Sunderland Partnership

Safer Sunderland Partnership

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Adult 5 – Michelle

(Month/Year of Homicide: September 2018)

Independent Chair – Richard Corkhill

Independent Author – Adam Lindridge

Report Completion Date:

April 2020

TABLE OF CONTENTS

GLOSSARY

AAFDA	Advocacy After Fatal Domestic Abuse
CHS/STFT	City Hospital Sunderland/South Tyneside Foundation Trust
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour-Based Abuse
DHR	Domestic Homicide Review
DHR Panel	Domestic Homicide Review Panel
DV	Domestic Violence
DVN	Domestic Violence Notification
DVPN/O	Domestic Violence Protection Notice/Order
GP	General Practitioner
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Review
IOPC	Independent Office for Police Conduct
MARAC	Multi Agency Risk Assessment Conference
NPS	National Probation Service
NPT	Neighbourhood Policing Team
PCC	Police and Crime Commissioner
RIC	Risk Indicator Checklist
SCAS	Sunderland Care and Support Limited
SCCG	Sunderland Clinical Commissioning Group
SSP	Safer Sunderland Partnership
VFN	VictimsFirst Northumbria
WWiN	Wearside Women in Need

FOREWORD – INDEPENDENT CHAIR

Safer Sunderland Partnership and the Domestic Homicide Review Panel (DHR) would like to express their condolences to Michelle's family and friends for their sad loss. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future.

As Independent Chair of the DHR Panel, I would like to thank all agencies involved, including Michelle's family, Advocacy After Fatal Domestic Abuse (AAFDA) and the many specialist partners that contributed to the process in an open and transparent manner. I would also like to formally acknowledge the support provided by Safer Sunderland Partnership in co-ordinating the DHR Panel process as well as the efforts of the author, Adam Lindridge, for his work on producing the Overview Report.

The DHR examines responses and support provided by partners to Michelle, a resident of Sunderland, prior to her death. Michelle was murdered at her home address in September 2018 by the perpetrator, her estranged husband, who subsequently took his own life. We know from Michelle's family she was a strong and independent person, who would live life to the full, and was someone who would go out of her way to help anyone.

We know Michelle experienced domestic abuse and had reported numerous incidents to Northumbria Police over several years. Protective measures (such as Domestic Violence Protection Orders) were used to help control the behaviour of the perpetrator – and Michelle also took proactive and positive steps herself to try and put an end to the abuse she was experiencing. There are however some missed opportunities, through our interactions with Michelle, to have utilised a better degree of professional curiosity to help us to elicit further information about her home life that would have put agencies in a better position to be able to assess the perpetrator's risk of harm.

There is also a tendency from agencies to rely too heavily on victim engagement with support services – and we need to do more to re-focus the spotlight towards tackling the behaviours of perpetrators. In addition, the case highlights the need for stronger Workplace Domestic Abuse Policies to encourage disclosures alongside an improved understanding of how the language and terminology used by partners can impact on our response to domestic abuse.

We have evidenced, through this DHR process, that there continues to be lessons that can be learned by agencies to further protect and safeguard victims of domestic abuse – and I am hopeful that, through implementation of the recommendations, partners will be in a better position to respond in future.

Richard Corkhill
Independent Chair – Michelle – DHR Panel

FOREWORD – MICHELLE'S FAMILY

The Domestic Homicide Review Panel invited Michelle's family to provide a foreword for the Final Overview Report. This narrative helps the reader to understand, in short, how Michelle was regarded by her family and how she impacted on their lives prior to her homicide.

****

Michelle was the fifth child of six wonderful children that myself and her late father were privileged to have. To Michelle, her family, from the very young ones through to the eldest, were everything; her love for us was unconditional, she would care and protect us with her life to which she sadly did.

Michelle showed her caring side from a young girl, from an injured bird to a stray kitten by bringing them home, and she would have loved to own a horse. As an adult, she loved her 2 dogs; first Roxy and then Buster, and was distraught when they died, and cried buckets, especially for Roxy.

To her many friends, Michelle was a joy to be with always leaving a part of herself with everyone she met, and her loyalty to them unflinching. She was a social butterfly.

In Michelle's work, people weren't just a number they were a person and she treated them with respect. She had dreams and inspirations, she should have years ahead of her to achieve her goals, but her life was brutally cut short.

Michelle was always on the side of the vulnerable, needy and the underdog, wanting to make a difference and, little did we realise, she was the most vulnerable of all which she hid too well with her beautiful smile.

There wasn't a cowardly bone in Michelle's body, she was straight to the point, but if made mistakes would say so, and apologise. She faced her problems never shying away from them.

Michelle was taken away from us in the most brutal, cruel and cowardly way, which has left her family and many many friends devastated. The chain has been broken, she will always be the missing link.

Sleep peacefully our beautiful, precious Michelle, in our hearts and thoughts you will forever remain. Till we meet again.

Your broken-hearted mother and family.

1 THE REVIEW PROCESS (INCLUDING PARALLEL REVIEWS)

1.1 This summary outlines the process undertaken by the Safer Sunderland Partnership's domestic homicide review (DHR) panel in reviewing the homicide of Michelle who was a resident in Sunderland. The victim was killed by her estranged husband who then went on to take his own life.

1.2 The following pseudonym 'Michelle' has been used in this review for the victim. Her estranged husband is referred to throughout as the 'perpetrator'. Pseudonyms are used to protect their identities and those of their family members.

1.3 At the time of the fatal incident, Michelle was 49 years of age. She was White British. The perpetrator was aged 53 and was also White British. The Panel considered protected characteristics and found no evidence of Michelle having been subject to discrimination and/or any barriers to accessing services. However, domestic-related homicide, especially intimate partner homicide, is a gendered crime, and means the protected characteristic of 'sex' was directly relevant to this DHR. We know women are disproportionately affected and that men are disproportionately perpetrators of domestic homicide. Murder followed by the suicide of the perpetrator, as in this case, follows a very similar unbalanced gendered split[1]. Michelle's homicide follows a pattern common in female intimate partner homicide cases. Women are significantly more likely to be seriously harmed or killed in situations of intimate partner violence and this should inform risk assessment/safety planning. Therefore, there is learning to consider in the way that agencies respond to female victims. It also demonstrates that suicide, and the threat of suicide, remains a significant risk (in terms of domestic abuse) and illustrates the critical importance of raising awareness of how suicidal persons need to be considered as potentially homicidal (in the context of domestic abuse).

1.4 Michelle had separated from the perpetrator and had started divorce proceedings which meant the protected characteristic of 'marriage' was relevant to the review. The Crime Survey for England and Wales published in November 2018 show that divorced women were more likely to be victims of domestic abuse than those who were married, civil partnered, cohabiting or single.

1.5 This case was a murder / suicide and so there were no criminal proceedings.

1.6 The Coroner held a pre-inquest hearing and separate inquests into Michelle and the perpetrator's deaths which were concluded in 2019.

1.7 The Coroner's inquest into Michelle's death reported Michelle was unlawfully killed and the cause of her death was Strangulation and Blunt Force Head Injury.

[1] A report published in 2018 by the Violence Policy Centre in America, which reviewed all murder-suicide cases over a six-month period, showed offences of this nature were committed overwhelmingly by male perpetrators and were most prevalent between two intimate partners, of which 96% of victims were females.

1.8 The Coroner's inquest into the perpetrator's death recorded a conclusion of suicide as a result of pressure to the neck due to hanging.

1.9 There was an Independent Office of Police Conduct (IOPC) Investigation that focused on investigating the nature and extent to Northumbria Police's contact with Michelle. The IOPC investigation identified no evidence to suggest that Northumbria Police may have caused/contributed to Michelle's death. It found the Police Officers involved had correctly followed policies and made appropriate decisions which were in line with Northumbria Police policies.

1.10 The Safer Sunderland Partnership received formal notification of Michelle's death from Northumbria Police in September 2018 and agreed the circumstances reached the criteria to undertake a statutory DHR; and subsequently informed the Home Office. An information scoping exercise was carried out by the Safer Sunderland Partnership in October 2018 and, following this, a decision to appoint an Independent Chair and Author was undertaken.

1.11 The first Panel meeting took place in November 2018 and the Final Overview Report was completed in early November 2019. It was presented to the Safer Sunderland Partnership Board for approval in December 2019 and was subsequently submitted to the Home Office DHR Quality Assurance Panel for endorsement thereafter.

1.12 It was not possible to complete the DHR within the six-month timescale (as set out within Home Office Domestic Homicide Review guidance). A draft copy of the IOPC report was provided to the Independent Chair in June 2019 which raised additional issues for the DHR Panel to consider.

1.13 All agencies that potentially had contact with Michelle and the perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them. Those agencies contacted who confirmed contact with Michelle and/or the perpetrator and were asked to secure their files and submit Individual Management Reviews (IMRs).

2 CONTRIBUTORS TO THE REVIEW

2.1 Five organisations had been involved with and/or held information regarding Michelle and/or the perpetrator prior to the homicide and suicide. Detailed chronologies and IMRs were requested from the following organisations:

- **Northumbria Police** – the Police Force responsible for the geographic area covering Sunderland.

- **VictimsFirst Northumbria** – a local charitable organisation, commissioned by the Northumbria Police and Crime Commissioner, providing emotional and practical support to victims of crime (including standard and medium risk victims of domestic abuse).

- **Wearside Women in Need** (WWiN) – a local charitable organisation, commissioned by Sunderland City Council, responsible for delivering specialist domestic abuse support services within Sunderland, including support for high-risk victims.

- **Sunderland Care and Support Limited** – a local authority trading company established by Sunderland City Council, which is responsible for delivering a range of social care, health and support services to residents across the city of Sunderland and in the region.

- **Sunderland Clinical Commissioning Group** (CCG) – CCGs are organisations set up by the Health and Social Care Act 2012 to commission the delivery of hospital and community NHS services in local areas for which they are responsible.

2.2 Assurance was sought from the organisations that IMR authors had no contact with Michelle or the perpetrator and had no management responsibility for those officers directly involved with the case. None of the members of the DHR Panel had any previous responsibility for delivery or direct management of services which had had contact with Michelle, the homicide perpetrator or members of the immediate family[2].

2.3 Information previously identified as part of the scoping exercise from North East Ambulance Service, National Probation Service, South Tyneside & Sunderland NHS Foundation Trust (City Hospital Sunderland) and Gentoo (the Registered Social Landlord) was also used. A short document was also requested from a health and social care charity (an organisation where Michelle worked in the months prior to her homicide). It was agreed by the DHR Panel that full IMRs were not required from these agencies due to limited involvement/interaction with either Michelle and/or the perpetrator.

2.4 The Independent Author also accessed some of the homicide investigation witness statements provided by Northumbria Police and these were used to help further strengthen chronologies and develop a fuller picture of Michelle and the perpetrator's experiences in the lead up to the homicide.

2.5 Involvement of family and friends of Michelle and the perpetrator is as follows:

Michelle – the victim

2.6 The Independent Chair met with Michelle's family in February 2019 to outline the DHR process. This involved Michelle's mother, brother and sister along with their Advocacy After Fatal Domestic Abuse (AAFDA) advocate. The Terms of Reference were also shared, and Michelle's family were invited to include

[2] In the interest of transparency, the DHR Panel member for Northumbria Police disclosed that, as a senior ranking officer, she is ultimately responsible for the management of the officers involved in the case and would also be contributing to the IMR process. The Panel felt this was not a significant conflict of interest and permitted future involvement.

any additional questions or concerns of their own. Having considered them they advised there did not wish to add anything further.

2.7 There was a regular dialogue between the Independent Chair, Independent Author, Michelle's family and their AAFDA advocate (by either telephone, email and/or face-to-face) throughout the DHR process to ensure family members and interested parties were kept appropriately informed.

2.8 Michelle's family and their advocate were provided with copies of the draft Overview Report to seek their views and thoughts prior to completion and submission to the Safer Sunderland Board and the Home Office DHR Quality Assurance Panel[3]. Contributions provided by Michelle's family have been invaluable to informing the review and have allowed the DHR Panel to gain a tangible understanding and appreciation of Michelle's life. We would like to thank them for their time and for sharing personal stories and anecdotes with the Panel about Michelle.

2.9 One of Michelle's closest friends was contacted by her employer, on behalf of the Independent Chair, but decided she did not wish to contribute and/or be involved with the review.

The perpetrator

2.10 The Independent Chair and an experienced DHR Panel Member met with the perpetrator's brother.

3 THE REVIEW PANEL MEMBERS

3.1 The core membership of the DHR Panel was as follows:

Panel Representative	Role and Agency
Barry, Martin	Team Manager, Adult Social Care Sunderland City Council
Begbie, Sandra	Business Manager Sunderland Care and Support Ltd
Corkhill, Richard	Independent Chair
Dawson, Tracy	Named Nurse Safeguarding Adults South Tyneside & Sunderland NHS Foundation Trust
Douglass, Stuart	Lead for Community Safety and Safeguarding Sunderland City Council
Kilgallon, Jim	Safeguarding Adults Adviser North East Ambulance Service
Lindridge, Adam	Independent Report Author

Panel Representative	Role and Agency
Lister, Julie	Operations Manager Gentoo
O'Neill, Karin	Head of South of Tyne NPS National Probation Service
Parker, Ruth	Chief Executive Victims First Northumbria
Paulsen, Amy	Strategic Safeguarding Specialist Sunderland City Council
Rogerson, Becky	Acting Director Wearside Women in Need
Sampson, Aelfwynn	Detective Chief Inspector – Safeguarding Northumbria Police
Scott, Richard	Designated Nurse Safeguarding Adults Sunderland Clinical Commissioning Group
Smith, Julie	Associate Lead for Community Safety Sunderland City Council

3.2 There were five DHR Panel meetings held, starting in November 2018 through to August 2019. Some agencies did not attend every Panel, as they were not directly involved with the case, but they were provided with copies of the draft Overview Reports, Action Plan and DHR Panel minutes and would submit their comments via Community Safety staff within the Safer Sunderland Partnership. The Panel included specialist organisations and experts in domestic abuse and victim support (i.e. WWiN and Victims First Northumbria, both independent charitable organisations)

4 INDEPENDENT CHAIR AND AUTHOR OF THE REPORT

Independent Chair – Richard Corkhill

4.1 The Chair is independent of, and has no current connection with, any agencies in the Sunderland area or Safer Sunderland Partnership. Richard Corkhill has over 30 years operational and senior management experience in social care and supported housing sectors. The latter included senior and strategic management of outreach and accommodation-based services for women and children who had experienced domestic abuse. He has been a self-employed Consultant since 2004 and is based in the North East of England. Since 2012, he has acted as Independent DHR Chair and/or Author for 15 DHRs. Richard has successfully completed on-line Home Office training for DHR Chairs/Authors. He regularly attends training, conferences and seminars, in order to maintain and update his knowledge of current research and practice on domestic abuse. Crucially, this includes events involving families affected by domestic abuse and domestic homicide. He has also acted as Chair and Author for Safeguarding Adults Reviews (SARs) and

other similar multi-agency review processes, including combined SARs/DHRs. He is fully independent and has never been employed by any of the organisations which were involved with Michelle or the perpetrator.

Independent Author – Adam Lindridge

4.2 The Author is independent of, and has no connection with, any agencies in the Sunderland area or Safer Sunderland Partnership. Adam is the Community Safety Business Manager for Gateshead Council and has been working in the field of Community Safety for more than 10 years. He is responsible for strategy and policy development for a range of Community Safety themes. He has knowledge and understanding of the domestic abuse agenda and has previously line managed the Gateshead Independent Domestic Violence Adviser Team. He completed online training for DHRs, attended several conferences and events and has shadowed several DHRs in recent years to support his development and learning. In addition, he has previously been involved as a Panel member and IMR author for a high-profile DHR in a neighbouring local authority. In the interests of disclosure, Adam has previously worked as an Intelligence Analyst for Northumbria Police (which included analytical work for homicide investigations between 2006-09).

5 TERMS OF REFERENCE

5.1 The purpose of a DHR is to:

- establish what lessons could be learnt from domestic homicides regarding the way in which local professionals and organisations work individually, and together, to safeguard victims;
- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse and to highlight good practice.

5.2 The table below summarises the key findings against each of the questions on the DHR terms of reference.

Terms of Reference Questions		Key findings	
(a)	What were the quality of risk assessments and risk management plans in response to known incidents? Were the risks to Michelle appropriately assessed at the correct level of risk? Were static factors present in all risk assessments?	• Risk assessments and risk management plans were implemented by agencies after every reported domestic abuse incident involving Michelle and the perpetrator. • The review found these were completed in a timely manner and fulfilled all requirements outlined within their respective domestic abuse policies and procedures. • The IOPC confirmed the assessment of risk the perpetrator posed towards Michelle was appropriate and proportionately handled by Northumbria Police. • Despite some static risk factors not being routinely recorded or identified, the review found that agencies still correctly assessed Michelle's level of risk of harm and that the response provided to Michelle was proportionate. • The level of risk escalated quickly. Michelle and agencies did not necessarily expect the risk from the perpetrator to escalate at the speed at which it did.	**Links to Key Finding(s):** 1, 2, 4, 5, 8, 11, 12 and 14
(b)	Were appropriate managers, agencies and professionals involved at the appropriate points and concerns about risks escalated in a timely and appropriate manner?	• Michelle had been appropriately contacted by agencies at various points throughout the period examined; albeit, at times, we found that Michelle did not want to, or feel ready to, to engage with the services that were offered. • There were instances where concerns about Michelle's risk from the perpetrator were escalated (e.g. the response provided by Northumbria Police following the disclosure of rape, referrals to MARAC process and the protective factor granted using DVPOs etc.) • However, there was a greater onus on Michelle and what actions she was required to take to safeguard herself with a lesser focus on tackling the behaviour of the perpetrator. • There was a potential disclosure made by Michelle to her employer in January 2014 prior to a period of absence. Her employer was unable to provide any further evidence or details on the circumstances of the absence – and so we cannot determine if the concern was acted upon in a timely and appropriate manner.	**Links to Key Finding(s):** 1, 2, 4, 8, 9, 14 and 15
(c)	There was an occasion when the perpetrator called Northumbria Police and was identified as the victim of domestic abuse. Did agencies have a clear understanding of who committed the violence in the relationship and did this impact on the risk assessments and risk management plans?	• It was clear that Michelle was a victim of domestic abuse perpetrated by the perpetrator. Michelle was, in all but one incident, recorded by Northumbria Police as a victim of domestic abuse.	**Links to Key Finding(s):** 1, 2, 4, 6, 8 and 12

Terms of Reference Questions		Key findings	
		• There are examples where the language[4] and terminology used to describe the abuse experienced by Michelle could be open to interpretation. It could be argued some of the wording used was victim blaming and minimized the abuse that was taking place. • Although all agencies involved within the review understood that Michelle was a victim of domestic abuse; there were examples where a greater level of professional curiosity could have been used to elicit further information about her home life and provide her with additional opportunities to disclose to professionals.	
(d)	With specific regard to domestic abuse, did the portrayal of Michelle's alcohol use and mental health by the perpetrator affect decisions made by organisations regarding her risk of domestic abuse?	• There were occasions where the perpetrator negatively portrayed Michelle's alcohol misuse to services – and in all but one occasion, alcohol consumption was recorded as an influencing factor; albeit, there is no indication of alcohol use prior to the homicide and suicide. • There is no suggestion this influenced or affected decisions taken by agencies regarding Michelle's risk of domestic abuse.	**Links to Key Finding(s):** 1, 4, 10 and 12
(e)	Was there any evidence that Michelle was experiencing coercive control by the perpetrator and is there any evidence that this impacted on her seeking help or prevented her from contacting services?	• There are some elements of the perpetrator using coercive control in the relationship but nothing to suggest his actions impacted on Michelle's ability to seek help and/or prevented her from accessing services. There is no evidence to suggest Michelle was being isolated from her friends and family or any indication to show financial control within the relationship. • Michelle did not see herself as being controlled and is described as independent, strong-willed and resilient and was able to seek advice, guidance and support from specialist services in relation to the domestic abuse she was experiencing.	**Links to Key Finding(s):** 1, 8 and 12
(f)	Was the perpetrator's known history of violent behaviour (including but not limited to domestic violence) and use of weapons given sufficient weighting in police risk assessments?	• The initial scoping exercise identified the perpetrator held a previous conviction for possession of a firearm and as such it was rightly included as part of the Terms of Reference for further exploration. However, it was later identified the conviction was non-domestic-related and related to the perpetrator shooting a boy with an air/pellet gun aged 9 years. • There was no indication of the perpetrator having used or having access to weapons.	**Links to Key Finding(s):** 3 and 12

[4] There were numerous examples identified, throughout records reviewed as part of the DHR, where the language used to describe domestic abuse and/or the relationship between Michelle and the perpetrator could be 'open to interpretation'. Some of this language was victim blaming. Some examples included:

- It is recorded that 'there are clear issues in the relationship which go back a number of years; however, it remains unclear who the main aggressor is'.
- Following an incident, it is logged that Michelle 'refused to support a prosecution …and gave the perpetrator house keys so he could let himself back into their home address…this suggests she is not in fear [of him]'
- One domestic abuse incident is described as 'marital difficulties'

Terms of Reference Questions		Key findings	
		• The perpetrator's previous criminal history, and history of violent behaviour, was not consistently identified as a static risk factor across all Risk Indicator Checklists completed for Michelle. It is important to note details of domestic abuse perpetrated by the perpetrator towards previous partners only came to light post-homicide and was not known to Police at the time. • We know that past behaviour is often a predictor of future behaviour and it is essential that we use this information to better protect victims from future abuse. • There is a history of Michelle and the perpetrator witnessing domestic abuse in their family setting.	
(g)	Were the correct referral pathways (including but not limited to MARAC) implemented in line with local policy, procedure and guidance?	• The review found the correct referral pathways were followed by agencies in line with local policy, procedure and guidelines. • Michelle was correctly referred to VictimsFirst Northumbria and to WWiN and was scheduled to be discussed in MARAC the week following her homicide. • All risk management and safety plans were found to be appropriate and the response provided to Michelle by agencies was proportionate.	**Links to Key Finding(s):** 4, 8, 9, 12 and 14
(h)	Were there any missed opportunities for routine or selective enquiry about domestic abuse where agencies knew Michelle was experiencing domestic abuse?	• There were some missed opportunities from agencies involved with Michelle to utilise a better degree of professional curiosity to help enquire about, challenge and elicit pertinent information to identify underpinning issues that she may have been experiencing in terms of domestic abuse. In most interactions with Michelle, professionals focused their efforts around her 'presenting need' and further enquiry could have been undertaken to consider possible indicators of abuse and the interplay between multiple presenting factors (e.g. potential injuries, depression and anxiety, alcohol use etc.). • There were missed opportunities for her line manager and colleagues to enquire about and act upon domestic abuse with the perpetrator and to signpost Michelle to relevant support services. • Presenting information appears to have been accepted at face value by professionals without any evidence of them trying to clarify or confirm if said action had taken place.	**Links to Key Finding(s):** 5, 6, 8, 9 and 15
(i)	Was appropriate use made of available civil/statutory tools and powers including but not limited to: Civil Orders, Domestic Violence Protection Notices (DVPNs), Domestic Violence Protection Orders	• Northumbria Police proactively made use of available civil and statutory tools and powers to help protect Michelle, including Domestic Violence Protection Notices/Orders. As far as we are aware, the perpetrator successfully complied with requirements of the DVPOs. • DVPOs present agencies with a window of opportunity to try and maximise engagement with victims. On the first occasion, VFN were unable to contact Michelle, and by the time	**Links to Key Finding(s):** 2, 5, 6 and 14

Terms of Reference Questions		Key findings	
	(DVPOs) and Domestic Violence Disclosure Scheme (Clare's Law)?	they did, the DVPO had expired; and on the second occasion, Michelle did not consent to referral. • Victims who call the Police are often calling when they feel the behaviour is of greatest concern to them. The DVPO created a 'space' for Michelle (away from the perpetrator) to consider her options and it was a potential missed opportunity for agencies to intervene and support her. Consideration should be given to how partner agencies can work better together, during the window of separation that a DVPO provides, to help maximise our ability as a partnership to engage with and signpost victims to specialist services.	
(j)	Where services and protection planning could not be delivered due to non-engagement of Michelle, were the reasons for non-engagement explored and what efforts were made to encourage engagement?	• The rationale for Michelle declining referrals to services and/or not wanting to engage is not routinely collected by partner agencies involved in the review. WWiN identified Michelle chose to turn down attending the Freedom Programme down due to her work commitments and caring responsibilities. Yet, we were unable to determine if this was the reason behind her previous decisions to not engage with services and therefore, we were unable to consider if these were potential barriers to Michelle.	**Links to Key Finding(s):** 4, 6 and 16
(k)	How effective was interagency working and interagency information sharing around addressing the risks that the perpetrator posed to Michelle?	• The review found minor evidence of occasions when information was not necessarily shared in a timely manner. We know information sharing, in line with the rules of consent and confidentiality, is essential to ensuring agencies have access to relevant information, at the point of contact with victim and/or perpetrator, to be able to adequately support and protect. Risk is fluid and dynamic which means that things can change very quickly and without access to timely and accurately recorded information we have the potential not to see the full scope of the domestic abuse situation. • Notification of the DVPO, along with the details of specific conditions, were not received by the CCG in a timely manner. Despite the DVPO being served, Michelle was coded as a 'victim of domestic abuse' on the GP IT systems but with no further information, and the information shared as part of a MARAC referral did not accurately reflect records. • In addition, the Non-Molestation Order was posted to Northumbria Police by Michelle's solicitor which was not received until after her homicide had occurred; Although it may not have led to any subsequent action, access to timely information helps to build a full picture and elicits a better understanding and assessment of the risks posed by the perpetrator. • There is some important learning around how agencies can improve their interaction and engagement with solicitors and legal services in anticipation of, and following, the serving of a Non-Molestation Order.	**Links to Key Finding(s):** 4, 5, 9, 12 and 15

Terms of Reference Questions		Key findings	
(l)	Michelle was a repeat victim of domestic abuse in this relationship and in previous relationship(s). The perpetrator was a repeat perpetrator of domestic abuse in this relationship and previous relationship(s). Was either Michelle and/or the perpetrator offered any form of assistance or intervention to address domestic abuse (including programmes for perpetrators or victims?). If so, what were the outcomes?	• WWiN provided Michelle with an array of options. She was provided with safety planning advice, offered support in relation to refuge accommodation and access to the Freedom Programme, offered telephone support on a fortnightly basis and support through the Court process (if, and when, the case progressed to the Criminal Court) and/or through the Civil route if the Injunction was contested. • There continued to be an overreliance on Michelle having to engage with services with a lesser focus on addressing the perpetrator's behaviour. Efforts should aim to take robust engagement and intervention with domestic abuse perpetrators to reduce risk and harm to the victim; and, more importantly, to help shift the focus towards holding perpetrators to account (but in a way that does not escalate the potential for further risk to the victim). • There is no evidence the perpetrator was considered for or offered a voluntary Domestic Abuse Perpetrator Programme. Although attendance at such programmes cannot necessarily be mandated, efforts could have potentially been made to engage the perpetrator (particularly during window of separation afforded by the DVPO).	**Links to Key Finding(s):** 4, 6, 8 and 11
(m)	Did either Michelle or the perpetrator's workplace have any cause for concern that Michelle may be at risk from domestic abuse by her husband?	• There was a potential disclosure made by Michelle to her previous employer in January 2014 prior to a period of absence. The employer had a Domestic Abuse Workplace Policy in place at the time; however, they were unable to provide any further evidence or details on the circumstances of the absence – and so we cannot determine if the concern was acted upon. • Michelle's most recent employer, who she had started working for in the months prior to her homicide, did not have a formal Domestic Abuse Workplace Policy in place. There were no disclosures from Michelle to her line management, whilst she was at work; however, there is evidence that she did informally discuss some aspects of the perpetrator's behaviour with her peers, but conversations did not necessarily raise any significant concerns with her colleagues for them to warrant seeking advice from management. The organisation has since implemented a Domestic Abuse Policy.	**Links to Key Finding(s):** 7
(n)	Did family, friends, neighbours and work colleagues have any cause for concern Michelle may be at risk from domestic abuse? If so, were they aware of support services and how to seek advice and support?	• Both Michelle and the perpetrator were described as quite private persons; and although their family, friends, work colleagues and neighbours had become aware that issues were manifesting in the relationship, they did not recognise the behaviour as domestic abuse; nor did they know the true extent of issues Michelle was experiencing.	**Links to Key Finding(s):** 13

6 SUMMARY CHRONOLOGY

6.1 The timescale used for the chronologies was the period spanning January 2014 through to September 2018 to consider any relevant history in the lead-up to Michelle's homicide. The period covered the early incidents of domestic abuse reported to Northumbria Police by Michelle up until the date of her homicide in September 2018.

6.2 Agencies were also encouraged to review historical information (prior to January 2014) and to include any noteworthy events linked to domestic abuse and/or information that may be pertinent to the case.

6.3 From 1979 through to 2010, the perpetrator was convicted of several offences ranging from assault, possession of a firearm (air weapon), burglary and criminal damage – and, in 1983, following a conviction for assault, he was sentenced to 3 months imprisonment at Medomsley youth detention centre. Medomsley has since seen several former staff members convicted over the historical physical and sexual abuse of young prisoners. The convictions were part of Operation Seabrook[5]. The perpetrator was due to be visited by Durham Constabulary the day after Michelle's homicide (as part of the trial preparation process and to provide a Victim Personal Statement to cover how the impact of the abuse, he experienced in Medomsley, had affected him).

Background to Homicide Incident

6.4 Michelle had resided at her privately-owned address for 18 years prior to her homicide. She and her recently estranged husband had been in a relationship for approximately 15 years. The perpetrator had co-habited at Michelle's property from 2008, and in 2010, they married and took on joint-ownership of the property. The couple had no children together and no other person lived at the address.

6.5 Michelle experienced domestic abuse, perpetrated by her estranged husband, for several years with numerous incidents reported to Northumbria Police prior to the homicide.

6.6 At the time of the homicide, the couple had separated, and the perpetrator was temporarily residing at a friend's property located about a mile and a half away from their shared privately-owned residence and was subject to a non-molestation order.

6.7 This section summarises the information known regarding Michelle and the perpetrator prior to the homicide:

- Michelle was born, and raised, in Sunderland and had lived in the local area her entire life. She was described as a normal, healthy woman who was caring,

[5] 'Operation Seabrook' is the criminal investigation by Durham Constabulary into allegations of sexual and physical abuse perpetrated by staff against detainees at Medomsley Detention Centre near Consett, County Durham. It was launched in 2013 and is investigating historical incidents that occurred, principally in the 1970s and 1980s.

loving and kind-hearted and was someone who gave a tremendous amount of time to help look after and support her close-knit family. She worked for a local support agency and had several close friends and acquaintances.

- The perpetrator was from the Sunderland area. He was described as a man who could be 'hot-headed' [volatile] and was quite a private person – someone who would not readily share or seek help in relation to any problems/issues he was facing. He had previously married and was a father to 3 children (now adults), by 2 ex-partners.

- Our evidence showed Michelle was a victim of domestic abuse in a previous relationship and the perpetrator also perpetrated abuse towards some previous ex-partners. Michelle disclosed to her GP that violence was perpetrated towards her by an ex-partner (prior to her relationship with the perpetrator); and that he also held historic convictions for assault against an ex-partner. In addition, there was evidence of domestic abuse manifesting itself within the perpetrator's family along with recent family bereavements (which included the suicide of the perpetrator's father and death of his brother).

- Evidence showed Michelle experienced domestic abuse, perpetrated by her estranged husband, for several years with nine separate domestic abuse incidents reported to Northumbria Police from 2014 through to her homicide.

- The first reported domestic abuse incident was in January 2014, and was recorded as a verbal altercation, which took place after the perpetrator became jealous over Michelle's past. Both parties were recorded as intoxicated and Michelle contacted Northumbria Police to seek support. The last incident was reported in September 2018 and related to a disclosure of rape by Michelle against the perpetrator – which was later retracted (by Michelle).

- We know that Michelle took proactive steps to help protect and keep herself safe – seeking legal protection through a non-molestation order. This was served on the perpetrator and less than 24 hours later he murdered Michelle and then went on to take his own life. At this stage, Northumbria Police were not aware of any form of non-molestation order being served.

- The non-molestation order had purportedly been 'a shock' to the perpetrator and he was 'quite angry' with Michelle about it. Witness statements obtained from Northumbria Police from the perpetrator's friends showed in the week/ days leading up to the non-molestation order being served, and around the time he had been accused of raping Michelle, he was reporting suicidal thoughts – and had been 'talked down from throwing himself off a bridge' by a close friend. The incident and/or concerns were not reported to Emergency Services.

- Michelle was described as independent, strong and resilient by agencies who were involved/engaged with her. She disclosed to WWiN her concerns of 'being frightened of what could happen if he [the perpetrator] lost everything' and within a statement in relation to the non-molestation order she described examples of the perpetrator being violent, controlling and jealous as well as verbally degrading towards her. She said she was terrified of the perpetrator,

the abuse was ongoing and that it had affected her mental health, making her constantly feel drained and anxious.

- Although Michelle's family were aware of some of the problems emanating between the couple, they were not aware of the full extent of the domestic abuse she was experiencing – with domestic abuse never fully disclosed by Michelle. Similarly, the perpetrator's family were also not aware of the full scope of the abuse in the relationship. There was no evidence to suggest Michelle was being isolated from her friends and family by the perpetrator.

- One of perpetrator's brothers described him as someone who 'wouldn't really tell anyone about problems he was having' and 'someone who would never have sought help with his own issues'. He felt it was the perpetrator who took 'the brunt of the blame' and was 'always the one who had to leave [the home] regardless of who was at fault'. He felt 'some of the domestic abuse was not always all down to the perpetrator but split fifty-fifty [between him and Michelle]' and 'alcohol/cannabis consumption' was a primary reason for the escalating domestic abuse between the couple.

- Witness statements taken from friends and work colleagues post-homicide described quite a volatile and turbulent relationship between the couple, with regular arguments and aggression directed towards Michelle from the perpetrator, often fueled by high levels of alcohol consumption. There were also several examples of Michelle disclosing quite controlling behaviour from the perpetrator. Statements also showed signs that Michelle minimized some of the abuse she was experiencing and implied she was in control of the situation and was seeking to end the relationship. Although concerned, no one appeared to regard the behaviors and actions of the perpetrator as domestic abuse and/or fully understood the true extent of the abuse that Michelle experienced.

6.8 There were five organisations that had been involved with Michelle and/or the perpetrator prior to or following the homicide: Northumbria Police, VictimsFirst Northumbria, Wearside Women in Need, Sunderland Care and Support Limited and NHS Sunderland Clinical Commissioning Group.

6.9 **Northumbria Police**

- There were 9 domestic abuse incidents reported to Northumbria Police in relation to Michelle and the perpetrator spanning almost a five-year period, until the last incident in September 2018. Michelle was a repeat victim of domestic abuse and was recorded as a victim for all but one incident.
- There was a clear escalation in the volume and severity of incidents from 2017 – which culminated in a disclosure of sexual assault in September 2018.
- Incident logs from Northumbria Police regularly identified alcohol/intoxication as a factor within the relationship. In most of the incidents, alcohol was found to be a presenting issue – with either Michelle, the perpetrator and/or both reported as having consumed excessive amounts.
- Two Domestic Violence Protection Notices/Orders were issued in March 2017 and August 2017. On both occasions, the perpetrator complied with the

requirement conditions (which included not to contact Michelle directly or indirectly or returning to their home for 28 days).

- In early September 2018, Michelle disclosed multiple assaults and disclosed a rape which she later retracted. During disclosure, Michelle stated she 'is having domestic violence issues with the perpetrator and is terrified to go home'. At this time, WWiN interacted with Michelle who stated she was committed to seeking legal advice to end the relationship.
- Following the rape disclosure, and based on professional judgement, Michelle was assessed 'high risk' by Northumbria Police and was subsequently referred to Multi-Agency Risk Assessment Conference (MARAC).
- Michelle's referral was not discussed at MARAC (as the homicide occurred before the meeting was scheduled to take place).
- The perpetrator was arrested and interviewed in relation to the rape. He was subsequently Released Under Investigation and was not subject to bail conditions. In terms of his ability to access the property, Northumbria Police had no legal basis to make the perpetrator surrender his keys.

6.10 **VictimsFirst Northumbria (VFN)**

- Of the 9 incidents reported to Northumbria Police, VFN received 3 x referrals – all in relation to Michelle. All 3 x referrals were received between January-April 2017
- As Michelle was recorded as standard/medium risk, her consent to a VFN referral was required. Michelle did not wish to seek specialist support for the other 6 incidents and did not consent for her details to be passed to VFN.
- For the 3 occasions, where Michelle did consent to a VFN referral, attempts were made to contact her via telephone. She was spoken to once, after the first incident, by a Case Co-ordinator but chose not to engage with services at that time[6]. VFN failed to contact Michelle in relation to the second incident, and closed the case, after 3 unsuccessful telephone call attempts.
- No contact at all was attempted for the third incident, after information on Northumbria Police system stated Michelle was 'already being supported by WWiN', the local specialist domestic abuse service in Sunderland.

6.11 **Wearside Women in Need (WWiN)**

- WWiN first had contact, and engaged, with Michelle at Southwick Police Station in September 2018 when she had disclosed the assault and rape.
- WWiN provided Michelle with appropriate advice, support and guidance – and arranged to see her at their offices two days later.
- WWiN completed a further Risk Indicator Checklist (RIC) and identified Michelle as medium risk. WWiN carried out an assessment of need in the context of several protective measures having been put in place already by Michelle, which included changing locks and a Non-Molestation Order.
- Michelle was offered support in relation to refuge accommodation and access to the Freedom (group work) Programme but chose to turn these offers down due to her work commitments and caring responsibilities.

[6] Victims of domestic abuse will often choose not to take up offers of help and support and this can be for a variety of reasons (e.g. not being ready to discuss their abuse, a fear of reprisals, feeling that things will get better etc.).

- WWiN offered telephone support on a fortnightly basis and support through the Court process (if, and when, the case progressed to the Criminal Court) and/or through the Civil route if the Injunction was contested.
- WWiN also offered support to gain information from Northumbria Police to establish any progression on the criminal complaint.

6.12 **Sunderland Care and Support Service Ltd**

- Michelle's employer became aware of domestic abuse in the relationship in 2014 – after Michelle took a period of sickness – whereby the presenting issue was initially recorded as 'domestic violence'.
- However, the reason for her absence was not passed onto Michelle's line manager and therefore was not acted upon under the Workplace Domestic Abuse Policy.
- There was no evidence of any discussion taking place regarding the incident; nor was there any record of how this absence type was decided upon.
- There was a potential missed opportunity for her employer to engage Michelle in a meaningful dialogue about her home life and any domestic abuse she was experiencing within her relationship.

6.13 **NHS Sunderland Clinical Commissioning Group**

- Michelle was in regular contact with her GP practice – having 34 contacts in the timescale of the review. 25 of the 34 were telephone consultations and 9 face-to-face.
- It was apparent Michelle sought out support from health professionals on repeated occasions for chronic concerns, as well as stress and anxiety. Historically, although outside of the timescale of the review, it was evident that Michelle had experienced issues with self-esteem and self-confidence – and incidents of domestic abuse perpetrated against her by ex-partners.
- It remains uncertain as to whether Michelle presented regularly at the GP to seek support; however, there were occasions where further professional curiosity and challenge may have elicited information about her home life.
- Routine enquiry around domestic abuse may have facilitated her to discuss issues and potentially access support.

Witness Statements

6.14 Information taken from witness statements, provided as part of the homicide investigation, provided a useful insight into the home life and experiences of Michelle and the perpetrator. **It is important to stress that this information was not known to agencies, prior to, or at the time of, the homicide occurring**; however, it has helped to demonstrate a clear pattern of abuse and conflict building within their relationship. The information was not interspersed throughout the Chronology, as a lot of material contained indeterminate dates and times; nor, did the Panel want to include some information as it was felt it could prove identifiable – and instead, have provided generic observations here.

Non-Molestation Order Statement

- Within the witness statement that Michelle made as part of her application for the Non-Molestation Order against the perpetrator in September 2018, she described several examples of physical violence, controlling and coercive behaviour and jealousy as well as numerous illustrations of the perpetrator being verbally degrading towards her.
- She stated the perpetrator had been violent and controlling since the very beginning of relationship, consistently accuses her of having affairs and liking other men and became obsessed. She said he would 'badger [her]' for days or months and that she felt there was nothing she could do to try and reassure him. She went on to say the situation significantly affected her mental health and she constantly felt drained, mentally and physically, and had become a very anxious person.
- Michelle referred to an incident in 2014, where the perpetrator punched her in the face, causing a black eye and, although Northumbria Police were called and attended, she stated that she felt too frightened to press charges. She also purported, through several examples, to have been punched, kicked, pulled by the hair and grabbed by the throat so she could not breathe. She went on to say she was terrified of the perpetrator, that the abuse and harassment was happening more often – including numerous text messages, calls and voicemails being left, often quite degrading, and that she was starting to become 'extremely concerned as to what he will do next'.

Statement(s) from family, friends, neighbours and colleagues (post homicide)

- Witness statements highlighted similar concerns with many describing the couple as having quite a volatile and turbulent relationship, often alcohol-fueled arguments which were aggressive in nature. Michelle disclosed several incidents of controlling/abusive behaviour, perpetrated by the perpetrator towards her, to others including examples where he had cut up her leather coats, chewed her wedding rings into pieces as well as threatening to kick her out of the house. Whilst, in some cases, there were signs of Michelle minimizing the abuse experienced, implying she was in control of the situation and occasionally blaming herself for some of the perpetrator's actions.
- There were signs, particularly towards the end of the relationship, where Michelle was starting to become fearful of the perpetrator's behaviour and actions – she was committed to ending the relationship and seeking legal support and advice, which we know she had commenced. Although the witness statements showed that she had confided in some family, friends and colleagues regarding some of the domestic abuse she was experiencing, the full extent and severity was not widely known to all. We know persons are often aware of or suspect something is happening but, do not necessarily feel able to (or know how to) get involved to help the situation.

Allegations obtained from previous partners (post-homicide)

- Following the perpetrator's suicide, information came to light when an ex-partner contacted Northumbria Police, as part of homicide investigation, and

provided a statement detailing the relationship with the perpetrator and included allegations of violence and abuse.

7 KEY FINDINGS

Key Finding 1: there was evidence Michelle was a victim of domestic abuse and that conflict was present within the relationship

Key Finding 2: the level of risk to Michelle escalated quickly following her decision to seek formal legal support

Key Finding 3: there was a history of witnessing/perpetrating domestic abuse

Key Finding 4: Michelle sought appropriate advice, guidance and support in relation to the domestic abuse that she was experiencing

Key Finding 5: Domestic Violence Protection Orders (DVPOs) presents agencies with a window of opportunity to try and maximise engagement with victims

Key Finding 6: there continued to be overreliance on Michelle engaging with services with a lesser focus on addressing the perpetrator's behaviour

Key Finding 7: strong workplace policies are important in supporting and encouraging victims to report abuse

Key Finding 8: professional curiosity is critical to eliciting an improved understanding of risk and family life / relationships

Key Finding 9: the timely sharing of information across partner agencies is essential to help develop a full picture of abuse

Key Finding 10: it is important that agencies use constructive language and terminology when referring to victims of domestic abuse

Key Finding 11: ensuring victims are safe and secure in their own home is important

Key Finding 12: Risk Indicator Checklists did not account for or document all static risk factors

Key Finding 13: Michelle's family, friends, work colleagues and neighbours were, to a greater or lesser extent, aware of the domestic abuse she was experiencing from the perpetrator

Key Finding 14: IOPC confirmed assessment of risk the perpetrator posed towards Michelle was appropriate/proportionately handled by Northumbria Police

Key Finding 15: agencies offering services to victims/perpetrators of domestic abuse should be in regular communication to ensure effective safety planning

Key Finding 16 – agencies do not routinely record the reasons why victims choose not to engage with specialist support

8 CONCLUSIONS AND LESSONS LEARNT

8.1 The main conclusions and key lessons arising from Michelle's case and agreed by the DHR Panel are:

- Michelle was a repeat victim of domestic abuse perpetrated by the perpetrator and it was clear that conflict was also an apparent feature within their relationship.
- After each domestic abuse incident, the DASH Risk Indicator Checklist was completed. The review found these were completed in a timely manner and fulfilled requirements outlined within local policies and procedures; albeit, some static risk factors were not routinely recorded.
- The assessment of risk the perpetrator posed towards Michelle was appropriate and proportionately handled by Northumbria Police.
- The use of alcohol by the perpetrator and Michelle appeared to be a contributory and consistent factor in all reported domestic abuse incidents (except for actual homicide and suicide incident).
- Leaving an abusive relationship is a particularly high-risk time for a victim, both during and after separation
- Domestic Violence Protection Orders (DVPOs) were appropriately used as protective measures to safeguard Michelle; albeit, there are opportunities for agencies to explore both how information about DVPOs is shared with partner agencies; and what additional support can be offered, during this window, to maximise opportunities for engagement with specialist domestic abuse services.
- There was evidence to show Michelle was becoming increasingly frightened of the perpetrator and starting to feel 'worried about what he might do if he lost everything'. Despite this fear, there were times throughout their interactions with services, where Michelle did not appear supportive of prosecution (this could have been for a variety of reasons) and/or the perpetrator could be seen to blame Michelle for some of the abuse.
- The perpetrator was a domestic abuse perpetrator in previous relationships, that exhibited similar hallmarks to his treatment of Michelle, and shows how past behaviour is often a predictor of future behaviour.
- Similarly, suicide and the threat of suicide remains a significant risk factor in terms of domestic abuse and greater emphasis needs to be placed on how suicidal persons (in domestic abuse contexts) as considered as potentially homicidal.
- There was often a greater onus placed on Michelle regarding what actions she was required to undertake to safeguard herself with a lesser focus on tackling the behaviour of the perpetrator. Where victims are not ready, or feel unable, to engage with services, the risk management plan needs to shift to the perpetrator as the focus of agency action.
- Strong workplace policies are crucial to supporting and encouraging disclosure of abuse. The lack of information sharing, following a sickness

absence potentially related to domestic abuse, was a potential missed opportunity.

- When Michelle did engage with services, she took all necessary steps to be able to safeguard and protect herself from further abuse. She engaged with WWiN and sought appropriate legal advice and support – including the non-molestation order.
- There were missed opportunities to utilise a better degree of professional curiosity to help identify any underpinning issues Michelle may have been experiencing in terms of domestic abuse.
- There are lessons to be learnt in the way language is used by some agencies to describe victims and their involvement with services to ensure that future victims are afforded all opportunities for services to engage with them.
- It is important for victims to feel safe and secure within their own homes. Northumbria Police had no legal basis for making the perpetrator surrender his keys to the property. Agencies need to consider how a wider suite of safeguarding measures can be put in place to help protect victims.
- There was no data collected to help examine the reasons why Michelle did not wish to take up the offer of support services – and this information would be useful to help identify potential barriers to services or gaps in services and help agencies to ascertain if their services are appropriately meeting victim needs.
- Michelle's family, friends and work colleagues were aware, to a greater or lesser extent, of the domestic abuse perpetrated by the perpetrator – but did not know the full extent and severity. There should be a greater emphasis on what advice, support and guidance is provided to bystanders as well as being able to spot signs of domestic abuse.

9 RECOMMENDATIONS

9.1 Based on the chronology, analysis of key findings and conclusions of the Overview Report, the DHR Panel agreed the following recommendations for national, regional and local bodies to help prevent similar incidents from happening in the future:

(1) Northumbria Police to ensure consistent and timely sharing of DVPO information to key partner agencies so as to maximise partnership opportunities to enhance victim engagement and safety.

(2) Safer Sunderland Partnership to engage with local solicitors to identify, better understand and, where necessary, improve the advice, guidance and support they provide to victims of domestic abuse.

(3)	Safer Sunderland Partnership to encourage local public and private sector organisations to review and implement a refreshed Domestic Abuse Workplace Policy
(4)	Safer Sunderland Partnership to commission training sessions to ensure staff with management responsibilities are equipped with the necessary advice and skills to confidently support employees when faced with a disclosure of domestic abuse
(5)	Safer Sunderland Partnership to re-introduce a targeted Sanctuary Scheme that consists of home security measures and outreach support.
(6)	Agencies should look to implement mechanisms to routinely capture and share information on why victims decline access to support services
(7)	Safer Sunderland Partnership to raise awareness of the impact of destructive and victim blaming language when responding to domestic abuse.
(8)	Safer Sunderland Partnership to raise awareness of the signs of domestic abuse; encourage bystanders to report domestic abuse; and promote where to seek advice and support.
(9)	Safer Sunderland Partnership to explore options for earlier intervention with perpetrators of domestic abuse
(10)	Safer Sunderland Partnership to widely disseminate key learning and themes emanating from this Review to promote awareness that the prevention of domestic abuse is 'everybody's business'.

(11) Safer Sunderland Partnership to write to the Ministry of Justice, the Law Society and the Bar Council requesting they flag to solicitors across England and Wales that separation from an abusive partner can also lead to an increased risk to victims

(12) Safer Sunderland Partnership to write to the Home Office and the College of Policing to request improvements are made to the Domestic Abuse, Stalking and Honour-based abuse (DASH) risk indicator checklist (RIC)

10. INDIVIDUAL PARTNER AGENCY RECOMMENDATIONS

10.1 The following recommendations have been made by partner agencies involved in the DHR Panel – as part of their respective IMRs:

10.2 **Wearside Women in Need**

- To explore with Northumbria Police the possibility of future domestic abuse referrals including perpetrator risk indicator measures (to help pre-populate Risk Indicator Checklist and offer greater understanding of a perpetrator's propensity to violence);

10.3 **Sunderland Clinical Commissioning Group**

- To recommend that GPs ensure that patients with complex medical health issues are offered face-to-face appointments.
- To ensure the learning from this review is highlighted to those leading digital transformation across primary care.
- To promote and monitor implementation of best practice in prescribing management in relation to anti-depressants.
- To ensure there is a robust process within CCG for management of DVPOs.
- To ensure the GP practice has a robust process for coding patients when they are informed of a DVPO.
- To ensure that enough information is provided to health staff on MARAC templates so that the context of domestic abuse is understood.
- To incorporate the learning from this review into the Domestic Abuse Health Advocates Pilot in Primary Care.
- To ensure that the high-level information from the review is shared with all Sunderland GPs and Practice staff.

10.4 **Sunderland Care and Support Ltd**

- To raise awareness of domestic abuse within the company and to promote and ensure that support is provided to victims of domestic abuse
- To remind all managers of their responsibilities when a member of staff is reporting an absence and ensure full details are passed to the line manager.
- Ensure managers are skilled and equipped to provide guidance and advice to victims of domestic abuse.
- Ensure domestic abuse is included as part of the company's safeguarding refresher training for its employees (with specific reference to the company's own Domestic Abuse Workplace Policy).
- To actively promote and implement a Domestic Abuse Champions Scheme

10.5 **VictimsFirst Northumbria**

- To refresh procedures to ensure Risk Indicator Checklists are completed by Case Coordinators with victims of domestic abuse for all future referrals.
- To ensure perpetrators history is reviewed by the Case Coordinator as part of future domestic abuse referrals.
- To update the Victim Needs Assessment to include a reason/rationale for a victim declining support/referral.

10.6 **Northumbria Police**

- Static Risk Factors: To consider how static risk factors are identified by officers where present in a relationship and that this specific identified risk factor remains as a constant in all future RIC and risk assessment work.
- Coercive Control: To continue to improve awareness and understanding of Coercive Control which has a serious impact on the victim as well as being a likely underlying factor of domestic abuse incidents and investigations.
- Bail: To ensure all officers investigating domestic abuse related rape investigations where the suspect is arrested, consider an application for bail with conditions rather than release under investigation (RUI) and decision making is fully documented. If this is not granted, further consideration of a DVPN/O should be given if criteria are met.

Domestic Homicide Review – Michelle

Safer Sunderland Partnership

April 2020

https://www.sunderland.gov.uk/domestic-violence