise a better degree of professional curiosity to help identify underpinning issues that she may have been experiencing in terms of domestic abuse.

50 Professional curiosity is the ability for professionals to explore and understand what is happening rather than making assumptions or accepting things at face value. It is acknowledged this can often be difficult, particularly when faced with complex domestic abuse situations, and with what is often a first point of contact between a professional and a victim. Nevertheless, professionals are expected to routinely enquire about, challenge and elicit pertinent information from clients to support in the development of a timely and accurate assessment a person's level of risk from harm.

51 We know Michelle regularly presented to her GP. It is uncertain as to whether contact was a way for her to seek support around the domestic abuse she was experiencing from the perpetrator; however, more enquiries may have afforded Michelle an opportunity to discuss and for her to be encouraged to access

support. It must be recognised that there were several GPs involved with Michelle throughout and it may have also helped if GPs had held more face-to-face consultations. These factors may have provided an opportunity to utilise routine, or indeed selective, enquiry about domestic abuse that she was facing. Some examples, where greater professional curiosity from Michelle's GP may have elicited underpinning concerns, include:

- In March 2014, Michelle presented to her GP upset and disclosed concerns about her husband as he had been 'falsely accused of something'. There was no evidence in the records to suggest that any further exploration was carried out in relation to what these allegations/issues were and the impact of this on Michelle's wellbeing. Similarly, in a telephone consultation with her GP, held several days later, Michelle stated she continued to feel 'very stressed' by recent events. This was less than eight-weeks after a domestic abuse was reported by Michelle to Northumbria Police.
- In August 2014, Michelle (via a telephone consultation) stated she had 'pulled a muscle at work' but had presented in the Minor Injuries Unit a few days prior stating she had been in a 'car accident'. This would have been an opportunity to undertake selective enquiry (as two different modes had been given to explain the injury sustained). It also highlights the importance of reviewing previous records which may have provoked more challenge.
- In July 2015, GP records contained letters highlighting Michelle was being treated for tendonitis. There was no further documentation as to whether there was any challenge around this diagnosis and was potentially missed opportunity to enquire further.
- In January 2018, Michelle had a face-to-face consultation with her GP relating to minor health concerns, which were not significant; however, it is the first face-to-face encounter since a DVPO was granted. Although the DVPO had expired, there was no enquiry from the GP around abuse and is another potential missed opportunity to elicit information about Michelle's home life.
- In February 2018, a telephone consultation with her GP stated Michelle had a back injury. At this stage, had past records been reviewed, it may have prompted further discussion in relation to domestic abuse.
- We know Michelle had numerous contacts with her GP for fit notes in relation to pain in her wrist. Michelle suffered from Kienbocks Diseases, which lends itself to discomfort in the wrists, and whilst it was the logical explanation for the pain that she was experiencing this seems to have been taken at face value, with very limited evidence of enquiries to elicit any other possible causes (e.g. was the perpetrator deliberately targeting her wrists – within the IMR, there is information Michelle was suffering from tendonitis within her left wrist, but no enquiry in terms of how this injury had occurred).

52 It is easy in hindsight to identify opportunities where professionals could have asked questions, challenged diagnosis and probed for further information about Michelle's homelife. However, regardless of how many policies, procedures and system controls are in place to safeguard and standardise referral pathways around domestic abuse, it is important to recognise how human-related factors can impact on decision making processes. Professionals may subconsciously decide a course of action to take without necessarily considering all available factors – it is often seen when quick snap judgements

are made based on past contact. For example, Michelle regularly contacted her GP with complaints of wrist pain relating to Kienbocks Disease. It could be argued that, when describing the pain, the issue of domestic abuse wasn't fully considered or appreciated (as there was a logical link with her long-standing condition) and, although trained and aware of domestic abuse, professionals may have discounted information to justify a subconscious assessment of a situation. In most interactions with Michelle, professionals focused their efforts around her 'presenting need' and further enquiry could have been undertaken to consider possible indicators of abuse and the interplay between multiple presenting factors (e.g. potential injuries, depression, anxiety, alcohol use etc).

53 As mentioned in the previous section, it is critical to have strong workplace policies to be able to adequately protect and support employees and encourage reports of abuse. There were missed opportunities for her line manager and colleagues to enquire about possible domestic abuse with the perpetrator and to signpost Michelle to relevant support services.

54 Following several domestic abuse incidents, Michelle stated that she intended to seek support, was committed to ending the relationship and was considering civil action against the perpetrator. Presenting information appeared to have been accepted at face value by professionals without any evidence of them trying to clarify or confirm if said action had taken place (or to checking in with Michelle following or at future incident to see what progress had been made). Within the DASH Risk Indicator Checklist completed by WWiN in September 2018, Michelle stated that it ~~is~~ was the first time she had seriously thought about taking legal advice. It showed that despite Michelle saying she intended to speak with solicitors in January 2014, it was not until September 2019 – almost 4 ½ years later – that she felt ready to act and take up this offer. It highlights the importance of recognising the stages of change involved when ending an abusive relationship but also for professionals to not necessarily accepting presenting information at face value.

55 In relation to Michelle's contact with VictimsFirst Northumbria in March 2017, she disclosed that the domestic abuse she was experiencing 'was long running and she wanted to finally end the relationship'. There was no DASH Risk Indicator Checklist completed, which may have elicited a different response and provided Michelle with an opportunity to discuss her concerns.

56 On a positive note, there are examples where professional judgement had been used to help gather more information and/or to help safeguard Michelle from further harm. A DASH Risk Indicator Checklist was completed for Michelle, following her disclosure in September 2018 of rape and assault, and was recorded 'medium risk'. This was increased on professional judgement by Northumbria Police and a referral was subsequently submitted to MARAC. There are examples of the proactive use of DVPN/Os to help protect and safeguard Michelle. Similarly, during the time of the disclosure, professionals at WWiN were suitably concerned regarding Michelle's safety and based on the information shared and the level of distress displayed – assessed the situation as serious. They subsequently provided Michelle with safety planning advice and discussed Michelle's options and protective measures available such as

home safety, changing daily routine, non-molestation orders and access to refuge accommodation.

57 Following police attendance, and in interviews, the perpetrator makes several counter allegations against Michelle (e.g. saying she jumped on his back, she started the argument, injuries due to intoxication etc). This is part of the pattern of abuse and are potential indicators that the perpetrator is deflecting attention away from him towards Michelle trying to justify his actions. We need professionals to be aware of the complexities around domestic abuse and be confident to recognise all available interplaying factors involved.

Key Finding 9

The timely sharing of information across agencies is essential to help develop a full picture of abuse.

58 We know that timely information sharing, in line with the rules of consent and confidentiality, is essential to ensuring partner agencies who encounter either the victim and/or perpetrator have access to relevant information, at that point in time, to be able to adequately support and protect. Risk is fluid and dynamic which means that things can change very quickly and without access to timely and accurately recorded information we have the potential not to see the full scope of the domestic abuse situation.

59 The notification of the DVPO, along with the details of specific conditions, were not received into the CCG Safeguarding Inbox until the 21st September 2017, despite the DVPO being served on the perpetrator on the 29th August 2017 by Northumbria Police. Due to staff changes, we were unable to explore the potential reasons for the delay; however, in view of early learning from this DHR, the standard operating procedure for DVPO process has been amended by NHS Sunderland Clinical Commissioning Group which includes more robust timescales.

60 Additionally, there is no evidence that the DVPO notification, once received by the GP practice from the CCG, was saved in Michelle's health records. Michelle is coded as a 'victim of domestic abuse' of the system but with no further information. This lack of rationale/justification, if included on the system, may have resulted in GPs upon future interactions with Michelle to enquire about potential domestic abuse issues and is a missed opportunity. The system has been refined and the standard operating procedure has been amended.

61 In another example, in September 2018, a request for information for MARAC was completed by Michelle's GP and stated 'Michelle does not have any mental health, drug and alcohol misuse or previous abuse'. The response provided by the GP to MARAC was inaccurate and did not reflect records held by the GP that Michelle had experienced these issues. In addition, there was no evidence that data held by the GP in relation to the perpetrator was accessed to provide

a broader holistic understanding of domestic abuse within this/past relationships.

62 On the 18th September 2018, the perpetrator was served the Non-Molestation Order at his friend's home address and a copy was subsequently posted to Northumbria Police. We need to consider the delay in using postal services to share important information pertaining to domestic abuse cases – and whether a timelier method of informing Northumbria Police should be adopted by solicitors or those providing legal services. In Michelle's case, details of the non-molestation order were not received by Northumbria Police until after her homicide had occurred; and, although it is unlikely to have changed/led to any further action, access to timely information helps to build a full picture and elicits a better understanding and assessment of the risks posed by the perpetrator.

Key Finding 10

Importance of agencies using constructive language and terminology when referring to victims of domestic abuse.

63 The importance of partner agencies using constructive language and terminology when referring to victims of domestic abuse is crucial. There were numerous examples identified, throughout records reviewed as part of the DHR, where the language used to describe domestic abuse and/or the relationship between Michelle and the perpetrator could be 'open to interpretation'. Some examples include:

- It is stated that Michelle 'played the system to have her partner arrested…at her convenience'
- It is recorded that 'there are clear issues in the relationship which go back a number of years; however, it remains unclear who the main aggressor is'.
- Following an incident, it is logged that Michelle 'refused to support a prosecution …and gave the perpetrator house keys so he could let himself back into their home address…this suggests she is not in fear [of him]'
- It is noted that Michelle had 'previously reported similar incidents; yet refuses to assist police for reasons unknown'
- One domestic abuse incident is described as 'marital difficulties'

64 The wording and tone used is quite victim blaming and appears to minimise the abuse that has taken place in the relationship. We need to be careful to ensure that recording of domestic abuse accurately reflects the situation but is worded in a way that puts the victim at the heart of the conversation. We know that the actions undertaken by Northumbria Police following reported domestic abuse incidents, according to the IOPC report, were relevant and appropriate – based on their policies and procedures. However, the way in which these are worded could have the potential to influence future interactions – and for human-related factors to creep in.

65 Additionally, the wording recorded by Northumbria Police on the subsequent referral information to VictimsFirst Northumbria (VFN) also led to support

services not being potentially offered to Michelle. The provenance of the information is unknown (e.g. did Michelle tell Police she was being support by WWiN, so officers have recorded this as it is said, or have the Police wrongly recorded this information based on a referral to WWiN). Following a domestic abuse incident in April 2017, Michelle consented for a referral to be submitted to VFN, which could indicate she felt confident enough to engage in a conversation with support services at that time. This is the third and last time Michelle agrees to a referral. A VFN referral was subsequently made by Northumbria Police but identified Michelle as 'already being supported by WWiN'. We do not know what this relates to (i.e. was she signposted to WWiN by Police or did Michelle say that she was being supported etc.). We know from records that, at this time, Michelle was not currently engaged with and receiving support from WWiN. The VFN Co-ordinator noted the involvement of the specialist domestic abuse support service, identified that VFN would not be able to offer any additional support; and subsequently closed the case without attempting any contact with Michelle.

66 It demonstrates that the language used by agencies when signposting is crucial to ensuring victims are afforded every opportunity to be offered support and to minimise the potential for them to slip through the gap. Following this incident, there was a chance for services to potentially try and engage with Michelle but, due to inaccurate recording, no contact was made and is a missed opportunity.

67 On a positive note, the use of language by police officers was included in the Whole Systems Approach to Domestic Abuse training which was recently rolled out to Northumbria Police. This will help to improve future recording practices and understanding of how inaccurate recording can provide barriers to victims.

Key Finding 11

Ensuring victims are safe and secure in their own home is important.

68 It is important victims of domestic abuse feel safe within their own homes and should be afforded an opportunity to access a range of practical measures designed to enhance the security of their property. These measures should be part of a wider holistic multi-agency response to those households at risk of domestic abuse. It is known as a Sanctuary Scheme – and allows victims (where they want to and where is it safe to do so) to remain living safely in their home following adaptation. The schemes have been promoted by Government since 2005 and, although not statutory, they are widespread across England and part of a wider response package afforded to victims of domestic abuse. At the time of Michelle's homicide, there was no Sanctuary Scheme in Sunderland.

69 There are several instances recorded where Michelle appeared to be worried about the perpetrator's ability to access their shared property. There are occasions where he was arrested and/or removed from the property by the Police to prevent the potential for further incidents of abuse – however, this was

only a short-term measure. DVPOs were proactively used to safeguard Michelle from the perpetrator and we know Michelle had spoken with a solicitor to apply for an Occupation Order which was 'listed for further directions or determination at a further hearing (within the conditions of the Non-Molestation Order served on the perpetrator). An Occupation Order is used when the future occupation of a property is in dispute and regulates who can live in the home. It means the perpetrator would have effectively been required to leave the property so that it afforded Michelle a form of protection from further abusive behaviour. That said, the Sanctuary Scheme is often difficult to implement in cases where the home is owned, particularly as it requires the home owner consent to proceed with some of the additional measures; and therefore, it would not necessarily have been made available to Michelle (as the perpetrator was still living in the property at the time). The Sanctuary Scheme model could have been used to help provide Michelle with adaptations to enhance her security within her home should the Occupancy Order have been granted by the Courts – which was something Michelle was exploring at the time of her homicide – and if available, it could have offered a wider suite of safeguarding options.

70 Best practice Sanctuary Schemes would offer outreach support in addition to the physical works and would present an opportunity for specialist services to attend the property, enter into dialogue with the victim and to provide broader safety advice and guidance; thus, increasing the opportunity for engagement. The added support element would provide an individual safety plan designed 'with the victim' to meet lifestyle, commitments, and concerns – a model that is more effective than physical works alone and is dynamic in its approach as the needs change. This may have included providing Michelle with measures such as panic alarms, mobile phone, cocoon watch etc. The model is also more flexible – particularly as joint ownership of a property may present some added challenges in terms of making any major physical changes to the property.

71 Northumbria Police had no legal basis for making the perpetrator surrender his keys to the property; and therefore, although this potentially increased the potential risk to Michelle, there was no lawful basis to carry this out. A review of the Police IMR shows that Michelle was provided with advice in terms of crime prevention which included discussions regarding keeping door locked and keys in the lock to prevent external entry (particularly as the perpetrator had a set of keys that he would not give up) and to call 999, if he turned up. Michelle was also provided with similar advice by WWiN. We are aware Michelle had previously changed the door locks herself which indicated a degree of personal awareness of safety measures.

Key Finding 12

The Risk Indicator Checklist did not account for or document static risk factors.

72 The nationally used DASH Risk Indicator Checklist is a tool designed to provide a consistent way for practitioners who work with adult victims of domestic abuse

to help identify those who are at high risk of serious harm or death, and manage their risk. As per policy, a DASH Risk Indicator Checklist was completed by Northumbria Police on every reported domestic abuse incident. In all but one case, Michelle was identified as Standard Risk – which meant evidence provided at the time did 'not indicate likelihood of causing serious harm'.

73 The table below provides an overview of each DASH Risk Indicator Checklist (DASH RIC) completed for Michelle – and highlights the categories that were selected as part of the assessment process. Those marked in red is where the DHR Report Author has suggested the category on the DASH RIC should have been ticked based on information provided at the time:

	12 Jan 2014	29 Dec 2015	02 Jan 2017	09 Mar 2017	08 Apr 2017	27 Aug 2017	10 Jun 2018	07 Sept 2018	18 Sept 2018 (WWiN)
1. Injury?	Yes	Yes		Yes		**Yes?**		Yes	
2. Frightened?			**Yes?**		Yes		Yes	Yes	Yes
3. Afraid of further injury or violence?		Yes		Yes	Yes				Yes
4. Isolated?							Yes		
5. Suicidal thoughts?									
6. Separated?			Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Is there conflict over child contact?									
8. Stalk or harass?									
9. Pregnant/baby?									
10. Happening more often?							**Yes?**		Yes
11. Getting worse?							**Yes?**		Yes
12. Jealous?			Yes		Yes			Yes	
13. Weapons?									Yes
14. Threatened to kill you/someone?									
15. Strangulation?						**Yes?**		Yes	Yes
16. Sexual?								Yes	
17. Other persons threatened you?									
18. Hurt anyone else?	Yes								Yes
19. Mistreated animal?									
20. Financial issues?			**Yes?**	**Yes?**					
21. Drugs, alcohol or mental health?	**Yes?**	**Yes?**	Yes	Yes	Yes	Yes	Yes	Yes	
22. Suicide?									Yes
23. Broken bail/an injunction?									
24. Criminal history?	Yes			Yes					Yes

74 Having reviewed the DASH Risk Indicator Checklists alongside statements and information recorded by Northumbria Police, we can see that some categories were not answered (when it could have been argued that they should have):

- Alcohol/intoxication was present as an influencing factor in all incidents and should have been included on all the DASH Risk Indicator Checklists;
- The incident in January 2017 relates to the perpetrator removing a safe from the address which purportedly contained Michelle's severance payment – which Michelle thought he took 'to make a point that he was entitled to the cash from the divorce'. Similarly, in March 2017, the perpetrator disclosed arguments had taken place in relation to money problems. On neither occasion, was the question relating to financial aspects recorded as a yes.

- In August 2017, Michelle contacted Northumbria Police and told the call handler the perpetrator had 'tried to strangle her and that she had marks on her neck'. We know strangulation is one of the key significant predictors for future violence and demonstrates significant power and control. If a partner has attempted to strangle, the future risk of a victim being killed increases by up to seven times. It could be argued strangulation should have been included on the Risk Indicator Checklist at this point and may have resulted in Michelle being escalated on professional judgement. However, we must accept it is how the incident is described and how it is subsequently interpreted which needs to be considered at this stage. The Modus Operandi recorded on the crime record stated: 'known male assaults victim following verbal altercation by grabbing neck, no injury caused'. Similarly, the DVPO application outlines that the perpetrator 'grabbed Michelle by the throat'. There is no further mention (other than the initial call) of strangulation and the interpretation here is whether 'grabbed by the throat' should constitute as strangle/choke. Further probing questions about previous incidents may have also elicited additional information within this section.
- In June 2018, it is recorded the perpetrator's behaviour had escalated over the past few weeks and was getting worse. Similarly, these categories are not answered on the corresponding DASH Risk Indicator Checklist.

75 We recognise it is often difficult to complete and review a DASH Risk Indicator Checklist in hindsight, using statements and interviews, particularly without the benefit of being able to explore and probe answers with the victim. However, the paper exercise that has been carried out would indicate that some of the DASH Risk Indicator Checklist categories had not been answered correctly. Additionally, we can see some static risk factors were not identified throughout – for example, the criminal history question is indicated for the first incident and fourth incident, but not for subsequent events. This poses a question in relation to how effectively the DASH Risk Indicator Checklist were being quality-assured by the Central Referral Unit at that time.

76 At the time of the homicide, demand in relation to domestic abuse incidents to Northumbria Police was around 31,000 per year. By September 2018, the Central Referral Unit, who carried out Quality Assurance (QA) of the DASH Risk Indicator Checklists[25] had become part of the Multi-Agency Safeguarding Hub (MASH). Domestic abuse referrals involving children, regardless of risk, were discussed via the MASH arrangements within each Local Authority to identify support for families and young people suffering domestic abuse. In the case of the perpetrator and Michelle, there were no children in the household and so this Multi Agency approach was not taken. However, Police staff still carry out

[25] The Domestic Abuse, Stalking and Honour Based Violence Risk Indicator Checklist (DASH-RIC) is a tool used across partner agencies to consistently assess the immediate risk, threat and danger a victim is subject to. It provides practitioners who work with adult victims of domestic abuse with a simple way to be able to identify victims who are at high risk of harm – and is based on international research and common indicators recorded across hundreds of cases of domestic homicide and serious harm. It is a tool used by all agencies, including specialist domestic abuse services and the police, and provides a common approach to risk management. Further information is found at: http://www.safelives.org.uk

the function of QA within the MASH. This QA can, based on professional judgement, upgrade referrals to high-risk due to the presenting circumstances of the incident, the history of abuse and the risk factors from the perpetrator. Subsequent contact is then carried out by the local Neighbourhood Policing Team or Safety planners. All domestic abuse RICs submitted in relation to the perpetrator and Michelle had been subject to QA and based on the number of risks identified, no escalation in risk assessment took place. Contact by Neighbourhood Policing Teams with Michelle after incidents reported were as per guidelines.

77 Reviewing all of the DASH Risk Indicator Checklists together, we can see how they are often completed in isolation and that the cumulative impact of repeat incidents, particularly over a short time period, are not necessarily considered. For example, the perpetrator's previous criminal history was not consistent throughout and we can see several incidents over a three-month period in 2017, but no links were made to how the abuse was happening more often. We know current behaviours and past offending and criminal history can be used to more accurately assess the perpetrators dangerousness. This professional curiosity needs to be used by attending officers when assessing a situation. There is an argument for whether DASH Risk Indicator Checklists should be automatically populated with information and pull through certain categories that have been recorded during previous incidents to help inform more accurate completion; thus, improving safety planning. However, this needs to be balanced against concerns around attending officers making unconscious assumptions about a case and not considering the presenting factors.

78 Often, information sharing focusses on agency contact with victims, frequently leaving victim services 'guessing' the potential seriousness and likelihood of harm, most of which is derived from the victims view of the relationship rather than any factual history about the perpetrator or previous incidents. The DASH Risk Indicator Checklist is a one-sided approach and it fails to consider or account for perpetrator information, which if known, might significantly increase the risk posed.

79 Despite some of the categories not being answered, if the maximum 'score' based on our paper exercise was assigned to Michelle; she would have remained at 'Standard Risk' and, had she consented, would have been referred to Victims First Northumbria for support as per the local policy.

80 There is no research to support the idea that the sheer number of risk markers identified on a DASH Risk Indicator Checklists equates to imminence of homicide. Evan Stark argues that clusters of markers may be more effective in helping frontline professionals consider safety. For example, the presence of domestic abuse, coupled with a previous history of such behaviour and a recent separation, is more predictive of harm than counting numbers of markers. This DHR demonstrates how additional weight should be given in future risk-based assessments based on key markers (as opposed to sheer number of markers identified). More recent research by Dr Jane Monkton-Smith on the homicide

timeline[26] found an emerging pattern that could be broken down into eight separate stages. The current DASH Risk Indicator Checklist does not account for this type of weighting – relying too heavily on professional judgement – which may suggest that it, together with training, needs to be further developed. We recognise that the College of Policing has been piloting new risk identification tools with a small number of police forces and whether alongside this, consideration should be given (at a national level) to the key findings of this new and emerging research in supporting police and agencies as they make risk assessments in cases of coercive control and domestic abuse.

81 Separation is known to be the single biggest risk marker for homicide (Brennan 2016) and there is higher potential for homicide when the separation is followed by an escalation in concerning behaviour, either in frequency or seriousness. We know Michelle took her first proactive steps to ending the relationship by seeking the Non-Molestation Order and Occupancy Order. In addition, evidence shows Intimate Partner Homicide is more likely to display features of coercive control such as possessiveness and jealousy – and these traits are present within some of the domestic abuse incidents between Michelle and the perpetrator.

Key Finding 13

Michelle's family, friends, work colleagues and neighbours were, to a greater or lesser extent, aware of the domestic abuse she was experiencing

82 Michelle and the perpetrator were described as private persons; and although their family, friends, work colleagues and neighbours had become aware of domestic abuse that was manifesting itself in the relationship – the extent and severity of the abuse was unclear. Experience suggests other persons are often aware of or suspect something is happening but, for one reason or another, are reluctant to get involved. This is highlighted within the witness statements – whereby persons reported on numerous occasions hearing rows, shouting, banging and potential violence between the couple – but all did not necessarily want to (or know how to) get involved to help the situation.

83 A 'bystander' is someone who sees a situation but may or may not know what to do, may think others will act or may be afraid to do something. It is important to demonstrate how potential bystanders can positively discourage, prevent, or interrupt an incident of domestic abuse. We know from witness statements taken as part of the homicide enquiry that Michelle's friends and her neighbour had indications that domestic abuse was a prominent feature between the couple but did not feel confident enough or able to report their concerns to authorities or to signpost Michelle to support. We need to recognise it is often very difficult for bystanders, particularly those who are extremely close to the victim, to act. Victims will often confide in and disclose domestic abuse to their friends on a strictly confidential basis. This often places the receiver of the

[26] https://www.glos.ac.uk/news/pages/the-homicide-timeline.aspx

information in a unique, but often difficult and challenging situation. They tend to feel they are unable to 'break this trust/bond' and divulge their concerns with others or with services/authorities. If they do so, this may mean the one person the victim has felt able to talk to will, in future, not be perceived as a reliable source of support or somebody they can share personal information with.

84 Victims of intimate partner violence are more likely to contact friends or family members for help and support before a formal agency. We know that Michelle had a good family support network, but she was a private person and had kept a lot of the domestic abuse issues she was experiencing with the perpetrator to herself. She rarely disclosed to them the issues she faced around domestic abuse, and collectively, all family members stated they 'didn't really know the extent of what she was going through'. Nevertheless, family did recall some potential trigger signs of abuse such as loss of weight, feelings of tiredness, stress and indications of arguments and that the relationship was breaking down. As states above, it is often difficult for those who the victim has confided in, to know how to support and protect their friend, colleague or family member, especially if the victim has spoken to them in confidence and has asked them not to share or divulge these concerns with others.

85 Professionals need to bear in mind that often these informal networks hold vital information about the level of risk to victims of intimate partner violence. There is a need for better public awareness around the dynamics of domestic abuse (including signs and symptoms of coercive control) and details of the specialist support services that are available to offer advice and guidance.

86 Sunderland is a national Change That Lasts pilot (working with Women's Aid) and has developed 'Community Ambassadors' through the 'Ask Me' project. The project has a strong focus on speaking about domestic abuse and breaking the silence about it within communities to encourage reporting. Ambassadors play a key role in signposting to specialist services – refuges, helplines and outreach services and challenging the social culture which silences women. The 'Ask Me' pilot commenced in early 2018 and would have been in its infancy at the time of Michelle's homicide; however, the premise behind the pilot will help to develop a greater understanding and awareness of domestic abuse in local communities and encourage reporting by victims and bystanders.

Key Finding 14

IOPC confirmed the assessment of risk the perpetrator posed towards Michelle was appropriate and proportionately handled by Northumbria Police.

87 Based on all the evidence available, the assessment of risk relating to Michelle from the perpetrator was appropriate in the weeks leading up to her homicide. Following the allegations made on the 7th September 2018, the perpetrator was arrested in a timely manner – which removed any immediate risk to Michelle. The DASH Risk Indicator Checklist, when initially completed, scored a rating of

'medium' risk but was immediately increased to 'high' risk on professional judgement; which afforded Michelle a greater level of safeguarding response. The IOPC concluded there was an effective investigation carried out by Northumbria Police in relation to these allegations. Historic domestic abuse in both previous relationships and within his relationship with Michelle was identified and the risk was adequately considered by Northumbria Police when responding; moreover, the proactive use of 2 x Domestic Violence Protection Orders were also considered a positive protective factor and proportionate to the risk posed by the perpetrator. Finally, the Non-Molestation Order that was served on the perpetrator may have increased the risk of harm to Michelle; however, Northumbria Police and partners were unaware of the order, and therefore could not put any extra precautions in place to safeguard Michelle from potential harm. In addition, the Police Officer who had contact with the perpetrator between the 7th and 13th September 2018 did not express any concerns about his behaviour during arrest and after his release. In terms of the perpetrator's ability to access the property, Northumbria Police had no legal basis for making him surrender his keys; and therefore, although this increased the potential risk to Michelle, there was no lawful basis to carry this out.

Key Finding 15

Agencies offering services to victims and perpetrators of domestic abuse should be in regular communication to ensure effective safety planning.

88 There is some important learning around how partner agencies can improve their interaction and engagement with solicitors in anticipation of, and following, the serving of a Non-Molestation Order. Whilst we do not want to suggest that victims should not seek Non-Molestation Orders, for fear of further abuse, we need to consider the heightened risk this legal order can place on both victims and perpetrators. It is not clear what advice, support or guidance victims are provided with by solicitors when seeking a civil order; nor are there any links or discussions with specialist domestic abuse support services, who would be able to engage with the victim and develop timely safety plans and provide suitable advice. Solicitors should check that support is in place to help prepare and support victims through this stage (and is particularly important in cases where there are no previous agency involvement).

89 We know separation is the most dangerous time for victims and the serving of a Non-Molestation Order could be seen, particularly by the perpetrator, as a significant step towards the end of the relationship. As part of the processes adopted by MATAC (Multi-Agency Tasking and Co-ordination), the local arrangements for tackling domestic abuse perpetrators, there is a multi-agency discussion to identify the most appropriate time to serve warning letters on perpetrators. The process is planned and carefully considered – minimising the potential impact and risk to victims – and ensures relevant safety plans are in place prior. A similar level of response is not routinely afforded to victims who

seek a Non-Molestation Order and is a potential gap in terms of safeguarding future victims who use this route.

90 Similarly, when perpetrators are served with the order, we also need to be able to signpost them to services for advice and to discuss their potential options. It would be prudent for the Safer Sunderland Partnership to engage local solicitors to identify, better understand and, where necessary, improve the advice, guidance and support provided to victims and perpetrators of domestic abuse – and to further encourage referrals to specialist support services.

Key Finding 16

Agencies do not routinely record the reasons why victims choose not to engage with specialist support.

91 There is no data recorded, by agencies involved in the review, that would help to routinely identify the potential reasons why victims choose to decline referrals to specialist support. There were several occasions, following a domestic abuse incident, where Michelle declined consent for a referral to VictimsFirst Northumbria and on the occasions where she did consent, Michelle did not wish to receive any additional support. We need to understand why victims of domestic abuse do not wish to take up the offer of support from specialist services to help identify any potential gaps in service and to ascertain if the services offered are aligned to need.

17 CONCLUSIONS

17.1 The main conclusions and key lessons arising from Michelle's case and agreed by the DHR Panel are:

- Michelle was a repeat victim of domestic abuse perpetrated by the perpetrator and it was clear that conflict was also an apparent feature within their relationship.
- After each domestic abuse incident, the DASH Risk Indicator Checklist was completed. The review found these were completed in a timely manner and fulfilled requirements outlined within local policies and procedures; albeit, some static risk factors were not routinely recorded.
- The assessment of risk the perpetrator posed towards Michelle was appropriate and proportionately handled by Northumbria Police.
- The use of alcohol by the perpetrator and Michelle appeared to be a contributory and consistent factor in all reported domestic abuse incidents (except for actual homicide and suicide incident).
- Leaving an abusive relationship is a particularly high-risk time for a victim, both during and after separation
- Domestic Violence Protection Orders (DVPOs) were appropriately used as protective measures to safeguard Michelle; albeit, there are opportunities for agencies to explore both how information about DVPOs is shared with partner agencies; and what additional support can be offered, during this

window, to maximise opportunities for engagement with specialist domestic abuse services.

- There was evidence to show Michelle was becoming increasingly frightened of the perpetrator and starting to feel 'worried about what he might do if he lost everything'. Despite this fear, there were times throughout their interactions with services, where Michelle did not appear supportive of prosecution (this could have been for a variety of reasons) and/or the perpetrator could be seen to blame Michelle for some of the abuse.
- The perpetrator was a domestic abuse perpetrator in previous relationships, that exhibited similar hallmarks to his treatment of Michelle, and shows how past behaviour is often a predictor of future behaviour.
- Similarly, suicide and the threat of suicide remains a significant risk factor in terms of domestic abuse and greater emphasis needs to be placed on how suicidal persons (in domestic abuse contexts) as considered as potentially homicidal.
- There was often a greater onus placed on Michelle regarding what actions she was required to undertake to safeguard herself with a lesser focus on tackling the behaviour of the perpetrator. Where victims are not ready, or feel unable, to engage with services, the risk management plan needs to shift to the perpetrator as the focus of agency action.
- Strong workplace policies are crucial to supporting and encouraging disclosure of abuse. The lack of information sharing, following a sickness absence potentially related to domestic abuse, was a potential missed opportunity.
- When Michelle did engage with services, she took all necessary steps to be able to safeguard and protect herself from further abuse. She engaged with WWiN and sought appropriate legal advice and support – including the non-molestation order.
- There were missed opportunities to utilise a better degree of professional curiosity to help identify any underpinning issues Michelle may have been experiencing in terms of domestic abuse.
- There are lessons to be learnt in the way language is used by some agencies to describe victims and their involvement with services to ensure that future victims are afforded all opportunities for services to engage with them.
- It is important for victims to feel safe and secure within their own homes. Northumbria Police had no legal basis for making the perpetrator surrender his keys to the property. Agencies need to consider how a wider suite of safeguarding measures can be put in place to help protect victims.
- There was no data collected to help examine the reasons why Michelle did not wish to take up the offer of support services – and this information would be useful to help identify potential barriers to services or gaps in services and help agencies to ascertain if their services are appropriately meeting victim needs.
- Michelle's family, friends and work colleagues were aware, to a greater or lesser extent, of the domestic abuse perpetrated by the perpetrator – but did not know the full extent and severity. There should be a greater emphasis on what advice, support and guidance is provided to bystanders as well as being able to spot signs of domestic abuse.

17.2 The Analysis provides evidence and examples to support and/or discount the questions outlined within the Terms of Reference provided in Section One (Page 6) – however, to assist the reader, and as a quick summary:

Question		Response Summary	
(a)	What were the quality of risk assessments and risk management plans in response to known incidents? Were the risks to Michelle appropriately assessed at the correct level of risk? Were static factors present in all risk assessments?	• Risk assessments and risk management plans were implemented by agencies after every reported domestic abuse incident involving Michelle and the perpetrator. • The review found these were completed in a timely manner and fulfilled all requirements outlined within their respective domestic abuse policies and procedures. • The IOPC confirmed the assessment of risk the perpetrator posed towards Michelle was appropriate and proportionately handled by Northumbria Police. • Despite some static risk factors not being routinely recorded or identified, the review found that agencies still correctly assessed Michelle's level of risk of harm and that the response provided to Michelle was proportionate. • The level of risk escalated quickly. Michelle and agencies did not necessarily expect the risk from the perpetrator to escalate at the speed at which it did.	**Links to Key Finding(s):** 1, 2, 4, 5, 8, 11, 12 and 14
(b)	Were appropriate managers, agencies and professionals involved at the appropriate points and concerns about risks escalated in a timely and appropriate manner?	• Michelle had been appropriately contacted by agencies at various points throughout the period examined; albeit, at times, we found that Michelle did not want to, or feel ready to, to engage with the services that were offered. • There were instances where concerns about Michelle's risk from the perpetrator were escalated (e.g. the response provided by Northumbria Police following the disclosure of rape, referrals to MARAC process and the protective factor granted using DVPOs etc.) • However, there was a greater onus on Michelle and what actions she was required to take to safeguard herself with a lesser focus on tackling the behaviour of the perpetrator. • There was a potential disclosure made by Michelle to her employer in January 2014 prior to a period of absence. Her employer was unable to provide any further evidence or details on the circumstances of the absence – and so we cannot determine if the concern was acted upon in a timely and appropriate manner.	**Links to Key Finding(s):** 1, 2, 4, 8, 9, 14 and 15
(c)	There was an occasion when the perpetrator called Northumbria Police and was identified as the victim of domestic abuse. Did agencies have a clear understanding of who committed the violence in the relationship and did	• It was clear that Michelle was a victim of domestic abuse perpetrated by the perpetrator. Michelle was, in all but one incident, recorded by Northumbria Police as a victim of domestic abuse. • There are examples where the language and terminology used to describe the abuse experienced by Michelle's could be open to interpretation. It could be argued some of the wording used was victim blaming and minimized the abuse that was taking place.	**Links to Key Finding(s):** 1, 2, 4, 6, 8 and 12

Question		Response Summary	
	this impact on the risk assessments and risk management plans?	• Although all agencies involved within the review understood that Michelle was a victim of domestic abuse; there were examples where a greater level of professional curiosity could have been used to elicit further information about her home life and provide her with additional opportunities to disclose to professionals.	
(d)	With specific regard to domestic abuse, did the portrayal of Michelle's alcohol use and mental health by the perpetrator affect decisions made by organisations regarding her risk of domestic abuse?	• There were occasions where the perpetrator negatively portrayed Michelle's alcohol misuse to services – and in all but one occasion, alcohol consumption was recorded as an influencing factor; albeit, there is no indication of alcohol use prior to the homicide and suicide. • There is no suggestion this influenced or affected decisions taken by agencies regarding Michelle's risk of domestic abuse.	**Links to Key Finding(s):** 1, 4, 10 and 12
(e)	Was there any evidence that Michelle was experiencing coercive control by the perpetrator and is there any evidence that this impacted on her seeking help or prevented her from contacting services?	• There are some elements of the perpetrator using coercive control in the relationship but nothing to suggest his actions impacted on Michelle's ability to seek help and/or prevented her from accessing services. There is no evidence to suggest Michelle was being isolated from her friends and family or any indication to show financial control within the relationship. • Michelle did not see herself as being controlled and is described as independent, strong-willed and resilient and was able to seek advice, guidance and support from specialist services in relation to the domestic abuse she was experiencing.	**Links to Key Finding(s):** 1, 8 and 12
(f)	Was the perpetrator's known history of violent behaviour (including but not limited to domestic violence) and use of weapons given sufficient weighting in police risk assessments?	• The initial scoping exercise identified the perpetrator held a previous conviction for possession of a firearm and as such it was rightly included as part of the Terms of Reference for further exploration. However, it was later identified the conviction was non-domestic-related and related to the perpetrator shooting a boy with an air/pellet gun aged 9 years. • There was no indication of the perpetrator having used or having access to weapons. • The perpetrator's previous criminal history, and history of violent behaviour, was not consistently identified as a static risk factor across all Risk Indicator Checklists completed for Michelle. It is important to note details of domestic abuse perpetrated by the perpetrator towards previous partners only came to light post-homicide and was not known to Police at the time. • We know that past behaviour is often a predictor of future behaviour and it is essential that we use this information to better protect victims from future abuse.	**Links to Key Finding(s):** 3 and 12

Question		Response Summary	
		• There is a history of Michelle and the perpetrator witnessing domestic abuse in their family setting.	
(g)	Were the correct referral pathways (including but not limited to MARAC) implemented in line with local policy, procedure and guidance?	• The review found the correct referral pathways were followed by agencies in line with local policy, procedure and guidelines. • Michelle was correctly referred to VictimsFirst Northumbria and to WWiN and was scheduled to be discussed in MARAC the week following her homicide. • All risk management and safety plans were found to be appropriate and the response provided to Michelle by agencies was proportionate.	**Links to Key Finding(s):** 4, 8, 9, 12 and 14
(h)	Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew Michelle was experiencing domestic abuse?	• There were some missed opportunities from agencies involved with Michelle to utilise a better degree of professional curiosity to help enquire about, challenge and elicit pertinent information to identify underpinning issues that she may have been experiencing in terms of domestic abuse. In most interactions with Michelle, professionals focused their efforts around her 'presenting need' and further enquiry could have been undertaken to consider possible indicators of abuse and the interplay between multiple presenting factors (e.g. potential injuries, depression and anxiety, alcohol use etc). • There were missed opportunities for her line manager and colleagues to enquire about and act upon domestic abuse with the perpetrator and to signpost Michelle to relevant support services. • Presenting information appears to have been accepted at face value by professionals without any evidence of them trying to clarify or confirm if said action had taken place.	**Links to Key Finding(s):** 5, 6, 8, 9 and 15
(i)	Was appropriate use made of available civil/statutory tools and powers including but not limited to: Civil Orders, Domestic Violence Protection Notices (DVPNs), Domestic Violence Protection Orders (DVPOs) and Domestic Violence Disclosure Scheme (Clare's Law)?	• Northumbria Police proactively made use of available civil and statutory tools and powers to help protect Michelle, including Domestic Violence Protection Notices/Orders. As far as we are aware, the perpetrator successfully complied with requirements of the DVPOs. • DVPOs present agencies with a window of opportunity to try and maximise engagement with victims. On the first occasion, VFN were unable to contact Michelle, and by the time they did, the DVPO had expired; and on the second occasion, Michelle did not consent to referral. • Victims who call the Police are often calling when they feel the behaviour is of greatest concern to them. The DVPO created a 'space' for Michelle (away from the perpetrator) to consider her options and it was a potential missed opportunity for agencies to intervene and support her. Consideration should be given to how partner agencies can work better	**Links to Key Finding(s):** 2, 5, 6 and 14

Question		Response Summary	
		together, during the window of separation that a DVPO provides, to help maximise our ability as a partnership to engage with and signpost victims to specialist services.	
(j)	Where services and protection planning could not be delivered due to non-engagement of Michelle, were the reasons for non-engagement explored and what efforts were made to encourage engagement?	• The rationale for Michelle declining referrals to services and/or not wanting to engaged is not routinely collected by partner agencies involved in the review. WWiN identified Michelle chose to turn down attending the Freedom Programme down due to her work commitments and caring responsibilities. Yet, we were unable to determine if this was the reason behind her previous decisions to not engage with services and therefore, we were unable to consider if these were potential barriers to Michelle.	**Links to Key Finding(s):** 4, 6 and 16
(k)	How effective was interagency working and interagency information sharing around addressing the risks that the perpetrator posed to Michelle?	• There review found minor evidence of occasions when information was not necessarily shared in a timely manner. We know information sharing, in line with the rules of consent and confidentiality, is essential to ensuring agencies have access to relevant information, at the point of contact with victim and/or perpetrator, to be able to adequately support and protect. Risk is fluid and dynamic which means that things can change very quickly and without access to timely and accurately recorded information we have the potential not to see the full scope of the domestic abuse situation. • Notification of the DVPO, along with the details of specific conditions, were not received by the CCG in a timely manner. Despite the DVPO being served, Michelle was coded as a 'victim of domestic abuse' on the GP IT systems but with no further information, and the information shared as part of a MARAC referral did not accurately reflect records. • In addition, the Non-Molestation Order was posted to Northumbria Police by Michelle's solicitor which was not received until after her homicide had occurred; and, although it may not have led to any subsequent action, access to timely information helps to build a full picture and elicits a better understanding and assessment of the risks posed by the perpetrator. • There is some important learning around how agencies can improve their interaction and engagement with solicitors and legal services in anticipation of, and following, the serving of a Non-Molestation Order.	**Links to Key Finding(s):** 4, 5, 9, 12 and 15
(l)	Michelle was a repeat victim of domestic abuse in this relationship and in previous relationship(s). The perpetrator was a repeat perpetrator of domestic abuse in this relationship and previous relationship(s). Was either Michelle	• WWiN provided Michelle with an array of options. She was provided with safety planning advice, offered support in relation to refuge accommodation and access to the Freedom Programme, offered telephone support on a fortnightly basis and support through the Court process (if, and when, the case progressed to the Criminal Court) and/or through the Civil route if the Injunction was contested.	**Links to Key Finding(s):** 4, 6, 8 and 11

Question		Response Summary	
	and/or the perpetrator offered any form of assistance or intervention to address domestic abuse (including programmes for perpetrators or victims?). If so, what were the outcomes?	• There continued to be an overreliance on Michelle having to engage with services with a lesser focus on addressing the perpetrator's behaviour. Efforts should aim to take robust engagement and intervention with domestic abuse perpetrators to reduce risk and harm to the victim; and, more importantly, to help shift the focus towards holding perpetrators to account (but in a way that does not escalate the potential for further risk to the victim). • There is no evidence the perpetrator was considered for or offered a voluntary Domestic Abuse Perpetrator Programme. Although attendance at such programmes cannot necessarily be mandated, efforts could have potentially been made to engage the perpetrator (particularly during window of separation afforded by the DVPO).	
(m)	Did either Michelle or the perpetrator's workplace have any cause for concern that Michelle may be at risk from domestic abuse by her husband?	• There was a potential disclosure made by Michelle to her previous employer in January 2014 prior to a period of absence. The employer did have a Domestic Abuse Workplace Policy in place at the time; however, they were unable to provide any further evidence or details on the circumstances of the absence – and so we cannot determine if the concern was acted upon. • Michelle's most recent employer, who she had started working for in the months prior to her homicide, did not have a formal Domestic Abuse Workplace Policy in place. There were no disclosures from Michelle to her line management, whilst she was at work; however, there is evidence that she did informally discuss some aspects of the perpetrator's behaviour with her peers, but conversations did not necessarily raise any significant concerns with her colleagues for them to warrant seeking advice from management. The organisation has since implemented a Domestic Abuse Policy.	**Links to Key Finding(s):** 7
(n)	Did family, friends, neighbours and work colleagues have any cause for concern Michelle may be at risk from domestic abuse? If so, were they aware of support services and how to seek advice and support?	• Both Michelle and the perpetrator were described as quite private persons; and although their family, friends, work colleagues and neighbours had become aware that issues were manifesting in the relationship, they did not recognise the behaviour as domestic abuse; nor did they know the true extent of issues Michelle was experiencing.	**Links to Key Finding(s):** 13

18 RECOMMENDATIONS

18.1 Based on the chronology, analysis and conclusions of the Overview Report, the DHR Panel agreed the following recommendations for national, regional and local bodies to help prevent similar incidents from happening again in the future:

(1) Northumbria Police to ensure consistent and timely sharing of DVPO information to key partner agencies so as to maximise partnership opportunities to enhance victim engagement and safety.

(2) Safer Sunderland Partnership to engage with local solicitors to identify, better understand and, where necessary, improve the advice, guidance and support they provide to victims of domestic abuse.

(3) Safer Sunderland Partnership to encourage local public and private sector organisations to review and implement a refreshed Domestic Abuse Workplace Policy

(4) Safer Sunderland Partnership to commission training sessions to ensure staff with management responsibilities are equipped with the necessary advice and skills to confidently support employees when faced with a disclosure of domestic abuse

(5) Safer Sunderland Partnership to re-introduce a targeted Sanctuary Scheme that consists of home security measures and outreach support.

(6) Agencies should look to implement mechanisms to routinely capture and share information on why victims decline access to support services

(7) Safer Sunderland Partnership to raise awareness of the impact of destructive and victim blaming language when responding to domestic abuse.

(8)	Safer Sunderland Partnership to raise awareness of the signs of domestic abuse; encourage bystanders to report domestic abuse; and promote where to seek advice and support.

(9)	Safer Sunderland Partnership to explore options for earlier intervention with perpetrators of domestic abuse

(10)	Safer Sunderland Partnership to widely disseminate key learning and themes emanating from this Review to promote awareness that the prevention of domestic abuse is 'everybody's business'.

(11)	Safer Sunderland Partnership to write to the Ministry of Justice, the Law Society and the Bar Council requesting they flag to solicitors across England and Wales that separation from an abusive partner can also lead to an increased risk to victims

(12)	Safer Sunderland Partnership to write to the Home Office and the College of Policing to request improvements are made to the Domestic Abuse, Stalking and Honour-based abuse (DASH) risk indicator checklist (RIC)

Individual Partner Agency Recommendations

18.2 The following recommendations have been made by partner agencies involved in the DHR Panel – as part of their respective IMRs:

Wearside Women in Need

- To explore with Northumbria Police the possibility of future domestic abuse referrals including perpetrator risk indicator measures (to help pre-populate Risk Indicator Checklist and offer greater understanding of a perpetrator's propensity to violence);

Sunderland Clinical Commissioning Group

- To recommend that GPs ensure that patients with complex medical health issues are offered face-to-face appointments.
- To ensure the learning from this review is highlighted to those leading digital transformation across primary care.
- To promote and monitor implementation of best practice in prescribing management in relation to anti-depressants.
- To ensure there is a robust process within CCG for management of DVPOs.
- To ensure the GP practice has a robust process for coding patients when they are informed of a DVPO.
- To ensure that enough information is provided to health staff on MARAC templates so that the context of domestic abuse is understood.
- To incorporate the learning from this review into the Domestic Abuse Health Advocates Pilot in Primary Care.
- To ensure that the high-level information from the review is shared with all Sunderland GPs and Practice staff.

Sunderland Care and Support Ltd

- To raise awareness of domestic abuse within the company and to promote and ensure that support is provided to victims of domestic abuse
- To remind all managers of their responsibilities when a member of staff is reporting an absence and ensure full details are passed to the line manager.
- Ensure managers are skilled and equipped to provide guidance and advice to victims of domestic abuse.
- Ensure domestic abuse is included as part of the company's safeguarding refresher training for its employees (with specific reference to the company's own Domestic Abuse Workplace Policy).
- To actively promote and implement a Domestic Abuse Champions Scheme

VictimsFirst Northumbria

- To refresh procedures to ensure Risk Indicator Checklists are completed by Case Coordinators with victims of domestic abuse for all future referrals.
- To ensure perpetrators history is reviewed by the Case Coordinator as part of future domestic abuse referrals.
- To update the Victim Needs Assessment to include a reason/rationale for a victim declining support/referral.

Northumbria Police

- Static Risk Factors: To consider how static risk factors are identified by officers where present in a relationship and that this specific identified risk factor remains as a constant in all future RIC and risk assessment work.
- Coercive Control: To continue to improve awareness and understanding of Coercive Control which has a serious impact on the victim as well as being a likely underlying factor of domestic abuse incidents and investigations.
- Bail: To ensure all officers investigating domestic abuse related rape investigations where the suspect is arrested, consider an application for bail with conditions rather than release under investigation (RUI) and decision making is fully documented. If this is not granted, further consideration of a DVPN/O should be given if criteria is met.

GLOSSARY

AAFDA	Advocacy After Fatal Domestic Abuse
CCTV	Closed Circuit Television
CHS/STFT	City Hospital Sunderland/South Tyneside Foundation Trust
CPS	Crown Prosecution Service
CSB	Community Safety Board
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour-Based Abuse
DHR	Domestic Homicide Review
DHR Panel	Domestic Homicide Review Panel
DV	Domestic Violence
DVN	Domestic Violence Notification
DVPN/O	Domestic Violence Protection Notice/Order
FWIN	Forcewide Incident Number
GP	General Practitioner
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Review
IOPC	Independent Office for Police Conduct
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MIU	Minor Injuries Unit
NFA	No Further Action
NPS	National Probation Service
NPT	Neighbourhood Policing Team
PCC	Police and Crime Commissioner
PPIT	Priority Perpetrator Identification Tool
RIC	Risk Indicator Checklist
SCAS	Sunderland Care and Support Limited
SCCG	Sunderland Clinical Commissioning Group
SSP	Safer Sunderland Partnership
THRIVE	Threat, Harm, Risk, Investigation, Vulnerability and Engagement
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
VAWG	Violence Against Women and Girls
VFN	VictimsFirst Northumbria
WWiN	Wearside Women in Need

Domestic Homicide Review – Michelle

Safer Sunderland Partnership

April 2020

https://www.sunderland.gov.uk/domestic-violence