HARTLEPOOL BOROUGH COUNCIL

DOMESTIC VIOLENCE HOMICIDE REVIEW

OVERVIEW REPORT

Death of Annie

Report produced by David Pickard
on behalf of the Safer Hartlepool Partnership

Completed June 2019

Tribute to Annie from her family

Annie was a beautiful young mother of three wonderful children; it is so unfair and unjust that they will grow up without her support, love and guidance. She will not see their birthdays; she will never see them graduate or attend their weddings. She will never get to hold her grandchildren in her arms or shower them with love. She will just miss so much of their lives, we're sure her children will have been her final thoughts.

The children love and miss her dearly, they happily recall fond memories of making crafts at home and playing with mammy in the park, listening to her sing along to her favourite songs and smelling her favourite bath bombs and scented oils. They miss the one on one outings they used to have with her, real alone time and cuddling up on the couch watching movies in their pyjamas on rainy days.

Annie was and is loved so much by all of us and will continue to be remembered by her playful giggly laugh that she always had.

Annie was fun to be around, she was light-hearted, like to laugh a lot and was always smiling regardless of what was happening in her life. We often look back on funny memories and focus on remembering the good times, she always injected some funny drawings into Pictionary sessions, was a master crafter, very chatty and loved listening to music.

Annie had been controlled, coerced and manipulated for years, by her partner, a brute, evil domestic abuser. He controlled every aspect of her life, from who she spoke with, to how she parented and even how she dressed. He had worn her confidence and resistance down over time, but in the last few months of her life, we had the old Annie back, the Annie that was full of life, vibrant, funny and confident, such a beautiful person inside and out. The Annie that we all knew and loved.

We feel so blessed that we had the time we did with her, but also robbed that we have not had longer. She was so young when she was murdered, she had her whole life ahead of her, so many dreams and things she wanted to achieve. She had received her provisional licence and wanted to learn to drive, she was going to yoga, making new friends and reconnecting with family, she dreamed of holidaying with her children and making new memories. She was so determined to rebuild her life after what she has been through and she should have gotten the chance to live it to the full.

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1. Introduction

1.1 The key purpose for undertaking Domestic Homicide Reviews (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 This Domestic Homicide Review (DHR), commissioned by Safer Hartlepool Partnership, examines the circumstances surrounding the death of Annie, a 29 year old mother of three young children. Annie was stabbed to death in Hartlepool in August 2018 by her ex-long term partner, the perpetrator who was the father of the three children. The perpetrator pleaded guilty to her murder in January 2019 and was sentenced to life imprisonment and ordered to serve a minimum term of 29 years on 6th February 2019. This report examines the contact and involvement that professionals and agencies had with Annie and her ex-partner between January 2013 and the time of Annie's death.

1.3 It should be noted that pseudonyms are used throughout this report complying with guidance produced by the Home Office.

1.4 The review has been led and authored by an Independent Chair who has no association with the professionals or organisations concerned. He is a retired Assistant Chief Constable who Chair's the Hartlepool and Stockton on Tees Safeguarding Children Partnership. Whilst the Independent Chair/Author was not experienced in carrying out Domestic Homicide Reviews, he was experienced in leading on a number of high level criminal investigations during 30 years' service within Durham and Cleveland Police. On retiring from Cleveland Police in 2014 he undertook the role of Independent Chair of two local Safeguarding Children Boards and oversaw a number of complex serious case reviews. The majority of the panel members had no direct involvement in this tragic case, however as is the case in small geographical areas a number had had some involvement from a management perspective i.e. Director of Children's services. The Police representative had overseen an investigation relating to the injury of one of the children some months after the event in the role as DI of the Unit, no charges were made and everyone exercised independence throughout.

1.5 The Independent Chair and Review Panel express deepest and heartfelt condolences to Annie's family and friends for their loss. Only they can truly comprehend the pain and distress caused by Annie's death. We have endeavoured to give Annie and her family a voice in this review and capture the richest learning possible from this dreadful tragedy.

1.6 The Independent Chair would like to thank the Review Panel for their dedication, time commitment and thoughtful consideration for this review. There was a clear desire to identify any learning and ensure appropriate

change.

1.7 The Independent Chair would also like to thank frontline professionals from a range of organisations and agencies who have cooperated and assisted with the review as well as those staff who supported the review from an administrative perspective.

2. Time-scales

2.1 Safer Hartlepool Partnership were formally notified of Annie's death on 8th August 2018. The domestic homicide scoping panel reviewed the circumstances of the case on 14th August 2018 against the criteria set out in the multi-agency statutory guidance for conducting a DHR and recommended that a DHR should be undertaken. The chair of the Safer Hartlepool Partnership ratified the decision to commission a DHR and the Home Office were informed of this outcome.

2.2 The Home Office Statutory Guidance advises that where practicable a DHR should be completed within 6 months of the decision made to proceed with the Review. There was a slight delay to the publication of the report due to working alongside a Mental Health Homicide Review (MHHR) which had been commissioned later than the DHR.

2.3 The DHR was concluded June 2019.

3. Confidentiality

3.1 The findings of this review remained confidential and were only available to participating professionals, their line managers, Annie's immediate family and members of the Domestic Homicide Review Panel until the report was approved for publication by the Home Office Quality Assurance Group.

4. Dissemination

4.1 The organisations contributing to the review (listed in 10.1) have received copies of this report for learning within their organisations. In addition, copies of the review will be sent to:

- Teeswide Safeguarding Adults Board
- Hartlepool Health and Wellbeing Board
- Cleveland Police and Crime Commissioner
- Hartlepool & Stockton-on Tees Safeguarding Children Partnership
- NHS England North Region

5. The Review Process

5.1 The review process follows the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews (as amended in December 2016). Domestic Homicide Reviews (DHRs) came into force on 13th April 2011.

5.2 DHRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be 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 person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;
- A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death.

5.3 The purpose of a DHR and the Review Panel is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies; how and within what time scales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses, including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future; to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. Scope of the review

6.1 The review places a particular focus on the period from 1st January 2013 to the date of Annie's death on 3rd August 2018. That is not to say that earlier information is not included where this might provide important context for the review.

6.2 The Review Panel agreed the following Terms of Reference:

i) To establish the history of the victim and perpetrator's relationship and provide a chronology of relevant agency contact with them, the children of the family, and the parents of the victim and perpetrator. The time period to be examined in detail is 1st January 2013 to 3rd August 2018. Agencies with knowledge of the victim and perpetrator in the years preceding this timescale are to provide a brief summary of that involvement. Any interaction with family members or friends which has relevance to the scope of this review should also be included.

ii) To examine whether there were signs or behaviours exhibited by the perpetrator in his contact with services which could have indicated he was

a risk to the victim or others.

iii) Where any mental health diagnosis was made in relation to the perpetrator, did this influence the response to any domestic abuse or risk issues; the decision making in addressing wider complex family issues; or the making of referrals to other support services

iv) Agencies reporting involvement with the victim and the perpetrator to assess whether the services provided offered appropriate interventions and resources, including communication materials. Assessment should include analysis of any organisational and/or frontline practice level factors impacted upon service delivery, and the effectiveness of single and inter-agency communication and information sharing both verbal and written. Did full and relevant information sharing take place? Was there evidence of a multi-agency and coordinated approach to assessment and management of risk? If not, why did this not occur and what were the implications of this as regards effective management of the case?

v) Did any agency hold any information provided by broader family networks or informal networks? Was this information responded to and acted upon appropriately?

vi) Was your agency aware of any influence from social networking or web-based sites which may have/did impact on the behaviour of the perpetrator?

vii) To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

viii) To examine the level of domestic abuse training undertaken by staff who had contact with the victim and/or the alleged perpetrator, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC), and to appropriate specialist domestic abuse services.

ix) To determine if there were any barriers which may have affected the victim's ability to disclose abuse or to seeking advice and support.

x) In liaison with the Advocacy After Fatal Domestic Abuse advocate the Chair to contact family, friends, and colleagues to invite their contributions to the Review and, whilst acknowledging the pitfalls of hindsight, seek their views as to whether anything needs to change to reduce the risk of similar events in future.

7. Methodology

7.1 This review is guided by:-

- The processes outlined in the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- Learning from other Domestic Homicides Reviews

8. Research

8.1 This report emanates from information gathered from sources detailed within the Appendices and also includes research references.

8.2 Issues around equality and diversity were considered and these are reflected (where relevant) throughout the review with particular focus on age, race, gender and religion. Individual Management Reviews (IMRs) or summary reports were sought from all agencies, organisations or departments that had any recent involvement with Annie, her children and her ex-partner. The agencies involved were asked also to consider any relevant information before the period under review that might have had an impact on the case.

8.3 The IMR authors were provided with and followed the IMR template from the Home Office guidance as well as a checklist of what makes a good quality IMR. There was also a presentation delivered on the overarching process for the DHR.

8.4 The review has kept to the prescribed DHR Home Office process but also aligned to a MHHR which was conducted using a different approach and methodology. However, the integrity of the analysis for the purpose of the DHR has been maintained.

9. Family Involvement and contact with the Perpetrator

9.1 Information from the families was gathered after a careful introduction to Annie's mother and sister, explaining the process and encouraging them to participate. Regard was given to the very helpful advice and guidance contained in the Advocacy after Fatal Domestic Abuse and Home Office leaflet for families and this was provided to further aid the family's understanding of a DHR and inform them of support available to them.

9.2 In this review the Chair maintained an on-going dialogue with the family and also with those supporting them. The frequent contact with the family was greatly assisted by the advocate from the charity Advocacy after Fatal Domestic Abuse who regularly visited the family with the DHR chair. Her support to the family and the Chair was commendable and therefore also to the outcomes of this DHR.

9.3 The father of the perpetrator was approached to contribute to the DHR but declined to do so.

9.4 Family perspectives, experiences and input are conveyed throughout the report.

9.5 The DHR Chair and Review Panel would like to thank the family for their time and thoughtful approach in assisting this review. Their input has been invaluable.

9.6 The family had the following specific thoughts on some of the contents of this report:

- They were frustrated over the way the Potentially Dangerous Person (PDP) referral for the perpetrator had been managed by Cleveland Police and felt that this was a significant missed opportunity to help Annie.

- They struggled to understand how staff within the Tees Esk and Wear Valleys NHS Foundation Trust (TEVW) could identify the perpetrator as potentially posing a threat to their lone female workers, but this risk was not identified in relation to any other woman.

- In addition, the perpetrator had reported a background of domestic violence, a history of cruelty to animals, children and attempts to cause harm to others to the TEWV workers. The family were concerned that these disclosures did not seem to prompt those staff to consider any risk to Annie.

- They believed that the perpetrator had controlled and been abusive to Annie throughout their relationship and that he could not handle Annie moving on with her life.

- A sense of disappointment with how the police carried out the investigation into the injury caused to Annie's youngest child. The family fully understood the reasons why Annie was also investigated over this matter but felt there was no attempt to understand the domestic abuse Annie was suffering from the perpetrator. This was despite the fact the police were informed by a close family member the previous day that historical domestic abuse existed in their relationship and had previously reported domestic abuse incident. Following this, there was no follow up with the reported controlling and coercive behaviour from the perpetrator, him instructing Annie to destroy emails and texts from him to her so the police could not discover them.

- The family felt that when the youngest child was injured, something was going to happen to the perpetrator, a consequence, even if he wasn't imprisoned, a caution, at least a review into him as a person, and a flag for domestic abuse, they believed the investigation dragged on too long. Although the focus was on the children, and rightly so, two months passed between that critical incident and contact made

with Annie for help. By this time, the family felt the perpetrator would have plenty of opportunities to coerce, manipulate and threaten Annie into saying she was fine and safe.

- Family members appreciated, as much as Annie did not disclose directly to a service that she felt in danger of her life, she did disclose this to friends and carried a personal alarm. They believe more training needs to be done to understand why someone in Annie's situation would not openly disclose that she felt she was in danger to the services she has involvement with. They firmly believe the reason for Annie not disclosing was the fear of not getting her children back and feel there needs to be a better understanding of how the removal of children from the home impacts a parent and especially a parent suffering or recovering from domestic abuse.

- They also appreciated the highlighted good practice and actions that were taken to help Annie and the children, they thank those services for their professionalism and care.

- The family's involvement in the review process has been hard and emotional but they did it to help and prevent something so horrendously tragic from happening again to another family. They urge all the agencies to please take these recommendations seriously and act on them.

Contact with the Perpetrator

9.7 The perpetrator was offered the opportunity to contribute to this DHR and agreed to be seen by both the Independent Chair and a representative from Sancus Solutions on behalf of the MHHR (see 11.1)

9.8 He was interviewed in prison not long into his life sentence. The primary purpose of this interview was to establish if he believed any agency working with him could have made a positive intervention to prevent him from killing Annie.

9.9 He identified a number of issues that adversely affected his relationship with Annie and his own perceived well-being:
- The impact of having their children removed
- His feeling of receiving limited support from mental health practitioners, and
- The side effects of the medication he was taking for his restless leg condition.

9.10 When their children were taken into care in May 2017, he acknowledged that this was a trigger for a significant deterioration in his mental health and subsequently additional pressure on his relationship with Annie. He believed that the social worker in the case was making him out to be a 'monster' and did not genuinely work with either him or Annie to help them improve their

parenting skills to get the family back together. He believed the social worker had a fixed agenda to get his children adopted. He felt the length of time that he was under police investigation also added to his stress. It was of note that he did not acknowledge or talk about the reasons why the children had been taken into care or his referral from the social worker to Harbour. Harbour works with families and individuals who are affected by abuse from a partner, former partner or other family member.

9.11 He believed that he received little support from the Crisis [1]and ADHD[2] (Attention Deficit Hyperactivity Disorder) teams at TEVW. He talked about deep seated mental health issues from childhood and his belief of a family history of mental health. He shared that he had sought help in 2012 over his mental health and spend some time at a TEVW facility in Victoria Road, Hartlepool which he said was a terrible experience, but would not be drawn on why. He indicated that these early issues were never explored or investigated by mental health practitioners to truly understand him. He was more complimentary over the engagement with the Affective Disorders Team at TEVW, but this was largely about his belief of a positive relationship with one female worker. He did acknowledge that he was never truly open and honest with staff that engaged with him citing he found it hard to trust them and that he believed being honest would work against access to and a possible return of the children. He described his numerous self-harming episodes as a vicious circle as he couldn't be honest about what was in his head due to the indicated trust and access to his children issues. He indicated that when he was taken to a place of safety for assessment (Roseberry Park) under S136 of the Mental Health Act in August 2017 he believed he should have been 'kept in' and not discharged the next day, but again acknowledged he was not truthful and open with staff with regard to his feelings. When asked why he had failed to attend a number of appointments with the TEVW teams working with him and Hartlepool & East Durham Mind he again indicated that it was due to difficulties with trust and an inability to open up.

9.12 He talked at length about the side effects of the drug Ropinirole he was taking for his restless legs namely his belief that it caused him additional anxiety, restlessness and a tendency to impulsive behaviour. He stated that the side effects were under-estimated by the 'NHS' and better understood in America. He alluded to the fact that this could have been a contributor to the killing but stopped short of directly saying so. He was vague that a review had been requested into his medication in November 2017 stating that there was no alternative treatment available.

9.13 He indicated that it was him not Annie that had moved on with his life from

[1] The Crisis Management Team (CMT) provides support through management of crisis level issues, managing additional risks, exposures and stakeholder interests in response to an event or disaster requiring the activation of the CMT.

[2]Attention Deficit Hyperactivity Disorder is a medical condition. A person with ADHD has differences in brain development and brain activity that affect attention, the ability to sit still, and self-control.

January 2018 and that she was the one trying to maintain a relationship to increase the chance of getting the children back. He said Annie would often arrive uninvited at his flat up to a month before the murder, particularly if she believed he had female company there. He also added that both of them would tell agencies what they wanted to hear and played the 'game' to improve the chance of the children being returned.

9.14 He never gave the impression that he took responsibility for killing Annie and avoided that conversation at all times. He would not engage in a discussion over their domestic abuse history or of his coercion and control of Annie. There were some aspects of remorse shown but the over whelming impression gained was of an individual that had not taken responsibility for his actions and was seeking to place blame elsewhere.

10. Domestic Homicide Review Panel

10.1 The members of the Review Panel are set out below:

Dave Pickard	Independent Chair	
Denise McGuckin	Director of Regeneration and Neighbourhoods	Hartlepool Borough Council
Karen Agar	Associate Director of Nursing (Safeguarding)	Tees Esk Wear Valley NHS Foundation Trust
Sally Robinson	Director of Children's and Joint Commissioning Services	Hartlepool Borough Council
Lindsay Robertson	Head of Quality and Adult Safeguarding	Hartlepool & Stockton on Tees Clinical Commissioning Group
Jill Harrison	Director of Adult and Community Based Services	Hartlepool Borough Council
Mark Haworth	Detective Inspector	Cleveland Police
Lesley Gibson	Chief Executive	Harbour
Lindsey Robertson	Deputy Director of Nursing, Patient Safety and Quality	North Tees and Hartlepool NHS Foundation Trust
Rachel Parker	Community Safety Team Leader	Hartlepool Borough Council
Gaynor Goad	Manager	Hartlepool and East Durham Mind
Ann Powell	Director	National Probation Service
Kay Glew	Director of Neighbourhoods	Thirteen
Jean Golightly	Director of Nursing and Quality	Hartlepool & Stockton on Tees Clinical Commissioning Group

10.2 The Review Panel consisted both of agencies that had involvement with Annie and the perpetrator and also those who had wider knowledge of working in the field of domestic abuse and had specific responsibilities around this. Chronologies and Individual Management Reviews (IMR's) were provided

from all of the above agencies and additionally from Hartlepool Borough Council Drug and Alcohol Service.

10.3 The chronologies were shared, and an integrated chronology produced. It is from this integrated chronology that the key events timeline in this report emanates.

10.4 The IMR's were produced as requested and the Chair and Review Panel wish to thank the authors for these and for attending the Panel meetings to present the IMR's and answer questions from the panel. On request some authors produced further information to sit behind the IMR's and to clarify where necessary.

11. Parallel Process

11.1 A Mental Health Homicide Review (MHHR) was commissioned by NHS England (North) in December 2018 as the perpetrator had been in receipt of mental health care within six months of when he murdered Annie. There has been close communication and co-operation between the DHR Panel, the Independent Chair and NHS England (North), including the lead investigator from Sancus Solutions, appointed by NHS England (North) to undertake the MHHR. The terms of reference for the MHHR were shared with the DHR Panel and subsequently amended to ensure improved co-ordination between the two reviews. It has proved difficult to ensure complete co-ordination due to the differing purposes, methodology and time scales of each review. The primary focus of the MHHR is on the effectiveness of the mental health care received by the perpetrator, the subsequent management of risk and the prescription of medication. Elements of this are commented on within this report, informed by the respective organisations IMR's however the MHHR will explore this in greater detail.

12. Facts

12.1 On the evening of 3rd August 2018 Annie was attacked in a street in Hartlepool by the perpetrator using a knife. A forensic post mortem was conducted which concluded that Annie had died as a result of receiving multiple stab wounds. During the course of the investigation, the perpetrator was arrested and charged with Annie's murder. He pleaded guilty to her killing in January 2019. He was sentenced to life imprisonment and ordered to serve a minimum term of 29 years. A female co-defendant was also charged with Annie's murder. She was subsequently found guilty of manslaughter. Her contact with Annie has been examined by all agencies as part of this DHR and it was found that her actions fell outside the scope of this review. She therefore does not feature in this report.

13. Background Information

13.1 Annie was born in 1989. She was 29 years old at the time of her killing by the perpetrator. The relationship with the perpetrator began in 2006 and a year later had their first child. Although outside of the time frame of this DHR in 2007 Children's Services were involved in supporting the family and reference is made to a suspected violent relationship between the perpetrator and Annie. This domestic abuse was never disclosed or formally reported to any agency by Annie, however Annie's family, were firmly of the belief that the perpetrator was both physically assaulting and controlling Annie following the birth of their first child. It is the view of the family that Annie was protecting the perpetrator despite this abuse. Children's Services closed their case in 2008 as Annie had fully engaged with the support received although the perpetrator's engagement was more limited.

13.2 Annie and the perpetrator had a second child in 2010. There were no reported concerns by any agencies although Annie's family continued to believe that the perpetrator was still abusive towards Annie. He would attempt to control her behaviour and to limit contact with her family.

13.3 In January 2012 Annie reported a domestic abuse incident to the police. She had found evidence that the perpetrator had been contacting other women online and when she challenged him on this, he grabbed her with both hands and dragged her out of the house, by her hair in front of their children. The perpetrator was arrested and received a caution for the offence of common assault. A risk assessment was conducted which resulted in a standard risk and the children were seen and spoken to. This was the first and only incident of domestic abuse that Annie formally reported to the police.

13.4 Two days after this incident the perpetrator contacted the police stating he had slit his wrists. He was taken to hospital by ambulance and treated for superficial injuries. This was the first of a number of self-harming incidents by the perpetrator carried out in the following years.

13.5 Within the timeframe of this review, the first contact with Children's Services was in December 2013 when a referral was received requesting a social care assessment of the family due to concerns that the perpetrator was abusing the children emotionally. A core assessment was completed which commenced a period of statutory involvement with the family with services being provided to the children and their parents under section 17 of the Children Act, 1989. The assessment identified positive factors including the engagement of both parents with the assessment, the positive wider family support available to the children and support to the children in school. In terms of risk factors, the assessment identified issues relating to the parents unstable relationship, suspected historical domestic abuse including current controlling behaviour of the perpetrator towards Annie, unmet mental health needs in relation to the perpetrator and concerns about the development, progress and behaviour of one of the children in school.

13.6 Over the following 16 months, the case remained active to children's social care whilst a programme of support was provided to tackle the risk factors identified in the assessment. These interventions included parenting and

relationship sessions with both parents, regular home visits and contact with the children, Child in Need review meetings involving professionals working with the children and/or their parents and referrals for specialist support services identified as needed to meet the parent's needs. This included a referral for Annie to Harbour's Freedom Programme in accordance with the plan to address the risk factors related to domestic abuse. Following this referral, the records indicate that Annie completed the Freedom Programme offered by Harbour. At the same time as the referral was made for Annie, a corresponding referral to the Harbour perpetrator programme was discussed with the perpetrator, however he declined this referral. He was subsequently referred to MIND to access support services regarding his own mental health. An appointment was offered by MIND but the perpetrator did not attend this.

13.7 In February 2014 the perpetrator was referred to the TEWV single point of access for an assessment of symptoms of hyper-sexuality and mood swings. He was offered two appointments which he failed to attend.

13.8 In April of 2014 the perpetrator informed the social worker he would agree to a referral to the Harbour perpetrator programme and this was made within two days of the discussion. Records indicate the perpetrator was offered two appointments by Harbour but did not attend these and therefore, the case was closed by Harbour.

13.9 On 3 July 2014, Annie attended the social work offices to discuss her relationship with the perpetrator, she stated he had 'split up from her' but they were still living in the same property and she felt she was being manipulated by him, including him making threats of self-harm if she were to leave him. The social worker discussed a number of options open to Annie, however she declined referrals to these services. Annie expressed the view that she wanted to 'stop feeling scared of him', but it would appear felt powerless as to what she could do the address this. It is not known why Annie felt powerless in her relationship with the perpetrator. Annie was a private person and did not disclose details of her relationship to friends or family. However, the interaction with social care and the support she received enabled her to separate from the perpetrator.

13.10 The day after this office visit, on 4 July 2014, a safeguarding strategy meeting was held in response to an allegation by Annie's oldest child that the perpetrator had hit the child and there was bruising to the shoulder. This incident was a precipitator for Annie to inform the social worker that she wanted to leave the perpetrator and she was supported to move to her mother's home. The social worker made arrangements to support Annie to secure appropriate alternative accommodation for herself and the children, she was offered three properties but declined these advising she only wanted to move once to provide stability for her children. During this work, Annie disclosed to her social worker that she was being harassed by the perpetrator who was sending her up to 30 text messages a day. The social worker provided advice on what Annie could do to tackle this and agreed to refer Annie to the Harbour Outreach Service which she completed on 9 July 2014. Annie was offered two appointments by Harbour for one to one support but

did not attend either of the appointments made.

13.11 With regard to the outcome of the child protection investigation, an interview was undertaken with the child and the injury was medically examined. During interview the child said that his sister had bitten him causing the injury. The conclusion of the medical examination was that a child's bite could not be ruled out and therefore the allegation was not substantiated. A reconvened strategy meeting was held on 14 July 2014 which concluded that the children had suffered significant harm in terms of their emotional welfare due to the parental relationship, however, this risk was reduced due to the actions of Annie taking the children to reside with her at her mother's home. The consensus view of the meeting was that whilst Annie remained separated from the perpetrator, the risks were manageable and that there was no need to progress to an Initial Child Protection Conference. It was however, agreed that should Annie return to the relationship then a further strategy meeting should be convened.

13.12 The records indicate that the following six months were quite a settled period for Annie and her children. Annie secured her own property later in July 2014 and she remained at this address until her death. Annie and her children continued to receive support and services from children's services in accordance with the plan, with a focus on supporting Annie's parenting, routines and boundary setting with the children.

13.13 Between July and October 2014, the perpetrator sought advice from the social worker regarding his own needs in relation to mental health and accommodation. At his request he was re-referred to the perpetrator programme but failed to attend two appointments offered by the service. This was the third attempt to refer the perpetrator to the perpetrator programme.

13.14 In July 2014 the perpetrator came into contact with TEWV mental health services after he was referred to the Crisis Team due to experiencing suicidal thoughts and relationship difficulties. On 30th July 2014 this led to a referral from TEWV to both the police and children's services that the perpetrator had advised his worker he had access to a shotgun. Annie's social worker contacted Annie to ensure she was aware of this information. The police investigated this allegation and found no evidence of the perpetrator having access to a shotgun. He indicated it was a throw away comment to the member of staff from TEWV.

13.15 On 10 May 2015 a home visit was undertaken to Annie by the social worker to inform her of the department's intention to step the case down to preventative services as the plan had been delivered and the children were no longer considered to be in need of statutory services. At this appointment, Annie informed the social worker that she and the perpetrator had resumed their relationship, she expressed the view that he had changed since he had started working and they were very happy. This information should have prompted a further strategy meeting with regard to any safeguarding implications for the children. They had been separated for just over a year with the perpetrator residing at a number of addresses.

13.16 In 2015/2016 the perpetrator had contact with the TEWV Crisis Team and received some short term support. He was offered a joint assessment by the Single Point of Access Team and the ADHD Team after being referred by his General Practitioner (GP) following the perpetrator requesting an assessment for ADHD. The perpetrator was offered an appointment in January 2016 but failed to attend and the referral was closed.

13.17 On 19 May 2015 the case was closed to social care and became active to early help services. In January 2016 Annie gave birth to their third child. The family continued to receive early help support with evidence of regular team around the child meetings held to discuss the progress and wellbeing of the children. The case was closed to preventative services in July 2016 following satisfactory progress in the care and development of the children.

13.18 For the following year there was no relevant contact from any agency with either Annie or the perpetrator, although the perpetrator had five GP appointments and Annie had nine GP appointments.

Timeline

Below is a time-line of significant events leading up to the murder of Annie from July 2017. It does not cover all contact with agencies such as visits to the GP, which are included in a combined chronology, only those of relevance to this DHR.

Table 14.1 – Key Event 1

Key Event 1	
15/5/17	Annie attended the Urgent Care Centre in Hartlepool with her youngest child who had sustained a puncture wound to the face. They were referred to James Cook University Hospital in Middlesbrough where the child was admitted. Annie indicated that the injury was caused when the perpetrator accidently discharged an air rifle and a foreign body ricocheted from the kitchen floor hitting the child in the face. The remaining children were placed with family members under safeguarding arrangements for neglect and the perpetrator was arrested by the police on suspicion of assault on the youngest child. During the investigation the police spoke to Annie's brother who provided a statement to police detailing prolonged emotional and physical domestic abuse by the perpetrator on Annie.
16/5/17	Annie was investigated by the police over concerns that she had misled them about the events surrounding the injury to her child. No further action was taken on this matter. The perpetrator released from custody pending further police enquiries. Not to return to home address and temporary accommodation found.
17/5/17	Safeguarding Strategy meeting held with regard to all three children. To remain with family members pending further enquiries and assessment. Conversations to take place with Annie and the perpetrator regarding the potential of the children being taken into care.
27/5/17	Anonymous phone call to the police stating that the perpetrator had been instructing Annie to destroy emails and texts containing information that they are lying to the police. No record of this information being followed up or any work being completed in relation to forensic examination of devices.
9/6/17	Brother of Annie reported to the police that the perpetrator had turned up at Annie's mothers address extremely drunk and angry. The three children were present at the house. Whilst on the phone to the police the perpetrator moved away from the address.

14/6/17	All three children were taken into the care of Hartlepool Borough Council and were placed in foster care.
3/7/17	The perpetrator referred by the family social worker to Harbour for inclusion in the Perpetrator Programme. The rationale for the referral included a history of long-standing domestic abuse within the perpetrator and Annie's relationship and both admit that the perpetrator is very controlling and manipulative. There have been concerns that the perpetrator is emotionally abusive towards Annie and the eldest child and that this has impacted on dynamics within the household. It is believed that when the perpetrator's mental health deteriorates the domestic abuse and neglect within the household significantly worsen.

Table 14.2 – Key Event 2

Commencement of Key Event 2	
7/7/17	The perpetrator attended, in company with Annie, North Tees Hospital A&E Department with self-inflicted stab wounds to his left wrist where he disclosed this was an attempt to end his life. He indicated he continued to feel suicidal due to his ongoing personal issues. Also seen by the North Tees Liaison Psychiatry where it was agreed that medication to be reduced to 7 days supply to minimise risks and due to ongoing suicidal thought. GP to review medication and monitor mood as the perpetrator reported non-compliance with antidepressants. Helpline numbers including Lifeline, Crisis team, MIND and contingency plans discussed with the perpetrator and his partner Annie. SAFER referral made for children
12/7/17	Annie was contacted by Harbour to explain a referral had been received from Children's Social Care (CSC) for the perpetrator to attend the Perpetrator Programme. Annie had no concerns about the perpetrator attending the programme or about her own safety. Support offered by Harbour was declined. Annie did not want to receive updates but was encouraged to contact Harbour should circumstances change at any point
14/7/17	The perpetrator seen by AMH Hartlepool Crisis Resolution following referral from GP re long history of mental health problems. Indicates he continually thinks about ending his own life. No evidence of harm towards others. The perpetrator hoped to get back together with his ex- partner and get the children back from foster care. Agreed management plan that the Crisis team to provide the perpetrator with a period of intensive home treatment to further assess his mental health and any associated risks. Crisis team to consider medication review. Discussed risks to staff with the police - advised that home visit should be carried out with police support or seen within a place of safety. The perpetrator has moved back in with Annie.
18/7/17	The perpetrator seen by TEWV – AMH Hartlepool Crisis Resolution

	had capacity and insight into the situation and his emotions.
20/7/17	The perpetrator discussed in TEWV – AMH Hartlepool Crisis Resolution meeting request received from family social worker to establish if the perpetrator was engaging with mental health services re a court application in regard to his children. Social worker also shared the concerns of a history of domestic violence between the perpetrator and his partner Annie and a suspicion that the perpetrator engages with services superficially until he is no longer required to do so then disengages.

25/7/17	The perpetrator seen by TEWV – AMH Hartlepool Crisis Resolution continued to have fleeting suicidal thoughts but believed no plans to do so.
28/7/17	The perpetrator seen by TEWV – AMH Hartlepool Crisis Resolution accompanied by Annie who did not take part in the consultation. The perpetrator indicated he still had some suicidal thoughts but hoped to have the children returned. Referral to Affective Disorders team and ADHD team for longer term support
31/7/17	The perpetrator seen by TEWV – AMH Hartlepool Crisis Resolution accompanied by Annie who did not take part in the consultation. Plan: no further role for the crisis team. AMH Hartlepool Crisis Resolution referral closed. Transfer to Affective Disorder team.
8/8/17	The perpetrator attended Harbour for assessment and DASH risk assessment. The DASH risk assessment for perpetrators undertaken and was informed by the referral from CSC; Annie (who had been consulted prior to the perpetrators attendance), and the perpetrator. Main risk factors identified - the perpetrator causing injury to youngest child (said by both parents to be an accident); the perpetrators depression and self-harm; and historic domestic abuse. The perpetrator reported to be open and honest during assessment and motivated to change behaviours he recognised had impacted negatively on Annie in the past. Annie re-contacted to inform of the outcome of the assessment i.e. the perpetrator deemed suitable for the programme. Annie reiterated she had no concerns. Offers of support and future updates on the perpetrators progress declined by Annie who was encouraged to contact Harbour should circumstances change at any point.
15/8/17	The perpetrator attended North Tees and Hartlepool Hospital A&E Department under the influence of alcohol having stabbed himself in his left wrist with a fork. Sectioned under S136 of the Mental Health Act and taken to Roseberry Park. Indicates to staff that he lives with his ex-partner Annie but is in the process of moving out to an apartment which he is decorating this at present and that he has a

	girlfriend. Risks considered – Self to self, admits to self-harming in response to argument with his partner – under the influence of alcohol – denies current thoughts. Risk to others – denied any current risks, current investigations re children. Risk from others – historical only.
16/8/17	The perpetrator discharged from Roseberry Park and to the Affective Disorder Team
18/8/17	The perpetrator seen by TEWV – AMH Hartlepool Affective Disorders. At end of the consultation the perpetrator became over familiar with female member of staff and a decision was made for the perpetrator not to be seen by any lone worker. Alert: RISK TO OTHERS (amended to change risk) fire arms. No home visits/no lone female workers.
22/8/17	The perpetrator underwent second assessment with Harbour and commenced the Preventions Programme.
25/8/17	The perpetrator seen by TEWV – AMH Tees ADHD accompanied by Annie, who did not take part in the consultation, indicated there is a background of domestic violence and a self-reported history of cruelty to animals and children, fire setting and attempts to cause harm to others.
26/8/17	The perpetrator contacts Crisis Team by phone asking to be sectioned. Denied being suicidal and advice given with the Affective Disorders Team to follow up.
28/8/17	Annie contacts ambulance as the perpetrator had inflicted superficial cuts to himself whilst intoxicated. The perpetrator transported to Roseberry Park for assessment. Discharged with a plan that the Crisis Team will contact Affective Team tomorrow & arrange a joint visit. Annie given Trust information leaflet for relative or carers.
29/8/17	The perpetrator did not attend the second session at Harbour.
30/8/17	The perpetrator seen by Crisis Team accompanied by neighbour.
31/8/17	The perpetrator seen at the Urgent Care Centre Hartlepool with a laceration to his right wrist and hand. Stated he had fallen over onto some glass in an alleyway. Received treatment and was discharged. Later that day attended joint assessment with Crisis and Affective Disorders teams. To be seen further by the Affective Disorders Team.
2/9/17	Police receive report from the perpetrator's neighbour that he has slashed her sister's tyres as she thinks that the perpetrator believes she gave a statement to the police with regard to the children being

	taken into care. No further police action. Later that day neighbour also reports to the police that the perpetrator was drunk and banging on her windows, causing them distress and trying to force his way in. The police find him passed out on his lawn and advised him re his behaviour.
4/9/17	The perpetrator seen by Affective Disorder Team. Annie to have a carers assessment.
5/9/17	The perpetrator attended session 3 at Harbour resulting in them sending an e-mail to the children's social worker raising concerns regarding the perpetrator's mental health and presentation at session. Sender also asked colleague to check on how Annie was.
5/9/17	The perpetrator referred to Drug & Alcohol services due to concerns over his binge drinking by Social Worker Community Mental Health Team.
7/9/17	The perpetrator attended North Tees and Hartlepool Hospital A&E Department suffering from 14 small cuts to his left arm stating he fell on a bucket of knives. He denied it was an attempt to take his life. Seen by Mental Health Services for Older People (MHSOP) North Tees Liaison Psychiatry. On the same day he had sent a text to the children's social worker stating he had decided to take his life as this was best for the children and requesting, they be returned to their mother.
8/9/17	The perpetrator's neighbour (same neighbour that made contact to the police on 2/9/17) rang the police saying the perpetrator was threatening them making comments such as he is not getting his children back there is nothing stopping him. She feels vulnerable and afraid. No police units available for despatch despite a second call some one hour forty minutes later.
11/9/17	The perpetrator seen by Affective Disorder Team indicates he has moved into his own property.
12/9/17	The perpetrator attends session 4 at Harbour.
18/9/17	The perpetrator arrested by police for the offence of harassment relating to neighbour on 8/9/17. Released no further action.
19/9/17	The perpetrator attends session 5 at Harbour
26/9/17	The perpetrator attends session 6 at Harbour. The perpetrator disclosed concerning statements regarding suicide attempt.

Table 14.3 – Key Event 3

Commencement of Key Event 3:	
27/9/17	Following information sharing between staff from Children's

	Services, Harbour and Cleveland Police a Potential Dangerous Person (PDP) referral concerning the perpetrator is made to Cleveland Police by one of their Detectives.
3/10/17	The perpetrator attended session 7 Harbour programme.
4/10/17	Children's social worker indicates the perpetrator knows where she and the children's foster carer live and has concerns what he may do with this information. Location of interest markers placed on both properties on the police command and control system.
9/10/17	Children's social worker and foster carer visited by police and given advice with regard to crime prevention.
9/10/17	The perpetrator attends first Drug & Alcohol Substance Misuse Service consultation.
11/10/17	Children's social worker shares with staff member from TEWV – AMH Hartlepool Affective Disorders Team that a PDP referral for the perpetrator has been submitted. The perpetrator not answering his phone to the Affective Disorders Team to arrange further appointments. Affective Disorders Team to contact Harbour to explore their concerns re the perpetrator.
12/10/17	The perpetrator attended North Tees and Hartlepool Hospital A&E Department with a self-inflicted cut to his left arm after consuming whiskey. Seen by TEWV – Referral to MHSOP North Tees Liaison Psychiatry and later left the hospital prior to official discharge.
16/10/17	Harbour remove the perpetrator from programme due to his mental health issues and a failure to answer phone calls and texts.
16/10/17	The perpetrator did not attend Drug & Alcohol Substance Misuse Service appointment.
16/10/17	Unplanned meeting in the community with the perpetrator by TEWV – AMH Hartlepool Affective Disorders team member. The perpetrator challenged re his lack of engagement with the team and that he could access more support if he utilised the service more appropriately.
16/10/17	Annie attends Harbours Adult Outreach Service after self –referral. She did not want support but agreed to receive updates on the perpetrator's attendance on the Perpetrator Programme
24/10/17	Cleveland Police analytical team have reviewed PDP referral and determined that the perpetrator posed a high risk.
25/10/17	Cleveland Police carry out a PDP screening meeting re the perpetrator. MAPPA co-ordinator informally consulted with and

	recommends a multi-agency meeting for information sharing and to identify any actions with regard to safeguarding. Passed to a Detective Inspector to manage.
2/11/17	The perpetrator attended North Tees Hospital, following a GP referral, and was admitted. Complaining of severe headache and abdominal pain believed due to alcohol withdrawal. The perpetrator absconded from the hospital two and a half hours later.
4/11/17	The perpetrator attended North Tees Hospital A&E Department complaining of continued abdominal pain. Advised to continue with alcohol services and referred back to GP
6/11/17	The perpetrator seen by TEWV – AMH Hartlepool Affective Disorders
15/11/17	No diagnosis that the perpetrator has ADHD to remain open to the Affective Disorder Team and to consider a forensic assessment.
22/11/17	The perpetrator seen by TEWV – AMH Hartlepool Affective Disorders agrees to referral to Forensic services.
28/11/17	The perpetrator does not attend Drug & Alcohol Substance Misuse Service appointment.
11/12/17	The perpetrator attends Drug & Alcohol Substance Misuse Service appointment.
14/12/17	Cleveland Police Force Tasking and Co-ordinating meeting where the perpetrator was raised under the area of individuals suspected of committing other sexual offences and that he had been referred as a PDP having been assessed as high risk by the analytical team. The outcome was the endorsement of the DI CAIU (Detective Inspector Child Abuse Investigation Unit) to manage.
17/12/17	The perpetrator attends TEWV – AMH Hartlepool Affective Disorders Team and discusses forthcoming family court case to decide future placement of the children.
28/12/17	The perpetrator does not attend meeting with AMH Hartlepool Affective Disorders Team.
5/1/18	Annie self refers into Harbour Outreach Service – initial assessment over the telephone – no immediate safety concerns.
10/1/18	The perpetrator attends North Tees Hospital A&E Department for treatment of alleged accidental overdose, disclosed that it was intentional. SAFER referral sent for children. Absconded from department.
12/1/18	Numerous attempts made during this week by AMH Hartlepool

	Affective Disorders Team to contact the perpetrator. Not successful.
18/1/18	Referral from Children's Services for Annie to attend Harbour Freedom Programme.
18/1/18	Annie attends Harbour Adult Outreach for full assessment. Main motivation for self-referral is potential return of children. DASH risk assessment graded as standard – no domestic abuse for 2 / 3 years; separated from the perpetrator for 4 months; no contact with the perpetrator during this time, no threats, Annie felt safe. Some concern that the perpetrator may self-harm. Annie working with a range of agencies to address her own physical and mental health needs, financial difficulties, and child care proceedings. One to one support to continue and referrals made to Harbour's Freedom Programme, Counselling Service, and Recovery Programme.
18/1/18	The perpetrator attends TEWV – AMH Hartlepool Affective Disorders Team
22/1/18	Care Orders obtained for all three children at the Family Court.
23/1/18	Referral from Children's Services for Annie to receive 1-1 counselling with Harbour.
29/1/18	The perpetrator attends TEWV – AMH Hartlepool Affective Disorders Team. No longer having contact with Annie which was recommendation from court. Feels Annie could have fought for access more and questions their relationship
1/2/18	Annie attends an initial assessment and intervention at Hartlepool & East Durham Mind
7/2/18	Cleveland Police Force Tasking and Co-ordinating meeting; The perpetrator was raised where it was identified that there had been no update on actions taken. As no intelligence had been received on the perpetrator since October, the decision was to discharge him from the meeting and for the DI CAIU to continue to manage the perpetrator.
22/2/18	Following second review one to one Adult Outreach Support closed at Annie's request and she commences Freedom Programme at Harbour
26/2/18	The perpetrator attends TEWV – AMH Hartlepool Affective Disorders Team. The perpetrator's profile would suggest that he has significant traits of schizotypal, schizoid and depressive personality patterns. These are unlikely to be at level of pervasiveness to be considered as a personality disorder.
7/3/18	The perpetrator presents to the Urgent Care Centre Hartlepool stating he has fallen out of his first-floor flat window.

12/3/18	Annie commences programme at Hartlepool & East Durham Mind.
28/3/18	The perpetrator attends TEWV – AMH Hartlepool Affective Disorders care to be discharged back to GP.
11/4/18	The perpetrator's case with Drug & Alcohol Substance Misuse Service closed due to non-attendance.
19/4/18	The perpetrator attends TEWV – AMH Hartlepool Affective Disorders care confirmed to be discharged back to GP.
30/4/18	Annie commences counselling sessions with Harbour.
4/5/18	The perpetrator did not attend initial assessment with Hartlepool & East Durham Mind.
4/5/18	The perpetrator's referral to AMH Hartlepool Affective Disorders formally closed.
21/5/18	Annie completed 10 sessions at Hartlepool & East Durham Mind.
23/5/18	Annie commences six-week Recovery Service Survivor Group sessions.
24/5/18	Annie successfully completes the Freedom Programme at Harbour.
18/6/18	Annie completed last counselling session with Harbour.
13/7/18	The perpetrator did not attend re-scheduled initial assessment with Hartlepool & East Durham Mind.
1/8/18	Annie continues to attend Recovery Service Survivor Group. At this meeting briefly mentions having trouble with her neighbour but didn't want to discuss it.
August 18	Annie is murdered by the perpetrator.

Table 14.4 – Key Event 4

Key Event 4:	
6/8/18	Information from witness stating that three weeks prior to her death Annie had told them that she had received threats from the perpetrator including one that he was going to stab her.

15. Analysis of Key Events

15.1 Agencies were asked to provide chronologies of their involvement with both Annie and the perpetrator as part of their IMR's.

15.2 The focus for this section of the report will be an analysis of the response of the agencies involved with Annie and the perpetrator;

why decisions were made, and actions taken or not taken as indicated by the IMR's.

15.3 The Review Panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time. This section sets out the learning identified from the four key events and any associated recommendations. An action plan has been developed to deliver these recommendations and is shown at **Appendix 3.** Other learning identified as a result of analysis of the organisations' completed IMR's has been captured on an additional action plan shown at **Appendix 4.**

15.4 Recommendations are identified within each key event.

Key Event 1 – 15/5/2017 Injury caused to youngest child when the perpetrator discharged air rifle.

15.5 The perpetrator was cleaning an air rifle when it was discharged and subsequently a foreign body hit and was lodged in the face of their youngest child. Annie immediately sought medical attention for the child who was admitted to hospital.

15.6 The perpetrator was arrested by the police on suspicion of assault on the child. Annie was also investigated as it was believed she had misled the police on behalf of the perpetrator to minimise the incident. During police enquiries Annie's brother disclosed to them that he believed that Annie had suffered years of physical and emotional abuse from the perpetrator.

15.7 Safeguarding arrangements were instigated for all three children who were removed from the family home and subsequently taken into care.

15.8 The perpetrator was released by the police whilst enquiries into the incident continued. No further police action was taken with regard to the allegations against Annie. On his release the perpetrator did not initially return to the family home and it is not clear when he did so, however the perpetrator and Annie did maintain contact. This incident appeared to be the trigger for the perpetrator to carry out more frequent self-harming episodes as detailed in key event two.

15.9 It cannot be ascertained why Annie minimised the circumstances surrounding the injury to her youngest child. There are two plausible explanations, the first being she was afraid of losing her children and the second that she was trying to protect the perpetrator or indeed a combination of the two. Despite the disclosure by Annie's brother to the police that she was the victim of longstanding domestic abuse perpetrated by the perpetrator, she was not asked about this during interviews. The police did say that she gave no indication of being the subject of coercion and control from the perpetrator as a reason for lying on his behalf. There was no link drawn by the police to this when they received an anonymous phone call stating that the perpetrator had

been instructing Annie to destroy emails and texts containing information that they are lying to the police. There was no record of this information being followed up or any work being completed in relation to forensic examination of devices.

15.10 An advice file on potential charges against the perpetrator was submitted to the Crown Prosecution Service (CPS) in February 2018 some 10 months after the originating incident. CPS indicated that they were willing to consider firearms and neglect charges however the Detective Inspector overseeing the case wished to pursue an assault charge. The CPS indicated further evidence would be required before they would consider this, resulting in significant further delay, whilst additional medical and ballistic evidence was obtained. At the time of Annie's murder, the case was still unresolved.

15.11 The DHR panel explored the reasons for the significant drift and delay in the investigation and the police indicated that it was due to a combination of factors:

- Capacity issues within the Vulnerability Unit with reduced resource attempting to investigate a large number of cases. Of note is the fact that Cleveland Police have lost some 500 police officers from their establishment since 2010.
- The investigation was perceived as being a lower priority as the risk to the children had been significantly reduced due to them being taken into care.
- Disagreement within the investigation team and with the CPS as to what charges the perpetrator should face and the resulting additional enquiries required.

15.12 The Police's belief of a reduced risk to the children was a sound judgement however it would appear that as part of this investigation limited consideration was given to the potential risk to Annie. She appeared to be perceived as a potential offender rather than a potential victim, as Annie had never indicated any domestic abuse or coercion and control from the perpetrator, but often such abuse is hidden by the victim and in this case. Women's Aid[3] and their work with the Women's Aid federation of services, found that domestic abuse is very common, however this is often difficult to accurately quantify. Domestic abuse is a largely hidden crime, occurring primarily at home. Women often don't report or disclose domestic abuse to the police (HMIC, 2014)[4] and may underreport domestic abuse in surveys, particularly during face-to-face interviews (ONS, 2015)[5]

Annie may have had additional motivation to do so as she was attempting to get her children back.

[3] Womens Aid womensaid.org.uk

[4] Her Majesty's Inspectorate of Constabulary (HMIC). (2014) *Everyone's business: Improving the police response to domestic abuse*. Published online: HMIC, p. 31

[5] Office for National Statistics (ONS). (2015). *Crime Statistics, Focus on Violent Crime and Sexual Offences*, 2013/14. *Chapter 4: Intimate personal violence and partner abuse.* Published online: ONS, p. 3

There were clues as to the negative relationship between Annie and the perpetrator such as the comments from Annie's brother and the anonymous information reported to the police both described in 15.9 above which were not acted upon. This was a missed opportunity for the police to better understand the relationship between Annie and the perpetrator and to explore the potential of Annie being a victim of domestic abuse as part of the investigation. The focus of the investigation appeared to be only on the child and not the potential vulnerability of Annie.

15.13 Annie's family have the perception that if this investigation had been conducted in a more timely and effective manner, the perpetrator would have been convicted of the harming the youngest child and may have received a prison sentence, thereby being unable to be in a position to kill Annie. The perpetrator was eventually charged with a firearms offence over this incident after Annie's death. It was due to be heard at the same time as the murder case but was 'left on file' due to the perpetrator receiving a life sentence for murder. It is the view of both the Police and CPS that if the perpetrator had been charged with the same firearms offence prior to his killing of Annie it is unlikely that he would have received a custodial sentence as a result of the perpetrator's limited previous convictions and sentencing guidelines.

15.14 **Recommendations Key Event 1**

1. Cleveland Police review their domestic abuse training for staff to satisfy themselves and the Safer Hartlepool Partnership that it effectively encompasses and addresses the hidden signs of domestic abuse.
2. Cleveland Police ensure that the decision-making rationale for prioritisation of investigations is clearly recorded.
3. Cleveland Police review the governance and oversight of investigations with regard to timeliness and ensuring all available evidence is captured.

Key Event 2 - Escalation in the perpetrator self harming (6 self harming episodes, 1 overdose and falling from 1st floor flat window)

16.1 This key event examines the circumstances surrounding the escalation in the perpetrator's self-harming episodes following key event 1. As indicated, there is a parallel independent MHHR on-going and, to prevent duplication of enquiry, that review will examine the effectiveness of the clinical interventions, relevant safeguarding procedures, information sharing and the quality of the associated risk assessments from those agencies delivering that service to the perpetrator.

16.2 This DHR has examined these issues within the parameters of the chronologies and IMR's from respective agencies and also the internal Serious Incident (SI) Review undertaken by Tees Esk Wear Valley NHS Foundation Trust (TEWV). The identification of areas for learning and associated recommendations in this report for this key event will be complementary to and further developed within the MHHR when published later this year.

16.3 The perpetrator's first involvement with TEWV following key event one was in July 2017 when he presented at his local A&E department, with Annie, with a stab wound to his arm. Triggers for this presentation were; the recent deaths of both his mother and grandfather, losing his job and his children having been placed in foster care (following an incident with an air rifle which caused harm to his youngest child). This had caused strain on his relationship. He reported that he had been referred to MIND, he was signposted to appropriate support services and a referral to Children's Social Care was made. Soon after this he was further assessed by the Crisis Resolution team continuing to seek support. It was noted that he was engaging with MIND and he was offered a period of intensive home treatment. There had been liaison with the children's Social Worker and information was shared about his involvement and engagement with TEWV mental health services and the risks around home visits. A referral was made to both the ADHD team for assessment and the Affective Disorders Team([6]) for specialist support.

16.4 Before any further contact could be made by the Affective Disorders[6] and ADHD teams, the perpetrator was detained and assessed at the Crisis Assessment Suite under Section 136 of the Mental Health Act (1983) in August 2017.This was in response to self-harming with a fork and voicing an intention to end his life due to situational stressors; the deaths of his mother and grandfather, his children being in foster care and side effects of Ropinirole (treatment for his restless legs first prescribed in July 2012). He lived with Annie and was in the process of moving out. He described excessive alcohol consumption and arguments with Annie when she refused him access to the

[6] The affective team, also known as the community resource team, offer individuals support with a wide range of mental health difficulties, including severe depression, anxiety, personality disorders, OCD, eating disorders and several other non-psychotic conditions.

knife drawer. It was noted that no major risks were identified, and the perpetrator was discharged from Section 136 to be followed up by the Affective Disorders Team.

16.5 The perpetrator was open to the Affective Disorders Team from July 2017 – May 2018 and the ADHD team co worked with them until November 2017. He was allocated a Care Coordinator and managed under the Care Programme Approach (CPA). He was provided support to monitor his mental state and associated risks. There were ongoing social stressors in his life associated with the welfare of his children, the on/off relationship he had with Annie and the friendship he had with a neighbour. This neighbour was not the neighbour who made reports to the police on 2/9/17 and 8/9/17 but was subsequently convicted of manslaughter of Annie alongside the perpetrator's murder conviction.

It is recorded that there were continuous risks around self-harm / suicidal thoughts / overdose, the overfamiliar personal remarks he would make to professionals and the side effects he was reportedly experiencing from Ropinirole. This had resulted in the perpetrator presenting to mental health services via Crisis Resolution (28/08/2017) and Liaison Psychiatry (07/09/2017 & 12/10/2017) three times during the period he was open to the Affective Disorders Team. As a result, a frequent attenders meeting was held between TEWV mental health services, and a plan devised on how best to collaboratively meet his needs.

16.6 The assessment for ADHD was carried out, from August 2017 through to October 2017, which included gathering information from the perpetrator's father, GP and himself. Following a review of these assessments, and oversight from the Consultant Psychiatrist, there did not appear to be any signs or symptoms suggestive of any attention difficulties or any evidence suggestive of hyperkinetic disorder[7] .

It was recommended further assessment from the Affective Disorders team around potential risk and consideration of assessment of personality issues was required. A forensic assessment was also recommended for consideration, due to a background of suspected domestic violence and a self-reported history of cruelty to animals and children, fire setting and attempts to cause harm to others. The effects of Ropinirole were highlighted to his GP and the team for review.

16.7 During his time with the Affective Disorders team, in September 2017, the perpetrator shared an Independent Psychiatric report that had been completed for his court application regarding his children. This recorded a diagnosis of Recurrent Depressive Disorder and acknowledged the side effects from Ropinirole. The Independent Psychiatrist indicated therapeutic interventions as; a pharmacological review, undergo bereavement counselling

[7] 'Attention Deficit '(ADD), 'hyperkinetic disorder; and 'hyperactivity' are various terms used by people and professionals to describe forms of ADHD (Attention Deficit Hyperactivity Disorder).

and Cognitive-Behavioural Therapy (CBT) [8] to work with his depression and his underlying emotionally unstable and alexithymic[9] personality components. It was agreed to hold a formulation meeting with the Psychologist and a referral to the forensic services was also continued to be pursued.

16.8 The perpetrator's pharmacist and TEWV staff contacted his GP to suggest a review of medication as he believed that the Ropinirole was aggravating his impulsiveness. The GP made a referral for the perpetrator to the neurology department at James Cook University Hospital, Middlesbrough in November 2017. An appointment was made to see the perpetrator at the neurology department in February 2018 however he failed to attend.

16.9 In October 2017, information was shared by the children's Social Worker that the perpetrator had been referred as a Potentially Dangerous Person due to concerning behaviour and that he was engaging in the Perpetrator Programme with Harbour. This was third party information that had been received from Harbour domestic abuse services. A plan was agreed between the Care Coordinator and the children's Social Worker which included; a multi-agency meeting with social services, Harbour and the Police due to the on-going risks reported. To gain information from Harbour with regards to the specific concerns that prompted the PDP referral. To make a referral for psychological assessment and to contact the forensic team for advice and a potential referral as planned. On 16th October an unplanned meeting in the community with the perpetrator took place by AMH Hartlepool Affective Disorders team member. He was challenged with regard to his lack of engagement with the team and advised that he could access more support if he utilised the service more appropriately.

Information from Harbour was also shared, in December 2017, via the children's Social Worker relating to the perpetrator's report of self-harm, he was not seen by TEWV services on that occasion.

16.10 The psychological assessments were concluded in February 2018 and it was suggested that the perpetrator had *'significant traits of schizotypal[10], schizoid and depressive personality patterns. It was noted that these were unlikely to be at the level of pervasiveness to be considered as a personality disorder'.*

16.11 In April 2018 a plan was agreed with the perpetrator to; access bereavement services if he decided this may be of benefit in the future, continue to use meaningful activities and use behavioural activation to improve and maintain

[8] Cognitive Behavioural Therapy (CBT) is a talking therapy that can help people manage their problems by changing the way they think and behave. Its most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems.

[9] Alexithymia is a personality construct characterized by the subclinical inability to identify and describe emotions in the self. The core characteristics of alexithymia are marked dysfunction in emotional awareness, social attachment, and interpersonal relating.

[10] People with schizotypal personality disorder are often described as odd or eccentric and usually have few, if any, close relationships. They generally don't understand how relationships form or the impact of their behaviour on others.

his mood. The discharge plan from the Affective Disorders Team incorporated relapse prevention planning and guidance within it for others about how to help him at times of acute stress. Current risks were assessed and addressed by the team and he was discharged from the service on 19/04/2018. This was the last contact the team had with the perpetrator and the referral was closed down on 04/05/2018. The formal diagnosis recorded at the time of discharge was 'Recurrent Depressive Disorder'[11].

16.12 A forensic referral was considered as part of the assessment of the perpetrator by the Affective Disorders Team. The requirement for such a referral would need to include a diagnosis of a mental disorder alongside behaviours that would suggest that he was of harm to others. Although the perpetrator did not have a diagnosis, consultation was carried out with the forensic team, who advised to continue with planned psychological assessments to determine any mental health disorder, but that support could still be given in the absence of a diagnosis and to arrange a professionals meeting to discuss. The decision making for not taking this forensic assessment further was explored as part of the Trust SI process. It was felt that on conclusion of the assessments by the ADHD and Affective Disorders teams, the perpetrator was settling in mood, his self-harming had reduced. The multi-disciplinary team agreed that this was no longer required as he did not have a mental disorder and his risks had decreased. Within the SI review process further consideration was given as to whether this was a missed opportunity, but the outcome of this was that it was considered not to be the case in view of the rationale above, including that the assessments carried out gave no indication that this was required.

16.13 There had been a recommendation, from the Independent Psychiatrist's report, for CBT as a follow on from bereavement counselling. There was no reference to any sessions of CBT in the Electronic Care Record (ECR), however, the perpetrator had been offered and declined bereavement counselling. In the last face to face sessions with the Psychologist and the Care Coordinator, the perpetrator considered that his mental state was stable and that he did not feel that he needed to commence with bereavement therapy. It was the opinion of those TEVW staff working with him that there was no evidence to suggest that he lacked capacity to make decisions about his care and treatment.

16.14 The discharge plan incorporated relapse prevention planning, however there was no documentary evidence that the Children's Social Care Services were informed of the perpetrator's discharge. In keeping with the Care Programme Approach, the Care Co-ordinator up-dated his risk assessment and a letter was sent to the GP surgery regarding his discharge.

16.15 There are five references in the ECR where Annie had accompanied the perpetrator to his appointments, or in crisis, however she was not proactively engaged in the assessment process. These were missed opportunities to gather further information to aid decision making in the wider family context and to inform future assessments or referrals to appropriate support services

[11] Recurrent depressive disorder is diagnosed when an individual has suffered at least 2 depressive episodes.

for both the perpetrator and Annie. There are records to indicate that she was offered and accepted a Trust information leaflet for relatives or carers, she was given advice when she contact the Crisis Resolution Team and that she was to be offered a carer's assessment. There is no evidence that the carer's assessment took place.

16.16 The impact the perpetrator's mental health would have on his children was taken into account on each contact. There is evidence that the PAMIC tool **(**a tool to assess the impact of parental mental ill health on children**)** had been completed on one occasion and relevant referrals were completed to Children's Social Services when required. There is evidence of continued liaison with the children's Social Worker to ensure the risks to the children were addressed. The children were in the care of the Local Authority and the perpetrator only had supervised access to them.

16.17 Following the review of the perpetrator's ECR, it was identified that there were potential risks to the following; Annie, their children and professionals. TEWV's involvement predominately focused on risk to self, the children and professionals. The references made to 'relationship difficulties', 'heated arguments', 'controlling behaviour' and 'history of domestic violence' that are evident in the perpetrator's ECR, suggests that further exploration around these comments or concerns may have led to a better indication of the potential risks in the relationship between him and Annie. It is noted that there are no records to suggest that domestic abuse was discussed in any depth with the perpetrator or Annie or other agencies involved. There continued to be no further acknowledgement of these risks to Annie, or any new partners, after TEWV services were made aware that he was attending the 'Harbour Preventions Programme'. It was not clear following receipt of the information that a PDP referral had been submitted for the perpetrator whether this caused a re-assessment of risks to others.

16.18 Risks toward professionals were identified i.e. overfamiliar personal remarks and angry thoughts. These were appropriately recorded to manage this risk within TEWV. These were shared with the children Social Worker, however, there is no evidence to suggest the wider sharing with professionals from other agencies i.e. Harbour, MIND and GP. It is also not clear how this perceived risk to staff resulting in the perpetrator not to be seen by lone female workers or at home was factored into his risk to others which remained at low throughout his treatment with TEWV.

16.19 There was evidence of open and effective channels of communication and information sharing from TEWV to both the perpetrator's GP and with Children's services. This was less apparent with other agencies particularly when informed of the PDP referral where no contact was made with either the police or Harbour. Had professionals liaised directly with other identified agencies involved such as Harbour, MIND, Lifeline and the Police a wider range of information would have added to a more comprehensive assessment and management of risk. This is linked to the recommendations in key event three.

16.20 The perpetrator was referred to Hartlepool & East Durham Mind by his GP and TEWV believed that he had engaged however he did not attend assessments with MIND.

16.21 **Recommendations Key Event 2**

1. TEWV to ensure all frontline staff attend Domestic Abuse training focussing on staff always considering potential vulnerabilities of other members of the household when undertaking assessments of a patient's mental health and associated risks encouraging the adoption of a think family approach..

2. TEWV to provide guidance to staff when working with the perpetrator of domestic violence and including this within the Domestic Abuse policy.

3. TEWV to ensure effective supervision processes are in place so that when a carers assessment is offered that it is completed.

4. When there is multi-agency involvement in a patient's case, TEWV to ensure open channels of communication should be maintained with all agencies involved.

5. When there is multi-agency involvement in a patient's case, TEWV to ensure any alerts pertaining to potential risks should be shared across all agencies.

6. All safeguarding concerns should be recorded in line with TEWV processes, policies and procedures.

7. TEWV to review their risk assessment arrangements to ensure it captures new information and intelligence such as the PDP referral.

8. NHS England (North) share the MHHR report when finalised with the Safer Hartlepool Partnership to ensure co-ordination between relevant recommendations.

Key Event 3 – Potentially Dangerous Person (PDP) Referral to Cleveland Police 27th September 2018

17.1 Guidance from the College of Policing defines a PDP as a person who is not currently managed under one of the three MAPPA categories (see **Appendix 2**), but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm. The College of Policing guidance issued to police forces on the identification and management of a PDP is shown at **Appendix 1**.

17.2 Practitioners from Children's services, Cleveland Police and Harbour who were engaged with the perpetrator shared together escalating concerns over the behaviour of the perpetrator. They believed that the perpetrator would not reach the threshold for consideration under MAPPA and were looking to see if

there was another approach that may address these concerns. The police Detective Constable took advice from within Cleveland Police and was directed towards the PDP process and subsequently made a referral based on the following shared intelligence and information at that time:

- The perpetrator was using the wrong ammunition in the afore mentioned air rifle which was of a larger calibre and therefore made this a 'specially dangerous weapon'.
- The current risk assessment from mental health services states that there are to be no lone female workers with the perpetrator.
- The perpetrator is increasingly making inappropriate sexual comments to female workers.
- The perpetrator is only attending his appointments at MIND as he likes the sound of the female worker's voice.
- The perpetrator has been reported to be carrying a pocket knife on his person.
- The perpetrator has been harassing a neighbour whom he blames for his children being removed, banging on her door whilst intoxicated late at night being verbally abusive, making sexualised comments and demanding to be let in.
- The perpetrator has allegedly been harassing the sister of the above neighbour and slashed her car tyres, this is currently under police investigation.
- The perpetrator is experiencing side effects from his medication for restless leg syndrome which include impulsive tendencies and nymphomania.
- The perpetrator has reported behaviour which Harbour has raised a sexually predatory by going to 'Loons' nightclub on his own at the weekend in an attempt to appear lonely and vulnerable and using this to target women and take them home with him.
- The perpetrator has reported he is regularly watching videos online of beheadings and is not disturbed by this, he can watch them without flinching.
- Harbour describe the perpetrator as very unstable and state his attitudes, beliefs and values are skewed.
- The perpetrator has been using amphetamines and alcohol.
- The perpetrator reports he tried to hang himself on Friday 22nd September 2017.
- The perpetrator has had three other recent self harm attempts where he has cut himself with knives and stabbed himself in the arm with a fork. The perpetrator has received hospital treatment for each of these incidents and on one occasion was detained under Section 136 of the Mental Health Act in Roseberry Park by police.
- When discussing the possibility of his youngest child being adopted following a recent meeting with social care the perpetrator told Harbour workers 'that will never happen'. The Harbour workers have expressed concern and said due to his tone and demeanour this comment made them feel very worried and they could not be sure that it was not a veiled threat.
- The perpetrator has been looking for professionals on social media and alluding to personal friendships when concerns are raised with him.
- The perpetrator has very recently moved to an address which is in very

close proximity to his children's foster placement and his Mental Health Keyworkers home address – it is unclear if this is deliberate or coincidental

17.3 On receipt of the PDP referral a Detective Chief Inspector (DCI) commissioned police checks on the perpetrator but did not request a risk assessment to be carried out on the perpetrator as a PDP until 18/10/17.

17.4 On 11/10/17 Children's social worker shared with a staff member from TEWV – AMH Hartlepool Affective Disorders Team that a PDP referral for the perpetrator has been submitted.

17.5 A PDP risk assessment was carried out by the police's analytical team and the result of that was sent to the DCI on the 24/10/17. The perpetrator was assessed as presenting high risk as a PDP however it was not clear to whom. Reference was also made in the risk assessment to being considered under the force's un-convicted sexual offender process although the perpetrator would not have met the criteria for that scheme. This introduced confusion within the police as to whether he was being considered as a PDP or an un-convicted sexual offender.

17.6 Cleveland Police has a PDP policy which indicates that if a PDP referral is made that following risk assessment a formal screening meeting should be held with the MAPPA co-ordinator (a member of the National Probation Service) to make a determination regarding whether the case fits the criteria for MAPPA, the criteria for PDP or does not fit the criteria for either.

17.7 On the 25/10/17 the DCI had a conversation with the MAPPA co-ordinator in the corridor at a police station to discuss the perpetrator's referral. The MAPPA co-ordinator recommended holding a multi-agency meeting to further share information and intelligence on the perpetrator and help inform whether he met the criteria for a PDP. The DCI tasked a Detective Inspector within the Child Abuse Investigation Unit (CAIU) to manage this process and the perpetrator's PDP referral which according to the PDP policy includes interim risk management strategies to be set by the referring District / agency and the PPU.

17.8 There is no record of the required multi-agency meeting or interim risk management strategies being implemented.

17.9 Cleveland Police hold regular Force Tasking and Co-ordination meetings chaired at a strategic level to identify, manage and task force resources to areas of demand and risk. It will also consider high risk individuals or groups. In this meeting in December 2017 the perpetrator was raised under the area of individuals suspected of committing other sexual offences and he had been referred as a PDP having been assessed as high risk by the analytical team. The outcome was the endorsement of the DI CAIU to manage. There was no update given on action taken to date and therefore no challenge as to why the multi-agency meeting had not taken place or interim risk management strategies being implemented in the two months that the DI had meant to be

managing the case. It was not clear whether the perpetrator had yet been formally identified as a PDP or not.

17.10 At the next Force Tasking and Co-ordination meeting in February the perpetrator was again raised where it was identified that there had been no update on actions taken. As no intelligence had been received on the perpetrator since October the decision was to discharge him from the meeting and for the DI to continue to manage the perpetrator. This was another missed opportunity to challenge the fact that no updates had been received and identify the DI had not completed the actions. Again, it was not clear what the perpetrator's status was and what was expected in the management process.

17.11 There is no further reference in police records of the perpetrator's PDP referral after this date until after he committed the murder.

17.12 The DHR panel explored the circumstances of the PDP referral in depth and discovered that Cleveland Police had commissioned an internal review into the circumstances outside of the IMR process. It was felt that the learning from the failure to hold a multi-agency meeting and the confusion over the whole management of the PDP referral could not wait until the publication of this DHR report. Therefore, in December 2018 the Panel wrote to the Chief Constable to seek assurance that the lessons from the police internal review had been implemented to minimise the risk of a re-occurrence. As a result of this the review was shared with Panel members in February 2019 and in March 2019 the Independent Chair and the Director of Regeneration and Neighbourhoods from Hartlepool Borough Council spoke with the author of the police review. These discussions helped inform the recommendations in this section.

17.13 It was clear that both some staff within Cleveland Police and the majority of staff from partner agencies did not know or understand the Cleveland Police PDP process and policy. The College of Policing guidance on PDP is publicly available and on searching the internet it is possible to find some police forces who publish their PDP policy. Cleveland Police PDP policy is confidential and not published externally.

17.14 The Independent Chair was given access to the PDP policy which staff did not fully follow during the perpetrator's referral.

17.15 The internal review carried out by Cleveland Police created a chance to involve partner agencies who are referenced in the PDP policy. This was a missed opportunity to identify their lack of knowledge over the process and start to address it. A key partner in this process is the National Probation Service (NPS) who have a close relationship with the police in the management of MAPPA and who are named as partners in the screening meeting in the PDP policy. They have significant value to add to the PDP process and indeed a number of police forces mirror their PDP process alongside the MAPPA process working closely with NPS. Other forces including Cleveland Police manage the process with a more internal focus.

17.16 There appears to be no explanation as to why the required multi-agency meeting or implementation of interim risk management strategies did not happen, other than human error. There were opportunities to identify and correct this at the Force Tasking and Co-ordination meetings that did not happen.

17.17 The fact that a multi-agency meeting did not take place was a significant missed opportunity to consolidate and share intelligence/ information on the perpetrator. It would have allowed a clearer assessment on whether he reached the threshold of a PDP and the potential implementation of appropriate risk management strategies.

17.18 Taking into account the guidance issued by the College of Policing on PDP and the criteria examples it is the view of the DHR Panel that the perpetrator probably would not have met the threshold of being classed as a PDP. It was thought that the intelligence and information held on the perpetrator did not substantiate the high level of risk required to reach this threshold. That may well have been the outcome of the multi-agency meeting if held, despite the perpetrator's concerning behaviour recognised by agency staff. It was also unlikely that the MAPPA threshold would have been achieved, but if the meeting had taken place, there was an opportunity to adopt a multi-agency problem solving model to address those concerns.

17.19 There was no professional challenge to Cleveland Police from those involved in the original PDP referral: the social worker, detective constable, Harbour worker and subsequently the TEVW worker who had been made aware of the referral, as to why nothing seemed to be happening after the referral. If this challenge had occurred, it would probably have prompted the multi-agency meeting. Of note it was the view expressed by some third sector organisations that they do not feel empowered to challenge statutory agencies and that their views are not listened to by some of those agencies. In addition, housing agencies have a valuable role to play in multi-agency meetings and too often they are overlooked in contributing to multi-agency problem solving. The housing agency, Thirteen Group had a number of contacts with both Annie and the perpetrator and would have been in a position to add further information to the multi-agency meeting if held.

17.20 Part of the rationale for the PDP referral was information received that the perpetrator has reported he is regularly watching videos online of beheadings and is not disturbed by this, he can watch them without flinching. This did not prompt a counter terrorism Prevent referral by any agency. Prevent is one of the four strands of the Governement's counter-terrorism strategy, CONTEST, which aims to **stop people from becoming terrorists** or supporting terrorism. This was a missed opportunity to again attempt to understand the perpetrator in greater detail.

17.21 **Recommendations Key Event 3**

1. The Safer Hartlepool Partnership to seek assurance that the 11 recommendations from the Cleveland Police internal review are implemented.
2. Cleveland Police should engage with partner agencies, particularly the National Probation Service, in reviewing multi-agency knowledge and where appropriate involvement in the identification and management of a PDP.
3. Once the above has been achieved all agencies to ensure that their staff are aware of the PDP policy and process.
4. All agencies to review their policy on encouraging professional challenge and ensure staff are confident to do so including encouraging and listening to challenge from third sector organisations.
5. The Safer Hartlepool Partnership to review the effectiveness of Prevent training and that multi-agency staff recognise when and how to make a referral.

National Recommendation

6. The Home Office to consider placing the guidance on identification and management of PDP on a statutory basis to mirror MAPPA to prevent differing practices across England and Wales.

Key Event 4 - Annie not disclosing threats made to her

18.1 It is difficult to accurately understand the nature of the relationship between Annie and the perpetrator from the first key event in July 2017 until January 2018. It would appear that Annie was attempting to support the perpetrator throughout his self-harming incidents whilst also being focussed on making changes in her life to secure the return of her children to her care. The perpetrator had secured alternative accommodation however it is believed that he and Annie were still in some form of a relationship during this time period and Annie accompanied the perpetrator to the majority of his mental health appointments.

18.2 January 2018 appeared to be a significant time for Annie in understanding her current domestic situation. She had come to understand the negative and undermining effect that the perpetrator's coercive and controlling behaviour was having on her and her overall parenting ability. Her children had been made subject to a care order at the family court however she was given hope, that it may be possible to get her children back, as the family court had ordered a further assessment of Annie as a single carer as part of the final court decision.

18.3 She ended her relationship with the perpetrator and engaged with social care seeking advice and support to place her in the best position to achieve her ambition of being permanently re-united with her children. This led to her successfully undertaking a number of programmes with both Harbour and Hartlepool & East Durham Mind as detailed in the timeline. The position that

Annie was in between January 2018 and the time of her murder is perhaps best summarised by the Judge's remarks when sentencing the perpetrator:

"*The evidence in this trial has demonstrated to me that she was a remarkable and determined young woman. She decided to change her life; to leave the man who abused her; to break free; to make enormous efforts to improve her skills as a parent by attending whatever courses were necessary; to make new friends; to concentrate on doing all that she could to make a loving home for her children, and to ensure that they were returned from foster care. It is never easy for an abused woman to break free, but certainly in the last few months of her life she did it and did it successfully. And she did it although she received a constant stream of messages, sent over the internet or by text, many of them deeply unpleasant and threatening, and all of them manipulative, from her ex-partner. She didn't waver. She got on with her life, focusing on what was important and ignoring, as best she could, everything that her ex-partner, and to some extent her next-door neighbour was throwing at her. Her successful efforts to break free and rebuild her life, in the face of this stream of intimidating and destabilising messages, shows that she was a determined and remarkable young woman, with very considerable resilience and astonishing mental strength.'*

18.4 What did not become apparent until after Annie's murder and was discovered during the police investigation, was the number of threatening social media messages and texts Annie received from the perpetrator. Of particular note some three weeks prior to her death, Annie told two friends she had made as fellow participants at Harbour whilst at the Freedom Programme, that she had received a text from the perpetrator stating he was going to stab her. She asked these friends to promise not to say anything to anyone about this and they thought Annie did not believe the threat from the perpetrator.

18.5 The panel had to consider why Annie did not disclose these threats to anyone other than her two friends. If this information had been disclosed, as a potential threat to life, it is reasonable to assume that appropriate safeguarding steps would have been put into place for Annie in addition to the perpetrator being investigated for making the threats. Attempting to understand why Annie did not disclose was even more troubling as she had developed very good relationships with staff from both Harbour and Hartlepool & East Durham Mind and was attending programmes right up until her murder. At the Harbour Recovery Service Survivor Group meeting on 1st August 2018, two days prior to her death, when asked how she was, Annie indicated she was well but was having a problem with her neighbour (subsequently convicted of manslaughter of Annie alongside the perpetrator's murder conviction). When this problem with the neighbour was probed further Annie minimised it and would not give any detail.

18.6 Staff from all the agencies that had contact with Annie in the months immediately prior to her death would ask how she was and reported that she always indicated she was happy having made the decision to move on with her life and taking the steps to do so. They never once gained the impression that she felt unsafe or in danger.

18.7 There are a number of potential reasons why Annie chose not to disclose the threats she had received:

- She did not believe them;
- She felt the disclosure would harm the chance of her children being returned to her; or
- A combination of both.

18.8 Annie did give the impression to the two friends she disclosed the threats to that she didn't believe them, but they also gained the impression that the reason that she asked them not to say anything to anyone was, Annie did believe this would stop her getting the children back. It is impossible to say whether Annie believed the threats or not, however, she did carry a rape alarm and tragically this was not enough to save her when she activated it upon being attacked by the perpetrator.

18.9 On the balance of probabilities the fear of disclosing the threats preventing Annie getting her children back was probably the primary reason she did not disclose. Annie was going through the process of being assessed by Children's Services with regard to the possibility of her children being returned to her care. The process had not been finalised at the time of her murder. It is understandable that Annie was concerned that this may have had a negative impact on the assessment. In the short to medium term that would have been the case as no child would have been returned into a potentially dangerous environment. However, in the longer term the impact would have been lessened as a disclosure would have allowed the appropriate safeguarding and investigations to have taken place and to have reduced the associated risk. For whatever reason, Annie appears not to have had enough confidence in any agency to disclose the threats due to her belief that this would have a perceived longer-term damaging impact on getting her children back.

18.10 A national Commission focusing on domestic and sexual abuse against the most marginalised women and girls was launched by AVA (Against Violence & Abuse) and Agenda, the alliance for women and girls at risk In October 2017. They published their final report *Breaking Down the Barriers* [12]in February 2019.The Commission was established to evidence the connections between women's experiences of domestic and sexual violence and multiple disadvantage, and to fill a vital gap in the current response to their needs. The below is extracted from the summary:

Women facing multiple disadvantage are being prevented from seeking help for fear of losing their children.

Throughout the Commission evidence, it was made very clear how significant the role of being a mother was to women facing multiple disadvantage who had also experienced violence or abuse. This featured strongly in relation to

[12] https://avaproject.org.uk/breaking-down-the-barriers-findings-of-the-national-commission-on-domestic-and-sexual-violence-and-multiple-disadvantage/

women's ability to access help and support that addressed their needs and identities as mothers, as well as around the legacy of trauma where children had been removed either temporarily or permanently from their care.

Many women described the fear of losing their children as a huge barrier to seeking support.

The Commission acknowledges that in some instances it is unsafe for children to remain with the non-abusive parent and that children's safety must be paramount. However, much more could be done to improve support for women to deal with what they are facing and provide them support to parent.

18.11 Whilst the report highlights that many women do not seek help for fear of losing their children it is reasonable to assume the same applies to those women seeking to get their children back, as in Annie's case. Domestic abuse was not the sole factor that resulted in Annie's children being taken into care however the above findings were probably in Annie's mind in deciding not to disclose the threats received.

18.12 The decision to take a child into care is not taken lightly and indeed Children's Services will always do all they can to keep a family together when it is safe to do so. The grounds for Annie's children being taken into care were entirely appropriate when the youngest was badly injured following an act by the perpetrator. In child protection procedures the legislation is directed entirely towards safeguarding the child and their welfare. In law there is no requirement to consider the impact of a child's removal on the carers or on their relationship. Having a child removed can be traumatic for a parent and may increase their vulnerability. This can be seen in this case by the perpetrator increasing the frequency of his self-harm attempts, whilst conversely it eventually acts a trigger for Annie to break free from the perpetrator and move forward with her life in the hope of having her children returned.

18.13 The perpetrator did receive support mainly from mental Health services following the children being taken into care however his engagement was erratic with a number of appointments not attended.

18.14 Annie received significant support from both Harbour and Hartlepool & East Durham Mind after her own self-referral in January 2018. However, the question remains, did those agencies and others that had contact with her recognise her potentially increased vulnerability in failing to seek help for fear of not getting the children back?

18.15 Whilst Annie did not disclose some of the high risk factors that are known to preclude domestic homicide that she was suffering at the hands of the perpetrator, the potential reason for this has been explored throughout this key event. There is however, substantial research showing how these risk factors and the principal of male entitlement can lead to serious injury and indeed death of a victim. The following is taken from https//www.reducingtherisk.org.uk

15 high risk factors of serious harm or homicide in domestic abuse cases

1. **Victim's perception of risk of harm**: victims of domestic abuse often tend to underestimate their risk of harm from perpetrators of domestic violence. However, If they say they fear further harm to themselves, their child(ren) or someone else this should be taken seriously when assessing future risk of harm.
2. **Separation** (child contact): victims who attempt to end a violent relationship are strongly linked to intimate partner homicide. Many incidents happen as a result of child contact or disputes over custody.
3. **Pregnancy/new birth** (under 18 months old): domestic abuse can start or get worse in pregnancy. Victims who are assaulted whilst pregnant, when they have recently given birth or who have young children should be considered as high risk. This is in terms of future harm to them and to the unborn/young child.
4. **Escalation**: repeat victimisation and escalation must be identified. DA victims are more likely to become repeat victims than any other type of crime; as violence is repeated it gets more serious.
5. **Community issues/isolation**: needs may differ amongst ethnic minority victims, newly arrived communities, asylum seekers, older people, people with disabilities, as well as travelling or gay, lesbian, bisexual or transgender people. This might be in terms of perceived racism, language, culture, insecure immigration status and/or accessing relevant support services.
6. **Stalking**: persistent and consistent calling, texting, sending letters, following. DA stalkers are the most dangerous. Stalking and physical assault, are significantly associated with murder and attempted murder. This is not just about physical violence but coercive control and jealous surveillance.
7. **Sexual assault**: those who are sexually assaulted are subjected to more serious injury. Those who report a domestic sexual assault tend to have a history of domestic abuse whether or not it has been reported previously. Many domestic sexual offenders are high risk and potentially dangerous offenders.
8. **Strangulation** (choking/suffocation/drowning): escalating violence, including the use of weapons and attempts at strangulation must be recorded when identifying and assessing risk. This includes all attempts at blocking someone's airway.
9. **Credible threats to kill**: a credible threat of violent death can very effectively control people and some may carry out this threat.
10. **Use of weapons**: abusers who have used a weapon, or have threatened to use a weapon, are at increased risk of violent recidivism.
11. **Controlling and/or excessive jealous behaviour**: complete control of the victim's activities and extreme jealousy are associated with serious violence and homicide. Consider honour based violence – the victim may not have the freedom of choice. Examples may include fear of or actual forced marriage, controlling sexual activity, DA, child abuse, rape,

kidnapping, false imprisonment, threats to kill, assault, harassment, forced abortion. The perpetrator may well try and control professionals as well.

12. **Child abuse**: Evidence shows that both DA and child abuse can occur in the same family. Child abuse can act as an indicator of DA in the family and vice versa.
13. **Animal/pets abuse**: there is a link between cruelty to animals, child abuse and DA. The use or threat of abuse against pets is often used to control others in the family. Abuse of animals may also indicate a risk of future harm.
14. **Alcohol/drugs/mental health**: the abuser's use of drugs and alcohol are not the cause of the abuse, as with all violent crime they might be a risk of further harm. Physical and mental ill health does appear to increase the risk of DA.
15. **Suicide-homicide**: threats from an offender to commit suicide have been highlighted as a factor in domestic homicide. A person who is suicidal should also be considered homicidal.

It is clear from conducting this domestic homicide review that a substantial number of the above factors were present in Annie's life.

18.16 **Recommendations Key Event 4**

1. All agencies to ensure that staff recognise the increased vulnerability of parents who have a child(ren) taken into a care and how they may not seek help or disclose risks to themselves when in the process of seeking to get the child(ren) back.
2. As above but for carers worried about having a child(ren) taken into care.
3. The Safer Hartlepool Partnership share this DHR report with the Commission on Domestic & Sexual Violence and Multiple Disadvantage.

19. Identification of Good Practice

19.1 There were a number of times that staff from a number of agencies went the 'extra mile' in an attempt to support both Annie and the perpetrator:

- In July 2014 the social worker spent a significant amount of time with Annie supporting her in her desire to separate from the perpetrator due to his coercion and control. She sourced a number of alternative properties and referred her to Harbour with regard to addressing the concerns over the alleged domestic abuse.

- On the times the perpetrator attended the A&E department at North Tees Hospital staff always ensured that detailed capacity assessments were carried out at the appropriate and expected times on attendances, referrals to mental health services were always followed up by a face to face visit and when the perpetrator absconded the staff made every effort to ensure his safety was maintained and he was brought back to the clinical area.

- Unplanned meeting October 2017 in the community with the perpetrator by TEWV Hartlepool Affective Disorders team member. He was challenged re his lack of engagement with the team and told that he could access more support if he utilised the service more appropriately.

- Support to Annie shown by staff at both Harbour and Hartlepool & East Durham Mind throughout her engagement.

20. Predictability and Preventability

20.1 In terms of considering whether the homicide could have been predicted, the test used is that it is considered that the homicide would have been predictable if there was evidence from the perpetrators' words, actions or behaviour at the time that could have alerted professionals that they might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

20.2 In terms of the test used for preventability, it is considered that the homicide would have been preventable if there was evidence that professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are invariably things which could have been done to prevent any tragedy

20.3 There have been a number of missed opportunities identified in this report to better understand the potential risk posed by the perpetrator to Annie including:-

- the mismanagement of the PDP referral and the failure to convene a multi-agency meeting reducing effective information sharing,
- the fact that a carers assessment was not conducted with Annie and as a result this not informing the potential risk to her,
- the fact no Prevent referral was made, and
- a necessary focus on child protection at the expense of recognising wider potential vulnerability.

These and others have been identified as learning points and associated recommendations made.

20.4 Despite these missed opportunities it is the belief of the Panel members that Annie's murder was not predictable. From January 2018 Annie had separated from the perpetrator and was successfully moving on with her life building both her confidence and self-esteem. There was no relevant interaction with the perpetrator by any agency from the end of March 2018 until he killed Annie four months later. After her death it did become known that the perpetrator had threatened Annie on numerous occasions prior to her death however this was not disclosed to any agency to act upon. Annie indicated to those agencies she was working with that she was happy and well. Under all

the circumstances none of the agencies involved had any evidence or suspicion that the perpetrator was about to carry out a deadly attack on Annie.

20.5 By the very nature that Annie's murder was not predictable it was also not preventable as none of the agencies involved had any evidence or suspicion that the perpetrator was about to carry out a deadly attack on Annie.

21. Summary of Recommendations.

1. Cleveland Police review their domestic abuse training for officers and staff to satisfy themselves and the Safer Hartlepool Partnership that it effectively encompasses and addresses the hidden signs of domestic abuse.

2. Cleveland Police ensure that the decision-making rationale for prioritisation of investigations is clearly recorded.

3. Cleveland Police review the governance and oversight of investigations with regard to timeliness and ensuring all available evidence is captured.

4. TEWV to ensure all frontline staff attend Domestic Abuse training focussing on staff always considering potential vulnerabilities of other members of the household when undertaking assessments of a patient's mental health and associated risks encouraging the adoption of a think family approach..

5. TEWV to provide guidance to staff when working with the perpetrator of domestic violence and including this within the Domestic Abuse policy.

6. TEWV to ensure effective supervision processes are in place so that when a carers assessment is offered that it is completed.

7. When there is multi-agency involvement in a patient's case, TEWV to ensure open channels of communication should be maintained with all agencies involved.

8. When there is multi-agency involvement in a patient's case, TEWV to ensure any alerts pertaining to potential risks should be shared across all agencies.

9. All safeguarding concerns should be recorded in line with TEWV processes, policies and procedures.

10. TEWV to review their risk assessment arrangements to ensure it captures new information and intelligence.

11. NHS England (North) share the MHHR report when finalised with the Safer Hartlepool Partnership to ensure co-ordination between relevant recommendations.

12. The Safer Hartlepool Partnership to seek assurance that the 11 recommendations from the Cleveland Police internal review are implemented.

13. Cleveland Police should engage with partner agencies, particularly the National Probation Service, in reviewing multi-agency knowledge and where appropriate involvement in the identification and management of a PDP.

14. Once the above has been achieved all agencies to ensure that their staff are aware of the PDP policy and process.

15. All agencies to review their policy on encouraging professional challenge and ensure staff are confident to do so including encouraging and listening to challenge from third sector organisations.

16. The Safer Hartlepool Partnership to review the effectiveness of Prevent training and that multi-agency staff recognise when and how to make a referral.

17. All agencies to ensure that staff recognise the increased vulnerability of carers who have a child(ren) taken into a care and how they may not seek help or disclose risks to themselves when in the process of seeking to get the child(ren) back.

18. As above but for carers worried about having a child(ren) taken into care.

19. The Safer Hartlepool Partnership to share this DHR report with the Commission on Domestic & Sexual Violence and Multiple Disadvantage.

National Recommendation

1. The Home Office to consider placing the guidance for the identification and management of PDP's on a statutory footing to mirror MAPPA to prevent differing practices across England and Wales

APPENDICES

APPENDIX 1

College of Policing Guidance: Major investigation and public protection
Potentially dangerous persons
This module presents the rationale behind managing potentially dangerous persons (PDPs). It explores the ways which PDPs are identified, and describes the key elements involved in their management.

Contents

A) Introduction
B) Initial referral
C) Risk assessment
C).i Agencies checks
C).ii Risk matrix
C) iii Referral for ratification
D) Managing PDPs
D).i Victim considerations
D).ii Information sharing
D).iii Necessity and proportionality
D).iv Stored and shared safely and securely
D).v Deregistration of a PDP
D).vi Requests under the Freedom of Information Act 2000

A Introduction

A PDP is a person who is not currently managed under one of the three MAPPA categories, but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm.

Examples of PDPs include:

- a person charged with domestic abuse offences on a number of occasions against different partners but never convicted of offences that would make them a MAPPA-eligible offender
- an individual who is continually investigated for allegations of child sexual abuse but is never charged or never receives a civil order, but whom agencies still believe poses a serious risk of sexual harm to children
- a terrorist suspected but not convicted of an offence
- where a community psychiatric nurse (CPN) shares information with the police that a patient with mental ill health has disclosed fantasies about committing serious violent offences. The patient is not cooperating with the current treatment plan, and the CPN believes serious violent behaviour is imminent.
- a person who has committed offences abroad that had they been committed here would result in the offender being managed under MAPPA.

These types of individuals could still benefit from active risk management but would not be managed under MAPPA. This management would usually involve two or more agencies, although there may be cases where only the police are involved. There must be a present likelihood of the subject causing serious harm in order for their case to be managed.

Although there is no statutory multi-agency framework to govern PDPs, a multi-agency approach is considered good practice. The CJA 2003 provides the legislative framework for the responsible authority to establish arrangements in relation to MAPPA offenders, but this **does not** extend to PDPs. The police, however, can decide that the risk posed by a PDP requires them to retain and share information. The authority to so lies in the positive obligations under the European Convention on Human Rights (ECHR), as incorporated under the Human Rights Act 1998. These are Article 2 (the right to life) and Article 3 (the right to freedom from torture or inhuman or degrading treatment or punishment).

Further information
Violent and sexual offences that meet the threshold of serious harm are outlined in Schedule 15 of the Criminal Justice Act 2003 (CJA).

B) Initial referral

Chief officers must ensure forces have a robust mechanism for receiving and auctioning PDP referrals. The process should be communicated to all staff, with clear instruction on how to access the PDP referral form.
A PDP may be identified in a number of ways, including:

- where there is an unproved allegation of a Schedule 15 offence (CJA)
- information or intelligence acquired or received by police
- as cases referred to MAPPA that do not qualify for MAPPA management but meet PDP criteria
- referral from another agency, such as mental health services, childcare services or social services
- referral from any individual or unit within the police force with information that someone meets the PDP criteria.

Any police officer or member or police staff who either has a concern regarding a potential PDP, or has been passed information alerting them to another persons' concern should be encouraged to talk to a member of the MOSOVO team regarding the referral.

C) Risk assessment

As potential PDPs may pose an immediate threat, the initial risk assessment is crucial and central to their effective management.

On receipt of a potential PDP referral, a member of the MOSOVO team develops an intelligence profile to inform risk assessment. Local force intelligence systems, PND, and partner agencies checks assist in building this profile. The results of the checks informs the ratification decision making.
The person in charge of the MOSOVO unit is responsible for ensuring that risk assessments of PDPs take place in a timely fashion, are informed by current and relevant information and intelligence and the right actions are taken to manage the risk.

For risk assessment to be as accurate and informed as possible, it is essential that any information available to the police or partner agencies which indicates that someone is likely to commit an offence or offences causing serious harm, or is likely to commit more serious offences is considered. All police officers and staff must, therefore, ensure any information is recorded and routed correctly in line with their local force policies.

The assessment of PDP referrals should only be carried out by staff with the appropriate training and experience, ie a MOSOVO officer or offender manager. They are responsible for initiating intelligence work, checking the referral, and determining whether they are eligible to be registered on ViSOR as PDP. Referrals should be assessed according to the apparent risk they pose, including the initial risk assessment.

The assessment should include:

- the nature and pattern of the individual's behaviour
- the nature of the risk
- who is at risk (eg, particular individuals, children, vulnerable adults)
- the circumstances likely to increase risk (for example, issues relating to mental health, medication, drugs, alcohol, housing, employment, relationships)
- the factors likely to reduce risk
- all relevant medical evidence available and consideration of whether there is a reasonable medical explanation for the behaviour displayed.

If eligible for MAPPA, (in accordance with Chapter 6 of MAPPA Guidance) the referral should be passed on to the MAPPA coordinator in line with MAPPA Guidance and local policy. If the individual is not eligible for MAPPA, staff should decide if the referral merits further attention at this stage.

C i) Agencies checks

Staff should check with the following agencies:

- health (including mental health)
- local authority social care services (for children and adults).

Staff should also check with any other agencies they feel may hold information pertinent to the prevention and detection of crime. These agencies include, but are not limited to, the probation service, the local housing authority and local education authorities.

Staff should seek clarification on what the agency's view is on the risk presented and what actions they are currently undertaking or intend to undertake to manage the risk.

C ii) Risk matrix

Staff may use a risk matrix that considers the likelihood and severity of risk. This can help confirm imminence and the likelihood of causing serious harm.

If the individual being referred is under 18 years of age, staff should consider making a safeguarding children referral. Children's services (plus the youth offending team, if applicable) should be involved in any resulting processes to manage the individual as a PDP.

Screening decision

The completed PDP referral form should be submitted to the identified supervisor for a screening decision. A clear force policy should be in place which clarifies decide how these screening decisions are made and if they should involve other agencies at this stage.

The screening decision should be made by the supervisor, according to risk and, in any event, within five working days of the initial assessment. The decision should be noted on the PDP referral form. If the outcome is to not progress managing the individual as a PDP, the PDP referral form and all associated documents should be retained in accordance with APP on information management. If the decision is made to seek ratification as a PDP, the form should be sent to an officer of at least superintendent rank, including an outline of actions to manage the risk(s) presented.

C iii) Referral for ratification

The decision to ratify (or not) an individual as a PDP should be made by a suitably senior officer with the appropriate training and experience. The decision should be:

- made according to the risks assessed
- made within five working days of receiving the referral
- noted on the PDP referral form.
-

If the decision is made not to ratify, this should be recorded on appropriate force and national systems, such as ViSOR. The PDP referral form, together with all associated documents, should be retained in accordance with APP on information management.

If the decision is made to ratify the individual, forces should determine which policing unit will be responsible for managing the PDP and make this information available to all relevant police officers and staff (eg, communications room staff). The decision to ratify should be recorded on appropriate force and national systems, such as ViSOR.
Once a PDP is ratified, a ViSOR record should be created in line with Home Office ViSOR Standards. Forces should determine which policing unit will be responsible for managing the ViSORrecord.

D) Managing PDPs

Forces determine how PDPs are managed. This will include risk management strategies that are developed between the force and partner agencies, who work closely to share information regarding the PDP. This may include convening PDP meetings, which should include all relevant agencies. All PDP

meetings should be recorded on the PDP meeting form and the minutes attached to the PDP's ViSOR record.

Every PDP should have a risk management plan recorded on ViSOR. An offender manager will be allocated by the head of the MOSOVO unit to take responsibility for the management of the PDP. In addition to the usual policing tactics for preventing crime and reducing harm, the offender manager should consider the following areas as part of any PDP risk management plan:

- information sharing
- disclosure to third parties
- appointing an offender manager
- review of unsuccessful criminal investigations
- applying for a civil order
- risk management options used in managing MAPPA offenders.

It may be appropriate to inform the PDP that they are being managed as such. This is decided on a case-by-case basis and the rationale for any such decision should be fully documented. MOSOVO officers must be mindful of the Human Rights legislation that exists to protect an individuals' right for a private life and to live free from degrading treatment, but this must be balance with the proportionate action that the police are duty-bound to take to protect the public. For example, PDPs engaged as part of a risk management plan should be informed of their status. This would not be appropriate, however, if the risk management plan included covert tactics.

If the PDP moves from one force area to another, local force procedures for the transfer of this assessment and all other records including management activities and issues should be followed. These procedures should comply with the Home Office ViSOR Standards.

PDP cases should not be managed indefinitely and should be reviewed at regular intervals. Staff should review and update the PDP risk management plan at least every six weeks. The police have primary responsibility for coordinating the management of PDPs. Other agencies may be given responsibility for leading on specific risk management actions.

D i) Victim considerations

Victim safety, preventing repeat victimisation and avoiding the creation of new victims are fundamental to public protection. Agencies should ensure that their decision making is based on effectively engaging current and potential victims, where practicable and appropriate. By doing so agencies can establish that risk assessment and risk management plans properly reflect victim concerns and provide appropriate measures to protect them.

The safeguards relating to disclosing information about a PDP to third parties are as important as those for MAPPA offenders. For more information, agencies should refer to the chapter on disclosure in the current MAPPA guidance.

As part of any PDP risk management plan, the police should decide whether third-party disclosure is necessary. If a PDP meeting is being held, disclosure should be given due consideration on a case-by-case basis as a standard agenda item. The decision to disclose should balance the PDP's right to Article 8 and the victim's right to Article 3. Decision makers will need to consider how best to make a victim safe. This will include deciding whether informing the PDP, and/or the victim, will assist or hinder this. Proportionality is a consideration and this should be linked to the options available to manage the PDP.

D ii) Information sharing

As in all cases where information is retained and shared, staff should take account of whether any infringement of ECHR, Article 8 (the right to respect for private and family life) is necessary and, if so, that it is for one of the reasons specified in Article 8(2). These reasons include public safety, in the interest of national security, the prevention of disorder or crime, or for the protection of the rights and freedoms of others. For further information see managing information.

Section 115 of the Crime and Disorder Act 1998 allows any person to pass information to certain relevant authorities (including the police and probation services, health and local authorities) where the disclosure is necessary or expedient for the purposes of any provision of this Act. This helps implement the provisions of that Act, including local strategies to reduce crime and disorder.

D iii) Necessity and proportionality

The amount of information to be shared with only the appropriate staff in each agency must be proportional to the risk presented.

For example, the PDP referral form may contain the personal data of multiple individuals (eg, victims and perpetrators). Staff should consider the interests of all these people when sharing this information. In addition, information shared with a single point of contact (SPOC) in an agency does not give that SPOC the authority to share the information more widely across their organisation than is strictly necessary.

The more information shared beyond that which is necessary, the more likely the sharing will be disproportionate and, therefore, unlawful.

D iv) Stored and shared safely and securely

All information about PDPs must be kept and shared safely and securely, and should only be available to, and shared with, those who have a legitimate interest in knowing it. Safeguards must be in place to ensure that people who do not have a legitimate interest in the information cannot access it. The more sensitive the information and the more serious the consequences of accidental

loss or disclosure of such information, the more stringent the procedures needed to protect it.

Agencies must ensure that staff have confidence in the administrative procedures underpinning efficient PDP management. Accurate, clear and timely record keeping is necessary to demonstrate accountable information sharing and show safe and secure information storage and retrieval procedures.

Effective policing of PDPs requires information sharing and efficient information management. See APP on information management.

D v) Deregistration of a PDP

A suitably senior officer with the appropriate training and experience can decide to deregister a PDP if:

- the PDP becomes eligible for MAPPA management
- there are no longer reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm
- after review, no additional reason has been raised that suggests it is necessary continue to manage the individual as a PDP.

The decision to deregister an individual as a PDP should be ratified by a superintendent or above with the appropriate training and experience to perform this role. This should be recorded on the original PDP referral form and noted on the PDP's ViSOR record, following which the ViSOR record will be archived.

D vi) Requests under the Freedom of Information Act 2000

The management of MAPPA offenders attracts a significant amount of interest, and forces receive many requests under the Freedom of Information (FOI) Act 2000 for information on local processes and offenders. The management of PDPs can attract similar levels of interest. Any FOI requests must be referred to the NPCC national policing freedom of information and data protection central referral unit (CRU) who will provide advice, best practice and consistency. After referring a request, staff should not respond to the applicant before hearing from the CRU.

MAPPA

APPENDIX 2

1. Introduction

The MAPPA (Multi-Agency Public Protection Arrangements) is a national framework to assess and manage the risk posed by serious and violent offenders. The MAPPA cannot address the risks posed by all potential perpetrators of abuse, its focus is convicted violent and sexual offenders living in, or returning to, the community.

2. What is MAPPA?

MAPPA are a set of arrangements to manage the risk posed by certain sexual and violent offenders. They bring together the Police, Probation and Prison Services into what is known as the MAPPA Responsible Authority.

A number of other agencies are under a legal duty to co-operate with the Responsible authority. These include: Children's Services, Adult Social Services, Health Trusts and Authorities, Youth Offending Teams, local housing authorities and certain registered social landlords, Job Centre Plus, and electronic monitoring providers.

The purposes of MAPPA are:

To ensure more comprehensive risk assessments are completed, taking advantage of co-ordinated information sharing across the agencies; and
To direct the available resources to best protect the public from serious harm.
How Does MAPPA Work?

Offenders eligible for MAPPA are identified and information is gathered/shared about them across relevant agencies. The nature and level of the risk of harm they pose is assessed and a risk management plan is implemented to protect the public.

In most cases, the offender will be managed under the ordinary arrangements applied by the agency or agencies with supervisory responsibility. A number of offenders, though, require active multi-agency management and their risk management plans will be formulated and monitored via MAPPA meetings attended by various agencies.

3. Who are MAPPA Offenders - MAPPA Levels

There are 3 categories of offenders eligible for MAPPA:

- Category 1 - Registered sexual offenders:

Sexual offenders who are required to notify the police of their name, address and other personal details and notify the police of any subsequent changes.

- Category 2 - Violent offenders:

Offenders sentenced to imprisonment/detention for 12 months or more, or detained under hospital orders. This category also includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children; and

- Category 3 - Other dangerous offenders:

Offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.

ACTION PLAN

Action Plan

APPENDIX 3

Recommendation	Scope of recommendation i.e. local or regional etc.	Action to take	Lead Agency	Progress	Target Date	Date of completion and outcome
1. Cleveland Police review their domestic abuse training for officers and staff to satisfy themselves and the Safer Hartlepool Partnership that it effectively encompasses and addresses the hidden signs of domestic abuse.		Cleveland Police to review training to satisfy that it highlights domestic abuse.	DSI LT Cleveland Police		30/9/19	
2. Cleveland Police ensure that the decision-making rationale for prioritisation of investigations is clearly recorded.		Cleveland Police decision-making rationale for prioritisation of investigations is clearly recorded.	DSI LT Cleveland Police		30/9/19	
3. Cleveland Police review the governance and oversight of investigations with regard to timeliness and ensuring all available evidence is captured.		Cleveland Police review governance and oversight of investigations with regard to timeliness ensuring all available evidence is captured.	DSI LT Cleveland Police		30/9/19	
4. TEWV to ensure all frontline staff attend Domestic Abuse training focussing on staff always considering potential vulnerabilities of other members of the household		Safeguarding children level 3 training which focuses on domestic abuse to be reviewed to ensure it identifies the need to consider	KA TEWV		31st July 2019	

Action Plan

APPENDIX 3

Recommendation	Scope - i.e. local or regional etc.	Action to take	Lead Agency	Progress	Target Date	Date of completion and outcome
when undertaking assessments of a patient's mental health and associated risks encouraging the adoption of a think family approach.		other members of the household when undertaking an assessment. All staff meeting the intercollegiate level 3 training to have received the domestic abuse training package.			November 3oth 2019	
5. TEWV to provide guidance to staff when working with the perpetrator of domestic violence and including this within the Domestic Abuse policy.		TEWV to provide guidance for staff when working with the perpetrator of domestic violence updating domestic abuse policy Circulating a briefing to managers to share with team members. Update the Trust	KA TEWV		March 2020 (policy due for update and there is an audit underway which will inform the policy review) July 31st 2019 July 31st 2019	

Action Plan

APPENDIX 3

Recommendation	Scope - i.e. local or regional etc.	Action to take	Lead Agency	Progress	Target Date	Date of completion and outcome
		intranet site				
. 6. TEWV to remind staff the need for carers assessments.		Circulate a briefing to managers to ensure this is shared with all staff.	KA TEWV		31/07/19	
7. When there is multi-agency involvement in a patient's case, TEWV to ensure open channels of communication should be maintained with all agencies involved.		Safeguarding training to be reviewed to ensure this reflects the need for information with the multi-agency network to ensure risks shared and safeguarding is a prioritised. Review of Level 1 and 2 safeguarding adult training. Level 2 and 3 safeguarding children training.	KA TEWV		31/07/19	
8. All safeguarding concerns should be recorded in line with TEWV processes, policies and procedures.		Review processes, policies and procedures for staff recording safeguarding concerns	KA TEWV		30/9/19	
9. TEWV to review their risk assessment arrangements to		TEWV to review risk assessment	KA TEWV		30/9/19	

Action Plan

APPENDIX 3

Recommendation	Scope - i.e. local or regional etc.	Action to take	Lead Agency	Progress	Target Date	Date of completion and outcome
ensure it captures new information and intelligence.		arrangements processes and their ability to react to dynamic information or intelligence.				
10. NHS England (North) share the MHHR report when finalised with the Safer Hartlepool Partnership to ensure co-ordination between relevant recommendations.		NHS England to share MHHR report when published.	KC NHS England		When MHHR report published	
11. The Safer Hartlepool Partnership to seek assurance that the 11 recommendations from the Cleveland Police internal review are implemented.		Cleveland Police to provide Safer Hartlepool Partnership (SHP) up to date report on implementation of recommendations from internal PDP report / review.	DSI LT Cleveland Police		30/9/19	
12. Cleveland Police should engage with partner agencies, particularly the National Probation Service, in reviewing multi-agency knowledge and where appropriate involvement in the identification and management of a PDP.		Cleveland Police to share with partners their PDP processes.	DSI LT Cleveland Police		30/9/19	

Action Plan

APPENDIX 3

Recommendation	Scope - i.e. local or regional etc.	Action to take	Lead Agency	Progress	Target Date	Date of completion and outcome
13. Once the above has been achieved all agencies to ensure that their staff are aware of the PDP policy and process.		All Agencies to ensure their staff understand Cleveland Police PDP policy and processes	All Relevant Agencies		31/12/19	
14. All agencies to review their policy on encouraging professional challenge and ensure staff are confident to do so including encouraging and listening to challenge from third sector organisations.		Relevant Agencies to check / review guidance to staff on their understanding and importance of professional challenge.	All Relevant Agencies		30/9/19	
15. The Safer Hartlepool Partnership to review the effectiveness of Prevent training and that multi-agency staff recognise when and how to make a referral.		SHP to review the effectiveness of Prevent training.	RP Hartlepool Borough Council		30/9/19	
16. All agencies to ensure that staff recognise the increased vulnerability of carers who have a child(ren) taken into a care and how they may not seek		All Relevant Agencies to brief staff with regard to increased vulnerability of carers who have had a child(ren) taken into	All Relevant Agencies		30/9/19	

Action Plan

APPENDIX 3

Recommendation	Scope - i.e. local or regional etc.	Action to take	Lead Agency	Progress	Target Date	Date of completion and outcome
help or disclose risks to themselves when in the process of seeking to get the child(ren) back.		care.				
17. As above but for carers worried about having a child(ren) taken into care.			All Relevant Agencies		30/9/19	
18. The Safer Hartlepool Partnership to share this DHR report with the Commission on Domestic & Sexual Violence and Multiple Disadvantage		SHP to send DHR report to Commission upon completion.	RP Hartlepool Borough Council		30/9/19	
The Home Office to consider placing the guidance on identification and management of PDP's on a statutory footing to mirror MAPPA to prevent differing practices across England and Wales	National					

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
Hartlepool and Stockton Clinical Commissioning Group	JG Director of Nursing and Quality,	**Actions by this agency (to be agreed with the GP practice)** • Add the 'relationships' to existing names within the 'contacts and relationships' links in the patient's electronic GP record.	Administration team have commenced adding the 'relationships' for all new patients and have started to populate for existing patients as and when patients are seen in the practice.	Ongoing
		• Practitioners need to seek assurance that patients are safeguarded when domestic abuse risk factors are identified.	Shared as best practice at practice meetings and is included in the adult safeguarding policy?	Completed
		• Ensure all staff are up-to-date with safeguarding adults and children training.	Safeguarding training is ongoing. Current compliance is: Safeguarding Adults Level 1 87% Safeguarding Adults Level 2 82% Safeguarding Children Level 1 85% Safeguarding Children Level 2 87% Safeguarding Children Level 3 81% Further safeguarding training is planned to be completed in for September / October 2019.	Ongoing
		• Develop a Domestic Abuse Policy for the GP practice.	Domestic abuse has been incorporated into a new safeguarding adults policy which has been shared in the practice and is available on internal website.	December 18

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
		• Implement a Domestic Abuse Policy audit to assess the domestic abuse knowledge of staff.	Audit is being planned to complete by the end of 2019.	December 19
		• On receipt of any children's strategy minutes from children's social care these should be referenced in both parents GP records to inform future healthcare practitioners of a possible domestic abuse risk.	Shared as best practice at practice meetings.	Completed
		• Improve the documentation of any discussion that has taken place with the patient about possible domestic abuse, particularly referencing partners (including ex partners, children and other family members).	Shared as best practice at practice meetings. Peer GP record audits are completed and shared within the practice?	Ongoing
		• Explore processes that could support the review of 'frequent attenders' of the GP practice. This would provide an opportunity to asses if any further support /change of management /reduce possible risks which could include domestic abuse risks could be made to improve their management and reduce attendance.	Examples of good practice has been shared with the practice to support a review. Initial data collection has been completed and is currently being analysed to provide specific practice data. This will support the identification and details of any frequent attenders to further explore any required actions.	December 19
Cleveland MAPPA Strategic Management Board	AP Head of National Probation Service	• Cleveland MAPPA Co-ordinator consults with Police PDP process owner to review and clarify how the two processes should work alongside each other.	MAPPA Co-ordinator and Police planning meeting arranged for July 2019	September 2019

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
		• MAPPA Co-Ordinator to ensure that any involvement with PDP cases from a formal MAPPA perspective is recorded and that agreed actions are reviewed in a timely manner.		
Hartlepool and East Durham Mind - In Mind Service – Improving Access to Psychological Therapy Services and (Mindskills Recovery College)		• Recommend that we add information to the GP letter regarding potential risk of DV, thereby alerting and raising awareness of the GP and enabling them to use their processes.	Discussion during supervision and team meeting	05/12/2018
		• Recommend that a “data label” for vulnerability be added to the patient management system so that this can be used to identify individuals and any additional support they may need. This will include the “The vulnerable person” and flag up partner in cases of DV. (Search the system for active patient or potential referrer)	Completed	05/12/2018 by Mindskills Recovery College Manager
		• Monitor on-going vulnerability and changes to circumstances – optional aggravated behaviour towards the learner/patient	Discussions during supervision and team meeting Risk Training for all staff	05/12/2018 by supervisors ALL STAFF (INmind and Mindskills) completing

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
				risk training by 02/07/19
		• Historic DV will be treated as current DV and make formal contact with other agencies so we can share information and monitor any changes to the learner's circumstances.	Discussion during supervision and team meeting Risk Training for all staff	05/12/2018 by supervisors ALL STAFF (INmind and Mindskills) completing risk training by 02/07/19
		• To put in place staff training to ensure that all information and intelligence in regards to a patients risk or vulnerability to domestic abuse be shared to maximise the opportunities to minimise risks of harm to the patient.	New Risk training to be delivered, implementing Evidence based risk factors and "red warning signs" and classification of suicidal thoughts (Cole-King) Any new clinical staff will be training. This will be mandatory training	Risk training for Managers completed 27/03/2019. All clinical and community staff will be trained by 02/07/ 2019
		• To ensure we have all other professionals' details and these are added to the patient's file and relevant permissions for information sharing are clarified at the point of assessment and these are reviewed throughout their time within the service.		

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
		• The findings from this report will be taken to the Clinical Governance meeting to provide on-going monitoring and reviewing of safeguarding and risks in relation to hidden harm, DV and high risk individuals that will be now flagged as data labelled.		
		• Changes in "Did Not Attend" process within the INmind service.	All counsellors and therapists have been informed about the new process. Clients who DNA will be contacted on the day of their appointment to check for well-being and risk.	05/12/2018
Hartlepool Borough Council's	Drug & Alcohol Service	• Workers within the Drug & Alcohol Service should give consideration to the 'Think Family' approach to the sharing of information appropriately across agencies and the impact on the wider family where individuals fail to engage with services, in particular the risks to self and others.		
		• When conducting case closures the service should be recording the outcome of any discussions with other agencies involved.		

IMR Agency Recommendations

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Agency	Owner	Action	Progress	Timescale
Thirteen	KG, Director of Neighbourhoods	• Monitor new ways of working through the operating model to ensure that our Neighbourhood Coordinators build up the relationships with their customers, minimising where possible the amount our staff move between patches to build up that historical knowledge.		December 2019
		• Where reports of ASB are reported a personal contact should always take place to help build up information and ensure that the complaints are fully investigated and support provided where appropriate for customers.		Complete
		• Explore further opportunities for Thirteen to be included in data sharing with other agencies where they are one of our customers and a multi-agency approach is already evident.		December 2019
Harbour Services	LG, CEX,	• A key finding of this Individual Management Review is that **t**here is a need to improve efforts to co-ordinate responses in the future to ensure a shared understanding and management of risk where domestic abuse is an issue but where MARAC thresholds are not met. The following actions are recommended to address this issue: i. Harbour protocols to be amended to ensure staff request a copy of the standard DASH risk assessment		30/09/19

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
		undertaken from the referring agency, and/or alternatively involve the referring agency in initial assessments undertaken with clients. ii. Harbour protocols to be amended to ensure staff request a multi-agency meeting in complex cases where MARAC thresholds are not met.		30/09/19
		• The second key finding of this review is that there is a pressing need to improve understanding locally around victim motivations for engaging with services and potential barriers to disclosure. The following action is recommended to address this issue: •Harbour's domestic abuse and risk assessment training for professionals to be strengthened to include more information on motivations for engaging with the service. This to include what victims may not be telling us and how we work with people to give confidence to share without being judged.		30/9/19
		• Subject to further discussion with partners it is anticipated that these recommendations will be implemented by September 2019.		

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
Cleveland Police	687 MH	• Full review of the process for the management of dealing with un convicted sex offenders		Ongoing
		• PPNs have now been implemented by Cleveland Police and the training of all staff from control room to front line officers and specialist departments, in order to highlight and submit appropriate referrals covering all vulnerability / age groups		Ongoing
		• Mental Health to be clearly identified and managed from an early point or contact in order to prevent future offending, provide support to the most vulnerable within the communities Cleveland Police serve		Ongoing
		• Mental Health Training to all first line officers / Supervisors, in order that Mental Health can be identified / supported		Ongoing
		• Future national 2 x days training to support mental health / recognising and responding vulnerability best practice to be adopted		2020
		• Look beyond the obvious training to staff and police officers ongoing problem solving approach around dealing with mental health to be developed for front line officers		Ongoing

IMR Agency Recommendations

APPENDIX 4

Agency	Owner	Action	Progress	Timescale
Hartlepool Borough Council's	(HBC) Children's and Joint Commissioning Services	• Where an individual fails to attend services identified as being required as part of a plan to safeguard a child or promote his/her welfare, social workers should discuss the reasons for this with the individual, removing any barriers to non engagement and/or reflecting on the implications of this for the protection and welfare of their child/ren. The outcome of these conversations should be detailed in the child's record.	Communication sent to children's services workforce outlining recommendations and actions required by workforce Actions complete.	
		• Prior to a case being closed, the social worker should check the recommendations of any previous child protection strategy meeting or conference to ensure these have been fully complied with. Where there are outstanding matters or a change in circumstance relevant to these recommendations a case should not be closed until risk factors are properly assessed.		

GLOSSARY

Agencies organisational Description	
Hartlepool Borough Council	Is the local authority of the Borough of Hartlepool. It is a unitary authority, with the powers and functions of a non-metropolitan county and district council combined.
Tees Esk Wear Valley Foundation Trust	Tees, Esk and Wear Valleys Foundation NHS Trust is an NHS trust that provides mental health services. It covers the 1.4 million people living in County Durham, Teesside, North East Yorkshire and York, England.
Hartlepool & Stockton Clinical Commissioning Group	Clinical Commissioning Group - Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Cleveland Police	Cleveland Police is responsible for policing the area of former county of Cleveland in north east England including Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland.
Harbour	Harbour works with families and individuals who are affected by abuse from a partner, former partner or other family member.
North Tees and Hartlepool Foundation Trust	Provide integrated hospital and community-based services to around 365000 people living in East Durham, Hartlepool, Stockton on Tees and surrounding
Hartlepool and East Durham Mind	Involving individuals and communities in mental health support and wellbeing
National Probation Service	The National Probation Service for England and Wales is a statutory criminal justice service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties
Thirteen	Landlord and housing developer, providing homes for rent and sale providing customers with homes, support and opportunities to grow.

Acronym	Definition
ADHD	Attention Deficit Hyperactivity Disorder is a medical condition. A person with ADHD has differences in brain development and brain activity that affect attention, the ability to sit still, and self-control.
Affective disorder team	The affective team, also known as the community resource team, offer individuals support with a wide range of mental health difficulties, including severe depression, anxiety, personality disorders, OCD, eating disorders and several other non-psychotic conditions.
Alexithymic	Is a personality construct characterized by the subclinical inability to identify and describe emotions in the self. The core characteristics of alexithymia are marked dysfunction in emotional awareness, social attachment, and interpersonal relating.
AMH Hartlepool Crisis Resolution	Crisis teams support people who might otherwise need to go to hospital, for example due to psychosis, severe self-harm or suicide attempts. They usually include a number of mental health professionals, such as a psychiatrist, mental health nurses, social workers and support workers.
AVA	Against Violence and Abuse
CAIU	Child Abuse Investigation Unit - All allegations of abuse made by the public or other agencies, such as health or children's services, are brought to the attention of the area command Child Abuse Investigation Unit (CAIU).
CBT	Cognitive behavioural therapy is a talking therapy that can help people manage their problems by changing the way they think and behave. Its most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems.
Chronology	A chronology is a key part of an assessment. It is used to record significant events to help professionals from a range of disciplines understand what is happening in the life of a child or young person.
CPA	The Care Programme Approach (CPA) is a package of care for people with mental health problems.
CPS	The Crown Prosecution Service (CPS) is the principal public prosecuting agency for conducting criminal prosecutions in England and Wales. It is headed by the Director of Public Prosecutions (DPP).
Crisis Team	The Crisis Management Team (CMT) provides support through management of crisis level issues, managing additional risks, exposures and stakeholder interests in response to an event or disaster requiring the activation of the CMT.
CSC	Childrens Social Care - Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.
DASH	DASH stands for domestic abuse, stalking and 'honour'-based violence.– When someone is experiencing domestic abuse, it's vital to make an accurate and fast assessment of the danger they're in, so they can get the right help as quickly as possible.

DHR	A Domestic Homicide Review (DHR) is a multi-agency 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 person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of ...
DI CAIU	Detective Inspector Child Abuse Investigation Unit
ECR	Electronic Care Record
Freedom programme	The Harbour Freedom Programme is a 12 week course that will help women to understand the beliefs held by abusive men and the effects of abuse upon children. The programme aims to help participants to help themselves and increase their self-confidence.
GP	General Practitioner - a doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.
Harbour outreach service	- Harbour Domestic Abuse Services. Harbour's Adult Outreach Service provides telephone, one to one, and group support for men and women who have or are living with domestic abuse. This service can arrange to meet clients at their home or somewhere else suitable.
Harbour Perpetrator programme	The Domestic Abuse Perpetrator Programme (DAPP) aims to help people who have been abusive towards their partners or ex-partners to change their behaviour and develop respectful, non-abusive relationships.
IMR	Individual Management Reviews - Each agency that has been involved in the case under review should undertake an Individual Management Review (IMR) of its involvement. An IMR is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.
MAPPA	Multi-agency public protection arrangements to ensure the successful management of violent and sexual offenders
MARAC	Multi Agency Risk Assessment Conference 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.
MHHR	Mental Health Homicide Review - In April 2013 NHS England became responsible for commissioning independent investigations into homicides (sometimes referred to as mental health homicide reviews) that are committed by patients being treated for mental illness. ... Make recommendations for the delivery of health services in the future.
MHSOP	Mental Health Services for Older People
NPS	National Probation Service for England and Wales is a statutory criminal justice service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties.
PAMIC	Is a tool to assess the impact of parental mental ill health on children.

PDP	A potentially dangerous person (PDP) is a person who has not been convicted of, or cautioned for, any offence that places them into one of the three MAPPA categories but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence that will cause serious harm
Personality Disorder	A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person.
PPU	Public Protection Unit
Preventative services	Preventive care is the care you receive to prevent illnesses or diseases. It also includes counseling to prevent health problems. Providing these services at no cost is based on the idea that getting preventive care, such as screenings and immunizations, can help you and your family stay healthy.
Preventions programme	Preventions programme Comprehensive primary prevention programs, practices, and approaches (upstream) are activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.
Recovery service survivor group	Recovery service survivor group
SAFER referral	The SAFER Referral Tool has been designed to help ensure appropriate, quality referrals of children in need or children who may be suffering significant harm to social care services
Sancus Solutions	Sancus Solutions – appointed by NHS England (North) to undertake the Mental Health Homicide Review
Schizoid	Schizoid personality disorder is a personality disorder characterized by a lack of interest in social relationships, a tendency towards a solitary or sheltered lifestyle, secretiveness, emotional coldness, detachment, and apathy.
Schizotypal	People with schizotypal personality disorder are often described as odd or eccentric and usually have few, if any, close relationships. They generally don't understand how relationships form or the impact of their behaviour on others.
Section 136 Mental Health Act (1983)	Section 136 is part of the Mental Health Act. This is a law. Police can use this section if they think you have a mental illness, and you need 'care or control'. ... The police can use Section 136 to take you to a place of safety. Or to keep you somewhere, if you are already in a safe place.
Section 17 of the Childrens Act	Section 17 of the Children Act 1989 states that it is the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as it is consistent with that duty, to promote the upbringing of such children by their families.
Section 18 of the Mental	Section 18 of the Mental Health Act 1983 - power to re-detain an AWOL patient. Section 18 MHA 1983 provides a power for any patient absent without leave to be re-detained and returned to the

Health Act 1983	hospital by: an AMHP. anyone on the staff of the hospital. a constable.3 Aug 2016
SHP	Safer Hartlepool Partnership is Hartlepool's statutory Community Safety Partnership as defined by the Crime and Disorder Act 1998. The Partnership comprises of a core group of statutory partners, Elected Members and a range of other stakeholders from the public and voluntary sectors. Their main aim and purpose is to reduce crime and disorder, substance misuse and re-offending in Hartlepool..
SI	Serious Incidents Requiring Investigation (SIRI) A Serious Incident Requiring investigation (SIRI) can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened
Single point access team	The Single Point of Access works closely, at times of mental health crisis, with our crisis resolution teams and our partner organisations from across the public and private sectors, to direct people to services most able to aid their recovery.
TEWV	Tees, Esk and Wear Valleys Foundation NHS Trust is an NHS trust that provides mental health services. It covers the 1.4 million people living in County Durham, Teesside, North East Yorkshire and York, England.