Safer South Tyneside

# Domestic Homicide Review

## OVERVIEW REPORT

**Into the death of Louise**

# Contents

# Section One: Introduction

The Review Panel would like to offer their condolences to the family and friends of Louise and seek to reassure them that by undertaking this review we seek to learn the lessons from this tragedy. The Panel would like to thank Louise's family and friend, Henry and his family for their contribution to this report, their information was invaluable.

At the time of her death, Louise was living with her partner, Henry, and their two children who were both under 5 years old.

In the week leading up to Louise's death, there was a change in Henry's presentation. He believed that she was having an affair with a man who had sent her a friend request on Facebook. The couple had a joint Facebook account and there was no suggestion that Louise was having an affair but Henry was not able to accept this.

During that week, Henry presented very differently, he rang Louise constantly at work and accused her of not being there. On one occasion Louise asked her friend and work colleague to tell Henry that she was at work and standing next to her.

At the end of the week there was an altercation between Henry and Louise's mother. Henry drove to Louise's mother's house and demanded that she go with him to see Louise at work. He wanted her to confront Louise about having an affair. Louise's mother refused and she said that Henry had assaulted her, pulling her hair. Henry stated that Louise's mother assaulted him first and he then pushed her away. Henry made an allegation to the Police that Louise's mother assaulted him, he later retracted this. It was not known until later that the couple's two children were in the back of the car.

Louise's mother telephoned Louise who said she 'had had enough of him and just wanted to concentrate on her and the children.' She was not having an affair but working hard for her family and children's' future.

The following morning, Henry's father took him to the Walk-in GP centre. Henry saw the GP alone, there were no parking spaces and his father had the youngest child with him. Henry said that he told the GP that he had palpitations and pains in his head, he thought he might have 'bi-polar' and wanted to go to Bede Ward, which used to be a Mental Health in-patient facility but no longer is. Henry said he told the GP that he was having paranoid thoughts' but did not tell the GP he thought Louise was being unfaithful. The GP recorded that Henry complained of palpitations, anxiety, stress and low mood and denied any thoughts of suicide. The conclusion was the symptoms were stress related and gave Henry a leaflet and advice about Talking Therapies.

Louise was at work all day, Henry was with his family and he was said to be quiet. His father drove with Henry to pick Louise and her friend up from work. Louise's friend said that he sat in the front of the car and was very quiet; he sat with his head in his hands and did not say anything which was unusual for him. The friend was

dropped at home, then Louise, Henry and his father went for a pizza and then his father dropped Louise back at home, taking Henry back to his house. Louise then texted Henry saying that she did not want to be alone and therefore his father took him back to the couples' home.

The following day, Henry took a taxi to his car and then drove to a number of places; he said he said the sat nav took to a cliff edge to kill himself. He returned to South Tyneside and went to see his father. Louise's mother and step-father were worried that they had not heard from her and later that day, three members of the family broke into her house and found her body in the bedroom. The Police and ambulance were called and Louise was pronounced dead.

It appears that Henry had picked up a knife which was in the bedroom and stabbed Louise, either late the previous night or the early hours of the morning. 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. At the time of finding Louise's body, Henry's whereabouts were unknown, he later presented at the Police Station with his father.

Whilst at the Police Station, Henry was seen by the Criminal Justice Liaison Nurse, Northumbria Tyne and Wear Mental Health Foundation Trust (NTW). He was said to be acting oddly and appeared 'suspicious' and the Criminal Justice Liaison Nurse concluded that he needed a full mental health assessment. In consultation with the Consultant Psychiatrist, it was decided that a full assessment would take place once Henry was remanded in Prison. Henry was charged with Louise's murder.

Henry was transferred from Prison to Hospital for a full mental health assessment. He was diagnosed with schizophrenia and Henry was convicted of manslaughter with diminished responsibility and sentenced to a Hospital Order with restrictions under Section 37/41 Mental Health Act 1983.

**Background**

Louise and Henry knew each other since they were teenagers and had a long term relationship. They lived together with two children. Louise worked part time and Henry worked as a casual labourer. They had regular contact with both maternal and paternal families and help with child care.

# Section Two: The Review Process

Northumbria Police notified South Tyneside's Community Safety Partnership Board of Louise's death in 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.

The Community Safety Partnership identified an Independent Chair of the Panel and an Overview Report Writer.

The Independent Chair met with the Senior Investigating Officer to ensure that the review did not conflict with any criminal investigation and the Coroner was informed of the process.

Agencies known to have had contact with the victim or alleged perpetrator were contacted and asked to secure any records, and were advised that a DHR was taking place.

These agencies were asked to prepare a chronology of their involvement with the victim, perpetrator and the children. They were also asked to prepare Independent Management Reports (IMRs).

Louise's mother and step-father and Henry's parents were informed that a DHR was being undertaken. Henry was also informed and he consented to the sharing of information.

# Section Three: Contributors to the Review

The DHR Review Panel consisted of the following representatives:

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| Independent Chair | Head of Safeguarding |
| 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 | Community Safety Officer and Domestic Violence Coordinator |
| South Tyneside Council | Strategic Lead – High Impact Families, South Tyneside Council |
| 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 |

None of the members of the Panel had any direct contact or knowledge of Louise, Henry or the family.

Individual Management Reports (IMRs) were sought from a number of agencies and these are detailed and discussed in Section Five. None of the IMR authors had any direct contact or involvement with Louise, Henry or the two children.

The Independent Chair, Overview Report Writer and Community Safety Partnership Coordinator all had sight of two out of the four psychiatric reports on Henry commissioned for the Court. The decision was made not to share these with the Panel because of the degree of personal information within them but to feedback the conclusions. The Panel decided not to pursue the two outstanding reports as sufficient information had been gained.

The Independent Chair and the Overview Report Writer met with Louise's mother and step-father and one of her friends who Louise also worked with. The Community Safety Partnership Coordinator and the Overview Report Writer met with Henry and his parents. Information provided by the family was invaluable and provided an insight into Louise, her background and her hopes and ambitions for the future. All accounts were consistent about the couples' relationship although there were differences of opinions in relation to the circumstances leading up to Louise's death.

# Section Four: Involvement of family and friends

The following people were interviewed by the members of the Review Panel and their contribution was invaluable:

- Louise's mother and step-father
- Louise's friend
- Henry
- Henry's mother and father.

All those interviewed, said that Louise and Henry had a relationship which had its 'ups and downs', not dissimilar to a lot of relationships. No one reported any incident of domestic violence. Louise was described as a bright, bubbly young woman who was proud of her children and ambitious for them and the family. There was no evidence that Louise was having an affair and it appeared that family and Louise's friend had tried to convince Henry of this. Louise herself had told him that it was not true.

Henry reported problems with his mental health since he was a teenager but he did not tell anyone. He said the week leading up to Louise's death he felt unwell, he said he had 'pains in his head, paranoid thoughts and palpitations'. He believed Louise was having an affair because a man had sent her a friend request on Facebook, even though they had a joint account.

Louise's mother and Henry both talked about the incident when he went to her house and wanted her to go with him and confront Louise about having an affair. Henry said that Louise's mother pushed him and she said that he assaulted her. Louise's mother rang Louise and told her about the incident to which Louise replied 'she had had enough of him and wanted to concentrate on her and the kids'.

Henry attended the out of hours GP surgery and was examined and given information about Talking Therapies. Both he and his family believe that the GP should have 'done more', however Henry could not recall what information he gave to the GP, he believed that he said he had paranoid thoughts and believed that Louise was 'cheating on him'.

On the night before Louise's body was found, Henry's family said he was quiet and there was no indication of potential violence. His father said he would not have taken him back to Louise if he had any concerns. Louise's friend also confirmed that Henry was quiet.

# Section Five: Terms of Reference

The panel sought to examine the following issues:

- 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.

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

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

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

- Whether agency transition planning arrangements were sufficiently robust?

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

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

- 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?

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

    - Professional standards

    - Domestic violence policy, procedures and protocols

- Were agency procedures in place and fit for purpose?

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

- 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?

- 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.

- 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?

- 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 Six: Agency Involvement

Individual Management Reports (IMRs) were completed by the following agencies:

- 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

Each agency's IMR covers the following:

> A chronology of involvement with Louise, Henry and in some cases their children. What was done or agreed and whether internal procedures were followed. Each agency drew their own conclusions and recommendations to address the issues set out in the terms of reference.

Some accounts had more significance than others and covered different timescales, dependent on their involvement. The accounts varied in terms of the quality of content and the information provided.

DWP Jobcentre Plus had limited contact with Louise who was recorded initially as a lone parent in 2011 when she claimed for Income Support. In March 2013 she

notified the DWP that she was moving in with her partner and Henry claimed for the family unit.

Henry had a number of claims for benefits and there was regular face-to-face contact, he mostly complied with the policy of fortnightly attendance although there were some sanctions. Henry did start his own business as a casual labourer and signed off from Job Seekers Allowance.

The North East Ambulance Service NHS Foundation Trust (NEAS) had two contacts with Henry when Henry was assaulted in a nightclub in 2012 and when his father made a call to 111 before the incident to say that Henry was suffering from palpitations. The call was triaged according to NHS Pathways and there was no indication that Henry required an ambulance.

In relation to Louise, there were seven contacts including the day her body was found. There were three face-to-face contacts related to minor injuries and a non-traumatic back pain. There were four telephone contacts made to 111 for minor injuries.

South Tyneside NHS Foundation Trust (STNHSFT) first contact with Louise was when she was pregnant with Child 1. She continued to have contact with the Health Visitor for routine reviews of Child 1 and Child 2, after her second child was born. There were no concerns about the development of either child. Routine or selective enquires about domestic abuse were not asked of Louise apart from one appointment at the Early Pregnancy Assessment Clinic when it was recorded that she answered ‘no’ to the question.

There was School Nurse involvement with Child 1 because of concerns about his behaviour in School and a query that he may have Attention Deficit Hyper-Activity Disorder (ADHD). Louise had a difficult relationship with the school in relation to Child 1’s behaviour and there is no evidence that the School Nurse made any attempt to discuss Child 1’s behaviour directly with Louise.

Child 1 attended A&E on three occasions, one for an irritable hip and two for minor injuries. On all occasions, Child 1 was discharged back to the GP. Child 2 was seen for skin problems of gastro-oesophageal problems.

Louise attended A&E on six occasions between November 2011 and October 2014, with minor injuries often relating to road traffic accidents and on one occasion with back pain and muscle injury. No routine or selective enquiry was made and the injuries were never questioned.

Henry attended the Ear, Nose and Throat Department (ENT) with tinnitus (ringing in his ears) in response to a Claims Lawyer. It was reported that he gained a number of musculoskeletal injuries e.g. whiplash following road traffic accidents.

The IMR produced by South Tyneside College relates to Louise and her success at gaining a Level 3 City and Guilds Diploma. The college had no concerns about Louise, she only had 75% attendance but that was within acceptable standards.

Northumbria Police had no involvement with Louise until her death. There was some involvement with Henry, as a schoolboy they were called to a fight and he was arrested and received a reprimand. In 2009 he was stopped for an illegal number plate on his car. The first significant involvement was in 2004 when he applied for a shotgun licence but was refused because of the two previous incidents.

There was some Police involvement with Henry's father, in 2013 ammunition was found in Child 1's bedroom and his father was questioned about this and a Child Concern Notification was submitted to Children's Social Care. In June 2014, Henry's paternal Aunt complained to the Police that Henry and his father had broken into her home and Henry's father had assaulted her partner. Henry was arrested and cautioned for criminal damage and his father for common assault.

Just before Louise's death, there was an incident at her mother's house between her mother and Henry. There are differing accounts of this incident but both agree that Henry drove to the house to ask Louise's mother to go with him to where Louise worked so he could confront her about having an affair. Louise's mother refused. Henry said Louise's mother assaulted him and he reported this to the Police but later retracted. Louise's mother said that Henry assaulted her. It was not known until after Louise's death that the two children were in the back of the car.

The Police recording of this incident is confusing, Louise was recorded as the perpetrator because the Officer wanted to record the incident as domestic abuse and the altercation was brought about because Henry believed Louise to be having an affair. The Police conducted an internal investigation and the error in recording was put down to and error by the individual Officer.

Two days after the incident between Henry and Louise's mother, the Police were called the couple's house following a report that three people were breaking in. These were members of Louise's family and they were concerned that they had not seen her all day. On arrival, the Police found Louise's body in the bedroom with a number of stab wounds. They called an ambulance and Louise was reported dead. At this time, Henry's whereabouts were unknown but he later presented at the Police Station with his father and was arrested for Louise's murder.

Henry told the Police that he could recall waking up and holding a knife that he kept in his room, he said he was 'hearing voices saying that Louise had been sleeping around'. He said that he looked at the person in the bed and it looked like Louise but he did not think it was her and he stabbed her. He then took a taxi to where he had left his car the previous night and drove to a number of places, including the side of a lake where he contemplated jumping in. He then drove back to his father's house.

Henry was found guilty of the manslaughter of Louise with diminished responsibility and was sentenced to a Hospital Order with restrictions.

South Tyneside Homes provided a history of Louise's tenancies. She was the occupant of three addresses before her last tenancy. This last address was initially a joint tenancy between Henry's father and another male who was the son of Henry's father's ex-partner. This other man relinquished his half of the tenancy in 2007 and the property was bought by Henry's father in 2013 under the Right to Buy Scheme.

In a 'Getting to Know You' survey conducted by the Housing Provider, Louise referred to herself as Henry's father's niece. Louise submitted a housing application in April 2013 to include Henry and Child 1, this was the first time that Henry was registered as an occupant of the house.

Northumberland Tyne and Wear NHS Foundation Trust (NTW) had some involvement with Louise when she was a young adult. She was referred by her GP due to concerns about her home situation and relationships and she was placed on anti-depressants. It was recorded that Henry was her boyfriend and she wanted to train as a Nurse but he said he would end the relationship if she did so. There was evidence that Louise's mood improved and after five failed appointments she was discharged from the Service.

Child 1 was referred to Children and Adolescent Mental Health Services (CAMHS) within NTW because of concerns about the child's behaviour. CAMHS did not see Child 1 rather suggesting that a referral be made to a Consultant Paediatrician to rule out any physical cause for the behaviour.

Henry was seen at the time of his arrest by the Criminal Justice Liaison Nurse because he appeared to be acting oddly. He was smiling at the ceiling, could smell burning but there was none evident, he said he had driven to Leeds in response to hearing songs and voices making reference to him which he saw as a sign to attempt suicide. The Criminal Justice Nurse concluded that Henry would need a full Forensic Mental Health Assessment and agreed with the Consultant Psychiatrist that this could be done once Henry was remanded in custody.

The IMR covering the involvement of the GP practice was completed by a GP at the request of NHS England on behalf of NHS South Tyneside Clinical Commissioning Group (CCG). Louise was well known to the GP Service and had 89 contacts with the Surgery, 52 of which were GP contacts, 15 Nurse contacts, 18 midwife contacts and 4 contacts with the GP out-of-hours service. In total, Louise saw 21 different GPs because the Surgery is a large Teaching Practice. The author of the report concluded that many of the consultations were for minor illnesses. Louise did have tonsillitis and had a tonsillectomy. There were also some minor injuries e.g. back and knee pain following road traffic accidents.

Henry had a number of GP consultations for injuries following road traffic accidents. He also reported an injury to his nose following an assault in 2012. He was seen by the GP Out of Hours service the day before Louise's body was discovered. Henry complained of palpitations, stress and anxiety and said he had low mood and felt depressed. He reported that he thought his partner was 'cheating on him'. The GP recorded that the examination was normal and believed Henry's symptoms to be stress related and he was given the number of Talking Therapies which is a service for people with mild to moderate mental health problems and the phone number of the Crisis Line.

Child 1 was seen by the GP for minor illnesses and concerns expressed by the school about the Child's behaviour e.g. not looking at people directly, putting inanimate objects in their mouth and no understanding of bad behaviour. Child 1 was

referred to CAMHS and later on to Paediatrics on the advice of CAMHS. Child 2 was seen for minor illnesses and immunisations.

No routine or selective enquiries were made by the GP in relation to domestic abuse during any of Louise's appointments or in relation to Child 1's behaviour. Whilst Louise had a number of attendances at the Surgery, the author of the IMR felt that this was consistent with a person who did not cope well with minor illnesses. However, he felt that Child 1's behaviour was a missed opportunity to explore wider family and social issues in more detail.

The IMR provided by Children and Families Social Care reports the first contact with the family was in 2013 when they received a Child Concern Notification from the Police that ammunition had been found in Child 1's bedroom and this belonged to Henry's father. It was concluded that Child 1 was unlikely to have been able to reach the ammunition and the decision for 'no further action' was taken. Other information provided was Henry's father had two impending prosecutions for failure to comply with a firearms certificate and offering to supply cannabis. There was no discussion with the Police about these two outstanding offences and no consideration of the information when deciding to take no further action in relation to the Child Concern Notification.

The IMR for the Early Years and Children's Centres Team relates to the involvement with Child 1 and concerns about the child's behaviour and possible link to ADHD. The Early Help Worker was to complete an assessment and Louise was seen at home on eight occasions by the Children's Centre Worker to undertake a bespoke Early Years Parenting Programme. Henry was present for three visits but left early on two occasions. Louise responded positively to the Programme and it was reported that there was an improvement in Child 1's behaviour. Questions about domestic abuse were not asked but no concerns were raised about the couple's relationship. Child 1's behaviour was seen as a developmental problem rather than a wider social or family issue.

The IMR completed on behalf of the school detailed involvement with Child 1 and Louise and Henry. The school raised concerns about Child 1's behaviour e.g. chewing things, making silly noises, difficulty remembering basic things such as group colour. Louise also expressed concerns e.g. Child 1 hitting and digging at the baby, wetting the bed, only drinking out of certain cups, eating rubber and making loud noises.

There were a number of meetings at the school, the Class Teacher agreed to use a positive behaviour chart in class, the Support Assistant to complete one to one and nurture group work and the Family Support Worker to visit Louise at home. There were questions raised about Child's 1 ability and Henry did not like this. It is recorded that Henry and his father thought that Child 1's behaviour was typical for a child that age. Also Henry and Louise had different parenting styles, with Louise setting boundaries. Louise also said that Henry's father spoilt Child 1 and did not enforce boundaries. The School believed that they provided a great deal of support to Child 1 but Louise reported a breakdown of relationships and the School believed that there could have been better communication between agencies.

# Section Seven: Key Themes

In relation to Louise and Henry, there were no issues of alcohol or drug use. Louise was an able and ambitious young woman who wanted the best for her family. She was proud of her children and worked hard for them, both in terms of earning a living and working with the Incredible Years Parenting Programme to improve Child 1's behaviour. At the time of Louise's death, Henry was working as a casual labourer.

There was no evidence of domestic violence. None of the family members or the friend interviewed reported any physical violence or coercion in the relationship. They all reported that the couple had their 'ups and downs' but this appeared no different to many couples. None of the agencies reported any incidents or concerns about domestic abuse.

Routine or selective enquiries into domestic abuse were not asked other than on one occasion when it was recorded that Louise answered 'no'. In terms of the concerns about Child 1's behaviour, this was seen as developmental and a question of parenting styles rather than looking at wider family or social issues. Whilst there was no evidence of domestic abuse in relation to this family, it is within agencies' policies to make enquiries and wider social issues need to be taken into consideration such as the differing parental expectations, Henry's father who was said to have 'spoilt' Child 1, ammunition in Child 1's bedroom and the incident between Henry, his father and paternal Aunt.

Louise attended the GP Practice on 89 occasions for minor injuries and illnesses. She was seen by 21 different GPs and other Health Professionals. Routine or selective enquiries into domestic abuse were not undertaken. The GP Surgery is a large Teaching Practice which explains the number of different GPs seen and whilst there is no evidence that Louise's medical needs were not met it was felt that the number of different GPs seen may have created a potential for missing patterns of behaviour or wider social issues.

There was the incident between Louise's mother and Henry, days prior to her death. Henry drove to Louise's mother's house and wanted her to go with him to where Louise worked and confront her about having an affair. Louise's mother refused and Henry said she attacked him, she said he attacked her. When Henry reported this to the Police, Louise was recorded as the perpetrator and this was confusing. On investigation by the Police, this appears to be an error made by an individual Police Officer who recorded the incident as domestic abuse and Louise as the perpetrator because the incident was about her. When Henry retracted his complaint, the incident was never followed up and therefore Louise's mother was not interviewed and the nature of the incident was not explored. The children were present but were in the back of the car, and this was not known until after Louise's death.

There were concerns about Henry's health the week leading up to Louise's death. Henry, his family and Louise's friend reported that he appeared quiet and preoccupied with Louise having an affair; he would ring Louise at work demanding to know where she was, believing that she was elsewhere. There was evidence that

people tried to reassure Henry about Louise but he was not able to accept that she was not having an affair.

On the day before Louise's body was found, Henry went into the out of hours GP service and complained of feeling unwell. He said that he said that he thought he was 'bi-polar' but could not recall all that he said to the GP e.g. he could not recall if he said he was hearing voices but he thought he did. The GP examined Henry who was complaining of palpitations, stress, low mood and anxiety and it is recorded that he believed that Louise was 'cheating on him'. The GP said that Henry appeared 'calm and quiet' during the consultation, he complained about being angry and upset the night before but this was not explored in detail. Henry was given advice to contact Talking Therapies the following week.

Later that day, Henry contacted Bede Wing, which used to be a Mental Health In-patient Ward but now is an out-patient facility. The Panel were informed that many of the public may associate Bede Wing with mental health and therefore see it as a place to contact. It was out of hours when Henry contacted them and therefore there was no response. He also contacted 111 but hung up before he was connected.

Henry has subsequently been diagnosed with Schizophrenia and was found guilty of manslaughter with diminished responsibility and sentenced to a Hospital Order with restrictions.

The day before Louise's body was found, Louise was working and Henry and his father picked her and her friend up as they often did. Louise's friend said Henry was sat in the front with his head in his hands and did not say anything; this was not his usual presentation. Henry's father was driving and dropped Louise's friend off then the three went for a pizza, he returned home and Henry was going to stay the night at his father's but Louise texted to say she did not want to be alone. Henry's father said he would not have returned Henry if he thought there was going to be any risk. From the information provided by the GP earlier that day, Henry's father and Louise's friend, there was no indication of any potential violence from Henry towards Louise.

# Section Eight: Lessons to be learnt

### South Tyneside Council on behalf of the School

The school identified that communication could have been better between agencies An example being that one agency did not attend a school or Early Help Meeting or send a representative or report.

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.

### 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.

### 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.

### 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.

## 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.

## 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.

## 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 Nine: Effective Practice

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 Ten: Conclusions

This section asks the following questions:

- Could Louise's death have predicted?
- Could her death have been prevented?
- Have all the questions in the Terms of Reference been considered?
- Is there wider learning that may improve practice in the future?

Could Louise's death have been predicted?

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 Louise's death have been prevented?

Could her death have been prevented? There were two opportunities to make further enquiries about risk: firstly, Henry's assault against 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. On the day before Louise's body was found there was a change in Henry's presentation but no indication of violence, indeed he was presenting as quiet and calm.

What is the learning from the Terms of Reference?

All agencies fully cooperated with the review process and demonstrated a willingness to look critically at their own practice and embrace the learning.

The Review Panel concluded that most assessments were done in a timely manner and there was effective intervention. However, there lacked robust interrogation of

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.

Whilst there was no indication of domestic abuse, 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.

Learning from the Terms of Reference:

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, and are working through, their action plans.

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).

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.

## 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 GP during the out of hours 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.

## 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.

## Whether agency transition arrangements were sufficiently robust?

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

## 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.

## 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, but not always, incorporated within Child Safeguarding training. Within the training offer, 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 employed by 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 at 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).

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.

## 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 recorded 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, but there was no evidence at the time.

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

- 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, and 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.

- 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 Risk Indicator Checklist (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'.

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 (Sept 2015) re-launched its Quality Assessment framework in September 2015 and 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.

## 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.

## 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? When interviewed, Henry reported

symptoms of mental disorder since teenage years but said that he 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.

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.

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, 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.

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. This included reducing the parameters of the work the Service undertakes and increasing the staff structure and the level of management oversight.

# Section Eleven: Recommendations

Single Agency Recommendations:

The following are recommendations identified by single agencies through the IMR process:

**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.

**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.

**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.

**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.

**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’.

Recommendations identified by the Panel

The following are recommendations identified by the Panel:

### 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.

### 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.

### 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.

### 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.

# Section Twelve: Action Plan

An action plan has been agreed by the Panel, this includes both single agency actions identified through the IMR process and the actions identified following the review.