# Domestic Homicide Review

Name: Annie
Died: August 2018

Chair: Paul Cheeseman
Author: Ged McManus
Date: June 2019

## INDEX

## 1 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Annie[1], a resident of Redcar-Cleveland prior to the point of her death in August 2018. The panel would like to offer their condolences to Annie's family on their tragic loss.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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.

1.3 Annie and Simon[2] had known each other for around nine years. They were partners but sometimes had breaks in their relationship and there is evidence that Simon had a relationship with another woman. They both lived at separate properties in Redcar, but Simon often stayed at Annie's house. Annie had two adult children from a previous marriage and she was in contact with them both prior to her death. Simon had been married previously and has adult children although he only maintained contact with one of them.

1.4 The review will consider agencies contact and involvement with Annie and Simon from 1 October 2017, until Annie's death in August 2018. This time period was chosen because it encompasses the only recently reported incident between Annie and Simon. The panel considered carefully whether to go back further to the only previously reported incident in 2011. On balance it was decided that was not proportionate and that learning would be limited given the significant changes that have happened to local services since then.

1.5 The intention of the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

[1] A pseudonym see para 3.2
[2] A pseudonym see para 3.2

1.6 **Note:**

It is not the purpose of this DHR to enquire into how Annie died. That is a matter that has already been examined during Simon's trial.

## 2 Timescales

2.1 This review began on 22 November 2018 and the panel met on four occasions. The review was concluded on 14 June 2019, following consultation with Annie's family.

## 3 Confidentiality

3.1 The findings of each review are confidential. Information is available only to participating officers, professionals and their line managers during the review process.

3.2 Pseudonym's have been used to protect the identity of the victim. The victim's family chose the pseudonym Annie. The DHR panel allocated the pseudonym Simon to the perpetrator.

Annie age 66, white female

Simon age 61, white male

## 4 Terms of Reference

4.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

4.2 **Timeframe under Review**

The DHR covers the period 1 October 2017 to the homicide of Annie in August 2018.

4.3 **Case Specific Terms**

**Subjects of the DHR**

Victim: Annie aged 66 years

Perpetrator: Simon aged 61 years

**Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Annie as a victim of domestic abuse and what was your response?

2. What risk assessments did your agency undertake for Annie; what was the outcome and if you provided services were they fit for purpose?

3. What was your agency's knowledge of any barriers faced by Annie that might have prevented her reporting domestic abuse and what did it do to overcome them?

4. What knowledge did your agency have of any alcohol, drug, gambling, addictions or mental health issues in respect of Simon and/or Annie? What services did your agency provide in response to these issues?

5. What knowledge or concerns did the victim's family and friends have about Annie's victimisation and did they know what to do with it?

6. What knowledge did your agency have that indicated that Simon might be a perpetrator of domestic abuse and what was the response? Did your agency consider making a referral to a Multi-Agency Risk Assessment Conference [MARAC], Multi-Agency Public Protection Arrangements [MAPPA] or any other programme intended for the

management of individuals considered to be prolific or that presented a high risk of harm to others?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Annie and Simon?

8. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

9. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Annie and Simon, or on your agency's ability to work effectively with other agencies?

10. What learning has emerged for your agency?

11. Are there any examples of outstanding or innovative practice arising from this case?

12. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Redcar - Cleveland Community Safety Partnership?

## 5 Methodology

5.1 Following Annie's death, a referral was made to the Redcar-Cleveland Community Safety Partnership by Cleveland police. A Scoping Meeting took place on 12 September 2018, where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed on 7 November 2018. A trial date was set for Simon in February 2019. In the meantime, work commenced on gathering the information needed for the review. Simon pleaded guilty before the case went to trial and the DHR panel was then able to progress its work.

## 6 Involvement of Family, friends, work colleagues and wider community

6.1 The panel chair wrote to Annie's son and daughter who agreed to contribute to the review. They met the panel chair and were happy to speak about their mother and their experiences.

6.2 Annie's children provided details of her family life and more recent relationship with Simon.

6.3 Annie was born in Guisborough and had two brothers who pre deceased her. Her parents died some years ago. Annie went to a local secondary school and later worked as a sewing machinist and school dinner lady.

6.4 Annie met her husband locally and during the relationship had her son and daughter. They recalled that their parents were keen western fans and went to western evenings dressed as cowboy and cowgirl. They would come home, Dad would go to bed and Annie would sit up drinking on her own. Annie had always drunk heavily and there were arguments with her husband. Eventually the couple drifted apart and separated after twenty-five years of marriage.

6.5 Annie's husband moved out of the family home and she continued to misuse alcohol. Her daughter moved out leaving only her son living with her and they eventually moved to a bungalow. Her son recalled that Annie's drinking continued and there were lots of incidents; she would go missing, she would lock him out and he said it was not a pleasant time. Eventually he met his future wife and he moved out to live with her, leaving Annie on her own.

6.6 Annie's children recalled that each of them had periods in their lives when they lost touch with her and there were some fall outs related to her drinking. She would often be difficult to get hold of. They said that apart from Simon, they were not aware that Annie had any other relationships. She did not socialise and spent most of her time at home on her own drinking. Eventually, because of her lifestyle she lost the bungalow and walked away leaving with nothing but a bag of clothes and some photographs.

6.7 Over the years Annie's children tried lots of time to get their Mum some help. This involved giving her leaflets for alcoholics anonymous or the Samaritans. They also told her to go and see her GP. Whenever they spoke to her about her drinking she would say 'I know, I know'. They are aware she did attend at the GP surgery although they do not know what she told the GP. They did not go with their Mum to the surgery, so they do not know if she ever tried to access any help.

6.8 Annie's children had limited contact with Simon and first met him around 2010. It seems that for a time Annie and Simon lived in the same block of bed sits and it is probable that is where they met. Many people living in the bed

sits had drugs and alcohol problems and the police were often in attendance. With help from her children Annie moved out into a home of her own in Redcar. Simon maintained his tenancy at the bed sit but in effect moved in with Annie for periods of time although their relationship was always on and off.

6.9 Annie would meet up with her children, visit for family meals and have days out together. They recalled that in the periods she was not with Simon she would drink less and that "she was their mum again". Conversely when Annie was drinking, she behaved in ways which were difficult to understand, for example she failed to attend her son's wedding when she had been invited and she knew everyone was waiting for her.

6.10 Annie's children said that she was a quiet person who kept herself to herself and did not readily engage with 'authority'. They were not aware of specific alcohol services in the area or how to engage with them.

6.11 Her children believe that Annie was unaware of Simon's manslaughter conviction, as were they [see paragraph 14.6]. Had they known they would have tried to do something to protect their mother from the relationship and they would certainly have prevented contact with their own children. They were aware of the concept of coercion and control but did not appreciate that their mother may have been subject to some form of control by Simon. On reflection and knowing what Simon did to her when he killed her, they believe he may have been exercising control. For example, there were periods when she would just disappear, and they were unable to contact her. They could not recall any specific occasions when Simon had caused Annie physical harm although on one occasion, they did see she had a mark on her face, but she told them she had fallen and her explanation was accepted.

6.12 Annie had not been in employment for many years and her family were not aware of any close friends.

## 6.2 The perpetrator

6.2.1 Simon agreed to see the Chair and author who visited him in prison. Simon told them that he had left school at fifteen years of age with no qualifications

and had gone to work at British Steel in Redcar where he worked for ten years until being made redundant. He got married when he was eighteen years old and had four children with his wife. He said that a turning point in his life was the death of one of his children following a road accident after which he began to drink large amounts of alcohol, particularly vodka and his marriage broke up.

6.2.2 Although he misused alcohol from then on, Simon maintained employment. Having been made redundant he retrained as a window fitter and later obtained a City and Guilds qualification in bar and cellar work and became the assistant manager of a hotel.

6.2.3 Simon said that he was misusing alcohol at the time of his convictions in 1993 for Threats to kill and 1996 for manslaughter – both in relation to his then female partners. During his prison sentence for manslaughter he could recall attending three sessions on anger management. After his release from prison he began drinking the same day.

6.2.4 Soon after his release from prison Simon was working as a decorator on a contract in Bradford when he met a new partner. He moved to Bradford and lived and worked there for thirteen years before that relationship broke up. He continued to drink large amounts of alcohol every day.

6.2.5 Following the breakup of that relationship, Simon returned to live in Redcar. He moved into the bed sit where he maintained a tenancy until Annie's murder. Annie also lived in the same accommodation and that is where the couple met, before she eventually moved out when her children found her a house to live. Simon said that Annie was fully aware of his past convictions but that he thought her children were not. The couple continued in a relationship but sometimes did not see each other for several weeks and Simon acknowledged that during that time he had other relationships.

6.2.6 In the months prior to Annie's murder Simon said that the couple spent most days together. He would go to a local shop at about 10AM to buy a newspaper and a three litre bottle of cider. The couple would then read the

newspaper and do the crossword together whilst drinking cider. When it was gone Simon would go and buy more.

6.2.7 In relation to the day of Annie's murder, Simon said that the couple had been drinking solidly for four days after Annie had missed her son's wedding. During an argument he intended to go home and attacked Annie to shut her up after she began screaming.

6.2.8 Simon could remember accessing alcohol services on one occasion but said that he had stopped attending as he didn't think it was doing any good. He had discussed his drinking with his GP whilst attending other appointments but that had not resulted in any action. Simon had never really been motivated to stop drinking and was quite happy with his life prior to Annie's murder.

## 7 Contributors to the review/ Agencies submitting IMRs

7.1

| Agency | Contribution |
|---|---|
| Cleveland Police | IMR |
| South Tees Clinical Commissioning Group | IMR |
| Tees Esk and Wear Valleys NHS Foundation Trust | Short report |
| National Probation Service | Chronology of historic involvement |

7.2 As well as the IMRs, each agency provided a chronology of interaction with Annie and Simon including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Annie or Simon or any involvement in the provision of services to them. The police IMR author was involved in the investigation into Annie's murder but had no prior knowledge of her or Simon before that.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to Annie and Simon and any other action taken.

7.4 It should also provide an analysis of events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.

7.5 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.6 The IMRs in this case were of good quality and focussed on the little information existing around Annie and Simon. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation

## 8 The review panel members

| | |
|---|---|
| Paul Cheeseman | Independent Chair |
| Ged McManus | Support to chair and author |
| Annie Potter | Head of quality and adult safeguarding, South Tees Clinical Commissioning Group |
| Karen Agar | Associate Director of nursing [safeguarding] Tees Esk and Wear Valleys NHS Foundation Trust |
| Darren Birkett | Detective Inspector Cleveland Police |
| Rachel Hodge | Probation officer, National Probation Service |

| | |
|---|---|
| Jay Hosie | Redcar-Cleveland Community safety Partnership |
| Richinda Taylor | CEO EVA Women's Aid |
| Mandy Cockfield | Service manager Redcar-Cleveland Adult Social Care |
| Leanne Best | Domestic Abuse coordinator Redcar-Cleveland council |
| Gary Besterfield | Service manager Addaction |
| Joanne Walker | Support to panel |

## 9 Author of the overview report

Paul Cheeseman was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He was judged to have the skills and experience for the role. He was assisted by Ged McManus who wrote the report. He is currently Independent Chair of a Safeguarding Adult Board in the north of England and has chaired and written previous DHRs and Safeguarding Adult Reviews. Both practitioners served for over thirty years in different police services in England. Neither of them has previously worked for any agency involved in this review. Ged McManus has chaired and written one previous DHR in Redcar-Cleveland.

## 10 Parallel Reviews

10.1 An inquest was opened and adjourned. It was finalised without a hearing after Simon's trial.

10.2 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. [There has been nothing to suggest that a disciplinary inquiry or process is merited in respect of any agency involved in this review].

11 **EQUALITY AND DIVERSITY**

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

age
disability
gender reassignment
marriage and civil partnership
pregnancy and maternity
race
religion or belief
sex
sexual orientation

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 All subjects of the review are white British. At the time of the review they were living in an area which is predominantly of the same demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.3 Domestic homicide and domestic abuse in particular, is predominantly a gender crime with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. For example, in 2017, according to the Office of National Statistics homicide report[3] "There were large differences in the victim-suspect relationship between men and women. Half of female adult victims aged 16 and over were killed by their partner or ex-partner[1] (82 homicides) in the year ending March 2017. In contrast, only 3% of male victims aged 16 and over were killed by their partner or ex-partner (13 offences)

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2017

11.4 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 [care and support] assessment is completed. Neither Annie or Simon ever came to the attention of Adult Social Care and therefore there was no opportunity to consider whether a care and support assessment was appropriate. The panel discussed in the light of the information now available, whether either Annie or Simon would have had a level of need requiring a care and support assessment and concluded that they would not.

## 12 DISSEMINATION

Home Office

Redcar-Cleveland CSP

South Tees Clinical Commissioning Group

Tees Esk and Wear Valleys NHS Foundation Trust

Cleveland Police

National Probation Service

Police and Crime Commissioner Cleveland

## 13 BACKGROUND INFORMATION (THE FACTS)

13.1 Both Annie and Simon had a history of alcohol misuse and were chronic alcoholics. Despite this, they functioned within their day to day lives and did not rely on the support of statutory or third sector services.

13.2 Annie maintained a tenancy on a small property in Redcar where she had lived for the year prior to her death. The property was privately rented through an agency and Annie was considered to be a good tenant. Neither

the agency or landlord had received complaints about Annie or the management of the property.

13.3 Simon lived in a block of bedsits where each resident had a separate room but there were some shared facilities. He was a long-standing resident and someone who other residents turned to when they had problems with the property. His landlord described Simon as a good tenant who, despite his alcohol misuse, did not cause problems to the landlord or other tenants.

13.4 Only two incidents involving the couple were reported to the police, the first in 2011 and the second in 2017. Little was known about them as a couple to agencies in Redcar-Cleveland.

13.5 Following an evening spent together at Annie's house in August 2018, Simon murdered her before leaving the house and going to tell his daughter what he had done. He was heavily intoxicated. He then returned to his own home and was found to have self-harmed when police officers forced entry in order to arrest him.

13.6 He told officers in a prepared statement that Annie "went for me" and "went berserk" in an argument, shouting at him: "Help. Get the police. He's hitting me." He said he panicked in a drunken state and repeatedly put his hand over her mouth to stop her shouting and screaming. He added that she stopped struggling and moving and was lifeless: "I thought she had calmed down. I cannot explain how Annie died".

"I had no intention whatsoever of harming her. My only intention was to calm her down."

13.7 Annie lost three teeth, probably caused by a direct blow to her jaw. The cause of her death was suffocation. Her injuries do not support Simon's explanation to the police of what happened.

13.8 Simon initially pleaded not guilty to her murder and his case was scheduled for a full trial. He pleaded guilty before the case went to trial and was sentenced to life imprisonment with a minimum tariff of twenty-three years. This means he will not be considered for release on licence until the expiration of this period.

## 14 Chronology

14.1 THE FACTS BY AGENCY

The agencies who submitted IMRs, short reports and chronologies are dealt with in a narrative without comment which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 16.

### 14.2 Prior to the terms of reference

14.3 On 6 February 1992, Simon appeared at court and was fined for assault causing actual bodily harm.

14.4 On 22 October 1993, Simon appeared at court and was sentenced to two years imprisonment for threats to kill his then female partner.

14.5 In 1995 Simon's GP made a referral to mental health services due to depression and anxiety.

14.6 On 13 May 1996, Simon was sentenced to three years imprisonment for the offence of manslaughter. This was in relation to the death of his female partner who he had lived with since his last release from prison.

It was said in court that there was a stormy relationship between them, the victim was three times over the legal alcohol limit for driving and was strangled during a drink related argument over an alleged affair. Post mortem showed that the victim suffered with an undiagnosed and serious cardiac disease and could have died at any time. The slightest squeeze to throat would have resulted in instant death. The basis of the guilty plea was a lack of intent to cause serious harm. There was no evidence of a struggle.

Simon also had a history of personal problems during recent years; he experienced the death of a paraplegic child; his marriage with his childhood sweetheart ended; he consumed excessive amounts of alcohol whilst working in licenced premises. The victim's daughter talked of her mother's relationship with Simon initially having a very calming effect on him.

The sentencing judge's comments were recorded as follows

"you killed [your partner] by strangling; her. Your plea is accepted on the basis that you didn't intend to harm or even kill her. Guilty plea, some indication of remorse and some evidence that you contemplated suicide. I recognise some

of the recent tragic events in your life, both of you had a lot to drink. This is an exceptional case in many respects as outlined in pathological reports and I accept that death was instantaneous when you squeezed her neck. Not the normal manslaughter/provocation case, difficult sentencing exercise - however you behaved in an unlawful & dangerous manner by putting your hands around her throat. There has to be a price".

14.7 In 1999 Annie suffered a stroke and in 2000 was treated for depression she was found in the road in a drunken state was taken to the local hospital Emergency Department and discharged the same day.

14.8 In 2003 Annie was found intoxicated in the street and taken to the local hospital Emergency Department, she was later discharged home.

14.9 On 22 May 2011, Annie rang the Police to say that Simon had assaulted her. Simon was arrested and interviewed but released with no further action as Annie did not wish to provide a statement nor support a prosecution.
Annie answered yes to 9 of the 27 DASH[4] questions and the incident was graded as medium risk by the attending officer and supervisor. Comment was added to the DASH form around Simon's previous domestic related manslaughter conviction in 1995. A referral to domestic abuse services was made. The police made a follow up call to Annie and sent a standard letter which contained support and advice and useful telephone numbers. From the material that is available it does not appear that Annie sought any further support from services following the receipt of this letter.

14.10 On 1 May 2012, Simon self-referred to a drugs and alcohol treatment open access clinic. He disclosed a long history of alcohol misuse and his previous convictions. He requested help to reduce his alcohol intake. He claimed that his alcohol use was to blame for his violent past and as a result he tended to isolate himself when he could during drinking episodes as he was worried he may get into conflict with others. He said that during violent episodes he had no empathy for those involved and any harm to others was intentional. The notes from that disclosure do not reveal the names of the person[s] he was referring to in respect of that remark.

The service was at this time provided by Tees, Esk and Wear Valley NHS Foundation Trust

[4] The Domestic Abuse, Stalking and Honour Based Violence [DASH 2009] Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council [NPCC]

14.11 On 4 May 2012 a FACE[5] risk assessment was completed which identified risks around Simon's alcohol misuse. It was noted that home visits were not to be done by a lone worker and an alert was placed on the trust computer system highlighting Simon's conviction for manslaughter and that he may present a risk to others. There is no record of information being shared with other agencies.

14.12 On 8 August 2012, Simon attended the drugs and alcohol clinic appointment. He reported a significant reduction in alcohol consumption and was discharged from the service with information on how to seek further help if required.

14.12 Tees, Esk and Wear Valley NHS Foundation Trust Substance Misuse Services ceased provision in 2013. Redcar & Cleveland Borough Council entered into a contract with Lifeline Project on 14th January 2013.

14.13 In 2013 Annie told her GP that she had stopped drinking alcohol, but her depression had become worse and she was referred to in house counselling at the GP practice.

14.14 On 27 July 2013, a female neighbour reported that Simon had punched her and pulled her hair. He was arrested and charged with assault, but the case was withdrawn at court when the victim chose not to provide[6] evidence.

14.15 In 2016, Simon told his GP that he was consuming 210 units per week[7] but did not want any interventions. The GP did not document what advice was given or if a referral was made.

14.16 On 20 December 2016, police were contacted by a female [not Annie] who stated she was feeling suicidal after an argument with Simon. She said that she had been in a relationship with Simon for around three months and they were both alcoholics. Appropriate medical treatment was sought for her.

14.17 On 26 August 2017, following a call from a member of the public that a man was walking in the street bleeding from a head wound emergency services found Simon in the street with a woman. Details of the woman were not

[5] The FACE risk profile is a commercial mental health assessment tool that is part of a collection of tools produced by "FACE Recording & Measurement Systems"
[6] Barriers to reporting see paragraphs 16.3.6 and 16.3.7

[7] The Chief Medical Officers' guideline for both men and women is that: You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.

obtained, however, after treatment the couple went to Annie's address, so the panel assume it was most probably Annie who was with him.

14.18 **Within the dates of the Terms of Reference**

14.19 On 13 October 2017, Annie attended a GP appointment following a number of letters encouraging her to do so. She had her blood pressure checked and the doctor discussed her alcohol consumption. Annie told the doctor that her consumption of alcohol had reduced and was within normal limits.

14.20 On 29 October 2017, Annie telephoned the police and reported that Simon had taken her house keys. She said, "he was a horrible person and was always trying to take her stuff". Annie was intoxicated at the time of this call which was made at 09:33. Annie rang the police control room back at 11:54 to say that she had found the keys and everything was ok. As it was a domestic incident, an officer attempted to see Annie in person on 29 October and again on 30 October but there was no answer at the door or to telephone calls. Police officers did eventually see her on 31 October. The officer attempted to complete the DASH questions with Annie, but she chose not to provide answers and insisted she did not require any support, that there were no issues and she did not wish to provide consent to share information with other agencies. The officer raised the issue of alcohol consumption with Annie as she was intoxicated at 0930 when making the call and Annie said she was an alcoholic but was reducing her intake.

The incident was classed as standard risk by the attending officer and supervisor with no crime recorded and because of this standard grading with no consent to share, no referrals were made to support agencies. Annie could not remember the previous call she made to police in 2011 without prompting and she stated that Simon had never been violent towards her previously. She stated they had agreed to separate after this incident.

14.21 On 17 March 2018, a female reported that Simon had sexually assaulted her by putting his hand between her legs whilst they were drinking with a group of people in a third parties' home. Other people present said that they did not see anything or chose not to make a statement. Hence, although Simon was arrested there was insufficient evidence to support a charge.

14.22 On 13 June 2018, Annie reported a burglary at her home. She was seen by police at Simon's home and a statement was obtained. Two people were later charged with the burglary.

15 **OVERVIEW**

15.1 This overview has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs and supplementary reports from some agencies. Information from police statements has also been used. The findings of previous reviews and research into various aspects of domestic abuse has been considered.

15.2 In preparing the overview report the following documents were referred to:

- The Home Office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews 2016
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Key findings from analysis of Domestic Homicide Reviews. Home Office December 2016
- Evan Stark (2007) Coercive Control. How Men Entrap Women in Personal Life. Oxford University Press.
- Agency IMRs and Chronologies.
- Recommendations from a previous DHR in Redcar-Cleveland.

15.3 Simon had a history of violence before he met Annie. Between 1992 and 1996 he was convicted of assault, false imprisonment and manslaughter. All of the victims were women and the victim of manslaughter was Simon's partner who he lived with at the time.

15.4 The circumstances of the death of Simon's partner in 1996 bear a striking similarity to Annie's death. Both Simon and his partner misused alcohol and he strangled her to death following an argument. Simon was sentenced to three years imprisonment and due to the time that he had spent remanded in custody before the trial, served only a year in custody before his release.

15.5 It is believed that Annie and Simon met in Redcar in 2009. Both of them were chronic alcoholics.

15.6 Simon did not come to the attention of the police again until 2011 when, following a domestic abuse incident, Annie called the police to report that Simon had assaulted her. She later chose not to make a statement or support a prosecution and therefore no action was taken against Simon.

15.7 In 2012, Simon sought help to reduce his alcohol intake and within three months reported a significant reduction in alcohol consumption. He was discharged from the service and there is no record of him seeking further help.

15.8 Simon came to the attention of the police on three other occasions, when three different women contacted them.

- 2013, a female neighbour reported to the police that Simon had assaulted her. The case was withdrawn when the victim withdrew her evidence.
- 2016, a female who had been in a relationship with Simon for three months reported that she was feeling suicidal. Police arranged appropriate medical treatment.
- 2018, a female reported to police that Simon had sexually assaulted her at a party. The report could not be substantiated.

15.9 Annie also contacted the police in October 2017 when she alleged that Simon had stolen her house key, she later rang back to say that she had found the key. Despite this police officers attended and treated the call as domestic abuse, but Annie chose not to complete the DASH risk assessment or seek any support.

15.10 Both Annie and Simon's alcohol misuse was known to their GP's, but it appears that at least in recent times they did not want support to reduce their alcohol intake. Annie said her alcohol consumption was within normal limits. Simon said that he was drinking 210 units per week but declined any support.

15.11 In the twenty-six years, between 1992 and Annie's death in 2018, Simon was involved in incidents of violence, domestic abuse or sexual assault involving seven different women. What in hindsight can be seen as a pattern of drink fuelled abuse, was not apparent to the police or any other agency. The relatively long periods between reports of Simon's poor behaviour meant that each incident was treated in isolation despite the fact that he had a conviction for killing his partner.

## 16 ANALYSIS

### 16.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Annie as a victim of domestic abuse and what was your response?

16.1.1 There were two incidents of domestic abuse reported by Annie to Cleveland police.

16.1.2 On 22 May 2011, Annie rang the Police to say that Simon had assaulted her. Simon was arrested and interviewed but released with no further action as Annie chose not to provide a statement nor support a prosecution. A DASH risk assessment was completed and graded as medium risk. The officers dealing with the matter were aware of Simon's manslaughter conviction. A referral to domestic abuse services was made. The police made a follow up call to Annie and sent a standard letter, which contained support and advice and useful telephone numbers.

16.1.3 Due to changes in local domestic abuse services it is not possible to say whether or not Annie was engaged with Domestic Abuse services after this incident in 2011.

16.1.4 On 29 October 2017, Annie telephoned the police and reported that Simon had taken her house keys. She said, "he was a horrible person and was always trying to take her stuff". Annie was intoxicated at the time of this call which was made at 09:33. Annie rang the police control room back at 11:54 to say that she had found the keys, and everything was ok.

16.1.5 Due to the nature of the incident, officers attempted to see Annie in person but were not able to do until 31 October 2017. The attending officer attempted to complete a DASH risk assessment, but Annie said that she didn't need support and chose not to answer the questions. The officer raised the issue of alcohol consumption with Annie as she was intoxicated at 0930 when making the call. Annie said she was an alcoholic but was reducing her intake. Annie could not remember the previous call she made to police in 2011, without prompting, and she stated that Simon had never been violent towards her. She stated they had agreed to separate after this incident. The incident was classed as standard risk by the attending officer and supervisor with no crime recorded and because of this standard grading with no consent to share, no referrals were made to support agencies.

16.1.6 The actions of Cleveland police in both incidents met the expected standards. Officers dealing with the incident in 2011 were aware of Simon's manslaughter conviction but could not consider a disclosure under Clare's law [The Domestic Abuse disclose scheme] as this legislation did not take effect until 2014.

16.1.7 The purpose of Clare's Law is to provide members of the public with a way to make enquiries about an individual who they are in a relationship with, or who is in a relationship with someone they know if they suspect that the individual may be abusive toward their partner.

16.1.8 Anyone can make a request for disclosure if there is concern that an individual may harm their partner, not just the potential victim. However, just because a third party has made the application it would not necessarily mean that the disclosure is made to them; it may be more appropriate for someone else to receive the information.

16.1.9 The Right to Ask gives the victim [actual or potential], third parties [neighbours, friends and relatives] and agencies the ability to make an application to the scheme.

16.1.10 The Right to Know is when the police make a proactive decision to disclose details when they receive information to suggest a person may be at risk.

16.1.11 Following the 2017 incident, a disclosure to Annie under the right to know could have been considered. However, the panel heard from the police representative that, taking into account the relatively low level of the incident and the fact that Annie said the couple had split up, then the case would not have met the threshold for a disclosure to be made. The panel thought that was a reasonable judgment to make.

16.1.12 The panel considered whether there was evidence that Simon had subjected Annie to coercion and control and in doing so referred to the Crown Prosecution Service policy guidance.

16.1.13 The Crown Prosecution Service policy guidance on coercive control states[8];

Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs

[8] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or University
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next.

16.1.14 The panel saw that Simon had assaulted Annie on one occasion and may have taken her door key on another. Her family thought that he may have prevented her from contacting them. In the absence of other information, the panel felt that, whilst there was some evidence, there was insufficient information with which to come to a positive conclusion.

16.2 **What risk assessments did your agency undertake for Annie; what was the outcome and if you provided services were they fit for purpose?**

16.2.1 The only risk assessment known to have been undertaken in respect of Annie was in relation to the domestic abuse incident of 22 May 2011, which was before the start date of this review. However, the panel looked at what had been done and concluded that the incident had been risk assessed and dealt with appropriately at the time.

16.2.2 Officers attempted to carry out a DASH risk assessment in relation to what they suspected was a domestic abuse incident in October 2017. However, Annie chose not to answer questions nor to access any support. There was no evidence of any assault and the suspicion of domestic abuse arose from Annie's report that Simon had stolen her door key. The incident was recorded as a standard risk and no further action was taken. This was appropriate in the circumstances.

16.3 **What was your agency's knowledge of any barriers faced by Annie that might have prevented her reporting domestic abuse and what did it do to overcome them?**

16.3.1 The two agencies that had contact with Annie during the review period were Cleveland police and her GP.

16.3.2 The police dealt appropriately with the two incidents Annie reported six years apart. They did not know of any barriers that Annie faced. The fact that at the time of the second incident, Annie was unable to recall the first incident without prompting and said that Simon had never been violent to her, caused

the panel to reflect that Annie's misuse of alcohol could have been a barrier to her reporting any other incidents.

16.3.4 Annie attended her GP surgery for a routine appointment in October 2017. Her alcohol intake was discussed and she said that it was within normal limits. The GP did not have any reason to suspect domestic abuse.

16.3.5 The panel did not identify any barriers to reporting abuse that agencies could reasonably have recognised. However, in light of the information now available, the panel felt there may have been barriers to Annie reporting abuse. There are a number of pieces of research and publications that identify barriers common to many victims of domestic abuse which prevent them from reporting their experiences. Here are two of them.

16.3.6 Research conducted by Her Majesty's Inspector of Constabulary [HMIC][9] found the following reasons for not reporting domestic abuse to the police; Fear of retaliation [45 percent]; embarrassment or shame [40 percent]; flack of trust or confidence in the police [30 percent]; and the effect on children [30 percent].

16.3.7 The Victim Support report 'Surviving justice' 2017 report contains the following information

**Barriers to reporting as cited by Victim Support caseworkers**

| Barriers to reporting | Percentage of respondents citing barrier |
|---|---|
| Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger | 52% |
| Fear they would not be believed or taken seriously | 42% |
| Fear, dislike or distrust of the police/CJS | 25% |
| Concern about their children and/or the involvement of social services | 23% |
| Poor previous experience of police/CJS | 22% |
| Abuse normalised, not understood or believed to be deserved | 15% |
| Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator | 14% |

[9] Everyone's business: Improving the police response to domestic abuse; March 2014 HMIC [now Her Majesty's Inspector of Constabulary and Fire and Rescue Services [HMICFRS]]

| | |
|---|---|
| Cultural or community concerns | 9% |
| Financial concerns | 7% |
| Housing concerns | 4% |
| Embarrassment | 3% |

16.4 **What knowledge did your agency have of any alcohol, drug, gambling, addictions or mental health issues in respect of Simon and/or Annie? What services did your agency provide in response to these issues?**

16.4.1 Medical records indicate that in 1999 Annie suffered a stroke. In 2000 and 2003 she was taken to hospital due to the extent of her intoxication. Annie did not readily engage with health care practitioners. She did not respond to routine age-related health screening appointments and was not well known to her GP surgery.

16.4.2 In 2013, Annie told her GP she had stopped drinking. At a routine GP appointment in 2017, she told the doctor that her drinking was within normal limits. Later in October 2017 when police attended to a report of a stolen door key, Annie told the officers that she was an alcoholic but was reducing her intake.

16.4.3 Due to changes in the provider of alcohol support services it is not possible to access all historic records but from the records available there is no evidence that Annie sought help from the services available in Redcar-Cleveland or that a referral was made by any agency.

16.4.4 Annie was treated for depression for many years but there was never any cause for a mental health assessment and she therefore had no diagnosed mental health condition.

16.4.5 Simon also had a long history of alcohol misuse and the judge in sentencing him after the manslaughter conviction of 1996 referred to his heavy drinking.

16.4.6 In May 2012, Simon self-referred to a drugs and alcohol treatment clinic, requesting help to reduce his alcohol intake. He claimed that his alcohol use was to blame for his violent past and as a result he tended to isolate himself when he could during drinking episodes as he was worried he may get into conflict with others. He said that during violent episodes he had no empathy for those involved and any harm to others was intentional. After three months Simon reported that he had significantly reduced his alcohol consumption and

was discharged from the service with information on how to get further help if he needed it. Although records are incomplete the available records indicate that Simon did not engage again with alcohol treatment services. [see paragraph 16.6.6]

16.4.7 In 2016, Simon told his GP that he was drinking 210 units per week but did not want any intervention.

The Chief Medical Officers' guideline for both men and women is that:[10]

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.

16.4.8 Both Annie and Simon, although chronic alcoholics did not come to the attention of services on a regular basis. Simon told his GP that he did not want help. Annie minimised her drinking when asked about it by her GP. The panel heard that the patient's consent is required in order to make a referral to alcohol treatment services and as both Simon and Annie did not consent then a referral could not be made.

16.4.9 Annie's family were aware of their mother's misuse of alcohol and tried to talk to her about it without success. They did not know where to turn for support. The author of the report attempted to research from a public point of view, how to access alcohol support services in Redcar-Cleveland by a number of internet searches. He was unable to find information which would easily point to services. That matter, which is said to be due to a recent change of service provider was immediately brought to the attention of the service provider and commissioner for their resolution.

16.4.10 In 2016/17 Public Health England estimated that there were 1877 dependent drinkers in Redcar-Cleveland [17.4 per 1000 population] with 519 people accessing treatment services. 72% of estimated dependent drinkers in Redcar-Cleveland were therefore not accessing services.

16.4.11 In the same period the national estimate was of 589,101 dependent drinkers [13.5 per 1000 population] with 103,471 people accessing treatment services.

[10] How to keep health risks from drinking alcohol to a low level. August 2016

82% of estimated dependent drinkers nationally were therefore not accessing services.

16.4.12 Therefore, although Redcar-Cleveland has a higher than average number of dependent drinkers, more of them access treatment than the national picture.

16.4.13 The panel was aware of 'Transformation Challenge key workers" who are available in Redcar-Cleveland to support vulnerable people to access services. The aim of Redcar and Cleveland Transformation Challenge Team is to improve the lives of the most vulnerable adults in six priority areas. The team of Community Key Workers focus on a person's individual needs and work intensively with them to achieve a better quality of life.

16.4.14 The service was available from November 2017. The panel thought that both Annie and Simon might have benefitted from this type of support but saw that given their relative lack of contact with agencies after November 2017, there was little opportunity for anyone to refer them to the service. The panel reflected that the professionals best placed to refer Annie and Simon for support, if it had been available would have been their GP's. This is a learning point.

16.5 **What knowledge or concerns did the victim's family and friends have about Annie's victimisation and did they know what to do with it?**

16.5.1 Annie's family were aware of her relationship with Simon and had met him a number of times during the course of their relationship over nine years. The family were not aware of any issues in relation to domestic abuse before Annie's death. Annie was seen on one occasion with a facial injury but explained this by saying that she had fallen over. Given Annie's alcohol misuse the explanation was accepted without question.

16.6 **What knowledge did your agency have that indicated that Simon might be a perpetrator of domestic abuse and what was the response? Did your agency consider making a referral to a Multi-Agency Risk Assessment Conference [MARAC], Multi-Agency Public Protection Arrangements [MAPPA] or any other programme**

**intended for the management of individuals considered to be prolific or that presented a high risk of harm to others?**

16.6.1 Simon's known history of domestic abuse is

- 1992 assault
- 1993 false imprisonment and threats to kill
- 1996 manslaughter
- 2011 assault on Annie
- 2017 allegation of theft of door key [recanted by Annie]

16.6.2 Simon's historic offending was clearly extremely serious. The incidents involving Annie were less serious and were graded as medium risk [2011] and standard risk [2017]. In dealing with these seemingly isolated incidents the police completed risk assessments and referrals in line with policy at the time. There was nothing within the incidents themselves or the risk grading of them that gave rise to a need for a MARAC referral within the existing criteria.

16.6.3 Simon was also involved in other incidents which the panel thought showed that he was a risk to women.

- 2013 punched a female neighbour and pulled her hair.
- 2016 female who was in a relationship with Simon reported feeling suicidal following an argument.
- 2018 female reported that Simon had sexually assaulted her.

Both allegations of assault could not be proved.

16.6.4 Simon was a MAPPA eligible subject based on his previous serious offending.

16.6.5 The case was not referred to MAPPA by any agency. The following is an extract from current MAPPA guidance in relation to the risk of harm.

11.7 For the purpose of this Guidance, serious harm is defined as: "An event, which is life-threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible."

11.8 The level of risk of serious harm is the likelihood of this event happening. The levels are:

• Low: current evidence does not indicate a likelihood of causing serious harm.

• Medium: there are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

• High: there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

• Very High: there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious.

16.6.6 The panel discussed Simon's documented conduct during the review period and concluded that there was insufficient information to indicate a risk necessitating a MAPPA referral. The panel heard that even if a referral had been made that the number and seriousness of other cases referred to MAPPA, would have meant that it is highly likely that the case would have been screened out.

16.6.7 The panel discussed Simon's comments at a drugs and alcohol treatment clinic in 2012 that, 'his alcohol use was to blame for his violent past and as a result he tended to isolate himself when he could during drinking episodes as he was worried he may get into conflict with others. He said that during violent episodes he had no empathy for those involved and any harm to others was intentional'. Whilst this was outside the review period the panel noted that the information was not shared with any other agency. As a result, enquires were made of the current service provider with regard to their response now to such a disclosure.

16.6.8 The current provider of drugs and alcohol treatment services was represented on the panel. The panel heard that in circumstances such as those presented by Simon in 2012, the most important thing would be to begin a gradual reduction in alcohol consumption which would give the client more control

over their actions and thereby reduce the risk to them and others. This could be followed up with other therapies. If a risk to a specific person was identified, then local safeguarding procedures would be followed.

16.7 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Annie and Simon?**

16.7.1 See paragraph 11

16.8 **Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?**

16.8.1 Cleveland police was the only agency with any knowledge of domestic abuse in Annie and Simon's relationship. The couple were not known to domestic abuse support agencies in Redcar-Cleveland during the review period.

16.8.2 There were two incidents reported to Cleveland police that are relevant. The first in 2011 was outside the review period but the panel looked to see what had been done.

- Simon was arrested
- DASH risk assessment completed [medium]
- Referral to domestic abuse services
- Follow up call and letter to Annie

The panel thought that the level of service provided was good and complied with contemporary policy.

16.8.3 The second incident in 2017 was not reported as domestic abuse. However, from the nature of Annie's call about a stolen key, the police suspected that a domestic abuse incident had taken place and treated it as such. The panel saw that;

- The police visited Annie.
- Attempted to conduct a DASH risk assessment [standard].
- Showed concern for Annie's welfare by enquiring about her alcohol consumption.

- No referrals were made as Annie did not consent to sharing information.

The panel thought that the attendance of an officer in person to an incident which the police suspected may be domestic abuse was good practice. The actions of the attending officer complied with policy.

16.9 **Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to the Annie and Simon, or on your agency's ability to work effectively with other agencies?**

16.9.1 No agency has reported issues in relation to capacity or resources. Annie and Simon were unknown to most services.

16.10 **What learning has emerged for your agency?**

16.10.1 Individual agencies have not identified learning in this case. However, the panel has identified learning and this is shown at paragraph 18.

16.11 **Are there any examples of outstanding or innovative practice arising from this case?**

16.11.1 The panel did not identify outstanding or innovative practice. The panel did recognise that Cleveland police's attendance at an incident which had not been reported as domestic abuse but which they suspected to be domestic abuse was good practice.

16.12 **Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Redcar-Cleveland Community Safety Partnership?**

16.12.1 Redcar-Cleveland Community Safety Partnership has commissioned one previous DHR which was not published due to concern about the welfare of children affected by that review. The panel for this review has been given the opportunity to review the learning and recommendations from the previous review.

16.12.2 The previous review made six panel recommendations of which one may be relevant to this review:

The Community Safety Partnership should implement a publicity campaign aimed at improving the confidence of victims and witnesses in reporting domestic abuse.

No further recommendation is made by this review as the Community Safety Partnership has put in place an appropriate publicity campaign.

16.12.3 The previous review also contained a further thirty-two single agency recommendations, which the panel for this review has examined and found are not relevant to this review.

## 17 CONCLUSIONS

17.1 Annie and Simon had been in a relationship for nine years. It is thought that they met whilst living in the same block of bed sits. With the help of her family Annie moved out and lived in a small rented house in Redcar. Simon maintained the tenancy of his bed sit but often stayed with Annie.

17.2 During the course of their relationship Annie called the police on two occasions. In 2011, she reported that Simon had assaulted her but chose not to make a statement and no action was taken. In 2017, she reported that Simon had stolen her door key but withdrew the allegation saying she had found the key. The two isolated incidents were dealt with correctly and neither of them highlight that Annie was at high risk of harm from Simon.

17.3 The couple both misused alcohol for many years. Despite this they were not reliant on local statutory or voluntary services and lived an independent life, largely under the radar of local services. Simon sought help to control his alcohol consumption on one occasion in 2012, but otherwise declined help. Annie minimised the extent of her alcohol consumption when asked about it.

17.4 Annie's family knew of the relationship between the couple and met Simon. They were unaware of any issue of domestic abuse between the couple although the, sometimes sporadic, nature of contact with Annie meant that they had times when they did not see her. In hindsight the family wonder if this lack of contact may have been due to pressure from Simon.

17.5 Simon misused alcohol and was abusive to women. The full list of his known potentially abusive behaviour is shown below.

- 1992 assault.
- 1993 false imprisonment and threats to kill.
- 1996 manslaughter.
- 2011 assault on Annie.
- 2016 female who was in a relationship with Simon reported feeling suicidal following an argument.
- 2013 punched a female neighbour and pulled her hair.
- 2017 allegation of theft of door key [recanted by Annie].
- 2018 female reported that Simon had sexually assaulted her.

17.6 No allegation after the 1996 manslaughter conviction led to a conviction and the relatively long periods between reports of Simon's poor behaviour meant that each incident was treated in isolation, despite the fact that he had a conviction for killing his partner. Although there are no records available it is known that Simon was sentenced to three years imprisonment, he then spent nine months on licence supervised by the predecessor organisation to National Probation Service after his release from prison. This was followed by nine months on 'at risk' licence which means that he would not have had to attend appointments, but had he committed any further offences then he would have been liable for recall to custody. As the conviction was for manslaughter then there was no requirement for further probation involvement and Simon was not engaged in any way with the National Probation Service.

17.7 Annie's family believe that she was unaware of the seriousness of Simon's previous offending, as were they. Had they been aware they would have tried to talk to her and dissuade her from the relationship.

## 18 LEARNING

### 18.1 Narrative

Annie and Simon were chronic alcoholics who continued to function and did not readily seek assistance from services. Annie's family were aware of her problems but did not know how to seek help or encourage her to do so.

### Learning

There is a need to publicise local services and empower individuals and their families to seek appropriate help and support.

### 18.2 Narrative

Simon had a history of violence towards women including killing a previous partner. Despite that, his violence towards Annie and other women did not meet the threshold for any further intervention or multi agency management.

### Learning

The seriousness of previous offending should be a factor in professional judgement of when to make a MARAC referral. This is particularly the case where a person has caused a death previously.

### 18.3 Narrative

Both Annie and Simon were chronic alcoholics who did not readily engage with services, minimised their issues and declined support.

### Learning

People who do not easily engage with services can be supported to do so. Professionals need to be fully aware of the available services in their area.

## 19 RECOMMENDATIONS

19.1 Redcar-Cleveland Community Safety Partnership should work with partners to ensure that local alcohol services are accessible and easily understood to potential service users and their families. For example, an internet search has found that local alcohol services are almost impossible to understand. Some results bring up previous provider CGL. Those that bring up Addaction then provide links to Blackpool and Hartlepool.

19.2 Redcar-Cleveland Community Safety Partnership and Cleveland police should ensure that professionals use their professional judgement to consider the seriousness of previous offending as a factor in making MARAC referrals. In cases where a person is responsible for a previous death a MARAC referral should always be considered.

19.3 Redcar-Cleveland Community Safety Partnership should seek assurance that professionals in Redcar-Cleveland are fully aware of the Transformation Challenge Key worker team and how referrals can be made.

**Appendix A**

| No | Scope of Recommendation | Action to Take | Lead Agency | Lead Officer | Key Milestones Achieved in Reaching Recommendation | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|---|---|
| 1 | Redcar-Cleveland Community Safety Partnership should work with partners to ensure that local alcohol services are accessible and easily understood to potential service users and their families. For example, an internet search has found that local alcohol services are almost impossible to understand. Some results bring up previous provider CGL. Those that bring up Addaction then provide links to Blackpool and Hartlepool. | | | | | | |
| 2 | Redcar-Cleveland Community Safety Partnership and Cleveland police should ensure that professionals use their professional judgement to consider the seriousness of previous offending as a factor in making MARAC referrals. In cases where a person is responsible for a previous death a MARAC referral should always be considered. | | | | | | |
| **3** | Redcar-Cleveland Community Safety Partnership should seek assurance that professionals in Redcar-Cleveland are fully aware of the Transformation Challenge Key | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | worker team and how referrals can be made. | | | | | | |
| | | | | | | | |