Domestic Homicide Review

Amanda

September 2021

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Dated: 17th October 2023

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Section 1: Introduction

1. This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004. It follows the death of a female in County Durham in September 2021. The perpetrator was her ex-partner who was also killed during the same tragic incident.

2. The review examines agency responses and support given to the victim prior to her death in September 2021. It will also consider the actions and decision-making of professionals regarding their contact with the perpetrator.

3. In addition to agency involvement, the review will examine the past, to identify any relevant background information or potential abuse that was known or suspected before their tragic deaths. This will include whether support was accessed and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify lessons that can be learned from this incident.

1.4 The circumstances of the death were initially provided by Durham Constabulary to the Chair of the Safe Durham Partnership (via email) on 15th October 2021. A Domestic Homicide Review (DHR) Preliminary Panel meeting took place on 1st November 2021 and recommended to the SDP Chair in a formal letter on 5th November 2021 that a DHR be instigated.

1.5 To protect the identity of those involved, pseudonyms were agreed for both subjects in the review. The victim will be referred to throughout as Amanda. The perpetrator will be referred to as Jamie. They were former intimate partners. These pseudonyms were agreed with the families.

1.6 Initial scoping suggested the relationship between Amanda and Jamie had lasted for only two years. However, there did appear to be significant information directly relating to domestic abuse from before that time. The panel therefore agreed to review all agency records going back five years to 2016. However, the Independent Chair requested that if further relevant information were discovered from before those dates then this would also be included in their chronologies and considerations.

1.7 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 and abuse. 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.

Section 2: Timescales

2.1 The review began on 30th November 2021 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 12th January 2022. This was convened remotely due to the restrictions then in place with the COVID-19 pandemic. The panel met again on 27th April, 22nd June and 25th July 2022. The Domestic Homicide Review was concluded in September 2022.

2.2 The DHR was not adversely affected by the COVID-19 pandemic. Legal restrictions ended in March 2022 (four months into this DHR process). Meetings continued to be held remotely which is now standard practice for most multi-agency meetings. These still gave the opportunity for valuable and constructive dialogue and challenge. The final presentation to the Community Safety Partnership was on 19th September 2022.

Section 3: Confidentiality

3.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

3.2 The victim, Amanda, was 31 years old at the time of her death. Her ex-partner, the perpetrator, Jamie, was 27 years old at that time. They were both British citizens residing permanently in the UK. Their ethnicity is white British.

Section 4: Terms of Reference

4.1 The terms of reference were agreed at the convening of the first DHR panel:

1. Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

2. Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

3. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

4. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
6. Was the victim subject to a MARAC or other multi-agency fora?

MARAC is the Multi-Agency Risk Assessment Conference; where local professionals meet to exchange information and plan actions to protect the identified highest risk victims of domestic abuse.

7. What information was known about the perpetrator? Was he subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse

8. Were child protection procedures correctly followed in this case?

9. Were senior managers of the agencies involved at the appropriate points?

10. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

11. Did any restructuring during the period under review have any impact on the quality of service delivered? How did the onset of the COVID-19 pandemic affect service delivery?

Section 5: Methodology

5.1 The decision to undertake a Domestic Homicide Review was taken by the Chair of the Safe Durham Partnership on 5th November 2021. This followed an earlier meeting of the 'Domestic Abuse and Sexual Violence Executive Group' (DASVEG) DHR Preliminary Panel on 1st November 2021. The DHR Preliminary Panel had a detailed debate and all relevant partner agencies were present. The vast majority of agency representatives believed the criteria was met to undertake a Domestic Homicide Review and therefore that was the recommendation made to the Chair.

5.2 The aim of the DHR panel was to deliver the findings of the review as soon as practicable. The circumstances of the deaths were unusual. There was no criminal trial process as the perpetrator (and driver of the vehicle) had also died. The DHR Panel Chair is confident the review maintained focus and the final report was completed in good time.

5.3 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of Section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

1. *A person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

2. *A member of the same household as himself."*

1. For this review, the term domestic abuse is in accordance with the statutory definition of domestic abuse contained within the Domestic Abuse Act 2021:

'Definition of "domestic abuse"

(1) This section defines "domestic abuse" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected", see section 2.

2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if—

(a) the person is a parent of the child, or

(b) the person has parental responsibility for the child.

(3) In this section—

1. *"child" means a person under the age of 18 years;*
2. *"civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004;*
3. *"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);*
4. *"relative" has the meaning given by section 63(1) of the Family Law Act 1996.*

3 Children as victims of domestic abuse

1. *This section applies where behaviour of a person ("A") towards another person ("B") is domestic abuse.*

(2) Any reference in this Act to a victim of domestic abuse includes a reference to a child who—

(a) sees or hears, or experiences the effects of, the abuse, and

(b) is related to A or B.

(3) A child is related to a person for the purposes of subsection (2) if—

(a) the person is a parent of, or has parental responsibility for, the child, or

(b) the child and the person are relatives.

(4) In this section—

1. *"child" means a person under the age of 18 years;*
2. *"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);*
3. *"relative" has the meaning given by section 63(1) of the Family Law Act 1996.'*

The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

1. The Safe Durham Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

The statutory guidance states the purpose of the review is to:

4. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

6. Apply those lessons to service responses including changes to policies and procedures as appropriate.

7. Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

8. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

Initial scoping suggested that several agencies in County Durham had extensive involvement with both subjects of the review. Chronologies were requested and seven organisations were required to submit an Individual Management Review regarding their agency's involvement. The chronologies provided a detailed timeline of contacts with the victim and perpetrator. The IMRs gave an analysis of those contacts. As well as viewing records, some agencies also interviewed staff involved.

From scoping exercises, it also appeared that the victim or perpetrator had limited contact with support agencies outside the County Durham area. Enquiries were carried out with these organisations who also submitted a chronology of their involvement.

Section 6: Involvement of family, friends, neighbours and wider community

6.1 The victim's family were contacted at an early stage in this process. Introductions were made via the police Family Liaison Officers. The Independent Chair then spoke several times on the telephone with the victim's sister and her brother's girlfriend. This was followed by a formal letter to outline the process. Covid restrictions were still in place at the start of the DHR, but telephone conversations included the background of the relationship, previous relationships and the day of the tragedy. Pseudonyms for the subjects of the review were agreed. The role of independent advocacy was discussed but the family were content that they were able to support each other at this difficult time.

6.2 The Independent Chair met in person with the family (Amanda's sister, her brother's girlfriend and 'step mum') in June 2022. The family provided helpful supporting information about Amanda's life. Clearly, this is an emotional time for them and they are still coming to terms with their loss.

6.3 During the meeting, the family were able to express their own personal memories of Amanda and also fill in 'gaps' relating to some of the background of incidents when various agencies had been involved in her life. The Independent Chair read through the entire report and the family were invited to add their own thoughts, amendments and corrections.

6.4 The family described Amanda's childhood. Her mother was alcohol dependent and the family moved around a lot; living in Peterlee, Hartlepool and Northern Ireland. For their own protection, Amanda and her siblings were removed from their mother's care. Eventually, their 'step mum' (who was also present at the meeting with the Independent Chair) obtained a residence order and Amanda, her brother and sister achieved more stability in their lives.

6.5 The family are aware Amanda made some unwise choices in her relationships. Several former partners were extremely violent towards her. One of them broke her arm. She was still suffering discomfort with her arm many years later.

6.6 The whole family agree that, in their own words, 'Amanda just wanted to be loved'. Having experienced a difficult childhood, Amanda wanted love and affection that her own mum sadly could not provide due to her own difficulties. They also believe that Amanda had low self-esteem. The impact of this cumulative harm may have affected some of Amanda's decision

making in adult life as she sought stability from relationships that were unhealthy.

6.7 Amanda apparently believed everyone in the local community ‘hated’ her. Nothing could be further from the truth. The local community knew she had difficulties, but that same community turned out in their hundreds on the day of Amanda’s funeral. The church was so full that hundreds more had to stand on the grass outside.

6.8 The family were able to recall some of the incidents reported to various agencies. They all knew Amanda had been assaulted and that she had given different accounts of her injuries to medical staff. They all agreed she would say she tripped or fell when in fact she had been assaulted by a partner.

6.9 Amanda did call the police if she was in fear for her life, but the family estimate she reported no more than a quarter of the actual incidents she was suffering. When the Independent Chair raised an issue that there appeared to be a period of ten months in 2020 to 2021 when police were not called, they said Amanda was still being regularly physically assaulted (and allegedly sexually abused) by Jamie but that she just would not report this. They are all in firm agreement for the reason behind this; all three of Amanda’s children had been removed from her care due to the violence within her relationships. She wanted above anything else, to have her children back. The family state that Amanda would hide her injuries, not telephone the police or not even return calls to organisations such as Harbour Domestic Abuse Support Service, as she feared she would lose contact time with her children. They also remember that when she began working with the ‘Pause’ Service in 2021, she tried to go out to meetings, or meet the professional in the garden, as Jamie was inside the house and she wanted to keep this from practitioners. Her thoughts were always on hiding the relationship so that she could increase contact, and ultimately have the return of her children to her care.

6.10 All of her family had warned Amanda about Jamie. They knew he was violent. But they maintain this was because Amanda wanted affection. They recall many times, he would assault her, or damage her property, or lock her in the house. But he would later take her out for a meal or send flowers. The family tried to get Amanda to see past these gifts and see the true nature of the relationship.

6.11 On the day of the tragedy (when Amanda went with Jamie and two others to Blackpool) they believe she didn’t tell them about the trip in advance as she knew her family would try to convince her not to go. However, they also believe Amanda had started to realise that the relationship with Jamie was destructive and that she needed to move on.

6.12 Amanda’s brother’s partner was very close to her and they had known each other for many years. She retained some of Amanda’s social media posts

and showed a poignant one to the Independent Chair during the family meeting. The post is dated July 2021 and it gives a summary of Amanda's thought processes at that time. The post reflects her early life experiences and how now, as a young woman, she finds herself in a place she did not expect to be. But she does talk about her 'three gorgeous children'. In the social media post, she acknowledges she has trusted the wrong people and that they have bullied her. Sadly, the tone of the report supports what Amanda's family believe; that she had decided she had to move on and get out of an unhealthy, abusive relationship.

6.13 Amanda's family will remember her as a loving sister and above all a loving mum to her three children.

6.14 The perpetrator also died during the road collision in September 2021. His family also met with the Independent Chair during the DHR process. Their thoughts are reflected in paragraph 16.11.

6.15 Discussions with both families also included how, if appropriate, to involve Amanda's and Jamie's children in the DHR process. Both sets of families did not want to directly involve the children at this time. They are still young and the families / guardians did not want the children to suffer additional distress. However, the families were mindful of the need to talk about the circumstances and believe this would be something to pursue in the coming years.

Section 7: Contributors to the Review

7.1 Ten agencies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) have been requested and provided. The review chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview report author.

7.2 The following organisations were required to produce an Individual Management Review:

- County Durham Clinical Commissioning Group

- Durham and Darlington Probation Service

- Durham Constabulary

- Tees, Esk & Wear Valleys NHS Foundation Trust

- Harbour Domestic Abuse Service

- County Durham and Darlington NHS Foundation Trust (includes main hospital services and maternity services)

- Barnardo's (Pause Durham)

7.3 In addition, brief reports were provided by North Tees and Hartlepool NHS Foundation Trust (detailing three attendances by the victim), by Durham County Council Adult Health Services (who had no direct contact but did hold information referred from other agencies) and by the 'Talking Changes' programme.

At the first DHR panel, there was a lengthy discussion around the people who would be subjects of this review. Clearly, the subjects would include the victim and perpetrator. The victim had three children. The perpetrator had two children. However, none of the children were in their care at the time of the incident nor for a significant time beforehand. The victim and perpetrator did not have any children together. Therefore, the decision was made not to include the children as subjects of the review. However, Child Services at Durham County Council were an integral part of the Domestic Homicide Review Panel and offered valuable support in providing relevant information.

Section 8: The Review Panel Members

1. The Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

2. The Domestic Homicide Review panel also comprised of the following people:

    1. Jane Sunter, Strategic Manager, (Public Health), Durham County Council

    2. Andrea Petty, Strategic Manager (Partnerships), Durham County Council

    3. Bev Walker, Designated Nurse, County Durham Clinical Commissioning Group

    4. Karen Agar, Associate Director of Nursing (Safeguarding), Tees, Esk & Wear Valleys NHS Foundation Trust

    5. Detective Superintendent Lee Gosling, Durham Constabulary

    6. Jac Tyler, Strategic Manager (Children & Families), Durham County Council

    7. Kay Linsley, Senior Probation Officer, Durham & Darlington Probation Service

    8. Rachael Williamson, Service Manager, Harbour Domestic Abuse Services

    9. Mike Egan, Associate Director of Nursing (Patient Experience, Safeguarding & Legal Services), County Durham and Darlington NHS Foundation Trust

    10. Helen Coyne, Pause Service, Barnardo's

None of the panel members had any direct dealings with the subjects of the review nor had management responsibilities to any front line worker involved with any of the subjects.

Section 9: Author of the overview report

9.1 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the Safe Durham Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding, investigation of child abuse, rape & other serious sexual offences and abuse of vulnerable adults. He has extensive experience as an author and panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

Mike has completed DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as AAFDA training on 'involving children in DHRs' in 2021. He has also designed and delivered domestic abuse training (identification, risk assessment and risk management) to staff across the public and voluntary sector.

Section 10: Parallel Reviews

10.1 The inquest into Amanda's death was opened in September 2021 and then adjourned pending the police investigation. The inquest reconvened in July 2022 and was further adjourned. The eventual findings of HM Coroner were that Jamie died as a result of a Road Traffic Collision. Amanda was unlawfully killed.

10.2 Although the victim and perpetrator had children, these had all been removed from their care a long time before the incident that led to their deaths. They had no children together. All five children were from earlier relationships with different partners. There was no requirement for a Child Safeguarding Practice Review but the DHR panel agreed to set a specific term of reference to consider any learning that emerged relating to child protection issues. Child Services were part of the Domestic Homicide

Review Panel and the Durham Safeguarding Children Partnership Business Manager was informed of the DHR.

10.3 None of the subjects of the Domestic Homicide Review had been assessed nor were in receipt of services, under the Care Act 2014. There was no requirement for a Safeguarding Adult Review. However, the completed DHR, including conclusions and recommendations, will be shared with the Durham Safeguarding Adults Partnership.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim and perpetrator were not married. Their marital status did not affect any of the services provided.

11.3 No issues were identified during this review applicable to gender reassignment, race or religion.

11.4 Neither the victim nor the perpetrator were recorded with any disability, though the perpetrator did have a diagnosis of attention deficit hyperactivity disorder (ADHD).

11.5 With regards to the protected characteristic of sex - the victim was female and the perpetrator was male.

The Crime Survey for England and Wales (CSEW) year ending March 2022 shows the following trends.

1. An estimated 6.9% of women (1.7 million) and 3.0% of men (699,000) experienced domestic abuse in the last year.
2. A higher proportion of adults who lived in single-parent households experienced domestic abuse in the last year than those living in no-children households or households with other adults and children, however, household structure may have changed as a result of abuse experienced.

Crimes recorded by the police show the following trends.

1. In the year ending March 2022, the victim was female in 74.1% of domestic abuse-related crimes.
2. Between the year ending March 2019 and the year ending March 2021, 72.1% of victims of domestic homicide were female compared with 12.3% of victims of non-domestic homicide.

Of the 269 female domestic homicide victims, the suspect was male in the majority of cases (260). In the majority (77.0%) of female domestic homicides the suspect was a male partner or ex-partner, whereas in the majority (62.5%) of male domestic homicides, the suspect was a male family member.

Section 12: Dissemination

12.1 The following organisations will receive a copy of the report following the Home Office's quality assurance process.

1. All organisations within the Safe Durham Partnership.
2. The Durham Safeguarding Adults Partnership
3. The Durham Safeguarding Children Partnership
4. The DHR Panel for Durham
5. The Home Office DHR team
6. Office of Police and Crime Commissioner for Durham
7. The Domestic Abuse Commissioner for England & Wales

Section 13: Background Information (the facts)

Case specific background

13.1 The victim, Amanda, was born in 1990 in the UK. She had three children, but all had been removed from her care. Amanda was a vulnerable woman who had experienced a difficult childhood. She had been removed from her own mother's care due to her mother's alcohol dependency. She was 31 years old at the time of her death.

13.2 Amanda had suffered violence and abuse at the hands of several previous partners and had accessed support services in relation to this domestic abuse.

13.3 The perpetrator, Jamie, was born in 1994 in the UK. He was 27 years old at the time of his death. He was known to agencies for committing domestic abuse towards several partners. Jamie was diagnosed with ADHD. He had two children but both had been removed from his care.

13.4 Amanda and Jamie had been in a relationship for two years prior to the road traffic collision that caused their deaths.

13.5 In early September 2021, Amanda, Jamie and two friends set off on a trip to Blackpool. They travelled by car. There were apparently no issues during the day but on the return journey an altercation took place. Amanda and Jamie were both sitting together in the rear of the car.

13.6 Amanda sent several texts to her family indicating that an argument had started. When they arrived back on the motorway in County Durham all four agreed to go to a fast food outlet. While in the ‘drive through’ Jamie assaulted Amanda by punching her in the face. The driver and front seat passenger then left the vehicle and refused to get back inside.

13.7 Jamie then got into the driver’s seat and Amanda into the front passenger seat. Shortly afterwards, Amanda opened the passenger door and put her leg out of the car but Jamie leaned over and slammed the door shut. He then drove out of the service station but returned a few minutes later. Jamie asked their friends to get back in but they refused. Jamie then drove again out onto the motorway.

13.8 Amanda then made four separate silent ‘999’ calls from her mobile phone. The final call was put through to the police at 1.29 a.m. A few minutes later, the vehicle left the road. The car had crossed over the opposite carriageway and was found in a field later that morning. Both Jamie and Amanda had been ejected from the vehicle. Both died at the scene from their injuries. The fatal collision occurred on a straight, quiet stretch of road.

13.9 It is not known whether the collision was caused deliberately by Jamie manoeuvring the car off the carriage way, or if the domestic abuse incident had distracted the driver who lost control of the vehicle. The toxicology reports confirm Jamie has traces of alcohol in his system. The level of cannabis within his body exceeded the legal prescribed limit for driving a motor vehicle.

Section 14: Chronology

14.1 This is a summary of relevant incidents or events relating to Amanda, Jamie, their children or former partners. It does not contain all contacts with agencies but only those that may be relevant to this Domestic Homicide Review.

14.2 Jamie was known to mental health services from 2006. He was diagnosed with ADHD. This diagnosis followed face to face and school assessments. He was supported via CAMHS (Child & Adolescent Mental Health Services). However, his engagement was sporadic and by 2011 he stopped contact. As his prescribed medication was a controlled substance, the medication was withdrawn.

14.3 On 28th September 2014, police were called to a domestic abuse incident. Jamie's former partner (not Amanda) alleged he had assaulted her by kicking and punching, resulting in bruising to her arms, legs and soreness to her neck. She also reported a previous incident when he had tried to strangle her. Jamie was arrested and was subsequently convicted at court of battery. He stated he had anger management issues and was seeking help through the 'Talking Changes' system.

14.4 On 14th October 2014, Jamie and his ex-partner's case was discussed at the Multi-Agency Risk Assessment Conference (MARAC) which reviews the highest risk domestic abuse cases.

14.5 On 25th October 2014 Jamie was again arrested for assault on the same former partner. She reported he had kicked her in the lower back and pulled her back into the house following a dispute over child contact. His partner did not want him arresting and declined to engage with the police. Jamie was then released with no further action.

14.6 On 2nd June 2015, Amanda's case was heard at the MARAC. The perpetrator was not Jamie. It was her current partner and father of her two older children.

14.7 On 17th June 2015, police were referred to a domestic abuse incident by another agency stating that Jamie had tried to suffocate or strangle his partner (again, not Amanda but a different victim). Officers visited the woman who denied the circumstances on the referral and stated she was not in an abusive relationship and did not want any help. The police referred the incident to Child Services. The case was listed at the MARAC two weeks later.

14.8 On 28th July 2015, Amanda's case was again heard at the MARAC. This was with a separate partner and followed a referral from Child Services.

14.9 On 8th January 2016, Amanda had an appointment with her GP. She requested a change in night sedation as she was having nightmares. The

sedation was linked to bereavement (her mum had died a few months earlier). Her medication was amended by the GP.

14.10 On 23rd January 2016, Amanda rang the police to report her boyfriend (not Jamie) had entered her address and assaulted her. When officers attended, Amanda stated she had not been assaulted and had no injuries. She signed the officer's pocket notebook to say it had been a verbal argument.

14.11 On 30th January, Amanda saw her GP suffering with symptoms of depression. The diagnosis was a mixed anxiety and depressive disorder plus obsessive compulsive disorder. The treatment plan was to continue with fluoxetine, a trial of mirtazapine (an anti-depressant) and advice on accessing cognitive behaviour therapy (via 'Talking Changes')

14.12 On 9th February, during a 'team around the child' meeting, (a multi-agency professionals meeting, also attended by families), it was noted that contact had been stopped between Amanda and her eldest child. Amanda's aunt had a Special Guardianship Order for the child and reported that the child had behavioural problems following contact with Amanda.

14.13 On 10th February, Amanda rang the police to report that her partner (not Jamie) had assaulted her. He had hit her head off a table and had now left the house. When officers attended, Amanda would not provide a statement. Officers searched the surrounding vicinity but could not locate the partner. This same man was sentenced at court on 17th February for an unrelated serious assault (causing grievous bodily harm). He received a 20 month custodial sentence and so, with no assistance from Amanda, no further action was taken regarding his assault on her.

14.14 On 11th February, Amanda had an appointment at her GP. She disclosed taking an overdose a few days ago though stated no current suicidal ideation. The diagnosis was depression. Amanda also complained of stiffness in her arm from a fracture the year before.

14.15 On 1st March 2016, a referral was received at Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV) regarding the overdose. The notes also mentioned the previous domestic abuse. Amanda was provided with mental health information and a helpline number for domestic abuse support. However, Harbour Domestic Abuse Service records confirm Amanda did not make contact with their service.

14.16 On 10th May 2016 Amanda attended an appointment with her GP. Again, she had symptoms of depression. The plan was to retain her dosage of mirtazapine and begin a trial to increase her dose of fluoxetine. Amanda reported she was waiting to see a therapist from 'Talking Changes'.

14.17 On 20th May 2016, one of Jamie's children was placed on a Child Protection Plan under the category of neglect.

14.18 On 21st May, Amanda was arrested for taking drugs into prison for her boyfriend (this was not Jamie). She was later convicted of this offence.

14.19 On 7th June 2016, Amanda attended an appointment at her GP. She disclosed her arrest and told the GP she felt pressured into the offence. She had symptoms of depression and stated her abusive partner has been 'hassling' her. She confirmed she was on the 'Talking Changes' waiting list.

14.20 On 10th June 2016, Harbour Domestic Abuse Service received a referral from a social worker. Jamie and his partner (not Amanda) were expecting a child together in August and the social worker had suggested some domestic violence work as part of the Child Protection Plan prior to the baby's delivery. (Jamie and his partner already had a child together and this child was removed from their care due to previous issues of domestic abuse).

14.21 On 5th July 2016, Amanda attended her GP. She was feeling stressed as her brother had been assaulted and was in hospital. The diagnosis was mixed anxiety and depressive disorder with an acute stress reaction. Although Amanda was still on the 'Talking Changes' waiting list, the GP noted her condition did not warrant a referral to the Mental Health Crisis Team.

14.22 On 29th July 2016, Jamie's partner contacted Harbour. She stated Jamie now worked away and so would not be able to attend any further assessments. The perpetrator case work was then closed.

14.23 On 30th July 2016, Jamie and his partner's unborn baby was formally made subject to a Child Protection Plan under the category of neglect.

14.24 On 1st August 2016, Amanda visited her GP. She talked about her poor sleep pattern. The diagnosis remained mixed anxiety and depressive disorder. She had another appointment the following month on 16th September when she reported excess alcohol use. The GP referred Amanda for a blood test but she subsequently did not attend the appointment.

14.25 On 17th September 2016, Amanda rang the police to report an argument with her partner (this male was not Jamie, nor was he the same male who had committed earlier domestic abuse towards her; that male was in prison). Police attended and the boyfriend left the address when told to do so. Officers noted that Amanda's speech was slurred and she was under the influence of alcohol. She agreed to call the 'Harbour' contact number.

14.26 On 28th September 2016, Amanda again rang the police. Shouting and screaming could be heard in the background. Amanda was having an argument with her new partner (the male who left on police request 11 days earlier). When officers arrived, the male had already left. Amanda did not want any further action taken and the officers left the address. The male returned a short time later. Amanda telephoned '999' to report he had come back to the house. Officers attended and arrested the male. He was subsequently charged with harassment and bailed with conditions not to

contact Amanda or to attend her address. The police incident reports were shared with Child Services. Amanda declined support from Harbour.

14.27 On 21st October 2016, Amanda had another appointment with her GP. She said she had not attended her appointment arranged with 'Talking Changes' therapy service. She was due in court next week and was worried she may be sent to prison. She disclosed thoughts of self-harm.

14.28 Also on 21st October, Amanda rang the police to report her partner had hit her in the face, pulled her to the ground by her hair and poured a full can of alcohol over her. When police arrived, neither Amanda nor her partner were present. Officers tried to contact the telephone number that had made the original call but this was Amanda's friend's phone who stated Amanda was not with her. Officers tried repeatedly to contact Amanda at her home or on the phone but without success. The case was closed. In the meantime, her partner was arrested for a separate incident and remanded to court. Police were unable to pursue the domestic abuse offence as Amanda would not speak to them about it.

14.29 On 27th October 2016, the GP records were updated that Amanda had been discharged from the Talking Changes service as she had not attended more than one pre-arranged appointment.

14.30 On 3rd November 2016, Harbour Domestic Abuse Service notes record that Amanda's ex-partner was due out of prison imminently. (He was sentenced to 20 months custody back in February for a serious assault – not on Amanda). The notes indicate this male now regards himself as single and that he is aware of his jealousy when he learned Amanda had been in a relationship with another man. He expressed an interest in taking part in the Perpetrator Programme organised by Harbour.

14.31 On 14th November 2016, information from the Probation Service was shared with police and Child Services that this male who had just been released from prison, was associating with Amanda.

14.32 On 23rd November, Amanda was convicted of conveying drugs into prison. She had attempted to take cannabis, diazepam and Subutex into HMP Holme House for her partner who was serving a prison sentence. Amanda was sentenced to 14 weeks imprisonment, suspended for 12 months and a 12 month Suspended Sentence Order with a single requirement of 15 days RAR (Rehabilitation Activity Requirement).

14.33 Amanda had her first appointment with her probation officer a week after her sentence. They discussed the levels of coercion that had been involved for her to try to take the drugs into prison. Amanda was assessed as low risk of reoffending and low risk of causing serious harm. She complied with the requirements of her order and one of her targets was to contact Harbour Domestic Abuse Service to re-engage on their 'Freedom Programme'.

14.34 On 4th December 2016, Amanda rang police from a telephone box in a hysterical state. They attended Amanda's home where they found her conscious but intoxicated. She told the police she had taken a quantity of Valium. Officers took her to hospital where she reported suicidal ideation. She had a clump of hair extensions in her hand and several cuts and bruises to both arms and legs. Further enquiries ascertained Amanda had been out for the day drinking with her ex-partner (the male released from prison in November). He had assaulted her. The details of the incident were shared with the Independent Domestic Violence Advocate (IDVA) and Child Services.

14.35 Liaison Psychiatry had been contacted by staff at the hospital when Amanda was transported there by police. However, Amanda declined to see them. Therefore their assessment had only limited information as Amanda would not engage.

14.36 On 9th December, police were contacted by an anonymous female who stated Amanda was being assaulted by her boyfriend. When officers attended, they spoke to the female who said she had telephoned to prevent anything happening. This female and Amanda were both intoxicated. However, the male was arrested for the assault on Amanda five days earlier. Amanda declined to provide any witness statement and so there was no further criminal prosecution due to a lack of evidence. However, officers did issue the male with a Domestic Violence Protection Notice (DVPN) which barred him from Amanda's home.

14.37 On 11th December, Amanda reported to police that her ex-partner had contacted her on his release from custody. Police and Harbour Domestic Abuse Service worked together to apply to the court for a Domestic Violence Protection Order (DVPO). This barred the male from Amanda's home for a full 28 days.

14.38 On 13th December, Amanda and her partner's case (not Jamie) was heard at the MARAC (Multi-Agency Risk Assessment Conference) which discusses cases and formulates plans to protect the highest risk victims of domestic abuse.

14.39 On 16th December, Amanda rang the police to report her ex-partner had tried to get her into his car. Police searched the local area but could not find the male. They rang Amanda who stated she was with a friend and was fine. However, following this initial call back, officers could not contact Amanda. She was found at her address. The police report was shared with Child Services and Harbour, though Amanda declined the subsequent offer of support from Harbour.

14.40 On 29th December 2016, Jamie's ex-partner rang the police to report when she had woken on her sofa, she had found him in the room standing over her. Officers established the couple had recently split up and Jamie still had a key to the property. He had attended to collect some child's belongings

(Jamie's grandmother had custody of the child). He handed the house key over when instructed to do so by police. Officers also arranged with the landlord to change the locks at the property. His partner (not Amanda) told officers he had threatened to damage the house but would not assist in providing a witness statement so no further action was taken.

14.41 On 10th January 2017, during a formal PLO meeting (Public Law Outline – initial consideration of removing the child from a parent's care) a social worker recorded that she needed to intervene to stop Jamie from intimidating his ex-partner.

14.42 On 12th March 2017, Amanda rang police to report her ex-partner had made threats to smash her windows and 'beat up' her brother. She was contacted on the telephone and initially agreed to speak with officers. However she subsequently said she was not available. Officers tried several more times to make contact with Amanda, including asking Harbour Support Service to call her, but without success. The matter was then closed.

14.43 On 29th March 2017, the Probation Service shared information with the police, Child Services and Harbour that Amanda had reconciled her relationship with her ex-partner.

14.44 On 6th May 2017, Amanda called police to report her brother was trying to kick her back doors in and smash her windows. When officers arrived, her brother had already left, there was no damage caused and Amanda did not want any action taken. Therefore no further investigation was carried out. The details of the incident were shared with Child Services.

14.45 On 8th May, Amanda was taken to North Tees Hospital, having taken an overdose of diazepam and gabapentin. She was too drowsy to be seen by the Liaison Psychiatry Team but did agree to see them the next day. The assessment was carried out the next morning. Amanda denied any suicidal ideation when she took the tablets, telling professionals that she took them to help her sleep. She reported ongoing arguments with her ex-partner and how he continued to threaten her. She referred to an incident the previous weekend when he had taken their dog. She also reported 'binge drinking' and drug taking at weekends. The mental health practitioner also noted that Amanda was currently on probation. She had two children but had no contact with them as they were looked after by the Local Authority. Amanda consented for this information to be shared with her probation officer. She declined a referral to Harbour Support Services but did speak with the Drug and Alcohol Referral Team (DART). She requested a referral back into 'Talking Changes' which was made on her behalf. Amanda's GP was also updated.

14.46 On 2nd June 2017, Amanda's GP received a letter from 'Talking Changes' that Amanda had not responded to their letters so had been discharged from their service.

14.47 On 3rd June, Jamie's partner (not the woman he had previously assaulted and not Amanda) reported to police that he would not leave her house. He had threatened to damage her house and car. Jamie was arrested. However, his partner would not provide any form of witness statement and so no further action was taken due to insufficient evidence.

14.48 On 8th June, Jamie's ex-partner rang police to report once again he was refusing to leave and banging on her door. He had entered her house, pushed her and tried to snatch her phone. In doing so, Jamie caused her to fall onto their 4 year old child. Jamie was not arrested. His ex-partner stated she only wanted him warning and would not support a prosecution. The police report of the incident was shared with Child Services.

14.49 On 14th June 2017, the same ex-partner rang the police to report Jamie was at her address being verbally aggressive, had attempted to smash the windows and threatened to burn the house down. Police attended and arrested Jamie. He was subsequently charged with harassment. The details of the incident were shared with mental health services, Child Services and Harbour. An IDVA from Harbour supported Jamie's ex-partner through the legal process. Jamie was convicted at court on 28th June and was issued with a restraining order.

14.50 On 12th July 2017, Jamie had his first appointment with Durham Tees Valley Community Rehabilitation Company (DTVCRC). This followed his conviction for harassment against his former partner. As well as the restraining order, Jamie was given a 12 month Community Order and 60 hours unpaid work (UPW). The restraining order was issued for 24 months. Two days later, the probation officer completed their assessment on the internal 'OASys' system. They concluded Jamie was a medium risk of serious harm to the public and to 'known adults' (partners or future partners).

14.51 On 20th July, Jamie had an appointment at his GP Practice. He disclosed to the Nurse Practitioner that he thought his current girlfriend (not Amanda) was 'cheating' on him. He believed his jealous accusations were pushing his girlfriend away. He admitted to smoking cannabis but had no suicidal thoughts nor any thoughts of harming his girlfriend. He was signposted to 'Talking Changes.' (He was later discharged from that service for not engaging).

14.52 On 22nd July 2017, Durham Police received an 'abandoned' 999' call. A female voice was heard to scream 'get off' and 'get out' and appeared very distressed. The call was traced to Amanda's home. When officers arrived they spoke to Amanda. Her partner was not present. She told the officers she was 'friends' with this male but that he was now in a relationship with someone else (the male was not Jamie). She went on to say that she and the male had argued and he would not leave so she dialled '999.' As no offences were disclosed, no further police action was taken.

14.53 On 4th September 2017, Jamie was issued with a final warning regarding his persistent failure to comply with the requirements of his Community Order i.e. not attending appointments with his probation officer.

14.54 On the same date, Jamie's ex-partner rang police to report he was breaching his injunction by contacting her, contacting her friends and following her. Jamie was arrested and charged with harassment and breach of a restraining order. He was convicted on 7th September. The existing restraining order was revoked without a Pre-Sentence Report (PSR). Jamie was sentenced to six weeks in custody and a Suspended Sentence Order (SSO) for 24 months. Unfortunately, the following day, the SSO was terminated as it was 'not supervised'. The details were shared with Harbour and Child Services.

14.55 On 27th September, the same ex-partner informed Harbour Domestic Abuse Service that Jamie had been driving past her house. She had apparently reported this to the police but had been advised he was not breaking any laws as the injunction related to her former address. Although police confirm they did speak with Jamie and he denied being in contact with his ex-partner, no domestic abuse report was submitted. This is not in line with policy.

14.56 On 5th October 2017, Jamie's ex-partner (not Amanda) reported he had driven erratically near her car, driving close behind her and staring at her. Jamie was later arrested and charged with a breach of his restraining order. The police report was shared with Child Services. (Jamie was later convicted of this offence in January 2018).

14.57 On 18th October, Jamie's ex-partner made a request to Harbour Domestic Abuse Service for a disclosure on Jamie's previous offending (the Domestic Violence Disclosure Scheme- DVDS – or 'Claire's Law'). The Harbour professional completed the necessary paperwork to progress the application. The disclosure was subsequently made to the applicant. Most of the information about his domestic abuse offending related to the ex-partner who had made the application.

14.58 On 27th October, Jamie's ex-partner (not Amanda) rang the police to report she had received six separate telephone calls from a withheld number. The majority of the calls had been made at unsocial hours. Her support worker at Harbour had advised the female to report the matter to the police. The police carried out enquiries but there was no evidence to link Jamie to the calls. The ex-partner was provided with a crime reference number so that her network provider would be able to change her telephone number.

14.59 On 20th November 2017, Jamie's ex-partner reported to Harbour Domestic Abuse Service that Jamie's new girlfriend had threatened her when she was in the town centre. She stated she had reported this to the police. Enquiries showed this was an argument on 'Facebook' between two adult

females. Both were warned regarding their conduct. No formal police action was taken.

14.60 On 23rd January 2018, Jamie appeared at court for a breach of a restraining order and driving without a licence or insurance. He was found guilty and sentenced to an 18 month Community Order with 200 hours unpaid work (UPW) and 25 days' Rehabilitation Activity Requirement (RAR). This was his 3rd offence against the same victim in a seven month period. He had his first appointment with his probation officer a week later. He was again assessed as a medium risk to partners and future partners.

14.61 On 15th February 2018, Jamie failed to attend his appointment with his probation officer. This followed his failure to attend three UPW appointments and one citizenship induction session. However, he did attend all six planned appointments from 22nd February to 5th April. (In July he only attended two out of seven UPW appointments but did attend six out of seven the following month. This was a pattern which was repeated throughout the year).

14.62 On 1st March 2018, police received a call. A female could be heard screaming and appeared to be arguing with a male. Officers attended Amanda's home and spoke with her and her female friend. Both stated there had been no argument and they had been shouting at the dogs. There was no one else present and no sign of a disturbance and so the officers left. A short time later, further information was received that both women were being held against their will. There was no reply when officers called. Officers attended the following morning and spoke to Amanda. She stated she had not been held against her will but did say that she had a verbal argument with her ex-partner (the male was not Jamie).

14.63 A week later, on 8th March, Amanda reported to a Police Community Support Officer that her ex-partner (not Jamie) had been to her address on several occasions since they split up in February. She went on to say that the week before, he had jumped over her back fence when police arrived. She had denied he was present as he had threatened her to say nothing. Since then, he had entered her home and assaulted her. This was not submitted as a crime report by the PCSO. The gap was later highlighted by the Central Referral Unit, but this was not followed up.

14.64 On 13th March, Amanda had an appointment with her GP. The diagnosis was anxiety and depression. She continued to see her GP throughout the year. Treatment included reviews of her medication and signposting to 'Talking Changes.'

14.65 On 31st March 2018, Amanda rang police to report she had an argument with her partner (not Jamie, but the same male who had threatened her earlier in the month). She stated he had thrown her out of his address. She stated she had also received threatening texts from the male's mother. Finally, she stated the male had slapped her across the face and grabbed

her by the hair. When officers attended to speak with her, Amanda told them she had not been assaulted and that she had fabricated the story about her partner in order to 'stir up trouble' for him. The police report was shared with Child Services.

14.66 On 29th April 2018, Jamie's mother reported to police that her son had been in an argument with her ex-partner. This was apparently due to her ex-partner being abusive towards her. The ex-partner's account was that Jamie had taken a hammer from his car and threatened the other male with it stating, 'I will give you this'. No person was willing to provide any witness statement and there was no CCTV footage. No further action was taken by the police but the details of the incident were shared with Harbour Domestic Abuse Service.

14.67 On 17th October 2018, a multi-agency strategy meeting was convened by Child Services. Amanda's unborn child was placed on a Child Protection Plan under the category of neglect.

14.68 On 7th January 2019, Jamie appeared at court for a breach of his order (missing appointments). His community order was subsequently extended by six months.

14.69 On 17th January, Amanda had an appointment with her GP. She had symptoms of depression but her mood was stable. She stated she was stressed by her new baby and social services involvement. The treatment plan extended her medication.

14.70 On 9th March 2019, Amanda rang the police to report her concerns about her ex-partner's child access which was not in line with the agreement of Child Services (the ex-partner was not Jamie). This information was shared with Child Services.

14.71 On the same date, Jamie was named as a suspect in a burglary at a community centre. He attended the police station as a voluntary attender with his solicitor. He denied any involvement. There was insufficient evidence against him and no further action was taken .

14.72 On 5th April 2019, Harbour staff spoke to Amanda who agreed to them making a 'Safe Referral'. This was to survey her property to consider physical security improvements such as door locks. Harbour then made the referral but the contractor was unable to make contact with Amanda.

14.73 On 15th April, Jamie appeared at court for a breach of Community Order. He was fined £140.00.

14.74 On 24th April, Amanda started the 'Freedom Programme' arranged by Harbour Domestic Abuse Support Service. The Freedom Programme examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help them to make sense of and understand what has happened to them, instead of the whole experience just feeling like a 'horrible mess'. The Freedom

Programme also describes in detail how children are affected by being exposed to this kind of abuse and very importantly how their lives are improved when the abuse is removed. Amanda only attended two of the first five sessions and so her case was closed.

14.75 On 29th May 2019, information was shared from a social worker with Amanda's GP Practice. A fight had taken place outside Amanda's home between her baby's father and Jamie. The baby was present. The fight involved weapons including a hammer. Amanda had denied the incident took place, but CCTV footage refuted her account. Child Services had intervened and Amanda had signed a 'Section 20' agreement. The baby had been placed with a member of his father's family while an investigation took place. Although there was a police investigation, no males were identified and no person was willing to provide a statement. It appears that the Child Services information was not shared with police at that time.

14.76 On 30th July 2019, Amanda had a telephone consultation with her GP. It related to her mental health. Amanda discussed her current legal proceedings regarding custody of her baby.

14.77 On 1st August 2019, Amanda self-referred herself to Harbour. She wanted to finish the 'Freedom Programme' she has started in April. She told staff that social care were involved with her children and her baby had been removed from her care. Amanda engaged well with the programme. Between September and November, she attended all but one of the eleven sessions.

14.78 On 11th October 2019, Amanda had an appointment with her GP. She had not been sleeping since her baby had been 'taken away' due to an incident outside her house. The GP advised the practice do not encourage sleeping tablets due to their addictive nature and side effects. Although Amanda believed her depression had got worse, she denied any thoughts of self-harm. Her dosage of existing medication was increased to help her mood.

14.79 On 29th November 2019, Jamie was arrested for using threatening or abusive words or behaviour likely to cause harassment, alarm or distress. This was not a domestic abuse related incident but involved Jamie and another adult male. One had been armed with a stick and one with an axe. Jamie received a police caution for the incident.

14.80 On 11th December 2019, Amanda attended her GP. She was tearful over her baby's removal from her care. She told the GP she was 'fighting' to get the baby back and would be in court in January. She had low mood but denied any suggestion of suicidal thoughts and also stated she was not drinking alcohol. She did say some of her medication was making her feel like a 'zombie'. The GP advised she stopped taking amitriptyline and issued a prescription for mirtazapine as well as retaining her fluoxetine. They also discussed 'Talking Changes'.

14.81 On 15th January 2020, police were called to a report of a male (Jamie), assaulting a female and was seen to 'drag her up the street and stop her getting on the bus'. He and the female were then seen by witnesses to be fighting before both got into a car and left. Jamie was traced and arrested for affray and assault. He admitted to assaulting a member of the public and received a police caution for assault. He refused to say who the female was. Police believed the victim was Amanda. She spoke with officers on the telephone but said she did not know Jamie. Amanda denied anything had happened but would not disclose her current location to officers. The police incident report was shared with Child Services.

14.82 On 5th February 2020 Amanda spoke with her GP. She said she 'was not in a good place'. She had symptoms of depression and had poor sleep. Her child had been taken into care and she was feeling upset and stressed. Although Amanda had negative thoughts she did not have any suicidal ideation. The GP recorded Amanda had mental health problems and considered her 'vulnerable'. Amanda had stated she was at risk of losing her house. The GP believed the council should take her vulnerability into account when dealing with her housing request. The plan is recorded as 'medications issued, Talking Changes recommended and printout given for housing appeal'. Checks carried out during the DHR process confirm that Amanda received support from the Housing Solutions team. Staff assisted her with benefits applications and shortfalls in rent were paid to her landlord. Amanda was not evicted.

14.83 Amanda saw her GP a few weeks later as she was tired for much of the time. The GP signposted her to Cognitive Behaviour Therapy (CBT) services to help with her anxiety and depression.

14.84 On 26th February 2020, Amanda attended her first session of YAMM ('You, me and mum' – a parenting support group) convened by Harbour Domestic Abuse Service.

14.85 On 4th March 2020, Harbour Domestic Abuse Support Service referred Amanda to 'partner link support' as her ex-partner (not Jamie) was now on a perpetrator programme. This meant that she was kept up to date on her ex-partner's progress. Amanda's current partner by this time was Jamie.

14.86 Also on 4th March, Amanda attended the Urgent Treatment Centre. She reported she had 'knocked her left arm off a wall one day earlier'. The x-ray showed a radial head fracture. Staff at the hospital noted there was a 'flag' on the system that Amanda is a victim of domestic abuse.

14.87 On 11th March, Amanda attended her third group session at YAMM. From this point, all face to face group work was halted due to the restrictions of the Covid-19 lockdown (subsequent contact at YAMM was via a 'WhatsApp' chat group).

14.88 On 2nd April 2020, Amanda sent abusive text messages to her (paternal) aunt. The aunt had a Special Guardianship Order (SGO) in place with

custody of Amanda's youngest child. The aunt had stopped all face to face contact between Amanda and her baby due to shielding issues linked to covid.

14.89 On 6th April, Amanda reported to Harbour staff that she had been intimidated by her ex-partner and his new girlfriend while she was out. They had allegedly stopped their car at a junction and shouted abuse at her. Amanda was advised to log the matter with the police as this would assist in any future application for a non-molestation order. Police records confirm they received no subsequent report from Amanda.

14.90 On 26th May 2020, Amanda had a telephone consultation with her GP (no face to face appointments due to lockdown restrictions). She had low mood and anxiety which had become worse during lockdown. Amanda stated she was worried that she might never go out again. She had no suicidal ideation but had started drinking alcohol again (drank a bottle of wine last week). She was speaking once a week on the phone to a support worker from Harbour which she found helpful.

14.91 On 11th June 2020, Amanda was named as a suspect in a harassment case reported to Durham Police, in which one female had allegedly shouted at another. Amanda was spoken to by officers but denied the allegation. No further action was taken.

14.92 On 2nd July 2020, Amanda rang the Urgent Treatment Centre. During the call she stated she 'had a small trip' a day earlier which had caused bruising and swelling to her toe. She was advised to attend, which she did. Staff noted that on her arrival she changed her account to say she had been at a party during lockdown and had fallen from a bouncy castle. Staff also noted the domestic abuse 'flags' on their system. The x-ray revealed a fracture to her toe and also a historical fracture.

14.93 On 7th August 2020, Jamie appeared at court for handling stolen goods, driving whilst disqualified and driving with no insurance. He received a Community Order for 12 months, 100 hours UPW and 10 days' RAR. Three days later, the probation officer completed their assessment; Jamie was assessed as medium risk to known adults and children. This is recorded as predominantly linked to his domestic abuse behaviours.

14.94 On 9th August 2020 Amanda checked Jamie's social media account and confronted him about messaging someone else. He pushed Amanda onto the bed and punched her to the right hand side of her face. Amanda managed to leave and texted a friend to collect her. When her friend arrived, Jamie would not let Amanda out of the house and dragged her back into the property. Eventually, Amanda left but returned later the same day for her medication. Jamie begged her to stay with him and she did. This incident was not disclosed to police for another two months (in October 2020, Amanda called the police about another domestic abuse incident. During discussions with attending officers, she also disclosed this

August incident. Jamie was arrested for criminal damage, assault, harassment and breach of bail conditions).

14.95 On 11th August, Amanda had an 'e-consultation' with her GP. A further sick note for depression was issued. An appointment was made for 13th August but she did not attend.

14.96 On 18th August, police received a call from a distressed female crying "he's going to get in". The caller cleared the line before further details could be given. Police attended but Jamie had already left. Amanda disclosed previous incidents of harassment and threats by Jamie. Amanda had ended the relationship after reading a newspaper article about Jamie and his abusive past. He had then attended her address and shouted through the letterbox 'You'll not see your family again'. She did not want formal action taking, but requested he was warned not to attend her address. He was later warned about his conduct. The incident was assessed as medium risk.

14.97 On 25th August (and the following month), Amanda received an update from Harbour on her ex-partner's progress on the perpetrator programme (this was a different male to Jamie, though by this point she had been in a relationship with Jamie for about a year).

14.98 On 1st October 2020, Amanda rang the police. The police recorded she sounded hysterical and was stating her door had been kicked in and Jamie was at her address but had left when she telephoned the police. The incident was assessed as medium risk. Jamie was traced and arrested. While in police custody, he was referred to the Liaison and Diversion team. An assessment was carried out but Jamie was reluctant to engage. He reported no issues with his mental health, did not have any self-harm of suicidal thoughts and did not want any support. He acknowledged using cannabis but not on a daily basis. He was bailed with conditions imposed to protect Amanda. Jamie was convicted of criminal damage the following week and received a conditional discharge. However, it was a different police officer which arrested Jamie to the one which bailed him and put the court file together. There was an error during the handover and no restraining order was applied for through the courts. A restraining order would have afforded longer term protection for Amanda.

14.99 On 5th October, Jamie's probation officer discussed his recent arrest. He admitted he kicked the door as Amanda wouldn't let him collect his clothes. He maintained the relationship was over.

14.100 On 25th October, police received a call from Amanda's friend. Amanda had texted her friend asking her to phone the police. Jamie had attended her home in breach of his current bail conditions not to attend her address. He was arrested for harassment. The incident was assessed as medium risk. When he appeared at court the next day, he was sentenced to a conditional discharge. Jamie disclosed to the court that he had been living at Amanda's address for the last 18 months.

14.101 On 12th January 2021, Amanda rang the Mental Health Support Team at TEWV following a suggestion from her work coach (an employment advisor from the DWP). She talked about her anxiety and depression. Her nan died a few days ago and she felt everything was 'getting on top of her.' Amanda had no suicidal ideation or intent to self-harm. She added she was due to see her GP the next day to discuss a possible referral back to 'Talking Changes.' TEWV were not aware of the relationship with Jamie. However, there is nothing recorded that domestic abuse or risks from others was discussed during this contact.

14.102 Amanda spoke with her GP on 25th January and 8th February. She still had low mood, anxiety and nightmares. Her medication was reviewed and she confirmed she had spoken with mental health services.

14.103 On 12th March 2021, Amanda had her first contact (introductory phone call) with 'Pause Durham'. This is a service (part of the Barnardo's children's charity) which is designed to address the needs of women who have experienced repeat removals of children from their care. Amanda had been referred to 'Pause' by Child Services.

14.104 On 25th March, another telephone call with 'Pause' recorded further details linked to Amanda suffering domestic abuse and that this was the reason her children were removed. The discussion also included her mum's death, her depression, debt issues and her previous work with Harbour.

14.105 On 15th April 2021, Amanda sent a text to her Harbour 'partner link' worker. When they spoke, Amanda disclosed her ex-partner (not Jamie), had made threats to assault her a few weeks ago. She went on to say she had reported this to the police and that the ex-partner had not contacted her since (though police have no record of this call). Amanda became upset on the phone stating that she felt very stressed. She declined to speak to her GP but did say she would contact the 'Talking Changes' service. The Harbour 'outreach' service was also discussed but Amanda declined this at that time.

14.106 On 4th May 2021, Amanda was due to have her first face to face meeting with the 'Pause Durham' service. At Amanda's request, this was changed to a telephone contact. Amanda disclosed the same domestic abuse threats made by her ex-partner that she had disclosed to Harbour a couple of weeks earlier. She also stated she had been referred to 'Talking Changes' by Harbour. Following the telephone call, the first face to face meeting with Pause Durham took place on 12th May. A further face to face meeting took place on 25th May when a baseline assessment was completed. Amanda told the Pause professional that she was not in a relationship and that her last relationship ended six months earlier.

14.107 On 6th May, Amanda attended an initial assessment with a qualified therapist at the 'Talking Changes' service. They discussed her anxiety and depression. Weekly appointments were scheduled. However, when

Amanda only attended three out of her first six appointments she was discharged from the service in line with their policy.

14.108 On 10th May, Amanda attended the Urgent Treatment Centre. She reported she had been a passenger in a car during a road traffic collision. She complained of pain to her arm, chest and back. Police did not receive any reports of a road traffic collision on that date near that location, nor with Amanda named as an injured person at any incident.

14.109 On 26th May, Amanda attended her first 'Pause' women's group. She attended a further group meeting on 23rd June.

14.110 On 14th June 2021, Amanda attended the Urgent Treatment Centre. She had a burn to her foot. She reported to staff she had stood on her straighteners two days earlier. The burn was 7cm long and 3cm wide. Dressing was applied.

14.111 On 3rd July 2021, Amanda again attended the Urgent Care Centre. She had a fractured elbow and so was referred on to North Tees and Hartlepool Hospital. Initially, she reported she had tripped and slipped. However, Amanda changed her account and said she had fallen off a bouncy castle at a party. The NTHH contact was a 'virtual' appointment (not in person).

14.112 Amanda attended further Pause women's groups on 7th, 14th , 21st and 28th July and 11th August. She became emotional during the sessions and said this was due to missing her children. Amanda also asked for financial support and received fuel top ups and groceries.

14.113 On 6th August 2021, Jamie's community order was terminated as the time frame had expired.

14.114 On 12th August 2021, Durham Police received a call of Jamie driving a vehicle erratically, causing a nuisance and also he was shouting at a female that 'she had better get into the house or he will bray her'. Police spoke with Amanda who told officers she had argued with her partner, Jamie, but stated he did not live with her. She denied there had been any threats or assault. Police correctly recorded this incident as domestic abuse. The incident was assessed as standard risk.

14.115 On 16th August, Amanda again attended the Urgent Treatment Centre. She reported she had slipped on some steps the day before, had fallen and injured her elbow. Practitioners believed it may be a fracture so a follow-up (virtual) appointment was made with North Tees and Hartlepool NHS Trust for 18th August. No fracture was found.

14.116 On 23rd August, Amanda attended another Pause women's group but cancelled her 1:1 session on 25th due to feeling unwell. Instead, her support worker did a home visit and dropped off a nurture pack of groceries and flowers. Due to Amanda disclosing she had been in contact with people with Covid, the support worker didn't enter the house.

14.117 On 25th August, a friend of Amanda's called the police to report Amanda's partner was banging on the door trying to gain entry. She told police that Amanda had recently found an article on the internet showing Jamie had assaulted previous partners. Amanda had asked her not to contact the police but her friend was worried about her. When officers spoke with Amanda she said there and been no assault but just wanted the relationship to be over. She would not give any further information. On the same day, a client of Pause Women's Service who knew Amanda reported to Pause staff that there had been a domestic incident involving Jamie. Pause staff ensured police were involved and made a referral to Harbour Domestic Abuse Support Service. The incident was assessed as medium risk.

14.118 On 1st September 2021, Amanda attended a Pause women's group session. She reported she'd had no contact with Jamie and confirmed she had spoken with a Harbour support worker. This is the last recorded contact with any professionals prior to the tragic fatal road traffic collision a few days later.

Section 15: Overview

15.1 The perpetrator and victim had significant involvement with local services spanning many years.

15.2 Amanda and Jamie did not have any children together. However, both had children from earlier relationships. All of their children had been subject to child protection procedures and had subsequently been removed from their care.

15.3 Jamie had a long criminal record with convictions for assaults, threatening behaviour, harassment, breach of restraining orders, breach of bail, handling stolen goods, criminal damage and driving whilst disqualified.

15.4 Jamie also had contact with mental health services and drug / alcohol support services.

15.5 Amanda had frequent contact with health professionals linked to her diagnosis of anxiety and depression. She also had several periods of engagement with specialist support services linked to domestic abuse and to women who have had children removed from their care. She disclosed excess alcohol use to professionals.

15.6 Amanda had suffered domestic abuse perpetrated by at least three partners and ex -partners before she started a relationship with Jamie.

15.7 Jamie had been dealt with for perpetrating domestic abuse towards at least two partners and ex-partners before he began a relationship with Amanda.

15.8 Both Jamie and Amanda had been discussed several times at MARAC meetings (Multi-Agency Risk Assessment Conferences where professionals discuss action plans to protect the highest risk victims of domestic abuse). However, this was not from their own relationship together. The discussions related to their former partners. Amanda was listed as a victim of domestic abuse from a former partner. Jamie was shown as a perpetrator of domestic abuse towards a former partner.

15.9 Amanda had attended main hospitals and the Urgent Treatment Centre on many occasions. The reasons were both for physical injuries and from taking overdoses of medication. She did state on some occasions she had suicidal ideation. Her physical injury appointments showed a pattern of either changing her account of how the injury had been caused or of a delay in presenting at the hospital to be treated.

15.10 Jamie had spent lengthy periods of time subject to supervision by the Probation Service (including DTVCRC). This was predominantly linked to his history of domestic abuse offending.

Section 16: Analysis

16.1 The circumstances that led to the deaths of these two young people are both tragic and unusual. Following an extensive police investigation, it cannot be ascertained whether the vehicle leaving the carriageway in the early hours in September 2021 was a deliberate act or was due to the reckless actions of the driver.

16.2 What is known is that the driver and passenger had been in an intimate personal relationship for two years. There was a long history of domestic abuse perpetrated by Jamie towards Amanda. Jamie was driving the car. Subsequent samples from his body showed the level of cannabis in his system was above the legal limit to drive a motor vehicle (the legal limit is 2 micrograms per litre of blood, his had 25 micrograms, i.e. 12 times the legal limit). There were also traces of alcohol and temazepam. The occupants of the vehicle had been awake all day and into the early hours and travelled long distances to visit Blackpool and then return to the North East.

16.3 What is also known is that Jamie had physically assaulted Amanda only minutes before the fatal collision. It is confirmed that Amanda made four silent ‘999’ calls from her mobile phone just prior to the incident.

16.4 The Domestic Homicide Review Panel agreed a robust set of terms of reference to analyse events and agency responses in the preceding years and months before this tragedy.

16.5 Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

16.5.1 Both the victim and perpetrator in this case had been involved in a significant number of domestic abuse incidents with previous partners. The police recorded many previous domestic abuse incidents when Amanda was shown as the victim, prior to her relationship with Jamie. They recorded a number of previous incidents where Jamie was recorded as the abuser to previous partners in domestic abuse incidents.

16.5.2 With regard to Amanda suffering domestic abuse before she began a relationship with Jamie; this had included assaults, threats and criminal damage. Police and other agencies had obtained non -molestation orders, restraining orders and Domestic Violence Protection Orders (DVPOs) to protect her. Harbour Domestic Abuse Support Service had offered a place on their 'Freedom Programme' but Amanda did not fully engage with the process.

16.5.3 Amanda had suffered a number of injuries during her relationships with other partners prior to her relationship with Jamie. In 2015 she required surgery after her arm was broken in two places. Her former partner had pushed her over in the street. But Amanda told the social worker she had tripped over the dog. (Her friends confirmed it was her partner who caused the injuries but Amanda maintained her account about the dog).

16.5.4 Jamie was extremely violent to a previous partner. He assaulted her by hitting and then strangling her. She was hospitalised twice in 2014. He was abusive to another (third) separate partner, prior to his relationship with Amanda; in 2017 he was convicted of harassment towards this partner and a restraining order was obtained to protect her.

16.5.5 There were six incidents of domestic abuse between Amanda and Jamie reported to Durham Police between January 2020 and September 2021.

16.5.6 The first incident between the couple occurred when a male member of the public intervened when Jamie was shouting at Amanda at a bus stop. Jamie then knocked the man to the ground. Amanda was then dragged into a car by Jamie which was driven away from the scene. Witnesses knew Jamie and he was arrested. They did not know the female's (Amanda's) identity. Through use of their intelligence systems, police concluded the victim was Amanda. They attended her address but there was no reply.

Eventually she was contacted on the telephone but she denied knowing Jamie. He was interviewed and received a caution (as the victim's identity could not be confirmed). It is clear positive action was taken by the police (the arrest of Jamie and the contact with Amanda). But a second home visit may have meant officers could have spoken to Amanda in person and also ascertain if she had any injuries. This did not take place. Amanda was elusive in her dealings with police. The police shared the details of the incident with Child Services. This was the right thing to do but may have been a reason why Amanda was reluctant to confirm the incident (see Section 17 'Conclusions and Learning').

16.5.7 The other five incidents reported to the police related to assault, harassment, criminal damage and breach of bail conditions. On each occasion, Durham Police clearly identified this was domestic abuse and took positive action. Referrals were also made to other agencies for support. Each of these incidents will be considered in detail in paragraph 16.8 ('key points or opportunities for assessment and decision making'). However, it should be noted that police responded swiftly (five of the six incidents had a response time of between six and thirteen minutes), details of the incidents were shared with both Child Services or Harbour Support Services when appropriate (four incidents were subject to a multi-agency triage process) and each incident was subject to a formal risk assessment.

16.5.8 Durham Police actions demonstrate their officers and staff are alert to the signs of domestic abuse. However, during the review it was highlighted many officers have not had formal domestic abuse training or refresher training in the last three years. Likewise, during the review of their agency responses, the Probation Service also identified shortcomings in their actions which may be addressed by a review of training needs. Probation officers should receive training in identification of domestic abuse every three years.

16.5.9 Amanda had been registered with her GP Practice since 2010. Jamie had been with the same GP Practice since birth.

16.5.10 Amanda had many consultations and appointments with her GP. She disclosed mental health issues and had symptoms of anxiety, depression and obsessive compulsive disorder. There are records of intentional overdoses with alcohol in 2016 and 2017. At each interaction, Amanda's mood was assessed, she was prescribed anti-depressants and was appropriately referred or signposted to talking therapies and counselling. Amanda's attendance at her GP was sporadic. The notes confirm a number of 'DNAs' (Did Not Attend) for both the GP and 'Talking Changes' appointments.

16.5.11 Multiple ‘stressors’ are recorded in Amanda’s medical notes. These included abusive intimate partner relationships, mental health issues, suicide and self-harm attempts and unplanned pregnancies. A significant loss is also recorded with the death of her mother in 2015. Amanda was known for excessive alcohol use. Her mother died from alcoholic liver disease.

16.5.12 Although Amanda’s medical needs were addressed at her GP appointments, the pattern of physical injuries (including burns and fractures) when she attended Urgent Care Centres or Emergency Departments at hospital, were not picked up on in Primary Care. No enquiries were made within Primary Care about the possibility of domestic abuse from those hospital attendances or of continuing domestic abuse within her relationship(s).

16.5.13 Amanda had four contacts with Tees, Esk & Wear Valleys NHS Trust (TEWV). Two contacts were in 2016. Both related to her attendance at hospital for drug overdoses of diazepam. The first entry (March 2016) has only brief notes and it is unclear if Amanda was medically assessed at the time. The second contact (December 2016) outlines that Amanda was accompanied by the police. Amanda declined to engage in the assessment or answer any questions other than to confirm she had no intention to harm herself.

16.5.14 In May 2017, Amanda again attended hospital after overdosing on drugs. She was intoxicated and so was too drowsy for an assessment. She did agree to an assessment with Liaison Psychiatry the next day. She denied suicidal ideation but stated she took the tablets to help her sleep to avoid arguments with her ex-partner (this male was not Jamie). She also disclosed suffering domestic abuse. Amanda already had an appointment with her GP later that day and so was advised to speak with the GP about medication for her low mood. She did agree to a DART referral to access drug and alcohol support services. The TEWV practitioner also contacted Amanda’s probation officer to update them on the incident. Due to the disclosure of domestic abuse, the practitioner also discussed a referral to the local domestic abuse support service (Harbour) but Amanda declined. The details of this assessment confirm that TEWV services were alert to the domestic abuse and how to refer appropriately.

16.5.15 Amanda’s last contact with TEWV was in January 2021 when she telephoned the Mental Health Support Team due to her anxiety and depression. She had recently lost her Nan and felt like things were getting on top of her. The practitioner confirmed Amanda already had an appointment with ‘Talking Changes’ arranged by her GP. However, there is no record of any discussion of domestic abuse issues or risk from others

even though previous TEWV discussions had recorded her suffering domestic abuse.

16.5.16 Jamie was known to TEWV services as far back as 2006. He had a number of referrals to Child and Adolescent Mental Health Services (CAMHS) with a diagnosis of attention deficit hyperactivity disorder (ADHD). He stopped taking his medication in 2011. His family informed practitioners the medication had reduced his aggression.

16.5.17 During an assessment in 2014, he disclosed anger as his predominant concern. He also disclosed perpetrating domestic abuse towards his partner (not Amanda) including non-fatal strangulation. It is a concern that the TEWV assessment showed no evidence of risk to others, despite the disclosure that had been made. No actions are recorded in relation to potential safeguarding of the victim.

16.5.18 Jamie had two referrals to Liaison and Diversion in 2020. On both occasions he was detained in police custody for criminal offences. On the first assessment he was difficult to engage. He was proactively asked about domestic violence and abuse. He did not report being in a relationship at the time. He refused to explore medication for his ADHD. On the second occasion (when he was in custody for harassment linked to a domestic abuse incident) he refused the offer of an assessment.

16.5.19 The 'Pause' Service in Durham is a Barnardo's service commissioned by Durham County Council Children's Services. It is a service designed to address the needs of women who have experienced repeat removals of children from their care. Pause were only involved with Amanda for the last six months of her life but had begun to build a trusting relationship with her. Case notes show that Pause staff were sensitive to Amanda's needs; e.g. changing appointment times or venues or providing her with food parcels when she was struggling financially. The Barnardo's Pause Practitioner allocated to Amanda had undertaken training in relation to domestic violence and abuse through Pause and was aware of the potential indicators of domestic abuse and violence. The Practitioner knew what to do if any concerns were identified. Amanda did not disclose any information about the perpetrator and denied being in a relationship with anyone.

16.5.20 The initial referral to Pause was from a social worker in Child Services. In March 2021, a risk screening tool identified historic domestic abuse but no current relationship or significant risks. Two months later, the practitioner raised with their manager, the suggestion of possible domestic abuse perpetrated by Jamie. However, Amanda always maintained that her relationship with Jamie was over. The same month, during a telephone call, Amanda disclosed an incident involving an ex-partner who had threatened

her (this was a different male to Jamie). Again, she told Pause professionals she was not in a relationship with anyone.

16.5.21 There were other signs of domestic abuse such as cancelling attendance at Pause group sessions because of illness. On one occasion this was due to Amanda burning her foot. She stated this was from standing on hair straighteners. There was no professional curiosity to explore Amanda's account of the injury. However, on the one confirmed incident of domestic abuse (in August 2021) the Pause practitioner did correctly refer the matter to Harbour Domestic Abuse Support Services and ensured the police were involved. The impact of Covid-19 will be discussed under a separate term of reference but it is worth noting here that the pandemic did affect the ability of staff in organisations such as 'Pause' to be able to have face to face private meetings in the home which could have given wider opportunities for dialogue, assessment and support.

16.6 Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

16.6.1 North Tees and Hartlepool NHS Foundation Trust have a comprehensive 'Adult Safeguarding Policy'. The policy has a full section encompassing domestic abuse. There is also now a separate stand-alone policy covering domestic abuse. This Domestic Abuse Policy is currently being reviewed to incorporate developments within the Domestic Abuse Act. The Hospital Trust also employs an IDVA (Independent Domestic Violence Advocate) to ensure direct support to victims.

16.6.2 County Durham and Darlington NHS Trust have a Domestic Abuse Policy which supports staff with identifying, responding to and supporting individuals who may be exposed to domestic abuse. The Trust also has experienced staff who are available to provide advice, support and guidance with specific incidents. Domestic abuse forms part of the training programme across the Trust to continually develop practitioners with current issues and ensure they have the skills and tools available.

16.6.3 The GP Practice does have policies and procedures in place relating to domestic abuse. However, opportunities were not taken to enquire directly with the patient. The GP did have knowledge of domestic abuse taking place and was assured that other agencies were involved but did not enquire further with Amanda herself.

16.6.4 Tees, Esk & Wear Valleys NHS Trust does have a domestic abuse policy in place (though one was not drafted during the earlier incidents that occurred seven years before Amanda's and Jamie's death). Their contacts with the victim were not consistent and varied from very thorough actions, information exchange and referrals through to very little action or consideration of the issue of domestic abuse. However, the lack of awareness does relate to earlier appointments (in 2014). The later appointments were more robust and matched the expectations within the Trust's policy.

16.6.5 The 'Pause' service (Barnardo's) does not have a specific domestic abuse policy in place. When considering the vulnerability of their clients this is a gap. A policy would help staff in their decision-making and give confidence in areas such as exchange of information which would in turn safeguard victims. The service does have safeguarding policies in place relating to children and adults.

16.6.6 The Probation Service does have an extensive policy in place relating to domestic abuse. There are identified gaps in the risk assessment and risk management relating to the perpetrator in this case which will be explored in paragraph 16.8

16.6.7 Durham Police have a domestic abuse policy which sets out the roles and responsibilities of officers and staff. Positive action against perpetrators is promoted within the policy. Force policy is for officers to submit a Domestic Abuse Report for every incident defined within that policy. This includes the completion of a nationally agreed risk assessment tool. These risk assessments will be reviewed in paragraph 16.8

16.7 Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

16.7.1 Information appears to have been held securely by agencies yet was readily available, highlighting domestic abuse concerns via 'flags' on agency systems and shared appropriately with partner agencies. This is good practice.

16.7.2 Much of the good work began in 2015 with the creation of the Multi-Agency Safeguarding Hub (MASH). This was further enhanced in 2018 when a joint domestic abuse screening process was introduced. On a daily basis, every police domestic abuse incident where children are linked or involved (and

are not currently open to Early Help or Child Services) are jointly triaged with police, child services and child health. Any children that are currently open to child services are safeguarded by direct contact to the relevant professional or team.

16.7.3 Domestic abuse cases are shared with Harbour Domestic Abuse Support Service when consent is obtained (or in any event if the incident is assessed as high risk).

16.7.4 There were some single agency shortfalls in the level of information sharing linked to the perpetrator which are addressed separately under 'key points or opportunities for assessments and decision making'.

16.8 What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

16.8.1 Both the victim and perpetrator were frequent users of a variety of statutory and voluntary services which meant there were many opportunities for effective intervention.

16.8.2 Amanda attended main hospitals (North Tees and Hartlepool NHS Trust) and the Urgent Care Centre at Peterlee (part of County Durham & Darlington NHS Trust) on many occasions. Some of her attendances were for drug overdoses. She was cared for and pertinent questions about domestic abuse and mental health problems were discussed during the treatment for her overdose. However, on at least six attendances in 2016, 2020 and 2021, Amanda presented with physical injuries. These included accounts of a wardrobe falling on her toe, burning her foot on hair straighteners, knocking her arm on a wall (resulting in a fracture to the elbow) and tripping on a step (causing a fractured toe). She always presented after a delay and not immediately after the incident. On some occasions she changed her account. During one contact, she relayed a chest injury in an apparent road traffic collision over the telephone. When asked to attend for an examination she did not attend. These attendances; the questionable nature of how the injuries were caused, the delay in presenting and changing her account of what had happened, represented a pattern. Due to her drug overdose attendances (when domestic abuse was disclosed) and also through her involvement in MARAC (high risk domestic abuse) the hospital systems had clear domestic abuse 'flags' to advise staff that Amanda may be a victim of domestic abuse. Despite these markers, there was no proactive questions put to Amanda nor even any professional

curiosity about her injuries. These attendances have to be considered as missed opportunities for intervention.

16.8.3 Primary Care accepts they too had access to this information about these attendances at hospital with varying accounts of how they occurred. The GP Practice did not proactively speak to Amanda about potential support.

16.8.4 Harbour Domestic Abuse Support Service note there was a pattern of non-engagement from Amanda. This, plus the high number of incidents, together with abuse from several partners meant that a more focused approach via a Harbour 'around the table' meeting would have given the opportunity for specialist domestic abuse support workers to consider other approaches or proactive contact with Amanda.

16.8.5 Tees, Esk & Wear Valleys NHS Trust had only limited involvement with the victim and perpetrator. There was a missed opportunity to explore with Jamie any onward referrals for perpetrator support (though he did not always readily engage). There were also occasions when opportunities were missed to explore intelligence sharing with the police around both Amanda and Jamie regarding their previous abusive relationships with other partners.

16.8.6 The perpetrator was managed for lengthy periods by the Probation Service including (before reorganisation), by the National Probation Service or Durham Tees Valley Community Rehabilitation Company (DTVCRC).Their involvement and management of Jamie will be explored in paragraph 16.11. But there were some key opportunities involving him that should be noted here.

16.8.7 Following Jamie's conviction on 28th June 2017 for harassment (a domestic abuse related offence) a Pre-Sentence Report (PSR) was completed by his probation officer. The PSR noted that Jamie had no previous convictions for domestic abuse. Indeed, the PSR stated that Jamie's behaviour was 'out of character'. This was inaccurate. Jamie had already been convicted in 2014 for an offence of battery against a former partner. Although there was a gap of three years between these offences, this lack of knowledge may have led to an underestimation in the assessed risk at the sentencing stage. Plus of course, there were other matters during that period, which although not resulting in convictions, were reported to the police as domestic abuse related incidents. Consequently, the PSR recommended a community order (which was agreed by the court) with stand-alone unpaid work (UPW) of 60 hours. Because this was a stand-alone order, there were no other interventions requested e.g. a Rehabilitation Activity Requirement (RAR) which could have included a focus on domestic abuse and maintaining healthy relationships. However, it should also be noted that the probation

officer did apply for a restraining order to protect and safeguard the victim from further harm and this was granted by the court.

16.8.8 Following a Breach of his Restraining Order,(by trying to contact his ex-partner) Jamie appeared back at court in September 2017. The community order was revoked and he was sentenced to a 24 month Suspended Sentence Order (SSO). Unfortunately this order had no supervision requirements and so contact with the Probation Service ended as there was no role for them within the new order. So although any further breaches may have resulted in a prison term, (i.e. a breach of his suspended sentence), there could be no proactive work to manage his behaviour around domestic abuse.

16.8.9 Jamie was convicted of a further Breach of the Restraining Order in January 2018. The breach occurred when he had followed his ex-partner in a vehicle. On this occasion his sentence was a Community Order for 18 months, complete 200 hours UPW and a Rehabilitation Activity Requirement (RAR) of 25 days. This was the third conviction against the same victim (his ex-partner – not Amanda) in seven months. This offence had occurred less than two months after the previous Breach of Restraining Order offence.

16.8.10 For this PSR, the probation officer had quickly identified the pattern of domestic abuse. The officer obtained copies of all police callouts and this concluded Jamie continued to pose a medium risk of serious harm to partners and future partners. However, there were significant gaps in other aspects of the subsequent risk assessment. Probation officers use the 'OASys' system to record details of their risk assessments with offenders. Policy is that this risk assessment should be completed within 15 days of the offender's first appointment. The assessment was completed nearly ten weeks after that first appointment. The reason recorded is staff sickness. There is minimal content in the assessment. The risk of serious harm sections have only minimal information and omit both the previous battery and harassment offences in the analysis. There is no reference to the 14 police callouts (which were referenced in the PSR). Also, the police callouts are only cited from information from Jamie himself. He stated they were 'verbal only' arguments. The probation officer did not enquire proactively with the police to the actual nature of these callouts.

16.8.11 It is positive that a SARA (Spousal Assault Risk Assessment) was carried out. The assessed level of risk to 'known adults' (namely partners and future partners) was medium. Current guidance indicates that when there may be a risk to (as yet unknown) partners, then they should be considered within the category of 'public' as they are not individuals who are known or identifiable at the time of the assessment. Jamie should have been recorded as a 'medium' risk to the public at that stage (this would include

Amanda who was ‘as yet unknown’). At that stage, he was assessed as a low risk to the public.

16.8.12 Jamie’s ‘Sentence Plan’ contained three objectives. One was in relation to UPW. Another related to maintaining employment. The third objective was to increase Jamie’s understanding of the consequences of domestic abuse on the victim and others via use of the ‘Citizenship’ programme. This is good practice. Unfortunately, there is no evidence that any of the work to address domestic abuse was conducted throughout the period of the community order. There was only one planned RAR activity recorded. This was a ‘Citizenship Induction Session’ on 7th February 2018. Jamie failed to attend this appointment. Given the nature of Jamie’s repeated domestic abuse offending, this is a major omission within this case.

16.8.13 There is another area of concern regarding safeguarding activity within the duration of the management of this community order. This relates to two separate disclosures that Jamie was in a new relationship.

16.8.14 In October 2018 he told his probation officer he was in a new relationship but refused to provide the female’s name. Nothing in the notes suggest the probation officer made any attempts to gather further information. It is therefore unknown how long the relationship had been ongoing or if the new partner had any children. This is a concern when considering his domestic abuse history and that the OASys assessment explicitly indicated that entering a new relationship was likely to increase risk. Probation Service procedures state staff must *‘undertake actions as necessary to obtain information from children’s services or police domestic violence teams when required’.*

16.8.15 Another such disclosure took place in January 2019. During an appointment with his probation officer Jamie told the professional he had missed one of his UPW sessions due to a verbal altercation with his partner. Although the probation officer informed Jamie that this was not an acceptable reason for missing an appointment, there is no evidence that they made any attempt to gather further information about this relationship. There were no updates to the SARA (Spousal Assault Risk Assessment).

16.8.16 There was no contact between Jamie and the Probation Service between April 2019 (the end of his community order) and August 2020 (when he was convicted at court for handling stolen goods and driving offences). Following that conviction, Jamie was sentenced to a further community order and there was a further risk assessment completed. This was the first time that there was a full review of Jamie’s previous domestic abuse related offending. (Battery, Harassment and two separate Breaches of Restraining Orders).

16.8.17 Jamie was assessed as medium risk to ‘known adults’, to children and to the public. The risks to the public are documented as other road users and pedestrians, given the nature of his driving offences (driving while disqualified and no insurance). The risk to future (as yet unknown) partners should also been part of the risk to the ‘public’ but this was omitted. Management of this phase by the Probation Service (then still Durham Tees Valley Community Rehabilitation Company) was restricted due to the Covid-19 pandemic. An ‘Exceptional Delivery Model’ had been implemented to provide a framework of working for probation staff. This meant face to face meetings were significantly reduced and staff were working within a very challenging environment while managing offenders.

16.8.18 Only two months into his new community order, Jamie was arrested following a domestic abuse incident. He had kicked the front door of his new girlfriend’s accommodation and caused criminal damage. The new girlfriend was Amanda. Police had secured bail conditions to protect Amanda; not to contact her and not to approach her address. This incident was only ten days after Jamie had stated to his probation officer that he was single.

16.8.19 The probation officer did discuss the domestic abuse incident with Jamie a few days later. The conversation was on the telephone due to the Covid-19 ‘Exceptional Delivery Model’ in place to reduce all but essential face to face contact. Jamie insisted the relationship was over and that he had ’kicked off’ when he went to collect his clothes. The probation officer correctly focused the discussion on how Jamie can manage his emotions and deal with problems more appropriately. However, there was a missed opportunity to find out more about the relationship between Jamie and Amanda (e.g. how long they had been in a relationship, how they met or if they had any children). In addition, no check were made with Child Services or Durham Police. Practice guidance states ‘*all cases with a serious domestic abuse related index offence or where it is suspected abusive behaviour is taking place, must have relevant checks’.*

16.8.20 A review assessment should have been completed as this is a significant change in circumstances. The Risk Management Plan (RMP) should have been updated to reflect the bail conditions in place to protect the victim. Furthermore, the RMP stated that if Jamie was to enter a new relationship, then a referral into MARAC and a ‘Claire’s Law’ disclosure was to be considered. There is no evidence recorded that either of these options were considered. (Note: Claire’s Law is discussed in more detail below).

16.8.21 On 15th October, Jamie’s case was transferred to a different probation officer that covered his own home locality. Jamie was arrested for a further offence of harassment on 25th October. At this incident, he had attended Amanda’s address when an argument began and he refused to leave.

Again, there is no evidence that the details were verified with the police and so only Jamie's account of what happened was considered. This was the second arrest relating to the same victim in just over three weeks. Jamie was convicted of criminal damage the day after the incident. In court papers, he said he had been residing with Amanda for 18 months, though Amanda disputed this and in a witness statement said they had only been in a relationship since September 2019 (i.e. just over a year). This means the relationship began after the ending of the previous Probation Service involvement back in April 2019.

16.8.22 The police call-out information was requested by the probation officer on 13th November 2020. This data contained a lot of details that was previously unknown to the Probation Service (there were three incidents in 2020 of assaults and controlling behaviour when Jamie was not managed by them). There was also reference to a much earlier incident in June 2015 when Jamie had used a pillow to try to suffocate a previous partner. At this point, there should have been a review to fully consider the risks posed by Jamie towards Amanda. No such review took place.

16.8.23 From 17th December 2020 to 19th March 2021, all Jamie's appointments with the Probation Service were via telephone (due to Covid-19 'lockdown'). This is contextually important to note as the opportunity for challenge was reduced. Staff were adapting to new practices. The next office based appointment was in April 2021. Given the frequency of incidents the previous year, the case history and the telephone-only contacts for several months, this was an opportunity for a full review of the risks involved. No review took place.

16.8.24 Jamie's community order (and thus management by the Probation Service) ended in August 2021. The 'OASys' system has no updates on any final review of risks. Both the 'termination' and 'review' sections of the documentation were left blank. This again was a missed opportunity. However, again there are contextual considerations. In addition to emerging from the Covid-19 lockdown, in June 2021, the Probation Services were undergoing significant organisational restructuring. The DTVCRC and the National Probation Service (NPS) were unifying into a single 'Probation Service'. This transition was a particularly challenging and confusing time for staff. We cannot be certain if the risks were not reviewed or if it was a lack of accurate recording on legacy systems at that time.

16.8.25 Police were called to six separate domestic abuse incidents between Amanda and Jamie between January 2020 and September 2021. As has already been stated, police responded swiftly and took positive action. Jamie was arrested on several occasions. If charged, he was either kept in custody or given bail conditions to protect Amanda. Where there was no power of arrest, officers took the initiative and directed Jamie to leave the

property or transported Amanda to a relatives' address where she felt safe. Risk assessments were completed on each occasion and necessary referrals made to other agencies.

16.8.26 There were some missed opportunities within previous police attendances. One of these did not relate to Jamie, but to one of Amanda's previous partners. In March 2018, this male had entered her home and assaulted her. She had been reluctant to tell police what had happened but did later disclose this to a Police Community Support Officer (PCSO). The PCSO did not submit any crime report and so there was no subsequent investigation.

16.8.27 In January 2020, when a third party had reported a female (Amanda) had been dragged into a car by a male (Jamie), she was not seen in person. Although she had declined to say where she was, and officers did contact her by telephone, they could have followed up with a home visit later. Efforts to speak to Amanda in person may have revealed other evidence such as physical injuries. Another omission occurred in October 2020, when police paperwork for the court case involving Jamie did not request a restraining order and so the order was not granted.

16.8.28 A missed opportunity for the police was not related to a single incident but across the whole pattern of domestic abuse incidents between Amanda and Jamie. Of the six reports to police, five were graded as 'medium' risk and one as 'standard' risk. This could indicate a cumulative risk of harm. The DASH risk assessment tool is victim led (i.e. the attending officers asking the victim a series of questions). Risk levels can be determined by the responses given by the victim (though there is also an element of 'professional judgement'). Police were aware Amanda had already suffered three previous abusive relationships before she began a relationship with Jamie. Officers have noted Amanda may be difficult to engage or inconsistent in her responses. This could have warranted consideration of a higher risk assessment as the victim may have been trying to minimise the incidents. In particular, Jamie had been violent and abusive to previous partners (including an incident of attempted strangulation when the victim's lips were blue in 2015 and at least two incidents which resulted in the hospitalisation of his ex-partner). He had been listed at the MARAC meeting (Multi-Agency Risk Assessment Conference – discussing the highest risk domestic abuse cases) several times as his previous partners had been assessed as 'at risk of significant harm'. It is accepted that those MARAC cases had been several years earlier. Nevertheless, he was a male known for extreme violence to intimate partners.

16.8.29 Durham Police policy is to refer all domestic abuse cases through their Central Referral Unit (CRU). The CRU has experienced safeguarding officers who will assess the DASH risk assessments submitted by frontline

officers who have attended the actual domestic abuse incident. The majority of domestic abuse incidents between Jamie and Amanda were assessed as 'medium' risk. Within a DHR, we should avoid hindsight bias. But the circumstances of the incidents, Jamie's previous levels of violence and the potential for Amanda to minimise the abuse, suggests this case *could* have been escalated to the MARAC process as a 'high' risk case, i.e. Amanda *could* have been assessed as at risk of significant harm. In addition, there were concerning elements of control exercised by Jamie within the relationship. For example, Jamie would call Amanda abusive names regarding her weight and throw away any healthy food she had purchased.

'Clare's Law': The Domestic Violence Disclosure Scheme (DVDS)

16.8.30 Clare's Law (DVDS) was introduced across England and Wales in March 2014. It followed the case of the murder of Clare Wood. Clare was a 36 year old woman with a 10 year old daughter. She had met a male named George Appleton on 'Facebook' and they had formed a relationship. Unknown to Clare, Appleton had a long history of violence towards women which included harassment and kidnapping a former partner and holding her at knifepoint for several hours. When Clare had ended the relationship with Appleton, he had threatened to kill her. These threats were not taken seriously by the police and no officer warned Clare about Appleton's background. In February 2009, Clare was murdered by Appleton. He had raped and strangled her, then set her body on fire. A subsequent campaign by Clare's family and friends resulted in the introduction of 'Clare's Law'. The Domestic Violence Disclosure Scheme is an option for professionals to consider, to protect victims of domestic abuse.

16.8.31 The DVDS has two distinct processes. (the 'right to ask' and the 'right to know'). The first process is triggered by a member of the public applying to the police for a disclosure. The second is triggered by the police making a proactive decision to disclose information to protect a potential victim. Although the police are the lead agency, both processes will involve a multi-agency decision making panel who make the decision whether to disclose or not, after considering all salient points linked to necessity, legal compliance and proportionality. These are not straightforward decisions. Multi-agency professionals will take into account the nature of offending, the sensitivity of the information they may disclose, any risks associated with making the disclosure (for example potential harm to perpetrators or their families), the risks of not disclosing and *who* they may disclose the information to.

16.8.32 During reviews of agency actions for this DHR, three organisations have references in their notes to the Domestic Violence Disclosure Scheme.

(The Probation Service considerations are already documented in paragraph 16.8.20).

16.8.33 The first episode was in October 2017 when Harbour Domestic Abuse Support Service were approached by Jamie's ex-partner. This female had experienced domestic abuse from him (the victim was not Amanda). The Harbour support worker completed and forwarded the necessary paperwork. The applicant was subsequently given a disclosure of Jamie's offending. Harbour Support Services were not updated with the result.

16.8.34 The next consideration for the DVDS was in August 2020 and followed police officers attending an incident of harassment (Jamie had been kicking at the door of Amanda's property). Amanda told the officers she had read articles online about Jamie's previous abusive relationships. Although there was no direct request from Amanda for information on Jamie's background (the 'right to ask'), nor was there a proactive decision by the police to consider a disclosure (the 'right to know'). Notes suggest the reason a disclosure was not made was that :

1. Amanda seemed to already be aware of his offending
2. There was no physical assault on that occasion
3. The relationship had ended

This was a missed opportunity to intervene. It appears the decision was made by the attending officer, though a review of the incident by the CRU also presented an opportunity to consider a disclosure.

16.8.35 Amanda clearly was aware of Jamie's behaviour towards her. She may have read some details of his previous offending. But Jamie had abused several partners in the past. He was a serial perpetrator of domestic abuse. It is highly unlikely that Amanda would have been aware of every aspect of his offending. This included assaults (in some instances resulting in the hospitalisation of ex-partners), criminal damage, breach of restraining orders, harassment (including following ex-partners in his car) and strangulation of an ex-partner to the point of her passing out. He was a very violent, controlling individual.

16.8.36 Even though Amanda stated the relationship was over, this should not have stopped a disclosure taking place. The DVDS disclosure made in 2017 (following the request made by via Harbour Support Service) was made by an ex-partner. On that occasion a disclosure had been made. In addition, we know that many relationships within an abusive setting can fluctuate. Even though a relationship may finish, they can often start again for a variety of reasons. Jamie and Amanda's relationship continued long after this date.

16.9 When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

16.9.1 Amanda had frequent contacts with a variety of statutory agencies. Following domestic abuse incidents, she was offered advice and signposted to organisations such as Harbour Support Services, 'Talking Changes', and 'Pause'. She was frequently asked by professionals what she would like to happen. She rarely provided evidence that would have led to prosecutions of both Jamie and her previous partners. When considering Amanda's life 'through her own eyes', these were difficult decisions for a vulnerable woman to make.

16.9.2 During her involvement with 'Pause', Amanda was allocated a practitioner the same day as she was referred to the service and the practitioner maintained regular contact. The Pause model puts the client at the centre of its work and all actions are based on what the woman herself identifies as her focus.

16.9.3 Amanda's GP ensured her medication was prescribed or amended as necessary. She was regularly offered access to support services such as Talking Changes.

16.9.4 Amanda's contact with TEWV included a full assessment of her needs. This included both Liaison Psychiatry and the Mental Health Support Team.

16.9.5 When Amanda did engage with Harbour Support Services she was provided with assessments and support. Safety plans placed Amanda at the centre of the process. But more work could have been considered in relation to the frequency of referrals relating to Amanda and the small number of times she actually engaged.

16.10 Was the victim subject to a MARAC or other multi-agency fora?

MARAC is the Multi-Agency Risk Assessment Conference; where local professionals meet to exchange information and plan actions to protect the identified highest risk victims of domestic abuse.

16.10.1 Amanda had been discussed as a victim at the MARAC in 2015 and 2016. These were in relation to a previous abusive partner.

16.10.2 Jamie was never a victim of domestic abuse (MARAC is a victim focused process). But one of his previous partners had been discussed at the MARAC in 2014 and 2015. Jamie was discussed at those meetings as he was the perpetrator.

16.10.3 Amanda's relationship with Jamie was never discussed at the MARAC. The MARAC could have been an opportunity for professionals to share inter-agency information, build a full picture of the relationship and formulate multi-agency action plans to protect Amanda. The case was not escalated to the MARAC as the risk assessments were not assessed as 'high risk'.

1. What information was known about the perpetrator? Was he subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse

16.11.1 Jamie had a total of 18 criminal convictions between 2007 and 2020. The offences included; assaults, criminal damage, theft, drug possession, breaches of bail conditions, breaches of restraining orders, harassment and driving whilst disqualified.

16.11.2 Jamie had never been part of MAPPA. His previous offending and sentencing did not warrant his inclusion.

16.11.3 Jamie was never a subject within the MATAC process. MATAC is a means of managing serial perpetrators of domestic abuse. There is no doubt that Jamie was a serial perpetrator and had assaulted, abused or harassed several former intimate partners. However, the MATAC process uses a 'Recency, Frequency, Gravity and Victim' (RFGV) scoring matrix. Only the

most prolific identified offenders are then managed within the MATAC process. MATAC can only proactively manage a certain number of offenders as there are limited resources available.

1. Jamie had received restraining orders with different partners though not with Amanda. The orders were granted to protect victims and he had subsequently breached those orders.

2. He had lengthy periods managed by the Probation Service (or DTVCRC). His compliance in terms of attending appointments or completing unpaid work is described by his probation officer as ‘sporadic’.

3. Jamie suffered the loss of his brother following a drugs overdose in May 2018.

4. Jamie’s family know that he had been in trouble with the police. They also accept he had been violent to several of his partners including Amanda. His older brother told the Independent Chair of the DHR that his view was that the only way Jamie would have stopped such behaviour would have been to put him in prison. He recalls Jamie ‘didn’t care what others thought of him’. He does remember Jamie was often calling at his door in the early hours after Jamie told him that he and Amanda had argued.

5. Jamie’s mother knows her son had done wrong in the past. But she remembers he was also a loving son and grandson. He was especially close to his grandma. She said, ‘Jamie was the only one who would take care of her’.

6. Jamie’s family acknowledge he was the perpetrator of the abuse and that it was Amanda who was the victim. They know they often split up and then resumed their relationship. They know that Jamie earned a lot of money when he was working away in the building trade. He would spoil Amanda with treats on his return to County Durham. Jamie paid to refurnish the whole house and regularly took Amanda out for meals or away to spa hotel weekends. They believe this was an attempt to convince her to stay with him.

2. Were child protection procedures correctly followed in this case?

16.12.1 Amanda and Jamie did not have any children together in their relationship. However both had children from previous relationships. Amanda had three children and Jamie had two children. The DHR Panel for this review agreed to include child protection procedures as a specific 'term of reference' so that any learning could be captured. However, initial scoping did confirm all children had been removed from their parent's care prior to the incident which led to this tragedy.

16.12.2 All five children were subject to Special Guardianship Orders. This followed concerns by agencies about domestic violence and abuse within Amanda's and Jamie's previous relationships with former partners.

16.12.3 There was only one incident which directly involved a child during Amanda and Jamie's relationship. This occurred in May 2019 when a fight had taken place outside Amanda's home between Jamie and the baby's father. The fight involved weapons including a hammer. The baby was present. Amanda denied the circumstances to the social worker, though her account was refuted by CCTV footage. 'Section 20' proceedings were initiated immediately and the baby was removed from Amanda's care. The baby had been on a Child Protection Plan since birth.

1. Clearly, there had been significant involvement from agencies prior to the removal of all five children from their parent's care. This preceded Jamie and Amanda's relationship. This Domestic Homicide Review is focused on learning linked to the deaths of Amanda and Jamie together with harm to any children in their care. As all children had been correctly safeguarded by the start of their relationship, it is not appropriate or relevant for this review to consider any child protection concerns before that time. No child was harmed during their relationship.

2. However, learning has emerged during the gathering of information during this Domestic Homicide Review. Several agencies record Amanda's reluctance to be involved with their service. This ranges from not feeling able to assist the police with a prosecution, through to declining involvement with Harbour or Talking Changes. It is also apparent many of her injuries presented at hospital were caused during incidents of domestic violence and she tried to hide the true cause of these injuries.

3. During meetings between the victim's family and the Independent Chair for the DHR, the family expressed a view that Amanda deliberately tried to hide

the levels and severity of the abuse she was experiencing. She told her family many times that she did this as she wanted to increase her 'contact time' with her children and ultimately to have them placed back in her care. Amanda genuinely thought she was doing the best thing possible to gain further access to her children by minimising or hiding the domestic abuse. This 'hidden harm' actually made it less likely the children could be returned to her care.

4. This was a difficult area for Child Services and other agencies to manage. There is no doubt that it was the right decision to remove the children from Amanda's care while she was in such a violent and abusive relationship. But she continued to suffer domestic abuse and would not report most incidents to the police through fear of losing even her limited contact with her children. Amanda's family believe she only ever reported about a quarter of the domestic abuse incidents to the police. This included when there was a ten month gap of no incidents being reported (from 2020 to 2021). They state that during that time she was regularly assaulted, her property damaged and she was locked in the house. This is a complex arena for professionals to navigate and further work on a multi-agency basis is necessary if progress to protect vulnerable victims and their children is to be made.

3. Were senior managers of the agencies involved at the appropriate points?

16.13.1 There were no specific points which required a direct intervention from senior management. However, there were patterns linked to risk assessments and risk management which have been highlighted throughout the review. Senior management intervention regarding these themes may have assisted in escalation of the case for further actions.

4. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

1. There were no issues identified during the review linked to the ethnicity, culture or religion of the victim or perpetrator. There were no language barriers. Their marital status or sexual orientation had no impact on services.

2. The victim and perpetrator had accessed physical and mental health services. The perpetrator had a diagnosis of ADHD from childhood. This was highlighted within the report but he was not registered with any disability. Neither victim nor perpetrator were in receipt of services under the Care Act 2014.

5. Did any restructuring during the period under review have any impact on the quality of service delivered? How did the onset of the COVID-19 pandemic affect service delivery?

1. The only agency which was affected by significant restructuring was the Probation Service when it was reformed from the separate organisations of the National Probation Service and Durham Tees Valley Community Rehabilitation Company. The details of the changes are contained within the report.

2. The Covid-19 pandemic affected service delivery across many services. Although emergency service providers (police or Accident & Emergency Departments) continued to operate 24 hours per day, many other agencies needed to curtail their face to face contact during ‘lockdowns’. When supporting vulnerable individuals this clearly meant that the same standard of service (be this support or challenge) could not be provided and presented additional difficulties to professionals trying to manage cases within these circumstances.

Section 17: Conclusions and Lessons Learned.

17.1 This is a tragic case of two young people killed after a fatal road traffic collision in September 2021. Both were well known to services across County Durham. Their relationship had lasted around two years. Throughout that time, the relationship had been violent and abusive. Both had been involved in previous abusive relationships with former partners. Both had their children removed from their care due to the nature of these dysfunctional relationships.

17.2 Amanda had come to the attention of the police on 54 occasions between 2012 and 2021 due to suffering domestic abuse with four different partners. Her case had been listed at the Multi- Agency Risk Assessment Conference (MARAC) for the highest risk victims in 2015 and 2016 (though not with Jamie as the perpetrator; in these MARAC cases she was a victim with other abusive partners). She was a vulnerable young woman in need of protection.

17.3 Jamie had come to the attention of the police on 23 occasions between 2013 and 2021, due to perpetrating domestic abuse towards three different partners, including Amanda. He had twice been subject to restraining orders, issued by the courts to protect his former partners. He had been listed as a perpetrator at the MARAC in 2014 and 2015 (though not with Amanda as the victim. These MARAC cases were from previous relationships, who had been assessed as 'at risk of significant harm').

17.4 Amanda did not always engage with available services. Following contact with statutory services, including police, health services or child services she was referred or signposted to specialist support, such as Harbour Domestic Abuse Service and 'Talking Changes' therapy. Her initial crisis episode; for example a domestic abuse incident or a drugs overdose, were effectively managed in most instances and referrals were made. But Amanda found it difficult to continue with offers of support. She had many referrals to Talking Changes over several years. These included signposting from her GP, Psychiatric Liaison or from her self-referrals. But after initial appointments were booked, Amanda did not subsequently engage in the full assessment. Only once (in May 2021) did she proceed past the initial assessment. However, even then, she was discharged from the Talking Changes service after only attending three of her first six appointments.

17.5 She was referred to Harbour Domestic Abuse Service by Durham Police, Child Services and the Pause (Barnardo's) service. Her engagement was sporadic. Although Amanda did complete most of her attendances on the Harbour 'Freedom' programme in 2019 or the 'YAMM' ('You, Me and Mum) sessions in 2020, for many referrals she did not reply to messages or calls.

17.6 The relationship between Amanda and Jamie was unknown to several services. During contact with his probation officer in October 2020, Jamie stated he had been in a relationship with Amanda for 18 months. The Probation Service were unaware of this. The same month, police attended Amanda's home and found Jamie hiding behind the door of the spare bedroom. He was arrested for breaching his bail conditions but it was apparent to officers that he had been residing there for some time. The Pause worker tried to arrange meetings at Amanda's home in May 2021. Amanda preferred to speak on the telephone or speak outside in her garden. It may be she was concerned about the Covid pandemic (though by that time meetings indoors were permitted and she had started attending group sessions elsewhere the same month). It is also a strong possibility that Jamie was living there. This may have been through fear of him. It is also highly likely that by hiding his presence at the home, she was attempting to gain further access to her children who had been removed from her care. She had suffered many abusive relationships and clearly loved her children. But whatever the reason, masking the relationship from services placed Amanda at further risk of harm.

17.7 The perpetrator, Jamie, was not managed as part of the MATAC programme. MATAC (Multi Agency Tasking and Coordination) produces tailored plans to manage serial perpetrators of domestic abuse. Clearly, Jamie was a serial perpetrator and was known to have committed domestic violence towards at least three separate partners. Durham Police policy is to prioritise the most prolific offenders via a 'recency, frequency, gravity and victim' (RFGV) model. The RFGV scoring matrix did not place Jamie in the highest cohort of offenders. The programme has limited resources and so he was not proactively managed within MATAC.

17.8 There were positive police responses to individual incidents and he was arrested and charged. But on one of those, officers did not apply for a restraining order which could have given greater protection to Amanda.

17.9 There were also gaps in the management of Jamie by the Probation Service. The lack of detail and intrusion within his risk assessments and risk management planning are already documented. Opportunities were missed to review and escalate his level of risk.

17.10 There should have been a disclosure made to Amanda about Jamie's previous violent and abusive relationships. Although Amanda had herself looked at news articles online, it is unlikely that she knew all of the details. The frequency and severity of his violence and control were such that a disclosure under the Domestic Violence Disclosure Scheme (DVDS – 'Clare's Law') was warranted. Both the Probation Service and Durham Police had policies in place that could have led to a disclosure but no disclosure took place.

17.11 Amanda frequently attended hospital services. Following incidents of taking an overdose, Amanda received appropriate medical care and was offered

support from Liaison Psychiatry. She did not always engage with the support, but when she did, she received a full assessment and there were discussions about her experiencing domestic abuse. Amanda was also signposted to specialist domestic abuse services.

17.12 Amanda had many attendances at urgent treatment centres or at main hospitals with physical injuries. Staff did not apply sufficient professional curiosity regarding reasons behind her many different physical injuries, together with varying accounts of how they occurred and her delayed presentation. There were domestic abuse ‘flags’ displayed on the agency systems. These should have led to staff clarifying or even challenging Amanda’s account and potentially conducting a domestic abuse risk assessment.

17.13 The risk level of domestic abuse incidents reported to the police were reviewed within the Central Referral Unit and four of these incidents were subject to multi-agency triage. The initial risk assessments were victim led and conducted by front line officers immediately after the incident was reported. When considering the background of Amanda suffering abuse from a number of previous partners, her overdoses, plus the levels of violence that Jamie had perpetrated both to Amanda and his previous partners, there were signs that this relationship may have been a higher risk and could have been considered for inclusion in the MARAC process. Both Amanda (as a victim) and Jamie (as a perpetrator) had featured at MARACs with former partners.

17.14 Domestic Homicide Reviews should focus on learning. They are not about blame. Although there are several identified areas that are highlighted as in need of action to improve service delivery, it should also be acknowledged that in most of the interactions with agencies, good and effective practice was taken; either to protect the victim or to manage the perpetrator’s behaviour. These interventions included medical care, signposting to specialist support services, or enforcement action.

17.15 Despite a lengthy and detailed criminal investigation, it cannot be ascertained whether the fatal incident in September 2021 was deliberate or reckless. The perpetrator had heavy traces of cannabis within his system, was driving at high speed, was only a provisional licence holder and was disqualified from driving. The victim had made several ‘silent 999’ calls after suffering a physical assault in the vehicle a short time earlier. This incident resulting in Amanda and Jamie’s deaths followed two years of domestic abuse by the perpetrator.

Section 18: Recommendations

Recommendation 1

The Domestic Abuse and Sexual Violence Executive Group (DASVEG) should consider a local review of interactions with victims of domestic abuse where the victim's children have been removed from their care. This is a multi-agency piece of work which needs to consider the options that will both continue to safeguard the children but also to present goals for the victim of domestic abuse to achieve, if they are to increase their contact time, or ultimately achieve the return of their children to their care. Any victim of domestic abuse should be provided with all the information necessary to remove themselves from harm, be open and honest with professionals and make informed decisions. The importance of reporting any domestic abuse incidents must be clear, especially when dealing with a victim within a chaotic or abusive relationship. Any progress should be shared with the Durham Safeguarding Children Partnership.

Recommendation 2

The Domestic Abuse and Sexual Violence Executive Group should receive multi-agency reassurance that there has been a proportionate review of procedures and protocols for serial and repeat perpetrators of domestic abuse that sit outside the existing MATAC process. Recent reviews of MATAC has shown it to be an effective system to manage the most prolific offenders. But MATAC must prioritise the cases if it is to maintain its effectiveness.

Recommendation 3

The Probation Service went through significant structural changes in 2021. During this review, gaps were identified in the quality and consistency of some risk assessments and risk management plans of offenders who had perpetrated domestic abuse. This Domestic Homicide Review highlights it would be appropriate for managers to confirm to the Safe Durham Partnership, that new structures are embedded, staff are supported, and processes are working effectively.

Recommendation 4

The Domestic Abuse and Sexual Violence Executive Group should conduct an audit of the local Domestic Violence Disclosure Scheme procedures. DVDS is a multi-agency process. By reviewing a sample of cases (both 'right to ask' and 'right to know'), the DASVEG can receive assurances that processes and decision-making are proportionate and protecting potential victims.

Recommendation 5

The Domestic Abuse and Sexual Violence Executive Group should receive reassurances from health organisations that they have measures in place to audit the use of routine and selective enquiry. This should apply to any cases where practitioners have concerns about the nature of physical injuries presented.

Recommendation 6

The Safe Durham Partnership should convene a multi-agency learning event to highlight the incidents, processes, decision-making and learning identified during this Domestic Homicide Review. The delegates will be frontline practitioners and their line managers, who may encounter victims and perpetrators of domestic abuse.

Recommendation 7

All agencies should review their training programmes for domestic abuse in line with workforce development. The DHR identified many agencies had not received domestic abuse training or refresher training for over three years. This is understandable given the pressures from the Covid-19 pandemic, but all agencies should now ensure that training of frontline professionals and their managers is brought up to date.

REFERENCES

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

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

MAPPA guidance (Ministry of Justice 2012)

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Vulnerability, Knowledge and Practice programme (Home Office, National Police Chief's Council, College of Policing 2020-2021)

Assessment of pilot scheme DVDS (Home Office 2014)

Research paper – Coercive control (Torna Pitman, British Journal of Social Work (2017)

Crime Survey for England and Wales (CSEW) year ending March 2022

A Domestic Homicide Review of the death of Amanda

September 2021

EXECUTIVE SUMMARY

Report Author: Mike Cane

Dated: 17th October 2023

Contents

Page Numbers

1. The Review Process

1. This summary outlines the process undertaken by the Safe Durham Partnership Domestic Homicide Review Panel in reviewing the death of Amanda, who was resident in their area. This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004. She died in a fatal road traffic collision in County Durham in September 2021. The perpetrator was her ex-partner who was also killed during the same tragic incident. Despite a lengthy and detailed criminal investigation, it cannot be ascertained whether the fatal incident in September 2021 was deliberate or reckless.

1.2 'Amanda' is a pseudonym, used throughout this review to protect the victim's identity. Throughout this review, the perpetrator of the domestic abuse will be referred to by the pseudonym 'Jamie.'

Subjects of the Review:

1. The victim; Amanda, a female aged 31 years at the time of her death.

2. The perpetrator; Jamie, a male aged 27 years at the time of their death.

1. There were no criminal proceedings in this case as Amanda and Jamie both died in the tragic accident. The inquest into Amanda's death was opened in September 2021 and then adjourned pending the police investigation. The inquest reconvened in July 2022. As of August 2022, the police enquiry has concluded and a date for a full inquest is pending.

2. The review began on 30th November 2021 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 12th January 2022. This was convened remotely due to the restrictions then in place with the COVID-19 pandemic. The panel met again on 27th April, 22nd June and 25th July 2022. The Review was concluded in September 2022.

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1.5 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

1. *A person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

2. *A member of the same household as himself."*

1. The statutory guidance states the purpose of the review is to:

1. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

3. Apply those lessons to service responses including changes to policies and procedures as appropriate.

4. Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

5. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. To establish whether the events leading up to the homicide could have been predicted or prevented.

2. Contributors to the review

2.1 Ten agencies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) have been requested and provided. The review chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview report author.

2.2 The following organisations were required to produce an Individual Management Review:

- County Durham Clinical Commissioning Group
- Durham and Darlington Probation Service
- Durham Constabulary
- Tees, Esk & Wear Valleys NHS Foundation Trust
- Harbour Domestic Abuse Service
- County Durham and Darlington NHS Foundation Trust
- Barnardo's (Pause Durham)

2.3 In addition, brief reports were provided by North Tees and Hartlepool NHS Foundation Trust (detailing three attendances by the victim), by Durham County Council Adult Health Services (who had no direct contact but did hold information referred from other agencies) and by the 'Talking Changes' programme.

At the first DHR panel, there was a lengthy discussion around the people who would be subjects of this review. Clearly, the subjects would include the victim and perpetrator. The victim had three children. The perpetrator had two children. However, none of the children were in their care at the time of the incident nor for a significant time beforehand. The victim and perpetrator did not have any children together. Therefore, the decision was made not to include the children as subjects of the review. However, Child Services at Durham County Council were an integral part of the Domestic Homicide Review Panel and offered valuable support in providing relevant information.

The IMR authors were completely independent and had no role in any of the decisions made or actions undertaken by their respective agencies prior to Amanda's death.

3. The Review Panel members

3.1 The Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

The Domestic Homicide Review panel also comprised of the following people:

7. Jane Sunter, Strategic Manager, (Public Health), Durham County Council

8. Andrea Petty, Strategic Manager (Partnerships), Durham County Council

9. Bev Walker, Designated Nurse, County Durham Clinical Commissioning Group

10. Karen Agar, Associate Director of Nursing (Safeguarding), Tees, Esk & Wear Valleys NHS Foundation Trust

11. Detective Superintendent Lee Gosling, Durham Constabulary

12. Jac Tyler, Strategic Manager (Children & Families), Durham County Council

13. Kay Linsley, Senior Probation Officer, Durham & Darlington Probation Service

14. Rachael Williamson, Service Manager, Harbour Domestic Abuse Services

15. Mike Egan, Associate Director of Nursing (Patient Experience, Safeguarding & Legal Services), County Durham and Darlington NHS Foundation Trust

16. Helen Coyne, Pause Service, Barnardo's

None of the panel members had any direct dealings with the subjects of the review nor had management responsibilities to any front line worker involved with any of the subjects.

4. Author of the overview report

4.1 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the Safe Durham Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding, investigation of child abuse, rape & other serious sexual offences and abuse of vulnerable adults. He has extensive experience as an author and panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

Mike has completed DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as AAFDA training on 'involving children in DHRs' in 2021. He has also designed and delivered domestic abuse training (identification, risk assessment and risk management) to staff across the public and voluntary sector.

5. Terms of Reference for the review

5.1 The terms of reference were agreed at the convening of the first DHR panel:

17. Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

18. Did the agency have policies and procedures in place relating to domestic abuse? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

19. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

20. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

21. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

22. Was the victim subject to a MARAC or other multi-agency fora?

    MARAC is the Multi-Agency Risk Assessment Conference; where local professionals meet to exchange information and plan actions to protect the identified highest risk victims of domestic abuse.

23. What information was known about the perpetrator? Was he subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

    MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

    MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse

24. Were child protection procedures correctly followed in this case?

25. Were senior managers of the agencies involved at the appropriate points?

26. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

27. Did any restructuring during the period under review have any impact on the quality of service delivered? How did the onset of the COVID-19 pandemic affect service delivery?

6. Summary chronology

6.1 The victim, Amanda, was a vulnerable woman who had experienced a difficult childhood. She had been removed from her own mother's care due

to her mother's alcohol dependency. Amanda had three children, but all had been removed from her care.

6.2 Jamie was diagnosed with ADHD when he was younger but stopped any medication or support for this in 2011.

6.3 Amanda had suffered violence and abuse at the hands of several previous partners and had accessed support services in relation to this domestic abuse.

6.4 In May 2016 Amanda was convicted of smuggling drugs into prison for a previous partner for which she received a suspended sentence and was under the supervision of a probation officer.

6.5 Amanda was diagnosed with anxiety and depression for which she was prescribed medication and 'talking therapies'. She had attended hospital following overdoses on prescribed medication.

6.6 Jamie had been the perpetrator of domestic violence to a number of ex partners and his ex-partner's case was heard at MARAC.

6.7 Jamie had numerous criminal convictions relating to domestic violence perpetrated towards partners, harassment of an ex-partner, violence against other males and driving motor vehicles without insurance or a driving licence.

6.8 In January 2018 (as a result of his 3rd offence against the same victim in a seven month period) at court Jamie was found guilty and sentenced to an 18 month Community Order with 200 hours unpaid work and 25 days' Rehabilitation Activity Requirement. He was assessed by his probation officer as a medium risk to partners and future partners.

6.9 Amanda began a relationship with Jamie in early 2019. The exact date is unknown as both Amanda and Jamie kept the relationship hidden from professionals and friends / family for some time.

6.10 Amanda accessed many services to support her coping with the removal of her children from her care and the domestic abuse she was experiencing.

6.11 In August 2020 Amanda had ended the relationship with Jamie after reading a newspaper article about his abusive past. He had then attended her address and shouted through the letterbox 'You'll not see your family again'. She did not want formal action taking, but requested he was warned not to attend her address. Police later warned him about his conduct.

6.12 In October 2020 Jamie kicked in the door at Amanda's house. He was arrested and charged. He was convicted of criminal damage the following week. Due to an error on the file, a restraining order was not applied for.

6.13 Amanda attended the Urgent Treatment Centre twice in 2020 and then four times between April 2021 and August 2021, stating she had slipped, burnt

herself, bumped herself and had been in a car accident. There was a ‘flag’ on their system noting Amanda was a victim of domestic abuse.

6.14 There were two domestic incidents where police attended between Amanda and Jamie in August 2021.

6.15 Amanda worked with ‘Pause Durham’ (part of the Barnardo’s charity) and ‘Talking Therapies’ to support her following the removal of her children from her care and bereavement following the death of her mother. A Pause meeting on 1st September 2021 was the last contact with services before her death. She told professionals the relationship with Jamie was over.

6.16 In early September 2021, Amanda and Jamie were killed during a fatal road traffic collision. Jamie was driving. He has assaulted Amanda only minutes earlier. Amanda had made four silent ‘999’ calls immediately before the collision. They both died at the scene.

7. Key issues arising from the review

7.1 The perpetrator and victim had significant involvement with local services spanning many years.

7.2 Amanda and Jamie did not have any children together. However, both had children from earlier relationships. All of their children had been subject to child protection procedures and had subsequently been removed from their care.

7.3 Jamie had a long criminal record with convictions for assaults, threatening behaviour, harassment, breach of restraining orders, breach of bail, handling stolen goods, criminal damage and driving whilst disqualified.

7.4 Jamie also had contact with mental health services and drug / alcohol support services.

7.5 Amanda had frequent contact with health professionals linked to her diagnosis of anxiety and depression. She also had several periods of engagement with specialist support services linked to domestic abuse and to women who have had children removed from their care. She disclosed excess alcohol use to professionals.

7.6 Amanda had suffered domestic abuse perpetrated by at least three partners and ex-partners before she started a relationship with Jamie.

7.7 Jamie had been dealt with for perpetrating domestic abuse towards at least two partners and ex-partners before he began a relationship with Amanda.

7.8 Both Jamie and Amanda had been discussed several times at MARAC meetings (Multi-Agency Risk Assessment Conferences where professionals discuss action plans to protect the highest risk victims of domestic abuse). However, this was not from their own relationship together. The discussions related to their former partners. Amanda was listed as a victim of domestic abuse from a former partner. Jamie was shown as a perpetrator of domestic abuse towards a former partner.

7.9 Amanda had attended main hospitals and the Urgent Treatment Centre on many occasions. The reasons were both for physical injuries and from taking overdoses of medication. She did state on some occasions she had suicidal ideation. Her physical injury appointments showed a pattern of either changing her account of how the injury had been caused or of a delay in presenting at the hospital to be treated.

7.10 Jamie had spent lengthy periods of time subject to supervision by the Probation Service (including DTVCRC). This was predominantly linked to his history of domestic abuse offending.

8. Conclusions and Lessons Learned.

8.1 This is a tragic case of two young people killed after a fatal road traffic collision in September 2021. Both were well known to services across County Durham. Their relationship had lasted around two years.

Throughout that time, the relationship had been violent and abusive. Both had been involved in previous abusive relationships with former partners. Both had their children removed from their care due to the nature of these dysfunctional relationships.

8.2 Amanda had come to the attention of the police on 54 occasions between 2012 and 2021 due to suffering domestic abuse with four different partners. Her case had been listed at the Multi- Agency Risk Assessment Conference (MARAC) for the highest risk victims in 2015 and 2016 (though not with Jamie as the perpetrator; in these MARAC cases she was a victim with other abusive partners). She was a vulnerable young woman in need of protection.

8.3 Jamie had come to the attention of the police on 23 occasions between 2013 and 2021, due to perpetrating domestic abuse towards three different partners, including Amanda. He had twice been subject to restraining orders, issued by the courts to protect his former partners. He had been listed as a perpetrator at the MARAC in 2014 and 2015 (though not with Amanda as the victim. These MARAC cases were from previous relationships, who had been assessed as 'at risk of significant harm').

8.4 Amanda did not always engage with available services. Following contact with statutory services, including police, health services or child services she was referred or signposted to specialist support, such as Harbour Domestic Abuse Service and 'Talking Changes' therapy. Her initial crisis episode; for example a domestic abuse incident or a drugs overdose, were effectively managed in most instances and referrals were made. But Amanda found it difficult to continue with offers of support. She had many referrals to Talking Changes over several years. These included signposting from her GP, Psychiatric Liaison or from her self-referrals. But after initial appointments were booked, Amanda did not subsequently engage in the full assessment. Only once (in May 2021) did she proceed past the initial assessment. However, even then, she was discharged from the Talking Changes service after only attending three of her first six appointments.

8.5 She was referred to Harbour Domestic Abuse Service by Durham Police, Child Services and the Pause (Barnardo's) service. Her engagement was sporadic. Although Amanda did complete most of her attendances on the Harbour 'Freedom' programme in 2019 or the 'YAMM' ('You, Me and Mum) sessions in 2020, for many referrals she did not reply to messages or calls.

8.6 The relationship between Amanda and Jamie was unknown to several services. During contact with his probation officer in October 2020, Jamie stated he had been in a relationship with Amanda for 18 months. The Probation Service were unaware of this. The same month, police attended Amanda's home and found Jamie hiding behind the door of the spare bedroom. He was arrested for breaching his bail conditions but it was apparent to officers that he had been residing there for some time. The

Pause worker tried to arrange meetings at Amanda's home in May 2021. Amanda preferred to speak on the telephone or speak outside in her garden. It may be she was concerned about the Covid pandemic (though by that time meetings indoors were permitted and she had started attending group sessions elsewhere the same month). It is also a strong possibility that Jamie was living there. This may have been through fear of him. It is also highly likely that by hiding his presence at the home, she was attempting to gain further access to her children who had been removed from her care. She had suffered many abusive relationships and clearly loved her children. But whatever the reason, masking the relationship from services placed Amanda at further risk of harm.

8.7 The perpetrator, Jamie, was not managed as part of the MATAC programme. MATAC (Multi Agency Tasking and Coordination) produces tailored plans to manage serial perpetrators of domestic abuse. Clearly, Jamie was a serial perpetrator and was known to have committed domestic violence towards at least three separate partners. Durham Police policy is to prioritise the most prolific offenders via a 'recency, frequency, gravity and victim' (RFGV) model. The RFGV scoring matrix did not place Jamie in the highest cohort of offenders. The programme has limited resources and so he was not proactively managed within MATAC.

8.8 There were positive police responses to individual incidents and he was arrested and charged. But on one of those, officers did not apply for a restraining order which could have given greater protection to Amanda.

8.9 There were also gaps in the management of Jamie by the Probation Service. The lack of detail and intrusion within his risk assessments and risk management planning are already documented. Opportunities were missed to review and escalate his level of risk.

8.10 There should have been a disclosure made to Amanda about Jamie's previous violent and abusive relationships. Although Amanda had herself looked at news articles online, it is unlikely that she knew all of the details. The frequency and severity of his violence and control were such that a disclosure under the Domestic Violence Disclosure Scheme (DVDS – 'Clare's Law') was warranted. Both the Probation Service and Durham Police had policies in place that could have led to a disclosure but no disclosure took place.

8.11 Amanda frequently attended hospital services. Following incidents of taking an overdose, Amanda received appropriate medical care and was offered support from Liaison Psychiatry. She did not always engage with the support, but when she did, she received a full assessment and there were discussions about her experiencing domestic abuse. Amanda was also signposted to specialist domestic abuse services.

8.12 Amanda had many attendances at urgent treatment centres or at main hospitals with physical injuries. Staff did not apply sufficient professional

curiosity regarding reasons behind her many different physical injuries, together with varying accounts of how they occurred and her delayed presentation. There were domestic abuse ‘flags’ displayed on the agency systems. These should have led to staff clarifying or even challenging Amanda’s account and potentially conducting a domestic abuse risk assessment.

8.13 The risk level of domestic abuse incidents reported to the police were reviewed within the Central Referral Unit and four of these incidents were subject to multi-agency triage. The initial risk assessments were victim led and conducted by front line officers immediately after the incident was reported. When considering the background of Amanda suffering abuse from a number of previous partners, her overdoses, plus the levels of violence that Jamie had perpetrated both to Amanda and his previous partners, there were signs that this relationship may have been a higher risk and could have been considered for inclusion in the MARAC process. Both Amanda (as a victim) and Jamie (as a perpetrator) had featured at MARACs with former partners.

8.14 Domestic Homicide Reviews should focus on learning. They are not about blame. Although there are several identified areas that are highlighted as in need of action to improve service delivery, it should also be acknowledged that in most of the interactions with agencies, good and effective practice was taken; either to protect the victim or to manage the perpetrator’s behaviour. These interventions included medical care, signposting to specialist support services, or enforcement action.

8.15 Despite a lengthy and detailed criminal investigation, it cannot be ascertained whether the fatal incident in September 2021 was deliberate or reckless. The perpetrator had heavy traces of cannabis within his system, was driving at high speed, was only a provisional licence holder and was disqualified from driving. The victim had made several ‘silent 999’ calls after suffering a physical assault in the vehicle a short time earlier. This incident resulting in Amanda and Jamie’s deaths followed two years of domestic abuse by the perpetrator.

9. RECOMMENDATIONS

9.1 The Domestic Abuse and Sexual Violence Executive Group (DASVEG) should consider a local review of interactions with victims of domestic abuse where the victim’s children have been removed from their care. This is a multi-agency piece of work which needs to consider the options that will both continue to safeguard the children but also to present goals for the victim of domestic abuse to achieve, if they are to increase their contact

time, or ultimately achieve the return of their children to their care. Any victim of domestic abuse should be provided with all the information necessary to remove themselves from harm, be open and honest with professionals and make informed decisions. The importance of reporting any domestic abuse incidents must be clear, especially when dealing with a victim within a chaotic or abusive relationship. Any progress should be shared with the Durham Safeguarding Children Partnership.

9.2 The Domestic Abuse and Sexual Violence Executive Group should receive multi-agency reassurance that there has been a proportionate review of procedures and protocols for serial and repeat perpetrators of domestic abuse that sit outside the existing MATAC process. Recent reviews of MATAC has shown it to be an effective system to manage the most prolific offenders. But MATAC must prioritise the cases if it is to maintain its effectiveness.

9.3 The Probation Service went through significant structural changes in 2021. During this review, gaps were identified in the quality and consistency of some risk assessments and risk management plans of offenders who had perpetrated domestic abuse. This Domestic Homicide Review highlights it would be appropriate for managers to confirm to the Safe Durham Partnership, that new structures are embedded, staff are supported, and processes are working effectively.

9.4 The Domestic Abuse and Sexual Violence Executive Group should conduct an audit of the local Domestic Violence Disclosure Scheme procedures. DVDS is a multi-agency process. By reviewing a sample of cases (both ‘right to ask’ and ‘right to know’), the DASVEG can receive assurances that processes and decision-making are proportionate and protecting potential victims.

9.5 The Domestic Abuse and Sexual Violence Executive Group should receive reassurances from health organisations that they have measures in place to audit the use of routine and selective enquiry. This should apply to any cases where practitioners have concerns about the nature of physical injuries presented

9.6 The Safe Durham Partnership should convene a multi-agency learning event to highlight the incidents, processes, decision-making and learning identified during this Domestic Homicide Review. The delegates will be frontline practitioners and their line managers, who may encounter victims and perpetrators of domestic abuse.

9.7 All agencies should review their training programmes for domestic abuse in line with workforce development. The DHR identified many agencies had not received domestic abuse training or refresher training for over three years. This is understandable given the pressures from the Covid-19 pandemic, but all agencies should now ensure that training of frontline professionals and their managers is brought up to date.

Updated May 2024

Action Plan following the death of: Lyndsey Watkins (Amanda)

Action Plan produced by Helen Riddell & Lucy Wilkins

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
RECOMMENDATION 1: The Domestic Abuse and Sexual Violence Executive Group (DASVEG) should consider a local review of interactions with victims of domestic abuse where the victim's children have been removed from their care. This is a multi-agency piece of work which needs to consider the options that will both continue to safeguard the children but also to present goals for the victim of domestic abuse to achieve, if they are to increase their contact time, or ultimately achieve the return of their children to their care. Any victim of domestic abuse should be provided with all the information necessary to remove themselves from harm, be open and honest with professionals and make informed decisions. The importance of reporting any domestic abuse incidents must be clear, especially when dealing with a victim within a chaotic or abusive relationship. Any progress should be shared with the Durham Safeguarding Children Partnership.	Local and national learning may apply	The Durham Safeguarding Children's Board (DSCP) to engage with the Pause Programme to explore how to engage parents following the removal of a child.	DSCP	Initial planning meetings have taken place. Workplan being developed. Initial planning meetings took place and a workplan was developed. **May Update includes:** There is now ongoing work with the 'graduate' group form the Pause project, helping to support them, and where appropriate signpost additional services that can continue support. .	September 2024	**Completed May 2024**

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
				.		
	Local and National	DSCP to look at developing a pledge between children and parents around how we will work with parents and children following care proceedings or the removal of children.	DSCP	Links made with Children in Care council on how to progress this with the voice of children and young people central. **May Update:** The initial links made with Children in Care council to Include how to progress this with the voice of children and young people has been completed. This consultation work has led to a change of format from a pledge to a best practice guide to include child & parent voices and how services will respond. The best practice guide is now under development in coproduction.	December 2024 (This is still on track)	

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
	Local	DSCP to support awareness raising with Children's Services around the importance of relationships with parents following the ending of care proceedings. This to include the importance of reassessing parents annually.	DSCP	May 2024 update: Work in children's social care on managing risk and the importance of reassessing and ongoing communications is underway and being managed in individual teams with appropriate support for staff. This work will be further supported by the creation of the best practice guide (From the action above).	March 2024	**Completed April 2024**
RECOMMENDATION 2: The Domestic Abuse and Sexual Violence Executive Group should receive multi-agency reassurance that there has been a proportionate review of procedures and protocols for serial and repeat perpetrators of domestic abuse that sit outside the existing MATAC process. Recent reviews of MATAC has shown it to be an effective system to manage the most prolific offenders. But MATAC must prioritise the cases if it is to maintain its effectiveness.	**Local**	Durham Constabulary to monitor top 10 identified perpetrators each month through the MASH on a monthly basis and identify appropriate actions.	Durham Constabulary	The Constabulary monitor top 10 VAWG and top 10 Soteria offenders every 3 months. It is called SPIP which stands for safeguarding perpetrator identification process. The reason for this quarterly reporting is to engage in meaningful work with these offenders in order to affect behaviour change. The nominals are identified using recency frequency and harm scoring. What also runs parallel to this is is MATAC. This is a similar algorithm around	March 2024	**Completed March 2024**

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
				DA specific offenders tailored to medium risk assessed cases. These nominals are identified more regularly and allocated to a domestic abuse navigator who engages with the suspect and again looks at that behaviour change piece of work.		
	Local	Red Sigma (Durham Constabulary recording system) will be updated to ensure that when a victim does not want to pursue a complaint the rationale is recorded.	Durham Constabulary	This action is now complete and the updates to Reg Sigma were communicated to DASVEG In March 2024	March 2024	**Completed March 2024**
RECOMMENDATION 3: The Probation Service went through significant structural changes in 2021. During this review, gaps were identified in the quality and consistency of some risk assessments and risk management plans of offenders who had perpetrated domestic abuse. This Domestic Homicide Review highlights it would be appropriate for managers to confirm to the Safe Durham Partnership, that new structures are embedded, staff are supported, and processes are working effectively.	Regional/ National. The North East Probation Service is part of HMPPS and is bound by policy and practice guidance issued nationally.	NE continuous improvement strategy is responsible for ensuring practice is assessed regularly and learning from this directs practice development activities in the PDU.	National Probation Service	Strategy implemented. Heads of PDU provide quarterly feedback on activities to improve practice. Monthly Practice Development days and protected time.	Completed Completed	**Completed April 2022** **Completed September 2022**
		RCAT audits received quarterly, and recommendations made to team managers regarding practice development requirements		RCAT audit feedback used to inform PDDs.	Completed	Sept 2023 (PDU tracker)

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
		OASys (our assessment system) countersigning framework and guidance in place to ensure consistent standard of work across the PDU.		Countersigning framework implemented and effective management oversight in place. Data in relation to oversight activity is available for managers	Completed	July 2022
		HMPPS also has its own action plan and policy framework for Domestic Abuse following a thematic inspection.		Safeguarding and DA checks undertaken as per current policy in the PDU	Completed	Sept 2023
		Probation Service has recruited Practitioners to fulfil caseload requirements.		Staffing levels on or near establishment/ Required capacity.	Significant improvement in staffing but remains understaffed by 15%. Resources directed to CD&D instead of other areas of NE.	September 2024
RECOMMENDATION 4: The Domestic Abuse and Sexual Violence Executive Group should conduct an audit of the local Domestic Violence Disclosure Scheme procedures. DVDS is a multi-agency process. By reviewing a sample of cases (both 'right to ask' and 'right to know'), the DASVEG can receive assurances that processes and decision-making are proportionate and protecting potential victims.	**Local**	Review of internal and external awareness of DVDS	Durham Constabulary	DASVEG task and finish group set up. Each agency provided an update on procedures Targeted local communications	Completed	60% Increase in requests
RECOMMENDATION 5: The Domestic Abuse and Sexual Violence Executive Group should receive reassurances from health organisations that they have measures in place to audit the use of routine and selective enquiry. This should apply to any cases	**Local**	Engage with ICB/Public Health commissioners to explore how routine/selective	ICB Public Health	Partnership meetings/subgroup in place to explore with key agencies	March 2025	

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
where practitioners have concerns about the nature of physical injuries presented		enquiry can be reviewed Further develop/deliver training opportunities to all partners in the health system				
RECOMENDATON 6: The Safe Durham Partnership should convene a multi-agency learning event to highlight the incidents, processes, decision-making and learning identified during this Domestic Homicide Review. The delegates will be frontline practitioners and their line managers, who may encounter victims and perpetrators of domestic abuse.	**Local**	Deliver a multi-agency conference that puts a spotlight on coercion and control	Durham County Council	Conference planned and successfully delivered Sessions delivered by Professor Jane Monkton Smith that highlighted the Homicide Timeline/Suicide Timeline Keynote speech by the Domestic Abuse Commissioner Authentic survivor voice workshops by Luke Heart and Georgia Hooper	Completed	Completed November 2023 (White Ribbon Focused) 598 participants from across the multi-agency partnership Evaluation feedback rated the conference as excellent.
		Bespoke events planned for children's social care that focus on embedding the Homicide Timeline into frontline practice	Durham County Council	Workshops to be delivered by Professor Jane Monkton Smith planned. May 2024 update is that these sessions were so well attended and useful and the feedback was so positive that further sessions for the autumn have been planned.	May 2024	Completed

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
		Development of bespoke training modules suitable for multi agency partners that highlight coercion and control and its impact on children and families	Durham County Council	Secured the support of Dr Emma Katz to act as consultant in the development of training materials Developed a core set of modules as follows: **Module 1**: Types and impact of CC in the relationship **Module 2**: Types and impact of CC post separation **Module 3**: Exploring Victims strategies/ management of safety **Module 4**: How practitioners expect mothers/ children to act as if there is no abuse	September 2024	
RECOMMENDATION 6: All agencies should review their training programmes for domestic abuse in line with workforce development. The DHR identified many agencies had not received domestic abuse training or refresher training for over three years. This is understandable given the pressures from the Covid-19 pandemic, but all agencies should now ensure that training of frontline professionals and their managers is brought up to date.	**Local**	Ensure a review of single agency training takes place in line with DA Act 2021 and focuses on coercion and control	Durham County Council	Multi agency workforce development steering group in place Review of training offer taken place	Completed	
	Local	Roll out the Domestic Abuse Practice Standards level 1 – 3 across the multi agency partnership including the Voluntary and Community Sector	Durham County Council	Between July 2022 and December 2023 there have been 799 practitioners trained in the DAPS programme. 668 in Level 1, 101 in level 2 and 30 in Level 3.	March 2024 May 2024 update: These sessions have been fully booked and the feedback is very positive.	Completed

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
				Train the trainer model has been adopted and implemented for L1 The IDVA within CDDFT is also rolling out DAPS as their core DA training need		

Annex 2

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Julie Bradbrook
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Neighbourhoods and Climate Change
Durham County Council
County Hall
Durham
DH1 5UG

29th February 2024

Dear Julie,

Thank you for resubmitting the report (Amanda) for Durham Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in February 2024.

The QA Panel considered this to be a good report that feels open and well-written with helpful inclusion and representation from a local domestic abuse charity. The report also provides a clear and focused overview of the issues presented from Amanda's death with good evidence of family involvement throughout the process. The report also helpfully includes the consideration and nature of Amanda's domestic abuse, the loss of children in her care and her resulting mental health issues.

The QA Panel noted that although some of the issues raided in the previous feedback letter were not addressed the view of the Home Office is that the DHR may now be published.

There are some areas of development listed below which the QA Panel would like the CSP to note.

- The specific date of death is still given in 13.5 and 16.1. only the month and year is required.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel