A DOMESTIC HOMICIDE REVIEW (DHR)

‘CALLUM’

DHR18

APRIL 2020

PETER MADDOCKS

INDEPENDENT AUTHOR AND CHAIR OF THE DHR PANEL

April 2022

Contents

Introduction

1. This report begins by expressing sincere condolences and sympathy to Callum's family on behalf of the Stoke-on-Trent Safer City Partnership which commissioned this domestic homicide review (DHR) and the people and various organisations who contributed to the review. The chair had a copy of Callum's photograph at meetings of the panel which could not be face-to-face due to Covid-19. Callum was loved and is missed by his family. In public media statements, they describe Callum as a loving, kind and hardworking person. We have worked to tell his complex story with sensitivity and to make sure that we have understood what happened to make sure that where lessons can be learnt that this happens.
2. This DHR examines the response of organisations and the appropriateness of professional support given to 33-year-old Callum who was fatally stabbed by 28-year-old Stacey when he attempted to wrestle a knife from her during an argument at Stacey's home. They had both been drinking alcohol. The court was told that Stacey had sustained bruising to an eye earlier in the argument and that Stacey had picked up the knife to harm herself. Callum's family did not accept the court's verdict that Callum's death was manslaughter rather than murder.
3. The Crown Court Judge in sentencing Stacey accepted that she had great remorse about Callum's death and that it had a profound impact on her and her family. Like Callum, Stacey has a great deal of complexity and difficulty in her life that we have worked to understand to make sure any learning from Callum's tragic death is used to prevent similar deaths in the future.
4. In addition to recent agency involvement, the review also examines the past to identify any relevant background or trail of abuse or neglect before the death; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
5. The key purpose for undertaking a domestic homicide review is to enable lessons to be learnt from deaths where a person dies as a result of violence, abuse or neglect by a person related to the victim, has been in an intimate relationship or a member of the same household.
6. For lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.
7. The review considers the contact and involvement of different professionals and organisations with Callum and Stacey from January 2019 until the date of Callum's death in 2020.

Timescales

8. The Chair of the Stoke-on-Trent Community Safety Partnership commissioned the DHR in May 2020. The review began work in September 2020. This took account of the criminal process being completed and

compliance with public health measures to minimise Covid-19 infections.

9. This Overview Report and its accompanying Action Plan were approved by the Stoke-on-Trent Community Safety Partnership Board on 1 October 2021.

Confidentiality

10. The findings of a domestic homicide review are confidential as far as identifying the subjects, their families or professionals. Information is available only to officers/professionals and their line managers who participated in the DHR. Callum and Stacey are pseudonyms used in the report to protect their identity and provide privacy for their families. Both had children from previous relationships; any reference to the children is gender-neutral (use of 'them' rather than 'he/him' or 'her'). Professionals are referred to by their roles such as GP, housing officer or police officer for example. Three adults are referred to several times in the report and have also been given the following pseudonyms.

Pseudonym	**Relationship**
Jason	Friend of Stacey
Steve	The former partner of Stacey with whom Stacey stayed when she first went to Derbyshire after leaving Callum
Debbie	Callum's former partner and mother of his children

Methodology, scope and terms of reference

11. The circumstances of Callum's death were reported to the chair of the Safer City Partnership (the community safety partnership who are the responsible authority for the DHR) shortly after Callum's death and an early decision was made that the circumstances of his death were likely to come within the scope of a DHR. Due to the involvement of services across different local authority and police areas and the impact of a Covid-19 national lockdown, a formal scoping discussion was incorporated within the first meeting of the panel in September 2020.
12. The panel confirmed that the criteria for a domestic homicide were met given that Callum and Stacey had been in an intimate relationship, there was a history of domestic abuse and Stacey was convicted of killing Callum[1].
13. The methodology of the review complies with national guidance. This includes identifying a suitably experienced and qualified independent person to chair and provide this overview report for publication.
14. The initial scoping panel, which consisted of agencies with whom the victim and/or perpetrator had contact, agreed on the list of services who would be asked to provide an individual management report if their involvement was significant. The detail is provided in paragraphs 23-25.

[1] The circumstances under which a domestic homicide review must be carried out are described in the legislation and national guidance described in Multi-agency statutory guidance for the conduct of domestic homicide reviews (December 2016).

15. The Home Office was informed of this decision on 12th May 2020, and family members were notified in the following weeks by the police family liaison officer.
16. The timeline for the DHR is from January 2019 until the date of Callum's death in the spring of 2020. Although some services were told that Stacey and Callum's relationship began in February 2019 through social media there was a record of Stacey telling a family support worker that she had been assaulted by Callum in January 2019. This was never reported to the police or any other person.
17. Agencies contributing reports or information to the domestic homicide review used the terms of reference set out in national guidance with additional general areas arising from the particular circumstances of this DHR as described in the following scope of the review. This included;

    a) Ensuring that the panel membership included professionals and organisations with specific knowledge and expertise relevant to Callum and Stacey's circumstances and difficulties;
    b) Stacey had moved to Derbyshire to make a fresh start without Callum the DHR examines as far as possible the circumstances under which Callum resumed contact and was at Stacey's property when he died;
    c) Stacey was a victim of domestic abuse in this and earlier intimate relationships; the DHR examines the support given to her as a repeat victim of domestic abuse;
    d) Callum had a history as a domestic abuse offender in this and earlier relationships; the DHR examines how this was understood and managed;
    e) The DHR examines how Stacey was supported to address her substance misuse and how it was understood;
    f) The DHR examines how Stacey was supported regarding her mental ill-health and how this was understood;
    g) The DHR examines how Stacey's child was supported and safeguarded and the extent to which the child's lived experience, views, wishes and feelings were sought, explored and taken into account;
    h) The review gave careful and regular attention to how family, friends and support networks could be identified and encouraged to contribute to the review; this had to take into account Callum's family being very unhappy with the outcome of the criminal process.

Involvement of family, friends, work colleagues, neighbours and the wider community

18. Callum's parents have been separated for several years and Callum's mother had no contact with Callum or the rest of the family who have been supported by a member of the Victim Support national homicide team who has been an important link between Callum's family and the DHR. The independent reviewer and homicide caseworker established contact before the DHR began

work to discuss how to involve Callum's family who had found the circumstances of Callum's death and the subsequent criminal proceedings very difficult and distressing. The family did not agree with the sentence of the court which concluded that Stacey had not intended to kill Callum who died when trying to take a knife from Stacey when she was attempting to self-harm. Because of the family's level of anger and distress complicated by the poor health of Callum's father, the formal involvement of the family in the DHR arrangements was postponed until all of the criminal processes had been concluded. It was judged to be inappropriate to seek any contact with Stacey or her family until Callum's family had been offered an opportunity to speak with the independent reviewer. The homicide caseworker who had an established relationship with Callum's father initially spoke to him about the DHR and he agreed to have a letter from the independent reviewer and subsequently agreed to have a telephone discussion with the independent reviewer. Covid regulations prevented any face-to-face contact. Following these discussions, Callum's father confirmed he did not want to be involved in giving information to the DHR. He made this decision in consultation with his remaining children who were concerned about his health. The independent reviewer encouraged Callum's father to think about whether the family wanted to provide any written information such as their description of Callum for inclusion in the report.

19. The homicide caseworker also supported Callum's ex-partner who is referred to as Debbie in this report. After Callum's father had been consulted about his involvement in the DHR the homicide caseworker spoke with Debbie about the DHR. Debbie felt unable to be involved with the DHR and did not want to speak with the independent reviewer. Debbie has also found Callum's death and the repercussions including for her children to be very difficult. At Debbie's request, the independent reviewer wrote her a letter but did not have any direct discussion with her until this draft report was presented to the partnership board. At Debbie's request, she had a copy of the report to read before submission to the Home Office. The independent reviewer also contacted Debbie by phone on several occasions to allow her to discuss the report. Debbie has not provided any further information or comment about the report.
20. Contact with Stacey was postponed until Callum's father and Debbie had been spoken to. Contact was then made with the offender manager at the prison where Stacey is serving her sentence. The offender manager discussed the DHR with her and gave her written information about the DHR. Stacey has not wanted to have contact with the independent reviewer or to give any information. Given Stacey's history of childhood abuse and not wishing to engage with the DHR no contact was made with Stacey's extended family
21. Taking account of the wishes and feelings of Callum's family and Debbie and the decision by Stacey not to provide information for the DHR, no approach was made to the other adults who are referred to in the report.

Contributors to the review

22. More than 30 organisations in Stoke-on-Trent, Staffordshire and Derbyshire were contacted as part of the scoping for the review, to inquire about any contact and knowledge they had about Callum or Stacey. Of those who confirmed having contact and information, all were asked to provide a chronology. For organisations that had substantial contact or information, an individual management review (IMR) was requested. All reports were provided by people who were independent of any involvement or decision making with either Callum, Stacey or their respective children.
23. The following organisations in Stoke-on-Trent provided an individual management review:
    a) Community Drug and Alcohol Services (Stoke-on-Trent) had contact with Stacey at various times over 13 years up to September 2019 primarily about her use of alcohol and cannabis; this included the offer of 1.1 counselling and group work at different times;
    b) National Probation Service had contact with Callum for over 15 years following his conviction for various offences which included violence to a former partner;
    c) North Staffordshire Combined Healthcare had brief and sporadic contact with Callum in criminal justice settings in 2012 and 2013; Callum was referred to the Mental health Access Team by his GP in June 2019 with thoughts of self-harm although he only attended an initial appointment; there was more extensive contact with Stacey since 2013 when she completed a course of CBT[2]; Stacey was referred to secondary mental health services in 2017 and diagnosed with an emotionally unstable personality disorder;
    d) Staffordshire Police had contact with Callum over several years in connection with offences of violence which included assaulting previous intimate partners; Callum had served a prison sentence for breaching a restraining order and for burglary; the Staffordshire Police had contact with Stacey as a victim of domestic abuse in previous relationships as well as responding to incidents involving Stacey and Callum;
    e) Stoke-on-Trent Clinical Commissioning Group provided primary health care through GP practices for Callum, Stacey and her child; Callum and Stacey had regular contact with their GP about low mood and substance misuse; the DHR was not provided with access to Stacey's GP records[3];

[2] Cognitive behavioural therapy through what was the Healthy Minds services; Stacey accessed the service again in 2014, 2015 and 2016 although did not complete the initial assessment on each occasion.

[3] Stoke-on-Trent CCG declined to review the perpetrator's GP records from practices in Stoke-on-Trent and cover these within their IMR. These records might contain relevant and significant information to the DHR which remain unknown. The perpetrator's GP records were accessed by Derbyshire CCG from practices in Derbyshire.

f) Stoke-on-Trent City Council Children and Family Services (includes education); children's social care services had contact with Stacey and her child from 2009 in response to child safeguarding concerns and this included use of child in need (CIN) and child protection plans; the service also had contact from 2011 with Callum about domestic abuse and his children; involvement included support through CIN plans and child protection plans.

24. The following organisations in other local authority areas provided an individual management review.
    a) Derbyshire County Council Children's Services received the initial referral from Stoke-on-Trent children's services notifying that Stacey and her child were moving to Derbyshire; completed a single assessment and following the decision at the transfer in child protection conference in October 2019 stepped down to CIN support;
    b) Derbyshire Police investigated the circumstances of Callum's death; beforehand the Derbyshire Police had little contact or knowledge about either Callum or Stacey; they received a referral and copy of the DIAL risk assessment by Staffordshire Police in August 2019 when Callum was accused of criminal damage to Stacey's abandoned home in Stoke-on-Trent and participated in the transfer in child protection conference.
25. Summary information was provided by
    a) Derby and Derbyshire Clinical Commissioning Group regarding the GP practice that had two contacts with Stacey both within 48 hours in December 2019 about her use of alcohol and low mood;
    b) Derbyshire Community Health Services provide the 0-19 children's service. This is a universal public health service that every child and their family have access to and incorporates the Healthy Child Programme. The 5-19 element is led by the school nursing service. Stacey's child was not known to DCHS until later August 2019 when a verbal handover was received from the school nursing team in Stoke-on-Trent. The information received was that Stacey's child was subject to a child protection plan. Stoke on Trent school health reported that there were no unmet health needs identified. The school nurse did not attend the transfer in child protection conference as there were no identified unmet health needs;
    c) Derbyshire Recovery Partnership; Stacey self-referred in October 2019 and a telephone assessment was completed during which she acknowledged using alcohol as a coping strategy; Stacey also disclosed childhood sexual abuse; Stacey was offered a face-to-face appointment in early November 2019 although this was not kept; Stacey made contact again in January 2020 when she said that CSC had advised she contact them; Stacey reported that she did not feel

her drinking was problematic but agreed to be booked on to an ITS course in May 2020[4];

d) Glow (including services provided by Concrete within the same group) is a charity working to end relationship abuse across Staffordshire provided outreach support in 2011 and made a referral to MARAC; provided access to the Freedom program in 2012 although case records were destroyed under data protection requirements; had contact in 2017 about abuse from a partner (not Callum) and provided brief support in 2018 to Callum when he was living in a probation approved accommodation to help apply for housing;
e) Midlands Partnership NHS Foundation Trust (0-18 services) provided school nursing services; a school nurse completed a vulnerable child assessment in June 2019 as part of CIN arrangements; the assessment identified no unmet health needs; a school nurse attended the child protection conference in August 2019;
f) Savana provides independent sexual violence advice services; Stacey referred herself for counselling with support from a social worker in 2017; after initial contact, Stacey did not take up counselling support;
g) Staffordshire Housing Association; Callum was a tenant of a one-bedroom flat during which time the landlord dealt with complaints of anti-social behaviour by Callum and visitors to the flat;
h) Staffordshire Victim Gateway; had no contact with Stacey or Callum; in August 2019 when Stacey reported to Staffordshire Police that she had been receiving text messages threatening her, phone contact was attempted without success; a follow-up letter to Stacey who was living in Derbyshire was sent with details of the Derbyshire victim support services; the service followed up in September 2019 when Stacey had told Staffordshire Police about messaging; as before attempted phone contact followed up with a letter;
i) Stoke-on-Trent City Council Housing provided housing to Callum's former partner Debbie where he lived with their children before they separated; Callum had a tenancy of his own between February 2008 and August 2009 during which time he presented with significant antisocial behaviour including threatening, aggressive and intimidating behaviour and was made the subject of an injunction not to return to the property; Stacey made three applications for housing between January 2010 and January 2013 all when fleeing domestic abuse; she was provided with private rented accommodation; Stacey was never a tenant of city housing;
j) University Hospitals North Midlands had contact with Callum on two occasions in 2019 after he fell from a ladder sustaining a fractured ankle with a second follow up appointment that he attended but left before being examined; in March 2017 Stacey presented intoxicated having self-harmed with a razor; the incident falls outside the scope of

[4] Intuitive thinking skills to support with ongoing recovery.

the DHR but the attendance was known to CSC in Stoke-on-Trent and Staffordshire Police; Stacey described historic sexual abuse as a child and being isolated from her family who had turned against her; during the scoped timeline for the DHR Stacey had three contacts; in late April 2019 she attended a walk-in centre but left before being seen; the following day Stacey attended the hospital emergency care centre (ECC) with a broken nose reporting she had been protecting a friend in a fight; Stacey attended in early May 2019 to undergo further treatment on her nose;

k) West Midlands Ambulance Service had one contact in June 2019 when responding to a reported overdose by Stacey.

The review panel membership

26. The panel was chaired by the author of this report. The first meeting of the panel was in December 2020 to consider the agencies' IMRs. A second and final meeting in March 2021 discussed the draft report. All panel members were independent of any involvement or decision making about Callum, Stacey or their respective children. The voluntary sector was represented on the panel, both through New Era domestic abuse services and through Community Drug and Alcohol Services, which is a consortium of organisations including two voluntary sector agencies.

Organisation	**Job title or role**
Stoke-on-Trent Community Drug and Alcohol Services	Lisa Reilly, Operations Manager
National Probation Service	John Mason, Deputy Head Stoke/Staffordshire Local Delivery Unit Ed Lambert, Senior Probation Officer
North Staffordshire Combined Healthcare	Amy Davidson, Head of Safeguarding Maeghan Hepher, Senior Safeguarding Nurse
Staffordshire Police	Mark Harrison, Review Team Specialist Investigations
Stoke-on-Trent Clinical Commissioning Group (CCG)	Lisa Bates, Designated Nurse for Adult Safeguarding
Stoke-on-Trent City Council- Children and Family Services (including education)	Francine Salem, Strategic Manager - Safeguarding and Quality Assurance
Derbyshire Health Services	Juanita Murray, Designated Nurse Safeguarding Children – Derbyshire Clinical Commissioning Group
Derbyshire County Council Children's Services	Karen Barden, Assistant Head - Child Protection Service
Derbyshire Police	Detective Inspector Brian Bilby, Adult Rape and Domestic Abuse Lead

Specialist advisors[5]	
Derby and Derbyshire Safeguarding Children Partnership	Neil Lowther Child Safeguarding Practice Review Manager
Glow (domestic abuse services)	Lucy Willis Head of Domestic Violence and Abuse Services
Stoke-on-Trent and Staffordshire Safeguarding Children Board	Stephanie Nightingale
Derbyshire Community Safety Partnership	Alison Boyce Domestic Abuse Manager
Stoke-on-Trent Community Safety Partnership	Nathan Dawkins Commissioning Officer – Community Safety

The author of the overview report and chair of the review panel and the statement of independence

27. Peter Maddocks is the independent author of this report and chaired the panel. He has worked in social care services as a practitioner and senior manager in diverse local authorities as well as with national government services and the voluntary sector. He has a professional social work qualification and is registered with Social Work England (the social work regulator). He has completed domestic homicide reviews with other community safety partnerships in England. He has undertaken agency reviews and provided overview reports to several safeguarding boards in England and Wales. In compliance with national guidance, he has used the online toolkit and online learning provided by the Home Office as well as participated in seminars and other training related to domestic abuse. He has never worked for any of the organisations that have contributed to this review and nor has he held any elected position in Stoke-on-Trent, Staffordshire or Derbyshire. He is not related to any individual who either works or holds an elected office in Stoke-on-Trent, Staffordshire or Derbyshire.

Parallel reviews

28. There were no parallel reviews. The criminal proceedings were completed as the DHR began work.

[5] The specialist advisor from Glow (domestic abuse services) was on the panel in accordance with para 29 of the guidance. Children's Safeguarding Board representatives were on the panel due to the issues covered concerning the perpetrator's child, who had been subject to statutory interventions. All were full panel members but their respective agencies/partnerships had no direct involvement with any of the parties so were there to provide specialist advice and not to represent their agencies/partnerships.

Equality and diversity

29. Callum was, and Stacey is white British and English speaking. There is no record of any formal or informal religious affiliation or faith for either of them. They were both born in Stoke-on-Trent with extended family living in the city.
30. Callum's family provided a background statement as part of the criminal proceedings. In that information, Callum's family say that he had learning difficulties in childhood and was partially deaf and that Callum's disability meant that he experienced periods of unemployment. This is the only reference to any disability recorded by any service for either Callum or Stacey.
31. Gender is a significant risk factor for being a victim of domestic abuse; women are more likely than men to be subject to abuse. Poverty or lack of access to financial or social resources contributes to dependency on a violent partner as a risk factor. Before Callum's tragic death he had been known to the police as a perpetrator of domestic abuse and Stacey had required police assistance when she was a victim of domestic abuse with Callum and with previous partners.
32. Stacey fled in August 2019 to Derbyshire to escape Callum's domestic abuse described later. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men[6]. On average, two women are killed each week by their current or former partner in England and Wales, a figure that has changed relatively little in recent years[7]. It impacts women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Women's inequality limits their ability to escape from abusive relationships; it can make it more difficult for them to enforce their rights and are more likely to experience sexual harassment and violence. Stacey suffered poor mental health and substance misuse and had great difficulty in escaping violent and exploitative relationships over many years.
33. A Home Office Research Study in 2004[8] reported that interpersonal violence such as domestic abuse, sexual assault and stalking is both widely dispersed and it is concentrated. It is widely dispersed in that some experience of domestic violence (abuse, threats or force), sexual victimisation or stalking is reported by over one third (36 per cent) of people. It is concentrated in that a minority, largely women, suffer multiple attacks, severe injuries, experience more than one form of inter-personal violence and serious disruption to their lives. This is reflected in Stacey's history. Domestic abuse starts early in the life of those relationships where it is present. If domestic abuse was going to

[6] Office for National Statistics. 'Domestic Abuse in England and Wales'. 2018. Crown Prosecution Service 'Violence against women and girls report.' 2018.
[7] Office for National Statistics 'Crime Statistics, Focus on Violent Crime and Sexual Offences, Year ending March 2016, Chapter 2: Homicide'. 2016
[8] Walby, S. and Allen, J. (2004). Domestic violence, sexual assault and stalking: findings from the British Crime Survey. London: Home Office.

become a repeated act, it had started during the first year of a relationship for 49 per cent of women and is reflected in this relationship. The study reported that among women subject to domestic abuse (non-sexual threats or force) in the last year, the average number of incidents was 20. Injuries were often sustained as a result of domestic abuse, especially among women. During the worst incident of domestic abuse experienced in the last year, 46 per cent of women sustained a minor physical injury, 20 per cent a moderate physical injury, and six per cent severe injuries, while for 31 per cent it resulted in mental or emotional problems. Domestic abuse is highest among women who are separated; women living in one-parent households with children are much more likely to have experienced domestic abuse; the presence of children in the household is associated with nearly double the risk of domestic abuse for women. This reflects Stacey's circumstances. Women who report that they are in poor health have suffered more than twice the rate of domestic abuse and of stalking than women who report that they are in good health. Women who sustained injuries in their worst incident of domestic violence were asked if they used medical services on that occasion. Only 30 per cent of women reported injuries sustained in domestic violence.

34. Callum and Stacey both had difficulties with their emotional and mental health and were in regular contact with their respective GP practices. Stacey disclosed that she had fled an abusive relationship during her first GP appointment in Derbyshire; she also disclosed her reliance on alcohol. Callum had depression and was on anti-depressant medication prescribed by his GP. Callum was not diagnosed with a mental illness or disorder.
35. Stacey presented with symptoms of low mood and self-harm and was prescribed anti-depressant medication at different times and was referred to mental health services when she lived in Stoke-on-Trent. Stacey was diagnosed in June 2017 with an emotionally unstable personality disorder[9]. Domestic abuse is a very significant although all too often unrecognised issue for mental health care services. Some research studies put the number of women mental health patients being subjected to domestic abuse as high as 69 per cent[10].
36. Depression and self-harm are therefore significant health problems, particularly for women in abusive relationships. In research studies, the experience of domestic abuse is strongly and consistently associated with both depressive disorders and self-harm. In 2013 researchers published a systematic review of longitudinal studies to explore intimate partner violence (IPV), incident depressive symptoms and attempted suicide[11]. They identified

[9] Emotionally unstable personality disorder can cause a wide range of symptoms which include emotional instability, disturbed patterns of thinking, impulsive behaviour and unstable relationships. This is explored later in the report.

[10] Khalifeh. H, Moran. P, Borschmann R, Dean. K. (2014) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, Volume 45, Issue 4 March 2015 , pp. 875-886

[11] Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, et al. (2013) Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts:

16 longitudinal studies involving a total of 36,163 participants. All the studies included women, but only four also included men. All of the studies were undertaken in high and middle-income countries. For women, 11 studies showed a statistically significant association (unlikely to have occurred by chance) between intimate partner violence (IPV) and subsequent depressive symptoms. In a meta-analysis of six studies, the experience of IPV nearly doubled the risk of women subsequently reporting depressive symptoms. Also, there was evidence of an association in the reverse direction. In a meta-analysis of four studies, depressive symptoms nearly doubled the risk of women subsequently experiencing IPV.

37. These findings suggest that women who are exposed to IPV are at increased risk of subsequent depression and that women who are depressed are more likely to be at risk of domestic abuse. The findings suggest that clinicians such as primary health care and mental health professionals need to pay careful attention to past experiences of violence and the risk of future violence when treating women like Stacey who present with symptoms of depression.

Dissemination

38. All organisations and people who participated in the review will receive a copy of the published overview report. A copy of the report will be sent to the Staffordshire Police, Fire and Crime Commissioner and the Derbyshire Police and Crime Commissioner. The report will be shared with the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board. The report, endorsed by the Derbyshire Community Safety Partnership, will also be shared with relevant organisations and people in Derbyshire to disseminate learning. The commissioning body and the independent author for this DHR thank the various organisations and people who have participated in the DHR process. This is in addition to members of the family who have been involved with the review.
39. A copy of the report will be provided to the Stoke-on-Trent Safeguarding Children Partnership drawing particular attention to the potential for further development in how MASH responds to domestic abuse notifications.

Background information and chronology

40. Callum and Stacey's relationship began in February 2019 after meeting via social media. After about six months Stacey moved to Derbyshire to escape from domestic abuse. Callum continued to harass and stalk her. The judge in sentencing Stacey for Callum's manslaughter described their relationship as 'toxic'. The trial heard evidence about Callum's history of violence in his previous intimate relationships and that he had convictions for assaults.
41. Callum was known to criminal justice services over several years for offences some of which had involved previous partners. He had difficulties with substance misuse and poor mental health. Apart from primary health care and

---

A Systematic Review of Longitudinal Studies. PLoS Med 10(5): e1001439. https://doi.org/10.1371/journal.pmed.1001439

the probation service who were responsible for community supervision and post custody contact Callum was not a client of any other service such as the local drug and alcohol services. CSC was involved when Callum lived with Debbie the mother of his children.

42. Stacey and her child had received support from various services in Stoke-on-Trent being identified as a victim of domestic abuse from as early as 2009. Children's services became involved and continued to provide support through assessments, a child in need and child protection plans up until Stacey moved to Derbyshire.
43. In 2011 a referral was made to MARAC[12]. Stacey was referred to a local specialist domestic abuse service which no longer exists and there are no legacy records to consult.
44. More recently, in January 2017 the Staffordshire Police referred Stacey to Glow the domestic abuse service following further domestic abuse with a different partner. Services were offered although were not taken up by Stacey. At around the same time, Stacey referred herself to a specialist sexual abuse service. She participated in one of the six counselling sessions that were offered. At the time she did not feel able to take up the service. Stacey contacted the same service three months later and although she attended an initial counselling appointment she declined further contact and involvement was closed by December 2017.
45. Children's services were involved with Stacey and her child between February 2017 to February 2018 through a CIN plan[13]. During this time Stacey was in a relationship with a male who was a high-risk perpetrator of domestic abuse. There was a MARAC in January 2018. In February 2018 children's services in Stoke-on-Trent closed their involvement satisfied that Stacey was staying away from people who were a danger to herself and her child.
46. In early February 2019 CSC in Stoke-on-Trent was contacted by a family friend who was worried about Stacey and her child. The friend described that different men were visiting Stacey's home whom she did not know and that there was evidence of significant alcohol consumption. The friend had found no food in the house and described the home conditions as 'filthy'. The friend was worried about Stacey's child who was also described as being in a 'filthy condition'. The friend also reported that Stacey had self-harmed with a razor having cut her cheek and neck. A home visit was completed and the home was described as 'immaculately presented and well furnished'. Stacey declined any support and commented that she thought the referral had been malicious. The referral was closed.
47. Although Stacey had long-term difficulties with substance misuse (primarily alcohol and cannabis) and had her first contact with the Stoke-on-Trent community drug and alcohol service (CDAS) when she was 15 years old, CDAS was only involved for a short time during the scoped timeline of the

[12] Multi-agency risk assessment conference that discusses how to co-ordinate and support a plan of safety for high risk domestic abuse victims.
[13] There had been previous contact as far back as just after Stacey's child was born which is outside the scope of the DHR timeline.

DHR from February 2019 until Stacey moved to Derbyshire. The CDAS assessment recorded Stacey's disclosure of drinking 15 units of alcohol per day and that she had self-harmed in the past. Stacey described living with her child with no family support and having recently separated from her partner (not believed to be Callum). She described Jason as her next of kin. Stacey also described having been a victim of domestic abuse and had been supported by a local domestic abuse Freedom Programme[14]. The CDAS sent a safeguarding referral to children's services which confirmed that there was no current involvement. Following a discussion with Stacey who was seen to be taking steps to seek help through the CDAS and having contact with the Early Help service, it was decided that no involvement was required from the social work services. The day after there was an anonymous telephone call to children's services to report that Stacey had self-harmed (cutting her face) and was struggling to afford food. The decision was to continue with an early help assessment which concluded with a plan to continue supporting Stacey to attend appointments with CDAS and to continue her medication for depression.

48. At about the same time Callum was warned by his landlord service about breaching his tenancy agreement because of drug use at his rented home.
49. In late March 2019 CSC in Stoke-on-Trent was contacted anonymously by an adult who knew Callum. This person reported that Callum was in a relationship with Stacey and that he had a history of domestic abuse and drug use and was known to CSC and the police. The caller thought that Callum was supposed to notify the police if he began an intimate relationship. The caller went on to report that there were pictures on social media. The caller reported that they had received threatening messages from Callum. The family support worker (FSW) who is not a qualified social worker subsequently discussed the information with Stacey who denied being in a relationship with Callum. CSC decided no further action was required relying (inappropriately) on Stacey having completed domestic abuse training and would not 'tolerate' being in an abusive relationship. The FSW was asked to monitor and if there was evidence of a relationship with Callum an assessment was recommended. Lessons are highlighted later.
50. Four days later the police received a complaint about arguments, noise and screaming at Stacey's home and that children were at the property. The first response officers found five adults and three children at the property. One of the adults was Callum. The police officers recorded that there was no disturbance whilst in attendance but there had been a party and loud music. Advice was given. No information about this complaint and contact with the police was reported to the MASH or police safeguarding team; no offences had been committed but the respective history of Callum and Stacey would have been known.
51. The day after the police contacted CSC in Stoke-on-Trent was told by a concerned adult that different men were visiting Stacey's property and that

[14] https://www.freedomprogramme.co.uk/

drugs and alcohol were being consumed. The caller was concerned that Stacey's current partner (believed to be Callum) was carrying a knife and had been taking Stacey's child out to commit offences. Although CSC decided that an assessment should be completed, Stacey did not consent to this but agreed to help and support continuing to be provided by the Early Help service. In the absence of an assessment that should have involved contacting other services, CSC remained unaware of conversations between the school and Early Help about concerns that Stacey's child was presenting with some sexualised behaviour at school or about the recent contacts with the police.

52. In mid-April 2019 the police received three further complaints on the same evening about noise and the use of drugs at Stacey's home. The responding officers found no disturbance and no children were present in the house. The officers spoke to a third party who had been at the house with their two children. The officers were told there had been an argument with a member of the public. There was a consultation between the police and the local authority emergency duty team (EDT) who advised that Stacey and Callum had been in a relationship since late March 2019. The information about the police contact was discussed at the following day's MASH (multi-agency safeguarding hub) which decided that no referral or further action was required. There is no record of clarification about where Stacey's child was when the police officers visited. The discussion at MASH should have been an opportunity for the respective agencies to have reviewed information and contact with Stacey and her child. Even without the hindsight of the DHR, the decision to take no further action suggests a lack of curiosity about the circumstances of Stacey's child and the risk of domestic abuse.
53. In late April 2019, Stacey attended a walk-in centre at the local hospital but left without being seen. The following day she went to the hospital emergency care centre with a broken nose. Stacey reported being injured when protecting a friend from a fight. Although the hospital had information that Stacey had been previously referred to MARAC the record that was accessed by medical staff indicated that Stacey was a 'vulnerable adult' rather than a more explicit record about domestic abuse. The hospital Trust is implementing a revised alert system that makes domestic abuse more explicit. There is no record of any further probing and exploration with Stacey either about the nature of her 'vulnerability' or about the circumstances under which she had sustained her injury. No other service apart from the GP who had a routine notification was aware of this injury. The lack of access provided to this DHR to Stacey's GP records has prevented any further exploration of what the GP did with the information.
54. In mid-May 2019 the police responded to a call for assistance at Stacey's home involving two men; male 1 reported being assaulted by Jason who had been drinking and making threats of serious harm to male 1 as well as Stacey and her child. Stacey told the responding officers that Jason had made threats to end his life and had told her child that he wanted to kill him. Stacey wanted Jason to have mental health support. He had a history of self-harm. He was

detained by the police using their powers under sec 136 of the Mental Health Act[15] (rather than being arrested) and transported to the hospital where his mental health was assessed. A referral was sent to CSC who decided that an assessment should be completed although Stacey declined to participate and the referral was closed. Following a discussion in the MASH, the police and CSC subsequently visited Stacey at her home to discuss the risks associated with Jason and the need for her child to be kept safe. Stacey signed an agreement to not allow Jason to visit the house or to have contact with her child when Stacey was not in the house. CSC involvement remained closed but was open to the early help service. Stacey's relationship with Callum was not considered in the MASH and was not raised during the visit to Stacey's home. The use of written agreements that place an onus on victims of domestic abuse to protect themselves and their children had been identified as inappropriate practice in a previous DHR as well as the fact that such agreements have no legal authority or sanction and are therefore unenforceable.

55. Two days after the police had detained Jason a relative who wanted to remain anonymous called CSC to inform them that Stacey was drinking heavily and taking drugs every day; the caller had concerns about Jason, that Stacey's child was often missing from home and was beginning to "get naughty" and that Stacey was accruing significant rent arrears. No action was taken.
56. Seven days later CSC had an anonymous telephone call to report that Stacey was in a relationship with Callum. The caller reported that Callum had been to prison for offences including robbery and violence; the caller referred to specific crimes Callum had committed. The caller reported that Callum had children and had assaulted them and their mother. The caller believed that Stacey had been in a relationship with Callum for two to three months. The caller also reported that Jason was going to the address regularly and that the caller thought he should not be at the property. The caller was advised to report the information to the police which they subsequently did and the police deployed police officers to visit Stacey and found Callum in the property along with Stacey's child and another unknown male. Callum said he did not know the identity of the male and Stacey declined to name him. It was subsequently established that the male was Jason who Stacey had agreed not to have in her home and not to have contact with when her child was in the house. The police and CSC had a strategy discussion a week later. Four days before the strategy meeting a social worker had contacted Stacey who reported that she and her child were staying at Callum's home. The strategy meeting agreed that s47 enquiries would be completed and that an initial child protection conference (ICPC) would be convened.

57. On the day of the strategy meeting, Callum's offender manager (OM) contacted the MARAC coordinator about Callum's disclosure that he was in a relationship with Stacey and was staying at her home. Callum had just had his

[15] The powers given to the police under the Mental Health Act 1983 to detain a person when it is judged necessary for their safety rather than to arrest them.

first meeting in late May 2019 with the OM following his release on licence from prison for an offence that was not related to domestic abuse. Callum talked about his relationship with Stacey saying that it had started in March 2019. Callum said that he had discussed his history of domestic abuse with Stacey. He also reported an increase in his use of alcohol and asked for mental health support. The OM recommended that Callum should contact his GP which he did as described in the next paragraph and the OM scheduled future supervision sessions at fortnightly rather than monthly intervals. The OM case responsibility had been transferred to a probation officer grade OM given the implications for child protection. The OM emailed the police to inform them about Callum's relationship with Stacey and also phoned and spoke to CSC. The OM later sent notifications to the MARAC coordinator, police and CSC.

58. Callum's GP made a referral to the mental health access team in early June 2019 requesting an assessment due to his presentation with symptoms of depression. The GP referral described that Callum had stopped taking his anti-depressant prescription about three months previously and had described feeling increasingly stressed over the last two to three weeks. He had also had thoughts about self-harm. Although the mental health access team made four phone calls on different days to make an appointment Callum did not respond to the contact to make an appointment. It would be expected practice that the GP would have a routine notification about the contact with the access team. The DHR has limited information about what the GP did in response to this information; Callum's history as a perpetrator of domestic abuse and violence combined with his poor mental health and thoughts of self-harm are important markers of concern for Callum's health and welfare and in respect of his relationships.
59. The ICPC involved the different agencies providing information. The OM's information about Callum highlighted his offending history which included convictions for violence and domestic abuse. It described risk factors that included Callum's substance misuse, violence, poor thinking skills and management of emotions and his association with negative peers.
60. The ICPC focussed more on the risk from Jason. There was less attention given to Callum's history or the risks associated with his increasing alcohol consumption and his mental health. The ICPC agreed that a CIN was appropriate rather than a child protection plan. Stacey's difficulties with alcohol and mental health were discussed as historical difficulties.
61. At the end of June 2019, the ambulance service received a call from Callum to say that Stacey had taken an overdose. The ambulance crew that had been deployed were told by Stacey who had cut herself with a razor that she had not taken anything and she declined to be taken to the hospital. The ambulance service contacted the police believing that there had been an incident of domestic abuse. Stacey had 'superficial' cuts to her arms. The police telephoned Stacey who had left Callum's property and was returning to her home; she denied that she had taken any tablets. The police checked their information system and identified that Stacey was known to the

community psychiatric team and had a history of self-harm. Police officers were deployed to Stacey's home and were joined by WMAS paramedics who assessed that Stacey had older superficial cuts to her arms and she was continuing to deny having taken any overdose. The paramedics left. The police observed no evidence of domestic abuse; it is not recorded if Stacey was asked about domestic abuse. Stacey was left with her child and her adult brother at her home. No information was discussed at MASH or a contact made to children's services.

62. Five days later in early July 2019, the police responded to a call about a disturbance outside Callum's home. The response officers found Stacey threatening to throw herself from a first-floor window; Callum and his brother were also in the property. Stacey was intoxicated and Callum was under the influence of drugs and neither were considered to be in a fit state to look after Stacey's child who was found wandering in the street outside. The police, using their police powers of protection (PPOP) took Stacey's child to the home of a relative after consulting with CSC out-of-hours service[16]. There was a strategy meeting the following day which confirmed s47 enquiries would be completed and taken to another ICPC a month later; in the event, the ICPC was postponed until mid-August 2019.
63. Four days after the Staffordshire Police had to place Stacey's child with a relative overnight the Derbyshire Police contacted Staffordshire Police to advise of a third party report (Steve) that Stacey had texted her intention to not collect her child from school and to kill herself. The caller had been concerned that Stacey was too intoxicated to look after her child and had a history of self-harm and poor mental health. The Staffordshire Police located Stacey who smelt of alcohol but denied having any thoughts of self-harming. The police spoke with the social worker who had received a different account. It was concluded that Steve had contacted the services with good intent out of concern for Stacey who denied having any thoughts or intention to self-harm. Stacey had contact details for the mental health access team and a referral had been made to the service. Although there was a discussion between the police and CSC there was no strategy discussion to agree on what action should be taken about the contact or need for inquiries and assessment. Notably, there was no discussion with the school or with Stacey's child.
64. A CIN meeting in mid-July 2019 was told that Stacey was afraid of Callum who had sent many abusive text messages to her. Offender risk assessments of Callum had indicated a high risk of harm to others and Stacey was advised of this and was encouraged to accept support from the local domestic abuse service. Stacey texted the CDAS after the meeting asking for support. The police who were not a party to the meeting or CIN planning were not aware of the disclosures made by Stacey at the meeting about domestic abuse. It removed an opportunity for investigation and important intelligence to inform

[16] S46 Children Act 1989; a police officer has the legal right to remove a child from accommodation or to prevent removal, where they have reasonable cause to believe the child would otherwise be likely to suffer significant harm; it is not a court order and is only a temporary measure to address immediate risk.

what was likely to be ongoing contact and risk assessment with Stacey and with Callum.

65. Three weeks after the CIN meeting, in early August 2019, Stacey sent a text message to the FSW to say that she was staying in Derbyshire with a friend (her ex-partner Steve) to escape the 'stress' of Callum. Stacey also sent a similar message to the substance misuse service in Stoke-on-Trent (CDAS). Neither of the services discussed the information with the police or referred it to the MASH. Stacey reported that she thought Callum was responsible for causing damage to her property which included ripped underwear and damage to furniture and TV. This damage had been reported to the Staffordshire Police who had been alerted by Jason.
66. On the same day, Stacey spoke by phone with the FSW. Stacey said that Jason had seen the damage to her home. Stacey disclosed that Callum had broken her nose in January 2019 after a night out but at the time had claimed she had been assaulted by a stranger because she had been afraid of having her child taken into care. Although this information was shared with the social worker and probation officer there is no other record of the police being made aware or more substantial enquiries and risk assessment being completed. On the same day, Stacey phoned the social worker to say that she had received a video of Callum smashing up her property and stated that she did not want to return to Stoke-on-Trent.
67. Within ten minutes of Jason contacting Staffordshire Police a control room member of staff had made contact with Stacey who reported receiving over 700 threatening and abusive text messages warning her not to come back to Stoke-on-Trent. Stacey also alleged being assaulted by Callum on previous occasions but had not reported them because of his intimidation. Stacey explained that she had fled to Derbyshire with her child because of threats and she also said that the FSW had advised her to remove herself from Stoke-on-Trent and she was afraid to return to Stoke-on-Trent. Stacey said that she had been hit several times in front of her child but that she was too afraid to do anything about it as Callum threatened to get her child removed from her care. Stacey reported that Callum was on licence from prison and 'was classed as high risk' around Stacey. Stacey reported that Callum had threatened to come down to where she was living in Derbyshire with other members of his family. He threatened to find out where she was living although she did not think he had the address. The control room member of staff advised Stacey that Derbyshire Police would be in contact with her and gave her reassurance about using the triple nine emergency call system. The control room staff member did not complete a risk assessment with Stacey and was not expected to do this[17]. An hour after the call Stacey again contacted Staffordshire Police to report that Callum had sent a text message saying that he knew where she was living and that her friend (Steve) was also afraid of Callum. An hour and a half after the second call Jason contacted

[17] This is discussed later in the analysis for the purpose of learning given that this crucial range of disclosures were not part of any risk assessment.

Staffordshire Police to report that Callum had been to his property and had "kicked off" and had left shouting that he was returning with more people.

68. The following morning an officer from the Staffordshire Police harm reduction unit reviewed the incident log and made a desk-based assessment that the information did not fit the criteria of stalking and the incident was re-categorised as burglary and criminal damage. Factors that influenced the judgment were Stacey not wanting to engage with the DIAL[18] risk assessment and she did not support an investigation which are not valid reasons for stepping down a risk assessment or investigation. The DIAL was completed at a score of 10 medium risk. Stacey asked the police to speak to Callum to tell him not to contact her. The police spoke to Callum and warned him that Stacey did not want 'abusive contact with him'. Even without the benefit of hindsight that is afforded through the DHR this decision making was inappropriate and resulted in elevating rather than mitigating risk for Stacey and is explored further in the analysis later in the report.
69. A safeguarding referral was sent to Derbyshire Police three days after the police and CSC in Stoke-on-Trent had been told about the damage to Stacey's flat and that she had fled to Derbyshire with her child to prevent Callum from contacting her. The referral was accompanied by a copy of the DIAL risk assessment completed by Staffordshire Police. The referral informed Derbyshire Police that Stacey had been the victim of domestic abuse and unwanted text messages from Callum and was the reason for Stacey moving to Derbyshire and that she was keeping her location hidden from Callum. It also said that Stacey did not want to support the prosecution of Callum. The risk assessment from Staffordshire had graded the risk at medium. A phone call from Stacey to the FSW on the same day that the Derbyshire Police received the safeguarding referral from Stacey included her saying she no longer felt safe in Stoke-on-Trent. This was not passed on to the police or factored into any additional and separate DASH assessment.
70. Callum continued to keep his appointments with his OM in August 2019 where he described having some contact with Stacey. The OM was aware of the criminal damage to Stacey's flat via information from the police which also advised that no action was being taken given that Stacey was not supporting a prosecution. According to information the OM subsequently shared with CSC, Stacey had told Callum that she could not see him because of CSC involvement. This can be read in more than two ways; that Stacey did not want to provoke or escalate the domestic abuse by presenting it as a decision she was not in control of, or conversely, that Stacey would have wanted to see Callum if it was not for CSC preventing it. What is a fact is that Stacey was like many women in her position was very frightened that she would have her child taken from her and had been frightened enough of Callum to leave Stoke-on-Trent. This was not understood at the time by important

[18] Historically Staffordshire Police did not use the domestic abuse, stalking and harassment (DASH) risk assessment, using instead DIAL (Domestic Investigation Arrest Log or Domestic Intelligence Assessment Log). Staffordshire Police now use S-DASH (S for stalking is brought to the forefront of responders considerations)

professionals who therefore could not understand how that would influence Stacey's ability to engage with help. This is explored later in the analysis.

71. The child protection conference in mid-August 2019 was not attended by the police or probation service. It was agreed that Stacey's child should be subject to a child protection plan (CPP) under the category of neglect. It was noted that Stacey and her child had moved to Derbyshire.
72. Services in Derbyshire were notified of the outcome of the ICPC and the process of transfer from Stoke-on-Trent was started with a referral from children's services in Stoke-on-Trent to Derbyshire children's services who promptly allocated a social worker to open an assessment. Although this was good practice, the IMR from Derbyshire children's services highlights how the referral did not provide a full enough picture of Stacey and her child's circumstances. This allowed an unduly optimistic understanding to develop when for example services in Derbyshire were not told about the extent and nature of domestic abuse, the true circumstances under which Stacey left Stoke-on-Trent and would not understand that Stacey would be very wary of involvement of people like social workers. This is explored further in the analysis. A core group meeting discussed transfer arrangements to Derbyshire although little written and historical information was sent to children's services.
73. A transfer in child protection case conference (CPC) in October 2019 to discuss the transfer of support for Stacey and her child from Stoke-on-Trent to Derbyshire services agreed to step down from the child protection plan to a child in need (CIN) plan. The conference heard positive reports from school and that Steve the friend with whom Stacey and her child were living was a positive influence. Home conditions were described as good. It was thought (because of self-disclosure) that Stacey was drinking less alcohol and had referred herself to a local support service for victims of sexual violence. The social worker's report from Stoke-on-Trent children's services arrived on the day of the meeting.
74. A week after the transfer-in CPC in Derbyshire, Staffordshire Police were called to an address following a complaint of an assault. Response officers found Callum, Stacey and two other adults in the property one of whom, Jason was the original complainant. There were no signs of a disturbance and all denied having called the police. No further action was taken by the police. No other service was aware of this contact until the DHR. In his appointments with his OM since early September 2019, Callum denied being in a relationship with Stacey or having any contact with her.
75. A week later Stacey telephoned the Derbyshire Recovery Partnership service to self-refer or help with her use of alcohol. During the phone call, Stacey described using alcohol as a coping mechanism for several years. Stacey said that her social worker had advised that she contact the service because she was about to start counselling about her childhood and that this could trigger an escalation in her alcohol use. Stacey said that she had moved to get away from people associated with a lifestyle that involved substance

abuse. Although Stacey was offered appointments she did not attend and she was discharged from the service in December 2019.

76. In late December 2019, a relative of Stacey's contacted Staffordshire Police to report that Stacey was in danger from Callum who had also 'stamped all over' a friend of Stacey's. First response officers found Callum, Stacey and Jason at the property. None of them wanted to make any statement; all were described as very intoxicated. Stacey asked to be taken to her home address; the officers did this to ensure her immediate safety. No other service was aware of this contact. Stacey denied that Callum was visiting the property but admitted that Jason had been at the property.
77. Stacey moved into her rented property in Derbyshire in early February 2020. Ten days after moving into Derbyshire CSC was contacted by Steve through the out-of-hours service to be informed that Stacey had allowed Callum and Jason into her new property. He reported that photos were on social media websites showing Callum at Stacey's property along with other men including another ex-partner of Stacey's who had also been violent. When the social worker visited Stacey two days later she denied that she had seen Callum but was allowing Jason to visit. Stacey told the social worker that she had fled to Derbyshire because of Callum's abuse. Stacey agreed not to allow further visits by Jason until checks had been carried out.
78. A CIN meeting in mid-March 2020 agreed that checks would be completed on Jason and Stacey reported that she had appointments with the Derbyshire Recovery Partnership (DRP). Shortly after this meeting, the national lockdown arrangements prevented further face-to-face contact with Stacey or her child at her home and therefore nobody knew who was living there.

Overview

79. The circumstances of Callum's death and the relatively brief relationship with Stacey were complex. Callum and Stacey had a history of domestic abuse in other relationships as perpetrator and victim respectively. Callum had served a 20-week custodial sentence in 2012 and had been the subject of a restraining order that he breached on several occasions. His relationship with Stacey was a concern to some people who knew about it. This included Callum's OM who checked on whether there were any current risk markers such as a MARAC referral or safety plan and ensured that the police and CSC were made aware of the relationship. People who were not professionals raised concerns with children's services in Stoke-on-Trent and with the Staffordshire Police. Through the hindsight of the DHR, the follow up that was made to the individual contacts was limited to processing information without clearer attention to the history of both adults. Services in Derbyshire were deprived of significant history when Stacey moved to escape domestic abuse in the summer of 2019.
80. Callum's difficulties with his mental health and substance misuse exacerbated the risk he represented in the level of violence and abuse he displayed to intimate partners and other people. According to the CCG IMR, he was a more frequent user of GP services compared to other men of his age having

eleven consultations in seven months compared to a national average of five consultations per year. His consultations were for musculoskeletal pain, genitourinary problems and depression. He registered with three different GP practices between his release from prison in 2017 and when he died. None of the GP practices was aware of his domestic abuse history although it should have been information disclosed through details of the child protection conferences that had taken place for Callum's children and Stacey's.

81. Given his significant history as a perpetrator of domestic abuse, the absence of recent relevant perpetrator work being offered or attempted with Callum is a significant missed opportunity that is explored later in the report. The index offence for which Callum had been convicted and imprisoned was not domestic abuse. However, the transfer of Callum's supervision under licence to a more qualified and experienced OM was a good recognition of the risk that Callum represented in his intimate relationships and there is good evidence of the OM talking with Callum about his relationships and consulting with other services such as children's services and the police. The analysis later in the report explores the learning further.
82. Stacey's history of being a victim of domestic abuse in previous intimate relationships and abuse in her childhood from a close family member are significant vulnerabilities. She had poor mental health and substance misuse was a long term difficulty. Stacey's diagnosis of an emotionally unstable personality disorder in 2017 was unknown to any professional outside of the combined healthcare trust's mental health service in Stoke-on-Trent and, therefore, the implications for Stacey's additional vulnerability in relationships were not explored as part of risk assessments and support planning. Although she sought help and was offered services for example through the community drug and alcohol service in Stoke-on-Trent there was a limited enquiry about Stacey's experience of recent domestic abuse. Nothing is known by the DHR about her contact with the GP services in Stoke-on-Trent. Stacey's fear of having her child removed from her care made her vulnerable to men who used this as a threat and isolated her from potential help by minimising or misrepresenting threats when talking with professionals such as social workers or police officers.
83. It is probably significant that the only time that Stacey made disclosures about the level of domestic abuse she had suffered was to people who were seen to be less likely to take action about her child and occurred when she was most frightened and distressed. Important information was given to the FSW in Stoke-on-Trent and to the emergency call handler for example that did not get factored into a more structured assessment of risk. Although both showed great empathetic support to Stacey when she was very frightened, neither of them was in a position to understand the significance of the information being disclosed and it was not factored into formal risk assessments or investigations of whether criminal offences (harassment/stalking) had been committed. The only domestic abuse risk assessment that was completed resulted in a grading of risk that did not take account of relevant history or have full disclosure of information and was based on a misplaced

understanding of stalking and harassment behaviour. This is not a new finding unique to this DHR; it reinforces the importance of all professionals being able to recognise domestic abuse and have the capacity to assess risk. The Staffordshire Police DIAL risk assessment at a medium level was sent to Derbyshire Police. The significance of the harassment and stalking was not recognised and did not include any contextual information about either Stacey's longer-term vulnerability to domestic abuse or Callum's history as a domestic abuse perpetrator over many years.

84. Critical errors were therefore made about risk judgments when Stacey fled from Stoke-on-Trent and when Staffordshire Police were contacted and told about Callum's threat to find Stacey in Derbyshire. His behaviour should have been understood as harassment and stalking and the significance factored into the assessment of risk. The riskiest cluster of stalking behaviours is following to work or school, damage to property and leaving abusive messages. Stalking by a former or current intimate partner is the most dangerous form of stalking and is more likely to continue for a long time[19]. Instead, it was processed as burglary and criminal damage. The learning is explored further in later sections of the report.
85. The information passed to Derbyshire in the initial referral after Stacey moved with her child described the fact that there was a child protection plan but did not provide much historical information or the circumstances under which Stacey had fled from Stoke-on-Trent abandoning her home which was vandalised and other property destroyed. Parents who have children subject to child protection plans who move without notice to another area can often have their behaviour interpreted as being obstructive or unwilling to engage with professionals. Hester describes a three planet model to explain the contradictions and complexity facing professionals in navigating the respective 'planets' of child protection, domestic violence and family courts[20]. On the child protection planet, despite professionals identifying that the threat of violence comes from the male, it is the mother who will often be seen as being responsible for dealing with the consequences and the violent male effectively disappears from the picture as happened in this case. The absence of a good enough and comprehensive history and analysis from Stoke-on-Trent children's services meant that when Derbyshire children's social care services were completing their initial single assessment they were doing this based on observations of Stacey and her child in Derbyshire and what they chose to disclose. This led to an optimistic mindset.

[19] Campbell, J.C et al (2007) Intimate Partner Homicide Review and Implications of Research and Policy Trauma Violence Abuse 8: 246 cited by Monkton Smith, J., Williams, A., Mullane, F. Domestic Abuse, Homicide and Gender Strategies for Policy and Practice Palgrave Macmillan, pp154-155

[20] Hester, M. The Three Planet Model: towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence, British Journal of Social Work, 41(5), July 2011, pp.837-853

Analysis

86. The earlier section on equality and diversity in this report summarised the correlation and intersectionality between mental health and domestic abuse, particularly for women. It describes the barriers that face women such as Stacey if and when they attempt to leave an abusive relationship.
87. Controlling and coercive relationships represent an elevated level of risk, especially at the point of separation. It is the biggest trigger event for the most serious levels of violence including homicides. A perpetrator history such as Callum's, together with the trigger event of separation and Stacey feeling frightened enough to flee from Stoke-on-Trent should have resulted in a risk assessment at the highest level. The assessment should have been an opportunity to identify risk and to consider what support could mitigate risk for Stacey and her child. Another key dangerous behaviour on display was stalking which according to some academics can be even more indicative of a potential homicide than the previous history[21].
88. Monkton-Smith identifies eight stages in the most dangerous cases of domestic abuse[22]. Although the final three stages are related to instances where men have gone on to kill their partner or estranged partner and are therefore not relevant to this particular review, the first five stages have relevance in responding to and assessing the risk of domestic abuse.
89. The first five stages of Monkton-Smith's model are:
    a) A pre-relationship history of stalking or abuse by the perpetrator; none of the services (apart from the OM) in their various assessments have an account of Stacey or Callum's history of domestic abuse and his convictions for violence which were largely understood as the by-product of alcohol and drug consumption and was influential in how incidents were processed and understood;
    b) The romance developing quickly into a serious relationship; there is little information about enquiries into the history of the relationship by any service; there is no recorded insight into how the relationship had developed;
    c) The relationship becoming dominated by coercive control; disclosures to the FSW and the emergency call centre indicated there had been coercive behaviour from early on in the relationship and Stacey's fear of seeking help;
    d) A trigger to threaten the perpetrator's control; for example, the relationship ends or the perpetrator gets into financial difficulty; there

[21] Campbell, J.C et al (2007) Intimate Partner Homicide Review and Implications of Research and Policy *Trauma Violence Abuse 8:* 246 cited by Monkton Smith, J., Williams, A., Mullane, F. Domestic Abuse, Homicide and Gender Strategies for Policy and Practice Palgrave Macmillan, pp58-59

[22] Monckton Smith J. Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide. Violence Against Women. 2020 Sep; 26(11):1267-1285. doi: 10.1177/1077801219863876. Epub 2019 Aug 5. PMID: 31378158.

was little curiosity and understanding about the circumstances of Stacey's sudden abandonment of her home in Stoke-on-Trent as a trigger event or understanding of the significance of ongoing text messaging, vandalising of property and threats; Callum's health difficulties had an impact on his ability to work regularly;

e) Escalation; an increase in the intensity, frequency or variety of the partner's control tactics, such as stalking or threatening suicide; there is no evidence that Callum ever threatened suicide or other self-harm but there is evidence that he harassed and stalked Stacey after she left the relationship but that behaviour was dismissed in the police DIAL assessment.

90. According to Monkton-Smith's research, where the early stages 1-2 are positively identified, there is a much higher likelihood that attempts at separation should the relationship continue, will be met with significant resistance. Where there is a progression through stage three there is a much higher likelihood that separation will be very difficult or even dangerous. Progression through stages four and five provide the clearest indication of an increased potential for fatal domestic abuse. None of this is intended to suggest that Callum would have killed Stacey but does highlight the significant level of risk that was inherent in the relationship and was not recognised in Stoke-on-Trent and led to serious misdirection for services in Derbyshire.
91. Alongside understanding the motivation and behaviour of the perpetrator is understanding the strategies and impact on the victim. When a victim is disputing or disparaging reports or information, for example, this may be a reflection of the victim protecting herself from possible reprisals as well as reflecting concerns for example that children will be taken into the care of. It is an example of where sceptical curiosity is needed alongside a good enough understanding of coercive and controlling behaviour and the impact on victim behaviour. Victims develop strategies they hope will reduce the level of violence. An important step in providing help is to anticipate the barriers for example disclosure and exploring strategies with a victim and recognising that fleeing a relationship needs coordinated support.
92. The reason for including these observations at the outset of the analysis is to provide the context that from the start this relationship represented a high risk of dangerous domestic abuse with implications for how safety planning and child protection were planned.

Stacey's move to Derbyshire to make a fresh start without Callum and the circumstances under which Callum resumed contact

93. The circumstances under which Stacey moved to Derbyshire were not sufficiently understood at the time in Stoke-on-Trent and contributed to Derbyshire services being less informed than they should have been.
94. According to the conversation with the emergency call handler, it was the FSW who had advised Stacey to remove herself from Stoke-on-Trent. There is no record of the FSW seeking consultation with a supervisor before or after providing such advice. No DASH was completed, no referral to the police, the

domestic abuse service or CSC under domestic abuse pathway arrangements or contact with the MASH. Although the advice may have been well-intentioned it was inappropriate to encourage an intimidated victim of domestic abuse to flee without any adequate assessment and planning. It removed any opportunity for the police to consider what measures they need to take urgently to protect Stacey and control Callum. It removed any opportunity to consider access to a refuge with support to Stacey and her child.

95. It was the FSW who received the first notification by text that Stacey had fled Stoke-on-Trent. A similar message was also sent to the CDAS. Neither opened a DASH or made a referral through the domestic abuse pathway to the police or contacted the MASH. When the FSW spoke to Stacey the FSW was told about specific domestic abuse including a broken nose just after the relationship had begun in January 2019 although had been afraid to report it because of losing her child. Although there was a discussion with the social worker there was still no DASH completed and no contact with the police or strategy discussion at the MASH.
96. The first time that Staffordshire Police were made aware of Stacey having left Stoke-on-Trent to escape domestic abuse was after Jason's initial call to report the damage to Stacey's abandoned home in Stoke-on-Trent. It was the call handler who spoke with Stacey who heard the most extensive disclosures about coercive and controlling domestic abuse over several months. Call handlers are not required or encouraged to open a risk assessment. However, the information that the call handler was able to encourage Stacey to disclose was vital information that should have been factored into a risk assessment in terms of responding to the incident and subsequent DIAL or DASH assessment. Although there was subsequent contact with Derbyshire Police neither of the police services deployed an officer to respond, complete a risk assessment or take a statement. The desk-based DIAL assessment that was completed by Staffordshire Police the following morning categorised the contact as burglary and criminal damage and this was the assessment that was subsequently sent to Derbyshire. The DIAL did not include any of the information from the call handler. The police IMR cannot identify why such a decision was taken by an officer in a harm reduction team who would be expected to have a more informed and developed approach to risk assessment.
97. The child protection conference in Stoke–on-Trent that agreed to put in place a child protection plan for Stacey's child was under the category of neglect. The conference was not attended by the Staffordshire Police or the probation service and therefore did not have any direct input about Callum's history of domestic abuse or the concerns that the OM had although these had been discussed with the social worker. The conference gave greater attention to Stacey's substance misuse as a significant risk in the neglect of her child and was the main presentation of concerns in the referral made to Derbyshire Children's Services.

98. Although the referral to Derbyshire children's services was prompt on the part of both areas, the true circumstances under which Stacey had arrived in the county were obscured. Stacey's fear of losing her child meant that she had little incentive to disclose the true level and nature of domestic abuse that had triggered her move.

Callum's history as a domestic abuse offender in this and earlier relationship and how this was understood and managed;

99. Apart from the OM who was supervising Callum, there was little attention or knowledge about Callum's history of domestic abuse. The GP practice in Stoke-on-Trent had no accessible information about Callum's history of domestic abuse. Callum was being treated for depression; his symptoms did not include thoughts of self-harm which can be a significant risk factor for men who are perpetrators of coercive violence. Callum had blood tests as part of his health assessments and treatment and this showed on two occasions elevated testosterone levels. There is nothing on his medical record to explain this and there is no record of enquiry about the possible use of street acquired anabolic steroid supplements. These can have unwanted side effects including aggression, mood disturbance and an impact on libido. If Callum had been a user of steroids this would have been a further exacerbating factor. The Stoke-on-Trent CCG review noted that it is common practice in primary health care to inquire about self-harm but less attention is given to taking opportunities to explore with patients any concerns they have about harm to other people.
100. Given the extent and nature of the abuse and the fact that Callum had been prosecuted for breaching orders made in response to his offending as a perpetrator of domestic abuse, it is perplexing and worrying that it was not enquired into more carefully at critical points; this included strategy discussions, processing of referrals, the opening of assessments regarding Stacey's child, multi-agency discussion at child protection conferences and the development of child protection plans.
101. The domestic violence disclosure scheme (DVDS)[23] was not used to share information with a victim or potential victim.
102. Given that Callum's children had been the subject of child protection plans, all of the agencies should have had some information about Callum's extensive history.
103. Callum had been in prison and the subject of statutory community supervision. His level of risk remained high according to the assessments completed by the OM who shared information with the police and children's services. The OM was never a party to strategy discussions involving the police and children's services in Stoke-on-Trent.
104. In November 2012 Callum had been sentenced to a two years Community Order for Breach of a Restraining Order which included a requirement to

[23] The Domestic Violence Disclosure Scheme (DVDS), commonly referred to as Clare's Law in recognition of the tragic murder of Clare Wood by her ex-partner in 2009 and the subsequent campaign in her name to establish the DVDS.

complete the Integrated Domestic Abuse Programme (IDAP). This accredited programme started but was not completed due to Callum receiving a four years custodial sentence in January 2014 for robbery. Building Better Relationships (BBR) (another accredited programme) was identified for Callum to complete whilst in custody (BBR replaced the Integrated Domestic Abuse Programme). However, when the sentence plan was reviewed, whilst Callum was in custody, it was identified that because the index offence was not domestic abuse-related, he would not be able to engage with the BBR programme in custody. This decision did not reflect the national policy for accessing the intervention: whilst it is likely prioritisation for programmes would have considered the index offence, national guidance for BBR states that men can be referred for BBR if there is evidence of at least one episode of IPV (convicted or non-convicted) in the 24 months leading up to remand for the index offence.

105. BBR was not identified in the sentence plan when he was released from custody on a licence, but 1-1 work in supervision was alongside his engagement with the Resolve Accredited Programme. Resolve addressed expressive violence rather than instrumental intimate partner violence that so often is underpinned by power and control as in Callum's behaviour. Although it was not inappropriate, given the nature of two robberies, for Resolve to be undertaken, the rationale as to why this was undertaken, instead of BBR, is not clear and suggests that there was limited understanding of the nature of Callum's domestic abuse.
106. As a result of their IMR, the NPS acknowledged that there was scope for learning around the absence of BBR on his sentence plan when he was released on licence. Despite Callum's index offence being robbery, given his domestic abuse history and assessed risk of harm within relationships, he would have been eligible for BBR in the community on a licence.
107. As a result of this DHR, NPS has recommended that where service users have a significant history of domestic abuse/intimate partner violence, regardless of the index offence of the current sentence, that suitability for BBR (or equivalent Accredited Programme) is assessed and the outcome recorded in the OASys Risk Management Plan.

Stacey as a victim of domestic abuse in this and earlier intimate relationships and the support given to her as a repeat victim of domestic abuse;

108. Stacey's history of domestic abuse in a series of relationships and her childhood history of abuse from a member of her immediate family was known to several of the services in Stoke-on-Trent although was not part of the information communicated to services in Derbyshire. Apart from the Staffordshire Police, no other person opened a DASH or DIAL risk assessment when being told about domestic abuse. The Staffordshire Police DIAL risk assessment was seriously flawed when it failed to record and recognise the significance of harassment and stalking behaviour and the level of Stacey's fear that Stacey was shared by people who knew her.

109. Stacey's history as a victim of domestic abuse in several relationships combined with the additional vulnerabilities of poor mental health and difficulties with substance misuse made the relationship with Callum a cause for concern from the outset for the OM and for people who knew Callum and Stacey. The domestic violence disclosure scheme was not used or considered at any stage. Although the police are responsible for operating this 'right to know' scheme other services such as children's services or probation in Stoke-on-Trent could have prompted the police about whether the scheme had applicability for Stacey given her history of being abused by partners. It could also have been considered at the strategy discussions in the MASH and the child protection conference.
110. The extent to which Stacey was inhibited from disclosing abuse and the reasons for it were poorly understood. Some of this would have reflected the relative lack of appropriate experience and knowledge of the people that Stacey was able to make her most significant disclosures. This included the FSW and the emergency call handler. Both can be commended for having given Stacey the ability to talk about what was happening. Regrettably, much of that information remained hidden from any formal records of risk assessment.
111. Stacey's history had left a profound legacy of needs and vulnerability. Although her use of alcohol and cannabis were generally known there appeared to be a superficial understanding of the co-relationship with being a victim of domestic abuse. There was a naïve and misplaced reliance that Stacey could stop domestic abuse because she had participated in a training course.
112. Stacey was offered help through the mental health services and the CDAS. Neither were aware of the extent of Stacey's history of domestic abuse. The mental health service diagnosed that Stacey had an emotionally unstable personality disorder or borderline personality disorder (BPD) can cause a wide range of symptoms that can be grouped into four main areas according to the NHS[24] was potentially significant in understanding risk and for developing support strategies for Stacey.
113. For example, emotional instability can mean a range of often intensely negative emotions such as shame, panic and long term feelings of emptiness and loneliness. It is common for people with BPD to feel suicidal and despair and feel better a few hours later. An abusive relationship exacerbates negative feelings and feelings of loneliness and poor self-worth can be exploited and exacerbated by an abuser. Stacey's history of childhood sexual abuse had left her with many negative symptoms including poor self-esteem and a sense of shame disclosed in discussions with specialist services.
114. BPD can cause disturbing patterns of thinking. These might include upsetting thoughts such as thinking oneself to be a terrible person or not exist or brief episodes of strange experiences which might include hearing voices or having hallucinations.

[24] Borderline personality disorder - Symptoms - NHS (www.nhs.uk)

115. BPD can provoke impulsive behaviour that is difficult to control such as self-harm such as cutting or burning skin. It can also provoke reckless activity such as binge drinking or drug-taking which were issues for Stacey.
116. BPD can also contribute to unstable relationships; feeling abandoned when most needing support or feeling smothered characterised by a love-hate relationship.
117. Given the reality of Stacey's severe history of childhood abuse and being in serial abusive relationships combined with poor mental health, the diagnosis of personality disorder deserved consideration in assessments of need and risk and the development of support strategies for Stacey and her child.
118. Stacey's fear of losing her child to care was also a very significant issue that had an impact on how Stacey related to different professionals. It prevented her from feeling able to disclose what was happening in Stoke-on-Trent and when she moved to Derbyshire. The significance of a parent's fears about losing their child needs to be understood. Colluding with such fear and relying on a flight from abuse is not an effective strategy. Anticipating that it is a barrier that is also important for developing an effective relationship based help.
119. Stacey's reluctance to give a statement or to confirm her support for the police to investigate any domestic abuse concerns was accepted at face value and contributed to the crucial risk assessment being incorrectly recorded as a medium. It is an established policy across the country that a victim does not have to give consent for the police to conduct investigations into domestic abuse and where appropriate to use the courts or consult CPS about using criminal sanctions which are reflected in a local policy and operational push by Staffordshire Police.

How Stacey was supported to address her substance misuse and how it was understood

120. Substance misuse professionals will say that effective help can only be provided when the person acknowledges they have a substance misuse problem and they want help. Stacey's GP records have not been made available to the DHR and therefore no information is available about what advice or help was provided over a longer timescale.
121. The significant correlation between poor mental health, substance misuse and domestic abuse has been referenced in this report. Stacey had consulted her GP over many years with symptoms of poor mental health and her history of substance use was known. It is not apparent that the potential association with a history of childhood abuse and domestic abuse was considered and explored in consultations. The GP practice is a potentially vital part of encouraging disclosure and supporting a patient to accept help from services.
122. The CDAS sent a safeguarding referral to children's services when Stacey disclosed that she had been in abusive relationships although had not disclosed current abuse.

How Stacey was supported regarding her mental ill-health and how this was understood

123. Stacey's impaired mental health was poorly understood outside of the mental health service. There is learning for how formal enquiries and assessments such as CIN and child protection need to seek information from all relevant sources; primary health care has to be included in that process and active inquiry needs to ascertain what specialist services may have relevant information. Equally, people working in specialist services such as mental health and substance abuse need to remain aware and informed about the significant co-relation of domestic abuse for many if not most of their patients and that proactive enquiry should be encouraged and that practitioner has the knowledge and confidence to use relevant risk assessment and to make referrals to other services.

How Stacey's child was supported and safeguarded and the extent to which the child's lived experience, views, wishes and feelings were sought, explored and taken into account

124. There is little recorded evidence and information about how Stacey's child's views and wishes were sought and considered. The child experienced difficult and sometimes traumatic and frightening events that included being uprooted from Stoke-on-Trent, knowing the family home had been vandalised and was in the property where Callum was tragically killed.
125. A registered mental health nurse who worked for the Street Triage Service who visited Stacey in early July 2019 was told of fighting and the door of the property being forced open. Stacey also disclosed her long history of self-harm and substance misuse and the nurse noted that Stacey was unkempt and underweight and her property was 'untidy and unclean'. This is one of few recorded observations of conditions in the home or Stacey; the nurse did not make a referral to the MASH or children's services on the basis that the police in consultation with the social care out-of-hours service had arranged a place of safety for Stacey's child.
126. There was a good response by the police and children's services in 2019 when Jason displayed symptoms of disturbed or psychotic behaviour and made threats to harm himself and other people in Stacey's home. The police secured an urgent psychiatric assessment for Jason and followed it with a joint visit with a social worker to discuss the impact on Stacey's child and to seek assurances that the child was not to be exposed to the behaviour again. It remains unknown why more attention was not given to all of the various visitors to Stacey's home and in particular the information that a relationship was developing between Stacey and Callum.
127. The decision to open an assessment in April 2019 was blocked when Stacey declined to give her consent. Soon afterwards there was a discussion at the MASH after the police had made three separate calls to Stacey's home in response to noise nuisance and use of drugs. At this stage, the police and CSC both knew that Callum was in a relationship with Stacey. The MASH discussion was not a strategy discussion and no referral was opened by

children's services in Stoke-on-Trent who decided on two occasions that an assessment should be opened but when Stacey declined to give her consent these were closed without further enquiries being completed. The Haringey judgment in 2013 was an important ruling that clarified a local authority needed to have a lawful basis for processing information and opening enquiries without the consent of a parent. There are circumstances when not telling a parent or carer about a referral is appropriate; for example, someone is being harmed or may suffer harm in the future and/or it prevents a crime from being committed. The Haringey judgment in respect of the decision by that local authority's MASH to conduct an s 47 enquiry (Queen's Bench Division, HHJ Anthony Thornton, 13th March 2013) criticised that local authority for processing information without the consent of the subjects and without establishing a lawful basis upon which that decision had been taken about a public interest such as justifiably preventing a crime or harm to a child. There has to be a justifiable basis for proceeding without the consent of a parent. The judgment is not a prohibition on proceeding without the consent of a parent or carer but requires clear reasoning for deciding to proceed without informing or seeking consent to process a referral. Processing information includes making enquiries. Given the information that was available at the time a justifiable basis for continuing with an assessment could have been considered. The IMR from children's services in Stoke-on-Trent believes that a significant factor influencing decision making was a misapplication of thresholds and has been the subject of work since the DHR was commissioned. The service is working on reviewing the thresholds being applied in professional decision making for example when family support is appropriate and the circumstances under which an elevation to social work assessment and involvement is more appropriate.

128. Another factor may have been Stacey's willingness to accept the help of a family support worker (FSW) although the FSW could not have been expected to deal with the level of complexity presented by Stacey's circumstances. The importance of relationship-based support has been commented upon in the report but care is needed that relationship-based support does not become collusive or unable to adequately understand the nature and level of risk for example. Although the FSW was not qualified or experienced enough to be expected to work with the level of complexity that Stacey's history represented they can be commended for establishing a relationship with Stacey who was able to talk about some of the domestic abuse. Regrettably, these disclosures were not discussed with a supervisor or subject to a risk assessment. Given the FSW was talking with Stacey about fleeing Stoke-on-Trent there should have been a DASH and referral to MARAC.

129. There was more than one strategy discussion between the police and children's services in Stoke-on-Trent. None of the discussions included the school that had daily contact with the child. There was no notification to the school about any of the contacts that the police had. The HMICFRS PEEL[25]

[25] Detailed Findings - Effectiveness - Staffordshire - PEEL Assessment 2018/19 - HMICFRS (justiceinspectorates.gov.uk) accessed 11th January 2020

assessment updated in January 2020 reported that Staffordshire Police did not comply with the requirements of Operation Encompass which requires that schools be told before 09.00 when a child or young person has been involved or exposed to a domestic abuse incident the previous evening. Operation Encompass has been implemented since April 2021.

130. It is a concern that the significance of Stacey's relationship with Callum was not recognised particularly when the first child protection conference discussed risk for Stacey's child where the threat of Jason was more of a preoccupation. Not enough attention was given to collating the adults' respective histories and recognising the indicators of significant risk.
131. The GP practice had no information on Stacey's child's file about the considerable history of domestic abuse. There was limited information about the child protection plan and the GP practice was unaware that there had been a CIN plan. As the IMR comments, this limited the opportunity for contextual enquiry.
132. The information provided to Derbyshire children's services in the initial referral did not state that Stacey's child had been the subject of two child protection investigations in a very short period before the move and did not include the extensive history of Stacey and Callum. This meant that all of the services in Derbyshire were ignorant of the significant risk of emotional or physical harm to Stacey's child.
133. Since the DHR began work children's services in Stoke-on-Trent have been undertaking work to improve the quality of documentation to support transfers to other areas.

Conclusions

134. The risk of domestic abuse should have been evident from March 2019 when children's services in Stoke-on-Trent were told by a member of the public that Stacey and Callum were in a relationship and that person knew a good deal about Callum's history of domestic abuse. It was the least qualified people such as the family support worker or emergency call handler with whom Stacey was able to talk most openly. These were also moments when she was most frightened.
135. Probably the most significant issue for learning from the particular circumstances of Callum's death was the extent to which the services in Derbyshire were not alerted to the history and considerable needs that Stacey and her child had and the fact that she had abandoned her home in Stoke-on-Trent to escape an abusive relationship with Callum. If the transfer of information in respect of the child protection plans and the risk assessment by Staffordshire Police had been more focussed on the true nature and level of risk, different strategies would probably have been developed with greater attention to Callum and Stacey's contact. Derbyshire services thought that the main risk to Stacey's child was neglect and that it was Stacey's difficulties with low mood and substance misuse that were the significant factors to work on. They were encouraged by Stacey's narrative of having come to Derbyshire to make a fresh start and she appeared willing to accept help. The risk

represented by her history of domestic abuse, her friendship with Jason and the history of Callum was not made clear in the information given.

136. The practice of relying on a victim to flee from one area to another as a strategy to deal with domestic abuse is not appropriate and especially when there is no multi-agency plan of safety in place.

137. The circumstances under which Callum was in Stacey's home on the day he died remain unknown. The exceptional circumstances of Covid-19 had prevented any home contact by any service.

Lessons to be learnt

138. Things that make a difference include;

a) Using the domestic abuse disclosure scheme as a recognised procedure for sharing information with a victim or potential victim and ensuring people like social workers promote its use;

b) Improving local systems for targeting higher risk perpetrators and potential victims; assessing the risk of domestic abuse should not be restricted to an incident occurring; information about a prolific perpetrator forming an intimate relationship with a person who has a long history of being abused should provoke curious enquiry;

c) Better anticipation and understanding of why a woman with Stacey's history would be frightened of disclosing information about domestic abuse to police officers or social workers and the implications for how support is developed;

d) Clearer attention to how the views, wishes, feelings and lived experiences of children are sought and considered; there is little recorded information about 1.1 opportunities with Stacey's child at school or with professionals such as the school nurse for example; ensuring the school was involved in providing and receiving information through strategy discussion and use of Operation Encompass would have been an important part of that process;

e) Offering higher risk perpetrators of domestic abuse an opportunity to engage with a perpetrator programme that takes account of needs and history; addressing long term difficulties with substance misuse and low mood such as Callum's through encouraging a self-referral to a service or as part of supervision as an offender in the community and whilst he was in prison;

f) Understanding the significance of perpetrator and victim histories, high-risk trigger events such as separation (especially flight), harassment and stalking and addressed in risk assessments; understanding clusters of risk such as damage to property and leaving abusive messages;

g) Primary and secondary health care professionals (GPs, emergency care, mental health and substance misuse professionals) understand the significant relationship between

mental health and substance abuse and being a victim of domestic abuse; this has implications for routine enquiry, patient screening when discussing symptoms and checking information such as during presentations at hospital emergency care centres for example;

h) Explicit recording of risk that is easily accessible to professionals checking information systems for evidence of domestic abuse; this includes primary and secondary health care settings such as hospitals and minor injury centres;
i) Correct classification and understanding of the significance for risk assessment of stalking and harassment crime rather than as in this case burglary and criminal damage; the risk was high and there should have been a MARAC and an investigation as to whether there was evidence of stalking and/or harassment crime;
j) Processing of information in MASH and ensuring that there are properly structured strategy discussions and if necessary strategy meetings involving all relevant people that place information about incidents in a context of history and a better understanding of markers of high risk;
k) Ensuring information disclosed during emergency call contacts can be read by the police officers recording a formal risk assessment; this would have contributed to a better understanding by all services in Stoke-on-Trent and Derbyshire about the circumstances under which Stacey left Stoke-on-Trent (it is acknowledged that Derbyshire was reliant on information being sent through to them);
l) Confidence and the use of DASH by services other than the police; in this case, children's services, the CDAS and early help service all had information about domestic abuse; initial DASH assessments need to be followed by more in-depth exploration that for example uses the Monkton Smith eight stages to understand the level of risk ad develop safety plans[26];
m) Children's social care services completing timely and comprehensive assessments and parental consents; a parent withholding consent should not be an absolute obstruction to enquiry and investigation of risk; an earlier and more comprehensive statutory social work assessment as agreed at the first strategy meeting on the basis that there was a justifiable basis to do so even without parental consent;
n) Police and probation attendance at child protection conferences and ensuring that the level of risk represented by Callum's

[26] Monckton Smith J. Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide. Violence Against Women. 2020 Sep;26(11):1267-1285. doi: 10.1177/1077801219863876. Epub 2019 Aug 5. PMID: 31378158.

history and behaviour was understood and included in the record of the conference discussion and risks to be addressed;

o) Ensuring a victim of domestic abuse is not advised to flee their home without a coordinated safety plan and support;
p) Managing transfers when adults and children at risk of harm move to new locations; Stoke-on-Trent children's services providing a more comprehensive transfer summary to Derbyshire Children's Services that gave clearer attention to the significant history of domestic abuse; counter-intuitively if Derbyshire had insisted on having more comprehensive information from Stoke-on-Trent before accepting the transfer there would have been more robust understanding about the potential risks to be assessed;
q) Written agreements with victims to prevent domestic abuse are not appropriate; the focus has to be on the perpetrator's behaviour and the response from the respective agencies.

139. This DHR was commissioned by the Stoke-on-Trent Safer City Partnership and the responsible body will be accountable for the implementation of the learning from this DHR. The appendix at the rear of this report includes the recommended actions identified by agencies in their management reviews. It is inappropriate and impractical for the responsible body in Stoke-on-Trent to monitor the implementation of any recommendations or action plans in another area.

Recommendations

1. The Stoke-on-Trent Community Safety Partnership should, through the Domestic Abuse Commissioning and Development Board in Stoke-on-Trent and Staffordshire, request assurances from Staffordshire Police as the lead accountable body for MARAC in the area as to whether the policies and procedures are sufficiently clear for ensuring the MARAC routinely considers the applicability of the DVDS.
2. The respective Directors of Children's Services should ensure that policy and procedures include a reference to the DVDS and the role of children's services to enquire about the applicability of the DVDS.
3. The Director of Children's Services in Stoke-on-Trent should ensure that policy, guidance and professional development on conducting enquiries and assessments include specific reference to the importance of considering any history of domestic abuse especially when men move into households with children.
4. Staffordshire Police should consider how learning in respect of the disclosures made to emergency call handling staff is accessed and considered in DASH assessments.
5. Staffordshire Police should consider whether any further measures are required to improve the identification and targeting of higher risk perpetrators of domestic abuse and the development of risk assessment planning when DVPOs are breached.

6. The Stoke-on-Trent Community Safety Partnership should request assurance from the Domestic Abuse Commissioning and Development Board in Stoke-on-Trent and Staffordshire that;
    a) The training provided for staff in children's social care services includes recognition of higher risk indicators and action to be taken.
    b) That local strategies for developing multi-agency domestic abuse risk assessment include the identification of characteristics and behavioural clusters or markers of high-risk domestic abuse and the importance of exploring relationship history.
    c) Training to primary and secondary health care professionals on the links between domestic abuse, poor mental health and substance misuse and implications for practice and risk assessment.
7. The Safer Derbyshire community safety partnership should consider whether the DHR has identified any learning that is additional to the DHRs previously completed in the county.

National policy

1. The issue of accessing personal data held by general practitioners in the context of DHRs and reliance on consent rather than the legal obligation to be involved and contribute to the review and the substantial public interest to prevent domestic homicide.

Individual management review recommendations

Stoke-on-Trent Clinical Commissioning Group (CCG)

1. Assessment of risk of harm during mental health consultations needs to consider the risk of harm to others as well as to one's self. It is recommended that the enquiry and recording of such becomes an embedded practice in primary care.
2. Practices ensure that robust protocols are in place to appropriately code the records of children and families subject to safeguarding processes as per RCGP guidance.

National Probation Service

1. The National Probation Service to consider more formally the need to assess the risk of harm posed to perpetrators of domestic abuse, by their partners, where partners are repeat victims of abusive behaviours and, in particular, have additional vulnerabilities such as alcohol dependence, substance misuse needs or mental health needs.
2. Where service users have a significant history of domestic abuse/intimate partner violence, regardless of the index offence of the current sentence, that suitability for BBR (or equivalent Accredited Programme) is assessed and the outcome is recorded in the OASys Risk Management Plan.

3. Reinforce the message that SARA is to be reviewed when OASys is reviewed for relevant domestic abuse perpetrator cases, or a Professional Judgement entry to be included in nDelius to explain why it is appropriate not to review SARA.
4. Where service users have a demonstrated capacity for violence, consider risk both to and from others in a comprehensive manner.
5. OASys to be reviewed to support significant events including a changed assessment of the risk of harm.

North Staffordshire Combined Healthcare NHS Trust

1. All staff to record the rationale for decisions made to raise or not raise safeguarding concerns directly with Children's Social Care.

Stoke-on-Trent Children and Young People's Service

1. Training about completing assessments and application of Threshold to be given to Early Help workers

2. Early Help workers to be provided with support to develop child-focused thinking and recording

3. Research materials in respect of the 'Toxic Trio' to be provided to those completing assessments and used within analysis.

4. Children's social care services to ensure that consideration is given to contacting GPs when a CIN assessment is being completed where the consent of parent or carers with parental responsibility has been given.

5. A "seven-minute" briefing will be rolled out to inform of the Lessons Learned from this review to both Children's Social Care and Early Help.

Derbyshire County Council Children's Services

1. Local Authorities transferring cases should provide robust information at the onset of a request to transfer a case to ensure robust safeguarding decision making is achieved for children. Escalation processes should be invoked where information is not received or is inadequate for safeguarding children.
2. Cases should not be approved for closure without ensuring that partner / third sector agencies involved in the case have been consulted to ensure planned activities have been achieved or are in progress sufficiently that safeguards for the child will not be detrimentally affected by the closure.
3. If allocated workers are absent for more than 3 weeks a case support plan including cover arrangements should be drawn up by managers.