Safer South Tyneside

Domestic Homicide Review

OVERVIEW REPORT

Into the death of Louise

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Section 1. Introduction

This Domestic Homicide Review (DHR) was undertaken in respect of a woman in her 20s who was found dead at her home early in 2015. Her partner admitted to Manslaughter by Diminished Responsibility.

For the purpose of this report, the victim will be called 'Louise', this name was chosen by her family. Her partner, the perpetrator, has chosen to be called by the name Henry.

We would like to express our profound sympathy to the family and friends of Louise and assure them, by undertaking this review, that we are seeking to learn lessons from this tragedy, and to improve the response of agencies in cases of domestic abuse. We are also aware that the family suffered a further tragedy when a family member of Louise's took their own life following her death. We wish to thank Louise's family for their invaluable input into the review process. We also spoke to one of her friends and want to thank her, Friend 1, for her help.

In addition, the Review Panel interviewed Henry and his family and were grateful for the information they shared, we acknowledge that this tragedy has had an impact on so many people.

Every attempt has been made to ensure the anonymity of Louise's two children, the eldest one will be referred to as 'child 1' and the younger one as 'child 2'. All those involved with the family talked about Louise's love for her children and her pride in them.

1.1 Subjects of the Review

Louise	In her 20s	Deceased
Henry	In his 20s	Convicted
Child 1	Under 5 years of age	
Child 2	Under 1 year of age	

Louise, Henry and their children are of White British origin and their identity has been anonymised for the purposes of this report. They lived in a privately rented house within the Borough.

Early in 2015 Northumbria Police were called to the victim's house to a report of the door being kicked in. Upon arrival the body of Louise was discovered in the main bedroom.

Louise had sustained multiple stab wounds to her torso and deep cuts to her face and neck. There were also a number of defence wounds to her hands. The location of her partner, Henry, was unknown at the time.

Louise's partner, Henry, was subsequently charged with her murder. He was convicted of manslaughter by diminished responsibility and sentenced to a Hospital Order with restrictions under Section 37/41 of the Mental Health Act 1983.

Section 2. Domestic Homicide Reviews

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

(b) A member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death.

The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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 these lessons to service responses including changes to policies and procedures as appropriate;
- prevent domestic violence and abuse homicide, and improve service responses for all domestic violence and abuse victims and their children through improved intra- and inter-agency working.

Northumbria Police notified South Tyneside's Community Safety Partnership Board of Louise's death early 2015 and a Core Group met the following day and agreed her death met the criteria for a DHR.

DHRs are not enquiries into how the victim died or who is to blame, that is the purpose of the criminal court and the coroner.

Section 3. The Domestic Review Panel

Independent Chair	Head of Safeguarding, NHS South Tyneside CCG
Overview Report Writer	Independent Social Worker and Trainer
Department of Work and Pensions, Jobcentre Plus	Senior External Relations Manager
NHS England	Quality and Safety Manager (Cumbria and North East)
North East Ambulance Service NHS Foundation Trust (NEAS)	Named Professional for Safeguarding Vulnerable Groups

Northumberland Tyne and Wear NHS Foundation Trust (NTW)	Head of Safeguarding and Public Protection
Northumbria Community Rehabilitation Company	Director of Offender Management Gateshead & South Tyneside
Northumbria Police	Detective Chief Inspector
South Tyneside Clinical Commissioning Group	Safeguarding Adults Lead
South Tyneside College	Principal
South Tyneside Community Safety Partnership	Domestic Violence Coordinator
South Tyneside Council	Strategic Lead – High Impact Families, Service Manager Contact and Early Response
South Tyneside Homes	Tenancy Services Manager
South Tyneside NHS Foundation Trust	Strategic Lead Safer Care
Tyne and Wear Fire and Rescue Service	Watch Manager Community Safety

The Chair of the Panel, Carol Drummond, is a qualified Nurse and Health Visitor with over 40 years' experience with the NHS. She has an MA in Child Protection and has been in a senior role as Child Protection Lead for approximately nineteen years. She is currently employed by South Tyneside Clinical Commissioning Group. Carol has had no direct line management of any professionals involved with either family.

The CCG does not directly commission GP services as this is undertaken by NHS England.

The Overview Report Writer, Di Reed, is a qualified and registered Social Worker with over 25 years' experience. She has experience of both Children and Families and Adult Social Work and extensive experience in Mental Health, particularly managing Forensic Mental Health Services. Di Reed is currently working as an Independent Social Worker and trainer and has completed one previous DHR as an Overview Report Writer.

Section 4. Parallel Reviews

The DHR was held in parallel with the Criminal Investigation and the Court Case, and the Chair of the DHR remained in contact with the Senior Investigating Officer (SIO) to ensure that there were no conflicts between the two processes.

The Chair of the Panel also contacted the Coroner to discuss how the DHR should take into account the Coroner's inquiry.

Section 5. Timescales

The timescale for agency information and the production of the Independent Management Reviews (IMRs) was from the 1st October 2009 up to and including the time of Louise's death. The former date reflects Initial intelligence with regard to when Louise was first known to have formed a relationship with Henry.

Section 6. Confidentiality

For the purposes of confidentiality, the findings of this review are Restricted, until published. Information is available only to the participating officers/professionals and their line managers, until after the Domestic Homicide Review Overview Report has been accepted by South Tyneside's Community Safety Partnership and approved for publication by the Home Office's Quality Assurance Panel. The issue of confidentiality is understood by all participating officers/professionals and it has been explained to the family members who have contributed to the review.

Section 7. Dissemination

The Overview Report and Executive Summary will be shared with members of the Review Panel. The Report will be presented to South Tyneside's Community Safety Partnership Board. The Report will be shared with Louise's family, Henry and his family.

Section 8. Contributors to the Review

The following agencies were asked to secure information and complete IMRs:

- Department of Work and Pensions, Jobcentre Plus
- North East Ambulance Service NHS Foundation Trust (NEAS)
- Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
- Northumbria Police
- South Tyneside Clinical Commissioning Group (who commissioned an Independent GP to complete a report on behalf of the GP Practice)
- South Tyneside College
- South Tyneside Council
- South Tyneside Homes
- South Tyneside NHS Foundation Trust

In all cases, the IMRs were completed by an Officer not directly involved with the victim, the perpetrator, families, or line managed any staff directly involved.

The Chair of the Review Panel and the Overview Report Writer had access to two Psychiatric Reports which were completed on Henry for the Court process. Four were completed in total but only two were available. The Review Panel concluded that in the interests of confidentiality it was not appropriate to disseminate the reports to all members of the Panel nor did they feel that there was anything more to be gained by pursuing the two outstanding reports.

Section 9. Family, Friends and Significant Others Involvement

The Panel recognised the importance that information from family and friends brought to the Review. The Chair of the Panel had regular discussions with the Family Liaison Officer (FLO) and the SIO to ensure the involvement of family and friends.

The Chair of the Panel and Overview Report Writer met with Louise's mother and stepfather and, on a separate occasion, with one of her friends. The Overview Report Writer and the Domestic Violence Co-coordinator met with Henry and, on a

separate occasion, met with his parents. The information from Henry, both families and Louise's friend was invaluable to the review process.

Section 10. Information from Family and Friends

Louise's mother and stepfather were interviewed by the Chair of the Review Panel and the Overview Report Writer. They described Louise as a loving family member who would do anything for her children. She was a bright woman who was ambitious for her family. Her mother and step-father were not aware of any violence in the relationship, the couple had their 'ups and downs' like any other but had been together since their school days. They described the events that happened the day before the incident. Louise's mother said that Henry drove up on the grass in front of her house, she believed that he had waited until Louise's stepfather had left the home before confronting her. Louise's mother said that he was angry and accusing Louise of having an affair and wanted her mother to go with him and confront her at work. When she refused, he attacked her and pulled her hair. She did not realise that the children were in the car until after the incident was over. She contacted Louise who said that she 'had had enough of him and just wanted to concentrate on her and the children'.

The day after the incident, Louise's mother and step-father said that they were getting concerned about her because they would have expected to hear from her. Eventually they broke into the house and found her. They question why Henry and his family did not report her death sooner and that would have saved the family some trauma, particularly Louise's sibling who found her body and went on to take their own life.

Louise's friend, Friend 1 was interviewed by the Chair of the Review Panel and the Overview Report Writer. She talked about Louise being a lovely person who was easy to talk to, she 'lived for her children' and was very proud of them. Louise talked about having her own shop in the future and saw the future with Henry and the children. Louise offered Friend 1 lifts home from work, she drove and sometimes she would have the car and at other times Henry and the children would pick them up or Henry's father. Friend 1 said that when Henry would pick them up he would be friendly and talk about what the children had done that day. She said Henry and Louise made a 'good couple'. Friend 1 also described Henry's father as a nice man and he appeared to get on well with Louise.

In the week leading to Louise's death there appeared to be some changes in Henry's behaviour towards her. This was a busy week at work for Louise and she was working late. Henry would normally ring her at work about once or twice a day, however this week he was ringing approximately ten times a day.

Two nights before Louise's death, Henry rang Louise and accused her of not being at work but somewhere else. Friend 1 could hear Louise saying 'Henry I'm at work, I'm at work'. Louise told Henry to speak to her friend and she would confirm that she was at work. Henry spoke to Friend 1 on the phone who told him 'Louise is working next to me' and apparently Henry replied that he did not believe her and said 'I don't know you are there', meaning at work. Friend 1 said he sounded angry. Louise had

to leave work early on the that particular night because of Henry's behaviour and Henry's father picked her up from work.

On the morning of the day before her death, Henry was in the car when Louise and Friend 1 went to work and Henry said sorry for 'being awkward'. Louise and Friend 1 finished work late that night, approximately 7pm, and Henry and his father came in the car to pick them up. Henry's father was driving and Henry was in the passenger seat next to him with his head in his hands and very quiet. Friend 1 said that he did not say a word, not even hello, which was unusual for him. Louise said to 'ignore him', she did not seem to be upset, worried or anxious about his behaviour. Friend 1 said that she knew the couple had been arguing over the previous week but she was not sure about what.

Henry was interviewed by the Domestic Violence Co-ordinator and the Overview Report Writer. He talked about his relationship with Louise, when they met they were both in year 11 at school. He described their relationship as 'good when it was good and bad when it was bad.' He said that they were both 'a bit paranoid' of each other e.g. they would both accuse each other of things. He said there was no violence in the relationship.

Henry talked about the week leading up to Louise's death 'time was going slowly, he had pains in his head, paranoid thoughts and palpitations'. He said that he had not slept for six days, he would go to bed at 10pm but be restless. He thought Louise was having an affair, some man had sent a friend request on Facebook and he thought that this was the man she was having an affair with, even though it was a joint account. When he talked to Louise she had told him 'not to be so silly'.

In relation to the incident with Louise's mother, Henry said that he had gone to see her because he thought Louise was being unfaithful and not at work and he wanted her mother to go and check it out with him. He did not want to go alone. Henry said that Louise's mother 'went at him twice' and he 'threw her away'.

Henry described having 'paranoid thoughts', he said that his father took him to the walk-in centre on the day before the incident. Initially it was closed but they went back, his father did not go in with him because there was no parking. Henry said he told the GP that he had palpitations and pains in his head. He asked the GP a number of times if he could be 'bi-polar' because he knew someone who was. He asked if he should go to Bede Ward and the GP said if he wanted to. Henry said that he told the GP that he was having paranoid thoughts but did not give any detail, he did not tell him that he thought Louise was having an affair. Henry could recall that the GP gave him some written information and advised that he see his GP at the beginning of the following week, if the symptoms persisted?.

Henry said that he spent the rest of the day with his father and on the evening they all went out and he was going back to his father's house but then Louise texted him to go back home and his father took him home. He could not recall the events of Louise's death but talked about the 'sat nav' taking him to a cliff edge the following day to kill himself.

Henry said that he has been diagnosed with Schizophrenia and the medication is helping him, he wants to concentrate on getting better. Henry said that he has heard voices since he was 14 years old but did not tell anyone because he did not want anyone to think that there was anything wrong with him. He said that he always had ideas that people were talking about him because of his weight.

On reflection, Henry felt that the GP at the walk-in centre could have done more, he could have taken 'blood tests or sent him for help there and then'. Henry said that he felt that he 'wasn't taken seriously by the GP' and if something had been done differently the incident would not have happened. However, he did say that he could not recall if he had told the GP about hearing voices.

Henry's father and mother were interviewed by the Domestic Violence Co-ordinator and the Overview Report Writer. They were contacted separately and chose to be interviewed together and provided invaluable information. They talked about Louise and Henry as a couple and said 'when they were good, they were really, really good but they could have their arguments as well'.

During the week that led to the incident they were aware that Henry thought that Louise was having an affair with a man who had sent a friend request on Facebook. They said that Henry was not angry when talking about this but there was no reasoning with him and he talked about it constantly. They knew Louise was not having an affair but Henry would continue to believe this.

They described how Henry was that week and said that he had physical symptoms of ill health, he complained of pains in his head and palpitations and thought he had a brain tumour because of the pain in his head.

Henry's family talked about the incident between Henry and Louise's mother which occurred two days before Louise's death. They said that Henry was adamant that Louise's mother assaulted him. That night he stayed with his father. He appeared anxious and scared and did not want his father to go to sleep because he couldn't sleep. He was having pains in his chest and heart and appeared frightened.

Henry's father took him to the walk-in centre the following morning, he did not go in with him because he had Child 2 with him and couldn't find anywhere to park. Henry's father said that Henry looked physically unwell, his pupils were large, he was not sleeping, and he appeared anxious and frightened. Henry's parents believed that Henry told the GP all his symptoms, including hearing voices. The parents believed strongly that the walk-in centre should have done more, they said that Henry looked very unwell and presented with all the symptoms of a poster on the wall, presumably one detailing psychosis.

They said that on the night of the incident, Henry's father went to pick Louise and her friend from work with Henry. They dropped the friend off and then went for a pizza, Henry was going to stay with his father but Louise texted to say that she did not want to be alone and therefore his father took him home to her. Henry's father said that he would not have taken him home if he was concerned about his behaviour, on the evening he was presenting as 'quiet and subdued'.

Henry's parents suggested that a couple, who were friends of Louise and Henry, would be willing to be interviewed but they were on holiday abroad. Attempts were made to contact them via Henry's father on their return, but there was no reply. On balance, the Review Panel decided not to pursue this contact as information had been gained from family and friends.

Section 11. Background Information and chronology

Henry came to the attention of the Police in March 1999 when officers on patrol saw two school boys fighting in the street, he was arrested on suspicion of section 47 assault, Actual Bodily Harm. On investigation, it would appear that Henry had been called names by the other boy, he responded by attacking him, punching him in the face and kicking him on the ground. Henry admitted the assault and was reprimanded.

As a young person, Louise had contact with Mental Health Services due to low mood and social stress. In February 2008, the GP made a referral to Northumberland Tyne and Wear NHS Foundation Trust (NTW) in respect of Louise. She complained of feeling tired throughout the day, feeling low and having difficulty with college work and home. Louise was at College and wanted to train as a Nurse, she was also helping to care for her younger siblings because of family ill health. At the time of the assessment, it was reported that Louise had good eye contact and there was no suicidal ideation.

Louise was prescribed anti-depressants and seen by the Community Psychiatric Nurse (CPN). There was evidence within the chronology that Louise reported her mood had improved over the months but she still experienced stress.

The first reference to a relationship between Louise and Henry was a record in the patient notes held by NTW in May 2008. Louise said that she wanted to complete her Mental Health Nurse training but her boyfriend, Henry, said 'he would end the relationship if she went to University'.

The entries for June 2008 in the NTW notes suggested that Louise's mood had 'dipped', that is: lowered, she had missed some of her CPN appointments and time at college because of feeling low in mood and being weepy.

In June 2008, Louise was reviewed by the Doctor at NTW and was found? to be low in mood, weepy and dismissive of Henry. As a result of the assessment, her anti-depressant medication was increased to reflect her mental health problems.

Later in June 2008, Louise was seen by NTW, she said she had 'split up' from Henry. Louise also said her mood was better and she recalled that this was confirmed by her friends.

Louise had 5 failed appointments with NTW and was discharged from their service in August 2008.

Louise presented at the GP surgery pregnant with her eldest child, Child 1. The records indicated that Louise said she wanted to keep the baby but was concerned about being considered a 'young mum'. The entry from the GP records reported that

'boyfriend is happy' but Louise did not want him in the appointment with her. The 'boyfriend' referred to is Henry and the father of Child 1.

In October 2009, Louise stated she was living with Henry.

In December 2009, Louise attended the GP Surgery with eczema and reported feeling stressed because of she was worried about finding a job.

In February 2010, Louise attended the GP surgery with eczema and upper respiratory infection. In the same month, she submitted an application for re-housing to South Tyneside Homes (STH). She stated she was pregnant and the only other occupant listed at the address was Henry's father (Adult B). Louise described Adult B as her uncle.

In March 2010, Louise attended the GP's surgery with a temperature and itchy rash and was prescribed cream.

April 2010, Louise presented to the GP's surgery with a virus condition. Later in the month, Louise presented to the GP's surgery with a history of diarrhoea, colic and muscle strain. She was given advice regarding pain management and to contact the Labour ward if she was concerned about contractions or the baby was moving less.

Louise's first child was born and this was a normal delivery.

Louise presented to the GP surgery with pounding headache and blurred vision. Also there were two attendances at the GP surgery in relation to Child 1 vomiting.

Louise and Child 1 were seen for a post-natal check. She said she was living with her uncle at present (presumably Henry's father) and her boyfriend lived nearby but they had no plans to live together currently. She wanted to go to college and do midwifery.

Child 1 was admitted to Hospital because of diarrhoea and oral thrush, but discharged the same day. Child 1 was seen for the regular checks, health visitor appointments and immunisations and there were no concerns regarding the baby's care and development.

Louise continued to present at the GP Surgery with minor ailments: 14th September 2010 with hair loss and dermatitis; 27th September 2010 with rash and non-specific skin eruption; 7th October 2010 with sore throat and swollen tonsils.

In November 2010, Louise attended the GP Surgery with headaches, she said that she banged her head on the car boot the week before. She was given advice regarding pain relief. On 21st November 2010, Louise attended A&E because of the persistent headaches, the notes recorded that Louise appeared 'anxious in triage, shivering, unsettled.' Louise was reassured and discharged.

There followed a period with a number of health concerns in relation to Child 1:

- 27th December 2010, Child 1 was seen by the out of hour's service because of a viral illness
- 28th December 2010, Child 1 was taken to A&E because of fever and reduced feeding.

- 29th December 2010, Child 1 was taken to the GP surgery with respiratory infection.
- On 9th February 2011, Child 1 was taken to GP surgery with loose stools and unwell.
- 10th February 2011, Child 1 was taken to Hospital with Bronchiolitis and was admitted for observations and discharged the following day.
- 21st February 2011, Child 1 was taken to the GP with a clicking right hip and the GP referred the baby for an ultra sound to rule out a dislocated hip. The baby was seen on the 9th March 2011 following the ultrasound and the hips were normal.
- 4th April 2011, Child 1 was seen at GP? Surgery with loose stools.
- 2th May 2011, Child 1 was seen regarding ongoing viral infection.

April 2011, Louise attended the GP Surgery with sore throat and inflamed tonsils and she further attended the surgery on 12th May 2011 with ocular migraine.

June 2011, Louise took Child 1 to the GP surgery with conjunctivitis. The family were going to Tenerife within the next few days and she was concerned that the baby would not be well enough to go.

1st July 2011 is the date that South Tyneside Homes (STH) were informed that Louise and Child 1 were living at a new address (Address A) but the Housing Association had previous information that the family were already present at that address. The other occupants listed were Henry's father and two others. In a 'Getting to Know You' survey (Tenancy visit) on 15th August 2011 by STH, Louise, Child 1 and Henry's father were listed as tenants and had been there for one year.

In September 2011 Louise contacted the GP Surgery concerned that Child 1 had an allergy to cow's milk. At the consultation, she described the child as a 'happy and hyper active'. October 2011, Child 1 was taken to the GP Surgery with a respiratory infection.

25th November 2011, Henry attended Jobcentre Plus and indicated that he was interested in work experience and his change of address was recorded.

On 29th December 2011, Henry applied for a shot gun licence. On 20th March 2012 this was refused on the grounds that 'he had a violent past, had a degree of immaturity and a casual disregard for the law'.

There followed a number of attendances at the GP Surgery in relation to Louise:

- 29th December 2011 with a two-week pain to her left wrist (she was not able to identify the cause).
- 13th January 2012 with a sore throat and tonsillitis and she was prescribed penicillin
- 27th January 2012 with a low back pain following a road traffic accident.
- 6th February 2012 with dental pain.
- On 20Th February 2012 Louise attended A&E with severe tonsillitis and she was given penicillin and booked in for a tonsillectomy.

The Jobcentre referred Henry to two possible work placements in February 2012 but it is recorded that the outcome is 'not known'. He was referred to the Work Programme in April 2012.

Louise continued with health problems throughout the early months of 2012:

- On 20th March 2012 she attended the GP Surgery with headaches.
- On 26th March 2012 she had acute tonsillitis and was prescribed antibiotics.
- On 4th April 2012 she had menstrual problems e.g. persistent bleeding and attended again on 16th April 2012 for the same problem.

The records indicated that Child 1 also continued to have minor health problems and the following appointments were recorded:

- On 19th March 2012 Child 1 was taken to the GP surgery with eczema.
- On 29th March 2012 Child 1 went to the GP surgery with viral gastroenteritis and eczema.
- On 16th April 2012 Child 1 was taken to the GP surgery with a persistent cough and Louise was concerned about the possibility of asthma.
- On 4th May 2012, Child 1 had a small lump and rash to the nose.

On 11th May 2012, Louise took Child 1 to the GP Surgery with superficial burns to the thumb and fingers on the right hand. Apparently Child 1 touched the exhaust on Henry's quad bike when he looked away for a second.

Louise then had a road traffic accident on 13th May 2012 and attended A&E. She reported pain in her neck, shoulders and lower legs. There followed two appointments at the GP Surgery in relation to this road traffic accident: 12th June 2012 complaining of pain and 14th June 2012 complaining of anxiety.

On 18th June 2012, Henry requested a medical report from the GP for Lawyers Medical Services, this was completed for a fee of £25.

On 22nd June 2012 Child 1 was presented at the GP Surgery because of swallowing a coin, Louise was advised that it was non-toxic and likely to be passed. On 23rd June 2012, Child 1 was taken to the out of hour's service because the coin had not been passed and the child was drowsy. The advice given was to see the GP the following day for a urine sample.

Also on 22nd June 2012 the Police attended a night club where Henry had been assaulted by a group of males. 999 was called and an ambulance dispatched, Henry had sustained an eye and head injury and he was under the influence of alcohol. He attended A&E and was treated and discharged the same night. Henry attended the GP Surgery with acute rhinitis and said he had a blocked nose since the assault. No bruising or swelling indicated.

The next two significant entries in relation to Child 1 were:

- 24th July 2012 for a regular check by the Health Visitor who identified a squint to the right eye and made a referral to ophthalmology.

- On 27th June 2012, Child 1 woke up but was wobbly, Louise then heard a bang and the child was not able to weight bear. Child 1 was taken to the GP Surgery and then A&E and was diagnosed with an irritable hip. A referral was made to the paediatric clinic where the child attended on 30th June. An ultrasound was undertaken, the clicking was likely due to ligaments rather than bones and the child was referred back to the GP for follow up.

Over the next few months, Louise presented to the GP Surgery three times with a sore throat and swollen tonsils. She was given penicillin on 31st August 2012, and advice on 15th October 2012 and 12th November 2012. 19th November 2012 she presented at the Surgery with pain to her breast.

Child 1 was taken to the GP Surgery and seen by the Practice Nurse on 15th November 2012 with burns to the left foot after standing on Louise's hair straighteners. A dressing was applied to Child 1's foot and Louise was advised to keep straighteners away from the child.

During this time, Henry was sanctioned by Jobcentre Plus for failure to attend 22nd August 2012 and 9th October 2012.

On 9th January 2013, it is recorded that the Police had information that Henry was living at Louise's home, Address A, from this time.

Louise was again unwell with her tonsils. On 22nd January 2013 she presented at the Surgery with a sore throat and saw the Practice Nurse. A swab was taken. On 23rd January 2013, Louise presented at A&E with quinsy which is an abscess on her tonsils. This was incised, drained and she had IV antibiotics and was admitted overnight. On 2nd February 2013, Louise went to the GP Surgery with tonsillitis and was given penicillin. Louise presented to the Practice Nurse on 13th February 2013 with ear ache and prescribed antibiotics.

The next major contact in respect of Child 1 was an attendance at A&E on 21st February 2013 with a head injury. The history of the incident was that Child 1 was running around the house and hit their head on a table and plate. Following attendance at A&E, Child 1's injury was treated with a Steri-strip and the child was discharged home.

On 11th March 2013, both Child 1 and Henry presented at the GP Surgery with injuries from a road traffic accident. Both complained of neck pain and in addition Henry complained of pain at the top of his back. There were no obvious injuries to either Child 1 or Henry and they were given advice.

On 26th March 2013, Louise visited the Job Centre to say that she had moved in with her partner that day, Henry. Both Louise's and Henry's claims were amended accordingly. On 31st May 2013, the claim was ended because they had gone abroad. This is normal practice when a claimant goes on holiday.

In March 2013 Henry's father had his shot gun licence revoked for failure to store in a secure place. On 18th April 2013, the Police executed a warrant at the address where Louise, Henry, Henry's father and Child 1 lived. Henry's father had been arrested for supplying cannabis but this charge was later dropped. During the

execution of this warrant, the Police found a quantity of ammunition in Child 1's bedroom. Due to this, a referral was made to Children's Services. Henry's father said that he had forgotten to dispose of his bullets after his licence had been revoked and there was no further action from Children's Services.

Louise was confirmed as pregnant and both her and Henry made a joint application to STH for re-housing.

On 10th and 11th April 2013 Louise was experiencing abdominal pain, vomiting and diarrhoea. 18th April 2013, Louise was seen for slight vaginal bleeding and given antibiotics. On 2nd May 2013 Louise had a miscarriage.

Henry ended his claim for Job Seekers Allowance 31st May 2013 because he went abroad. He was awarded it again 18th June 2013.

On 23rd June 2013, Louise was seen by the out of hour's GP service with back pain caused by lifting Child 1 at the park. On 27th June 2013, Henry called 999 for an Ambulance for Louise because of persistent back pain. She was taken to A&E and diagnosed with muscle pain and she was discharged back to the GP.

Louise was seen again at the GP Surgery for tonsillitis on 3rd July 2013 and given penicillin, and on 25th July 2013 for a sore throat.

There was a letter dated 27th August 2013 from the Ear, Nose and Throat department (ENT) at Sunderland Hospital regarding a tonsillectomy for Louise. Apparently she had previously been too afraid to proceed with the operation. On 10th October 2013, Louise attended as a day patient for a bilateral tonsillectomy. She attended the GP Surgery 16th October 2013 with severe pain following the tonsillectomy.

On 11th October 2013, Henry was seen with viral warts and bilateral tinnitus caused by a road traffic accident 3 years ago. He was under the care of an ENT consultant as part of an insurance claim.

Child 1 was seen at the GP Surgery on 20th November 2013 because of a stammer and frustration because of an inability to communicate effectively. The child was referred to South Tyneside NHS Foundation Trust (STNHSFT) Speech and Language Department.

On 9th December 2013, Louise saw the Practice Nurse and said she was pregnant. On 12th and 13th December 2013, Louise had some slight vaginal bleeding. On 16th December 2013, Louise had a scan and no problems were found with her pregnancy and she was advised to book in with the midwife.

Henry was seen by the Consultant for tinnitus 16th December 2013, and it was noted that he had suffered a number of road traffic accidents. The tinnitus was classified as moderate/severe and permanent.

On 2nd January 2014 Louise was seen at the Job Centre and informed them she was starting a course on 6th January 2014. Henry signed off Job Seekers on 8th January 2014 because he had started self-employment.

Louise attended South Tyneside College (STC) from 16th January 2014 to 11th July 2014 on a Level 3 course. During her time at college, she expressed no concerns to her lecturers. Her attendance was 75% which was slightly low but not cause for concern.

On 17th January 2014, Louise was seen at the antenatal appointment. At this appointment, she was asked by the Midwife if she had ever suffered from 'any form of domestic abuse' and Louise answered 'no'. There was no record of who was present with her.

On 28th January 2014, Child 1 was seen by a speech and language therapist at STNHSFT Speech and Language Therapy Department (SALT). Louise was present and the outcome of the assessment was that the child's speech was intelligible for 70 – 80% of the time.

Louise was seen at the GP Surgery with a head injury on 29th January 2014 and continued headache and tenderness on 7th February 2014.

Louise attended SALT by herself on 25th February 2014 to give a history. 1st April 2014, there is reference to SALT intervention and Louise reported that Child 1 was better since the treatment started. A referral was made for a hearing assessment and this was normal. SALT wrote to the GP on 27th May 2014 to summarise their involvement with the Child 1 describing the child as an 'active child, some delay to attention and listening skills which can impact on the use of language in conversation and make the social use of language delayed for the child's age.' SALT set targets for the parents and nursery and an active support session was arranged for 3rd June 2014. This appointment was not attended and a follow up appointment sent.

Child 1 was seen by the Out-of-hours Doctors on 18th April 2014 for a rash and by the GP on 24th April 2014 for eczema.

On 17th June 2014, a report was made to the Police by Henry's paternal aunt claiming that both Henry and his father had attended her address and Henry had forced entry by kicking the door. Henry's father had threatened and assaulted his sister's partner. Henry was arrested and given a caution for criminal damage and his father was convicted of assault and received a 6 month conditional discharge.

During her pregnancy, Louise complained of Irritable Bowel Syndrome and iron deficiency and raised this at a number of antenatal appointments – 19th June, 26th June and 9th July 2014.

Louise was seen by the Health Visitor for an antenatal home visit. Other family members were present and therefore the question about domestic abuse was not asked. Her mood was described as 'alright' but she said that she found the pregnancy hard and tiring. Louise said she had good family support.

Louise's baby, Child 2, was born. There were no problems with the delivery and it was recorded that she was on her own during the birth. There is a record in the GP notes to monitor for mental health problems because Louise had suffered from depression in the past.

During this time, Henry fell and twisted his left knee resulting in pain and difficulty walking.

Following the birth of the baby, the Health Visitor completed a home visit. Louise, Henry and both children were present. No routine or selective enquiry was made about domestic abuse as Henry was there during the interview. Henry was observed feeding Child 2.

In August and September 2014, Child 2 was seen for infantile colic and admitted to Hospital on 17th September 2014 for observation. Child 1 was seen for gastro oesophageal reflux and eczema.

On 18th September 2014, a routine assessment was undertaken by the Health Visitor. Child 2 was developing normally and Louise was not expressing any concerns. She declined the offer of attendance at the Children's Centre and said she received a lot of support from the family.

On 24th September 2014, there was a telephone call between the School Nurse and School staff expressing concerns that Child 1 had Attention Deficit Hyperactivity Disorder (ADHD) tendencies e.g. chewed wheels off toy cars, the child rubbed a cord from a PE bag around their own neck and caused a friction burn but did not express any pain.

On 1st October 2014, the school held a regular review of children whose behaviour caused concern, Child 1 was discussed because of odd and challenging behaviour e.g. chewing things, making silly noises and struggling to remember some basic knowledge such as own group colour. The Class Teacher discussed the concerns with the parents and the School Nurse, who suggested a visit to the GP. Child 1 was reviewed by SALT at School on 3rd November 2014 and there were concerns that Child 1 may have ADHD.

Child 1 was taken to the GP surgery on 14th November 2014 because of concerns at school about behaviour. Louise reported that the child was a 'pleasure at home' but the Teacher noted a change in behaviour last year. The School Nurse advised a visit to the GP as the quickest route to address the behaviour. It was reported that Child 1 would hit and bite others but Louise said this was play fighting. Child 1 went to bite Child 2, the baby. Child 1 had poor concentration and school were ringing Louise daily about the behaviour. When the GP examined Child 1 there was no challenging behaviour but the decision was made that if behaviour continued a referral could be made to Children and Adolescent Mental Health Services (CAMHS).

Louise and Henry were in a road traffic accident on 21st October 2014, Louise reported pain in the back and neck the following day. Henry attended the out of hour's service with stiff neck and pain.

Henry was seen by the Police on 1st November 2014 as a suspect in the theft of a watch but this was not taken any further and he was eliminated from their enquiries.

On 17th November 2014, Louise attended the GP Surgery with lower abdominal pain. She said that she had started back at work part time and was slightly anxious.

On 18th November 2014, Louise contacted the Early Help Team expressing difficulties with Child 1. She had been to the GP for advice and a form was given to the school to be completed. Louise said she dreaded taking and picking the child up from school and wanted help. The school reported that communication with Louise had broken down.

24th November 2014, there was a meeting at school regarding Child 1. Attendees were: Henry, Louise, the Assistant Head and Inclusion Manager (AHIM), and the Family Support Officer (FSO). Louise said she was struggling with Child 1's behaviour at home, because of a lack of listening. Her and Henry were struggling to manage boundaries and this was always the case but intensified when the new baby arrived (Child 2). Also Louise working part time had exacerbated the situation. The school had suggested a referral to a Support Assistant (SA) for one-to-one and nurture group work. Also positive behaviour charts to be used in class and the FSO to visit Louise at home on 27th November 2014. Child 1's level of ability was discussed and Henry expressed concern about this.

27th November 2014, the home visit was made by the FSO and Louise expressed concern about Child 1 hitting and digging at Child 2, wetting the bed, using a bottle until summer 2014, eating rubber, not liking loud noises and finding it difficult to follow rules. Louise said that her and Henry had different parenting styles. She tried to establish boundaries but Henry was more relaxed. Louise now goes out to work more and Henry does more of the parenting. Child 1 has a GP appointment on 2nd December 2014 and a SALT appointment 13th December 2014.

On 1st December 2014, Child 1 was allocated to an Outreach Worker (OR), Early Help, to provide support around behaviours in the home.

On 2nd December 2014, Louise attended the GP Surgery to discuss Child 1. The decision was made to refer the child to CAMHS and a referral letter was sent 8th December 2014.

On 8th December 2014, a meeting was held at school. The parents were invited but did not attend because Child 1 had bumped their head and was not in school. However, the parents rang the school about Child 1 falling. Louise and Henry also wanted Child 1 moved to a different class away from another child who they considered to be a bad influence. The meeting was attended by the Outreach Worker, FSO, Special Education Needs Co-ordinator (SENCo), and the Assistant Head and Inclusion Manager (AHIM). The school felt that the other child did not influence Child 1 but the latter is influenced by bad behaviour in general. The decision was made for the Outreach Worker to visit the home with the FSO to complete an Early Help Assessment.

On 11th December 2014, there was a meeting at School with Louise, AHIM, FSO present. Louise said she was concerned about Child 1, as parents they had different parenting styles and that Henry would undermine any strategies that she was trying to put in place. Also Child A spent a lot of time with the parental grandfather. Both Henry and his father felt that the child's behaviour was typical of a child that age and

not a real cause for concern. The decision was made for the FSO to refer to the School Nurse.

On 11th December 2014, the Health Visitor visited the home to complete a routine assessment on Child 2. Louise was not asked about domestic abuse because Henry was present. There were no concerns reported, Louise reported that she had gone back to work part time, her mood was 'good' and she said she had family support.

On 12th December 2014, there was a joint visit by the Outreach Worker and the FSO to the home. There was a discussion around what services were available and Louise said she was not happy with the support from the school. It was agreed that the Outreach Worker would undertake 'Incredible Years Parenting' with the family within the home and complete an Early Help Assessment.

On 16th December 2014 there was a home visit by the Outreach Worker. Louise said she was worried about Child 1's behaviour. She said that Henry was never in the room with the family and would spend most of his time on the phone. Henry said he was buying, selling or browsing.

On 16th December 2014 there was liaison in the School between DG and the School Nurse who expressed concern about Child 1 eating inedible foods. The records indicated that there was a signpost to CAMHS and DG requested a Paediatrician referral. On 12th January 2015, NTW declined the referral in respect of Child 1, suggesting that because of the child's age a referral to a Consultant Paediatrician would be more appropriate to assess for any organic factors. If this was ruled out a further referral to CAMHS could be made.

On 12th January 2015 there was an Initial Early Help Meeting at the School in respect of Child 1. In attendance was CT, FSO, AHIM, SENCo, SA, Louise and Henry. The Outreach Worker was not in attendance. Child 1 continued to put inedible objects in the mouth and was not picking up phonic sounds. Louise said Child 1 did this at home. Child 1 also shouted in the Nurturing Group, which was repeated at home. Louise said that Child 1 was spoilt by the paternal grandfather, and that there were still conflicting parenting styles. The meeting felt that Child 1's problems were medical in nature and requested that Louise ask the GP to refer the child to the Paediatrician. It was agreed that to complete the targets for the Early Help plan the School Nurse should be in attendance and the next meeting was planned for 26th January 2015.

On 13th January 2015, Louise attended the GP Surgery with the Family Support and Lead for Early Help. Child 1 was not present but Louise discussed her concerns and said there were ongoing behavioural problems, e.g. Child 1 imitated a sword fight with scissors, kicked a child in class and grabbed another child. Child 1 swung another child around and dropped him or her. Child 1 was unable to maintain attention and had a high threshold for pain. Following the advice from CAMHS the GP made an urgent referral to a Paediatrician.

On discussion with the FSO, Louise said that neither Henry nor his father had engaged well at school and they seemed reluctant to believe that Child 1's behaviours were not just typical of a child of that age.

On 14th January 2015 there was a home visit by the Outreach Worker. Louise felt that Child 1's behaviour at home had improved and that Henry was 'more on board'. A referral to the Paediatrician had been made by the GP.

26th January 2015 there was an Early Help meeting at the school. The appointment with the Paediatrician was scheduled for 17th February 2015. SALT was going to refer to Occupational Therapy regarding Child 1's sensory needs and for an assessment in respect of attention and listening skills. The Outreach Worker was going to continue with the Incredible Years work with the parents focussing on behaviour and play. Louise was concerned that the Child 1 may have 'something wrong' because of the extra support and was reassured that it was not unusual for some children. The GP was chasing up an appointment with CAMHS.

On the same day as the meeting there had been an incident in school, where Child 1 and another child had been involved in 'strangling a third child with a scarf'. Louise was asked to take Child 1 home.

On 17th January 2015, Louise rang the school to express concern that the children were not being appropriately supervised because of the previous incident. She was reassured that supervision was in place and was advised to take Child 1 back to school that afternoon. On 5th February 2015, Louise discussed the incident with the Outreach Worker and said she did not feel that the school handled it well. Louise was advised to discuss this with the school. The Outreach Worker noted that Child 1's behaviour appeared to have improved at home.

On 17th February 2015, Louise and the FSO attended for the Paediatrician's appointment which was cancelled because the Doctor was off sick. The next appointment was scheduled for 17th March 2015. The suggestion was made that the next Early Help meeting be re-scheduled following this appointment.

During the period of January to March 2015, the following interventions were in place for Child 1: 15 sessions in the Nurturing Group, Outreach Support, SALT, an extra classroom assistant to manage behaviours and extra lunchtime supervisory assistant for Child 1 and one other child.

Louise was seen at home by the Outreach Worker on 25th February 2015 and 6th March 2015 and Louise felt that Child 1's behaviours had improved and she was continuing to use the strategies.

During this time, Louise had some problems with pain. She went to the GP with neck pain 9th February 2015 following a previous road traffic accident and then on 11th March 2015 with abdominal pain and she was to be referred to a Specialist.

6th March 2015 Louise received a letter from the Specialist to prescribe medication for the abdominal pain. The GP followed this up on the 10th March 2015 with a telephone call. Louise said she was fed up with the pain and having multiple examinations by different people and not getting to the bottom of the pain.

On 9th March 2015 there was a telephone call from the SENCO to say that the Early Help meeting had been re-arranged to 23rd March 2015.

On 11th March 2015 Child 2 was seen by the GP with acute bronchiolitis and eczema but generally presented as healthy and happy.

Two days before Louise's death, the Police were contacted by Henry stating that he had been assaulted by Louise's mother. He later retracted this and said that it was merely an argument because he 'found out that Louise was having an affair'. There was no indication that Louise was having an affair, rather it was a belief held by Henry. This incident was recorded as a domestic abuse incident and the recording was confusing. Louise's mother and Henry have a different interpretation of this incident, with Louise's mother alleging that Henry assaulted her.

The Police Officer recorded Louise as the perpetrator of the assault because she was the reason given for the incident i.e. that Henry believed she was having an affair. The Officer considered it to be a domestic abuse incident. The documentation completed by the Police to record the incident allows for a text box to be completed to provide further explanation. This was not completed and there was no explanation of why Louise was recorded as the perpetrator. There was an internal investigation by the Police and the recording of Louise as the perpetrator was considered to be an error by an individual Officer and not a procedural issue. Henry then retracted the allegation. Both children were present in the car but this was not known by the Police at the time and only came to light after Louise died. Due to the retraction, neither Louise nor her mother were spoken to by the Police.

On the morning of Louise's death, Henry was taken to the out of hour's GP by his father. He went to see the GP alone and complained of palpitations, anxiety, stress and low mood. Henry denied suicidal ideas. The conclusion was that his symptoms were stress related and he was given the contact number for Talking Therapies.

The following day, the Police were contacted because three men were trying to break into Louise's house. These were Louise's family and they were concerned about her because they had no contact with her all day. Louise was found in the house, the Police performed CPR and the ambulance was called. Sadly, Louise was reported dead.

From the Police report, following his arrest, Henry said they had gone out for a pizza the night before with Henry's father. The plan was for Henry to stay with his father, therefore they first dropped Louise at home and began to drive to Henry's father's home. Henry then received a text from Louise to say that she did not want to be alone and therefore Henry's father drove Henry back to the family home. The Police confirmed that Henry received this text from Louise. The children were with their paternal grandmother.

From the Police report and information from Henry, he said that he heard voices to kill, he saw Louise in bed but did not think it was her. There was a knife in the room and he picked this up and stabbed Louise. Early the following morning, Henry took a taxi to his car, which was at his father's house, and then drove to a number of places. He returned to South Tyneside and went to see his father. It appears that he told his father that he had stabbed Louise and some of his family attended the address and found her body. The details around the circumstances at this point are

confusing. Louise's family were concerned that they had not seen her and three family members broke into the house that evening and found her in the bedroom. Henry went with his father to the Police station to say that he had stabbed Louise and he was arrested. His father was initially questioned but was later released with no charges.

Henry was seen in the Police Station by the Criminal Liaison Nurse. He was said to be acting in a 'suspicious manner', he was unsure of the date and year but knew where he was. Henry declined to discuss the reason for his arrest but wanted to speak to a Solicitor and be put before a Judge. The Criminal Liaison Nurse described him as vague and distracted, looking around the room and smiling at the ceiling. He asked the Nurse if they could smell burning but there was no smell. He said over the last three weeks he believed that Louise was having an affair, he also said that he thought he had died and was in hell. Henry said he had driven to Leeds after hearing songs and voices making reference to him and he took this as a sign to attempt suicide, he said he had jumped in a lake but got scared and cold and returned home. He denied any current attempt of self-harm or suicide. The Nurse made the decision that a Forensic Assessment needed to be made by a Consultant Psychiatrist. In consultation with the Psychiatrist the decision was made to do a full assessment once Henry was remanded in Prison.

A Child Notification was made in relation to the two children and a strategy meeting was held. The children were staying with paternal grandmother at the time of the incident and they initially remained there but eventually they were made the subject of interim Care Orders and placed with maternal grandmother and their step-grandfather.

Section 12. Terms of Reference

The panel sought to examine the following questions:

1. Each agency's involvement with the victim and the person charged with the homicide between 1st October 2009 and the time of Louise's death. These dates were not exclusive and agencies should ensure that any significant relevant information prior to these dates was included.

2. Whether an improvement in internal and external communication and information sharing between services might have led to a different outcome?

3. Whether key opportunities for assessment, the timeliness, decision making and effective intervention were identified?

4. Whether appropriate services/interventions were offered/provided and/or relevant enquiries made in light of any assessments made?

5. Whether agency transition planning arrangements were sufficiently robust?

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner?

7. What training practitioners and managers had received and whether this was sufficient to enable them to carry out their roles effectively?

8. What impact did the services provided by each agency have on identifying and dealing with co-existing factors such as mental health, substance or alcohol missies or domestic violence?

9. Whether the work undertaken by services in this case was consistent with each organisation's:

    - Professional standards

    - Domestic violence policy, procedures and protocols

10. Were agency procedures in place and fit for purpose?

11. Whether practices by all agencies were sensitive to the nine protected characteristics as defined by the Equality Act 2010?

12. If there was a low level of contact with any agencies were there any barriers to either the victim or the person charged with the homicide accessing services and seeking support?

13. Does each agency hold any information offered by informal networks? For example, the victim or person charged with the homicide may have made a disclosure to a friend, family member or community member.

14. Was there evidence of robust management oversight of the case including whether practitioners working with either the victim or perpetrator had received appropriate supervision and was this of the required frequency and quality?

15. Were there issues in relation to capacity, resources or organisational change over the period of the review that impacted in any way on partnership agencies ability to respond effectively?

Section 13. Domestic Homicide Concluding Report

There was no evidence of excessive alcohol or drug use in relation to either Louise or Henry, and it was not considered relevant to the incident. The following is a review of all the IMRs:

13.1 Review of the IMR prepared by DWP Jobcentre Plus

The Electronic records held by the Jobcentre were scrutinised. No staff were interviewed for the purpose of the IMR.

Louise was recorded as a lone parent and therefore there was very limited face to face and telephone contact with her. She first claimed for Income Support (IS) in April 2011 and this was a claim as a lone parent.

In March 2013 Louise notified the DWP that she was moving in with her partner, Henry and therefore Henry began claiming for the family unit.

There was one further contact with Louise in January 2014 when she notified them she was starting a course at College and she indicated she was pregnant.

Henry had a number of claims for benefits and there was regular face to face contact at various times. This was largely confined to contact with a number of Job Centre Advisors or Assistant Advisors. Henry appeared to comply with the policy of fortnightly attendance to sign for his benefits and job search interviews, although there were some episodes of sanctions.

Henry first started claiming Job Seekers Allowance (JSA) in July 2011. At this time, he was claiming as a single person. There were three periods where his benefit claim had been disallowed and a sanction imposed. The IMR indicated that sanctions can arise for a number of different reasons including where a claimant fails to participate in an Advisor interview or intervention without good reason.

There were two separate periods when the claim was terminated because Henry had gone abroad, May 2012 and May 2013. This is in line with the Job Centre's policy and procedures.

It would appear that Henry generally complied with what was expected of him, it was not clear from the IMR what his hopes and expectations for work were. However, Henry did start his own business as a causal worker and at this point signed off from Job Seekers Allowance.

13.2 Review of IMR prepared by North East Ambulance Service NHS Foundation Trust (NEAS)

The report was prepared by scrutinising the electronic records, no staff were interviewed because on all the occasions of contact with Louise or Henry different members of NEAS staff were involved.

NEAS had two contacts with Henry, the first contact was when he was assaulted in a nightclub in 2012. The second contact with Henry was on 14th March 2015 when his father made a 111 call to say that Henry was experiencing palpitations. The call was triaged according to the NHS Pathways and there was no indication that Henry required an Ambulance response and was advised to attend A&E within the hour.

In relation to Louise, there were seven contacts, including on the day of her death. There were 3 face to face contacts. The first contact was 23rd January 2013 when Louise was believed to have symptoms of Quinsy.

The second contact, 27th June 2013 when Henry made a 999 call because Louise was unable to move because of back pain. This was a non-traumatic injury, Louise had been seen by the GP and been diagnosed with muscle spasm and medication given.

The final contact was when a 999 call was received by the Police to report Louise's death.

There were four telephone contacts made to 111 relating to physical ill health e.g. persistent vomiting and diarrhoea or pregnancy related and experiencing a bleed.

The author of the IMR found no evidence of concerns regarding domestic abuse. The response of the Call Handlers and Ambulance Crews appeared appropriate. There was no evidence that routine or selective enquiries into domestic abuse were made.

13.3 Review of IMR prepared by South Tyneside NHS Foundation Trust (STNHSFT)

The author of the IMR reviewed all electronic records relating to Louise, Henry and their children. The Health Visitor was interviewed. The School Nurse no longer works within the Trust but the Child Health Records were accessed.

Within the timescales of the Review, the first contact with Louise was during the pregnancy with Child 1. Louise said she was living with Henry at the time. The pregnancy and birth appeared uneventful and following the birth the Midwife and Health Visitor (HV) did not identify any concerns. The author of the report clarified that at the time routine enquiries during pre and post-natal contact were not standard practice. Due to policy changes and training, routine enquiries are now part of standard documentation.

There was an incident on 21st November 2011 when Louise attended the A&E Department due to a head injury caused by a car boot. She experienced visual problems and was discharged to the care of her GP. This was a missed opportunity to ask about domestic abuse.

On 31st March 2011, Louise admitted to the Health Visitor in a routine visit that she found parenting hard and tiring but she enjoyed being with her baby. It was not clear what support she got from Henry and grandparents.

Child 1 attended A&E on 3 occasions between July 2012 and May 2014. The first occasion was for an ‘irritable hip’, the second for a head injury and the third for a knee injury. On all occasions Child 1 was discharged back to the GP.

On 27th June 2013, Louise attended A&E with upper back pain and muscle injury, there was no routine or selective enquiry made.

On 16th December 2013, Henry attended the Ear, Nose and Throat (ENT) Consultant for tinnitus (ringing in his ears). The assessment was in response to a Claims Lawyer. It was reported that Henry gained a number of musculoskeletal injuries e.g. whip lash following a number of road traffic accidents.

On 16th December 2013, Louise was seen at the Early Pregnancy Assessment Clinic. She was seen on 8th January 2014 for a ‘meet and greet appointment’ at the GP clinic. Louise was seen the following week for the antenatal assessment and it is at this appointment that routine/selective enquiry is made about domestic abuse, Louise replied ‘no’ to the question.

Between November 2010 and October 2014, Louise attended A&E four times for road traffic or car accidents. These injuries were never questioned and no routine or selective enquiry was made.

Louise was seen on 21st July 2014 by the HV for a planned visit. No routine or selective enquiry was made because family members were present during the visit.

The baby was born and it appeared that Louise had no family or friend present with her which is considered unusual.

Following the birth of the baby there were routine visits from the HV. Three visits were recorded and on all occasions Henry was present and no routine or selective enquiry was made.

On discussion with the HV, the author of the Report recorded that she was aware of the policy to ask routine or selective questions about domestic abuse but there was no opportunity to do so. If the circumstances had indicated a concern she would have created an opportunity to ask these questions.

During this time, Child 2 needed to be seen by STNHSFT because of skin problems and gastro-oesophageal reflux problems. No concerns about the home situation or parenting were noted.

The author of the report accessed the School Nurse's records and there were problems identified with Child 1's behaviour in school and possible Attention Deficit Hyper-activity Disorder (ADHD). It appears that the relationship between Louise and the school was difficult and Louise was involved with the Early Help team. From the records, there was no evidence that the School Nurse made any attempt to discuss Child 1's behaviour directly with Louise or sought to review the child in school. It would have been considered good practice when both school and mother were reporting their concerns that the School Nurse should make herself available to facilitate a meeting or assessment to understand the situation and identify possible health intervention or referral opportunities. The School Nurse left the employment and therefore has not been available to interview.

There were missed opportunities to make regular routine and selective enquiries, either when Louise was seen at A&E, during contact with the HV and when problems arose with Child 1's behaviour at school. The author of the report outlined the Trust's policy and responsibility to make routine and selective enquiries. The Trust provide:

- Level 3 Domestic Abuse Training
- The training is incorporated into the Trust's Domestic Abuse Guidance (2014), Safeguarding Children Policy (2014) and Safeguarding Adults at Risk Policy (2015)
- Routine and selective enquiries are incorporated in the standard documentation within Maternity and Child Health Records
- In addition, during 2014 targeted training was provided to staff in the A&E Department, both children's and adults, due to lessons learnt from a previous DHR.

13.4 Review of the IMR prepared by South Tyneside College

Louise commenced a Level 3 City and Guilds Diploma at College. The course was 15 hours per week and she achieved 75% attendance. This was low but there was no cause for concern expressed by Louise or the College. Louise passed the course and completed all of her required course work.

The College provide all staff with Safeguarding Training. Staff are aware of how to raise concerns about students' welfare and no concern was expressed in relation to Louise.

13.5 Review of the IMR prepared by Northumbria Police.

The information was taken from the electronic records held by the Police and the Officer who dealt with the incident between Henry and Louise's mother two days before Louise's death was interviewed.

Northumbria Police had no significant involvement with Louise.

There was little involvement with Henry. He came to the attention of the Police in 2004 as a schoolboy when he had a fight with a fellow pupil. He was arrested for this and received a reprimand. The incident was described as two boys fighting.

In 2009, Henry was stopped for driving his car with an illegal registration plate. He was issued a Vehicle Defect Rectification Scheme form in order to get the registration replaced.

Henry applied for a shotgun licence but was refused because of the assault in 2004 and disregard for the law (he continued to display the illegal registration plate).

In 2013 a warrant was executed at the home address of Henry, Louise and Child 1. During the search a quantity of ammunition was found in Child 1's bedroom and Henry's father was questioned about this and a Child Concern Notification was submitted to Children's Social Care.

In June 2014, a report was made by Henry's paternal aunt to the Police saying that her brother and nephew had broken into her house by kicking in the rear door and Henry's father had assaulted her partner. Henry was arrested and cautioned for criminal damage and his father was convicted for common assault.

The IMR details the events leading to Louise's death. Much of this information in the Police report appears to have been taken from the investigation into her death and was information provided by Henry's family after the incident.

It would appear that during the days leading to Louise's death, Henry had been behaving 'erratically' and became fixated on the possibility that Louise was engaged in an affair with a 'black man' who was a friend of her employer.

Two days before Louise's death, there was an incident at Louise's mother's house, although there are differing accounts. Apparently Henry attended Louise's mother's house and confronted her about why she had not told him about Louise's infidelity. The incident was reported to the Police by Henry but not Louise's mother, he said that she had assaulted him. It later came too light that the two children were in the

car at the time of the incident but this was not known at the time. The allegation against Louise's mother was later withdrawn by Henry. Louise's mother said on interview with the Panel members, that Henry assaulted her.

This incident between Henry and Louise's mother was confusing because of the manner in which it was recorded. The Investigating Police Officer recorded Louise as the perpetrator. There followed an internal investigation by the Police and it was seen as an individual Officer's error to record the offence against Louise and therefore unlikely to happen again. However, the Review Panel expressed concern that Louise was recorded as a perpetrator when she was neither present at the incident nor responsible for the assault. It is important to ensure that this error would not occur in the future.

The assault against Louise's mother was considered to be 'common assault', Henry said he was 'pushed away' by Louise's mother. The Police Officer made a risk assessment and it showed the victim (Henry) to be at standard risk and the risk factor recorded was 'isolation'.

The record of 'standard risk' was considered appropriate as there had only been one notification of a domestic incident. Given this level, there was no requirement of need for a response to be escalated. Henry's mental health was not identified by the Police as a co-existing factor. On the custody record for his arrest for Criminal Damage 2014 it was documented that he was 'fit and well, not under any medication, he had not attempted self-harm in the past. He had no known or disclosed medical, mental health or self-harm issues and did not want to see the force medical officer.'

The learning point from this incident was that all allegations of domestic abuse should be 'thoroughly and robustly investigated' as stated in the current force policy on crime investigation. It would have been appropriate to talk to both parties involved in the incident, Henry and Louise's mother. Louise was not present during the incident and her only involvement was Henry alleging that she was having an affair.

On the same day as the assault against Louise's mother, Henry visited his own mother's house and said that he was 'hearing voices', he said that he and Louise were arguing and he accused her of having an affair. Henry stayed at his father's address that night and Louise returned home with Child 2 as Child 1 had already fallen asleep and therefore remained with his paternal grandmother.

The family were concerned about Henry and therefore his father took him to the walk-in centre on the following morning. The Doctor discharged Henry with no medication and advised him to see a specialist the following week.

Louise was at work the day that Henry went into the walk-in centre. After work, she, Henry and his father went for a pizza. Henry dropped Louise off at the end of the night and Henry was going to stay with his father. Louise texted to say she did not want to be alone and Henry returned home to Louise.

Henry's account to the Police was that during the night, he woke up and walked around the bedroom with a knife which he kept in the room. He said he was 'hearing voices saying that Louise had been sleeping around'. He said he looked at the

person in the bed and it looked like Louise but he didn't think it was her. He stated he stabbed her but he was not sure how many times.

Following this, Henry left the address, rang for a taxi and went to pick his car up. He drove round as far as North Yorkshire, returned later in the day to his father and he informed him that he had killed Louise.

Henry was subsequently charged with the Murder of Louise.

13.6 Review of the IMR prepared by South Tyneside Homes

The author of the IMR reviewed the electronic records, both in relation to the tenancy and re-housing and the database which holds details of any anti-social behaviour records. One Officer was interviewed in relation to the housing applications submitted by Louise.

Louise's housing history is confusing. She was the occupant at three addresses before her last tenancy. She was shown to be the occupant of her last address since July 2011. This address was initially a joint tenancy between Henry's father and another adult male. Apparently Henry's father was the ex-partner of the other gentleman's mother. Henry's father was recorded as being the occupant of Louise's last address from March 2007. The other male, relinquished his half of the tenancy in June 2007.

A 'Getting to Know You' survey completed in August 2011 indicates that Louise had lived in the property for one year and she detailed her relationship with the tenant (Henry's father) as 'niece'.

The property was bought by Henry's father in October 2013 under the 'Right to Buy Scheme'.

There was one complaint made by Louise against the neighbours, this was recorded as Anti-Social Behaviour and related to their children. A home visit was made and a follow-up telephone call and it appeared that the issue had resolved itself.

Louise submitted a further housing application in April 2013 to include her partner, Henry and Child 1. This application was completed on line. Henry was registered as being an occupant at another address.

In terms of the involvement of South Tyneside Homes, there was nothing to indicate any concerns in respect of housing issues or relationships and particularly from the point of Louise and the family living in a private tenancy.

13.7 Review of the IMR prepared by Northumberland Tyne and Wear NHS Foundation Trust (NTW)

The author of the report scrutinised both paper and electronic records and interviewed two members of staff.

In relation to Louise, she was known to NTW during 2008 when she was referred by her GP. This was in relation to her home situation and relationship problems. She was seen by the CAMHS Consultant Psychiatrist. She was prescribed anti-depressants.

It was recorded that Henry was Louise's boyfriend. She said she wanted to be a Nurse but that if she went to University he would end the relationship. It is also recorded that they had split up by the end of June 2008.

There is evidence that Louise's mood improved, she failed to attend five appointments and she was discharged back to the GP in August 2008. There was no further involvement with Louise.

Child 1 was referred to CAMHS by the GP in December 2014. Louise was expressing concern about the child's behaviour at school and home. This referral was declined by CAMHS and a letter sent to the GP to suggest that a referral be made to the Consultant Paediatrician to rule out any organic reason for the difficult behaviour.

In relation to Henry there was only one contact and this was at the time of his arrest and a referral was made by the Custody Sergeant to the Criminal Justice Liaison Nurse (CJLN). A brief assessment was completed and the following information was recorded:

- Henry said there was no family history of mental health or drug and alcohol problems
- He was initially unsure of the date and time but knew where he was
- He was described as vague and distracted, looking around the room and smiling at the ceiling. He asked the Nurse if they could smell burning but there was none evident.
- He said he had driven to Leeds after hearing songs and voices making reference to him and he took this as a sign to attempt suicide
- He denied any current thoughts of suicide or self-harm
- The CJLN concluded that Henry would need a Forensic Mental Health Assessment by a Consultant Psychiatrist and after consultation it was agreed that this should take place once he had been remanded into custody.

In terms of NTW's involvement with the family there was nothing significant of note in relation to the incident.

13.8 Review of the IMR prepared by an independent GP at the request of NHS England on the behalf of NHS South Tyneside Clinical Commissioning Group (CCG).

The author of the IMR reviewed the GP records for Louise, Henry, Child 1 and Child 2. Four GPs were interviewed and the notes held by the GP out of Hours Service were reviewed.

Louise was well known to the GP surgery and there were a number of contacts; in total 89 contacts with the GP surgery, 52 of which were GP contacts, 15 Nurse contacts, 18 midwife contacts and 4 contacts with the GP out of hours service. She saw 21 different GPs but the Surgery is a large Teaching Practice. The author of the report concluded that many of the consultations were for minor illnesses.

During 2012 and 2013, Louise had a number of consultations in respect of tonsillitis. During a severe episode in February 2012 she was admitted to Hospital and in October 2013 she had a tonsillectomy.

Louise had a number of road traffic accidents. She was seen in March 2012 for related problems e.g. back pain. She was seen in June 2013 on two occasions within three days. She complained of knee pain following a road traffic accident and panic attacks. Louise said she was worried about re-starting driving.

In January 2014, Louise reported a head injury from the previous week, she had pain in the side of her head and face. Louise reported to have panic attacks and was feeling stressed, she was pregnant and reported to the midwife on 19th June 2014 that she was feeling stressed due to family issues and college work.

At the time of Louise's postnatal check on 23rd September 2014 she was noted to have normal mood, had bonded with the baby and to have good family support. From November 2014 onwards she reported abdominal pain and had a number of tests and was treated with antibiotics. Her symptoms persisted to the time of her death.

Henry had a number of consultations in March 2011, March 2013 and October 2014 following road traffic accidents. In June 2012 he was assaulted and suffered an injury to his nose.

On the day prior to Louise's death, Henry was seen by a GP from the GP out of hour's service. Henry complained of palpitations, stress and anxiety since the previous night. He said he had low mood and felt depressed. Henry reported that he thought his partner was 'cheating on him' and he became very angry the previous night. The GP recorded that the examination was normal. It was thought that his symptoms were stress related. Henry was given the phone number for Talking Therapies and advised to see his own GP.

Until Child 1 was four years old he was seen for a number of minor illnesses. He was referred to Speech Therapy because of stammering.

In November 2014, Child 1 was taken to see the GP by Louise because the School were reporting aggressive behaviour and poor concentration. The possibility of a referral to Children and Adolescent Mental Health Services (CAMHS) was discussed. Louise returned Child 1 to the GP in December 2014 because of ongoing problems with his behaviour in school. The school said that Child 1 would not look at people directly, was always putting things in their mouth, did not like loud noises and had no understanding of bad behaviour.

On 13th January 2015 Louise returned to the GP and expressed concerns regarding Child 1's behaviour. The GP discussed Child 1's case with CAMHS who suggested a referral to Paediatrics to exclude any organic problem.

Child 2 had a few attendances at the surgery but these were for minor illnesses and immunisations and was seen 11th March 2015 with bronchiolitis and eczema.

The author of the IMR considered two questions: firstly, whether enquires about domestic abuse where undertaken and secondly, the consultation Henry received on 14th March 2015.

There was no evidence in the GP records of domestic abuse but nor was there evidence that Louise was asked about domestic abuse. The notes indicate that Louise always presented as 'bubbly, happy and personable'. She was 'fed up and upset' with continuing health problems but this was consistent with her medical situation.

The author stated that it is good practice for GPs to undertake routine or selective enquiries about domestic abuse and violence. Indications to do this, include presentations with anxiety, depression and chronic physical symptoms such as headaches, irritable bowel syndrome of gynaecological problems. In addition, it is appropriate to ask about domestic abuse when children present with behaviour problems or other difficulties such as enuresis or as part of an holistic assessment.

Questions should be asked when the patient is seen alone and Louise was typically seen alone.

The author felt that the lack of routine and selective enquiries was consistent with other reviews. GPs report that they have a lack of knowledge about domestic abuse and such questions are not embedded in practice because of a lack of confidence. The author felt that there may be a tendency on behalf of the GP to 'anchor bias and premature closure', that is, to look at other explanations e.g. there were some possible explanations for Child 1's behaviour and for Louise's headaches 20th March 2012 which may have distracted from further enquiry about other causes.

On discussion with the author of the IMR, he felt that Louise had a lot of contact with the GP surgery but this was not necessarily excessive. In his view, it reflected a young woman who did not cope well with minor illnesses. Louise saw a number of different GPs and the Panel were concerned that the frequent change of GP may have created a greater potential for concerns or issues to be missed.

The second most important factor, was the consultation Henry received by the out of hours GP. The consultation took place in the walk-in centre and therefore the GP had no prior knowledge of Henry or access to medical records. He was seen alone by the GP.

On interview with the GP, the report author reported that the GP found Henry to be overweight, calm and quiet during the consultation. His main complaint was one of palpitations and anxiety about his heart.

Henry complained about stress and anxiety and believed that his partner was cheating on him. He was calm throughout the consultation and did not appear disturbed or distracted. He did not report any symptoms of psychosis such as hallucinations.

Henry complained of being angry and upset the previous evening but this was not explored in detail. The only risk management undertaken was to provide the phone number for the Mental Health Crisis Line.

There was nothing recorded about alcohol or drugs but this has never been reported as an issue.

Henry left the consultation apparently reassured about his palpitations but with the issue of his anger not being addressed. The author of the report felt that GPs have been trained to deal with potential victims of domestic violence rather than the perpetrators and therefore the GP may not have routinely dealt with the issue of anger.

On discussion with the author of the IMR, he confirmed that there was no indication of serious mental illness on examination and this was evidenced by a suggestion of Talking Therapies rather than a referral to secondary mental health services. Talking Therapies usually deal with mild to moderate depression or anxiety.

13.9 Review of the IMR prepared in respect of Children and Families Social Care

The author of the report scrutinised the electronic notes. No staff member was interviewed, one person involved with the family had left the authority.

In April 2013 a Child Concern Notification (CCN) was received from Northumbria Police that whilst exercising a warrant they found a high quantity of ammunition for a shot gun in the toddler's bedroom. Henry's father had his shot gun licence revoked in March 2013. He advised that he had forgotten to dispense with the ammunition. The CCN notes indicate that it would be unlikely that Child 1 would have reached the ammunition however it was submitted as a referral to Children Services for Action. The decision taken by a Senior Practitioner was 'no further action' because there were no other concerns about Child 1's care.

The other information provided was that the father of Henry had two impending prosecutions for failure to comply with the firearms certificate and offering to supply cannabis. It appears that there was no discussion with the Police in relation to these offences. It would be an expectation that a further conversation with the Police would have assisted a full and comprehensive risk assessment and informed decision making. Without this information, the author of the report was not able to clarify whether the decision for 'no further action' was the correct one.

The next contact was at the time of Louise's death. The children were with paternal Grandparents at the time, interim Care Orders were taken out and eventually the children were placed in the care of maternal grandmother.

13.10 Review of the IMR prepared for the Early Years and Children's Centres Team

The author of the IMR reviewed the case file and interviewed two members of staff.

The family first came to the attention of the Children's Centre following a telephone call from the Early Help Advice Team on 18th November 2014. Louise had contacted the Early Help Advice Team seeking support to address issues raised by the school in relation to Child 1's behaviour.

The information was passed to the Emotional Support Worker (ESW) in the school. The ESW was the allocated professional within the school. Louise had been into the school and spoken with the Assistant Deputy Head.

The school convened a meeting for the 24th November 2014 and invited the Children's Centre Outreach Team to attend. There is no record in the notes of this meeting taking place.

On 1st December 2014, Child 1 was allocated to the Outreach Worker and the plan was to liaise with the ESW to discuss support and services required. The Outreach Worker was to undertake an Early Help Assessment with her acting as the Lead Professional.

On 8th December 2014 an initial Early Help meeting was scheduled to take place at the school. The notes held by the Children's Centre stated that Louise did not attend but the following workers did: ESW, Children's Centre Outreach Worker, Special Educational Needs Co-ordinator and School Assistant Head Teacher. There were no recorded minutes but it is understood that there were discussions about Child 1's behaviour and concerns raised by Louise.

On 12th December 2014 there was a meeting to see Louise at home by the ESW and Outreach Worker. Henry was not present. It was agreed to provide support for positive behaviour strategies. The Early Help meeting was re-scheduled for 26th January 2015.

The Children's Centre involvement with the family started on 1st December 2014 and ended 6th March 2015. Louise was seen at home on eight occasions. One was the introductory visit and 7 were a bespoke Incredible Years Parenting Programme. Henry was present on 3 occasions but left the home shortly after on two occasions and therefore did not participate in the programme. Louise said initially that she was keen for him to participate in the sessions. He was present during one of the sessions but was decorating the living room. This would have been an opportunity for the Outreach Worker to engage Henry and gather his thoughts and opinions. This did not appear to have happened.

Louise informed the Outreach Worker that herself and Henry shared the parenting around work commitments. Henry's father (paternal grandfather) took Child 1 to local areas for a 'kick about' and took the child fishing.

Due to Louise's work commitments the Incredible Years Parenting Programme was to be delivered in the home rather than a group setting. Child 1 was responding positively to the interventions and this was evidenced by the family being able to go out to a meal, a visit to a farm and a family party with no behavioural outbursts. It was said that this gave Louise confidence to engage with the programme.

The Outreach Worker stated that from her observations of Child 1's behaviour the problem appeared to be developmental rather than of the child witnessing abuse. On three occasions she had observed Henry in the home and she had not observed any issues between him and Louise and/or the children. On one occasion he supported

Louise to make a bottle feed, on another he was playing with cars with Child 1 before taking the child out and on the third occasion he was decorating.

The last home visit took place on 6th March 2015 and Louise said that there were 'more good days at home and school. There had been a change at school in teachers' attitudes, and she had noticed a change in Child 1's behaviour because of this.'

The Children's Centre notes indicate that Child 1 had been referred to a Paediatrician and the School Nurse advised that Louise attend with Child 1 because she would be able to say what the problems were.

The author of the IMR concluded that during these sessions, the Outreach Worker did not observe any relationship issues between Henry and Louise nor did Louise indicate there were problems. However, it would appear that questions about domestic abuse were not routinely asked.

13.11 Review of the IMR prepared in relation to the School

The author of the IMR met with the Head Teacher and Assistant Head and Inclusion Manager and they assembled the chronology to send to the report author. They met again after to go through the chronology. The author of the IMR is the Head of Education, Learning and Skills and she was asked to prepare the report because all senior workers in the school had previous contact with Louise.

Issues were first raised about Child 1's behaviour in October 2014 e.g. chewing things, making silly noises, difficulty remembering (even the group colour). The Class Teacher discussed with Louise and the School Nurse who suggested a GP appointment.

On 18th November 2014 the Family Support Officer received a call from the Children's Centre following Louise's phone call to them expressing concern about Child 1's behaviour. She said she 'dreads taking and picking the toddler up from school and wants help'.

What followed was a number of suggestions e.g. one was help from the school Nurse but she was not able to commit to an appointment until December because of dispensing flu jabs.

There was a meeting on 24th November 2014 at the school. Louise, Henry, the Assistant Head and the Family Support Worker attended. Louise said she was struggling with Child 1's behaviours at home. Child 1 would not listen and the parents were struggling to enforce boundaries. This had always been the case but with Louise working part time and the new baby, Child 2, this had made the situation worse.

The school suggested a referral to the Support Assistant for one to one and nurture group work. The Class Teacher was going to use a positive behaviour chart in class. The Family Support Worker was going to complete a home visit. Child 1's level of ability was discussed and Henry expressed concern about this, the report does not qualify what this means.

On 27th November 2014 the Family Support Worker made a home visit. Louise said she was concerned about Child 1's behaviour: hitting and digging at the baby, wetting the bed, only drinking out of certain cups, still having a bottle until the summer, eats rubber and does not like loud noises. Louise said that the parents had differing parenting style, she tried to impose boundaries but Henry had a more relaxed attitude to parenting.

The next meeting at School was 8th December 2014. Child 1 was not in school because he bumped his head and therefore the parents did not attend the meeting. The parents had expressed concern that another child in the class was influencing Child 1 and requested a change of class. The outcome of the meeting was a home visit by the Outreach Worker and the Family Support Officer.

A further meeting was held at the School on 11th December 2014, Louise was present, along with the Assistant Head and the Family Support Officer. Louise continued to express concern about Child 1's behaviour. She agreed that her and Henry had differing parenting styles and Henry could undermine any strategies that Louise tried to put in place. Child 1 spent a lot of time with his paternal grandfather and both Henry and his father felt that the behaviour was 'typical of a child of that age' and not a real concern which undermined any strategies Louise was trying to impose. The plan was for the Family Support Officer to refer to the School Nurse.

On 12th January 2015, there was an initial Early Help meeting. In attendance at this meeting were the Class Teacher, Special Educational Needs Co-ordinator, Louise, Henry and the Family Support Worker. There were discussions about Child 1's behaviour e.g. continuing to eat inappropriate things such as rubber, the toddler had picked up no phonic sounds, could follow some routines in class better but there were still concerns. Louise said that the paternal grandfather continued to spoil the child. It was felt that some of Child 1's problems were medical in nature and therefore the next meeting should be arranged as soon as possible when the School Nurse could attend.

The next meeting was 26th January 2015, it was not recorded who was in attendance. At lunchtime there had been an incident between Child 1 and another child, strangling a third child with a scarf. Child 1 was taken home because of this. Things were being put in place for Child 1: an appointment with a Paediatrician, an appointment with an Occupational Therapist to address sensory needs, attention and listening skills, and Speech and Language Therapy? to provide the Class Teacher with a set of activities. Child 1 continued to have 3 sessions a week with the Support Worker and the Incredible Years Programme with the Outreach Worker continued at home.

The author of the IMR concluded that the school had provided a great deal of support to the family however there could have been better communication between the agencies.

Section 14. Key Themes

Louise presented a high number of times at the GP surgery with minor illnesses and injuries. No concerns were expressed about the cause of the illness, injury or what

appeared to be a lack of ability to cope with minor health problems. The GP did not make routine or selective enquiries into domestic violence. The GP Surgery is a large Teaching Practice and Louise was seen by a number of different GPs and other professionals which may have created a potential for missing patterns of behaviour or wider issues.

Child 1 presented with behaviour problems, identified by Louise and the School. A number of agencies were involved with Child 1 and clearly a lot of good work was done but at no time was consideration given to domestic abuse being a cause of the problems. There was a belief that Child 1's problems may be medical or health related and developmental rather than a product of abuse. This may or may not be the case but consideration should have been given to wider factors.

Louise was seen by Midwifery and the Health Visitors in relation to both her children. When she had her eldest child, routine and selective enquiries about domestic abuse were not standard practice. They were when she had her second child but these did not routinely appear to take place. She was asked on one occasion about domestic abuse and it was recorded that she answered 'no' to this question.

Louise presented as an ambitious woman for herself and her family. She wanted to be a Nurse when younger but got pregnant with her eldest child. She was successful at completing a College Course and got a part time job. It was clear that she wanted the best for her children, she raised concerns about Child 1's behaviour and engaged with the Incredible Years Parenting Programme and improvements were seen.

There appeared to be wider family issues which remain unclear. For instance, Louise was living in the house where Henry's father had a tenancy, he then bought the house. She described herself once as his 'niece', this may have been for tenancy purposes. Henry's father was found in possession of ammunition in Child 1's bedroom and cannabis with the intent to supply. He had his shot gun licence revoked because of these concerns and Henry was refused a shot gun licence on the basis of illegal behaviour and a historical assault. Henry and his father were arrested and cautioned for criminal damage (Henry) and assault (his father) against Henry's sister and her partner. Louise referred to differing parenting styles between herself on one side and Henry and his father on the other. Louise trying to set boundaries and Henry and his father saying that there were no concerns regarding Child 1's behaviour.

From the IMRs there appears to be some information that does not correlate to other information e.g. Henry's housing history and gaps in signing-on for Job Seekers Allowance. Also the number of road traffic accidents the couple had and subsequent claims for injuries. Clarification around these issues is unlikely to add to the outcome of the final report.

Henry said that he believed that Louise was allegedly having an affair with a friend of her employer, there is no evidence for this. Henry went to see Louise's mother and confronted her with this and appeared to assault her although he maintains that she assaulted him. He then reported the matter to the Police and alleged that she had

assaulted him. How this information was recorded was confusing e.g. Louise was recorded as the alleged attacker but this was an individual Officer's error. Henry withdrew his complaint and therefore Louise's mother was not interviewed and the true nature of the incident was not explored. The children were present at the time but this was not known until after the event.

Henry said that he was hearing voices to kill someone and his mother was concerned about him. It was arranged for him to see the Out of Hours Doctor and he attended on the morning of the incident. Henry did not report hearing voices to the GP, he said he was anxious, stressed and had palpitations. The GP said he saw no sign of psychosis and referred Henry to Talking Therapies. Henry did admit to being angry the night before but this was not followed up or risk assessed by the GP. There is evidence that Henry contacted Bede Wing which he believed provided Mental Health Crisis Care but it is now an outpatient ward and the phone does not take messages. Henry also rang 111 for six seconds and then hung up.

The circumstances surrounding the finding of Louise's body the day after her death are confusing. It appears that Henry left early in the morning and drove as far as North Yorkshire. He then returned and told his father who did not initially inform the Police. The Police attended the house when they had a report of some men breaking in. This was Louise's family trying to locate her. Henry's father was initially questioned about his failure to report but later released with no charge. However, what we know is that Louise's body was laid in the house for some time, the paternal family were aware of her horrific death but did not inform anyone and her own family had to break in and found her body.

Section 15. Lessons to be learnt

15.1 South Tyneside Council on behalf of the School

The school identified that communication could have been better between agencies and one agency did not attend a school or Early Help Meeting or send a representative or report, otherwise information is not shared.

Training on domestic abuse needs to improve for all staff, face to face training for the Safeguarding Leads in School and on-line training for the other staff.

15.2 South Tyneside Council on behalf of the Early Years and Children's Centres Team

Henry did not participate in the Incredible Years Parenting Programme and this was not pursued or challenged by the Early Help Outreach Worker.

There was no evidence that the Early Help Outreach Worker made routine or selective enquiries about domestic abuse and these questions should have been asked as part of any intervention.

There was clearly a breakdown of the relationship between Louise and the school and the concerns about Child 1's behaviour. Louise talked to the Outreach Worker about this and it was recorded Louise 'feels helpless in this matter, no reassurance from the teacher regarding any issues raised'. The author of the IMR felt that this

was a 'profound' statement and more support should have been offered and greater liaison with different people within the School.

The author identified quality assurance as an area for further development in relation to the Early Help framework to ensure consistency in the quality of assessments and interventions.

The author identified that although supervision of the Outreach Worker took place there was a lack of detailed discussion, reflection and analysis therefore the quality of the supervision did not meet expected agency standards.

There were issues of recording of initial contacts, subsequent referral pathways and group supervisions.

15.3 South Tyneside Children and Families Social Care

Further information should have been sought from the Police in relation to the CCN referral in April 2013 when ammunition was found in Child 1's bedroom. This may have impacted on the decision-making to take 'no further action'. It is difficult to say what the impact may have been in retrospect.

The author identified that the quality assurance processes and Team Manager oversight was not sufficiently robust in respect of the 'no further action' decision-making processes.

15.4 NHS South Tyneside Clinical Commissioning Group (CCG) on behalf of the GP Practice

The author of the IMR identified that whilst there was no documented evidence of domestic abuse there were a limited number of opportunities to undertake selective enquiry. Since the review, the GP Practice has introduced a question about domestic abuse into some templates and that is leading to a greater tendency to ask questions in relevant situations.

Domestic abuse training for GPs and other Primary Care staff tended to be included within the training for Safeguarding Children and to a lesser extent Safeguarding Adults. The author felt that this led to insufficient attention given to the topic, the prevalence of abuse and the health impacts. The GPs, in their Safeguarding Policy, had made Domestic Abuse Awareness training mandatory for all staff on a three yearly basis.

15.5 South Tyneside NHS Foundation Trust (STNHSFT)

Domestic abuse routine and selective enquiry must remain a targeted and focussed training requirement for all Trust Staff who have face to face contact with clients, particularly those working with families.

Routine and selective enquiry training should be incorporated into all Safeguarding training.

15.6 Northumbria Police

The incident on the 13th March 2015 when Henry alleged he was assaulted by Louise's mother was not followed up when he withdrew the charge. All Officers need to be aware that the 'Proportionate Investigation' does not apply to allegations of

domestic abuse. All reports of domestic abuse should be 'thoroughly and robustly investigated' as clearly stated in the current Force Policy on Crime Investigation. Given this, the investigating officer should have spoken to both parties.

All Supervisors and Officers and staff responding to and investigating domestic abuse should be clear that it is the duty of the frontline supervisor to ensure that the Domestic Abuse, Stalking and Honour-Based Violence (DASH) form and domestic abuse screens are fully completed before the Officer terminates their duty. This includes the completion of a text screen on the record with details of the safeguarding carried out. The Supervisor should monitor incomplete forms.

There was an issue about recording the incident between Henry and Louise's mother which highlights the need to be clear about recording domestic incidents.

15.7 Issues identified by the Review Panel

The Panel identified that routine and selective enquiries were not made by any agency involved in with Louise and the family, other than on one occasion by the Midwife.

Also greater consideration should have been given to presenting behaviours such as the number of attendances at the GP Practice by Louise, and Child 1's behaviour problems. Louise presented with minor illnesses and injuries and the conclusion was that Child 1's behaviour was due to developmental issues rather than abuse. This may or may not be the case in both situations but what was lacking was a robust enquiry into the presenting issues.

The wider ramifications of domestic abuse need to be considered, that is: not just violence but coercive behaviour, and not purely related to the immediate/intimate partner but also other family members. In relation to Louise and her relationships, it was sometimes difficult for the Panel to understand the family dynamics e.g. Louise calling herself niece to Henry's father, ammunition in Child 1's bedroom, the paternal grandfather and Henry 'spoiling' Child 1 and not imposing boundaries. It is difficult to say that this behaviour amounted to coercive and abusive behaviour but the questions should have been asked.

The week prior to Louise's death, Henry appeared to be presenting with different behaviours. He was repeatedly ringing Louise at work, he was accusing her of having an affair, he did not believe that she was at work and the day before the incident he was unusually withdrawn. Henry attended the out of hours GP surgery, major mental illness was not identified but it would appear that Henry did not share all of his symptoms e.g. hearing voices. However, there is a wider issue of families, friends and communities identifying a decline in mental health and knowing how to access services e.g. what symptoms to look for, where to get help and how to identify possible risk factors.

Section 16. Effective Practice

16.1 South Tyneside NHS Foundation Trust (STHNSFT)

The author of the IMR found that routine practice was implemented safely, timely and in line with National and Trust legislative frameworks, policies and standards.

16.2 Northumbria Police

The refusal of a shot gun licence to Henry and the removal of the licence from Henry's father was effective practice. The firearms licensing department has a tailor made computer programme linked to the Police main computer system and alerts are made when concerns arise, hence the proactive response to Henry and his father.

Section 17. Conclusions

This section will consider the questions identified by the Review Panel, most importantly whether or not Louise's death could have been predicted and/or prevented.

17.1 Could Louise's death have been predicted or prevented?

After reviewing all the information, the Panel concluded that Louise's death could not have been predicted. There was no recorded history of domestic violence or abuse, other than the incident recorded on the 13th March 2015, which didn't involve Louise herself. Henry did not have a significant history of violence, there was one assault when he was a child.

Could her death have been prevented? There were two opportunities to make further enquiries about risk: firstly, the incident between Henry and Louise's mother and his attendance at the out of hours GP surgery. Even if more questions had been asked, he may have still been considered a low risk. There was insufficient information to say whether or not any additional risk assessment would have escalated the concerns.

The Review Panel did agree there were missed opportunities to make routine and selective enquires into domestic abuse and wider family relationships and dynamics, however there was no indication from the information gathered that there were concerns about domestic abuse.

17.2 Has the Review established what lessons are to be learnt regarding the way in which the local professionals and organisations work individually and together to safeguard victims?

All agencies fully co-operated in the review process and demonstrated a willingness to look critically at their own practice and embrace the learning. Some agencies have already established action plans.

17.3 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 be changed as a result?

The lessons learnt are identified in this report and there will be recommendations and an action plan produced which will be specific, measurable, achievable, realistic and timely (SMART).

17.4 Whether an improvement in internal and external communication and information sharing between the services might have led to a different outcome?

Given that no domestic abuse or violence was identified (other than the incident the two days before Louise's death, involving her mother) it is difficult to argue that there may have been a different outcome. However, there are lessons to be learnt in relation to internal and external communication and information sharing.

Some agencies identified gaps in recording of information e.g. Children and Families Social Care and the Police. This was in relation to the CCN referral submitted by the Police to Children's Services in April 2013 following the Police finding the ammunition in Child 1's bedroom. There was no follow up discussion from Children's Services to the Police to inform decision-making.

A number of agencies identified that the sharing of information could be improved, this was particularly in relation to the concerns about Child 1's behaviour. Both the school and Children and Families Social Care identified that if there had been more information shared in a timely manner this may have been more supportive to Louise.

17.5 Whether key opportunities for assessment, the timeliness, decision making and effective intervention were identified?

The Review Panel felt that there were opportunities for assessments and these were often timely. However there lacked a robust interrogation of the information particularly around Louise's frequent attendance at the GP surgery and Child 1's behaviour problems. Both received a timely and appropriate service but there was no robust analysis beyond the presenting information to any other possible cause of the problem. There was a lack of critical analysis and professional challenge. Examples of this are:

- The decision of 'no further action' by Children's Services following the CCN referral in April 2013. This was a missed opportunity to explore further any potential issues with the Police.
- The Early Help Plan which did not include Henry as part of the assessment or intervention. His lack of engagement was not challenged and therefore a missed opportunity.
- The out of hours GP during the consultation with Henry failed to thoroughly assess his claims of anger
- The Police failed to robustly follow up the incident between Henry and Louise's mother.

Opportunities to make routine and selective enquiries into domestic abuse were not made and this was in relation to all the main agencies involved with the family e.g. GP, STNHSFT, Social Care, Early Help and the School.

In relation to NTW, Louise was seen by Mental Health Services as an adolescent and this appeared to be appropriate to her needs. Child 1 was referred to NTW but the decision was made, because of the age of the child, that a referral to a Paediatrician was an appropriate response. Henry was seen at the time of his arrest,

this was a brief assessment which indicated a further more in-depth assessment was required. The decision was made to complete this when Henry was remanded, given that there appeared no immediate mental health risk issues this would seem appropriate.

17.6 Whether appropriate services/interventions were offered/provided and/or relevant enquires made in light of any assessments made?

Louise had her clinical needs met by the GP Practice and STNHSFT and the Ambulance Service when appropriate.

In terms of Child 1, concerns were raised about their behaviour and Early Help became involved at the request of Louise. There was evidence of effective interventions e.g. the Incredible Years Parenting Programme and this was tailored to meet Louise's needs because of working. However, it was also recorded that Louise felt unsupported by the School.

It was identified that, in respect of the incident between Henry and Louise's mother, the Police should have made more enquiries into the case, particularly as it had been identified as a domestic abuse situation.

17.7 Whether agency transition arrangements were sufficiently robust?

This did not apply to any of the agencies involved in the Review.

17.8 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner?

This was relevant to Children's Services and identified by the author of the IMR as an issue. A Senior Practitioner made the decision of 'no further action' following the CCN referral in April 2013. This is a delegated role to Senior Practitioners but what was lacking was a strengthened management oversight and quality assurance process in relation to the Senior Practitioner's decision making.

Louise raised concerns about the School and feeling unsupported in relation to Child 1's behaviour with the Early Help Outreach Worker and it would have been appropriate for the Early Help Worker to raise this with the school and escalate concerns.

17.9 What training practitioners and managers had received and whether this was sufficient to enable them to carry out their roles effectively?

In relation to the GPs, the domestic abuse training is usually incorporated within Child Safeguarding training. Within the training, the author of the IMR believed that more weight should be given to domestic abuse, how it presents and the impact on health.

Social Workers, Senior Practitioners and Team Managers in Children's Services have had training on improving the quality of decision making in relation to thresholds for intervention.

Within the Early Years' Service, all workers had training in relation to the Early Help Assessment and Intervention Framework

The staff at NTW receive three yearly updates on Risk Management and Care Coordination, Safeguarding, and Public Protection. NTW offer training on Domestic Abuse including the completion of appropriate documentation. The Domestic Abuse Policy was last updated in 2013 and outlines the course of action should any staff be concerned about domestic abuse. The Trust has a Safeguarding and Public Protection Team that includes dedicated Safeguarding Children and Domestic Abuse Practitioners who provide advice, support and supervision for staff when necessary.

Domestic Abuse awareness is part of induction for all new staff into NTW, in addition to ongoing training within the Trust's training strategy. Bespoke training is also provided to teams within the organisation on Domestic Abuse, including how to complete the documentation and making a referral to MARAC.

At the time of completing the IMR, NTW was delivering Level 3 training in domestic abuse. It is therefore reasonable to expect staff, given their level of training and knowledge, to fulfil expectations in relation to the identification and disclosure of domestic violence. In this case the victim did not make a disclosure of domestic abuse to NTW staff and was not subject to MARAC.

Staff from the North East Ambulance Service (NEAS) cover domestic abuse training as part of their Corporate Induction Training. Staff are aware of their roles and responsibilities with regard to safeguarding and how to raise a safeguarding concern should disclosure be made or suspicion of domestic abuse/violence occur. The Safeguarding Policies for Adults and Children include a section on Domestic Abuse/Violence.

The author of the Police IMR stated that all Officers and staff within Northumbria Police are knowledgeable about the potential indicators of domestic abuse and are aware of what to do if they have concerns about a victim or perpetrator. All of those procedures are available to Officers and staff via the Force Instructional Information System (IIS).

A full domestic abuse input is received by student Officers during their initial training and further training is delivered whenever there is a change in policy or procedure.

The Neighbourhood Policing Teams now manage all medium and standard risk victims and have responsibility for safety planning. As such they have good knowledge of the subject.

The Force also maintains Officers who are experts in the investigation of domestic abuse and the related safeguarding issues within the Protecting Vulnerable People Unit (PVP). These Officers also support high risk victims.

17.10 What impact did the services provided by each agency have on identifying and dealing with co-existing factors such as mental health, substance or alcohol misuse or domestic violence?

When Henry's father was arrested for a cannabis offence there was no analysis of the impact of this on any of the children he may have been caring for.

There was no evidence that either alcohol or substance misuse played a direct role in this incident.

There was no history of mental illness in respect of Henry. Louise had some involvement with Mental Health Services as a teenager but nothing recently. Henry presented to the out of hour's GP surgery. He complained of stress, anxiety and palpitations. Henry's mother retrospectively said that Henry was hearing voices. There was no evidence of psychosis on interview with the out of hours GP. The author of the IMR had no concerns about this consultation with Henry. Henry had not complained about hearing voices or any psychotic features and he was referred to Talking Therapies which would have been an appropriate response given his presentation during the consultation.

When Henry was arrested for the murder of Louise, there was evidence that the Police considered his mental health and he was seen by the Criminal Justice Liaison Nurse. When he was arrested for Criminal Damage in 2014, he was assessed as 'fit and well, not under any medication, he had not attempted self-harm in the past. He had no known or disclosed medical, mental health or self-harm issues and does not want to see the Force Medical Officer. No other issues were raised'. Therefore, mental health was considered as an issue but there was no evidence at the time.

17.11 Whether the work undertaken by services in this case was consistent with each organisation's:

17.11.1 Professional standards

The author of the CCG IMR believed that the GPs work was consistent with that of other GPs. He raised the issue of the out of hours GP not responding to Henry's disclosure of feeling anger and the incident with Louise's mother. Also the lack of routine and selective enquiries by the GPs.

In terms of Children's Services, the work undertaken in April 2013 was not in line with expectations, there should have been follow-up with the Police.

The care offered by NTW was in line with professional standards.

Paramedics undertake their role in line with the standards underpinned by the Health and Care Professions Council (HCPC). Call handlers receive training appropriate to their role and are subject to scrutiny by an audit to ensure they handle calls as per procedures.

Midwifes, Health Visitors and School Nurses undertake their role in line with the legislative framework as set out within the Nursing and Midwifery Council Professional Standards of Practice and Behaviour for Nurses and Midwives.

17.11.2 Domestic violence policy, procedures and protocols

In relation to the GPs, the policies, procedures and protocols have been updated since the Review.

With developments in domestic abuse, both nationally and locally from 2008, NTW has developed a Safeguarding and Public Protection Team and a Domestic Abuse Policy that provides staff with the relevant guidance. NTW has three Senior Practitioners who are experts in Domestic Abuse, they attend all MARAC meetings and provide advice, supervisions and support to staff across the organisation. NTW staff have ongoing training in domestic abuse which makes them aware of potential indicators and what to do in the event of concerns.

The Safeguarding and Public Protection Team offers a duty system so staff can ring and obtain advice as and when required, as well as support on completing the RIC and MARAC referral.

In NTW, systems are flagged for both victim and perpetrator so practitioners are aware of any potential issues.

In respect of NEAS, Children's Safeguarding Policies include sections on domestic abuse/violence and these policies are available to all staff via the intranet safeguarding page and via Q Pulse Management System which holds all policies.

STNHSFT have in place a policy to provide guidance to staff on Identifying and Responding to Domestic Abuse (2014/2017). This Policy was updated following a previous DHR and is promoted within training to staff. It is accessible to all staff via the intranet.

In relation to Northumbria Police, the Procedure for Investigating Domestic Abuse clearly states that enquiries should be intrusive and tenacious in establishing the true facts. As a result of Louise not being spoken to after the incident between her mother and Henry, an investigation into the Officer's conduct was undertaken. It has been quality assured and finalised by the Professional Standards Department as: 'no case to answer'.

17.12 Were agency procedures in place and fit for purpose?

In relation to Children's Services the quality assurance systems need to be strengthened to ensure that there is appropriate level of management oversight in relation to Senior Practitioner 'no further action' decisions. The Service has recently (Sept 2015) re-launched its Quality Assessment framework and the service is currently implementing a process for the random sampling and quality assurance of contacts that are not progressed.

Quality assurance was also highlighted as an issue within the Early Help Framework to ensure consistency in the quality of assessments and interventions.

In relation to Northumbria Police, the domestic abuse Policies and Procedures have been changed considerably over the years. Before 2008, a basic 10 point risk assessment, covering very few concerns, was typed into the incident log. This was then expanded to a separate 20 point risk assessment, with 5 significant concerns being given extra weighting in the risk assessment process. Since 2008 the

Northumbria Police risk assessment model for victims of domestic abuse is the Multi-agency Risk Assessment Conference (MARAC) model. This is a national model accredited by the voluntary organisation now known as Safe Lives (formerly CAADA). In 2009 CAADA upgraded the risk assessment tool to DASH (Domestic Abuse, Stalking and Honour-based Violence) model which consists of additional risk indicator questions. Northumbria Police went to a full DASH model in 2013.

The policy and procedure regarding domestic violence is available to all Officers via the Force intranet. The procedure clearly defines the responsibilities of all Officers and staff when dealing with cases of domestic abuse.

A leaflet containing safety planning guidance and contact details for various support agencies is always given to the victim. If the victim consents, the incident is referred to victim support services and all victims assessed as high risk are referred to an Independent Domestic Violence Advocacy (IDVA) service and MARAC.

17.13 Whether practices by all agencies were sensitive to the nine protected characteristics as defined in the Equality Act 2010?

All of the agencies indicated that they undergo Equality Training, there was no evidence of any breach of the nine protected characteristics as defined by the Equality Act 2010.

17.14 If there were low level of contact with any agencies were there any barriers to either the victim of the person charged with the homicide accessing services and seeking support?

The family accessed a range of services, in particular health services. There were a number of appointments at the GP's surgery and Louise saw a number of different GPs. The Panel felt that whilst there was no suggestion that her health needs were not met, this may have led to a missed opportunity to consider patterns of behaviour.

Louise said she felt unsupported by the school in respect of Child 1's behaviour and this was not followed up when she made a complaint to the Early Help Worker.

Henry and his family did try and access help for him before the incident. He attended the out of hours GP surgery because he was not feeling well, he rang Bede Wing and 111. The GP examined Henry and gave him contact details for mental health services available during the week. Henry rang Bede Wing, which used to be an in-patient facility, but no longer is. Bede Wing was never a place where the public could directly access mental health services, however the view of the Panel was that people locally knew of the service and equated Bede Wing with mental health care. The facility would not be available when Henry contacted it. Henry rang 111 which was an appropriate number but ended the call before he was connected.

There are two questions to consider, firstly in relation to information about domestic abuse and secondly to how easy was it for Henry to access mental health services.

Firstly, is sufficient publicity about domestic abuse and the services, particularly in relation to coercion? There is no evidence that Louise was a victim of abuse prior to her death. However there appears to be a lack of public understanding about what is meant by domestic abuse, that it can be coercion as well as physical violence. Also

that domestic abuse covers all family members and not just intimate partners. If people do not consider coercion and wider family members in relation to domestic abuse they will not seek the appropriate services.

Secondly, is there sufficient public and community awareness about the symptoms of mental health and where to access help? On interview, Henry reported symptoms of mental disorder since teenage years but did not tell anyone. The week prior to the incident, all those interviewed by the Panel, including Henry himself, reported a change in his presentation and this appeared to deteriorate over the week. Henry sought medical help from the Out of Hours GP service, but it is not clear whether or not he reported all of his symptoms. Henry said he told the GP that he thought he had Bi-polar disorder, which is a mental illness but not the one he has subsequently been diagnosed with. Henry also sought help from Bede Wing which was not appropriate and the 111 service but he did not follow through with this. It is clear that Henry was looking for help with his health and how he was feeling. He may not have been fully able to understand or express his symptoms and not aware of the Crisis service. The Panel concluded that there was a role for increased public awareness about symptoms of mental disorder and where to access help.

17.15 Does each agency hold any information offered by informal networks? For example, the victim or person charged with the homicide may have made a disclosure to a friend, family member or community member?

There was no evidence of any disclosure of domestic violence to family or friends of either Louise or Henry. There was evidence that his behaviour changed the week prior to the incident but there was no evidence of physical aggression, other than the one incident in relation to Louise's mother. On the evening prior to Louise's death, Henry presented as withdrawn e.g. his head in his hands and not speaking. His father made the salient comment that he would not have taken Henry home to Louise if he thought there was any risk.

17.16 Was there evidence of robust management oversight of the case including whether practitioners working with either the victim or person charged with the homicide had received appropriate supervision and was this of the required frequency and quality?

In relation to Children's Services, supervision was not offered to the Senior Practitioner who made the decision of 'no further action' in relation to the CCN referral in April 2013 because it was only one contact. However, the issue of the Quality Assurance Framework has already been raised.

In respect of the Early Years' Service, a group supervision was held on 22nd January 2015. A number of issues and concerns were discussed concerning Child 1's presenting behaviours in school and some actions were agreed. However supervision was lacking in reflection and analysis and any further strategies and interventions. Supervision records show that the Early Years Outreach Worker had one formal supervision. No concerns or issues were raised about the family but the supervision record lacked any detailed case discussion, reflection and analysis. The

supervision record was stored separately and not on the child's file in line with good practice.

17.17 Were there issues in relation to capacity, resources or organisational change over the period of the review that impacted in any way on partnership agencies and ability to respond effectively?

The GP Surgery is a large Teaching Practice with a number of GPs working there. Louise and her children saw a number of different GPs. There was no evidence that the number of different GPs affected the consistency of care and in relation to Louise's ongoing health problems and Child 1's behaviour there was consistency of GP. However there may have been a lost opportunity to see patterns of behaviour or wider concerns.

In relation to Children's Services, in April 2013 there were significant capacity issues within the Referral and Assessment Team coupled with a high volume of CCNs being received from the Police with a lack of clarity in relation to the level of risk identified and the reason for the submission of the CCN. The process has subsequently been reviewed with a more systematic approach to the prioritisation of CCNs, making a distinction between those for information only and those with action required.

In October 2013 a restructure of Children's Services occurred which remodelled the Referral and Assessment Team to reduce the parameters of the work of the Service undertakes and to increase the staff structure and the level of management oversight.

Section 18. Recommendations

18.1 Local recommendations:

All agencies to review how they ask people they come into contact with about possible domestic abuse (routine and selective enquiries). To consider the recommendations of a previous DHR and how the learning has been implemented.

All agencies to review what training, policies and procedures they have in place to ensure that there is a robust approach to identifying potential domestic abuse situations.

There needs to be greater awareness within the community about identifying symptoms of mental ill health and where to get help.

18.2 Agency recommendations:

18.2.1 South Tyneside CCG (on behalf of the GP Practice)

- NHS South Tyneside CCG to ensure that key topics highlighted in the Review are included within Domestic Abuse Training.
- NHS South Tyneside CCG to monitor uptake of Domestic Abuse Awareness training in Practices.
- Northern Doctors Urgent Care to review their training requirements regarding Domestic Abuse.

18.2.2 South Tyneside Council: Children's Service

- The Quality Assurance processes need to be strengthened in relation to management oversight of Senior Practitioner 'no further action' decision-making.

18.2.3 South Tyneside Council: Early Years Service

- Early Help and Advice Teams to review their systems for recording information and advice calls and referrals as appropriate.
- Training should be provided for Managers on reflective supervision and analysis of cases to promote reflective practice and ensure more effective management oversight within the supervision process.
- Case supervision should be held on file. Verbal discussions of cases and recommendations from management should be recorded within the contact notes of the file to evidence management oversight.
- Dissemination of learning from the IMR across the Early Help Partnership with a view to:

    a) Strengthening communication between all professionals with the Early Help Plan;
    b) Ensuring the engagement with families as a whole unit (as appropriate) in the work being undertaken; and
    c) Providing effective challenge where family members are not engaging and participating in the support and interventions provided in line with agreed plans.

18.2.4 South Tyneside NHS Foundation Trust (STNHSFT)

Delivery of Domestic Abuse Routine and Selective Enquiry will remain an integral part of safeguarding training, with managers and service leads asked to provide evidence of attendance by those staff working with families or who may come into contact with potential victims of domestic abuse during their work within the Trust A&E, Maternity, and Health Visiting Services.

To evaluate the uptake and impact of previous Routine and Selective Enquiry training delivered to STNHSFT A&E staff. An audit of assessment documentation will be completed to understand the effectiveness of training and impact on practice.

18.2.5 Northumbria Police

All Officers and staff responding to, and investigating, domestic abuse are to be reminded that 'Proportionate Investigation does not apply to reports of domestic abuse. All reports of domestic abuse are to be thoroughly and robustly investigated as clearly stated in the current Force policy on crime investigation. This can be found on the Force intranet.

In relation to investigating domestic abuse, all Officers and staff responding to and investigating domestic abuse are to be reminded that the Northumbria Procedure for Investigating Domestic Abuse clearly states that enquiries should be intrusive and tenacious in establishing the facts. Both parties should be spoken to in a domestic abuse incident.

All supervisors for Officers and staff responding to and investigating domestic abuse are to be reminded that it is the duty of the front line supervisor to ensure that the DASH form and domestic abuse screens are fully completed before the Officer terminates their duty, this includes completion of the DT screen with details of the safeguarding carried out. The form should be referred to the Central Referral Unit. The duty supervisor should monitor the incomplete domestic queue for front line staff This is a list of domestic abuse records which Officers have failed to complete. Incomplete records should be completed as soon as possible to avoid further delay in the risk assessment process. The Duty Supervisor is intrusive of reports of domestic violence and abuse to ensure 'all reports of domestic violence are to be thoroughly and robustly investigated'.

Section 19. Action Plan

The Review Panel identified the following areas to be incorporated into an action plan, alongside single agency actions identified through the IMR process:

19.1 Routine and selective enquiries into domestic abuse

Whilst there was no evidence of domestic abuse, there was evidence from the Review that routine and selective enquiries were not made in relation to possible abuse. This was learning identified in a previous DHR and the Panel concluded that there was a need to ensure that the recommendations made at that time are embedded in practice.

19.2 Consideration of wider social factors when assessing behavioural difficulties in children.

There were a number of concerns in respect of Child 1's behaviour There was evidence that he was seen by a number of different agencies. There appeared a presumption that the cause of his behaviour was 'organic' and the Panel concluded that wider social determinants should have been considered as part of the routine assessment. There was no evidence of domestic abuse but nonetheless such factors should have been considered.

19.3 Police recording of incidents

In relation to the assault between Henry and Louise's mother, two nights before she was killed, Louise was recorded as the perpetrator of this incident, albeit she was not present and played no part in the incident. There is evidence that the Police investigated this error and believed it to be an individual rather than procedural error and therefore unlikely to happen again. However, the Panel were concerned that an offence was recorded against Louise and therefore an action needs to be put in place to ensure that this error is not repeated.

19.4 Public awareness of how to identify and seek appropriate help for mental ill health

There is evidence that Henry sought help for his declining mental health, he went for a consultation with a GP at the walk-in centre and rang Bede Wing and 111. The Panel note that Henry and his family believe that the GP at the walk-in centre should have done more. However, on reviewing the information it is not clear how much Henry told the GP about hearing voices and his declining mental health. Even if he

had told the GP all the information, there was no indication of risk factors to self or others which would have met the criteria for a referral to the Mental Health Crisis Team. Henry rang Bede Wing which used to be an in-patient ward but is now an outpatient clinic, therefore there was no answer. He also rang 111 but put the phone down before it was connected. The Panel identified that there should be awareness-raising amongst the public to enable people to correctly identify and therefore report symptoms of mental illness and to be clearer about where to access help. There are parallels with physical ill health, for example there are campaigns on how to recognise symptoms of a heart attack or stroke.

Di Reed

July 2016

Glossary of terms

ADHD - Attention Deficit Hyperactivity Disorder

AHIM - Assistant Head and Inclusion Manager

CAMHS - Children and Adolescent Mental Health Services

CCN - Child Concern Notification

CJLN - Criminal Justice Liaison Nurse

CPN – Community Psychiatric Nurse

CYPS - Children and Young People Service

DHR – Domestic Homicide Review

DWP – Department of Work and Pensions

ENT – Ear, Nose and Throat Department

FLO – Family Liaison Officer

FSO - Family Support Officer

HV - Health Visitor

IMR – Independent Management Review

JSA - Job Seekers Allowance

NTW – Northumbria Tyne and Wear NHS Foundation Trust

OR - Outreach Worker

SALT – Speech and Language Therapist

SENCo - Special Education Needs Co-ordinator

SIO – Senior Investigating Officer

STC – South Tyneside College

STDH – South Tyneside District Hospital

STH – South Tyneside Housing

STNHSFT – South Tyneside NHS Foundation Trust

Recommendation	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones to achieve in enacting recommendations	Target date	Date of completion and outcome
To ensure Routine & Selective Enquiry are embedded in practice within STNHSFT (continued action from DHR#1)	Local	A&E Senior managers must ensure all staff are familiar with Trust Guidelines on: Identifying and Responding to Domestic Abuse. A&E group supervision, provided by safeguarding advisors will address how to ask patients routinely on domestic abuse issues. A review audit in 3 months and 6 months to determine changes to practice.	STNHSFT	All staff will access and be familiar with the Trust guidelines on domestic abuse and ensure the clinical policy signature sheet is completed as evidence. The safeguarding team advisors will provide 6-monthly safeguarding group supervision which will highlight routine enquiry. A review audit will be planned for end Sept 16/ end Mar 17.	Jul 16 Jul 16 Sept 16 Mar 17	

To ensure that staff who come into contact with potential victims of domestic abuse are effectively trained.	Local	Domestic abuse training to be delivered as part of the Child Safeguarding Training. Managers and Service Leads to provide evidence of staff who have been trained.	STNHSFT	Safeguarding Children and Families from Domestic Violence, Abuse & Managing Disclosure training module Training Attendance lists will demonstrate which staff continue to be trained with regard to domestic abuse	Sept 16 Sept 16	
To ensure that wider social factors are taken into consideration in Early Help assessments.	Local	Review assessment tool. Review training provision.	STC Early Help	Assessment tool reviewed & amended, if required Training package includes use of updated tool	Complete	Assessment tool reviewed April 2016 Training on new tool already complete – April/May 2016
Raise public awareness of how to identify and seek appropriate help for mental ill health	Local	Develop communications plan to raise awareness of mental health issues in the community	NTW	NTW website to be reconfigured to promote good mental health and wellbeing within the community. The website to offer signposting	Mid Oct 16	

		Raise awareness across organisations and communities of the evidence-based actions that can be taken to promote and protect mental health and emotional wellbeing across the lifecourse.	South Tyneside Council - Public Health	for mental health services Joint HWBS action plan signed off Action plan for emotional resilience sub-group implemented; with annual updates on achievements and progress.	Mar 17 2016-2020 Mar 17 Mar 18 Mar 19	
To ensure changes in key crisis mental health service provision are made clear to out-of-hours contacts.	Local	A message be put on the answerphone of the former Bede Wing, at South Tyneside Hospital, redirecting people requiring crisis support for acute mental health issues.	NTW	Answerphone message put in place.	Apr 16	Answerphone now advises the number has been changed. This has been fully operational from 13/04/16 redirecting out of hours 0191 454 8446 callers to 0303 123 1145.
To ensure that lessons learned from this DHR are included in domestic abuse training.	Local	GPs and practice staff to receive a lessons learned session with regard to this DHR.	STCCG	Lessons learned from DH2 will be shared within the planned education forum for GPs	Oct 16	
To ensure each	Local	GP Safeguarding	Named GPs and	Review the	Oct 16	

GP practice to monitor the uptake of Domestic Abuse training by GP staff.		Leads in each Practice to monitor the uptake of Domestic abuse training by GPs	Practice Safeguarding Leads	current DA training undertaken by GPs Develop a training plan to ensure GPs receive appropriate DA training	Mar 17	
To ensure the provision of Domestic Abuse training for out of hours GPs is current.	Local	Ensure DA training delivered to GPs working within the out of hours service is in line with the guidance from the colleges.	NDUC Safeguarding Lead	Out of Hours GP service to review the training requirements for GPs regarding Domestic Abuse	Dec 16	
To strengthen the management oversight quality assurance processes when decisions are made to take 'no further action' following referrals.	Local	Audit activity by managers in respect of contact decision making.	South Tyneside Council – Contact & Early Response	Audit programme developed with team managers from CRT to commence on a monthly basis with a feedback to service manager Service manager undertook audit in Feb 2016 to ensure the robustness of contact activity decision making.	Sept 16	

		Development of an early help system for all contact's not reaching social care threshold's to be offered a service. Development of a multi-agency safeguarding hub which will take over the CRT function.		MAAT to be established with partner agencies as part of early help offer Multi agency team to be established at point of contact for concerns for children and families	Jan 16 Oct 16	MAAT has now been set up and has supported and any concerns with thresholds following multi-agency checks are escalated to service manager for action. Families are offered a professional response to support early identified needs for the family. Work steams ongoing to progress this on a 4 weekly basis with multi-agency buy in at a chief executive level. This will ensure a multi-agency ownership of thresholds for families within South Tyneside
Review the systems for recording information,	Local		South Tyneside Council – Early Years' Service		Complete	Already in place. New "triage" system up and running (August

advice calls and referrals						2016) All contacts now recorded on Early Help Module, if considered below Section 17 threshold.
To provide training for Managers to promote reflective practice and ensure more effective management oversight within the supervision process.	Local		South Tyneside Council – Early Years' Service		Complete	Comprehensive system of supervision and group supervision in place since September 2015. Training provided. Case files regularly audited.
Case supervision to be held on file. Verbal discussions of cases and recommendations from management should be recorded within the contact notes of the file to evidence management oversight.	Local		South Tyneside Council – Early Years' Service		Complete	Supervision notes now kept on file – since feedback from DHR. Service Manager checks this through audit of case files audited by managers – termly.
Dissemination of	Local		South Tyneside	All staff meeting	Autumn 2016	

learning from the IMR to improve inter-agency working, engagement with families and professional challenge.			Council – Early Years' Service	in Autumn term 2016 will be used to disseminate learning and refresh training on use of assessment tool. New assessment format to be introduced in October 2016 (to meet Troubled Families criteria). Training to be provided in use of this format.		
All officers and staff responding to, and investigating domestic abuse are to be reminded that 'Proportionate Investigation does not apply to reports of domestic abuse. All reports of domestic abuse are to be thoroughly and robustly investigated' as clearly stated in	Local	Internal Email broadcast. Ensure the DA policy is available to all staff.	Northumbria Police	1.Broadcast to Officers to re appropriate investigation. 2.Understand and identify the risks.	Complete	An e-mail broadcast via Supt Ford to all front line Officers. Coercive control training delivered to all staff. A review of harm reduction plans has been completed. Standards of investigation of all crimes are reviewed by supervisors.

current force policy on crime investigation.						
All officers and staff responding to and investigating domestic abuse are to be reminded that the Northumbria Police Procedure for Investigating Domestic Abuse clearly states that enquiries should be intrusive and tenacious in establishing the true facts.	Local	Ensure a process to review DA cases Initiate training for all front line Officers	Northumbria Police	Highlight to Officers the need to initiate appropriate enquires. Ensure the DA policy is refined and available to all Officers	On-going November 2016	Risk assessment training on planned for 2016. DA Policy and Procedure has been reviewed and streamlined offering concise guidance to staff. There is a process in to review and Risk assessments.
All incidents of Domestic Abuse to be recorded accurately with a DASH risk identification checklist.	Local	To be included in Safeguarding training	Northumbria Police	Highlight to staff to complete DASH RIC. Ensure that incidents are not closed without appropriate update.	Complete	Refined policy is in place for staff in particular communications centre staff and supervisors' DA data is presented to Senior Management Board (SMB) under the 'victim's journey' section. As part of this

						Corporate Development audit DA records and Harm reductions plans.
The Role of the Duty Supervisor: All supervisors for officers and staff responding to and investigating domestic abuse are to be reminded that it is the duty of the front line supervisor to ensure that the DASH form and domestic abuse screens are fully completed before the officer terminates their duty. Where appropriate safeguarding is carried out the form should be forwarded to the Central Referral Unit. The Duty	Local	Internal e-mail broadcast highlighting the policy Use audits to assess that the Policy is been adhered to. Ensure CRU quality check referrals.	Northumbria Police	Action already taken is that CRU undertakes quality control checks As above	Complete	As above

Supervisor should monitor the incomplete domestic abuse queue for front line staff. The Duty Supervisor is intrusive in their supervision of reports of domestic abuse to ensure 'All reports of domestic violence are to be thoroughly and robustly investigated'						