A DOMESTIC HOMICIDE REVIEW (DHR)

‘Edie’

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Introduction

1. This report begins by first expressing sincere condolences to the family and any friends of the two young adults that this review is about. On behalf of the author of this report, the North East Lincolnshire Community Safety Partnership (NELCSP) who commissioned this domestic homicide review (DHR), as well as the different people and organisations who contributed to the review, we offer our deepest sympathies to those who knew and loved Edie and Ricky.

2. Edie was 28 years old and Ricky was 25 years old when they tragically died by suicide on different dates and in separate locations[1].

3. Edie had been a victim of domestic abuse in her intimate relationships with men and there was domestic abuse in her relationship with Ricky. They were both dealing with complex problems in their respective lives.

4. The review tries to understand as much as possible the circumstances of Edie and Ricky to prevent similar deaths and to stop domestic abuse.

5. Government guidance makes clear that if an adult takes their own life and the circumstances give rise to concern for example regarding evidence of domestic abuse, a DHR should be completed[2]. The DHR examines the response of organisations and the appropriateness of professional support given before Edie and Ricky's deaths. These services are described in paragraph 23.

6. In addition to looking at recent agency involvement, the review also examines the past to identify any relevant background or trail of abuse or neglect before the deaths; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

7. The key purpose of undertaking DHRs is to enable lessons to be learned. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future

8. The review considers the contact and involvement of different professionals and organisations with Edie and Ricky from the start of their relationship in April or May 2020 until Edie died in late January 2021.

[1] The pseudonym was agreed with Edie's family. Repeated attempts to speak with Ricky's family resulted in no response.
[2] The circumstances under which a domestic homicide review must be carried out are described in the Domestic Violence Crime and Victims Act 2004 and associated national guidance described in multi-agency statutory guidance for the conduct of domestic homicide reviews (December 2016).

Timescales

9. The Chair of the Safer North East Lincolnshire Partnership commissioned the DHR in May 2021. A panel in July 2021 agreed on the scope and key areas for learning, agreed on the membership of the panel and identified the organisations and people who would provide information to the review. The panel met four times to discuss information and analysis for learning and agreed on the draft overview report in May 2022. Submission of this report to the Home Office for evaluation was postponed in consultation with the Home Office until Edie's inquest was concluded in August 2022.

Confidentiality

10. The findings of a domestic homicide review are confidential as far as identifying Edie or Ricky, their families or professionals. Information is available only to officers/professionals and their line managers who participated in the DHR. Edie and Ricky are pseudonyms used in the report to protect their identity and provide privacy for their respective families. Edie had more than one child; for privacy, the number of siblings, their ages and gender are not included in this report. Ricky had no children.

Involvement of family, friends, work colleagues, neighbours and the wider community

11. Edie lived in North East Lincolnshire (NEL) for most of her life and her mother and sibling continue to live in the area. Edie's parents are separated. Edie's birth father continues to live in NEL and had some contact with Edie and her sibling. Edie's children are looked after by the maternal family. Edie was in regular contact with her mum and had supervised contact with her children until her death. There were complex Family Court proceedings running parallel to the DHR and the relationship with children's services had all but broken down exacerbated by different social workers being allocated as a result of recruitment and retention problems that are discussed later in the report. It was agreed in discussion with Edie's mum and with the panel that attempting to talk to Edie's children as part of the DHR was inappropriate due to the children's age, understanding and the work being done with them as part of the Family Court process. According to her mum, Edie was completing an Open University degree course when she died. The review has no further information about this. According to her mum, Edie continued to have interests in craft and design. Before she left school, she had ambitions to study law. Her mum said that Edie did not confide in her or talk about her relationships with men; although she knew that they were abusive Edie's mum says that there is much more detail that has become apparent after Edie's death. Edie had three particular friends at school with whom she had continued some contact although this had lapsed. The erosion of social contact and isolation from support networks was part of the coercion and control that Edie was subjected to by intimate partners. Edie's

sibling was nine years younger. Edie was out of contact with the family for extended periods and isolated from support.

12. Ricky was one of five siblings and his mum and two of his siblings live in the local area. Ricky's dad died when he was very young and was absent for much of his life. Ricky is a half-sibling to his mother's other children. The family moved from England to another home nation in the UK for a few years when Ricky was 2 or 3 years old. While there Ricky lived with foster carers between the ages of 11 and 13. Ricky began to drink alcohol in his adolescence and also came to the notice of local youth justice services. He left school without any GCSEs but completed some vocational training in bricklaying and agriculture. Ricky's mum moved back to NEL in 2017 or 2018. Ricky eventually moved back to NEL with one of his siblings with whom Ricky shared a home for a while. Ricky secured employment and met a young woman with whom he had his first significant relationship. More information is provided later in the report.

13. Edie and Ricky's families were provided with information about the review which included the proposed scope and terms of reference and also included details of advocacy and support services including AAFDA. This was done by letters hand-delivered to the respective addresses. The letter included the telephone and email contact details for the independent reviewer who also followed this up with phone calls to those family members whose contact details had been provided.

14. Edie's family was consulted about the scope and terms of reference and the reviewer and Edie's mum were in contact with each other during the review. Edie's mum read and commented on the draft report and will receive a copy of the final report after the evaluation by the Home Office.

15. Ricky's family did not respond to the invitations to participate in the review. Some of his family provided statements to the police following Ricky's death and where appropriate, relevant information from these has been included in this report.

16. Nether the police investigation nor the DHR process was able to identify a particular friend who knew either Edie or Ricky to speak to as part of the DHR.

Methodology, scope and terms of reference

17. The circumstances of Edie and Ricky's deaths were reported to the chair of the North East Lincolnshire Community Safety Partnership (the responsible authority for the DHR) shortly after their deaths and an early decision was made that the circumstances were likely to come within the scope of a DHR. Ricky was remanded to prison at the time of his death. This meant that coroners in

different areas were responsible for the respective inquests and were informed of the DHR.

18. The formal scoping discussion was incorporated within the first meeting of the panel in July 2021. The panel confirmed that the criteria for a domestic homicide came within the scope of national guidance for commissioning a DHR[3].

19. The methodology of the review complies with national guidance. This includes identifying a suitably experienced and qualified independent person to chair and providing an overview report for publication. A statement of independence is provided in paragraph 24.

20. The initial scoping panel agreed on the list of services that would be asked to provide information to the DHR and be represented on the panel. This included specialist organisations which are listed in the table in paragraph 22.

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

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

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

[3] The DHR is being conducted under Section 9(3) of the Domestic Violence Crime and Victims Act 2004 and in particular paragraph 18 of the statutory guidance Where a victim took their own life (suicide) and the circumstances give rise to concern, for example, it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

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

Contributors to the review

23. Over 20 organisations in NEL were contacted as part of the scoping for the review, to inquire about any contact and knowledge they had about Edie or Ricky. The South Yorkshire Police were contacted given that the prison where Ricky died is within their policing area and they completed the police investigation of Ricky's death and confirmed there was no third-party involvement.

24. The organisations represented on the panel in the following paragraph provided written information that was collated by people who had no involvement in contact or decision-making with Edie or Ricky;

a) Crown Prosecution Service (CPS); CPS were consulted by the police about charging decisions for Ricky in August, October and December 2020; CPS were invited to participate in the DHR in late 2021 after other services who were already party to the DHR had provided initial IMRs and it became apparent that there was probably learning to be identified about charging and prosecution processes;
b) Harbour Place; had contact with Ricky through their night shelter service between July 2019 and December 2019; this included providing help to Ricky to register with a GP and to get access to more secure housing;
c) Humberside Police; had extensive contact with Edie as a victim in domestic abuse incidents over several years including being party to child protection plans (CPP) for her children; had contact with Ricky in respect of property crime related to substance misuse which included being sentenced to a Community Order in December 2019 which was varied to suspended imprisonment 18 weeks concurrent suspended for 24 months with a rehabilitation activity requirement and an alcohol treatment requirement in February 2020; Ricky had no history of domestic abuse until his relationship with Edie; the police were first aware of Ricky's relationship with Edie in May 2020 when CSC requested a check of Ricky's history as part of their assessment; the first call-out was in June 2020 followed by further incidents in from August to December 2020 when Ricky was remanded to prison for an assault on Edie and unrelated property offences;
d) National Probation Service; the service had contact with Ricky as a result of the offences in 2019 and provided the Community Order supervision; the service had no contact with Edie other than a brief telephone discussion in April 2020 during one of Ricky's supervision sessions; it was during that telephone discussion that the supervising officer checked that Edie was aware of Ricky's long history of alcohol abuse and the implications for her children; the routine offender risk assessment of Ricky did not identify self-harm concerns;
e) Navigo Acute Mental Health Service; had first contact with Edie in 2011 when she was referred with low mood and thoughts of self-harm and depression and was offered three assessment appointments but did not attend; Edie was referred again in June 2013 by the health visitor with mild depression; Edie was signposted to Women's Aid having disclosed domestic abuse and feeling overwhelmed with the birth of her first child; Edie talked about wanting to leave the area, feeling trapped and being unable to leave because of housing debt; Edie was next referred in June 2020 by her GP who suggested an assessment for PTSD associated with Edie's history of being abused in relationships; the GP was providing support for anxiety and depression primarily through a repeat prescription of anti-depressants; the single point of access (SPA) team declined the referral when Edie described

having two separate court proceedings that were ongoing (family court in terms of her children and a criminal prosecution of a former partner); in 2019 the crisis team had a brief contact with Ricky at the night shelter when he was feeling very low, was threatening to harm himself and was feeling hopeless about being homeless;

f) North East Lincolnshire Health and Care Partnership (NELHCP) (two GP practices); Edie had extensive contact with the GP practice with a history of anxiety and depression; she was regularly prescribed medication to help with symptoms and for sleeping difficulties; she was screened for and did not disclose thoughts of self-harm; in mid-July 2020 she talked about domestic abuse as well as a relationship that was more recent although no details were sought or disclosed; the GP practice was routinely informed of Edie's presentation at the hospital emergency care centre (ECC) service following a non-domestic assault; in addition to contact with a GP the primary care nurse (PCN) who is a qualified psychological wellbeing practitioner had several contacts with Edie during 2020 and the PCN referred Edie to the Blue Door service in July 2020. A summarised history about Ricky who was registered in a GP practice which included reference to Ricky having been in care and having difficulties with alcohol over several years and being homeless, he had little contact with a GP the most recent being when he attended for a change of dressing to a stab wound to his leg in November 2019;

g) North East Lincolnshire Council Education and Inclusion; Edie's children were enrolled at local schools; they were subject to Family Court proceedings and were being looked after throughout the scoped timeline for the review; the schools say they had no information about incidents of domestic abuse involving Edie and Ricky; the children talked about Edie and missed her and welcomed the contact they had with her; the children also talked about some of the domestic abuse that they experienced when Edie was living with other men before the children became looked after; they did not feel safe, there was lots of swearing and shouting, and sometimes had nightmares about what would happen to their mum when she was in relationships where men abused her;

h) North East Lincolnshire Children's Services; the service had known Edie since 2005 when she had referred herself as a child in need of support and contact with the service continued until 2009; later involvement by CSC was from May 2013 after Edie's first child had been born and Edie was assaulted by her then partner; a child protection plan (CPP) was in place from 2013 until the family moved to a neighbouring area where the children were the subject of involvement by that local authority's children's services under a transfer-in CPP; the older child became looked after while living in that area and the interim care order was transferred to NEL when Edie

moved back; both of Edie's children became subject of Family Court proceedings becoming looked after in early 2020;

i) North Lincolnshire and Goole NHS Trust; Edie attended the hospital emergency care centre (ECC) on 15 occasions between October 2015 and November 2020; three of the occasions followed an assault although no detail about the circumstances or perpetrator was recorded; this included January 2020 and September 2020; Edie also had care during her pregnancies and the birth of her children; Edie reported having been in relationships with abusive men when she booked for maternity care in 2016. Ricky attended the ECC on seven occasions between September 2012 and December 2020; on the last occasion when he was accompanied by the police, he had an injury to his hand having 'punched something with glass' and was discharged into the custody of the police; the ECC also provided treatment when Ricky was stabbed in the leg in late 2019;

j) SERCO (Management agency for HMP Doncaster where Ricky was remanded and died); Ricky was remanded to the prison in December 2020; the prison stated that they only had information about property offences when Ricky was first remanded but became aware of the assault on Edie when he was again remanded later in the month; Ricky had been allowed contact with Edie by phone and this is the subject of analysis later in the report;

k) The Blue Door Service (IDVA service); had contact with Edie between 2016 and January 2021 linked to four men who were perpetrators of domestic abuse to Edie; Edie had contact with two IDVAs;

l) We Are With You (alcohol and drug services); had five contacts with Ricky between October 2019 and September 2020; the first referral was from Harbour Place for support with substance misuse (cannabis and Spice) although Ricky did not attend for two assessment appointments but was seen once at the night shelter when Ricky disclosed daily alcohol use which began when he was 12 years old; there was no further contact and Ricky was also out of contact with Harbour Place; in December 2019 Ricky was sentenced to and alcohol treatment requirement (ATR) after conviction for theft offences linked to his substance abuse; Ricky said he occasionally used cocaine and had reduced his use of alcohol; he disclosed a recent relationship breakdown and loss of home and job; he did not attend for subsequent appointments and was discharged back to his supervising probation officer; in March 2020 Ricky was seen in police custody having been arrested for property theft; he said his mental health was not good and he wanted help to reduce his use of alcohol; Ricky was subsequently given an 18 week suspended sentence; Ricky attended a telephone assessment appointment and the ATR appointments began; Ricky reported that his mental health was good and he attended 11 of the 15 ATR appointments by July 2020; there had been reported lapses with drinking in April and May 2020 when he acknowledged drinking to

manage his emotions; he had also attended appointments with the job centre and his supervision sessions with the probation officer; according to the service Ricky had gone through a relationship breakdown in April 2020 but had reunited in June 2020; there are no details about who the partner was although it is assumed by the DHR to be Edie; the service had contact with Ricky in September 2020 when he was drinking heavily although he declined to engage with the service and their involvement ended in November 2020;

m) Women's Aid; were parties to the MARAC and had a great deal of contact with Edie from August 2016 when Edie spent time in the refuge; Edie had recently fled her home in the neighbouring area to escape a very violent and controlling man who would remain a threat to Edie and was eventually convicted in 2020; while in the refuge Edie engaged with different services and people; Women's Aid had a referral in mid-August 2020 about domestic abuse the police had responded to; Women's Aid responded the same day and were told by Edie that she had separated from her partner (Ricky); Edie was invited to meet face-to-face at the centre but was not leaving her house; due to Covid home visits were not being offered at that time; the service continued to contact Edie by phone; Edie described being very stressed by the criminal proceedings against her ex-partner and was feeling guilty because his family had experienced a bereavement; although the service had agreed to keep contact with Edie they were unable to make contact with her until early October 2020 when the service was told by the police about further domestic abuse including harassment from Ricky; Edie was contacted the same day who said that having had no contact Ricky had turned up at her home; Edie did not want to come to the centre and home visits were still not available due to Covid; in early December 2020 the police made referral and after several attempts to contact Edie she declined any support. The service was told about Ricky's death and contacted Edie to offer bereavement support.

The review panel membership

25. The panel was chaired by the independent reviewer who is the author of this report. All of the panel meetings were virtual due to Covid restrictions. The first meeting of the panel was in July 2021 which agreed on the scope of the DHR. There were three further meetings. Panel members had no direct involvement in case management or decision-making about Edie or Ricky.

Organisation	**Job title or role**
Crown Prosecution Service (CPS) (attended panel in March 2022)	Jonathan Wettreich Deputy Chief Crown Prosecutor Magistrates' Court Team CPS Yorkshire and Humberside
Department for Work and Pensions	Rhonda Hackett

	Advanced Customer Support Senior Leader
Harbour Place[4]	Dave Carlisle Project Manager
Humberside Police	Emma Heatley Detective Chief Inspector
National Probation Service	Nick Hamilton-Rudd Head of the North & North East Lincolnshire Probation Delivery Unit Probation Service – Yorkshire and the Humber
Navigo Acute Mental Health Service	Ellie Walsh Assistant Director Adult Acute Mental Health Services Emma McCutcheon Lead Practitioner – Safeguarding
North East Lincolnshire CCG (replaced by the North East Lincolnshire Health and Care Partnership in July 2022)	Julie Wilburn Designated Nurse for Safeguarding Adults and Children
North East Lincolnshire Council Education and Inclusion	Jenni Steele Inclusion lead, Access and Inclusion Service
North East Lincolnshire Children's Front Door	Sarah Blanchard Service Manager
Northern Lincolnshire and Goole NHS Trust	Sharon Humberstone, Named Nurse Safeguarding Adults
SERCO (Management agency for HM prison where Ricky was remanded and died)	Sara Lockwood Head Of House, Block One, SASH, Equalities and Safeguarding
The Blue Door Service (IDVA service)	Stephenie Price Chief Executive
We Are With You (alcohol and drug services)	Lisa Pidd Contracts Manager
Women's Aid	Janice Woods Operational manager
Yorkshire Prisons Group	Russell Heritage Deputy Group Safety Lead Yorkshire Prison Group
Specialist advisors[5]	
FOCUS (NELC commissioned adult social care service)	Sue Bunn Head of Safeguarding

[4] Harbour Place provides night shelter and outreach services for street homeless and vulnerably housed people across North East Lincolnshire.

[5] All were full panel members but their respective agencies/partnerships had no direct involvement with any of the parties so were there to provide specialist advice and not to represent their agencies/partnerships.

North East Lincolnshire Council	Helen Cordell Domestic Abuse Coordinator
North East Lincolnshire Council Public Health	Carolyn Beck Strategic Lead on local suicide prevention
North East Lincolnshire Safer and Partnerships	Spencer Hunt Assistant Director, Safer and Partnerships
North East Lincolnshire Safeguarding Adult Board	Stewart Watson Business Manager
North East Lincolnshire Safeguarding Children Partnership Helen Willis	Helen Willis Safeguarding Children Partnership (SCP) Coordinator
North East Lincolnshire Community Safety Partnership	Rebecca Freeman Manager CSP

The author of the overview report and chair of the review panel and the statement of independence

26. Peter Maddocks is the independent author of this report and chaired the panel. He has completed domestic homicide reviews with other community safety partnerships in England. He has not worked for the organisations that have contributed to this review and nor has he held any elected position in NEL or South Yorkshire. He is not related to any individual who either works or holds an elected office in NEL or South Yorkshire.

Parallel reviews

27. There were no criminal proceedings. Edie and Ricky's deaths were the subject of separate HM Coroner inquests for the respective areas in which the deaths occurred. Ricky's death was recorded as a death by suicide in early 2022. Edie's death was recorded as a death by suicide in the summer of 2022.

28. Ricky's death was the subject of an independent investigation by the Prisons and Probation Ombudsman. An investigation happens when a person in prison custody dies due to any cause to make custody safer. That investigation found that Ricky should not have been allowed to contact Edie as a victim of his offending and that her telephone number should not have been included in his list of approved numbers to call. The report made a recommendation that prisoners' contact numbers be checked in line with national prison service instructions (PSI/ 04/2016)[6].

29. The telephone number Ricky used had been recorded as belonging to Ricky's sister. This is discussed later in the report. The investigation also found that because being charged with a violent offence against a family member is a risk factor for self-harm and suicide there should have been some consideration as

[6] The interception of communications in prisons and security measures.

to whether Ricky should have been placed on suicide watch or the prison care planning system for self-harm monitoring (ACCT). The DHR found other significant risk factors in Ricky's history that were not known to the prison and are discussed later in the report. The investigation concluded that Ricky gave no reason for prison staff to consider that he was at risk of killing himself and concluded that Ricky's death was not foreseeable or preventable. The investigation made recommendations about staff being issued with anti-ligature knives and dealing with emergency procedures.

30. The investigation confirmed that the court warrant detailing Ricky's offences leading to his remand did not arrive at the prison until the day after he had been processed through the prison reception and health assessment.

31. Family Court proceedings were concluded towards the end of the review with the children living with their maternal family.

Equality and diversity

32. Edie and Ricky were not married or in a civil partnership with each other or any other partner. Neither of them had a diagnosed or registered disability or mental impairment. Edie was female and Ricky was male from birth and continued to identify by their sex at birth. Edie's children were born to other men and was not pregnant at any time during the relationship with Ricky. Edie and Ricky were both white British and spoke English. There is no record of either of them having specific religious or faith-related beliefs that influenced their decision-making.

33. Intersectionality describes the interconnection of various factors including race, class, and gender among an individual or group. It is often related to an experience of discrimination or a disadvantage. Not all victims experience domestic abuse in similar circumstances. Personal histories of adverse childhood experiences (ACEs), poverty and housing insecurity can all contribute to a feeling of expendability. When compared with people bereaved through other causes, those bereaved by suicide are at an increased risk of suicide, psychiatric admission and depression[7].

34. Candidacy is another concept that offers the potential to understand how people seek and use help from different organisations as well as how professionals process information and provide advice and help[8]. The concept suggests that an individual's identification of their 'candidacy' to see themselves as experiencing abuse and how they use a service is structurally, culturally, organisationally and professionally constructed. For example, it is recognised

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

[8] Mackenzie. M, Conway. E, Hastings. A, Munro. M, and O'Donnell. C.A, (2014) Intersections and Multiple 'Candidacies': Exploring Connections between Two Theoretical Perspectives on Domestic Abuse and Their Implications for Practicing Policy. Social Policy and Society, Available on CJO 2014 doi:10.1017/S1474746414000244

that failure to support women who are not ready or able to leave a coercive and controlling relationship damages future opportunities to promote safety[9] and yet not all practitioners are aware of the material and structural reasons why leaving is not thought possible by many victims[10]. Some of this is reflected in how Edie in particular experienced services particularly about her children.

35. Edie and Ricky lived in rented properties located in areas of very high deprivation. Ricky lived in an area of NEL where less than 99.3 per cent of English postcodes are less deprived whilst Edie's home area was less than 93 per cent. NEL has some of the highest levels of deprivation in England with 31 LSOA [11] within the most deprived areas of England and is where Covid-19 has increased deprivation for the poorest households.

36. Domestic abuse also increased during the Covid lock down in response to stay-at-home restrictions and severely curtailed opportunities for face-to-face contact by services and is a factor in this review[12]. Violence increase was due to an increase in tensions in households, increased perpetrator's risk factors for violence, economic burden, and survivors' limited access to support services available pre-lockdown. COVID-19's response plan limited the spread of the virus; however, it weakened women's ability to respond to their violent perpetrators.

37. The area has some of the highest levels of health inequalities with higher rates of poor health and shorter life expectancy. The 2018 Mental Health and Wellbeing Needs Assessment found that those living in the most deprived parts of NEL are more likely to be admitted to hospitals for mental health and self-harm[13]. It's been well known for some time that suicide is an *inequality* issue as disadvantage and vulnerability, including becoming unemployed, being in debt and having insecure housing, make it more likely to die by suicide. So much so, that men, in the lowest social class, and living in the most deprived areas, are up to ten times more likely to die by suicide than those in the highest social class living in the most affluent areas. Rates of hospitalised self-harm are also twice as high in the most deprived neighbourhoods compared to the most

[9] Humphreys, C. and Thiara, R. (2003b) 'Neither justice nor protection: women's experiences of post separation violence', Journal of Social Welfare and Family Law, 25(3):195–214.
[10] Burman, E. and Chantler, K. (2005) 'Domestic violence and minoritisation: legal and policy barriers facing minoritized women leaving violent relationships', International Journal of Law and Psychiatry, 28(1):59–74.
[11] Lower layer super output areas are a geographic hierarchy designed to improve reporting of small area statistics in England and Wales.
[12] Jinan Usta, Hana Murr, and Rana El-Jarrah.COVID-19 Lockdown and the Increased Violence Against Women: Understanding Domestic Violence During a Pandemic. Violence and Gender.Sep 2021.133-139. http://doi.org/10.1089/vio.2020.0069
Piquero AR, Jennings WG, Jemison E, Kaukinen C, Knaul FM. Domestic violence during the COVID-19 pandemic - Evidence from a systematic review and meta-analysis. J Crim Justice. 2021 May-Jun; 74:101806. doi: 10.1016/j.jcrimjus.2021.101806. Epub 2021 Mar 9. PMID: 36281275; PMCID: PMC9582712.

[13] Director of Public Health Annual Report 2020 p25

affluent, which is significant because more than 50 per cent of people who die by suicide have previously self-harmed[14].

38. Alcohol-related mortality and morbidity is a significant issue in NEL and has been substantially above national rates for many years. The area has the highest alcohol-specific mortality rate and the highest of all the local authorities in the Yorkshire and Humber region reflecting a significant proportion of the population who drink heavily and persistently and is concentrated in the most deprived areas of the borough such as where Edie and Ricky lived. Substance misuse is the leading cause of death for the 18-44 age group. Relationship breakdown, abuse and job insecurity are also important associated factors.

39. Edie and Ricky had both experienced periods of homelessness. The national Rough Sleepers' Needs Assessment in 2019 demonstrated that the prevalence of physical and mental ill-health and misuse of substances is likely to be much higher for people who are without secure housing[15].

40. Numerous factors can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. However, there is a relationship between homelessness and mental health as can be seen in Ricky's circumstances as well as with domestic abuse and relationship breakdown.

41. Homelessness and mental health often go hand in hand. Having a mental health problem can create circumstances that can cause a person to become homeless in the first place. Poor housing or homelessness can also increase the chances of developing a mental health problem or exacerbating an existing condition. It makes it even harder for that person to develop good mental health, secure stable housing, find and maintain a job, stay physically healthy and maintain relationships. Single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32 per cent of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population[16]. Other psychological issues such as complex trauma, substance misuse and social exclusion are also common and are reflected in Ricky's circumstances.

42. Ricky was looked after in local authority care during his adolescence when living outside of NEL. Care-experienced children and young people like Ricky are consistently found to have much higher rates of mental health difficulties

[14] https://nspa.org.uk/wpcontent/uploads/2021/04/NSPA_InfoSheet_SocioeconomicDeprivationSuicidalBehaviour_v1.pdf
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944598/Initial_findings_from_the_rough_sleeping_questionnaire_access.pdf
[16] https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

than the general population, including a significant proportion who have more than one condition (The Mental Health Foundation, 2002[17]). They are approximately four times more likely to have a mental disorder than children living in their birth families (NSPCC, 2015). Almost half (rising to three-quarters in residential homes) meet the criteria for a psychiatric disorder (NSPCC, 2014[18]; Social Market Foundation, 2018[19]) compared to 10 per cent of the general population.

43. Being female is a significant risk factor for being a victim of domestic abuse; women are more likely than men to be subject to abuse. Poverty or lack of access to financial or social resources contributes to dependency on a violent partner as a risk factor.

44. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men[20]. On average, two women are killed each week by their current or former partner in England and Wales, a figure that has changed relatively little in recent years[21]. As Edie knew and described in some of her discussions at Women's Aid, it impacts women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Women's inequality limits their ability to escape from relationships with abusive men; it can make it more difficult for them to assert their rights and are more likely to experience sexual harassment and violence. Experience of domestic violence (abuse, threats or force), sexual victimisation or stalking is reported by over one-third (36 per cent) of people[22].

45. Women like Edie who report that they are in poor emotional, mental or physical health have suffered more than twice the rate of domestic abuse and stalking than women who report that they are in good health. Women who sustained injuries in their worst incident of domestic violence were asked if they used medical services on that occasion. Only 30 per cent of women reported injuries sustained in domestic violence[23].

46. Domestic abuse is a very significant although all too often an unrecognised issue for mental health care services. Some research studies put the number

[17] https://www.mentalhealth.org.uk/sites/default/files/mental_health_looked_after_children.pdf
[18] https://ora.ox.ac.uk/objects/uuid:b0b0c2a6-8f7b-42c0-99a6-a9f0e98dfe0b/download_file?file_format=pdf&safe_filename=NikkietalVoRReport2014.pdf&type_of_work=Report
[19] https://www.smf.co.uk/wp-content/uploads/2018/08/Silent-Crisis-PDF.pdf
[20] Office for National Statistics. 'Domestic Abuse in England and Wales'. 2018. Crown Prosecution Service 'Violence against women and girls report.' 2018.
[21] Office for National Statistics 'Crime Statistics, Focus on Violent Crime and Sexual Offences, Year ending March 2016, Chapter 2: Homicide'. 2016
[22] Walby, S. and Allen, J. (2004). Domestic violence, sexual assault and stalking: findings from the British Crime Survey. London: Home Office.
[23] Walby, S. and Allen, J. (2004). Domestic violence, sexual assault and stalking: findings from the British Crime Survey. London: Home Office.

of women mental health patients being subjected to domestic abuse as high as 69 per cent[24].

47. Depression and self-harm/suicide are significant health problems, particularly for women. Notably, in studies, the experience of domestic abuse is strongly and consistently associated with both depressive disorders and suicide. In 2013 researchers published a systematic review of longitudinal studies to explore intimate partner violence (IPV), incidents of depressive symptoms and attempted suicide[25]. They identified 16 longitudinal studies involving a total of 36,163 participants. All the studies included women, but only four also included men. All of the studies were undertaken in high and middle-income countries. For women, 11 studies showed a statistically significant association (an association unlikely to have occurred by chance) between intimate partner violence (IPV) and subsequent depressive symptoms. In a meta-analysis of six studies, the experience of IPV nearly doubled the risk of women subsequently reporting depressive symptoms. Also, there was evidence of an association in the reverse direction. In a meta-analysis of four studies, depressive symptoms nearly doubled the risk of women subsequently experiencing IPV. IPV was also associated with subsequent suicide attempts among women. For men, there was some evidence from two studies that IPV was associated with depressive symptoms but no evidence for an association between IPV and subsequent suicide attempts or between depressive symptoms and subsequent IPV.

48. These findings suggest that women like Edie who are subjected to IPV are at increased risk of subsequent depression and that women who are depressed are more likely to be at risk of IPV. They also provide evidence of an association between IPV and subsequent suicide attempts for women. The findings suggest that clinicians such as primary health care and mental health professionals should pay careful attention to past experiences of violence and the risk of future violence when treating women who present with symptoms of depression.

49. In a report that attracted considerable policy attention at the time, Sylvia Walby extrapolated from research conducted elsewhere to suggest that more than one-third of female suicides in England and Wales are partly caused by women having been subjected to domestic abuse[26]. There are, of course, several factors that contribute to a person's decision to take, or attempt to die by suicide. Nonetheless, research has now established a significant negative

[24] Khalifeh. H, Moran. P, Borschmann R, Dean. K. (2014) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, Volume 45, Issue 4 March 2015, pp. 875-886

[25] Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, et al. (2013) Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts: A Systematic Review of Longitudinal Studies. PLoS Med 10(5): e1001439. https://doi.org/10.1371/journal.pmed.1001439

[26] Walby, S (2004) The Cost of Domestic Violence. London: Women and Equality Unit. Cited by Munro VE, Aitken R. From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse. International Review of Victimology. 2020; 26(1):29-49. doi:10.1177/0269758018824160.

physical and psychological health effect associated with being subjected to domestic abuse[27]. Across several studies, women who are abused by their intimate partners are more likely than their non-abused counterparts to attempt suicide[28].

50. More women die as a result of domestic abuse perpetrated by a male partner. Men are more likely than women to die from suicide; around three-quarters of registered suicides in England and Wales in 2020 were among men (5224). This is a consistent trend since the mid-1990s. The Yorkshire and Humber region has the second-highest rates of suicide in the country[29].

51. Bereavement has been identified as a suicide risk factor that is heightened in the days and months following the death for up to 12 months[30]. The SOS Handbook for Survivors of Suicide published by the American Association of Suicidology reports that the trauma of losing a loved one to suicide is "catastrophic"[31]. Common feelings reported by survivors were shame and guilt; often expressed as self-blame, depression, humiliation, rejection, abandonment, loss, worthlessness, failure, lovability and others. For a woman such as Edie who had experienced a succession of abusive, coercive and controlling relationships with men and what we know about the adverse emotional and psychological impact of such abuse combined with recent bereavement Edie was likely feeling any one of common feelings associated with bereavement through suicide. Ricky left a voicemail message on Edie's phone just before he took his life when she did not pick up the call saying all that she had to do was give him a few minutes to talk and to say how much he loved her. The voicemail would have exacerbated such negative feelings. Shame and isolation along with stigma are also reported as significant for many survivors[32]. Bereavement experiences are 'more intense or unique to suicide'[33].

52. Studies have shown that exposure to the suicide of a close contact is associated with several negative health and social outcomes that are

[27] Oram, S, Khalifeh, H, Howard, L (2017) Violence against women and mental health. Lancet Psychiatry 4(2): 159–170

[28] Blasco-Ros, C, Sanchez-Lorente, S, Martinez, M (2010) Recovery from depressive symptoms, state anxiety and post-traumatic stress disorder in women exposed to physical and psychological, but not to psychological intimate partner violence alone: A longitudinal study. BMC Psychiatry 10: 98. Available at https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-10-98 (accessed 9th November 2021).

[29]Suicides in England and Wales: 2020 registrations ONS https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations#main-points

[30] Ajdacic-Gross, V., Ring, M., Gadola, E., Lauber, C., Bopp, M., Gutzwiller, F., & Rössler, W. (2008). Suicide after bereavement: An overlooked problem. Psychological Medicine, 38(5), 673-676. doi:10.1017/S0033291708002754

[31] Jackson J. Washington, DC: American Association of Suicidology; 2003. SOS, A Handbook for Survivors of Suicide

[32] Pompili M, Shrivastava A, Serafini G, et al. Bereavement after the suicide of a significant other. Indian J Psychiatry. 2013;55(3):256-263. doi:10.4103/0019-5545.117145

[33] Harvey JH. Philadelphia: Brunner/Mazel; 1998. Perspectives on Loss: A Sourcebook

dependent on an individual's relationship with the deceased. These effects include an increased risk of suicide in partners bereaved by suicide (friends or relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss[34]), increased risk of required admission to psychiatric care for parents bereaved by the suicide of an offspring, increased risk of suicide in mothers bereaved by an adult child's suicide, and increased risk of depression in offspring bereaved by the suicide of a parent. Some evidence was shown for increased rejection and shame in people bereaved by suicide across a range of kinship groups when data were compared with reports of relatives bereaved by other violent deaths[35].

53. Adult men in prison are significantly more likely to self-harm and die by suicide than peers in the general population[36]. After a decline in suicides through much of the 2000s,[37] the rate has risen against an overall fall in suicide rates in the general population in the same period[38]. Prisoners, whether on remand or sentenced, are at risk from a combination of factors many of which are reflected in Ricky's history. A combination of life experiences which in Ricky's case included adverse childhood experiences (ACE), being looked after, youth offending and very significant substance misuse from his childhood followed by long periods of homelessness and unemployment. A report by the Samaritans[39] highlights the profound emotional needs that prisoners such as Ricky can have. Problems with mental health, self-harm and poor social support combined with significant deprivation and disadvantage represent a level of complex vulnerability that can be exacerbated by relationship breakdown and prison incarceration as occurred in December 2020 for Ricky. That is not to say it could be predicted that Ricky would fatally self-harm but his level of risk was greater than was reflected in the information that was available to the prison or was easily accessible by primary health care professionals in the community such as GPs.

54. A 2016 publication from the Howard League for Penal Reform[40] and Centre for Mental Health provides evidence from prisoners who described historic mental health problems, exposure to trauma and abuse, an experience of being looked after in public care, homelessness and substance misuse which are reflected

[34] PHE A guide to suicide prevention
[35] Pitman. A et al, (June 2014) Effects of suicide bereavement on mental health and suicide risk The Lancet Psychiatry Vol 1, Issue 1, pp86-94.
[36] ONS 2019 'Male Prisoners Are 3.7 Times More Likely to Die from Suicide than the Public', https://www.ons.gov.uk/news/news/maleprisonersare37timesmorelikelytodiefromsuicidethanthepublic
[37] Ministry of Justice, 'Deaths in Prison Custody 1978 to 2018'.
[38] ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables
[39] Samaritans (2019) Unlocking the evidence: understanding suicide in prisons. Available from https://www.samaritans.org/about-samaritans/research-policy/prisons-and-suicide/ [accessed on 30th November 2021]
[40] Howard League (2016). Preventing prison suicide: perspectives from the inside. London: The Howard League for Penal Reform. Available from https://howardleague.org/publications/preventing-prison-suicide/ [Accessed on 30th November 2021].

in Ricky's life circumstances. The same study also highlights child custody and the risk of deportation being risk factors that are not relevant to Ricky's circumstances.

55. A rapid evidence assessment in 2018[41] highlighted that younger white men with little formal education or qualifications are at increased risk of self-harm, who are single or have experienced recent relationship breakdown and have no fixed abode. A history of self-harm, depression or feelings of hopelessness and substance misuse is a significant psychological factor as well as borderline personality disorders which Ricky was never diagnosed with.

56. Cross-sectional research literature summarised by a Home Office report[42] found that children who are exposed to domestic abuse are likely to suffer from arrange of immediate emotional impacts that included gear, anxiety and depression some of which persist into their later years as adults. Some children develop behaviours such as conduct disorders. Children who witness the most severe forms of domestic abuse are twice as likely to report symptoms of PTSD.

Dissemination

57. The following organisations and people will receive a copy of the published overview report in addition to Edie's mum. All organisations and people who participated in the review will receive a copy of the published overview report. The report will be shared with the Humberside Police Crime Commissioner, the chief officers of the responsible authorities in North East Lincolnshire (NEL)[43], the Community Safety Partnership Executive Board, the chair of the NEL Place Board incorporating Health and Wellbeing Board, the NEL Safeguarding Children Partnership and NEL Safeguarding Adult Partnership. A copy of the published report will also be sent to the Prisons and Probation Ombudsman.

58. The commissioning body and the independent author for this DHR thank the various organisations and people who have participated in the DHR process.

Background information and chronology

[41] Pope. L, 2018 Self-harm by adult men in prison: A rapid evidence assessment (REA) HM Prison & Probation Service. Available from https://www.gov.uk/government/publications/self-harm-by-adult-men-in-prison-a-rapid-evidence-assessment [Accessed on 30th November 2021].

[42] Oliver, R., Alexander, B., Roe, S. and Wlasny, M., 2019. The economic and social costs of domestic abuse. Home Office (UK). P77 https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-for-parents

[43] Humberside Police, North East Lincolnshire Council, Humberside Fire and Rescue Service, Clinical Commissioning Group and the Probation Service. Voluntary Action North East Lincolnshire: develops, promotes, informs and supports the local voluntary, not-for-profit and charitable sector to address local needs and Victim Support North East Lincolnshire will also have copies of the DHR as involved organisations in the CSP.

59. In early December 2020, Ricky was remanded following an assault on Edie and for committing other offences including theft from shops. A court date was scheduled for late January 2021. Ricky regularly telephoned Edie from prison (this is analysed in later sections of the report). Edie did not answer his last phone calls which went to voicemail. Ricky left a message saying that he would kill himself if Edie did not answer. Shortly afterwards Ricky took his own life whilst in prison. Edie took her own life less than a week later.

60. None of the organisations had a precise date for when Edie and Ricky's relationship began or the circumstances under which it started. Edie's mum thought that the relationship began 12 months before their deaths although did not have a specific date. Ricky's mum in her statement to the police said that Edie had met her son at a local food processing factory when they were both employed. It remains a possibility that they may have also known each other from when they had both experienced being homeless at different times. Ricky's homelessness had been long-term compared to Edie whose homelessness was associated with domestic abuse. Ricky had been seen in October 2019 at the night shelter by a Navigo practitioner where he talked about thoughts of jumping from the Humber Bridge having had enough of being homeless and being on the street was making him feel "rubbish". Ricky said that there was nothing that mental health services could offer him because all his problems were to do with housing. He was advised and supported at the time in his contact with the housing provider.

61. Edie had four significant relationships with men who were violent and abusive. One of those relationships began in 2016 with a man who displayed very dangerous levels of coercion and control. He raped and threatened Edie who was often unable to sustain complaints against him. He breached court orders and Edie had several episodes of seeking refuge when fleeing from domestic abuse as well as becoming homeless at times. A MARAC as recently as March 2020 concerned this man with Edie as the victim. Edie was also subjected to coercive and controlling domestic abuse from another man she had a much shorter relationship with in the early months of 2020.

62. Like many women who are abused, Edie had poor mental health. Edie's two children had been the subject of child protection arrangements and at the time of Edie's death were living with their maternal grandmother and subject to Family Court proceedings. Edie has a sister.

63. None of the services working with Ricky had any information or history about significant intimate relationships and no history of domestic abuse as a victim or perpetrator until the relationship with Edie. According to his mum, Ricky had one significant relationship before meeting Edie. This relationship appeared to provide a period of relative stability for Ricky. The couple rented a flat together and were employed. The relationship is said to have ended when Ricky's partner began a relationship with somebody else. His mum says that the ending

of the relationship was very difficult for Ricky who began drinking very heavily. He was aged 21 years old. Ricky lived with his sister for about 12 months but this arrangement broke down. Ricky's first contact with the night shelter and outreach service was in July 2019 when he said that he had been sleeping rough for three nights. Ricky did not provide any information about a relationship breakdown with a girlfriend. Ricky was a regular visitor to the night shelter service until December 2019 at which point, he said he was staying with a friend. There is no information recorded about who this friend was.

64. Ricky had experienced homelessness, poly-drug use (alcohol, cocaine and cannabis), and poor mental health including threats of self-harm since his adolescence. He had been a victim of crime on several occasions which included being stabbed in November 2019 as well as committing offences many of which were associated with his substance misuse. In December 2019 he pleaded guilty to burglary and theft and received a suspended prison sentence in February 2020 with a requirement to complete a rehabilitation activity and have alcohol treatment. His first appointment was on the 5th of March 2020 although he missed subsequent appointments in March 2020 to complete a more comprehensive assessment.

65. Ricky's mum says that Ricky was besotted by Edie and at first the relationship seemed to be positive for both of them. Edie's mum also confirmed this saying that Ricky had been a likeable young man although it became clearer that he had problems with alcohol when he became "a different person". Ricky's mum says that her son also began taking some of Edie's anti-depressant medication which exacerbated his problems and behaviour and described how his health began to decline. Although no service had any information about Edie and Ricky in a relationship until May 2020 the police responded to an incident at Edie's home in late April 2020 when an unidentified male had broken into her home to be allowed to use her shower. Edie declined to give the police details but said that it was someone she knew from when she had been homeless; this male may have been Ricky.

66. Ricky told the alcohol treatment worker during a phone call on the 20th of May 2020 that he had separated from his partner who had gone off with his friend. The partner is not named and there is no record of him being asked about this or any other relationships in this or other discussions. Ricky disclosed drinking 45 units of alcohol most days. He repeated that he had separated from his partner in a phone discussion a week later and again there is no information about who the partner was or the circumstances of the separation.

67. In late May 2020, CSC was told by Edie that she was in a relationship with Ricky and asked for checks to be made given Edie's history of being abused in relationships and the implications for Edie's children. The police confirmed that Ricky had no history of domestic abuse.

68. On the 20th of June 2020, the police responded to a third-party report of a disturbance at Edie's home. Edie and Ricky denied that they had been arguing and neither had any visible injury. Neither made a complaint and Edie declined to participate in a DASH assessment with the responding police officers. Edie asked the officers to leave the property who subsequently submitted a risk assessment recorded at medium. A referral through Operation Encompass was made (Edie's children were living with their grandmother at the time but this was good practice in keeping the school informed).

69. During a telephone support phone call from the alcohol support worker, Ricky stated that he was living with a partner; there is no name recorded or information about the partner's circumstances.

70. In early July 2020, Edie was reviewed by the GP (there had been a discussion by the multi-disciplinary team (MDT) in January and February 2020) and Edie was referred to the PCN mental health nurse for support who made contact with Edie made a referral to the Blue Door service in mid-July 2020.

71. At the end of July 2020, Edie asked CSC to include Ricky in a joint assessment as part of the Family Court proceedings. This was the first occasion that there is a record in CSC about Edie and Ricky's relationship. An initial parenting assessment was arranged with Ricky a week later.

72. At the end of July 2020, Edie's GP referred her to Navigo for psychological support in connection with domestic abuse. Edie had been receiving support for anxiety and depression and the GP wanted to explore whether there was a potential PTSD diagnosis due to multiple domestic abuse incidents. Navigo discussed the referral with Edie four days later, who explained that there were Family Court proceedings in progress. Edie was not offered service by the psychologist due to the ongoing court proceedings. The GP practice like other services in NEL is not part of an integrated pathway arrangement such as IRIS[44] which would have made a referral to domestic abuse services more likely and Edie was not offered any other psychological support service. Further analysis is provided later in the report.

73. On the same day that the initial social worker parenting assessment with Ricky was completed remotely because of Covid, the police responded to a report of an assault and domestic abuse at Edie's home. Edie and Ricky were both intoxicated. An argument had developed during which Ricky had grabbed Edie around her face and Edie had grabbed Ricky around his neck as a defence. The officer recorded that Edie and Ricky had been in an 'on-off' relationship for six months. Edie had sought safety at a nearby property and Ricky had damaged her property. Ricky's shirt was torn and he had blood on his knuckles and scratches on his neck. Ricky denied any offences. The incident was graded

[44] Identification and Referral to Improve Safety

at a DASH medium level. Referrals were made to children's social care, IDVA and Women's Aid. The DASH was shared with probation. Women's Aid made contact with Edie the same day who confirmed that she and Ricky had separated; she was worried that he had nowhere to live but she had to put her children first. The worker offered to meet Edie at the Women's Centre but Edie said that she did not go out and wanted a home visit; this was not possible due to Covid restrictions on home visits at the time. A follow-up phone call with Edie (date unknown) included Edie expressing her worry about her ex-partner (not Ricky but the longer-term relationship) being in court for his assaults on her coinciding with the death of his brother. Edie wanted 'all the court stuff' (referring to the criminal and Family Court proceedings) to be out of the way because she could not get support from Navigo until they were completed. Edie was given a named support worker to keep in contact with her and Edie was given a mobile number to contact if she wanted advice or support. Women's Aid was unable to complete any further successful contacts with Edie after that call until October 2020 despite regular calls to Edie.

74. Later the same day Ricky breached the terms of his bail by returning to Edie's home. A DASH risk assessment recorded that Edie was scared and worried about this affecting getting her children returned to her care. Edie was also scared that something might happen at her mother's home (where her children were living and might reflect what happened in previous relationships where a controlling man had used the children to get control over Edie). Edie said that Ricky has been sending threatening text messages. Edie said that Ricky kept coming to her home uninvited. The DASH was completed at a medium level. This is discussed in the later analysis as an example of where risk was probably not understood well enough and the creation of a legal definition of economic abuse from 2023 has implications for future risk assessments.

75. Edie texted the social worker the following day to report that Ricky had "kicked off" the previous evening and had been arrested, interviewed and given bail conditions.

76. Edie contacted the police on the 9th of August 2020 when Ricky again returned to her home in breach of his bail conditions making threats to damage and destroy her property. Ricky was interviewed but no further action was taken such as making a referral to the IDVA service or MARAC or any other multi-agency process. The incident was assessed at a medium level. A MARAC referral was considered but it did not meet the criteria. Edie did not consent to a referral to an IDVA. Ricky was not arrested; he was circulated as wanted. Edie's history and the emerging behaviour of Ricky as a perpetrator could have justified a multi-agency discussion of risk. Edie texted the social worker to say that Ricky had tried to come back last night and that she had not let him in and had called the police. She admitted that she had been tempted to let him in given she felt in need of support due to the brother of her previous partner having been killed the previous evening (this has been corroborated).

77. On the 10th August of 2020, Edie again texted the social worker saying that she had nobody to give her support and that Ricky's domestic abuse was "one drunken night". Edie was still distressed about the death saying that she did not know who she could talk to.

78. Less than a week later, Edie reported a further breach of Ricky's bail after he had arrived at her home and caused damage to her door by trying to kick a door panel in. Ricky was again interviewed and bailed. A target hardening referral was submitted and Ricky was circulated as wanted for the offences due to having no fixed abode. The IDVA based in the Police Force Control Room recorded the police making a report of stalking by Ricky although there was no contact with Edie. The Blue Door IDVA who was already working with Edie was not made aware of the information.

79. The following day Ricky again breached his bail by visiting Edie's property causing further damage to her door. He shouted abuse at Edie who locked herself in a room. Ricky eventually left the property before the police arrived. The incident was DASH risk assessed as medium noting that there had been a similar incident the previous evening and that Edie was scared and had referred to the assault on the 7th of August 2020. Edie described how the relationship was not how it was at the beginning and that it was becoming worse. Edie said the harassment and stalking with text messages were increasing along with increasing visits to the property. She said she was scared. Edie appears to refer to potential money laundering when she said that Ricky paid money into her account and then instructed her what to do with it leaving Edie with little money and that Ricky was also demanding money from her. Edie said that Ricky had reduced his drinking for a while but it had since escalated. Edie asked for support. A referral to the NDCV[45] was discussed with Edie who was considering a non-molestation order. There was no referral to the Blue Door IDVA which is separate from the IDVA located in the police force control room. The risk assessment remained at medium.

80. CPS was consulted on the 28th of August 2020 through their out-of-hours service about a charging decision in respect of the incidents and what charges should be filed. The police sent the file of evidence and although they did not provide a DASH risk report they identified Ricky as presenting a medium risk in terms of his offending. The police believed that there was sufficient evidence to support charging for common assault, criminal damage, threats to cause criminal damage and harassment. The outcome was Ricky being bailed. Further detail and analysis are provided later in the report about how and what decisions were made in this and subsequent contact with CPS.

[45] National Centre for Domestic Violence https://www.ncdv.org.uk/

81. On the 28th of August 2020, the police made a welfare check with Edie and recorded that she was offered support from the domestic abuse unit and IDVA service. A police officer in the domestic abuse unit spoke with the probation service to make them aware of the incidents and said that there would be a referral to the MARAC if more incidents occurred. A panic alarm had been fitted to Edie's property. Edie said that she had not been aware of what Ricky's bail conditions were and that she was not told about what had happened when he has been interviewed by the police. Edie said that she had been in contact with the IDVA service. She also reported being on anti-depressant medication from the GP but this was not helping. Edie also talked about how the domestic abuse was going to prevent her from having her children returned to her care.

82. On the 14th of September 2020, Edie was taken to the emergency care centre (ECC) by the police who had responded to a call for help. The police record says that Edie had an injury to her face and knees. The ECC record says that it was "hand injuries". The police had been called to a local property after Edie had been assaulted by a person that Edie would not identify. Edie was intoxicated and had lost her keys. Edie did not want to make a formal complaint to the police. No other information was recorded although the police officers offered 'safeguarding advice' including getting her door locks changed. There is no recorded evidence that the ECC staff made any inquiry about the circumstances of Edie being injured or whether she felt safe.

83. In mid-September 2020, Ricky was arrested for shoplifting food from a local shop.

84. On the 24th of September 2020, the police and probation service made a welfare check on Edie. Ricky had been released from custody subject to conditions and wearing an electronic tag. No other action was recorded. This is discussed later and was where there should have been clearer multi-agency safety planning and ensuring that there was a strategy for responding to Ricky in the event of making further threats to Edie.

85. On the 6th of October 2020, Edie told the police that Ricky had been sending multiple threatening text messages saying he was coming for her, he was going to ruin her life, and he was going to sell property from her home. He had managed to break into her home and had stolen her keys and a TV box. On the DASH Edie says that Ricky had been threatening to end it all on several occasions (meaning suicide). The report discusses how this information was a significant indicator of escalating risk. The DASH was completed at medium. Referrals were made to IDVA as well as CSC and Ricky was charged. The social worker recorded receiving the PVP (police vulnerable person) report (but there was no reference to the DASH) and noted that Ricky had kicked the door in and had put his hands around her throat. No action was recorded. Women's Aid had a police referral and a support worker contacted Edie the same day who said that she was OK and had no plans to return to the relationship with

Ricky. She was offered a meeting at the centre or by a video link which was declined; Edie was still not keen to leave her home. She again said that she just wanted “all the court stuff to be sorted”.

86. On the 7th of October 2020, the police consulted the CPS about a charging decision on the latest incidents with Ricky. The police proposed charges of burglary, common assault and sending malicious communications. The police assessed Ricky’s offending as a medium. Although the police referenced that the incidents in August were still outstanding and that Ricky was on police bail, they did not present them to CPS for a further charging decision. The CPS solicitor agreed that Ricky should be charged with offences of burglary where violence had been used and criminal damage. The CPS asked for Edie to be referred to support services and gave instructions to the court advocate to oppose bail. On the 8th of October 2020, the magistrate's court remanded Ricky and sent his case to the Crown Court. At the Crown Court on the 20th of October 2020, the judge granted conditional bail after enquiries confirmed that Ricky had employment from the 25th of October 2020. Further information about decision-making is provided later in the report.

87. The prison requested information from the GP on the 12th of October 2020 which was provided on the 21st of October 2020 after Ricky had been released.

88. On the 15th of October 2020, the IDVA service contacted CSC to say that Edie had asked for help in applying for a restraining order against Ricky. The IDVA was also trying to organise access to a virtual Freedom Programme for Edie[46].

89. Ricky was discharged from the alcohol treatment service in early November 2020 after having no recent contact.

90. The police resubmitted the August incidents to the CPS in November 2020 but some evidence was missing. The police referred this file again in December 2020 for a charging decision and on the 20th of January 2021, the CPS authorised charges of criminal damage and common assault for the incident on the 7th of August 2020 and a charge of harassment and criminal damage for the incidents which occurred later that same month. The offences were unable to be progressed following Ricky’s death

91. On the 8th of December 2020, Ricky visited Edie’s home uninvited. Edie attempted to prevent him from entering her home and was punched by Ricky causing facial bruising. Ricky repeatedly punched an internal door and left taking Edie’s phone. Edie declined medical attention. The DASH was completed at a medium level. A referral was made to IDVA, Women’s Aid and CSC. Women’s Aid tried to contact Edie the same day without success and continued to follow up until they spoke to Edie on the 17th of December 2020

[46] https://www.freedomprogramme.co.uk/

when Edie said that she did not want any support at that time but did want to participate in the next Freedom Program.

92. Ricky was arrested and while in police custody was taken to the hospital where he became agitated and aggressive. The police consulted CPS for a charging decision on the 9th of December 2020. The police proposed charges of criminal damage, assault occasioning actual bodily harm (ABH), theft and a public order offence for his conduct at the hospital. Charges of criminal damage, common assault and the public order offence were agreed upon. The CPS instructed the court advocate to oppose bail.

93. Ricky was remanded to prison the following day for the assault on Edie and other offences. The court warrant was sent to HMP Hull although Ricky was sent to HMP Doncaster. Ricky had a basic custody screening interview with the prison nursing staff. He hoped that he would be released at his court appearance at the end of December 2020. He had been bailed to his sister's address before his remand but confirmed he would not be able to return there. He provided some information about having grown up in public care as a child but did not want to talk in any detail. He confirmed he had some contact with alcohol services but no detail about the extent and severity of his drinking was disclosed; at least it is not recorded. Ricky stated that he did not use drugs which was not correct. He confirmed he did not have any thoughts of self-harm and had no mental health needs which again was not correct.

94. At the further remand hearing on the 29th of December 2020 via video link from the prison, the warrant was sent to HMP Doncaster. Both court warrants are for the offences against Edie as well offences of theft. Edie was recorded as Ricky's partner and next of kin.

95. On the 31st December 2020 and three weeks after Ricky was first remanded the police made a welfare visit designed to check on Edie's welfare and get her engagement to an OSARA[47] plan.

96. On the 16th of January 2021, the police made a further welfare visit to Edie's home where they found an unidentified man as well as children in the house. The police made a referral to CSC. When the police tried to phone Edie on the 21st of January 2021 after Ricky had died, she expressed her unhappiness that information had been passed to CSC. Women's Aid contacted Edie having been asked to give her support. Edie was upset and did not want to talk to the support worker. Edie said she had found out that Ricky had killed himself as she had seen it on social media. He had phoned and left voice mails to say if she didn't answer he was going to kill himself. Edie was very upset and said she had missed the last call as she was in the shower. The support worker

[47] Objective, Scanning, Analysis, Response and Assessment

agreed with Edie to make a follow-up call the following week as Edie didn't feel she wanted to talk.

Overview

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

98. Children's social care was involved with Edie during her adolescence when she came to the notice of criminal justice and adolescent mental health services. Edie was a victim of abuse in her intimate relationships with men before she met Ricky and was homeless on more than one occasion.

99. Ricky was a vulnerable young man who had experienced great adversity in his life beginning in his adolescence. He needed a great deal more help than he had and it is clear that places such as the night shelter tried to get him help. His dependency on Edie and his fear of abandonment were significant risk markers combined with his propensity for self-harm. He represented a risk to himself as well as to Edie. A combination of life experiences included his adverse childhood experiences (ACE), being looked after, youth offending and very significant substance misuse from his childhood followed by long periods of homelessness and unemployment. When he was remanded to prison his profile should have flagged a much greater level of risk if it had been known to the prison health care team. He had problems with his mental health, self-harm and poor social support combined with significant deprivation and disadvantage represented a level of complex vulnerability that was exacerbated by the breakdown of his relationship and prison incarceration. That is not to say it could be predicted that Ricky would fatally self-harm but his level of risk was greater than was reflected in the information that was available to the prison or was easily accessible by primary health care professionals in the community such as GPs.

100. Although it is not reflected in agency information, there may have been a degree of optimism at the outset that Ricky would represent a new opportunity for Edie; the absence of domestic abuse in his history may have given some reassurance at the beginning of their relationship. It was something that Edie commented on in one of her discussions with a support worker. She was very motivated to resume the care of her children and she was very conscious of

how the level of domestic abuse in her relationships was seen as a very significant risk factor for being reunited with her children. This may have led to Edie not feeling able to disclose the true extent of abuse from Ricky or other men in reporting incidents. It is notable for example that in July 2020 the GP at Edie's instigation was trying to find support for her as a victim of domestic abuse when at that stage there had been one third-party report to the police of an argument; the report to the police in early August 2020 was also from a third party.

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

102. The police received eight reports of domestic abuse some of which included clear breaches of bail conditions for Ricky to stay away from Edie's home. On none of those occasions was there a referral to MARAC because the DASH never went beyond medium. No additional substantive charges for example in respect of harassment were considered in response to Ricky's repeated breach of police bail conditions. Edie was saying she was scared, there was evidence of escalation and the nature of some of the assaults that for example involved strangulation. Additionally, there were discussions between other professionals such as CSC and IDVA about a restraining order. Ricky's remand to prison following his assault on Edie deserved multi-agency risk discussion and planning particularly when he was released on bail at the Crown Court hearing in October 2020

103. The decisions on charging Ricky with offences in October, December 2020 and January 2021 were compliant with the Code for Crown Prosecutors that is described in the later analysis. Lessons have been identified and are discussed in later sections of the report. Within the context of a DHR, it is acknowledged that there were opportunities to have considered harassment legislation although the CPS review comments that it would not have met the prosecutor's

code test. When the CPS were able to agree to the charges it was accompanied by advice to oppose bail for Ricky.

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

105. Edie was looking for help to deal with the very high level of stress she was under and consulted her GP practice. The decision by Navigo to decline access to a counselling service is explored in the analysis.

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

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

108. The Prisons and Probation Ombudsman investigation was satisfied that Ricky did not give any reason to suggest he had thoughts of self-harm. It also acknowledged that Ricky should not have been allowed to phone Edie and this is examined later in the report.

109. The prison reception process and health assessment relied on Ricky providing accurate and relevant information. The prison was not aware of some of the specific risk factors in Ricky's history and the more general adverse indicators that were described in earlier sections of this report. They had received information from the GP in October 2020 when Ricky was remanded although released before the information arrived. The GP Practice had the most complete information on Ricky's history of vulnerability although it was not included in the patient summary and was only accessed as a result of this DHR and the requirement for a detailed review of the patient's records. It was information that was important for Ricky's ongoing health care from the GP practice and was relevant to the health and risk assessment at the prison. The information given to the prison from the GP practice involved checking a summary of Ricky's patient records which did not include the details about his

vulnerabilities that have been disclosed to the DHR. Imprisonment should be an opportunity to offer advice and help to people suffering from emotional and mental ill-health and substance abuse histories.

Analysis

110. Women like Edie who are abused by intimate partners face many complex barriers to getting effective help. A consistent message from DHRs is that professionals all too often struggle to understand how women become entrapped in a cycle of abuse that can become framed as a "failure to protect" that makes a woman like Edie feel even more voiceless and not focus enough on addressing the perpetrator's behaviour and threat.

111. In 2013 when Navigo services were providing support to Edie she was in a long-term very coercive and controlling relationship. Edie who was presenting with symptoms of depression talked about her then-partner not changing his behaviour when his child was born, and how he drank excessively and physically assaulted her. She described wanting to be with her partner but wanting him to change; would like to just leave and go somewhere to make him realise what he could have but that she could not because she was in debt for rent and other services. She also talked about CSC being involved because of worries for her child. That short patient summary provides some insight into how Edie found it so very difficult to escape from a series of relationships with abusive men.

What contact, knowledge and information did services have with Edie that indicated, or could have indicated, that she was vulnerable to, or could be at risk from domestic abuse and what response was there? This includes whether relevant history was known about and considered alongside any enquiries or assessment of risk.

112. Except for the probation, prison and substance misuse service and to a lesser extent the hospital, services had knowledge and information about Edie's vulnerability to domestic abuse. Some services such as Women's Aid had most of their contact with Edie before the scoped timeline for the review and had provided refuge for Edie when she left previous relationships where she had been abused. Women's Aid described a young woman able to engage with services but who felt entrapped by her circumstances.

113. The only service that completed a DASH assessment during the scoped timeline was the police. On all of the occasions that a DASH had been completed the level of risk was recorded as medium and as such would not trigger a referral to the MARAC. The risk assessments were focused on the immediate presenting incidents completed by first response officers with an insufficient account of Edie's extensive history of being abused; two of these perpetrators continued to present a threat to her in 2020. The DASH risk assessments considered the escalation in the frequency of incidents and that

Ricky was breaching police bail and that Edie expressed her fear of Ricky. A detective sergeant in the police domestic abuse unit identified the pattern of escalating incidents and advised that a referral should be considered if there continued to be further incidents. There was no need to delay until further incidents occurred. Edie was identified as being one of the top 10 repeat victims of domestic abuse and the police allocated ongoing support through a PCSO after Ricky was remanded.

114. Since 2023 the Domestic Abuse Act (2021) provides a legal definition of economic abuse as controlling and coercive behaviour. It is behaviour that coexists with other abusive behaviour such as physical and sexual abuse, and psychological and emotional abuse. Economic abuse is behaviour that has a substantial and adverse effect on a victim's ability to acquire, use or maintain money or property or to obtain goods or services. The economic abuse perpetrated by Ricky as represented by his removal of Edie's property, seeking to control her bank account, and damaging and breaking into her home is behaviour that a risk assessment needs to explore rather than for example simply a property crime or criminal damage.

115. When Edie told social workers about her relationship with Ricky a timely request was also made to the police to check whether Ricky had a history of domestic abuse. This confirmed that Ricky did not have any history of domestic abuse or intimate partner violence. When Edie asked for a parenting assessment to take account of Ricky there was a limited enquiry by CSC. Although Ricky had no history of violence to partners or children there were significant areas of his history described in other parts of this report that deserved careful enquiry.

116. Edie's relationship with social workers was poor and was in large part a reflection of the focus on the risk to Edie's children who were not living with Edie from before her relationship with Ricky had started. The service acknowledged that there had been less attention on safety planning for Edie exacerbated by a turnover of different social workers. This reduced the opportunity to develop a relationship with Edie or to understand the complexity of her circumstances. The assessment and multi-agency contacts that CSC had was focused on the children. Edie's fear of losing her children represented a significant barrier in her interaction with social workers.

117. Edie's frequent contact with the GP was related to her history of domestic abuse and poor mental health was known for several years. The referral to mental health services in July 2020 was triggered when Edie began exceeding the prescribed doses of medication and her mental health showed no improvement. She had multiple and significant stressors which included Ricky's abuse, court proceedings involving her children and a violent ex-partner respectively. Although the GP recognised a link between the domestic abuse that Edie had suffered from her poor mental health there were no other referrals or actions after the mental health service declined the referral.

118. The mental health service had first known Edie in 2011 and was aware of her history of domestic abuse and was cited in the referral from the GP to assess Edie's mental health in the context of domestic abuse. The referral was declined because of the ongoing criminal proceedings involving a previous violent partner and the ongoing Family Court proceedings for the children. The referral was dealt with by one professional in the psychology team rather than being discussed by the single point of access team. The rationale for the referral being declined was concern that the stress of the complex court processes would make it very difficult for Edie to cope with and engage with any therapeutic support. The decision was not challenged or queried by the GP who made the referral or followed up by other professionals when Edie described wanting psychological support but having to wait for the court processes to be completed. The process for referral is being reviewed by the Head of Service. CPS has issued national guidelines for how victims needing access to therapy while criminal proceedings are taking place can access such help and support without compromising the court process[48]. It is a well-established principle that the well-being of victims should determine the decision making and accessing therapy should be delayed where this will harm the health and well-being of a victim.

119. The school had no contact with Edie during the scoped timeline of the review and say they did not know about the domestic abuse that occurred with Ricky and had little information about him. The school's notification under Operation Encompass in June 2020 was good practice although the children were not living with Edie who was having supervised contact with the children. One of the staff at school had worked at the refuge where Edie spent time and was profoundly affected by Edie's death.

120. Edie's presentation at the hospital emergency care centre included injuries to her hands. Hand and finger injuries are the most common upper extremity injuries in patients experiencing intimate partner violence (IPV), with fingers being the most common site and the medial hand the most common region of fracture[49]. Repeated injuries involving the same site and a combination of medial hand and head or face injuries could indicate IPV. Given the association of self-harm and a hand injury with domestic abuse, it should be expected practice to be making enquiries with a patient and looking for other indicators of abuse.

121. The Domestic Abuse Act 2021 has extended the definition of domestic abuse to include economic abuse. The legislation and revised definition which post-

[48] https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-vulnerable-or-intimidated-adult-witnesses

[49] Thomas, R., Dyer, G.S.M., Tornetta III, P. et al. Upper extremity injuries in the victims of intimate partner violence. Eur Radiol (2021). https://doi.org/10.1007/s00330-020-07672-1

dates the events in this review will require changes to future professional practice.

What risk assessments were completed and what measures including bail and use of legal orders were considered/used? Were referrals made to appropriate specialist services?

122. Risk assessments were completed with Ricky as part of the community sentence and supervision with the probation service and when he was remanded to prison. Comment has been made in other parts of the report about how the risk assessments were compromised by an absence of a more complete history of risk factors.

123. The probation service offender assessment as part of the routine OASys procedure indicated that Ricky was not a risk to himself or others. He had been convicted for offences where his difficulties with alcohol were a significant factor and were the reason for an alcohol treatment requirement being made a condition of his Community Order. Ricky completed work on managing stressful situations, problem-solving and thinking about more effective coping strategies. His lack of secure housing and employment were the main stressors discussed.

124. Ricky was the subject of police bail at different times before he was remanded back to prison. Although restrictions were imposed on having contact with or visiting Edie, he breached these on multiple occasions. National guidance makes clear that the DVPN/DVPO civil process is not a substitute for the criminal process of bail. National guidance assumes that a DVPN will be used when there is no other enforceable restriction available to manage a perpetrator such as bail conditions. It is a general assumption that strict bail conditions that are enforced should be sufficient. In this case, there were several occasions when Ricky visited Edie's property causing damage, stealing property and harassing her and was in breach of conditions not to contact or visit. Ricky demonstrated a disregard for the police bail conditions but could not be breached without new substantive charges. Before Ricky's remand back to prison in early December 2020, the offences were recorded as criminal damage and malicious communication along with burglary with violence rather than a wider consideration as to whether harassment offences should be considered to address the coercive nature of Ricky's behaviour toward Edie.

125. The CPS legal guidance for prosecutors when contemplating a harassment charge describes repeated and unwanted behaviour which causes a complainant alarm or distress. As discussed in earlier sections of this report harassment and stalking behaviour represents a significant and elevated risk. Ricky's behaviour did not fall within the types of behaviour described in legal guidance[50] for prosecutors that would be considered for an offence of stalking

[50] https://www.cps.gov.uk/legal-guidance/stalking-and-harassment

(watching, spying or conduct which resulted in Edie significantly changing her behaviour).

126. The CPS had the responsibility of deciding whether Ricky should be charged with any offences on four occasions between August 2020 and January 2021. The CPS prosecutor had to apply the Code for Crown Prosecutors (the Code) when doing so[51].

127. The prosecutor must decide if there is first, sufficient evidence to provide a realistic prospect of conviction, and secondly, if so if it is in the public interest to prosecute. This is "the Full Code Test."

128. For the Full Code Test to be applied, the police must have finished their investigation and carried out all reasonable lines of enquiry. However, sometimes as in this case, the police may not have finished their investigation but feel that the seriousness or circumstances of the case justify the making of an immediate charging decision because there are grounds to object to bail and keep the suspect in custody. Therefore, if there are reasonable grounds to suspect that the person to be charged has committed the offence and further evidence can be obtained to provide a realistic prospect of conviction, a prosecutor can authorise a charge if it is in the public interest. This is called the "Threshold Test."

129. The Code in paragraph 5.9 says a prosecutor must consider the following when determining whether there are substantial grounds to object to bail:

"This determination must be based on a proper risk assessment, which reveals that the suspect is not suitable to be bailed, even with substantial conditions. For example, a dangerous suspect who poses a serious risk of harm to a particular person or the public, or a suspect who poses a serious risk of absconding or interfering with witnesses. Prosecutors should not accept, without careful enquiry, any unjustified or unsupported assertions about risk, if released on bail, were to take place."

130. CPS expects cases to be presented to courts clearly and simply. A prosecutor should never proceed with more charges than are necessary. The Code makes clear that prosecutors should select charges which reflect the seriousness and extent of the offending, to give the court adequate powers to sentence and impose appropriate post-conviction orders.

131. When the CPS were consulted in August 2020 the prosecutor determined that the case was not suitable for a Threshold Test charging decision, applying Paragraph 5.9 of the Code. The prosecutor decided that there were no substantial grounds to object to bail, and so decided that the police could re-

[51] https://www.cps.gov.uk/publication/code-crown-prosecutors

bail the suspect so the investigation could be completed. The prosecutor noted that the suspect had breached his police bail but took the decision that bail conditions would suffice, as he had received the personal effects that he had attended the address for. The police were informed of this decision and were sent an accompanying action plan to support the police with their investigation.

132. When the police consulted CPS in October 2020, they referenced that the August incidents were outstanding and that Ricky was on police bail but did not present them to CPS for a further charging decision. The prosecutor applied the Full Code Test for the October matters and decided that there was a realistic prospect of conviction and that it was in the public interest to charge Ricky with offences of burglary where violence was used (a serious crime that requires Crown Court prosecution) and criminal damage. The prosecutor asked that Edie be referred to support agencies and gave instructions to the court advocate that the CPS should be opposing bail. Although Ricky was remanded by the magistrate's court he was released at the Crown Court; Ricky's advocate presented evidence that Ricky had a job starting imminently.

133. In December 2020 when the police consulted the CPS, the prosecutor applied the Full Code Test for the December matters alone and decided that there was a realistic prospect of conviction and that it was in the public interest to charge Ricky with offences of criminal damage, common assault, and the public order offence. The prosecutor gave instructions to the court advocate that the CPS should oppose bail. Ricky was remanded pending trial.

134. The prosecutors in October and December 2020 did not consider the August incidents which were still pending a charging decision. It meant that charges in respect of those incidents were not progressed or linked to the subsequent offences. The CPS acknowledge that if the prosecutor had considered the cases altogether then harassment offences could have been considered and as such represents a missed opportunity. However, the CPS review makes the point that harassment would not have enabled the case to be presented clearly and simply (as required by the Code for Crown Prosecutors). Further, if offences of harassment had been preferred it is arguable as to whether they would have made a difference to any sentence the court could impose as the charges chosen reflected the seriousness and extent of the offending. It would however have given a better opportunity for agencies to see Ricky's behaviour as part of wider and more concerning behaviour with a clearer emphasis on his risk as a perpetrator of domestic abuse rather than a property crime aggravated by violence. However, the panel understood that the CPS' sole statutory function is to independently and objectively assess evidence to determine whether a prosecution should be commenced.

135. In January 2021 the CPS authorised charges of common assault, criminal damage and harassment that spanned the August incidents. The prosecutor could have considered whether the incidents that occurred in October and

December 2020 should have formed a part of a wider course of harassment behaviour. The CPS has identified this as an opportunity that was not taken. The CPS review provided additional commentary about the selection of offences for charging. For example, the first part of the incident in October 2020 for which a charge of burglary where violence was authorised is an offence that can only be dealt with by the Crown Court where a person in the dwelling is subjected to violence or threats of violence.

136. When Ricky was remanded to prison, he was the subject of the routine reception health assessment when he told a nurse that he had no history of self-harm or mental health issues. He confirmed he had no thoughts of self-harming or suicide. He was placed in the First Night Centre before allocation to a cell. During that time, he told staff again that he had no history of self-harm and no thoughts of self-harm or suicide. The GP's disclosure of a patient summary about Ricky did not disclose a detailed history of his vulnerability.

137. Ricky arrived at HMP Doncaster without a copy of the court warrant being issued to the prison although it arrived the following day. At the time that the prison was completing the reception process, the prison believed that Ricky had been remanded for property offences. As part of the reception process, prisoners provide details of people, they wish to have contact with. Ricky provided Edie's telephone number saying that it was his sister's phone and he was allowed to make regular calls to her. Since Covid, prisoners are permitted to make calls from their cells and although Ricky's cellmate was aware that he was talking to his partner the prison staff believed that phone calls were being made to Ricky's sister.

138. When Ricky had a second court hearing in late December 2020 the court warrant that continued Ricky's remand to HMP Doncaster was sent through. The DHR has been told that it was at that stage that the prison recognised that Ricky had been remanded for an offence of assault on Edie as well as property offences. No restrictions were placed on his calls to 'his sister'. The Prisons and Probation Ombudsman investigation found that prison staff should have identified Ricky as a potential domestic abuse perpetrator and should have checked his contact numbers in line with national guidance PSI 04/2016. The DHR panel agree and there is a discussion of learning after this report for community and prison services.

139. Ricky had had little contact with a GP in NEL during the scoped timeline for the DHR despite significant health-related needs and his primary healthcare records contain some of the most extensive records about his history compared to other services. There had been contact with a GP in 2019 when it was recorded he was 'struggling with alcohol' and he reported relationship difficulties but there is no recording about who the relationship was with. Ricky was homeless and was having suicidal thoughts. He attended the GP in late

2019 when he had a dressing changed to a leg wound following a stabbing. He was also treated for a head injury following an assault.

140. Ricky's only contact with mental health services as an adult was brief when he spoke to a member of the crisis team at the night shelter. He was feeling suicidal talking about how he felt like jumping from the Humber Bridge and was struggling with living on the streets and being homeless. He was advised to talk with staff at Harbour Place and there was no further contact with Ricky.

141. Ricky's medical records would not have flagged any immediate and significant concerns about his health although the markers of vulnerability discussed earlier in the report associated with male self-harm in prisons were evident.

142. The assessments of risk associated with Edie are discussed in other parts of the report.

What were the circumstances of Ricky's remand into custody following incidents of domestic abuse of Edie? What measures were in place to ensure safety and support? What restrictions were in place about contact from Ricky to Edie?

143. Ricky's initial remand to prison did not flag the fact that he had been remanded following an assault on Edie and importantly that there had been an escalating pattern of harassment and abuse leading up to the remand. The prison says this was caused by the non-arrival of the court warrant until the following day by which time Ricky had gone through initial processing. Given that an important purpose of remanding to prison is to control the threat presented by a perpetrator of violence and to protect the victim this is a significant area where lessons need to prevent future reoccurrences.

144. None of the services outside the prison knew that Ricky was able to contact Edie. The prison believed that the number Ricky was phoning belonged to his sister and was presumed to be the person he was talking to. If there had been a multi-agency safety plan this could have been addressed and is discussed later in the report.

145. In any event, the prison did not put in place any instructions that there was to be no contact from Ricky to Edie after they had received the court warrant. Local and national guidance as referenced previously makes clear that communication can and must be restricted when a prisoner is identified as a perpetrator of domestic abuse. The guidance instructs that personal contact numbers must be checked when a prisoner is remanded for a harassment offence, is identified as a perpetrator of domestic abuse or potential perpetrator and there is a risk of intimidation of victims or witnesses.

146. The checking of phone numbers is quickly undermined if the only check is for prison staff to phone the number and seek confirmation that the information provided by the prisoner is correct. Men who are remanded following abuse, control and coercion will continue to exert control from within prison and a domestic abuse victim is unlikely to feel confident about contradicting information. Given the level of risk posed by prisoners who have perpetrated abuse, control and coercion, the system of checks needs to be more robust involving checking with community-based criminal justice services. A recommendation about ensuring victim details including phone numbers are part of the initial information the prison needs to verify is included later in this report. It also reinforces the importance of a safety plan being in place.

147. The police, Women's Aid and the IDVA service all offered contact with Edie before and after Ricky's death. The circumstances under which Edie heard about Ricky's death and the final message were very distressing.

What contact, knowledge and information did services have with Edie or Ricky that could have indicated a risk of self-harm and what response was there?

148. Edie and Ricky had both experienced poor mental health but were not diagnosed with a disorder or illness. Edie had long-term anti-depressant medication. The DHR has received no evidence of self-harm. Edie's children were probably a very important part of her emotional and mental resilience.

149. Ricky had a history of self-harm. He had taken an overdose in the summer of 2019 and he talked to a mental health crisis worker at the night shelter about his thoughts of jumping from the Humber Bridge feeling hopeless about his homelessness. One of the DASH assessments completed with Edie in October 2020 included information about Ricky threatening to fatally self-harm. Police officers have received training and guidance on identifying and recording suicide risk on intelligence markers. Thoughts of suicide, dependency on a victim and fear of abandonment are significant risk markers[52].

150. When Ricky was placed at HMP Doncaster his reception health assessment included a check of his health record which included a reference to a previous attempt at self-harm. It also recorded that at the time of the assessment, Ricky said his mental health was fine and he had no thoughts of self-harm. He shared a cell with another prisoner who did not report any concerns about self-harm before or after Ricky's death.

151. Edie's mum told the independent reviewer when reviewing the first draft of the report that Edie had contacted the prison on more than one occasion after discussions with Ricky on the phone had included him discussing thoughts of

[52] Monkton-Smith, J, Williams, A and Mullane, F, 2014 Domestic Abuse, Homicide and Gender Strategies for Policy and Practice Palgrave Macmillan p55.

self-harm. The reviewer rechecked information provided to the DHR by speaking with the Yorkshire Prison Group and HMP Doncaster who had no information about Edie contacting the prison with concerns about Ricky. No record of contact from Edie to the prison was found by the DHR agency review, the Yorkshire Prison's Group early learning review, the investigation by Serco or the Prisons and Probation Ombudsman investigation.

152. When Ricky died the prison attempted to contact Edie but got no response on the phone. They also attempted to contact his family and the police made a home visit to his mother to inform her of Ricky's death.

153. Edie found out about Ricky's death via a social media posting before the police or Women's Aid had spoken to her. Edie did not want to talk with the support worker from Women's Aid. Edie was able to say how upset she was that she had not spoken to Ricky.

What history of substance misuse and mental health was recorded and how was this assessed and understood within the context of domestic abuse?

154. The GP understood that Edie's poor mental health and the inadequacy of medication to ameliorate her symptoms were associated with her history of domestic abuse. The primary care nurse (PCN) was an important person that Edie used for support. This contact with primary care services was separate from any other processes or interventions and the GP appears to have little information about Edie and Ricky's relationship.

155. Ricky's history from childhood into adulthood as far as it is known by any service reflects a high level of adversity. The review is the first occasion when it has been collated. His lack of substantial contact with primary health services removed an opportunity for consultation and possible signposting to sources of help. His contact with the night shelter did not provide access to health care. As a care leaver, he should have expected better support as a young adult albeit the experience of being a looked-after child had been outside of NEL and England.

156. The response to the domestic abuse perpetrated by Ricky on Edie was primarily centred on the police which has been described in other parts of this report.

Was agency practice sufficiently sensitive and effective in establishing whether there were any special needs including potential barriers to Edie or Ricky, family or any friend seeking advice or help and whether there are any lessons to be identified regarding agency practice or policy? How did Edie's relationship with her children influence interaction and discussion about domestic abuse?

157. Edie's relationship with her children was an overriding issue and concern for her. One of the primary barriers to disclosing domestic abuse often described in research is the fear that abused mothers have of losing their children. This is compounded by fear of being judged or negatively evaluated as a parent for example when processes such as child protection plans are made or court proceedings are happening. Abused women can experience the concerns that professionals have about the impact of domestic abuse on children as being disinterested in why escaping from coercive and dangerous relationships is not about "making life choices". Feelings of low self-esteem, shame, embarrassment, guilt and powerlessness are all factors that contribute to the entrapment of women such as Edie.

158. Disclosure of abuse is made more difficult when abusive behaviour has formed part of long-established patterns to become normalised and victims have little expectation that help will be forthcoming or make matters worse such as losing children.

159. Edie's relationships with other men had been highly coercive and controlling with extreme levels of emotional, physical and sexual violence. The fear of repercussions particularly when subjected to threats as Edie experienced with all the men including Ricky. Fear is compounded when the perpetrator of the abuse suffers from anxiety or low mood and depression as Ricky did.

160. Edie had engaged with services such as Women's Aid and the IDVA service earlier in the life of her children; this level of engagement was less many recently. Covid and the lockdown was a significant issue in terms of services being able to provide home contact as well as Family Court proceedings that would determine where the children should be cared for.

161. Edie had become isolated from friends although still had contact with her mum who says that Edie did not talk much about her relationship with Ricky.

162. Ricky's history was complex and largely unknown to the services that had contact with him. He was vulnerable because of his homelessness and isolation. His long history of substance misuse exacerbated his poor mental health and he was prone to thoughts of self-harm.

163. Although Ricky was signposted and had contact with mental health, substance misuse and night shelter services these provided limited amelioration of Ricky's difficulties. He found it difficult to talk about his problems although cooperated and complied with his community supervision order. The complexity and level of vulnerability were not reflected in the information that was available to the prison.

Was there ever any cause to escalate any issues to senior managers in the agency or with any other specialist professionals or organisations? If so, were there any barriers or evidence of delay in terms of escalating issues? What outcome was there?

164. None of the services identified a need to escalate issues.

Were there issues regarding the capacity or resources of services that had an impact on the ability to help Edie or Ricky or to prevent domestic abuse, or had an impact on the ability to work with other services? This should include a comment about the quality of supervisory or management oversight and the extent to which professionals in the agency have enough training and understanding about domestic abuse, safeguarding and workload.

165. The ability to recruit and retain people to staff services is an ongoing challenge for many of the services. CSC in particular has longstanding difficulties in recruiting social workers. The quality of relationships that can be developed with abused women and their children is a cornerstone of effective help being offered.

166. The vulnerability of people who are homeless is well-known in national and local studies. The night shelter provided emergency accommodation for Ricky and tried to signpost him to relevant services.

Were there any issues regarding the impact of any organisational changes covered by the period under review that influenced how the agency or partnership arrangements were operating? This should include any specific issues relating to Covid changes to working arrangements and access to services.

167. The impact of Covid and the associated lockdown and restrictions on home visits and contacts have been commented on elsewhere in this report.

What can be identified as good practice in this case?

168. The support worker from Women's Aid continued to make calls to Edie even when she declined conversations or did not pick up calls and when Covid had prevented home visits.

169. Edie had contact and support from two IDVAs at different times which provided a better opportunity for trying to build a relationship and understand her circumstances.

170. The practice PCN mental health nurse at the GP provided regular opportunities for Edie to talk about the stressors in her life which centred on her contact with her children and the involvement of CSC. The nurse referred Edie to the Blue Door service in July 2020 where Edie was already open to an IDVA about a previous abusive partner.

171. The night shelter provided a safe refuge for Ricky over several months and attempted to signpost him to services.

172. The probation officer who was supervising Ricky made sure during a brief telephone discussion in April 2020 during one of Ricky's supervision sessions that Edie was aware of Ricky's long history of alcohol abuse and the implications for her children.

173. A police community support officer (PCSO) was allocated to make regular contact with Edie the knowledge that she was a higher-risk victim of domestic abuse.

What action(s) by the agency in retrospect might have led to better outcomes in this particular case? Why were these not considered/not taken at the time from the agency's perspective?

174. If Ricky's repeated breach of bail and offending against Edie had been considered as a pattern of abuse and harassment combined with an understanding of her long history as a victim of domestic abuse should have resulted in a referral to the domestic abuse service with a more coordinated response. The panel discussed the generally accepted principle that a referral to the IDVA service will take place with the consent of a victim; in this case, a Blue Door IDVA had Edie open to them because of her previous relationships where she had been abused and were not made aware of the abuse in Edie's relationship with Ricky. They were treated as separate incidents until the sergeant in the specialist team recognised they were not. A pilot scheme due to be launched in the East Riding by Humberside Police will give a clearer focus on victims who have a history of being repeat victims of domestic abuse.

175. Ricky should not have been able to contact Edie from within the prison. Although the court warrant was incorrectly directed to HMP Hull when Ricky was sent to HMP Doncaster it was received in HMP Doncaster within 24 hours and should have been reviewed and identified Ricky as a perpetrator of domestic abuse. A safety plan should then have been put in place following the national guidance already referenced.

176. The Prison and Probation Ombudsman (PPO) investigation established that the prison had access to Ricky's SystmOne medical records. This included the significant history that has been summarised earlier in the report; Ricky's history

of being in care; Ricky's alcohol abuse since adolescence; a previous attempt at self-harm and injuries following assaults. The PPO investigation acknowledged that being remanded to prison and charged with an offence of violence against a close family member is a known risk factor for fatal self-harm. The fact that the prison did not identify the offences of assaulting Edie undermined the management of risk to her in terms of Ricky's contact and was an important factor not considered in the prison risk assessment of Ricky. The PPO makes clear that as far as health screening was concerned, the proper processes were followed and there was no indication that Ricky was vulnerable to self-harm or thoughts of suicide. The PPO would have expected the prison to have considered using the Assessment Care in Custody Teamwork (ACCT) process if Ricky had been assessed as being at risk of self-harm based on the factors discussed in the equality and diversity section of the report[53]. The DHR panel agree. Custody can be an opportunity to help improve the health of a prisoner.

177. Ricky's mental health was adversely affected by his substance misuse and he did not have secure housing. Although he completed an Alcohol Treatment Requirement Order this did not provide a remedy. Environmental factors such as homelessness combined with high levels of drug and substance misuse can increase the risk of developing more severe mental and physical illnesses.

Conclusions

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

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

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

[53] Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm. The ACCT process requires that certain actions are taken to ensure that the risk of suicide and self-harm is reduced.

181. Edie's children were very important to her. Edie described them as the best thing that had ever happened to her and how much she loved them. They were probably an important source of resilience to Edie in dealing with the extraordinary stress in her life that was further magnified by Covid lockdowns. Social workers, police and other professionals had taken action to protect Edie's children from the abuse and violence from Edie's partners; CSC acknowledged that there was less recorded attention to understanding the complexity and disempowerment that affects women in Edie's circumstances. The focus was on 'failure to protect rather than a perpetrator pattern-based approach advocated through Safe and Together for example[54]. Research evidence has found mother blaming is a pervasive issue that re-victimises women[55]. Professionals who appear ineffective in the face of domestic violence can reinforce children's and victims' own sense of powerlessness[56]. Edie described shortly before her death feeling let down by a system that should be supporting families and not being listened to. Work being done to improve future practice is included in this part of the report.

182. Coercive control, a term developed by Stark[57] to describe a form of partner abuse that survivors reported as being akin to domestic or intimate terrorism is enshrined in UK law. Coercive control is not just about acts of extreme violence but describes behaviour by abusers to control and subjugate intimate partners. The domestic abuse that Edie experienced in more than one of her intimate relationships was akin to intimate terrorism and was terrifying for her and her children. It has implications for how professionals who are part of child protection plans involving domestic abuse think about and engage with parents like Edie. The fact that relationships with social workers had become so poor is indicative of how Edie felt isolated from that process.

183. The Domestic Abuse Act 2021 statutory guidance published in July 2022 sets out in detail the multiple forms of domestic abuse which includes for the first time economic abuse. It involves the control of money including income, spending, bank accounts and borrowing. It can include the destruction of property and refusing to contribute to household costs. Ricky's abuse of Edie included economic abuse. It is behaviour that does not occur in isolation from other forms of domestic abuse and is part of creating economic instability, dependency and restriction. Economic abuse is commonly part of a perpetrator's behaviour. Although a common form of abuse, its dynamics are different from other forms of abuse that involve proximity. Even when a perpetrator is unable to engage in physical, sexual or psychological abuse their

[54] https://safeandtogetherinstitute.com/
[55] Cramp, K. J., & Zufferey, C. (2021). The Removal of Children in Domestic Violence: Widening Service Provider Perspectives. Affilia, 36(3), 406–425. https://doi.org/10.1177/0886109920954422
[56] Stanley. N, Miller. P, Foster H Engaging with children's and parents' perspectives on domestic violence, Child and Family Social Work, 17(2), May 2012, pp.192-201.
[57] Stark, E., 2009. Coercive control: The entrapment of women in personal life. Oxford University Press.

victims may experience difficulty in ending economic abuse if a perpetrator has a few elements of identifying information.

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

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

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

187. The local authority commissioned and provided (with Respect) bespoke training on working with perpetrators for family support workers. DASH risk assessment training is being provided throughout the Front Door Service from March 2022. The service is promoting awareness about the role of MARAC and the circumstances under which referrals should be made by Children's Services. The Signs of Safety[58] rollout in Children's Services will focus on safety planning.

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

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

have not had enough training. They will be accessing local training as a result of the DHR.

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

190. Monkton Smith's eight-stage model of how dangerous intimate relationships develop[59] is an example of where understanding markers and patterns are important and has applicability in this case. Humberside Police have started training officers on the eight stages which are already incorporated into their secondary risk assessments. In 2022 they will train all front-line officers in this area to assist in providing that holistic approach to escalation. Although Ricky did not have any known history of stalking or abuse with intimate partners the relationship with Edie developed quickly, there was increasing evidence of coercion and extreme jealousy along with triggers when for example he was made subject to bail conditions that prohibited contact and visits to Edie and escalation. His poor mental health, history of self-harm and level of substance misuse were further factors to consider in a risk assessment.

191. Recognising that harassment and stalking represent a higher risk of abuse that is likely to persist non-fatal strangulation is an important risk factor and is now an offence in the Domestic Abuse Act 2021. Humberside Police have completed a standard operating procedure which is being embedded and includes all stalking offences to be reviewed by a Detective Inspector within 48 hours, where a robust investigation plan will be placed on the crime, ensuring that all evidence has been captured and an OIC allocated. Monthly audits are being carried out in this area to ensure that the SOP is being embedded. The Humberside Police are moving from DASH to the DARA (domestic abuse risk assessment)[60].

192. The decision to remand Ricky to prison represented a potential escalation in the level of risk to Edie given the enforced separation that Ricky had

[59] Monkton-Smith. J, Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide First Published August 5, 2019 Research Article https://doi.org/10.1177%2F1077801219863876

[60] https://whatworks.college.police.uk/research/documents/da_risk_assessment_pilot.pdf

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

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

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

195. The prison received the court warrant late. This does not remove their responsibility to have made sure the warrant was read on receipt and to have recognised that Ricky had been remanded for a domestic abuse offence and then followed the required procedures. This includes checking on the ID of contact numbers being provided by prisoners. The prison has already completed work to address the problems of the late arrival of the court warrant. Humberside Police are looking at a pilot in North Yorkshire which is working

with prisons to update them about domestic abuse perpetrators entering the prison system and ensuring that details including contact numbers of victims are accurately included. Humberside Police are encouraging their officers to submit intelligence reports for inclusion in the central prison intelligence system.

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

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

198. Work has commenced within NAVIGO via the safeguarding team with staff within the single point of access (SPA) and this will continue throughout 2022. Supporting and encouraging staff to think of a whole family approach is ongoing including encouraging staff to make more referrals and signposting to external agencies that can support service users. NAVIGO is also working with the Head of Children's Services to look at improving referrals to the psychology service. Referrals may not always be appropriate for therapy but may still need some form of regular emotional support which may come outside of psychological therapy services.

199. The stigma of suicide is a known barrier to bereaved family members seeking help, as well as to others offering support[61]. Survey data suggests that two-thirds of people in the UK bereaved by suicide receive no formal support from health or mental health services, the voluntary sector, employers or education providers. The type of support and how long it will be needed varies from person to person. The time point at which individuals decide to seek help differs too; it could be immediately, several months after their bereavement, or further down the line, for example around significant anniversaries or family events. The development of local suicide prevention and surveillance promoting local partnership working enables local teams to act quickly following a possible

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

suicide and provide timely support to families and communities. Having good working relationships between prison and relevant community-based services is an important part of risk assessment and organising support for bereaved relatives and friends.

Lessons to be learnt

200. Making a difference includes;

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

b) Monkton-Smith's research supports making risk assessments that identify clusters of risk markers and the motivation for domestic abuse as more reliable barometers of risk and go beyond matrices that rely on ordinal scales that simplify complex information into single boxes and actuarial scoring; the sergeant in the specialist police unit recognised that despite the DASH score at medium there was evidence of escalation that was not being taken into account; training based on Monkton-Smith eight-stage model is being implemented across Humberside Police;

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

d) Understanding that men who seek control in their intimate relationships can be dependent upon the woman for their sense

of identity or sense of self-worth[62]. Dependency and fear of abandonment together with a history of depression and threats of self-harm are significant markers of risk to the perpetrator as well as for their partner and are relevant in Ricky's circumstances;

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

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

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

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

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

j) Understanding the barriers for women in Edie's circumstances in escaping abuse, disclosing abuse and engaging with help; a relationship with an abusive partner is not a 'life choice' and the greatest threat facing victims is the extent to which they are

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

robbed of an ability to feel empowered and to make choices or are viewed as “failing to protect”;

k) Availability of health and psychological care that is timely; Edie’s health was adversely affected by domestic abuse but it did not result in effective interventions either for counselling or referring to other specialist services; it is not enough for healthcare staff to have an awareness of domestic abuse but to have the appropriate knowledge and for health care to be part of integrated pathways with domestic abuse services that are achieved for example through IRIS[63];

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

m) The prison and custody services, in general, are isolated from community-based services that have vital information that needs to be taken into account in risk-assessing prisoner safety and ensuring that victims of perpetrators who have been remanded are not allowed to continue their contact with a victim from within the prison. Prison and community-based services such as the police, court liaison and domestic abuse services have important roles in developing safety plans before, during and after remands or imprisonment for domestic abuse offences.

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

o) Prison health services assessment of prisoner risk from self-harm and suicide; primary health care is a repository of important information about the needs and vulnerability of prisoners; this information is often not summarised in the patient records and

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

therefore not easily accessible to a GP during patient consultation or for contributing to prisoner risk assessment; similarly, there is a need for prison health professionals to keep GP informed about significant health interventions whilst a patient is in prison.

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

Recommendations

1. The Domestic Abuse Strategy Delivery Group should explore national best practices regarding the provision that could be put in place to focus on repeat victims of domestic abuse along with perpetrator interventions and breaking the cycle and put forward recommendations as relevant.
2. The North East Lincolnshire Health and Care Partnership should work with GPs on using flags and codes on patient records of high-risk markers of domestic abuse and self-harm and that patient summaries include this information.
3. The prison should review and ensure that domestic abuse training is provided to staff working in prisons and ensure that staff completing reception and health screening processes with prisoners have enhanced levels of training and awareness about checking for evidence of domestic abuse whether or not it is associated with offences relating to the prisoner arriving at the prison.
4. The prison should provide a summary of learning for the reception and health care team and review operational guidance on checking for risk flags on community-based data systems.
5. The police and probation services should ensure that information about a prisoner having a history of domestic abuse is included and forwarded with the prisoner to the prison.

Issues for national policy

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

Individual agency management review (IMR) recommendations

North East Lincolnshire Health and Care Partnership

1. Ensure each GP practice has a mechanism by which vulnerable patients and/ or safeguarding issues are discussed in-house, inviting multi-disciplinary colleagues as necessary.
2. Each GP practice should have appropriate arrangements in place to ensure robust follow-up arrangements where patients do not attend appointments. This should include a relevant “did not attend/was not brought” policy and consideration of wider vulnerability factors which inform any risk assessment and escalation processes.
3. Where adults at risk are under services to have recorded contact details of professionals involved in the patient's care; such as the details of an IDVA or social worker. This can be recorded in the safeguarding template on the computer system so is hidden from online access.

Humberside Police

1. Ensure the Prison service has the contact details of the victim so they can put measures in place to prevent contact by both parties.

The Blue Door

1. Appropriate completion of DASH RIC, utilising professional curiosity to ensure sufficient information is captured.

We Are With You

1. Provide feedback to the staff team regarding the impact and importance of ensuring the service recognises and responds appropriately to changing circumstances that may affect risk.