# A Domestic Homicide Review

## Calderdale Community Safety Partnership

## The Overview Report

## December 2019

## Clare Hyde

## Jenny 2017

Contents

## 1 Family Key

| | |
|---|---|
| Jenny | The homicide victim, aged 23 |
| Tim | The perpetrator aged, 27 |
| H | Jenny and Tim's child |
| S | Jenny and Tim's child |
| Jenny's mother | |
| Jenny's sister | |
| Tim's father | |
| Tim's mother | |

## 2 Glossary of Acronyms

| | |
|---|---|
| GP | General Practitioner |
| OM | Offender Manager |
| MARAC | Multi-Agency Risk Assessment Conference |
| ALPS | Acute Liaison Psychiatry Service |
| DASH | Domestic Abuse Stalking Harassment |
| PTSD | Post-traumatic stress disorder |
| DHR | Domestic Homicide Review |
| CSP | Community Safety Partnership |
| ICST | Intensive Community Support Team |
| CMHT | Community Mental Health Team |

## 3 Introduction

1. This Domestic Homicide Review (DHR) concerns the murder of Jenny by Tim. The review panel offer their sincere condolences to Jenny's family and thank them for their contributions to this review.

2. The picture which emerged of Jenny throughout the course of this review is best summed up by the way in which she has been described by her mother and her sister.

3. Jenny's family described her as a strong, young woman and a really good mum to her two very young children. She worked hard in a full time job and was well thought of by her workmates. She was bright, funny and very close to her family. Jenny's mother said of her that she could quickly deal with tension and arguments by making everyone laugh. She also said "At the back end of the relationship with Tim, she was determined that it was over. The last eight weeks when she was living with her sister and at my house all she got were texts hassling her to go talk to him. It was only the last eight weeks that she started to tell us what things were really like in her life with Tim". Jenny's mum went on to say, "The children are missing their mum and H wears her perfume and dressing gown when they come to see me as it reminds them of their mum. Jenny was the life and soul of everything and brought everyone together. She was so loving, and I miss her every day and speak to her every day as if she was here. It's still in my head that she's going to walk into the house one day".

4. Jenny and Tim had known each other for approximately 5 years, they had 2 young children together, H and S.

5. In the five days prior to the homicide Tim was staying with his sister at an address in Leeds. Jenny lived in Calderdale.

6. Jenny and Tim had separated a number of times, the latest being a number of weeks before the homicide.

7. Tim murdered Jenny in August 2017 at her home in Calderdale. Both children were present in the house. Tim was arrested on the same day. He was subsequently charged with Jenny's murder. He appeared at Leeds Crown Court in January 2018, where he was found guilty of murder and was jailed for life with a minimum term of 17 years.

8. This DHR considers agencies' contact and involvement with Jenny, Tim, H and S between June 2012 and August 2017.

9. Tim has a history of one previous violent offence (GBH), for which he served a prison sentence and other non-violent offences. During the timescales of this review Tim was using cocaine and alcohol regularly.

10. Tim was in irregular contact with mental health services, and it was reported by himself, Jenny and his parents that he had considered taking his own life on two occasions. He also stated that he had attempted suicide whilst serving his first prison sentence on one further occasion.

## 4 Reason for conducting a Domestic Homicide Review in this case

11. The circumstances under which a Domestic Homicide Review must be carried out are described in legislation and national guidance. The relevant legal requirement is the Domestic Violence, Crime & Victims Act (2004) Section 9, which came into force on the 13th April 2011. The national guidance is described in *multi-agency statutory guidance for the conduct of domestic homicide reviews, which* was revised in 2013.

12. A domestic homicide review has to analyse the circumstances in which the death of person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or a member of the same household as themselves.

13. The circumstances of Jenny's death were referred to the Domestic Homicide Review Standing Group and discussed on 31st July 2018. That meeting made the decision that the circumstances met the criteria for a Domestic Homicide Review.

## 5 The purpose of the Domestic Homicide Review

14. The purpose of a Domestic Homicide Review, as stated in the statutory guidance, is to:

    a. 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;

    b. 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;

    c. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

    d. Prevent any homicide relating to domestic violence and improve service responses for all domestic violence victims through improved intra and inter-agency working.

15. Domestic Homicide Reviews are not inquiries into how the victim died or into who is culpable; that is a matter for the coroner and the criminal court respectively, to determine as appropriate. Domestic Homicide Reviews are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a Domestic Homicide Review, indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the Domestic Homicide Review process. Alternatively, some Domestic Homicide Reviews may be conducted concurrently with (but separate to) disciplinary action. The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions.

## 6 The terms of reference and key lines of enquiry

16. The national guidance describes generic terms of reference that provide a context for the development of more case specific key lines of enquiry and learning that are described. The full terms of reference are attached at *Appendix 1.*

17. The Terms of Reference were adapted and agreed by the DHR Panel as being appropriate to the specific circumstances of this case and specified that the review would:

- Construct a comprehensive chronology of involvement by the organisations and/or professionals in contact with Jenny and her family.

- Construct a comprehensive chronology of involvement by organisations and/or professionals with the perpetrator, Tim.

- Through the completion of Individual Management Reports establish whether there were any missed opportunities by practitioners to intervene earlier and more effectively. And to respond to the following key lines of enquiry;

    - What knowledge/information did your agency have that indicated that Jenny might be subjected to domestic violence and how did your agency respond to information including that provided by other agencies.

    - What services did your agency offer to Jenny; were they accessible, appropriate and sympathetic to her needs?

    - What information and/or concerns did the Jenny's family and friends have about victimisation?

    - Were agencies aware of any mental health issues for Tim? If so, what actions did you take?

    - Did Tim have a mental health assessment during the timescale for this review? If so, what was the outcome of the assessment?

    - How did any diagnosis or contact with Tim lead to a risk assessment? Specifically in respect of Jenny and the children?

    - Was Tim's self–reporting of PTSD ever verified?

    - What knowledge did your agency have that indicated that Tim might be a perpetrator of domestic violence?

    - Was the safety and well-being of Jenny and the child/ren considered by agencies at appropriate points?

    - Were referrals to Children's Social Care considered at appropriate points by all agencies?

    - Establish if agencies adhered to their own domestic abuse and safeguarding policies and procedures and if not what the barriers that prevented this from happening were.

    - Identify any issues with inter-agency working

    - Identify any aspects of the case that exhibit good practice

    - Identify any key themes and lines of enquiry to inform a practitioners' learning event.

- Make recommendations for action based on the lessons learned

- Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim, the alleged perpetrator or any other members of the family and also impacted on the agency's ability to work effectively with other agencies?

18. In addition, agencies and the DHR Panel were asked to consider relevant research or evidence from previous reviews conducted locally, regionally or nationally; consideration may also be given to evidence from other Community Safety Partnerships, Local Safeguarding Children's Board or evaluations of reviews; Take into account any common themes and actions arising from that research and those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case.

19. Agencies were also asked to consider any previous reviews of single agency practice. Taking into account any common themes and actions arising from those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case.

20. Each of the key lines of enquiry was accompanied by additional prompts for the agencies and their authors to consider when undertaking their agency review. For example, authors were asked to consider whether any information known to their services should have led to a different response and to consider the significant contributory factors that influenced how people made their decisions at the time.

## 7 Equality and Diversity

21. The victim and perpetrator's families are English, White British. Religion is not considered to be a feature of their lives.

22. The panel has been mindful of the need to consider and reflect upon the impact, or not, of sex and other protected characteristics of Jenny and Tim.

23. The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition), marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."

24. In this case, the victim's sex was female. Women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence and homicide. For example, the Home Office December 2016 analysis of Domestic Homicide Reviews in 2014/15 found that there were 50 male and 107 female victims of domestic homicide (which includes intimate partner homicides and familial homicides) aged 16 and over. The majority of principal suspects in domestic homicide cases were male (87% for combined years 2010/11 to 2014/15).

25. During the period under review, Jenny was pregnant and gave birth to her second child and this is a relevant protected characteristic as around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy. (Safelives.org.uk)

26. Tim disclosed to mental health professionals that he was questioning his sexual orientation and that this was causing him some distress.

27. The panel noted that Tim had been treated by his GP for anxiety and depression and was also referred to psychological services and specialist mental health services in relation to anxiety and depression during the period under review. Tim was not diagnosed with a severe and enduring mental health condition.

28. There were no other specific equality and diversity factors noted by the panel.

## 8 Parallel Processes

29. West Yorkshire Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

## 9 Dissemination Plans

30. The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process. The report will be published on the Calderdale Metropolitan Borough Council website.

- The victim's family via support services
- The perpetrator's Offender Manager, National Probation Service
- Calderdale Community Safety Partnership's membership
- Office for Police and Crime Commissioner
- Panel members

## 10 The methodology of the review

31. The Domestic Homicide Review was completed using the methodology and requirements set out in government national guidance that applied at the time of the review being commissioned and completed.

32. A review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel was chaired by an appropriately senior, experienced and independent person, who is also responsible for providing this overview report.

33. The panel established the identity of services in contact with the family during the time frame agreed for the review.

34. Reviews of all records and materials that were considered included;
    - Electronic records
    - Paper records and files
    - Patient or family held records.

35. Agencies that identified significant background histories on family members pre-dating the scope of the review provided a brief summary account of that history.

36. The agencies that had significant involvement were required to provide an individual management review (IMR) that were completed by senior members of staff who had no direct involvement or responsibility for the services provided. Individual management reviews were

completed using the Community Safety Partnership template (adapted from the national guidance) and were quality assured and approved by the most senior officer of the reviewing agency.

37. The following agencies have provided an individual management review that was completed in accordance with *multi-agency statutory guidance for the conduct of domestic homicide reviews,* any associated local guidance and relevant procedures including those of the Community Safety Partnership or Calderdale Safeguarding Children Board where appropriate:
    - West Yorkshire Police
    - National Probation Service
    - Calderdale Clinical Commissioning Group (CCCG)
    - Calderdale and Huddersfield NHS Foundation Trust
    - Barca- Leeds (representing Forward Leeds)

38. All IMR's have been challenged robustly and, where appropriate, subject to review and revision since their initial submission.

39. As no agencies identified significant recording of, or interventions for, domestic abuse the generic terms of reference described in national guidance were adapted to reflect this.

## 11 The scope of the review

40. The period of the review is from June 2012, when Jenny became pregnant with H, until the murder of Jenny in August 2017. Key incidents and events which fall outside of this timescale were also considered and are referred to in detail throughout this report.

## 12 Membership of the review panel and access to expert advice

41. The case review panel that oversaw this review comprised of the following people and organisations:

| Name | Position | Organisation |
|---|---|---|
| Clare Hyde | Independent Chair | Foundation for Families |
| Rachel Boakes | Safeguarding Adults Specialist Practitioner | Leeds Yorkshire Partnership Foundation Trust |
| Dr Susi Harris | Named GP Safeguarding Lead Adults | Calderdale CCG |
| Louise Moody | Minute Taker | Calderdale CCG |
| Mark Patterson | Calderdale Neighbourhood Manager | Together Housing |
| Sarah Sturgeon | Quality & Performance Manager | Barca-Leeds/ Forward Leeds |

| | | |
|---|---|---|
| Joanna Fraser | Serious Case Review Officer | West Yorkshire Police |
| Charlotte Palethorpe (CMBC) | Community Safety & Resilience Team Apprentice | Community Safety Partnership |
| Sarah Barker | CSP Team Leader | Calderdale Metropolitan Borough Council |
| Corinne Liddle-Johnson | Matron Maternity /Named Midwife Safeguarding | Leeds Teaching Hospital Trust |
| Paula Gardner | Operations Director | Barca-Leeds |
| DCI Stuart Bainbridge | Detective Chief Inspector | West Yorkshire Police |
| Maggie Smallridge | Head of Safeguarding | National Probation Service |
| Lindsay Britton-Robertson | Head of Safeguarding | Leeds York Partnership Foundation Trust |
| Beth Gelipter | Service Manager | CGL Leeds IOM |
| Luke Turnbull | Designated Nurse Safeguarding Adults | Calderdale CCG |
| Alison Sparling | Specialist Nurse Advisor for Adult Safeguarding | Leeds Teaching Hospitals NHS Trust |
| Dawn Gibbon | Named Midwife Safeguarding Children | Calderdale & Huddersfield NHS Foundation Trust |
| Vicky Thersby | Head of Safeguarding | Calderdale & Huddersfield NHS Foundation Trust |
| David Longthorpe | Head of Housing Management | Housing Leeds |
| Gill Marchant | Head of Safeguarding Designated Nurse Safeguarding Children and Adults | Leeds CCG |
| Wayne Logan | Team Manager Children's Assessment Team | Calderdale Children's Social Care |

42. The Co-Chairs of Calderdale Community Safety Partnership were satisfied that the Panel Chair and Author was independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the Panel to safely and impartially examine the events and prepare an unbiased report.

43. The third sector domestic abuse service provider was unable to commit to provide representation at the panel due to capacity issues at the time (Jenny had not accessed their

services and was unknown to them), however the Chief Officer of the domestic abuse service provider had sight of the report in its draft form and the opportunity to provide feedback in her role as a member of the Calderdale Domestic Abuse Partnership.

44. The Panel Chair and Author of the overview report attended every meeting of the panel.

45. Written minutes of the panel meeting discussions and decisions were recorded.

## 13 Independent author of the overview report and the chair of the review panel

46. The independent author was Clare Hyde MBE. Ms Hyde is founder and Director of The Foundation for Families, a not for profit community interest company established in 2010.

47. Ms Hyde was CEO of WomenCentre Calderdale and Kirklees between 1994 and 2009 and developed nationally acclaimed and evaluated domestic abuse and other services for at risk women and their families. Ms Hyde was a member of Baroness Corston's government commissioned review of women with vulnerabilities in the criminal justice system, which took place in 2005/6 following the deaths of 12 women in custody.

48. In 2005, Ms Hyde was awarded an MBE in recognition of her contribution to women and children's domestic abuse services.

49. Ms Hyde also worked for the NHS in a regional improvement role (between 2005 and 2011) and led the development and delivery of the Yorkshire and Humber Transformation of Adult Social Care programme during that period. Ms Hyde was also the National Institute of Mental Health England (NIMHE) Programme Lead for the region.

50. Ms Hyde has been working as an independent chair and lead reviewer for children and adults' reviews and domestic homicide reviews since 2011 and is currently working on a major thematic review of child sexual exploitation, she also provides supervision and mentoring to senior staff in a University Social Work department.

51. Ms Hyde has not worked for or with any Calderdale agency since 2012.

## 14 Family contribution to the Domestic Homicide Review

52. The victim's family were advised of the review through the police family liaison officer following the first meeting of the panel.

53. The author met three times with Jenny's mother alone, Jenny's mother and sister together in April 2019, and a further meeting with Jenny's sister in May 2019. They were advised about the process of the review and the terms of reference. They were also asked if they wished to attend or ask questions of the panel and contribute to the report in describing Jenny. They were given the opportunity to shape the terms of reference but declined and did not wish to attend a panel meeting.

54. They received specialist advocacy services from Victim Support's Homicide Service and Jenny's sister was given the details of and offered support to access a specialist voluntary sector counselling service.

55. The author provided a copy of the report to the family and was present to answer any questions and note any amendments or comments from them. The author has remained in contact with them following the sharing of the report and will update the family when the review is formally completed to discuss publication with them.

56. Tim was offered the opportunity, in writing, to contribute to the review but did not respond.

57. The young ages of the children and the specific difficult circumstances of the family following the homicide meant that a decision was made not to involve them in the review.

58. The perpetrators family were not asked to contribute to the review due to the specific circumstances at the time. These circumstances were ongoing as at November 2021 and it was still not appropriate to ask them to contribute.

## 15 Timescale for completing the Domestic Homicide Review

59. The Domestic Homicide Review panel met on 5 occasions between July 2018 and June 2019. The initial chronology of services' involvement was completed by August 2017. The first drafts of some of the narrative agency reviews were completed in September 2017. The final report was presented to the Community Safety Partnership in January 2020.

## 16 Status and ownership of the overview report

60. This report is the property of the Calderdale Community Partnership as the commissioning body for the review. All Domestic Homicide Review overview reports provided to Community Safety Partnerships in England are expected to be published. This report provides the detailed account of the key events and the analysis of professional involvement and decision making. It concludes with findings and recommendations to address the learning identified during the review.

61. The report is primarily written with the intention of addressing professionals involved with the design, oversight or delivery of multi-agency services although it should also provide accountability and information to other interested parties.

62. The report has to balance maintaining the confidentiality of the family and other parties who are involved, whilst providing sufficient information to support the best possible level of learning.

63. In reading this overview report, it is important to remain clear about the purpose of the review and of this overview report in particular. The Domestic Homicide Review examines with the benefit of hindsight and other analysis, if it is possible to identify whether alternative judgments and decisions could or should have been taken, and whether different outcomes might have been achieved. The review also aims to provide recommendations for improvements to multi-agency working. The review does not investigate the circumstances of the death of Jenny. This was dealt with through the criminal investigation and prosecution.

## 17 Synopsis of the Homicide

64. At approximately 12.46 hours on a date in August 2017, Jenny's mother attended a police station in Leeds to report her daughter missing. She reported that she had last spoken to Jenny at 7pm the evening before.

65. Jenny's mother went on to report that she had received a telephone call from Tim's father, who had informed her that Tim had dropped H and S off at his home in Leeds at approximately 2 am that morning.

66. Jenny's mother stated that she travelled from her home in Halifax to Leeds with Jenny's sister to look for Jenny as there had been no sign of her, and she was concerned for her safety.

67. At 15.15 hours on a date in August 2017, Jenny's mother rang 999 and stated that she was at Jenny's home address and had discovered her dead on the bed.

68. Police Officers attended the scene followed by a Yorkshire Ambulance First Responder, who pronounced Jenny deceased at 15.25 hours.

69. A pathology report concluded that, when the case was considered in its entirety and the pathological findings were put into the context of the available information, it was highly likely that Jenny died of mechanical asphyxia.

## 18 The narrative overview and summary of information about the contact and involvement of services.

70. This section of the report summarises the information known to agencies and professionals in contact with Jenny, Tim and the children. It provides the narrative summary of professional contact with the victim and the perpetrator between June 2012 and August 2017. (Information from July 2009 which relates to Tim's previous conviction for a violent offence is referred to as this is relevant to this review).

71. This chapter provides an account of the most significant events and decisions from the different services involved. The analysis of agency involvement is provided in the next chapter.

***2009***

72. In July 2009 Tim was sentenced to 48 months custody for offences of Section 18 and Section 20 of Wounding, this was an attack on a male stranger after a disagreement over a minor matter. This offence was committed with two other individuals. This was Tim's first conviction. Alcohol was a feature in relation to the offence.

***2011***

73. Tim was released from prison in July 2011 and was subject to Probation supervision until his licence end date, which was in July 2013.

74. After the licence end date, Tim had no further involvement with Probation until he committed the offence that this report relates to.

***2012***

75. In June 2012, Jenny presented for antenatal care for her pregnancy with H. Tim was present and named as the father of the baby.

76. Throughout 2012, Jenny attended routine ante-natal appointments and did not disclose domestic abuse when she was asked about it and no other concerns were noted by the midwives or health visitors.

77. Tim attended an appointment with his Offender Manager (OM1) in June 2012 and informed OM1 that his partner was pregnant.

***2013***

78. On 25th February 2013, Tim attended the Probation office with his partner and new baby. There is a lack of recording of who the partner/baby were, but it is presumed to be Jenny and H.

79. On 6th April 2013, the staff of a hotel in Leeds telephoned an ambulance to attend Jenny, who was aged 18 at the time, as she was heavily intoxicated, partially dressed and with a group of men in one of the hotel's rooms. The ambulance responders called the police upon arrival at the hotel, but no further details are held on the police system.

80. 19th June 2013, Tim attended his final appointment with his OM (OM3).

81. On 23rd June 2013, Tim was reported as a missing person to WYP by his parents. During their search for him WYP spoke to Jenny, who stated "that they had an argument and Tim had stormed out and said, "you will never see me again". She did say he has threatened to self-harm before but had not carried out these threats, however, she is worried for his safety".

82. Tim returned home safe and well a day later.

83. July 2013, Jenny applied online to Together Housing for re-housing. Tim was not included on the application.

84. In August 2013, Tim attended an appointment with his GP and reported that he was using cocaine and 'skunk', and that he was experiencing mood swings and paranoia. The GP gave Tim a telephone number to contact a local substance misuse service.

85. Later in August 2013, the police were called by a member of the public to a 'domestic incident' which involved 4 adults: Jenny, Tim and Tim's parents.

86. The police record of this incident states that Tim is shown as the perpetrator during the domestic abuse incident. Jenny answered no to there being any children in the household and no to recently having a baby within the past 18 months. There was no mention of the baby (H) during the incident and no referrals are recorded as being made to Children's Social Care or any other Partner agency. Jenny did not want any further help from the Police. No mental health issues were identified. A 'Standard risk assessment' was made.

87. Later in August 2013 Tim moved in with Jenny as a joint tenant.

88. Also in August 2013, Tim's father visited the GP on behalf of Tim and described Tim as being out of control at home; screaming & shouting. Tim's father was worried that Tim would hurt himself or someone else and explained that he was frightened to try to control him as Tim was a lot bigger than him.

89. Following Tim's father's visit to the GP, Tim was accompanied to A & E by Tim's mother and the police.

90. Tim and his parent's reported that he had been found by Jenny with a noose in his possession and she had informed his parents. Tim stated that he had been feeling suicidal and depressed for 2 months. He reported that he had seen his GP who had prescribed medication for anxiety but that he had felt no improvement. He stated that he felt increasingly depressed and unable to cope with family stress.

91. Tim stated that he had sent 2 suicide notes to his parents and ex-partner about a week ago. He explained that he was struggling to tell his family about some personal issues but that he felt relieved that he had now told his partner and his parents.

92. Tim's mother reported that he had previously attempted suicide.

93. It was noted that Tim had a 7 month old child and lived permanently with mother (it is not clear if this meant his own mother or Jenny).

94. A referral to the Intensive Community Support Team (ICST) was made for Tim, however, following a telephone discussion with him in August, Tim declined support and agreed to a referral to the Community Mental Health Team (CMHT).

95. In September 2013, Tim's father telephoned the police to report that Tim had turned up at the family home and had 'kicked off', causing damage to their car and a door in the house. Tim's father said that he thought that Tim was high on drugs. The police completed a DASH risk assessment (medium risk). Tim's mother did not consent to a referral to support services.

96. Tim was offered an appointment with the CMHT in September but did not arrive. A member of staff telephoned Tim and the phone was answered by Tim's mother who explained that Tim had been missing since earlier in September.

97. Tim was arrested September 2013 on suspicion of damage to his parent's car and property. Tim was cautioned and released. The police recorded that "*He has fully admitted damaging the car and door to the house. However, the complainant does not wish to pursue this matter and will not go to court. Due to this an adult caution is appropriate, the complainant agrees with this decision*".

98. Tim attended an appointment with the CMHT in September 2013 and reported that he was struggling to come to terms with some personal issues. A summary of the assessment found no evidence of thought disorder, paranoia, delusional beliefs or psychosis.

99. In October, Jenny completed a housing benefit claim stating that Tim had moved out of the property. (Leeds tenancy).

***2014***

100. In February 2014 Jenny moved to a private tenancy in Calderdale.

101. In February 2014 Tim registered at a Calderdale GP practice and gave his address as the same as Jenny's.

102. In April 2014 Tim had his vehicle seized for driving without insurance.

103. In December 2014 Jenny secured a tenancy with Together Housing in Calderdale and was named as the sole tenant.

***2015***

104. In April 2015 Jenny attended A & E suffering a miscarriage. She was 8 -9 weeks pregnant, and it was recorded that she lived with her partner. Agency records do not show that Jenny was asked about domestic abuse at this attendance, therefore it is not possible to say that domestic abuse was or was not a factor in the miscarriage. However, we know that violence often increases in pregnancy and women who experience domestic abuse are at higher risk of miscarriage.

105. In September 2015 Tim was accompanied by his parents to a GP practice in Leeds. Tim stated that he had tried to hang himself 2 weeks previously. He reported feeling very depressed, tearful and stated that he needed help.

106. Tim stated that he lived with his partner Jenny, and he would go there that evening. Tim also reported that *'he was in prison for violence 5 years ago, no further incidents since. He dabbled with cannabis in the past but denies any involvement with recreational drugs or alcohol. He reports on & off depression since his prison admission as he was seriously assaulted in prison. He feels he needs medication and counselling. Agreed to start Mirtazapine 15mg tablets and "Insight" contact details given, Tim agreeing to contact them'*.

In September 2015 Tim self-referred to 'Insight' Counselling Service.

107. In September Tim completed a 45 minute telephone assessment with Insight. At the assessment standardised measures indicated 21/27 for symptoms of depression (Severe) and 17/21 for symptoms of anxiety (Severe) and it was also identified that he was experiencing symptoms of PTSD.

108. During the assessment Tim stated that 5 years previously he was a victim of a serious assault while in prison. (August 2009) He stated this was the reason for his referral. He stated that he was in prison for a crime his friend committed and that he took the blame. He has been having flashbacks and nightmares since the event. He described feeling scared, anxious and emotional. He talked about reduced activity, poor sleep and poor appetite. He stated that he was taking Mirtazapine (anti-depressant) and that he lived with his girlfriend and child (who was then 2 years old)

109. He denied any thoughts to harm himself or others and admitted to trying to take his own life by hanging when he was in prison. Tim opted for Cognitive Behavioural Therapy.

110. In September, Tim revisited the Leeds GP practice, and it is recorded that Tim has "*good and bad days but can see things getting better in future. Had first appointment with "Insight" & found counsellor easy to talk to. Will be seeing her twice a week. Continues with medication, sleeping better. Drowsy in mornings so not driving. Boss understands. Has thoughts of suicide but "would never do anything about it" Cites his child as a protective factor*".

111. In September 2015 Tim attended an appointment for CBT therapy with the Insight service. His scores on clinical measures indicated moderate-severe symptoms of depression (19/27) and severe symptoms of anxiety (15/21)

112. Tim reported having a good relationship with his family and a supportive girlfriend. He talked about how he took the blame for his friend who assaulted a man and went to prison for 4.5 years. He talked about being assaulted in prison in 2009 and how he feels he couldn't protect himself and what if now he couldn't protect his family.

113. No risks to self or others were identified.

114. Tim did not attend his scheduled 2nd appointment with the 'Insight' service but did attend in October 2015.

115. Tim's scores on clinical measures indicated no symptoms of anxiety or depression.

116. Tim stated that he had been jogging and boxing which had helped his motivation. He had stopped taking his medication as he felt this was making him feel worse. He denied any flashbacks or nightmares to the assault. No risk to self or others were identified.

117. Tim did not attend further scheduled appointments with the 'Insight' service and was discharged by them in December 2015.

***2016***

118. In June 2016 a complaint was made to Jenny's landlord by a neighbour. The complaint was about noise nuisance and inconsiderate parking. During their investigations, Together Housing were told by another neighbour that Jenny and Tim had a '*volatile relationship*' and that the neighbour was afraid that Tim might '*explode at her'.*

119. In July 2016 Jenny booked for maternity care with S. Tim was named as the father.

120. In December 2016, when she was 26 weeks pregnant, Jenny attended an ante-natal appointment and was asked a routine question about domestic abuse. She responded that there were no issues of domestic abuse.

***2017***

121. In January 2017, Jenny telephoned the police to report that Tim (from whom she stated she had separated) had visited the house the previous evening and had taken her bank card and the back door key. He had withdrawn money from her account.

122. Later, on the same date, Jenny reported that the money and the card had been returned to her by Tim.

123. In January 2017, Tim was arrested for arson having set fire to his own car. Whilst in custody Tim underwent a risk assessment. He reported that he had tried to hang himself in 2009 and that he used cocaine on a daily basis. There was no 'cross reference' made to the previous day's reported incident of theft by Jenny and the domestic abuse risk assessment was not reviewed.

124. Tim was further arrested for possession of cocaine and tested positive for cocaine whilst in custody. He was released from custody in January 2017 with an Adult Conditional Caution.

125. The Adult Conditional Caution specified that Tim attended a substance misuse service.

126. In January Jenny informed the police that she did not want to take the theft of the bank card and money any further as they had been returned to her.

127. A DASH assessment was carried out (standard risk).

128. In January 2017 Tim re-registered with his Leeds based GP.

129. In January 2017 Tim attended his appointment with the substance misuse service and stated that he had been abstinent from alcohol, cocaine and cannabis for 14 days.

130. Tim stated that he had previous treatment in Calderdale and had counselling for PTSD and that he was coming off anti-depressants. He stated that his relationship breakdown with Jenny led to a relapse into drug use in 2016.

131. Tim also stated he had booked in with his GP to re-commence antidepressant medication. A further appointment was made.

132. In January, 16 days after it had taken place, the police reviewed the incident of theft of Jenny's bank card which had been recorded as a domestic abuse incident. The domestic abuse 'flag' was removed from the system as it was felt that "*There is no controlling, coercive, threatening behaviour, violence or abuse*".

133. Also in January, Tim visited his GP and explained that he had attended an appointment with the substance misuse service. Tim reported that he had previously taken antidepressants but had stopped last year. He also reported that he had used cannabis and cocaine but was no longer taking drugs.

134. Tim denied thoughts of self-harm. The GP diagnosed depression and prescribed an antidepressant.

135. In January 2017 Tim attended the substance misuse service for a comprehensive assessment.

136. It was noted that Tim "*Reports being a Binge drinker once every 4 months for a week where he will drink 2 bottles of whiskey a day with cocaine and cannabis. Reported abstinence for 3 weeks. Social Situation – reports living with parents, not currently employed, no children living with client and no contact at home address*".

137. The substance misuse service Recovery Worker further recorded:

- Criminal Justice – reports current convictions and on current Probation Order.
- Mental Health – Diagnosed with PTSD, had therapy and medication in 2015 but disengaged due to drug use, pressure from family and re-occurring nightmares triggered by the therapy.
- PTSD as a result of being assaulted in prison aged 19yrs.
- Tried to hang himself in prison after this; stopped by staff. Won £40, 000 compensation for the assault, came out of prison and tried to get on with life; working as a driver, but started smoking cannabis which affected his job. Started to binge on drugs and alcohol.

- Describes taking himself "away", staying in hotels and having binges- wanted to be alone, and block out his thoughts/ flashbacks.

- Not experienced nightmares for a couple of months now but thinks he will tonight after speaking about this with me.

- No history of aggression to himself or others, tends to become introverted and isolates himself, "until I snap out of it".

- Felt anxious before today's appointment; worried about telling me his past. Able to manage anxiety by self-talk.

- Panic attacks in the past- he thinks he is getting better at managing these now.

- Sleep is disturbed- frequently wakes.

138. The Recovery Worker offered Tim a referral to the Forward Leeds Specialist Team in respect of his report that he suffered from PTSD.

139. The Recovery Worker carried out a risk assessment and Tim "*stated no history of violence. Suicide Risk after disclosure but not current – stated child is a protective factor".*

140. The Recovery Worker also noted in respect of safeguarding "*Has supervised contact with his child- saw him in December and once in January with his ex-partner and his parents present. No lone contact with him. Denies any social care involvement*."

141. An entry was made to the Risk Assessment after the assessment session and the Recovery Worker stated a need for communication with a Criminal Justice worker. Update stated Jenny no longer pregnant and Tim reports trying to set fire to his own car after a recent drug binge. (Jenny was in fact 30 plus weeks pregnant at this point.)

142. In February 2017 Tim attended a further appointment with the substance misuse service.

143. The Recovery Worker noted that Tim reported that he had remained abstinent from drugs (6 weeks) and that his sleep has increased to around 5-6 hrs a week (this may have been an error in recording and should have read 5-6 hours per night)

144. The Recovery Worker discussed how to improve poor memory with Tim and agreed the following plan:

    - Refer to Specialist Team, but with a view to a waiting time which gives him chance of a lengthier spell of abstinence prior to therapy;

    - Start the Refresh Group;

    - 1:1 housing appointment.

145. Tim reported that speaking to H by phone helped motivate him.

146. In February the Substance Misuse Service Housing Support Officer telephoned Tim to offer support in making an application for housing, which Tim accepted, and an appointment was made.

147. In February 2017 Jenny, at 36 weeks pregnant, attended a routine antenatal care appointment. As she attended with H the midwife did not ask about possible domestic abuse on that occasion and did not ask in a less direct way.

148. In February an appointment letter was sent to Tim for mental health support for PTSD.

149. Also, in February Tim did not attend scheduled appointment with the Recovery Worker who telephoned Tim twice post non-attended appointment to check in with him. Tim did not answer the calls however he did drop into service after missing the appointment. The Recovery Worker was not available, and a further appointment was booked.

150. In March 2017 Tim did not attend a scheduled appointment with the specialist team for PTSD support.

151. In March, at her 38 week antenatal appointment, Jenny was asked about domestic abuse which she did not disclose.

152. In March Tim did not attend a scheduled appointment with the Substance Misuse Service and the Recovery Worker telephoned Tim twice but he did not answer.

153. The Recovery Worker also called Tim's mother but there was no answer. (The Recovery Worker sent a letter offering a final appointment for later in March 2017).

154. S was born in March 2017.

155. In March the Recovery Worker telephoned Tim and recorded "*he is back at work and feeling fine- says life is looking up. Unable to speak in detail as he was in a car but agreed to discharge- advised him to re-contact us in the future if needed.*" Tim was discharged from the service and stated that he had remained abstinent from drink or drugs for 10 weeks

156. In March 2017 Tim was reported missing by Jenny who stated that he had not been seen since 8pm the evening before. Tim returned to Jenny's address later that same day.

157. Tim attended his GP in April and reported that his sleep was still poor and that he was anxious about leaving the house.

158. In August 2017 Jenny telephoned the police and reported that she had been contacted by a neighbour who advised her that someone was at Jenny's home taking items from inside. They advised Jenny that there was a male there, with a van parked to the rear, loading it up with items from inside. Jenny stated that she believed it might be her ex-partner Tim.

159. Jenny's mother confirmed that at this point, Jenny was staying at her sister's house in an attempt to have no contact with Tim.

160. Also, in August an anonymous call was received by the police (from Jenny's mobile number) she reported that Tim had taken cocaine and was currently driving.

161. In August Tim telephoned the police to report that Jenny was extremely intoxicated and had got into her car around half an hour ago. The police were unable to locate the car. The phone call was made at 00:26 hours. The police incident log was finalised at 00:44 hours as an area search had not traced the car. It was not recorded if any checks were made at Jenny's home

address to check on her welfare or if the call was malicious or domestic related. It was noted that the last reliable intelligence on the vehicle had been at 21:06 hours.

162. On a date in August 2017, Jenny's mother reported her daughter missing to the police. She reported that she had last spoken to her daughter at 7pm the evening before. She stated that Jenny had gone off with her ex-partner Tim. At 8.35pm that same evening she had received another telephone call from her daughter.

163. Jenny's mother went on to report that she had received a telephone call from Tim's father who informed her that Tim had dropped H and S off at his home in Leeds at approximately 2am that morning.

## 19 Additional Information considered by the Review

164. The DHR panel members and the independent author made a decision to consider information which came to light during police investigations following the murder of Jenny.

165. The information relates to statements made by members of Jenny and Tim's families (some of which were reported upon by the press during Tim's trial).

166. Without considering this additional information it was difficult for the review to determine the extent of any domestic abuse prior to the homicide and therefore difficult to identify any learning for partner agencies.

167. The additional information considered relates to the knowledge various family members had that Tim had been abusive; including physical violence, controlling, coercive and possessive towards Jenny.

168. One key piece of information was provided by Jenny's sister who stated that she had seen text messages sent to Jenny from Tim in August 2017 which said *"Slag, watch what I do to you" "If I can't have you no one can" "I'm not the monster I used to be, what do you think I am going to do to you?"* and Jenny replied "*I know what you are going to do, you're going to kill me"*

169. Jenny's mother in discussion with the independent author confirmed that Tim had been abusive prior to the homicide and that Jenny was often bruised but would deny that Tim had caused the injuries deliberately. Jenny said that the injuries had been caused during 'play fighting'. Jenny's mother also observed holes in the wall at Jenny's home where Tim had punched the wall.

170. Tim's mother stated to the police, following the homicide. that Tim had been violent towards Jenny but that she believed that there had been no violence since the children were born.

171. From considering this additional information it is clear that Tim's abuse of Jenny was long standing.

## 20 Analysis of information against the key lines of enquiry

172. This section is informed by the discussions held with Jenny's family, information held by the police following the homicide, discussions which took place with the DHR Panel, the agency IMRs and by the wealth of research which exists in relation to domestic abuse.

173. Important messages for learning from this review are detailed within this section and are reflected as recommendations where relevant.

174. ***Were agencies aware of any mental health issues for Tim? If so, what actions did you take?***

175. Tim accessed support and interventions in respect of his mental health throughout the timescales of this review.

176. Agencies responded appropriately to Tim's symptoms as he presented, however, he did not always report the same symptoms or difficulties to different practitioners.

177. Agencies referred Tim for further assessments and interventions in respect of his mental health which are described in the following section of this report.

178. ***Did Tim have a mental health assessment during the timescale for this review? If so, what was the outcome of the assessment?***

179. Tim underwent a number of assessments in respect of his mental health.

180. In 2013, Tim was assessed by the Acute Liaison Psychiatry Service (ALPS) whilst in the A & E department (following a possible suicide attempt) and referred by them to the Community Mental Health Team (CMHT).

181. The CMHT carried out an assessment and concluded that there was "*no evidence of thought disorder, paranoia, delusional beliefs or psychosis".* The presenting problems indicated to the assessing practitioners were; Tim's mood, suicidal thoughts, increased alcohol and substance misuse, poor sleep and appetite and problems with concentration. In the assessment it was identified that the presenting problems were primarily driven by sexual orientation issues and the perpetuating factor of alcohol and substance use, although Tim was not of the view that he needed help with alcohol and substance misuse.

182. The assessing clinical team felt that Tim would benefit from counselling around his sexual orientation, rather than input from mental health services. Therefore, Tim was signposted to appropriate support services, and he was provided with a crisis mental health support number and Leeds Addiction Unit.

183. Tim did not access follow on support from either of these agencies.

184. In 2015 Tim underwent a 45 minute telephone assessment with the Insight counselling service. At the assessment, standardised measures indicated 21/27 for symptoms of depression (Severe) and 17/21 for symptoms of anxiety (Severe) and it was also identified that he was experiencing symptoms of PTSD.

185. Tim opted for Cognitive Behavioural Therapy (CBT) at the end of this assessment and attended his first appointment. His scores on clinical measures indicated moderate-severe symptoms of depression (19/27) and severe symptoms of anxiety (15/21). Tim described having a good relationship with his family and a supportive girlfriend (Jenny).

186. Tim attended his second CBT appointment within 2 weeks of the initial appointment and his scores on clinical measures indicated no symptoms of anxiety or depression.

187. This significant difference in Tim's scores on clinical measures within a two week period was discussed by the DHR panel members. It is possible that Tim was not honest about his symptoms and had under, or over, stated them. The reasons that he may have done so are not clear.

188. Tim was assessed by his GP as having depression and was prescribed medication to help alleviate his symptoms.

189. Tim was assessed in respect of his mental health issues at various points between 2013 and 2017, however he did not engage with services for sufficient time to complete treatments or interventions.

190. The impact of this non engagement in relation to identifying risk to Jenny and the children is described in more detail elsewhere in this report.

191. ***How did any diagnosis or contact with Tim lead to a risk assessment? Specifically, in respect of Jenny and the children?***

192. As part of the CMHT assessment, a risk assessment was completed with Tim, addressing both risk to self and others. He was assessed as being no risk to others with a score of 0, but risk of suicide and deliberate self-harm being scored as a 1, indicating low risk. At the time of assessment in September 2013 it is documented that his child, who was under a year old at the time, was living with his ex-partner. He reported only seeing his child when in the company of his mother. There is no further documentation to indicate that practitioners explored with Tim why this was the arrangement.

193. Jenny's mother confirmed that the informal supervised contact arrangements had been insisted upon by Jenny as she was concerned about Tim's drug use, and the threats which had been made to Tim by people selling drugs to him, and the risks this posed to the children.

194. ***Was Tim's self–reporting of PTSD ever verified?***

195. Tim did not make any reports of any symptoms of PTSD during the 2013 CMHT assessment. The practitioner, who carried out the assessment, also did not note any indication of PTSD.

196. In 2015, when Tim briefly engaged with the Insight Service, symptoms of PTSD were noted during the 45 minute telephone assessment. However, these were not identified in the following appointments Tim attended with the CBT therapist.

197. In summary, it appears that Tim reported to some agencies that he had been diagnosed with PTSD which had arisen as a result of his experiences in prison. However, PTSD was not formally diagnosed, and Tim was not always consistent in describing his symptoms

198. It is impossible to state therefore that Tim was suffering from PTSD.

199. ***Was the safety and well-being of Jenny and the child/ren considered by agencies at appropriate points?***

200. The safety of Jenny and the children was not always considered at appropriate points and there were occasions when agencies should have made further enquiries with other agencies or explored safeguarding further with Tim.

201. These occasions include:

- When Tim presented at A & E after a suicide threat and it was stated that Jenny, his partner, had 'cut him down'. This did not prompt an exploration of how Jenny was or indeed where she was.

- Tim also told the CMHT staff that he was only allowed supervised contact with his child, and this was not explored in relation to Jenny's safety.

- Tim's disclosure to the Recovery Worker in 2017, when he stated that he had supervised contact with his child and that his partner was pregnant (he later told the Recovery Worker that Jenny was no longer pregnant although this was not true).

202. There was scope for more questions to have been asked at this point around relationships/parenting status/safeguarding and there was also an anomaly between Tim's declaration of no history of violence and the offence of GBH reported during referral.

203. It is worth noting that if enquiries had been made to establish whether or not there was a history of domestic abuse or safeguarding concerns the response from other agencies would have been negative in this case, but that will not apply in other cases.

204. During the September 2013 incident between Tim and his parents, Tim's father reported to his GP that he was afraid that Tim would hurt him or someone else. The GP advised Tim's father to call the police which he agreed to do. It does not appear that the GP asked about the existence of a partner or children who may also have been at risk. However, as Tim was living with his parents at that point the GP responded appropriately to the immediate threat to Tim's parents and advised that they should call the police.

205. ***Were referrals to children's social care considered at appropriate points by all agencies?***

206. Throughout the period of the review Jenny and the children's contacts with maternity, health visitors and GP services were routine, and no concerns were ever recorded by professionals. Jenny was asked direct questions about domestic abuse during her pregnancies although this was not at every contact and did not happen when Jenny was discharged home after the birth of her second child.

207. We know that children suffer multiple physical and mental health consequences as a result of exposure to domestic abuse. In this case, the children were present in the house when Tim murdered Jenny and were taken by him, in the early hours of the morning, and handed over to his parents. For the older child in particular this will have been a traumatic experience.

208. There were no occasions which warranted a safeguarding referral to be made to Children's Social Care, however there were occasions upon which further enquiries with Children's Social Care could have been made and these are described in the paragraph above.

209. Again, it is worth noting that the family were not known to Children's Social Care in this case, so any enquiry to establish whether or not the family were known to Children's Social Care would have returned a negative response.

210. ***Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse, and aware of what to do if they***

***had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?***

211. Jenny did not disclose domestic abuse to any agency even when she was asked about it directly.

212. In January 2017, when the police were called by Jenny following the theft of her bank card and cash by Tim, the police recorded the incident as a domestic abuse incident and carried out a DASH assessment.

213. At that point there was one previous recorded verbal domestic abuse incident between Jenny, Tim and his parents. Jenny did not wish to proceed with the complaint in respect of the bank card and cash, as she stated that Tim had returned both.

214. In January 2017 the police made a decision, based on this, that '*There is no controlling, coercive, threatening behaviour, violence or abuse*' and the 'Domestic flag' was therefore removed from the system.

215. However, Jenny was 32 weeks pregnant at that point in time and reported that she and Tim had separated the week before. These two facts meant that Jenny was at higher risk of repeat and escalating incidents, and this does not appear to have influenced decision making.

216. Whilst Tim did not disclose that he was perpetrating domestic abuse to any agency, there were indicators that domestic abuse may have been an issue. For example repeated suicide threats, drug use and aggression which were documented by his GP and when Tim told his Recovery Worker that he had supervised access to his child.

217. ***Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?***

218. The DASH risk assessment was used on three occasions by the police:

- August 2013, when the police responded to a 'verbal incident' between Jenny and his parents in which Tim was noted to be the perpetrator.
- September 2013, when Tim damaged property belonging to his parents at their home.
- In 2017, when Tim took Jenny's bank card and cash. This was not considered as potential financial abuse.

219. On each of these three occasions the DASH risk assessment was 'medium' and on the latter two occasions the victims did not want to pursue charges.

220. None of the DASH assessments would have been at a sufficient level of risk to trigger a referral to MARAC, and there was a gap of 4 years between the second and third incident which would not have suggested that incidents were escalating.

221. ***Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?***

222. In this case there was no information gathered by any agency other than the police which related to domestic abuse.

223. The police shared information with child health services on the occasion in 2017, when Tim had taken Jenny's bank card and cash.

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

225. The key opportunities for assessment and decision making in this case were:

226. **West Yorkshire Probation Trust (WYPT)**

227. Between 2011 and July 2013, Tim was supervised by the WYPT in relation to the offence he committed in 2009.

228. Tim was sentenced to 48 months custody for offences of Section 18 and Section 20 of Wounding; this was an attack on a male stranger after a disagreement over a minor matter. This offence was committed with two other individuals. This was Tim's first conviction; he had had no prior contact with Probation. Alcohol was a feature in relation to the offence. Tim was released from prison in July 2011 and was subject to Probation supervision until his licence end date, which was in July 2013.

229. During this period of time, it was known by the Probation Trust that Tim was in a relationship and that his partner became pregnant and gave birth to H before the licence end date.

230. There is no information to suggest that any of the 3 Oms, who supervised Tim, explored relationship issues, the impending birth of a baby and safeguarding with Tim or that a home visit was carried out.

231. The National Probation Service IMR Author makes the point that "In 2012 the Trust had a Safeguarding Policy and practice would have been to take an investigative approach where there are known to be children, or a pregnancy, and it would have been policy to make an assessment if a referral to Children's Social Care was appropriate. There is no evidence of this decision-making process within the records. In addition to this, home visits were part of WY Trust policy where there were known to be children or a pregnancy".

232. During the licence period Tim was mostly seen at monthly intervals. This was in line with the National Minimum Standards for cases assessed as medium risk. Tim was not seen from late April 2013 to June 2013 this was outside of the National Minimum Standards and not good practice, especially when baby, who is presumed to be H, was very young. Towards the end of licence more telephone contact rather than face to face was utilised, it appears that this was agreed by OM3 without consulting a Senior Probation Officer. With hindsight this was not good practice, especially when the baby was very young.

233. Further good practice would have been to carry out a home visit when the baby was born.

234. **Police**

235. The police responded to three domestic abuse incidents which are described in detail elsewhere in this report. The third incident, in 2017, took place when Jenny was 32 weeks pregnant, and the couple had been separated for a week.

236. This incident was recorded as a domestic incident and the decision to later remove the domestic abuse flags is described elsewhere in this report.

237. Research consistently shows that risk to domestic abuse victims increases significantly both during pregnancy and at the time of separation, and the decision to remove the 'domestic flag' from the police system did not take this into account.

238. **Mental Health Services**

239. Tim's contact with primary mental health services was brief and he did not engage for a sufficient length of time to complete any intervention. This meant that the opportunity for practitioners to identify and assess any risk he posed to Jenny and the children was limited, but it would have been possible to explore his relationship with Jenny further given what Tim had disclosed e.g., suicide attempts, drug use, 'binges'.

240. Tim had no contact with secondary mental health services beyond his presentation at A&E. This contact followed a suicide threat or attempt. Tim was accompanied by his parents, although he had stated that it was Jenny who had found him hanging and had 'cut him down'*. Tim was seen by the ALPs team whilst in the A & E department.

*This account was later changed by Tim who stated that he had a rope in a bag but had not used it to try and hang himself. This later account was also confirmed by Jenny's mother in her conversation with the independent author.

241. **Drug and Alcohol Services**

242. In January 2017, Tim was referred to the service via a Conditional Caution following his arrest for possession of cocaine. Tim did not engage in person with the service beyond his second appointment; which was in line with the Conditional Caution requirements, although he reported at discharge that he was abstinent and doing well. He received a follow up phone call in March 2017 and reported to be abstinent and 'doing well'.

243. The service was aware that Tim was separated from Jenny and that he had a child (H). It is recorded that Tim "*Has supervised contact with his child- saw H in Dec and once in January with his ex-partner and his parents present. No lone contact. Denies any social care involvement.*"

244. The Recovery Worker did not ask Tim why he had supervised contact with his child which would have been an opportunity to assess whether or not domestic abuse or child safeguarding were concerns. The two appointments attended by Tim appropriately focused on the presenting issues of drug use and Tim's significant history of mental distress.

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

246. Jenny was not identified as a victim of domestic abuse by any agency other than the police in January 2017. Her wishes and feelings were ascertained on that occasion, and she stated that she did not wish to pursue the matter.

247. Jenny did not wish to access support and was not signposted to other agencies. There is no record to indicate whether or not the police discussed various support options with her at that time.

## 21 Learning from the review

248. By the time he killed her, Tim had been violent, controlling and coercive towards Jenny for several years.

249. This included financial abuse. Jenny worked and had a regular income whilst Tim did not. Tim reported that he used drugs and alcohol regularly and at one point was buying and using cocaine on a daily basis. Jenny reported to her family that Tim was in debt to drug dealers which would have compounded his financial issues and increased Jenny's fear and anxiety.

250. Tim had significant contact with mental health and substance misuse services. In this case individual mental health, substance misuse and other health agencies did not know about the domestic abuse. However, if the agencies had shared information on a multi-agency basis for example at the Hub following the DASH assessment in respect of the 2017 theft of Jenny's cash and bank card then the multiple risks (including Jenny being pregnant and the recent separation) may have been identified. The theft of Jenny's cash and bank card were not considered as potential financial abuse, and this was not explored with her by the attending officers.

251. In addition, Tim's contact with mental health services and substance misuse services was minimal and did not progress much beyond assessment stage. Had he continued with, or completed, treatments and interventions it may have presented an opportunity for him to be able to disclose that he was abusive towards Jenny or for a practitioner to be alerted to the abuse.

252. The compounding risks of domestic abuse, substance misuse and mental illness were not recognised for these reasons. However, Tim's history included:

- One previous serious assault for which he served a significant prison sentence
- Regular use of illegal drugs
- Misuse of alcohol
- Physical and verbal aggression towards his parents
- Parental concerns that he would harm himself or someone else
- Arson
- Driving without insurance
- The report of a neighbour that she was afraid that Tim might 'explode'

- The theft of Jenny's bank card and cash
- Threats of suicide which, in the context of domestic abuse, can be used by the perpetrator to control or coerce the victim and others.
- Symptoms of mental ill health and superficial or non–engagement with services.

253. It is possible that had any single agency or practitioner reviewed Tim's past and recent history and understood the possible safeguarding implications for Jenny (especially when she was pregnant, following separation and following the theft of her bank cards and money) there may have been an opportunity to identify and assess risk effectively.

254. As previously described Jenny's mother, in conversation with the independent author, stated that Jenny had been reluctant to permanently separate from Tim as she felt that she still loved him.

255. This further compounded risk and Jenny's vulnerability to Tim's coercion and manipulation.

256. Jenny did not disclose domestic abuse to any agency or individual practitioner, even when she was asked a direct question about it. However, it is apparent that her family and friends and Tim's family knew about some of the abuse.

257. It is also apparent from the conversations between the independent author and Jenny's mother and sister that they attempted to protect Jenny.

258. Jenny's sister described that Jenny would only share limited details of Tim's behaviour but that she had herself witnessed his aggression and his extremely controlling behaviour; for example Jenny having to 'prove' where she was by filming her surroundings to show to Tim if they were apart.

259. The fact that Jenny and her family and friends did not feel they were able to seek help or report the abuse should be of concern to agencies. There are many reasons why victims do not disclose domestic abuse and it is only by understanding these reasons that we can improve our responses to victims (and perpetrators).

260. Whilst Jenny was not receiving support from any agency in respect of domestic abuse, there will be other cases where victims *are* in contact with services but who are perceived to be reluctant to permanently separate from their abuser.

261. Enrique Gracia, writing for the British Medical Journal in 2004, made the point that domestic abuse against women is considered a very serious public health problem. "*But few public health problems share this feature of domestic abuse against women: a condition affecting about 25% of the population but only a few of those affected, between 2.5% and 15%, report that they are suffering from that condition". Gracia goes on to say "Although we can estimate how many women are victims of domestic violence most cases are unreported. This makes it even more important to understand why female victims of domestic violence do not report or seek help. It appears that the reasons so many cases go unreported are both personal (embarrassment, fear of retaliation, economic dependency) and societal (imbalanced power relations for men and women in society, privacy of the family, victim blaming attitudes). But we also need to understand whether or not all those unreported cases are really invisible to the social environment surrounding the victims (friends, family, neighbours, social services, public health sector). And if they are socially visible, but not reported, we need to respond*

*accordingly*". Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance, and inhibition Enrique Gracia, BMJ 2004 (Please note the use of the word 'condition' to describe domestic abuse is not endorsed by the DHR Panel, but should not detract from the overall theme of the article).

262. It is possible that Jenny's perception of her historical relationships with statutory agencies was not positive, and this may have made her reluctant to report what was happening; which places a responsibility on agencies to ensure that services provide reassurance and sensitive support which addresses this perception.

263. Other research suggests that women (legitimately) fear losing their children if social care become aware that there is domestic abuse occurring within the household, and this too may have prevented Jenny from disclosing what was happening.

264. The impact of living with violence and coercion on Jenny's decision making will have been significant.

265. Tim did not admit that he was an abuser and seek help to stop his abuse although there were several opportunities for him to do so. However, even if he had done so, the support options available to him are very limited in respect of voluntary perpetrator programmes or proven therapeutic interventions.

## 22 Recommendations

266. The learning from this review reflects the learning from other DHR's across England, and the independent author and the DHR Panel request that the Home Office consider how a national domestic abuse public awareness campaign could be developed as a matter of urgency.

267. The CSP and partners should ensure that the patterns of abuse and the risks associated with coercion, stalking and attempted strangulation are recognised by professionals and the public as high risk indicators for homicide, in particular the risk following separation which is known to be the single biggest risk marker for homicide.

268. Awareness of financial abuse and its impact on victims and children should be raised amongst frontline practitioners and should inform assessments of risk and need.

269. The CSP should assure itself that domestic abuse policies target the reduction of the gap between prevalence estimates and reported cases. These policies would benefit from a greater research focus on societal attitudes towards intimate partner violence issues (reporting, victim blaming, tolerance, inhibition, silence).

270. Prevention policies would also benefit from data monitoring indicators of social silence, inhibition, and tolerance. This could be done, for example, by monitoring changes in the number of cases reported by those who know about the violence (neighbours, relatives, friends, health or law enforcement personnel), as well as changes in social attitudes (such as victim blaming, balance of power between men and women in relationships, or zero tolerance attitudes).

271. The CSP and partner agencies who provide help and support to victims of domestic abuse and their children should:

a. Review their own roles in promoting the message that victims (and perpetrators) can trust agencies responses and proactively address the concerns that many female victims express about 'losing their children' if they disclose abuse.

b. Consider working with and listening to survivors of domestic abuse to better understand how their services and responses may prevent victims reporting the abuse and asking for help.

272. The availability and promotion of voluntary perpetrator programmes (and other agencies which offer support to perpetrators) is also an important part of the public health approach.

273. The CSP should assure itself that the support offered to the families of the victims and perpetrators of domestic homicide, particularly following the conclusion of criminal proceedings, is tailored to meet their needs over the short, medium and long term.

## 23 Individual Agency Recommendations

274. Some of the Individual Management Reports identified learning for individual agencies and these are detailed below:

275. **West Yorkshire Police**

276. West Yorkshire Police to ensure that during homicide investigations if details of previous safeguarding issues and crimes are identified, they are recorded as such on a Niche crime occurrence (to be CDI compliant) and investigated appropriately.

277. **Leeds and Calderdale Clinical Commissioning Group**

278. Both Leeds and Calderdale CCGs will produce and circulate a bulletin for GPs, highlighting potential risk factors for domestic abuse with a focus on the evidence-based indicators that someone maybe at risk of perpetrating domestic abuse. This bulletin will recommend that if 2 or more risk factors are present (such as self-harm, a history of harm to others, substance abuse, pregnancy, separation or a significant mental health presentation) a DASH risk assessment should be completed, and onward referrals considered. If there are children in the family the health visitor should be informed of the risk to the children. If family members are thought to be at immediate or significant risk appropriate plans should be made to keep them safe. In the case of recurrent communication difficulties with any member of a vulnerable family, (defined as a family with two or more risk factors as above) the GP should make an enquiry as to the possibility that the means of communication could be being interfered with by a third party. The GP should then discuss and document the safest and preferred method of communication and appropriately share this information with other health and social care services involved. Other markers of loss of self-determination by a potential victim should add weight to ensuring this recommendation is carried out.

279. Health Visiting service in Calderdale to explore opportunities to offer regular meetings between link Health Visitor and all GP practices in order to discuss cases where there is a risk of child protection issues.

280. **National Probation Service**

281. Domestic abuse call-out checks to be carried out in relation to every case.

282. Safeguarding checks/sharing of information to be carried out in relation to every child that a case has contact with.

283. Improved information sharing between prison staff and probation staff.

284. More investigative approach to be taken when assessing mental health (especially when issues have been raised by prison).

285. To correctly record management oversight of a case/MAPPA level 1 reviews.

286. More investigative approach to be taken by management when checking Safeguarding.

287. More investigative approach to be taken when OM's meet partner/new baby.

288. Review OASys when there is a significant event, such as a pregnancy.

289. Complete termination OASys when someone reaches the end of their licence.

290. To discuss the regular use of telephone contacts with management.

291. Carry out a home visit when a new baby is born.

292. **Leeds Teaching Hospitals Trust**

293. Children's Safeguarding Team to arrange an audit to be undertaken of 25 sample cases over the past month (January 2019) in relation to completion of the Risk Assessment on page 9 of the Children's Medicine Performa on ward L09 / Children Assessment Triage Unit (CAT) to ascertain if this is routinely omitted.

294. **Forward Leeds Drug and Alcohol Service**

295. Training/practice development groups to be held on topics of Professional Curiosity and Disguised compliance.

296. Training and awareness raising around PTSD and related issues.

297. Review service procedures relating to working with service users who are parents but do not live with the child/ren.

298. Reminder to all staff to consider historical offences of violence (particularly regarding potential for risk to staff and others) when completing risk assessments and risk management plans.

## 24 Conclusion

299. Tim was dishonest about significant life events, and it is possible that he invented or embellished some events in order to deflect attention from his own responsibility for his actions.

300. Whilst it is apparent that Tim was experiencing some symptoms of mental distress throughout the period of time considered by this review, there is no information to suggest that he had a serious or enduring mental health condition.

301. The DHR panel spent some significant time considering the potential symptoms of PTSD on Tim and whether or not this could have signalled an increased risk to Jenny. It is difficult however to be certain that Tim did suffer from PTSD as he did not attend the specialist PTSD service.

302. Perpetrators use suicide threats to control, manipulate and exert power over their partners. Tim's suicide threats were used as a method to control or manipulate Jenny, his parents, and professionals.

303. Tim's contacts with professionals focused on his mental distress and his drug and alcohol use. It is also possible that he manipulated professionals and he was certainly dishonest on more than one occasion. This contributed to the fact that his violence and abuse against Jenny was not exposed.

304. Tim was undoubtedly an aggressive man who frightened his parents and a neighbour, each of whom expressed concern about his potential to be violent.

305. Tim and Jenny's families were also aware, to some extent, that he was abusive towards Jenny and they felt unable to report the abuse or ask agencies for help.

306. It is extremely troubling that Jenny herself appeared to recognise that Tim might kill her and did not feel able to ask for help from any agency. This places a responsibility on agencies who provide support for victims of domestic abuse to ask why this is the case and what they can do individually and collectively to remedy this.

307. This DHR reflects learning from other reviews which have focused on homicides which appear to agencies to have been a 'one off' event. Domestic homicides are usually underpinned by a longstanding sense of ownership, coercive control, and possessive behaviours: they are not a random event.

## 25 References

308. Gracia Enrique (2004) Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance, and inhibition BMJ London.

309. Home Office Analysis of Domestic Homicide Reviews 2016.

## 26 Appendices

**Appendix 1**

**Terms of Reference**

**Introduction:**

1.1 This Domestic Homicide Review was commissioned by Calderdale Community Safety Partnership in response to the death of Jenny. The circumstances are that at 12.46 pm on [date redacted] Jenny's mother attended a police station in Leeds to report her daughter missing. She reported that she had last spoken to Jenny at 7pm the evening before.

1.2 Jenny's mother went on to report that she had received a telephone call from Tim's father, who informed her that Tim had dropped H and S off at his home in Leeds at approximately 2am that morning.

1.3 Jenny's mother stated that she travelled from her home in Halifax to Leeds with Jenny's sister to look for Jenny as there had been no sign of her, and she was concerned for her safety.

1.4 At 15.15 hours on (date redacted) Jenny's mother rang 999 and stated that she was at Jenny's home address and had discovered her dead on the bed.

1.5 Police Officers attended the scene followed by a Yorkshire Ambulance First Responder who pronounced Jenny deceased at 15.25 hours.

1.6 A pathology report concluded that when the case was considered in its entirety and the pathological findings were put into the context of the available information, it was highly likely that Jenny died of mechanical asphyxia.

1.7 Tim had murdered Jenny at her home in Calderdale. Both children were present in the house. Tim was arrested on the same day. He was subsequently charged with Jenny's murder. He appeared at Leeds Crown Court early 2018, where he was found guilty of murder and was jailed for life with a minimum term of 17 years.

1.8 The circumstances of Jenny's death were referred to the Domestic Homicide Review Standing Group and discussed on (date redacted). That meeting made the decision that the circumstances met the criteria for a Domestic Homicide Review.

1.9 The scoping period was agreed to be from June 2012 until the date of death.

**2. Legal Framework:**

2.1 A Domestic Homicide Review (DHR) must be undertaken when 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 him/herself, held with a view to identifying the lessons to be learnt from the death.

2.2 According to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) the purpose of the DHR is to:

a) 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;

b) 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;

c) apply these lessons to service responses, including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

**3. Methodology:**

3.1 This Domestic Homicide Review will be conducted using methodology which reflects multi-agency work systemically and aims to answer the question why things happened. Importantly, it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements.

3.2 This approach is based on the expectation that reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The methodology of the review adheres to the principles of;

- Proportionality;
- Learning from good practice;
- Engagement with families.

**4. Scope of Case Review:**

4.1 Subject Jenny: Date of Birth: removed

4.2 Scoping period: June 2012 until the date of death.

4.3 In addition, agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period, including an account of what is known about Tim's history of offending. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

**5. Agency Reports:**

5.1 Agency Reports will be requested from:

- West Yorkshire Police
- National Probation Service
- Substance Misuse Service (Forward Leeds)

- Leeds Teaching Hospitals Trust
- GP Calderdale Clinical Commissioning Group
- Leeds and York Partnership Foundation Trust

5.2. Agencies are asked to:

- Complete the IMR template.
- Construct a comprehensive chronology of involvement by the organisations and/or professionals in contact with Jenny and her family.
- Construct a comprehensive chronology of involvement by organisations and/or professionals with the perpetrator Tim.

5.3 Through the completion of Individual Management Reports consider the following:

- Establish whether there were any missed opportunities by practitioners to intervene earlier and more effectively. Specifically:
- Were agencies aware of any mental health issues for Tim? If so, what actions did you take?
- Did Tim have a mental health assessment during the timescale for this review? If so, what was the outcome of the assessment?
- How did any diagnosis or contact with Tim lead to a risk assessment? Specifically in respect of Jenny and the children?
- Was Tim's self–reporting of a diagnosis of PTSD ever verified?
- Was the safety and well-being of Jenny and the children considered by agencies at appropriate points?
- Were referrals to children's social care considered at appropriate points by all agencies?
- Establish if agencies adhered to their own domestic abuse and safeguarding policies and procedures and if not what the barriers that prevented this from happening were.
- Identify any issues with inter-agency working
- Identify any aspects of the case that exhibit good practice
- Identify any key themes and lines of enquiry to inform a practitioners' learning event.
- Make recommendations for action based on the lessons learned.
- Could communication and information sharing, within and between agencies have been improved during the scoping period?
- Did agencies adhere to their own domestic abuse policies?

**6. Engagement with the family**

6.1 A key element of the review is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. CCSP has already informed the family that this Review is being undertaken. The independent lead reviewer will follow up by making contact with family members who will be consulted on the terms of reference for the review.

6.2 Further contact will be made to invite participation in the form of a home visit and/ or telephone conversations. Contributions will be woven into the text of the Overview Report and the family will be given feedback at the end of the process.