THE EXECUTIVE SUMMARY

‘Edie’

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Index

The review process 3
1.1 Contributors to the review 3
1.2 The review panel members 6
1.3 Author of the overview report and executive summary 8
1.4 Terms of reference 8
1.5 Summary chronology 9
Key issues arising from the review 11
Conclusions 14
Learning 20
Recommendations 23
National policy 24

The review process

1. This summary outlines the process undertaken by the North East Lincolnshire Safety Partnership [1] in reviewing Edie's (28) and Ricky's (25) death. These pseudonyms are used to protect their identities and their respective family members; they died a week apart in January 2021. Both Edie and Ricky's deaths were recorded as suicide at the respective inquests in 2022.

2. Professionals are referred to by their roles such as GP, police officer or probation officer for example. Edie had children; Ricky did not. Edie is survived by her mum and sibling. Ricky is survived by his mum and a sibling.

3. The first meeting of the domestic homicide review (DHR) panel was in July 2021. The final panel meeting was in March 2022. All of the meetings were remote rather than face-to-face due to the COVID-19 pandemic.

1.1 Contributors to the review

4. Thirteen of the more than 20 organisations contacted as part of the initial scoping for the review confirmed that they had varying levels of contact with Edie, Ricky or Edie's children and provided information. All were asked to provide chronological information. Most of the organisations were required to complete an individual management review report that required an analysis of their contact whilst other organisations who had less significant involvement provided a short report.

5. The following organisations provided an individual management review (IMR):
   a) Crown Prosecution Service (CPS); CPS were consulted by the police about charging decisions for Ricky in August, October and December 2020;
   b) Harbour Place; had contact with Ricky through their night shelter service between July 2019 and December 2019; this included providing help to Ricky to register with a GP and to get access to more secure housing;
   c) Humberside Police; had extensive contact with Edie as a victim in domestic abuse incidents over several years including being party to child protection plans (CPP) for her children; had contact with Ricky in respect of property crime related to substance

[1] The community safety partnership set up under the Crime and Disorder Act 1998.

misuse which included being sentenced to a Community Order in December 2019 which was varied to suspended imprisonment 18 weeks concurrent suspended for 24 months with a rehabilitation activity requirement and an alcohol treatment requirement in February 2020;

d) National Probation Service; the service had contact with Ricky as a result of the offences in 2019 and provided the community order supervision; the service had no contact with Edie other than a brief telephone discussion in April 2020 during one of Ricky's supervision sessions; it was during that telephone discussion that the supervising officer checked that Edie was aware of Ricky's long history of alcohol abuse and the implications for her children; the routine offender risk assessment of Ricky did not identify self-harm concerns;

e) Navigo Acute Mental Health Service; had first contact with Edie in 2011 when she was referred with low mood and thoughts of self-harm and depression; Edie was referred again in June 2013 by the health visitor with mild depression; Edie was signposted to Women's Aid having disclosed domestic abuse and feeling overwhelmed with the birth of her first child; Edie was next referred in June 2020 by her GP who suggested an assessment for PTSD associated with Edie's history of relationships with men who abused her; the GP was providing support for anxiety and depression primarily through a repeat prescription of anti-depressants; the single point of access (SPA) team declined the referral when Edie described having two separate court proceedings that were ongoing (family court in terms of her children and a criminal prosecution of a former partner); in 2019 the crisis team had a brief contact with Ricky at the night shelter when he was feeling very low, was threatening to harm himself and was feeling hopeless about being homeless;

f) North East Lincolnshire Health and Care Partnership (two GP practices); Edie had extensive contact with the GP practice with a history of anxiety and depression; she was regularly prescribed medication to help with symptoms and for sleeping difficulties; she was screened for and did not disclose thoughts of self-harm; in mid-July 2020 she talked about domestic abuse as well as a relationship that was more recent although no details were sought or disclosed; the GP practice was routinely informed of Edie's presentation at the hospital emergency care centre (ECC) service following a non-domestic assault; in addition to contact with a GP the primary care nurse (PCN) who is a qualified psychological wellbeing practitioner had several contacts with Edie during 2020 and the PCN referred Edie to the Blue Door service in July 2020.

Although the CCG were able to provide a summarised history about Ricky who was registered at a GP practice which included reference to Ricky having been in care and having difficulties with alcohol over several years and being homeless, he had little contact with a GP the most recent being when he attended for a change of dressing to a stab wound to his leg in November 2019;

g) North East Lincolnshire Council Education and Inclusion; Edie's children were enrolled at local schools; they were subject to Family Court proceedings and were being looked after throughout the scoped timeline for the review;
h) North East Lincolnshire Children's Services; the service had known Edie since 2005 when she had referred herself as a child in need of support and contact with the service continued until 2009; later involvement by CSC was from May 2013 after Edie's first child had been born and Edie was assaulted by her then partner; Edie's children became subject of Family Court proceedings becoming looked after in early 2020;
i) North Lincolnshire and Goole NHS Trust; Edie attended the hospital emergency care centre (ECC) on 15 occasions between October 2015 and November 2020; three of the occasions followed an assault although no detail about the circumstances or perpetrator was recorded; this included January 2020 and September 2020; Edie also had care during her pregnancies and the birth of her children; Edie reported having been in relationships with men who abused her when she booked for maternity care in 2016. Ricky attended the ECC on seven occasions between September 2012 and December 2020; on the last occasion when he was accompanied by the police, he had an injury to his hand having 'punched something with glass' and was discharged into the custody of the police; the ECC also provided treatment when Ricky was stabbed in the leg in late 2019;
j) SERCO (Management agency for HMP Doncaster where Ricky was remanded and died);
k) The Blue Door Service (IDVA service); had contact with Edie between 2016 and January 2021 linked to four men who were perpetrators of domestic abuse to Edie; Edie had contact with two IDVAs;
l) We Are With You (alcohol and drug services); had five contacts with Ricky between October 2019 and September 2020; the first referral was from Harbour Place for support with substance misuse (cannabis and Spice) although Ricky did not attend two assessment appointments but was seen once at the night shelter when Ricky disclosed daily alcohol use which began when he was 12 years old; there was no further contact and Ricky was also out

of contact with Harbour Place; in December 2019 Ricky was sentenced to an alcohol treatment requirement (ATR) after conviction for theft offences linked to his substance abuse;

m) Women's Aid; was a party to the MARAC and had a great deal of contact with Edie from August 2016 when Edie spent time in the refuge.

1.2 The review panel members

6. A suitably experienced and independent person chaired the panel; details are provided in section 1.3. All of the panel members were independent of any involvement or decision-making regarding the events and people concerned with the circumstances examined by the review. The membership of the panel is listed below.

Organisation	Job title or role
Crown Prosecution Service (CPS) (attended panel in March 2022)	Jonathan Wettreich Deputy Chief Crown Prosecutor Magistrates' Court Team CPS Yorkshire and Humberside
Department for Work and Pensions	Rhonda Hackett Advanced Customer Support Senior Leader
Harbour Place[2]	Dave Carlisle Project Manager
Humberside Police	Emma Heatley Detective Chief Inspector
National Probation Service	Nick Hamilton-Rudd Head of the North & North East Lincolnshire Probation Delivery Unit, Probation Service – Yorkshire and the Humber
Navigo Acute Mental Health Service	Ellie Walsh Assistant Director Adult Acute Mental Health Services Emma McCutcheon Lead Practitioner – Safeguarding

[2] Harbour Place provides night shelter and outreach services for street homeless and vulnerably housed people across NEL.

North East Lincolnshire CCG (replaced by North East Lincolnshire Health and Care Partnership in July 2022)	Julie Wilburn Designated Nurse for Safeguarding Adults and Children
North East Lincolnshire Council Education and Inclusion	Jenni Steele Inclusion lead, Access and Inclusion Service
North East Lincolnshire Children's Front Door	Sarah Blanchard Service Manager, Children's Front Door
North Lincolnshire and Goole NHS Trust	Sharon Humberstone, Named Nurse Safeguarding Adults
SERCO (Management agency for HM prison where Ricky was remanded and died)	Sara Lockwood Head of House, Block One, SASH, Equalities and Safeguarding
The Blue Door Service (IDVA service)	Stephenie Price Chief Executive
We Are With You (alcohol and drug services)	Lisa Pidd Contracts Manager
Women's Aid	Janice Woods Operational Manager
Yorkshire Prisons Group	Russell Heritage Deputy Group Safety Lead Yorkshire Prison Group
FOCUS (NELC commissioned adult social care service)	Sue Bunn Head of Safeguarding
North East Lincolnshire Council	Helen Cordell Domestic Abuse Coordinator
North East Lincolnshire Council Public Health	Carolyn Beck Strategic Lead on local suicide prevention
North East Lincolnshire Safer and Partnerships	Spencer Hunt Assistant Director, Safer and Partnerships
North East Lincolnshire Safeguarding Adult Board	Stewart Watson Business Manager
North East Lincolnshire Safeguarding Children Partnership Helen Willis	Helen Willis Safeguarding Children Partnership (SCP) Coordinator

North East Lincolnshire Community Safety Partnership	Rebecca Freeman Manager CSP

1.3 Author of the overview report and executive summary

7. Peter Maddocks is the independent author of this report and chaired the panel. He has not worked for the organisations that have contributed to this review and nor has he held any elected position in NEL or South Yorkshire. He is not related to any individual who either works or holds an elected office in NEL or South Yorkshire.

1.4 Terms of reference

8. The timeline is from April 2020 when Edie and Ricky's relationship began until Edie's death in late January 2021 taking account of relevant history where it is known.

9. Agencies contributing reports or information to the domestic homicide review used the terms of reference set out in national guidance with additional general areas arising from the particular circumstances of this DHR as described in the following scope of the review. This included;

a) What contact, knowledge and information services had about Edie that indicated, or could have indicated, that she was vulnerable to, or could be at risk from domestic abuse and what response was there? This included whether relevant history was known about and considered alongside any enquiries or assessment of risk.
b) What history was known about Ricky and in particular risk to intimate partners?
c) What risk assessments were completed and what measures including bail and use of legal orders were considered/used? Were referrals made to appropriate specialist services?
d) What were the circumstances of Ricky's remand into custody following incidents of domestic abuse? What measures were in place to ensure safety and support? What restrictions were in place about contact between Ricky and Edie?
e) What contact, knowledge and information did services have with Edie or Ricky that could have indicated a risk of self-harm and what response was there?

f) What history of substance misuse and mental health was recorded and how was this assessed and understood within the context of domestic abuse?
g) Was agency practice sufficiently sensitive and effective in establishing whether there were any special needs including potential barriers to Edie or Ricky, family or any friend seeking advice or help and whether there are any lessons to be identified regarding agency practice or policy? How did Edie's relationship with her children influence interaction and discussion about domestic abuse?
h) Was there ever any cause to escalate any issues to senior managers in the agency or with any other specialist professionals or organisations? If so, were there any barriers or evidence of delay in terms of escalating issues? What outcome was there?
i) Were there issues regarding the capacity or resources of services that had an impact on the ability to help Edie or Ricky or to prevent domestic abuse, or had an impact on the ability to work with other services? This should include a comment about the quality of supervisory or management oversight and the extent to which professionals in the agency have enough training and understanding about domestic abuse, safeguarding and workload.
j) Were there any issues regarding the impact of any organisational changes covered by the period under review that influenced how the agency or partnership arrangements were operating? This should include any specific issues relating to Covid changes to working arrangements and access to services.
k) What can be identified as good practice in this case?
l) What action(s) by the agency in retrospect might have led to better outcomes in this particular case? Why were these not considered/not taken at the time from the agency's perspective?

1.5 Summary chronology

10. Edie's mum thought that Edie and Ricky's relationship started about 12 months before their tragic deaths. Ricky had been living at a local homeless shelter. He had been in a relationship that had broken down. There is little information about the relationship; there was no domestic abuse recorded against Ricky as either a victim or a perpetrator when

the police checked his record as part of an assessment by children's services in May 2020.

11. Edie had been a victim of four violent and abusive men. One of those relationships that had started in 2016 was still the subject of criminal proceedings and was a significant fact in Edie's children being on child protection plans and then proceeding in the Family Court.

12. Edie and Ricky both suffered from poor mental health. Ricky's health was further compromised by a long history of alcohol misuse that started in his adolescence.

13. The first record of domestic abuse between Edie and Ricky was in late June 2020 when police responded to a third-party report of a disturbance at Edie's home. Neither wanted to make a complaint and although Edie declined to participate in a DASH assessment a DASH was submitted at a medium level.

14. Edie's GP referred her to a local counselling service because of the level of stress that Edie was under and its impact on her emotional and psychological health. They declined the referral given there were criminal and Family Court proceedings happening.

15. In early August 2020, the police responded to a report of an assault and domestic abuse at Edie's house. Edie had sought safety at a neighbour's home. Ricky had assaulted her and damaged her property. A DASH assessment at medium was followed by referrals to the IDVA service, Women's Aid and children's services. By this stage, the Covid lockdown was preventing home visits although Edie was offered the opportunity to come to the Women's Centre although she declined this. Ricky was arrested and was made subject to police bail conditions to not contact or visit Edie. He broke his bail the same day. He again returned 48 hours later threatening to damage her home. He was arrested and interviewed by the police and remained subject to police bail.

16. Less than a week later Ricky breached his bail again when he visited Edie's home and damaged her door. He left before the police arrived. A DASH assessment was completed at medium.

17. There was a further breach of bail the following day. A file was submitted to the CPS out-of-hours service for a charging decision at the end of August 2020. The police believed they had sufficient evidence for charges to be made; CPS Disagreed and provided an action plan. Ricky remained subject to bail. The police made a welfare check with Edie and also spoke with Ricky's probation officer to make sure they were aware of the situation.

18. In early October 2020, Edie told police that Ricky was sending multiple threatening text messages. He had also made threats to “end it all”. The DASH was completed at a medium level followed up by a referral to the IDVA service. Edie was offered an appointment at the Women’s Centre but wanted to stay in her home.

19. The police submitted a file to CPS for the latest offences and CPS agreed to the charges that were put before the magistrate's court. CPS instructed the court advocate to oppose bail and Ricky was remanded. When he appeared at Crown Court his advocate told the judge that he had employment due to begin imminently; Ricky was released on bail.

20. In early December 2020, Ricky again went to Edie's home and assaulted her. Ricky was arrested and remanded to prison. The prison did not receive the court warrant when Ricky was transferred to prison. The information they had about charges related to theft and criminal damage. They were not aware that he was charged with assaulting Edie or that there was a history of domestic abuse. He was able to maintain contact with Edie by phone.

21. Ricky died by suicide in January 2021. A week later Edie took her life.

Key issues arising from the review

22. Edie’s relationships with men were abusive; often terrifyingly so for her and her children. A recent and long-term relationship that began in 2016 had been traumatically coercive and controlling and was a significant factor in her children being placed on child protection plans and the Family Court proceedings being started. The criminal prosecution of Edie’s previous partner was also still ongoing in 2020 and she talked more than once about the immense stress she was feeling. The entrapment of women by controlling and abusive men is a recurring theme in DHRs and research evidence summarised in the overview report and Edie’s story has to be understood as a woman entrapped by abusive men and its impact on her.

23. Ricky was a vulnerable young man who had experienced great adversity in his life beginning in his adolescence. He needed a great deal more help than he had and it is clear that places such as the night shelter tried to get him help. His dependency on Edie and his fear of abandonment were significant risk markers combined with his propensity for self-harm. He represented a risk to himself as well as to Edie. A combination of life experiences included his adverse childhood experiences (ACE), being looked after, youth offending and very significant substance misuse from his childhood followed by long periods of homelessness and unemployment. When he was remanded to prison his profile should have flagged a much greater level of risk if it had been known to the prison health care team. He had problems with his mental health, self-harm and

poor social support combined with significant deprivation and disadvantage represented a level of complex vulnerability that was exacerbated by the breakdown of his relationship and prison incarceration. That is not to say it could be predicted that Ricky would fatally self-harm but his level of risk was greater than was reflected in the information that was available to the prison or was easily accessible by primary health care professionals in the community such as GPs.

24. Although it is not reflected in agency information, there may have been a degree of optimism at the outset that Ricky would represent a new opportunity for Edie; the absence of domestic abuse in his history may have given some reassurance at the beginning of their relationship. It was something that Edie commented on in one of her discussions with a support worker. She was very motivated to resume the care of her children and she was very conscious of how the level of domestic abuse in her relationships was seen as a very significant risk factor for being reunited with her children. This may have led to Edie not disclosing the true extent of abuse from Ricky or other men in reporting incidents. It is notable for example that in July 2020 the GP at Edie's instigation was trying to find support for her as a victim of domestic abuse when at that stage there had been one third-party report to the police of an argument; the report to the police in early August 2020 was also from a third party.

25. Edie had become very scared of Ricky by early August 2020 and sought help to protect herself. This information was not given the attention it deserved either in terms of how risk was assessed and measured and how it was used to inform better multi-agency planning. If it had been there would have been a better opportunity to have considered how to control Ricky and to have given clearer priority to getting support for Edie who found herself excluded from services such as Navigo because of the ongoing court proceedings concerning her children. Unsurprisingly, Edie felt conflicting emotions about the relationship with Ricky; he scared her but it was also a relationship where she felt she could have somebody to help her cope. Edie had been isolated because of the lockdown and separated from her children. For a woman like Edie who had been dreadfully abused for so long combined with her difficulties with mental health would have undermined her sense of self. That history needed to be taken into account in assessing risk and need with Edie. It illustrates that a DASH assessment should not be relied upon as the only measurement of risk and particularly if it does not identify underlying patterns and history.

26. The police received eight reports of domestic abuse some of which included clear breaches of bail conditions for Ricky to stay away from Edie's home. On none of those occasions was there a referral to MARAC because the DASH never went beyond medium. No additional substantive charges for example in respect of harassment were

considered in response to Ricky's repeated breach of police bail conditions. Edie was saying she was scared, there was evidence of escalation and the nature of some of the assaults that for example involved strangulation. Additionally, there were discussions between other professionals such as CSC and IDVA about a restraining order. Ricky's remand to prison following his assault on Edie deserved multi-agency risk discussion and planning particularly when he was released on bail at the Crown Court hearing in October 2020

27. The decisions on charging Ricky with offences in October, December 2020 and January 2021 were compliant with the code for crown prosecutors that is described in the overview report. Lessons have been identified. Within the context of a DHR, it is acknowledged that there were opportunities to have used harassment legislation although the CPS review comments that it would not have met the prosecutor's code test. When the CPS were able to agree to the charges it was accompanied by advice to oppose bail for Ricky.

28. Although the IDVA service helped Edie throughout the timeline of this DHR the service was unaware of several incidents of domestic abuse. Women's Aid was only made aware of two. They were services that had good relationships with Edie and were therefore well placed to advise and support and provide advocacy.

29. Edie was looking for help to deal with the very high level of stress she was under and consulted her GP practice. The decision by Navigo to decline access to a counselling service was due to ongoing court proceedings; lessons have been learnt.

30. The transfer of information to the prison when Ricky was initially remanded in December 2020 was incomplete in terms of his assault on Edie and contributed to a lack of understanding about the risk Ricky represented to Edie. The prison was not told about Ricky's history of controlling and coercive abuse of Edie although should have known that he had been remanded for an assault on Edie. The first court warrant was delivered to HMP Doncaster the day after he had been remanded and had gone through the reception and First Night Centre processing.

31. If there had been better multi-agency planning before the remand hearing there would have been a better opportunity to control the contact between them. Even when information about Ricky being remanded because of his assault on Edie the true nature and implication of the abuse were not sufficiently understood. The implications for learning are discussed in the overview report.

32. The Prisons and Probation Ombudsman investigation was satisfied that Ricky did not give any reason to suggest he had thoughts of self-harm.

It also acknowledged that Ricky should not have been allowed to phone Edie and this is examined in the overview report.

33. The prison reception process and health assessment relied on Ricky providing accurate and relevant information. The prison was not aware of some of the specific risk factors in Ricky's history and the more general adverse indicators that were described in earlier sections of this report. They had received information from the GP in October 2020 when Ricky was remanded although released before the information arrived. The GP Practice had the most complete information on Ricky's history of vulnerability although it was not included in the patient summary and was only accessed as a result of this DHR and the requirement for a detailed review of the patient's records. It was information that was important for Ricky's ongoing health care from the GP practice and was relevant to the health and risk assessment at the prison. Imprisonment should be an opportunity to offer advice and help to people suffering from emotional and mental ill-health and substance abuse histories.

Conclusions

34. The circumstances of Edie and Ricky's deaths are tragic. There was probably a significant sense of co-dependency in their relationship. Each wanted someone they could find support from in dealing with their multiple adversities and difficulties. They both probably hoped in the first weeks of their relationship that they had found someone to love and feel supported.

35. Strenuous efforts were made by the prison and police to contact Edie when Ricky died. It is regrettable that despite efforts by the prison and by the police to contact her, Edie first became aware of Ricky's death through social media before a professional was able to talk with her. Support was offered to Edie but was declined.

36. The task of the DHR is to think about how to make it less likely that a woman like Edie is a victim of domestic abuse and to also think about how men like Ricky can be helped more effectively. That includes addressing behaviour that is abusive to intimate partners as well as vulnerability from issues such as homelessness, substance misuse and poor mental health.

37. Edie's children were very important to her and were an important source of resilience to Edie in dealing with the extraordinary stress in her life that was further magnified by Covid lockdowns. Social workers, police and other professionals had taken action to protect Edie's children from the abuse and violence from Edie's partners; CSC acknowledged that

there was less recorded attention to understanding the complexity and disempowerment that affects women in Edie's circumstances. The focus was on "failure to protect" rather than a perpetrator pattern-based approach advocated through Safe and Together for example. Work being done to improve future practice is included in this part of the report.

38. Coercive control, a term developed by Stark[3] to describe a form of partner abuse that survivors reported as being akin to domestic or intimate terrorism is enshrined in UK law. Coercive control is not just about acts of extreme violence but describes behaviour by abusers to control and subjugate intimate partners. The domestic abuse that Edie experienced in more than one of her intimate relationships was akin to intimate terrorism and was terrifying for her and her children. It has implications for how professionals who are part of child protection plans involving domestic abuse think about and engage with parents like Edie. The fact that relationships with social workers had become so poor is indicative of how Edie felt isolated from that process.

39. Edie was open to an IDVA and working with them about a previous relationship in which she had been abused. Edie had not been risk assessed by the IDVA about her relationship with Ricky because the Blue Door IDVA service did not receive information about all the incidents. The service has made changes about how they triage information and would process this differently. Although Edie was recognised to be very vulnerable to domestic abuse and had been the subject of MARAC referral about previous relationships the DASH assessments about Ricky never went higher than medium. In the absence of a MARAC, the control room IDVA has access to the Blue Door data system which would allow screening to check on current or recent involvement. The panel agreed that this would have been potentially important in alerting the Blue Door service in the absence of MARAC or a police referral with Edie's consent.

40. The Domestic Abuse Act 2021 statutory guidance published in July 2022 sets out in detail the multiple forms of domestic abuse which includes for the first time economic abuse. It involves the control of money including income, spending, bank accounts and borrowing. It can include the destruction of property and refusing to contribute to household costs. Ricky's abuse of Edie included economic abuse. It is behaviour that does not occur in isolation from other forms of domestic abuse and is part of creating economic instability, dependency and restriction. Economic abuse is commonly part of a perpetrator's behaviour. Although a

[3] Stark, E., 2009. Coercive control: The entrapment of women in personal life. Oxford University Press.

common form of abuse, its dynamics are different from other forms of abuse that involve proximity. Even when a perpetrator is unable to engage in physical, sexual or psychological abuse their victims may experience difficulty in ending economic abuse if a perpetrator has a few elements of identifying information.

41. An IDVA has been co-located at the children's front door service since March 2022, to support the identification of high-risk domestic abuse incidents, promote and increase MARAC referrals, strengthen safety planning for victims and have a victim focus within strategy meetings.

42. The local authority commissioned four days of domestic abuse training provided by Safe Lives in April 2022. The course content includes working with families and exploring domestic abuse, identifying abusive behaviours and multi-agency practice, its impact on children, the impact of domestic abuse on parenting, working constructively with perpetrators, the voice of the child and learning from serious case reviews.

43. The local authority commissioned and provided (with Respect) bespoke training on working with perpetrators for family support workers. DASH risk assessment training is being provided throughout the Front Door Service from March 2022. The service is promoting awareness about the role of MARAC and the circumstances under which referrals should be made by Children's Services. The Signs of Safety[4] rollout in Children's Services will focus on safety planning.

44. Ricky's vulnerabilities were not widely known or understood beyond the emergency night shelter services and to a lesser extent the probation service that supervised his Community Order. His adverse life circumstances had damaged him. Being homeless was a major contributory factor to his poor mental health and his use of substances was his way of dealing with his situation. This history was important for the prison to have been able to consider in risk assessment and prisoner care. The night shelter service recognises that the people who rely on their service are at risk of domestic abuse but that staff have not had enough training. They will be accessing local training as a result of the DHR.

[4] The Signs of Safety (SoS) framework is used in NEL (and many other local areas) to help professionals develop a shared understanding of risk to children discussed at child protection conferences.

45. Although Ricky had no previous history of domestic abuse and this may have misdirected Edie as well as possibly professionals; when the first incidents have reported the escalation in number, type and Edie's expression of fear should have seen a reciprocal escalation in the risk levels. Although bail conditions were set these were not effective in controlling his behaviour. If bail is being used in response to domestic abuse it should be supported by the level of multi-agency risk arrangement that the Police College advocate is used for DVPO, particularly if and when they are breached. The law was not used effectively enough and quickly enough to manage Ricky's threat to Edie. Not enough attention was given to risk markers such as harassment by phone and visiting Edie's home.

46. Monkton Smith's eight-stage model of how dangerous intimate relationships develop[5] is an example of where understanding markers and patterns are important and has applicability in this case. Humberside Police have started training officers on the eight stages which are already incorporated into their secondary risk assessments. In 2022 they will train all front-line officers in this area to assist in providing that holistic approach to escalation. Although Ricky did not have any known history of stalking or abuse with intimate partners the relationship with Edie developed quickly, there was increasing evidence of coercion and extreme jealousy along with triggers when for example he was made subject to bail conditions that prohibited contact and visits to Edie and escalation. His poor mental health, history of self-harm and level of substance misuse were further factors to consider in a risk assessment.

47. Recognising that harassment and stalking represent a higher risk of abuse that is likely to persist non-fatal strangulation is an important risk factor and is now an offence in the Domestic Abuse Act 2021. Humberside Police have completed a standard operating procedure which is being embedded and includes all stalking offences to be reviewed by a Detective Inspector within 48 hours, where a robust investigation plan will be placed on the crime, ensuring that all evidence has been captured and an OIC allocated. Monthly audits are being carried out in this area to ensure that the SOP is being embedded. The Humberside Police are moving from DASH to the DARA (domestic abuse risk assessment)[6].

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[5] Monkton-Smith. J, Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide First Published August 5, 2019 Research Article https://doi.org/10.1177%2F1077801219863876
[6] https://whatworks.college.police.uk/research/documents/da_risk_assessment_pilot.pdf

48. The decision to remand Ricky to prison represented a potential escalation in the level of risk to Edie given the enforced separation that Ricky had demonstrated he was not prepared to accept. It should have been backed up with safety planning for Edie and needed to give clear attention to ensuring that the prison was fully aware of the escalation and risk that had preceded the remand to prison. This includes making sure court liaison teams are being informed of relevant information to give to the court hearing an application to remand as well as being passed to the prison. Ricky was registered as a "DV risk" on the nDelius probation case management system in August 2020. Although this system is technically accessible to prison and probation staff it remains predominantly a probation system whereas the national prison system is NOMIS (National Offender Management Information System). If the nDelius system had been available to prison reception staff and checked as part of prison reception processes it would (subject to access protocols) potentially have flagged the record of domestic abuse as well as a recent alcohol treatment requirement and recent community offender supervision and may have prompted further follow up with Ricky and with the probation service. The prison is encouraged to include a check of any available community-based probation as well as health information systems as part of the prison reception process. It is also included as an issue for national development.

49. The panel discussed the disconnect between primary care and prison health information. GP Practices are trying to respond to prison requests and generally rely on the patient's summary record to flag risks and vulnerabilities. Ricky did not have any vulnerabilities flagged on his summary record which only became apparent as a result of the deep dive trawl of his records for the DHR. It is unrealistic for GPs to provide the level of interrogation in response to prison requests. It is a learning issue to come from the DHR that needs addressing but without a simple fix. Recommendations are made in this report and by the CCG agency reviewer at the end of this report.

50. Individual feedback has been given by the CPS reviewer to the CPS prosecutors involved in the decision-making of this case. There is a harassment and stalking lead with coordinators who oversee the handling of prosecutions. These thematic leads have been alerted to the findings in the CPS report to support lessons learned are shared with prosecutors and embedded into best practices across teams in the region. The CPS nationally is due to launch a public consultation seeking views on proposals for amending its domestic abuse guidance for prosecutors. The draft guidance will remind prosecutors to make proactive enquiries into impending investigations.

51. The prison received the court warrant late. This does not remove their responsibility to have made sure the warrant was read on receipt and to have recognised that Ricky had been remanded for a domestic abuse offence and then followed the required procedures. This includes checking on the ID of contact numbers being provided by prisoners. The prison has already completed work to address the problems of the late arrival of the court warrant. Humberside Police are looking at a pilot in North Yorkshire which is working with prisons to update them about domestic abuse perpetrators entering the prison system and ensuring that details including contact numbers of victims are accurately included. Humberside Police are encouraging their officers to submit intelligence reports for inclusion in the central prison intelligence system.

52. Specialist domestic abuse services were not aware of all the contact the police had about domestic abuse. The police are partners in the vulnerability hub that was been established in 2021. This provides a secondary triage to identify appropriate safeguarding pathways to be used based on more effective identification of risk, harm and vulnerability.

53. Other services such as the GP did not make referrals to a domestic abuse service when they became concerned about domestic abuse although the PCN mental health nurse did make one referral in July 2020. None of the services other than the police completed a domestic abuse assessment or made enquiries with Edie to find out about the threat of domestic abuse; the DASH assessments that were completed never progressed beyond medium and took insufficient account of information other than the incident being dealt with at the time. Services such as the emergency care centre did not show enough recorded curiosity about the circumstances of injuries or make enquiries to try to establish if Edie was experiencing domestic abuse, especially at the moment that she presented with injuries that were indicative of abuse.

54. When compared with people bereaved through other causes, those bereaved by suicide are at an increased risk of suicide, psychiatric admission and depression[7]; the stigma of suicide is a known barrier to bereaved family members seeking help, as well as to others offering

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[7] Pitman A, Osborn DPJ, King MB, Erlangsen A. Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry 2014;1(1):86-94

support[8]. Survey data suggests that two-thirds of people in the UK bereaved by suicide receive no formal support from health or mental health services, the voluntary sector, employers or education providers. The type of support and how long it will be needed varies from person to person. The time point at which individuals decide to seek help differs too; it could be immediately, several months after their bereavement, or further down the line, for example around significant anniversaries or family events. The development of local suicide prevention and surveillance promoting local partnership working enables local teams to act quickly following a possible suicide and provide timely support to families and communities. Having good working relationships between prison and relevant community-based services is an important part of risk assessment and organising support for bereaved relatives and friends.

Learning

55. The learning is summarised;

a) Not relying on single one-off DASH assessments frequently completed by first response police officers who are focussed on dealing with an immediate incident, are more familiar with the recording of evidential statements rather than more therapeutically informed conversation and are less likely to have specialist or detailed knowledge about domestic abuse in terms of how risk protocols are completed or risk markers that go beyond physical injury; all Humberside police officers have been trained in the college of policing vulnerability training and some officers have been trained in trauma-informed approach which is being delivered at present; ensuring that assessments are informed by up to date knowledge and understanding about the multiple forms of domestic abuse including economic abuse;

b) Monkton-Smith's research supports making risk assessments that identify clusters of risk markers and the motivation for domestic abuse as more reliable barometers of risk and go beyond matrices that rely on ordinal scales that simplify complex information into single boxes and actuarial scoring; the sergeant in the specialist police unit recognised that despite the DASH score at medium there was evidence of escalation that

[8] Pitman AL, Osborn DPJ, Rantell K, King MB. The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. J Psychosom Res 2016;87:22-29

was not being taken into account; training based on Monkton-Smith eight-stage model is being implemented across Humberside Police;

c) Referral to specialist domestic abuse services is an essential part of providing support and developing a more informed understanding of risk; their practitioners are also more likely to be trained in appropriate techniques such as motivational interviewing and opt-in language to enhance the opportunity for engaging with victims of domestic abuse and eliciting information and providing advocacy;

d) Understanding that men who seek control in their intimate relationships can be dependent upon the woman for their sense of identity or sense of self-worth[9]. Dependency and fear of abandonment together with a history of depression and threats of self-harm are significant markers of risk to the perpetrator as well as for their partner and are relevant in Ricky's circumstances;

e) Using legal sanctions effectively requires partnership working across services that are focussed on safety planning that supports the victim and addresses the perpetrator's immediate threat as well as longer-term behaviour management; it is necessary when bail or DVPO/DVPN are breached and/or remands to custody are made; Humberside Police reported that breaches of DVPO/DVPN are dealt with robustly and put before the next available court once an arrest has been made, on average Humberside Police have a third of all their DVPOs breached a month and dealt with at court.

f) Separation marks a potential escalation of risk such as when a perpetrator is forbidden from contacting or visiting a partner following abuse as occurred in this case; remand to prison requires an agreed safety plan involving all relevant parties;

g) As part of safety planning associated with remanding to prison following domestic abuse making sure good information is passed to court liaison services about the circumstances of a remand application following domestic abuse that includes details of the victim's contact details to be included in prohibited contacts under prison guidance;

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[9] Websdale, N. (2010) Familicidal Hearts Oxford University Press, p20, 243-244

h) Professionals should be curious about relationships especially when there is a known history of domestic abuse as was the case with Edie; she was in the highest group of repeat victims known to the local police neighbourhood area;

i) Recognising that self-harm, injuries to fingers or hands are potential indicators of domestic abuse; professionals particularly in minor injury or emergency care centres need to show purposeful curiosity in how they seek information, particularly about a woman's safety from abuse and know what to do to provide effective advice and help;

j) Understanding the barriers for women in Edie's circumstances in escaping abuse, disclosing abuse and engaging with help; a relationship with an abusive partner is not a 'life choice' and the greatest threat facing victims is the extent to which they are robbed of an ability to feel empowered and to make choices or are viewed as "failing to protect";

k) Availability of health and psychological care that is timely; Edie's health was adversely affected by domestic abuse but it did not result in effective interventions either for counselling or referring to other specialist services; it is not enough for health care staff to have an awareness of domestic abuse but to have the appropriate knowledge and for health care to be part of integrated pathways with domestic abuse services that are achieved for example through IRIS[10];

l) Understanding that people who become homeless and suffer poor mental health and are misusing substances are more likely to have suffered adverse childhood experiences (ACE); has implications for how health and emergency shelter settings, in particular, can apply the principles of more effective interventions such as trauma-informed care; none of the services had a clear enough understanding about Ricky's history which was influential in the multiple difficulties he had as a young adult. Interventions that promote resilience and social support are more likely to reduce poor outcomes;

m) The prison and custody services, in general, are isolated from community-based services that have vital information that needs to be taken into account in risk-assessing prisoner safety and ensuring that victims of perpetrators who have been

[10] Identification and Referral to Improve Safety of women affected by domestic abuse https://www.health.org.uk/publications/case-study-identification-and-referral-to-improve-safety-iris

remanded are not allowed to continue their contact with a victim from within the prison. Prison and community-based services such as the police, court liaison and domestic abuse services have important roles in developing safety plans before, during and after remands or imprisonment for domestic abuse offences.

n) Improving links between prison and community-based services; Edie is not the only woman to have continued receiving contact from a perpetrator sent to prison; prisons are by definition taking responsibility for people who are likely to be highly vulnerable with a significant potential for self-harm; screening for markers of risk can inform health care interventions.

o) Prison health services assessment of prisoner risk from self-harm and suicide; primary health care is a repository of important information about the needs and vulnerability of prisoners; this information is often not summarised in the patient records and therefore not easily accessible to a GP during patient consultation or for contributing to prisoner risk assessment; similarly, there is a need for prison health professionals to keep GP informed about significant health interventions whilst a patient is in prison.

56. A learning brief will summarise learning from the DHR. In addition to the recommendations below the probation service has issued guidance to staff on working with court staff to ensure that when prisoners are remanded to custody assumptions are not made about the likely transport destination. Where there is a need-based for risk assessment to make contact with the prison before the detainee's arrival the destination must be established. The police have provided further guidance on completing DASH risk assessments to take account of the context when responding to incidents.

Recommendations

1. The Domestic Abuse Strategy Delivery Group should explore national best practices regarding the provision that could be put in place to focus on repeat victims of domestic abuse along with perpetrator interventions and breaking the cycle and put forward recommendations as relevant.
2. The North East Lincolnshire Health and Care Partnership should work with GPs on using flags and codes on patient records of high-risk markers of domestic abuse and self-harm and that patient summaries include this information.

3. The prison should review and ensure that domestic abuse training is provided to staff working in prisons and ensure that staff completing reception and health screening processes with prisoners have enhanced levels of training and awareness about checking for evidence of domestic abuse whether or not it is associated with offences relating to the prisoner arriving at the prison.
4. The prison should provide a summary of learning for the reception and health care team and review operational guidance on checking for risk flags on community-based data systems.
5. The police and probation services should ensure that information about a prisoner having a history of domestic abuse is included and forwarded with the prisoner to the prison.

National policy

1. Consider whether further guidance is required on multi-agency risk management when remanding to prison following a domestic abuse offence
2. The Home Office consider whether further national policy and practice guidance is indicated on prison reception processes in checking probation and community health systems.