Safer Hartlepool Partnership

REPORT INTO THE DEATH OF CMH IN JULY 2012

Report produced by Mike Batty

25 April 2013

Revised # October 2013

1. Introduction

1.1 This report of a DHR examines agency responses and support given to CMH, a resident of Hartlepool, prior to the point of her death in July 2012. The review will consider agencies' contact/involvement with CMH and GBG from 1 January 2011. The Review Panel wishes to express its condolences to the family and friends of CMH.

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

1.3 The review took place in accordance with section 9 of the Domestic Violence, Crime and Victims Act (2004) and the associated Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, published by the Home Office. Some organisations are required by law to have regard to this Guidance, and can be directed by the Home Secretary to take part in a review like this. In the case of this review, this applies to

- Cleveland Police
- Durham Tees Valley Probation Trust
- Hartlepool Borough Council
- Hartlepool Primary Care Trust/ NHS Tees

However, the Review Panel cannot issue a witness summons. This means that there is no legal sanction or power to enforce a request for an interview. In the case of this review, this limitation was not an issue.

1.4 Apart from the criminal investigation by the police no other investigations or reviews have been conducted in relation to this case.

2. Timescales

This review began on 3 August 2012 and was substantially concluded on 30 January 2013. The delay in finalisation of the report is predominantly due to difficulties experienced in establishing the last few details via Police Family Liaison Officers, due to their commitment to a further murder investigation.

Mike Batty, the Head of Community Protection at Stockton-on-Tees Borough Council, was appointed by the Review Panel as the Independent Chair of the review. He has never been employed by any of the organisations mentioned in this report. He has worked in local government since 1982 and has worked on domestic violence issues since 1995 and chaired Stockton's Domestic Violence Strategy Group and its predecessor groups from their inception in 2002 until 2012. In this capacity he was a member of the Local Safeguarding Children Board from 2010 to 2012. He undertook the Home Office training for Domestic Homicide Review Chairpersons and has been awarded the Open College Network accreditation, although the training did not take place until February 2013, by which time this Review was substantially complete.

3. Confidentiality

The findings of each review are confidential. Full details are available only to participating officers/professionals and their line managers. Personal data has been anonymised in order to

comply with Home Office Guidance. All of the documentation used in compiling this report has been provided either with relevant consent or on the basis of public interest.

4. Dissemination

4.1 Copies of the report have been sent to

Christine Brown – Strategic Lead for Adult Safeguarding, NHS Tees

Danielle Chadwick – Service Manager, Harbour

Jason Dickson – Temporary Detective Chief Inspector, Cleveland Police

Steven Hume – Community Safety Manager, Stockton-on-Tees Borough Council

John Lovatt – Head of Adult Services, Hartlepool Borough Council

Maureen McEnaney – Head of Safeguarding & Review Unit, Children's Services, Hartlepool Borough Council

Denise Ogden – Director of Neighbourhood Services, Hartlepool Borough Council

4.2 Copies of the draft report were sent to the organisations which have contributed information to the report in order to give them the chance to comment.

5. Terms of Reference

The Terms of Reference for the review are set out below.

1. To review the circumstances surrounding the death of CMH at the hands of GBG in Middlesbrough on 2 July 2012.

2. In particular, to review the history of the relationship between CMH and GBG understood to have begun in 2009 [subsequently corrected to September 2010], and to examine whether there are any aspects of that history, or of the responses from public service agencies (in both the statutory and voluntary sectors) which might provide learning points which could lead to reductions in the risk of domestic homicide and/or improve agency responses.

3. In this case

   (a) neither of the key parties are from BME backgrounds

   (b) neither of the parties had any special immigration status

   (c) there was no known history of MARAC, MAPPA or DVPP involvement

   (d) there is no suggestion of 'honour based violence'

   (e) it is not expected that the DHR itself will be the subject of major news media interest, in view of the extensive coverage in local news media of the criminal trial

   (f) it is not anticipated that there will be any involvement of HM Coroner

   (g) this is the first DHR undertaken for the Safer Hartlepool Partnership

4. The family of CMH will be contacted via Cleveland Police Family Liaison Officers in the first instance, and will be provided with the Home Office leaflets and given the opportunity to contribute to the review process by submitting written comments and/or being interviewed by a member of the Panel, as they prefer.

The final report will be produced and submitted to the Home Office in January 2013.

6. The Review process

6.1 This summary outlines the process undertaken by the Safer Hartlepool Partnership's DHR Panel in reviewing the death of CMH, a 50 year old woman.

6.2 Criminal proceedings have been completed and GBG, a 47 year old man, was found guilty of manslaughter in October 2012 and sentenced to life imprisonment in November 2012.

6.3 The process began with an initial meeting of the DHR Panel on 3 August 2012. Those present were representatives of

- Cleveland Police
- Durham Tees Valley Probation Trust
- Harbour (a voluntary agency and provider of Victim Support, IDVA and Refuge Services)
- Hartlepool Borough Council
- Hartlepool Primary Care Trust / NHS Tees

plus the Independent Chair and his staff officer, Steven Hume, the Community Safety manager for Stockton-on-Tees Borough Council.

6.4 The agencies represented, plus the Crown Prosecution Service (CPS), Endeavour Housing Association, North Tees and Hartlepool NHS Foundation Trust, South Cleveland NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust (usually known as 'TEWV'), were asked to give chronological accounts of their contact with the victim and the perpetrator ('alleged perpetrator' at that stage) prior to the death. Where there was no involvement or significant involvement, agencies advised accordingly. Responses are summarised in Table 1 below.

Table 1

Agency	**Response?**	**Records?**	**Relevant to death?**	**Full IMR?**
Cleveland Police	✔	✔	✔	✔
Crown Prosecution Service(CPS)	✔	✔	✔	x
Durham Tees Valley Probation Trust	✔	x	-	x
Endeavour Housing Association	✔	✔	x	x
Harbour	✔	✔	✔	x

Hartlepool Borough Council	✔	✔	x	x
Hartlepool PCT/NHS Tees	✔	✔	x	✔
North Tees and Hartlepool NHS Foundation Trust	✔	✔	x	x
South Cleveland NHS Foundation Trust	✔	x	-	x
Tees, Esk and Wear Valleys NHS Foundation Trust ('TEWV')	✔	✔	x	x

6.5 The accounts of involvement with this victim cover different periods of time prior to her death. Some of the accounts have more significance than others. The extent to which the key areas have been considered and the format in which they have been presented varies between agencies.

6.6 All ten of the agencies contacted responded. Two of the agencies responded as having had no contact with either the victim or the perpetrator (Durham Tees Valley Probation Trust and South Cleveland NHS Foundation Trust), and no information to the contrary has come to light.

6.7 The remaining eight agencies responded with information including some level of involvement with the victim or perpetrator. For two of these agencies their involvement was of no direct relevance to the events that led to the death of CMH, as follows:-

- Endeavour Housing Association – the last contact related to an Occupational Therapy assessment which was carried out on 21 May 2012, which related to CMH's request for ground floor accommodation on the basis of her breathing difficulties.

- Hartlepool Borough Council – the last contact related to an application for Housing and Council Tax benefits involving CMH and GBG on 11 August 2011.

6.8 TEWV provided details of a series of referrals received in respect of GBG's mental health, none of which made any reference to domestic violence, and all of which he failed to attend. These records were consistent with the content of information provided by Hartlepool PCT.

6.9 Cleveland Police, the Crown Prosecution Service, Harbour and North Tees & Hartlepool NHS Foundation Trust all provided details in relation to the sole previously known incident of domestic violence on 2 December 2011 involving the couple and CMH's middle daughter, NH, who was 18 years old at the time.

6.10 These were the only relevant records reviewed by the Crown Prosecution Service (except for the record of the current proceedings against GBG relating to the death of CMH), Harbour, and North Tees & Hartlepool NHS Foundation Trust.

6.11 Cleveland Police and Hartlepool PCT/NHS Tees went on to complete Individual Management Reviews, at the request of the Panel. Each agency's Individual Management Review contains the following:-

- a chronology of contact with the victim and/or the perpetrator;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's point of view.

Harbour was not asked to complete an IMR because all of its documentation relevant to the review was made available to the Review Panel at its first meeting.

7. **The Facts**

7.1 According to police records, CMH and GBG first came into contact via an internet dating site in or around September 2010. Prior to this CMH had been married twice, her first husband being the father of her eldest daughter, and had at least one further long-term relationship, with a man who became the father of her two younger daughters, and whose surname she and all three daughters took. By 2010, she was in poor health due to COPD, and was a smoker and regular drinker. She was a small woman, no more than 5'3" in height and weighing no more than 100 lbs. At the time CMH was living in Newcastle and GBG in Middlesbrough. In February 2011 they moved together to a Middlesbrough address, together with NH, the middle one of CMH's three daughters, who moved to an address in South Bank in the summer of 2011. CMH and GBG subsequently moved together to an address in Hartlepool, and it is likely that this took place in or around August 2011 when the Benefits application was made (see paragraph 6.7 above). NH moved back to the Hartlepool address in late 2011. By early 2012 GBG was withdrawing money from CMH's bank account by using her card at ATMs in order to fund his gambling, and exhibited controlling behaviour in relation to CMH's contact with her daughters and her mother. CMH informed family members that GBG was hitting her but none of these incidents were reported to authorities or services, except for the one outlined in the next seven paragraphs.

7.2 A key focus for the work of the Panel was the sole previous reported incident of domestic violence in this relationship which took place on 2 December 2011, and which was the subject of records made by Cleveland Police, the Crown Prosecution Service, Harbour and North Tees and Hartlepool NHS Foundation Trust.

The Previous Incident

7.3 In brief, it appears from the police records, which are the most comprehensive, that NH, the middle daughter of CMH's three daughters and the only one living with her mother at the time, reported this incident at 22.20 hours on 2 December 2011, reporting that GBG had assaulted both herself and her mother. NH had been smoking in the back yard of their home and heard GBG and CMH arguing. She walked back into the house and saw GBG pinning her mother to the sofa, whereupon he released her, but they continued to argue. CMH took her phone out but GBG snatched it and broke it, then picked up some of his belongings and went out via the back door. NH followed him and he grabbed her by the wrists and threw her across the yard. GBG was arrested the following day, 3 December, in Middlesbrough. Statements were taken from NH and CMH and a mobile phone broken by GBG during the incident was seized as evidence.

7.4 Police Constable C completed a risk assessment using the CAADA model endorsed by ACPO with CMH which identified that 5 of the 27 potential risk factors applied to this case. This report was then assessed by JB, Risk Assessment and Safety Planning Officer employed by Cleveland Police, who classified it as 'standard risk', in line with recognised procedures. If a case exhibits at least 14 of the 27 risk factors it will be automatically be classified as 'high risk' and referred to MARAC, but professional judgement is also used. In this case JB identified that Police Constable C had identified that there had been previous incidents, although these had not been reported, and placed a Special Systems Marker on the home address, which would not always be done for 'standard risk' cases, but classified the case overall as 'standard risk' based on what was known of the history and on the bail conditions imposed.

7.5 GBG denied the offences. Advice was sought from the Crown Prosecution Service and GBG was charged with common assault and criminal damage and bail conditions were imposed on him not to make contact with CMH or NH. NH subsequently attended the Minor Injuries Unit in Hartlepool at 13.50 hours on 3 December 2011, presenting with a wrist injury which she stated was due to assault by "her mother's ex-partner" on 2 December at 21.00 hours.

7.6 The Witness Care team at Teesside Magistrates Court send a weekly list to local IDVAs (Independent Domestic Violence Advisors) of all new cases listed for the Specialist Domestic Violence Court. This is how the case in question was referred to the IDVA. In the case of Hartlepool, the IDVA service is provided by Harbour, a registered charity. The IDVA received the list in question on 14 December 2011.

On 12 December 2011, according to Harbour records, CMH made a withdrawal statement to the police. On 14 December at 12.12 p.m., during a home visit by the IDVA CMH made a signed statement to the IDVA confirming that she was unwilling to appear in Court or to provide evidence and Harbour contacted CMH at 15.30 p.m. to confirm the outcome from court, which was that GBG had entered a plea of 'not guilty' and a trial date had been set for 1 February 2012. Harbour staff explained their willingness to continue to support CMH through any court proceedings. To put this into context, the Hartlepool IDVA service regularly receives information from the Magistrates Court of about 60-80 cases per quarter, and 26% of these are discontinued.

7.7 Harbour contacted NH by telephone on 14 December at 12.21 p.m. and she made a similar statement (NH by this time was living at an address in Middlesbrough). Harbour staff subsequently contacted NH again on 15 December at 17.00 to confirm the outcome from court, as above. Neither CMH nor NH provided any explanation of their decisions to withdraw their statements to police. CMH stated that she wished to continue her relationship with GBG.

7.8 Following further contact between CPS and the Police, CPS took the decision to discontinue the case.

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7.9 It appears that CMH and GBG renewed their relationship but split up again on 29 June 2012, following a further incident in which GBG stole money from CMH. Both CMH and GBG then left their home in Hartlepool and went to stay with two separate sets of friends on the Brambles Farm estate in Middlesbrough. They met up again by arrangement on the evening of 2 July, and went alone to a friend's house where CMH was killed by GBG stabbing her repeatedly with a kitchen knife.

7.10 As part of the criminal enquiry by Cleveland Police into the homicide it transpired that GBG was on bail for an alleged sexual assault against a 12 year old girl in Guildford, which took place in 2006. He was charged for this in April 2012 by Surrey Police. The girl in question was the daughter of a woman with whom GBG was living at the time.

It also transpired as a result of the criminal investigation by Cleveland Police that a number of his former partners stated that they had been assaulted by him, but had not reported these assaults at the time they occurred.

7.11 The opportunity to participate in this Review has been explained to KH, the eldest of CMH's three daughters, who has acted as the main spokesperson for the family, by Police Family Liaison Officers, and the Home Office leaflet on DHRs was provided. Following this discussion KH confirmed that the family understood the DHR process but did not want to take part in it. She was 28 years old at the time of the homicide, the middle daughter was 19, and the youngest daughter was 17. All three daughters knew the perpetrator and the middle daughter had lived intermittently as part of a household with her mother and the perpetrator, whereas the eldest and youngest daughters lived independently in ……. and …….. respectively.

7.12 When the question of family involvement was discussed by the Review Panel, members of the Panel agreed that it would not be appropriate in the circumstances to involve GBG's family.

8. Analysis

8.1 In this case the only reported history of domestic violence between GBG and CMH prior to the death of CMH was the incident of 2 December 2011, detailed at paragraph 7.3 above.

8.2 The local multi-agency system seems to have worked effectively in relation to that incident, insofar as the IDVA was contacted by the Courts Service and support was offered to CMH, whether or not she participated in the criminal proceedings.

8.3 In the course of examining these events, the Panel has reached the view that there are learning points on how agency responses could be improved for the future by tightening procedures and providing additional training, as set out in the Recommendations, but that there were no clear indications at the time which would have set this case apart from other similar cases.

8.4 In taking this view, the Panel has been guided by the principle established by the Pemberton Domestic Homicide Review of 2008, stated in the report of the review as follows:

"we have attempted to view this case and its circumstances as it would have been seen by individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight ……. We have, however made every effort to avoid such an approach".

9. Conclusions and Recommendations

9.1 On the basis of the review, the Panel has concluded that, although further areas for improvement have been identified, there are no grounds for lack of confidence in local services. The process of review exposed a strong commitment to multi-agency working in the best interests of service users, willingness to co-operate with the review process, sound record keeping and consistent accounts of the key facts.

9.2 The recommendations of this review are set out in the Action Plan attached at Appendix A.

APPENDIX A - ACTION PLAN						
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and Outcome**
1. Proforma withdrawal statements should not be used within Cleveland Police and all withdrawal statements should include the information outlined in section 4.4.5 of NPIA Guidance on Investigating Domestic Abuse 2008.	Local	Managers to put in place systems to ensure that these points are implemented and monitored.	Cleveland Police		31 July 2013	
2. An MG6 should accompany all withdrawal statements and should again include all the points raised in the NPIA Guidance on Investigating Domestic Abuse 2008.	Local	Managers to put in place systems to ensure that these points are implemented and monitored.	Cleveland Police		31 July 2013	
3. The GP practice should encourage Tees Esk and Wear Valleys NHS Foundation Trust to attend a clinical education session(s) within the practice to improve knowledge within	Local	(a) GP practices to invite TEWV to one or more sessions.	Local Area Team for NHS England		30 Sept 2013	

the practice and awareness of mental health services on Tees, including accessing timely and contemporaneous information about care pathways.		(b) TEWV to deliver session(s) as requested.				
4. The GP practice should introduce an escalation process for dealing with patterns of concerns that are identified in relation to patients where it is suspected that domestic violence is taking place (on this occasion no such concerns were identified).	Local	Escalation process designed and put in place.	Local Area Team for NHS England	(a) Design of process (b) Trialling of process within the practice (c) Process implemented.	30 Sept 2013	
5. The GP practice should undertake training in relation to domestic violence in order to ensure contemporary knowledge and awareness of policy, procedures and referral pathways.	Local	GP practices to identify appropriate level of training and ensure that training is delivered to appropriate partners and members of staff.	Local Area Team for NHS England		30 Sept 2013	
6. The Local Area Team for Durham and Tees Valley for NHS England should consider the arrangements for training of GP practices on domestic violence issues (taking into account also the potential training needs in respect of	Local	NHS England to consider these issues, design training programme and deliver it.	Local Area Team for NHS England	Design. Deliver to all	30 Sept 2013 30 June	

safeguarding both children and vulnerable adults and preventing violent extremism), with a view to designing and developing a medium term training programme.				partners.	2016	
7. The Safer Hartlepool Partnership should undertake a review of progress against recommendations 1 – 6 above 12 months after their adoption, and should at that point consider how to resolve any recommendations which are not yet complete.	Local	Report to Safer Hartlepool Partnership	Chair of Safer Hartlepool Partnership	Report prepared and considered at a meeting of Safer Hartlepool Partnership	31 July 2014	