North Yorkshire
Community Safety Partnership

A Domestic Homicide Review of the death of Ellie

June 2023

Report Author: Mike Cane

14th October 2024

Pen Portrait – Family Memories of Ellie

Ellie was about as kind and caring as they come. Nothing was more important to her than her family & friends and she spent her whole life prioritising their happiness over her own.

Life was not always plain sailing for Ellie. She had her three children all whilst still in her teens and spent many of those years as a single mother. Despite the unconventional start to adulthood, nobody could ever question Ellie's commitment and dedication to being the best Mother possible to her three children… it was something that she prided herself on.

The second love of Ellie's life was her beloved Liverpool Football Club. She loved football from an early age and spent her whole life supporting Liverpool, going to many matches with her family. She would refer to Anfield as her second home!

A fantastic mix of shy and feisty, Ellie was nicknamed the 'angry little chef'… but at her core, everybody that knew her, knew that she was actually a giant personality with the biggest heart who deserved a better hand than she was dealt.

Section 1: Introduction

1.1 This Domestic Homicide Review examines agency responses and support given to Ellie, a resident of North Yorkshire, prior to her tragic death in June 2023.

1.2 In addition to agency involvement, the review will also examine the past, to identify any relevant background or indicators of harm or of potential abuse before her death. It will consider if support was accessed and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify lessons that can be learned from this incident.

1.3 The circumstances of the death were initially provided by North Yorkshire Police via email to the Chair of the North Yorkshire Community Safety Partnership on 29th June 2023.

1.4 To protect the identity of those involved, pseudonyms were used for both adult subjects in the review. The victim will be referred to throughout as Ellie. There is no other person directly involved in the death in this case, however, Ellie did have a partner. Initial scoping suggested an abusive relationship which resulted in the launch of a Domestic Homicide Review (DHR). The partner will be referred to throughout the review as Mary. Ellie's family were consulted and agreed to the use of these pseudonyms.

1.5 The review will consider all agencies' contact and involvement with Ellie and Mary from June 2018 through to the date of Ellie's death. This five year period was agreed as appropriate in order to give a full picture of Ellie's life and vulnerabilities. However, to fully understand Ellie's experiences and see life through her eyes, the panel agreed to consider any significant event or pattern of events spanning her lifetime. These are also documented within the review.

1. 6 The key purpose for undertaking DHRs is to enable lessons to be learned where a person is killed as a result of domestic violence and abuse or takes their own life and suffering domestic abuse or experiencing coercive control may have been a significant factor. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.7 The DHR Panel and North Yorkshire Community Safety Partnership extend their condolences to Ellie's family at this difficult time.

Section 2: Timescales

2.1 The review began in October 2023 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 23rd January 2024. There was a single agency Individual Management Review (IMR) author's briefing held on 13th March 2024. The panel met again on 4th June 2024 and finally on 16th July 2024.

2.2 The DHR was concluded in October 2024 following presentation to the North Yorkshire Community Safety Partnership, who agreed with the conclusions, learning and recommendations.

Section 3: Confidentiality

3.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Board.

3.2 The victim, Ellie, was 39 years old at the time of her death. Her partner, Mary, was 30 years old at that time. They had no children together, however Ellie has adult children from a previous relationship. All subjects of this review are British citizens who reside or did reside permanently in the UK. Their ethnicity is white / British.

Section 4: Terms of Reference

4.1 The terms of reference were agreed at the convening of the first DHR panel:

Were practitioners sensitive to the needs or vulnerabilities of the victim?
Were professionals knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim?
Did the agency have policies and procedures in place relating to domestic abuse? Were these policies complied with?
Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?
Did the agency adhere to information sharing protocols agreed with partners?
What were the key points or opportunities for assessment and decision making? Do assessments and decisions appear to have been reached in an informed and professional way?
Did the victim or partner access services whilst living elsewhere in the UK?
How were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
How did misuse of alcohol or other substances impact on this case?
Was the victim or partner ever listed at the MARAC? *MARAC is a Multi-Agency Risk Assessment Conference. It is a meeting of professionals to share information and formulate plans to protect the victim and their children in the highest risk domestic abuse cases (those cases where the victim is assessed as at risk of significant harm).*
What information was known about the partner? Was the partner subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place? *MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM*

Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines). *MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse*
Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the partner and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
Did any restructuring during the period under review have any impact on the quality of service delivered? Did the Covid-19 pandemic affect service delivery?

Section 5: Methodology

5.1 The North Yorkshire Community Safety Partnership (NYCSP) was formally notified of the circumstances of the death by the police on 29th June 2023. On 4th July, the NYCSP Chair made a decision that a DHR would be conducted. All agencies likely to be involved in the review were notified in writing to secure records. On 14th September 2023 an initial scoping exercise was commenced to determine the level of agency involvement.

5.2 The aim of the DHR Panel was to deliver the review as soon as practicable. One agency (Integrated Care Board- ICB - on behalf of the GP practice) felt they were unable to provide confidential records relating to the partner as she had never been charged or convicted of any domestic abuse offences relating to this victim. This decision was challenged by the Independent Chair for the review. Previous cases were highlighted and also the view of the Information Commissioner's Office (ICO) that such a statutory review necessitated exchange of sensitive information if the review was to be as thorough as possible. The DHR Chair referred to Article 6 (1) (e) and Article 9 (2) (g) of UK GDPR 2018. A chronology was produced but retained by the ICB and not shared with the DHR Panel. The ICB were able to confirm some events listed by other agencies. This was not ideal, but the Independent Chair is confident the review was delivered in good time.

5.3 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide or death and to determine whether a review is required. In accordance with the provisions of Section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship, or
b) A member of the same household as herself."

5.4 The North Yorkshire Community Safety Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review. Although the victim took her own life, the Partnership were concerned there may have been domestic abuse and elements of coercive control within her relationship with her partner.

5.5 For this review, the term domestic abuse is in accordance with the statutory definition of domestic abuse contained within the Domestic Abuse Act 2021:

'Definition of "domestic abuse"

(1) This section defines "domestic abuse" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected", see section 2.

2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if—

(a) the person is a parent of the child, or

(b) the person has parental responsibility for the child.

(3) In this section—

- *"child" means a person under the age of 18 years;*
- *"civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004;*
- *"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);*
- *"relative" has the meaning given by section 63(1) of the Family Law Act 1996.*
- *"relative" has the meaning given by section 63(1) of the Family Law Act 1996.'*

5.6 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

The statutory guidance states the purpose of the review 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 upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

Initial scoping suggested that several agencies in North Yorkshire and elsewhere had involvement with the subjects of the review. Chronologies were requested and eight organisations were required to submit an Individual Management Review (IMR) of their agency's involvement. Other agencies submitted summary reports of their limited involvement. The DHR Chair made enquiries to confirm the independence of the IMR authors.

Section 6: Involvement of family, friends, neighbours and wider community

6.1 Ellie's family were approached at the start of the Domestic Homicide Review. They were supported by an advocate from the AAFDA charity (Advocacy After Fatal Domestic Abuse).The Independent Chair telephoned Ellie's mum, brother and daughter and explained how the DHR would be conducted and progressed. He also clarified that although the title was 'Domestic Homicide Review', this was not an accurate description of the process. The Chair explained there was no third party involved directly in Ellie's death and that nationally matters were being reviewed to explore a more suitable title for this type of review. However, he noted that initial scoping suggested Ellie had been a victim in an abusive relationship.

6.2 The Chair then wrote formally to Ellie's family to set out the process and that the family were invited to take part. This was followed by further telephone calls to clarify a timetable. The family were thanked for their agreement to take part during this difficult time. The agencies involved as part of the DHR panel and the terms of reference for the review were shared with the family.

6.3 Further periodic calls took place and then the Independent Chair met face to face with Ellie's family in May 2024. Ellie's mum, brother, daughter and son attended. An advocate from AAFDA was also present. The meeting lasted several hours and discussions included Ellie's early life, together with her relationship history, the involvement of services and a review of each individual incident recorded by agencies. The family assisted by providing valuable clarification of events and sharing their own personal views of how Ellie's issues and contacts had been handled.

6.4 The family also wanted the review to note that there were many other incidents between Ellie and Mary that were not reported to the police or other professionals. Details of these incidents were provided to the review.

6.5 Ellie's family and friends shared 'screenshots' of various social media posts involving Mary and Ellie. The family state that Ellie was quite a private person and that some of the photos posted on social media appear almost 'staged' by Mary to give the impression of a happy and loving relationship.

The shared screen shots also include abusive and controlling messages posted online, for example:

- attempts to shame Ellie by reference to misuse of controlled drugs on a public forum
- extremely foul and abusive language towards Ellie's daughter and threats and abuse towards Ellie's son

- reference to having a meal and watching television with ‘MY woman’ (i.e. use of block capitals to indicate Ellie is her possession and controlled by her)

Other social media posts were made by Mary immediately after Ellie’s tragic death which appeared self-centred and caused further distress to Ellie’s family. These included threats to share Ellie’s last message sent to Mary, after Mary had been arrested by the police. Eventually she did share this message on a public forum, which Ellie had typed on the night she died after Mary had been released from police custody –

‘ I promise I’ll never ring them again and you always make sure I keep my promises.’

Clearly this message illustrates a controlling relationship and Ellie being in fear of Mary.

6.6 Three of Ellie’s close friends and colleagues also assisted the Domestic Homicide Review. They were able to share their memories of Ellie. Their views mirrored those of Ellie’s family. They describe how Ellie’s whole personality changed after she started a relationship with Mary. Both family and friends describe that Ellie physically changed and appeared a ‘shadow’ of her former self.

6.7 Ellie’s friends would speak to her most days. They each had special memories of her. Ellie and her friends always knew they were there for each other. They could (and did) ring each other at any time of the day or night if one of them had a problem. They were that close. All of that changed once Ellie started the relationship with Mary. Very quickly, the frequency of their meet ups or calls changed. From speaking every day, it would become once a week. Then eventually months went by. The friends would see Ellie riding through town on her bike when they were in their car. Sometimes she did not acknowledge them. Her friends tried to advise Ellie that the nature of the relationship with Mary was unhealthy. One of her friends recalled seeing Ellie with physical injuries and on one occasion saw Mary with her hands around Ellie’s throat. She challenged Mary, who denied what had taken place and she tried to speak with Ellie about it, but Ellie would not discuss it.

6.8 With two of Ellie’s friends, although they never fell out, they realised that Ellie just did not feel able to see them anymore. They could see the control that Mary was exercising over Ellie. If on occasion they did see Ellie in the street she would just nod or raise half a smile and walk on. One example was given when Ellie was with Mary at a table in a beer garden. Ellie’s friend smiled at Ellie and was walking towards her but Ellie ushered her away with her hand from under the table so that Mary could not see what she was doing.

6.9 A third friend continued to see Ellie as they worked together. They no longer went out socially, but Ellie did confide in her friend. At work, Ellie

often had bruises and once had a black eye. Ellie told her friend she had fallen off her bike but later did say Mary had caused the injury when she hit her in the face with a bag of broken glass. The same friend and workmate could see that Ellie constantly received texts from Mary while she was at work. The friend describes that Ellie was 'bombarded' with text messages asking where she was and who she was talking to.

Ellie's friend recalled an incident about two months before Ellie's death. Ellie had telephoned her friend while Mary was attacking her. She heard Ellie shout "Stop strangling me." Her friend drove to Ellie's house as fast as she could. She collected her and Ellie spent the night at her friend's house. All the next day, Mary was bombarding Ellie with text messages and calls saying, "I'm sorry, it won't happen again."

The same friend was at work with Ellie in June 2023. She described that Ellie looked really tired. Ellie told her that the police had dropped her off at work after she had called them during the night.

A few days later, Ellie sent a text to her friend as she was worried. Mary had been arrested and she didn't know when she would be released. Her friend invited Ellie to stay at her house for the night but Ellie declined. Her friend was still at work (she was there till 8.00pm). Ellie asked her to take some bread out of the freezer in the work's kitchen so that it would be ready for when she arrived at 8.00am to prepare the resident's breakfasts. Ellie never arrived for work the next morning. She did not reply to any texts. Eventually her friend became so concerned that she and her manager drove to Ellie's house where, sadly, they saw her body.

6.10 Ellie was very fond of her family. Indeed, her friends described that Ellie's family was everything to her. Ellie, her daughter and her friends would regularly go out socially together and everyone got on so well. But almost immediately after the relationship began with Mary, all of that changed. It was clear to all that Mary deliberately set out to create a wedge between Ellie and her family. Ellie's daughter described that she was 'pushed out' by Mary. Eventually, Ellie stopped all contact with her family. The family have no doubt whatsoever that this was at the direction of Mary. Mary had completely isolated Ellie from her friends and family.

6.11 The family are devasted at the loss of their daughter, their sister, their mum. They tried for many months to maintain contact with Ellie and it was heartbreaking for them to see how Mary was able to threaten and manipulate Ellie into not seeing them. This included Mary threatening to burn down Ellie's son's house with him and his new baby inside. Ellie was desperate to see her new grandchild but this was stopped by such threats and intimidation by Mary.

6.12 During a meeting with the Independent Chair, the family raised concerns about the police investigation following Ellie's tragic death. They struggle to understand how or why Mary was not charged with offences that led to the

death of their loved one. They believe there was evidence on either Ellie's or Mary's mobile phones that may have led to a charge and conviction. This lack of a sense of justice for Ellie continues to cause them pain and anger.

As a close friend of Ellie described it; "Ellie is dead. We know the police were really concerned about Ellie and so they acted against her wishes. But they didn't protect her. They took action to protect her but she is dead."

6.13 A full pen picture with family memories of Ellie is shown on the front page of this Domestic Homicide Review.

6.14 The Independent Chair of the DHR also wrote to Mary to enquire if she wished to contribute to this review. She did not respond to the letter.

Section 7: Contributors to the Review

7.1 Eleven agencies have contributed to the Domestic Homicide Review by the provision of summary reports or chronologies. Eight agencies then provided Individual Management Reviews (IMRs) to outline and analyse their own single agency actions, contacts and decision-making. The DHR Chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author.

7.2 The following organisations were required to produce an Individual Management Review:

- NHS Humber and North Yorkshire Integrated Care Board (representing the Primary Care Service)
- Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV)
- York and Scarborough Hospitals NHS Foundation Trust
- North Yorkshire Horizons (substance misuse services)
- North Yorkshire Police
- West Yorkshire Police
- Independent Domestic Abuse Service (IDAS)
- The Probation Service

7.3 Other agencies provided scoping, summaries and chronologies:

- Yorkshire Ambulance Service
- North Yorkshire Council Housing Needs Team
- Humberside Police

Section 8: The Review Panel Members

8.1 The Domestic Homicide Review panel comprised of the following people:

Name	Position & Organisation
Mike Cane	Independent Chair and Author
Odette Robson	Head of Community Safety & CCTV North Yorkshire Council
Allan Westcott	Community Safety Officer (Domestic Abuse) North Yorkshire Council
Joseph Howard	Deputy Head North Yorkshire Probation Delivery Unit
Vicky Anderson	North Yorkshire Local Area Manager Independent Domestic Abuse Service
Supt Graeme Wright	Head of Safeguarding North Yorkshire Police
DCI Lee Fletcher	Head of Safeguarding, Kirklees District, West Yorkshire Police
Olwen Fisher	Designated Nurse for Safeguarding Adults, NHS Humber & North Yorks Integrated Care Board
Rebecca Kendall	Safeguarding Lead North Yorkshire Horizons
Nicola Cowley	Head of Safeguarding and Complex Needs, York & Scarborough Teaching Hospitals NHS Foundation Trust
Nicki Smith	Associate Director (Safeguarding), Tees, Esk & Wear Valleys NHS Foundation Trust

Kim Robertshaw	Head of Housing Needs, North Yorkshire Council
Dr. Emily Roach	Trustee York LGBT+ forum
Pat Shipp	Project Officer (Domestic Abuse) Wakefield Council
Dan Atkinson	Public Health Manager (suicide prevention). North Yorkshire Council
Bridget Skaife	Partnerships Manager, Community Safety, North Yorkshire Council

The panel members were completely independent and had no direct dealings with the subjects of the review nor management responsibilities to any front line worker involved with any of the subjects of the review.

Section 9: Author of the overview report

9.1 The appointed Independent Author is Mike Cane. He is completely independent of the North Yorkshire Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and investigation of child abuse, rape and other serious sexual offences. He is a former member of a Safeguarding Adult Board, several Domestic Abuse Strategic Partnerships and a number of Safeguarding Children Partnerships. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years and was Chair of the Sexual Assault Referral Centre (SARC) management board. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as an Independent Chair/Author.

Mike completed accredited DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as taking part in AAFDA training on ‘best practice in managing DHRs’ in 2022.

Section 10: Parallel Reviews

10.1 The inquest into Ellie's death was opened in July 2023. Contact was made with HM Coroner's office and agreement reached that a copy of the Domestic Homicide Review would be provided at the conclusion of the DHR process. The post mortem report was still 'pre-inquest' and so not released to the DHR Panel.

10.2 Neither subject of the Domestic Homicide Review were accessing services under the Care Act 2014. There was no requirement for a Safeguarding Adult Review. However, vulnerabilities were identified relating to the victim and her partner. Adult Social Care were part of the DHR panel and a copy of the DHR will be shared with Adult Social Care and the North Yorkshire Safeguarding Adults Board.

10.3 One of Mary's victims was 16 years old at the time of the abuse taking place. However this information was for provided as historical context. The incidents occurred nine years before the tragic death of Ellie and matters were dealt with appropriately at that time.

There were some young people who witnessed abuse perpetrated by Mary against one of her former partners. Again, the incident resulted in appropriate referrals to Children's Services. A copy of this DHR will be shared with the North Yorkshire Safeguarding Children Partnership.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim and her partner were not married at the time of her death. Their marital status did not affect any of the services provided.

11.3 No issues were identified during this review applicable to gender reassignment, race or religion.

11.4 The victim has been identified as having some vulnerabilities around her mental health but was not registered as disabled, nor in receipt of statutory services. Both women had a history of periods of poor mental health. Indeed the Royal College of Psychiatrists warns in a recent online article that 'violence and abuse are driving mental illness in women and girls'. (March 2024).

11.5 The couple were in a same sex relationship. Data shows female same sex intimate couples are more likely to suffer violence from their partner. As it is

unknown whether Ellie would identify as a lesbian or as bisexual, both statistics relating to lesbians and bisexual women are included for completeness:

61.1% of bisexual women and 43.8% of lesbians experienced intimate partner violence during their life.[1] Analysis of the Crime Survey England and Wales carried out in 2018 by the Office for National Statistics indicates that bisexual women are nearly twice as likely (10.9%) as heterosexual women (6%) to report partner abuse whilst lesbians are also more likely than heterosexual women to report partner abuse (8% as opposed to 6%).[2]

Samaritans on their website[3] note that "Existing research suggests that LGBTQ+ communities are at a higher risk of suicidal thoughts, suicide attempts and self-harm compared to people who aren't LGBTQ+. In 2022, Samaritans responded to over 69,000 calls for help from people who spoke about gender identity or sexuality. Suicide is complex and being LGBTQ+ is not a risk for suicide in itself. National suicide rates for LGBTQ+ communities aren't available in the UK and Ireland, because sexual orientation and gender identity aren't currently recorded on death certificates. However, a growing amount of global evidence points to a higher risk of suicidal behaviour and self-harm for LGBTQ+ people and explores the lived experiences which may contribute to this."

11.6 With regard to sex, around three-quarters of suicides in England are males (4,129 deaths; 74.0%), consistent with long-term trends.

Of note, at the time of concluding this Domestic Homicide Review, HM Coroner's Inquest is paused. The ruling and the reasons behind Ellie's death are still to be established.

Between December 2022 and February 2024 out of 5,057 suicide deaths 3,644 (73.7%) were males and 1,287 (26.3%) were females. Within this, 37.9% of those were aged 25 – 44 years. This is just below the highest age group for suicide which is people aged 45 - 64.[4]

In addition lesbian and bisexual women are statistically more likely to have contemplated or attempted suicide than their heterosexual counterparts.[5]

In relation to suicides 'The Domestic Homicide Project' states:

'*Across the two-year period 1 April 2020 to 31 March 2022 there were 470 deaths in total which took place in a domestic setting or following domestic*

[1] Rollè L, Giardina G, Caldarera AM, Gerino E, Brustia P. When intimate partner violence meets same sex couples: a review of same sex intimate partner violence [published correction appears in Front Psychol. 2019 Jul 19;10:1706]. Front Psychol. 2018;9:1506.

[2] Donovan, Catherine, Butterby, Kate. 'An eight day working week: LGBT+ Domestic Abuse Sector Snapshot', FINAL REPORT, Durham University, 2020 p.7

[3] LGBTQ+ communities and suicide (samaritans.org)

[4] Gov.org Statistical report: near to real-time suspected suicide surveillance (nRTSSS) for England for the 15 months to February 2024 (Updated 30 May 2024)

[5] UCL: LGB adults at higher risk of suicidal thoughts and self-harm (9 June 2023)

abuse, including 43% intimate partner homicide, 24% suspected victim suicide, 22% adult family homicide, 8% child death, and 3% 'other'. Police are identifying more suspected victim suicides with a history of domestic abuse – up 28% to 64 cases in year two."[6]

The National Police Chiefs' Council notes on their webpage, in an article in March 2024, titled 'Scale of homicide and suicides by domestic abuse victims revealed' finds that the number of suspected victim suicides following domestic abuse has overtaken intimate partner homicides for the first time.'[7]

A higher proportion of female victims of domestic abuse reported that the perpetrator was male (56.0% compared with 3.1% female).[8] In this case the perpetrator was female and so is in a minority of abusers. However the ONS data has a caveat on their website stating, "Caution should be taken interpreting these figures because of the relatively large proportion of 'don't know' or 'don't wish to answer' responses to these questions."

Many more women than men experienced domestic abuse. For the year ending March 2023, the Crime Survey for England and Wales (CSEW)[9] estimated that 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 6 in 100 women and 3 in 100 men.

Section 12: Dissemination

12.1 The following organisations/people will receive a copy of this report after any amendment following the Home Office's quality assurance process:

- Ellie's family
- All organisations within the North Yorkshire Community Safety Partnership
- North Yorkshire Safeguarding Adults Board
- North Yorkshire DHR Panel
- Office of the Mayor for North Yorkshire and York
- Office of the Mayor for West Yorkshire
- Home Office DHR team
- The Domestic Abuse Commissioner for England & Wales
- HM Coroner

[6] The Domestic Homicide Project is a Home Office funded research project led by the National Police Chiefs' Council (NPCC) and delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing.
[7] The National Police Chiefs' Council Article: 'Scale of homicide and suicides by domestic abuse victims revealed' (March 2024)
[8] Office for National Statistics (ONS), released 24 November 2023, ONS website, article, Partner abuse in detail, England and Wales: year ending March 2023
[9] Crime Survey for England and Wales (CSEW)

Section 13: Background information

Case specific background

13.1 The victim, Ellie, was born in the UK. She was in a relationship with a male and they had three children together (all now adults). The relationship ended due to the male's violence and abuse towards Ellie. Police were involved and eventually the male was arrested, charged and convicted. This resulted in him receiving a restraining order. The children had very little contact with this male when growing up. As adults they have no contact with him.

13.2 Ellie was in a long term relationship with another male (Greg). Sadly, Greg died in 2014. This had a devastating effect on Ellie and her children. Greg treated the children as his own and they called him dad.

13.3 In April 2021, Ellie took an overdose of prescription drugs. This was around the time of the anniversary of Greg's death.

13.4 Ellie met Mary in early 2022. They met on a social night out. They were in a relationship for about 15 months prior to Ellie's tragic death. This was Ellie's first same sex relationship. Ellie's family informed the DHR Chair that Ellie had not been in any relationship since Greg's death until she met Mary.

13.5 Ellie made allegations of physical and emotional abuse perpetrated by Mary. She also reported she was suffering coercive control and harassment. Several incidents were reported to the police.

13.6 Mary had been abusive and violent to several former partners. She exercised coercive control over them. Police were involved and Mary was arrested and charged with domestic abuse related offences**. In this DHR report pseudonyms have been used for four of Mary's ex-partners who reported suffering abuse and control: Lucy (2017 - 2018), Sarah (2019), Chloe (2020 and 2022) and Kirsty (2020). There was also a fifth victim of Mary's violence and abuse. This was a child aged 16 years old when she was in a relationship with Mary, who was 21 years old at that time.**

13.7 Mary isolated Ellie from her large family.

13.8 In June 2023, Ellie's colleagues from her workplace called at Ellie's home as they were concerned she hadn't attended work and they could not get a response on her phone. They saw her body on the stairs and called the emergency services. A ligature was tied around Ellie's neck. Sadly, Ellie was already dead.

13.9 A subsequent post mortem examination was held. The inquest into Ellie's death is still pending. Therefore the post mortem report remains confidential and not shared with the DHR Panel. The issue of the level of

alcohol or controlled drugs within Ellie's body at the time of her death is still to be established.

13.10 The inquest into Ellie's death was opened in July 2023 and paused pending the conclusion of the police investigation. Contact was made with HM Coroner's Office by the DHR Chair but there was no date scheduled for the inquest at this time.

13.11 The police investigation into the circumstances leading up to Ellie's death concluded some time ago. No criminal charges were brought against Mary.

Section 14: Chronology

14.1 The Domestic Homicide Review Panel agreed to review agency records going back five years before Ellie's death. In some instances, earlier records were also checked as they could provide an insight into the life experiences of both Ellie and Mary. This is a chronology of those agency contacts.

14.2 On 11th August 2009 Ellie rang North Yorkshire Police to report that while she had been away, her ex-partner had been into her address and stolen her dog. Police records state Ellie and this male had been in a relationship for eleven years but separated three months ago. He had been bombarding Ellie with calls, texts and visits since the separation. Police notes also state that the male had previously attempted suicide in the garage. The incident was assessed by police as 'medium risk'. The male was arrested, charged and made the subject of a restraining order for twelve months.

14.3 On 8th November 2017 at 7.48pm police received a '999 call' from Mary's mum. Officers attended the address in Selby for a welfare check. Mary's mum was safe and well but she had received a call from Scarborough where Mary was living. Mary's partner (Lucy) had called Mary's mum (in drink) disclosing that she and Mary had had an argument and Mary had gone to the beach.

An hour later police received a call from the address in Scarborough. Lucy's sister reported that Lucy had an injury to her eye after being assaulted by Mary. Police attended. Mary and Lucy said they had been arguing all day and had been rolling around on the floor and slapping each other. Neither wanted to make a complaint against the other. Officers separated them with Lucy being taken to her sister's address and Mary remaining at the property. Lucy told officers that Mary is jealous of how much contact she has with her sister. She went on to say that the relationship is over, the tenancy is in her name and she wants Mary gone when she returns the next day. The incident was assessed as 'standard risk'.

14.4 On 28th November 2017 the incident reported earlier that month was heard at the MARAC (Multi Agency Rick Assessment Conference). Although MARAC only considers the highest risk domestic abuse cases it was referred to the meeting by the Probation Service. The police had assessed the incident on 8th November as 'standard risk' but after receiving further information, the Probation Service assessed it as 'high risk'. (Lucy had disclosed to her probation officer that earlier that day Mary had strangled her – before her sister had arrived.) The case was referred to the Independent Domestic Abuse Service (IDAS) as the couple had resumed

their relationship, however, when the IDVA (Independent Domestic Violence Advocate) contacted Lucy she declined further support.

14.5 On 11th March 2018 Lucy's sister called police to report that Lucy had been assaulted by Mary the day before. She stated that Lucy had texted her to say Mary had been drinking all night then tried to force her into sexual intercourse. When Lucy refused, Mary assaulted her. When officers attended, the address was in darkness. A neighbour told police that both females were 'in drink' the day before and that there was lots of screaming and shouting and that a window was broken. Officers managed to call Lucy on her phone but she said she didn't want to speak to police and would not reveal her location. Police located Lucy a few hours later. She told the officers she had not sent a text to her sister. She said there had been no assault, just a verbal argument. The incident was assessed as 'standard risk'.

14.6 On 21st March 2018 Lucy's probation worker contacted the IDAS outreach service. They disclosed that Lucy had expressed her fears about being controlled by Mary. They stated that although Lucy had declined support in the past she now feels she does need support. Lucy had told the probation officer that she felt totally controlled by Mary and can't go anywhere without her, e.g. to the hospital. Arrangements were made for IDAS to contact Lucy at her next probation appointment.

14.7 On 23rd March 2018 a neighbour dialled '999' to report that Mary was trying to kick the door in to her partner's flat. They stated this was not the first time this had happened. When police attended they found Mary outside. She was heavily intoxicated and argumentative. The door handle was damaged. Lucy told police they'd had an argument. Mary had become aggressive and tried to drag her from the pub. Members of the public had intervened and tried to stop her. Lucy also told police this was not the first time that Mary had been violent towards her and at a previous police attendance Lucy was too scared to tell them Mary had smashed the flat up including the television. Lucy said she wanted to get away from the relationship and would like agency support as she is afraid of Mary.

Mary was arrested for common assault and criminal damage. The incident was assessed as 'medium risk'. Police referred the matter to IDAS.

14.8 On 3rd April 2018 an IDVA telephoned Lucy and carried out a risk assessment. Lucy confirmed she was frightened of Mary when she was 'in drink'. She also disclosed that Mary wouldn't let her see her family or friends. The IDVA queried how Mary did this. Lucy replied that Mary would blackmail her by saying things like 'if you speak to them then we are over'.

14.9 On 6th April 2018 a MARAC meeting convened to discuss Mary and Lucy's case.

14.10 On 11th April the IDVA attended the magistrates court to support Lucy. Mary was charged with two counts of criminal damage and of assaulting Lucy. She pleaded guilty to these charges.

14.11 On 28th April at 8.17pm a third party called police reporting an argument and shouting at Lucy and Mary's address. Officers were initially committed dealing with another high risk incident and no other officer was available. When officers did attend at 11.30pm there was no reply at the address. The police log suggests neither Mary nor Lucy were spoken to and no domestic abuse risk assessment was ever carried out.

14.12 On 2nd May 2018 the IDVA telephoned Lucy. She told the IDVA she no longer needed support from IDAS. The IDVA asked Lucy if she would like a call at another time in case someone was there with her but she said she did not. The IDVA then contacted Lucy's probation officer to advise the case was closed but did offer to meet Lucy at the probation offices (away from Mary) if she wanted further support.

14.13 On 28th May 2018 a third party dialled '999' to report they could hear a female being assaulted with continued banging and shouting at the address. The names given were Mary and Lucy and the caller added that they had been drinking all afternoon. Officers attended and updated the police log that there were two females present and one male and that one of the females was asleep. The police log stated this was not a domestic issue and was believed to be a 'noise nuisance'. No Domestic Abuse Stalking and Harassment (DASH – see glossary) risk assessment was carried out.

14.14 On 2nd June 2018 at 11.53pm Lucy dialled '999' to report that she had been assaulted by Mary and that she was currently walking to her home. Lucy added that she is scared that Mary will come to her home and assault her again. She added that Mary does not have a key. Safety advice was given but the police log records 'all units are committed'. The call was then downgraded with a marker 'for allocation when sober'.

There was a further call from Lucy at 4.14 am. Mary had returned to the home and was kicking at the doors. Further calls were made at 4.31 am and 4.40 am, each time stating that Mary was trying to kick the door in. The police log was updated at 4.50 am stating that 'officers are due of duty at 06.00 and suggest the early turn attend'. There was a further call from Lucy at 5.08 am reporting that Mary had pulled the electric box from the wall. Officers did then attend; Mary was arrested for assault and damage. The incident was assessed as 'medium risk'. A referral was made to IDAS, but Lucy told the IDVA she did not require further support.

14.15 On 4th June, Mary self-referred into North Yorkshire Horizons for support with alcohol. She reported she was drinking three to four bottles of cider daily. She attended a triage assessment the following week.

14.16 On 20th June 2018 Lucy called the police to report Mary had put naked images of her on social media. She said the pictures were full nude and she (Lucy) is identifiable in them. The incident was initially assessed as 'standard risk' but was later increased to 'medium risk'. An investigating officer was allocated but Lucy subsequently contacted police to retract her statement. No further action was taken against Mary. This incident was referred to IDAS who after several unsuccessful attempts did manage to speak to Lucy. She declined any further support.

14.17 On 28th June a probation officer completed a pre-sentence report for Mary at York Magistrates Court regarding a common assault and battery against her partner Lucy which had taken place on 2nd June. The report noted there had been a previous assault by Mary on Lucy in March 2018.

14.18 On 19th July 2018 Mary was sentenced at York Magistrates Court to a 12 month suspended sentence order (with 8 weeks custody suspended for 12 months), requirements to complete 100 hours of unpaid work and to take part in rehabilitation activities managed by the Probation Service.

14.19 On 20th July 2018 a MARAC meeting convened to discuss Mary and Lucy's case.

14.20 On 30th July, police officers obtained a retraction statement from Lucy regarding the allegations she made of Mary sharing nude images of her on social media. Lucy stated she was now back in a relationship with Mary and that Mary has stopped drinking which was the cause of her poor behaviour. Mary had apparently denied to Lucy that she had shared the pictures and that someone else must have shared them whilst she was in the bathroom. She did not know who this other person could be. Officers noted they had doubts about Mary's account but were unable to take any further action.

14.21 On 1st October 2018 Mary was admitted to York Hospital. She reported chest pain brought on by several days of drinking large quantities of vodka and taking amphetamines. A mental health referral was sent to the Psychiatric Liaison Team (part of Tees Esk & Wear Valleys NHS Trust). The referral stated, although Mary was now fit for medical discharge, she disclosed that she did not wish to return home and was experiencing suicidal thoughts. She had been drinking excessively since the breakdown of her relationship the previous week. Following assessment a plan was agreed with Mary and shared with her GP.

The day after her hospital attendance, Mary had an appointment with her probation officer. She stated her A & E visit was due to a possible

overdose. The probation officer ensured that contact was made with the Horizons Service.

14.22 On 5th October, Mary's partner, Lucy was referred by her probation officer to IDAS for support. The outreach worker at IDAS tried several times to speak with the ex-partner. They did speak once and arranged an appointment time but the ex-partner did not attend. Subsequent calls went unanswered. The probation officer was advised that IDAS could facilitate a meeting during her contact time at the probation offices if she needed to.

14.23 On 23rd October, Mary attended North Yorkshire Horizons office for her triage assessment. This had been delayed by several months following several scheduled appointments that Mary did not attend.

However, Mary re-attended Horizon's office on 6th December 2018. She advised staff she had reduced her alcohol intake to weekends only and no longer required support from Horizons. All of this information was fed back to Mary's probation officer who confirmed with her employer.

14.24 On 30th December 2018, Mary attended York Hospital Emergency Department. Mary reported she had had an argument at 2.30 am. She had punched a wall and then a beer glass which broke into several pieces. Clinicians noted her sore right hand and lacerations over the knuckles. An impression was taken for a possible fracture.

14.25 On 11th January 2019, during a discussion with her probation officer, Mary stated that she was in a new relationship with a partner from Bradford who she had met on a dating website. Mary said she was no longer drinking heavily and declined any support from the Horizons Service. The details of the new partner are not recorded in the probation officer's notes.

14.26 On 28th February 2019 Mary attended a local hospital Minor Injuries Unit. She reported that the previous night, while drunk, she became involved in a fight. Mary stated that she did not know what had happened but had woken up that morning with bruising to her left eye socket, had headaches and was feeling dizzy. She also reported vomiting that morning but believed this was due to excessive alcohol consumption. Clinicians also noted a 4cm cut behind Mary's left ear and a swollen right hand. The medical notes record this was Mary's fifth hand injury in seven months.

14.27 On 8th March 2019 Mary had another meeting with her probation officer. She claimed not to have drunk alcohol since Christmas and attributed this to her new partner.

Mary's appointments with her probation officer continued on a fortnightly basis until her suspended sentence order terminated on 18th July 2019.

14.28 On 20th July 2019 Mary dialled '999' to report she had been kicked to the stomach, grabbed by the throat and punched in the face. She named the female assailant. When officers attended, Mary stated they had been in a relationship and there had been previous violence. The ex-partner (Sarah) approached police and asked that she give her side of the story. Sarah told the officers she and Mary had been arguing for weeks and that she has ended the relationship and told Mary she was leaving. Mary then became aggressive and started throwing Sarah's property around. Sarah then pushed Mary away and Mary said she was calling the police to report an assault.

Two days later Mary retracted her statement. There was no further action by police in relation to criminal investigations. The incident was assessed by attending officers as 'standard risk', but this was later reassessed by a Domestic Abuse Officer (DAO) as 'medium risk' due to Mary's previous behaviour.

14.29 On 2nd September 2019 Mary's ex-partner Sarah contacted West Yorkshire Police (as she now lived with her parents in Bradford) to report Mary would not stop texting, calling and threatening to come to her house. Sarah was worried about this due to suffering previous domestic violence from Mary plus Mary's violence and abuse to her previous partners.

When officers attended, Sarah disclosed a previous domestic assault when Mary headbutted her and also explained she had been suffering coercive and controlling behaviour and harassment perpetrated by Mary. Sarah had now separated from Mary but this had prompted the excessive texting, telephone calls and threats. Sarah added that Mary had also previously grabbed her by the throat. She said that towards the end of their relationship Mary's behaviour was increasingly controlling and coercive. As the crime was committed outside the West Yorkshire Police area, the enquiry was passed to North Yorkshire Police to further investigate .

14.30 On 11th September 2019 North Yorkshire allocated the crimes reported by Sarah to an officer for further investigation. The officer noted that within the DASH risk assessment that Mary had made threats to kill herself and tried to force Sarah into sleeping with her. The assessment noted that Sarah had considered suicide to stop Mary. The assessment also noted Mary used alcohol and drugs, controlled who Sarah could see, what she wears and actively tried to get Sarah to change jobs.

Mary was interviewed under caution at the police station as a voluntary attender on 9th December 2019 (three months later). She denied coercive controlling behaviour and assault. No further action was taken due to evidential difficulties. North Yorkshire Police records state the original officer had been on a lengthy training course and the crime investigation

was allocated to another officer to progress. The records do not give any other reason for the significant delay in progressing the enquiry.

14.31 On 28th February 2020 Mary self-referred to North Yorkshire Horizons for support with alcohol use and reported 'binge drinking'. On 3rd March 2020 attempts were made to call Mary but the wrong telephone number was recorded and North Yorkshire Horizons had no current address for her.

14.32 On 9th March 2020 Mary called the police in relation to ongoing domestic abuse. She stated she had bite marks to her face, stomach and arms and had been hit with a bedside cabinet. Both parties were 'in drink'. This incident occurred in the Humberside Police area. Officers could not locate the address and Mary had stated she had removed herself from the location. Officers contacted the named suspect (Chloe) who was Mary's new partner. She told officers she was fine but had left the address and was in bed at a family's home and did not know Mary's whereabouts.

Officers attended several addresses during the night looking for Mary and Chloe. Enquiries were also conducted at local hospitals but there was no trace of Mary or Chloe. Mary had described her injury as a 'bleeding hand'. This was not deemed to be life-threatening. Despite many messages being left on Chloe and Mary's phones neither made contact and the investigation was closed on the 23rd March.

14.33 On 15th March 2020, just after midnight, door staff from a nightclub dialled '999' for the ambulance service to report a female (Mary) had been assaulted by another female. The injuries were described as 'her ear bitten and hanging off'. The assailant had been evicted from the premises. Mary refused to attend hospital with the ambulance crew. The risks of not seeking treatment were explained to her and the ambulance service called the police.

When officers attended they confirmed the incident was 'domestic related', but Mary would not give an account of what had happened. The door staff mentioned there had been previous arguments between the two females. Police completed a brief risk assessment with the very limited information that had been disclosed. Mary stated it was her partner that had caused the injury but would not identify her.

Seven hours later police were called to an address in the same town by Mary's cousin. He reported Mary had 'kicked off' at his flat and she had been drinking. He went on to say Mary had stayed with him after an argument last night with her partner. The partner (Chloe) had turned up at his address that morning and she and Mary had an argument. They had then left his address and he believed they had gone back home to West Yorkshire.

North Yorkshire Police contacted colleagues in West Yorkshire. Mary was spoken to by officers and said she was fine. She was adamant she did not support any police action.

14.34 On 22nd September 2020 at 4.00am West Yorkshire Police were called to an address following a report of a domestic related assault. Initially the occupants would not allow officers entry but were eventually persuaded to do so. Mary was arrested for assault occasioning actual bodily harm on Chloe. The incident was assessed as 'high risk'. At the police custody office it was recorded that Mary had cuts and bruises to her head, arms and neck. She stated she suffered from anxiety and she took medication for this. Chloe declined to provide a statement and Mary was released from custody that same afternoon with no further action.

14.35 On 8th October 2020 Mary and Chloe's case was discussed at the MARAC in Kirklees, West Yorkshire.

14.36 On 14th November 2020 at 6.43pm police received a '999' call from a young female whispering 'police'. The call cleared before being put through, but during a call back, the female who identified herself as Kirsty, confirmed police were required. Kirsty was very distressed and loud music could be heard in the background. She stated she was from Batley and was with her new girlfriend Mary visiting Mary's friends. Mary had suddenly become nasty. A further call was received at 7.04pm with Kirsty reporting she had been beaten by Mary. She went on to say that Mary hit her because 'that's what she is like when she has had a drink'.

When officers attended, Kirsty stated there had been no assault but a verbal argument had taken place. She was taken to the train station to await her sister picking her up. She stated the relationship with Mary was now over and the incident was assessed as 'medium risk'.

Two hours later police were called via '999' by a female reporting that Mary was attacking everyone in the house and they wanted her removing. The caller said Mary was a friend and stated there was no physical attack, it was all verbal. Police took Mary to the train station.

14.37 On 16th November 2020 Mary rang West Yorkshire Police to report her partner Chloe, alleging malicious communications. Mary had apparently made contact to collect her belongings but then received abusive text messages. Mary subsequently stated she did not want any further action taken and the crime was finalised.

14.38 On 21st November 2020 police were called to an argument between Mary and Chloe. Police noted both parties were intoxicated. Chloe had wanted to leave but Mary wanted her to stay. Chloe had telephoned the police to prevent further escalation. The incident was assessed as 'medium risk'.

14.39 On 4th January 2021 West Yorkshire Police were called to a domestic abuse incident involving Mary and her partner Chloe. Following an argument Mary accused Chloe of cheating on her and so Mary said she was leaving and started to pack her things. Chloe was wearing a necklace, which Mary had bought for her previously. Mary grabbed Chloe by the neck in an attempt to remove the necklace. A television was also smashed during the incident. Chloe told the officers she did not want Mary arresting but officers did arrest Mary due to the nature of the incident and it was assessed as 'medium risk'. Mary was later released due to insufficient evidence.

14.40 On 15th February 2021 Mary attended York Hospital Emergency Department. She reported being assaulted by her partner, sustaining multiple abrasions and a contusion to her head. She stated she would contact the police. Staff at the Emergency Department submitted a MARAC referral (see glossary) to Kirklees Council. This was due to Mary's home address being in Dewsbury but on that evening she had come to Selby to go out drinking with friends.

14.41 On 1st April 2021 Ellie telephoned the '111 service' stating she had taken around 60 paracetamol as a self-harm attempt within the last hour. During the telephone assessment she said it had crossed her mind to end her life but this quickly passed and she now felt 'stupid for taking the tablets'. An ambulance was dispatched and Ellie was conveyed to York District Hospital. Ellie told the ambulance crew the reason for the overdose was that it was the anniversary of her partner's death.

After hospital treatment and checks, Ellie was clinically well. She was also reviewed by the Psychiatric Liaison Team (PLT).

14.42 On 16th April 2021 Ellie had a telephone consultation with her GP. The consultation was for an unrelated medical issue. However, the GP did ask Ellie about her mental health. Ellie stated she was feeling better and had no thoughts of self-harm or intention to overdose.

14.43 On 23rd June 2021 Ellie had another telephone appointment with her GP. The consultation was related to anxiety.

14.44 On 4th July 2021 at 2.17am police received a '999 call' reporting an all-night house party. A female (named as Ellie) was seen by a witness staggering to a car which then drove off. Ellie was heard to say she was collecting someone from nearby. Police searched for the vehicle and it was seen parked back on the drive at 2.32am. No further action was taken.

14.45 On 7th July 2021 Ellie had a telephone consultation with her GP. This was a follow up call regarding her mental health. Ellie stated she was a little better and her anxiety had improved.

14.46 On 28th August 2021 there was a further telephone consultation between Ellie and her GP. She requested more propranolol and reported she was trying to cut down on her alcohol use. She also said she had 'reduced her recreational drug use'. Ellie's propranolol prescription was altered accordingly.

14.47 On 23rd January 2022 at 3.30am police received a '999 call' from an 11 year old child reporting a fight at an address. A further call was received from a neighbour of a large party and an ongoing fight. Police attended and had to force entry to the property. Mary and her partner Chloe were present together with four children aged between eleven and sixteen years. The children were relatives of Mary or Chloe. They were distressed and in fear of Mary. Mary was arrested for an assault after she was reported to have pulled Chloe's hair and punched her. Mary had also smashed a glass and cut herself. An allegation was also made that Mary had taken one of the children by the scruff of the neck and pushed and pulled them around the house. A child concern referral was raised and shared with Child Social Care by the MAST (Multi-Agency Screening Team). The Emergency Duty Team in Huddersfield were also spoken to regarding Chloe's child who was present at the incident and lived in their area.

The incident was assessed as 'medium risk'. Chloe would not provide a statement and Mary was released with no further action due to lack of evidence.

Later that morning Mary attended York Hospital reporting she had been kicked in the head whilst having drinks with friends. A CT scan showed no bleeding or abnormalities.

14.48 On 19th February 2022 at 5.22am police received a call from a female reporting her partner had attacked her after an argument. She had locked herself in a room with the dog. On police systems the phone was linked to Chloe. Further calls were received from the phone with the caller saying the phone had been dragged out of her hand. Another female could be heard shouting in the background. The caller also stated that her son is in care and her partner is trying to stop her seeing her son. Both females could be heard shouting at each other. When officers attended both females were obstructive and would not let officers into the address. One of the females (later identified as Chloe) began making a '999 call' whilst the police were present. The other female (later identified as Mary) told police she was 'just a friend' and would not give her details. Chloe also refused to give her details but did disclose that the other female had punched and slapped her. Mary was then arrested. The incident was assessed as 'medium risk'. Chloe told police she had recently moved there to live with Mary. She also said that Mary was responsible for having her son taken away and made her lose family and friends. Chloe consented to a referral to IDAS.

14.49 Following Mary's arrest Chloe took an overdose of 30 x 20mg fluoxetine and was taken to hospital. She stated she had been assaulted by her partner prior to the overdose. However, the medical notes do not record any domestic abuse considerations by clinicians and no referral was made. Chloe was observed for six hours before being discharged from the hospital.

Chloe would not provide a statement and did not support police action. She stated Mary was her only support network. Mary was released with no further action due to lack of evidence.

14.50 Following the police referral to IDAS, a support worker conducted a further DASH risk assessment with Chloe on 16th March. The details disclosed included isolation, strangulation and controlling Chloe's bank account. The incident was assessed as high risk.

14.51 On 25th March 2022 a MARAC meeting (high risk domestic abuse cases) convened to discuss Mary and Chloe's case. Attendees shared information that the relationship had lasted for three years with physical violence, much of it unreported. The discussions included information that Mary had accompanied Chloe to hospital treatment so that Chloe could not seek help. Chloe had been completely isolated and forced to change her name, with Mary having access to her finances and controlling Chloe's spending. Chloe had sustained injuries including a broken finger. Chloe had attempted to take her own life after the last assault as she saw this as the only way she could escape the relationship. Chloe also disclosed strangulation to the point of unconsciousness.

14.52 On 29th April 2022 police officers from West Yorkshire Police carried out a 'Clare's Law' disclosure (DVDS – see glossary) to Chloe regarding Mary's abusive and violent behaviour to previous partners. The disclosure was made following a request from colleagues at North Yorkshire Police but was delivered by West Yorkshire officers as Chloe had now moved from North Yorkshire to Huddersfield. Chloe told officers the relationship was over and that Mary now had a new partner in North Yorkshire. Chloe was concerned for this new partner's safety. West Yorkshire Police records state North Yorkshire Police were informed about the disclosure being carried out to Chloe and intelligence passed about Mary having a new partner in the North Yorkshire area (the new partner was Ellie). However, North Yorkshire Police records do not have any finalisation of their request for the disclosure to Chloe nor of any intelligence received about Mary being in a relationship with Ellie (for analysis see paragraph 16.6.4, 16.9.2 and conclusion, learning and recommendations).

14.53 On 18th June 2022, Ellie climbed up on to the bridge over the river in her home town. Several members of the public intervened and talked to Ellie. Ellie's good friend (who contributed to this Domestic Homicide Review) was

with Ellie. Ellie told her friend she couldn't live life without her daughter. This was due to Mary forcing Ellie to make a choice between staying with Mary or keeping in touch with her family. Her friend talked her down off the bridge and took her home. Ellie described to her friend and to her (adult) son who was at home that Mary had told her directly "It's her or me" (referring to Ellie's daughter).

The family recalled this incident to the Independent Chair of the DHR panel during a face to face meeting. It was not believed that any agency was involved. Subsequent checks with North Yorkshire Police and the Yorkshire Ambulance Service show no record of any call to that location on that date.

14.54 Ellie's (adult) daughter telephoned her mum's GP Practice on 27th June. She has a record of the time / date of the call. She was so worried about her mother after the incident on the bridge the week before, plus she was aware of her overdose the previous year. Ellie's daughter expressed her concerns to the Independent Chair that the receptionist would not make an appointment for her mother nor permit the daughter to speak to a GP on her mother's behalf to ask for a call back for her mum. This caused the family significant distress. (See conclusions paragraph 17.10).

14.55 On 4th July 2022 Mary attended a local Minor Injuries Unit. She reported pain to the right hand side of the head and behind her right eye for the last week, having been hit with a bottle to the right side of the head a week and a half ago. After initial treatment she was advised to attend the Emergency Department at York Hospital. However, records checked as part of this review confirm she did not do so.

14.56 On 12th October 2022 police received a '999 call' from a male reporting two females were punching each other and one pushed the other head first into a wall. Both got into a vehicle where one was seen punching the other and the vehicle had driven off. Officers attended and both women returned to the address. The females were Ellie and Mary and they had been in a relationship for seven months. Ellie disclosed Mary had been punching and headbutting her and she had reacted to this by slamming Mary to the floor. She added that when she tried to leave in the vehicle Mary continued to follow her and punch her. Ellie then headbutted Mary in the vehicle, Mary grabbed the steering wheel and this caused the vehicle to drive into some bushes.

Ellie's son told officers this happened regularly and also that Ellie was losing her family due to Mary. He also referred to a deterioration in Ellie and the appearance of the house. Ellie stated to police that Mary is jealous of her relationship with her son.

Ellie was arrested for drink driving and assault. During interview she stated the assault was self-defence and that Mary is violent and aggressive in

drink. Mary was arrested for assault and failing to provide a specimen of breath. Mary denied assault but stated she couldn't remember anything as she had been drinking all day. While she was in police custody Mary was seen by the Liaison and Diversion Team (L&D -part of TEWV) due to her disclosing panic attacks and historic cutting of wrists. Mary declined an assessment.

Ellie was charged with drink driving. She later pleaded guilty and was disqualified from driving for 12 months. The incident was assessed as 'high risk'. Both Mary and Ellie were bailed for the assaults and subsequently no action was taken due to insufficient evidence. The case was referred to IDAS and a MARAC referral completed.

14.57 On 13th October 2022 Mary attended York Hospital Emergency Department following the domestic violence incident the night before. She stated she had suffered a punch to the left eye. She could not remember all of the events as she was under the influence of alcohol and cocaine.

14.58 Also on 13th October, IDAS received the North Yorkshire Police referral regarding the incident on 12th October. They tried several times to contact Ellie as well as leaving voicemails and texts but did not receive a reply.

14.59 On 14th October 2022 Ellie's (adult) daughter contacted North Yorkshire Police requesting a Domestic Violence Disclosure Scheme – DVDS (or 'Clare's Law') disclosure on behalf of her mother Ellie. The disclosure request related to Mary. The disclosure was authorised and delivered.

The disclosure was made in person as per Force policy (all DVDS disclosures in North Yorkshire are made in person) by a specially trained Domestic Abuse Officer (DAO). As the person at risk, Ellie signed the document. The information was provided verbally, read verbatim and no documentation was left (due to security of data). Information given to Ellie included domestic abuse perpetrated by Mary that had resulted in charges and also disclosed identified controlling behaviour examples where no charges had been made. The DAO highlighted that although no charges were made this is not uncommon in domestic abuse and discussed the reasons for this, such as fear. The officer also offered to discuss controlling behaviour further if Ellie so wished and highlighted that perpetrators will often appear loving and apologetic after abuse or control. The DAO commented that it appeared Mary was isolating Ellie from family and friends and that Ellie has deleted social media to appease Mary. Ellie provided her new number to the DAO who forwarded this to IDAS. Ellie also gave safe times to call. The DAO was interviewed as part of the DHR process. They recall Ellie was subdued and did acknowledge that Mary was isolating her. The DAO could not recall if Ellie seemed surprised by the information and Ellie didn't indicate what her plans would be regarding continuing the relationship.

14.60 On 19th October North Yorkshire Horizons received a referral from North Yorkshire Police stating Mary was using alcohol and cocaine on a daily basis and was a perpetrator of domestic abuse. Horizons contacted Mary and a triage assessment was arranged for the following day, but Mary did not attend. However Mary did ring the following day and another assessment was scheduled for 27th October. On that date a Horizons support worker telephoned Mary but Mary responded she was out and it was not a good time to speak so another appointment was arranged for 31st October. A support worker telephoned Mary on the 31st but there was no reply. The referral was then closed.

14.61 On 28th October 2022 a MARAC meeting convened to discuss Mary and Ellie's case (see analysis at paragraph 16.11).

14.62 On 3rd January 2023 Mary called police on the '999' system reporting that her brother's step son had logged into her iCloud and sent nude pictures of her girlfriend, Ellie, to her friends.

Mary's brother's step son was subsequently interviewed as a voluntary attender at the police station on 23rd March. There are no specific reasons recorded why there was such a delay. He stated during the interview that there was an ongoing family feud and that he was asked to take the phone to a repair shop and that there were already explicit images and he didn't send them to anyone.

14.63 On 7th January 2023 Ellie contacted North Yorkshire Police. She reported that the mother of Mary's relative (who was suspected of sending nude images) was putting abusive messages about her on social media. Initially Ellie wanted the matter fully investigated and she expressed concerns that a Police Community Support Officer (PCSO) has been assigned rather than a full warranted police officer. Police systems were updated but by then Ellie has re-considered and told officers she no longer wanted any formal action taken and simply wanted the incident logged.

14.64 On 11th June 2023 at 4.35am police received an abandoned '999 call'. A female could be heard asking for police before the line cleared. The telephone number was linked to Ellie. Officers attended and Ellie explained that Mary was in bed and had passed out but prior to this they had been arguing and Mary had damaged the television. Ellie had called the police as she had feared violence. The incident was assessed as 'high risk' (this incident and associated follow-up contact is analysed in detail at paragraph 16.7).

14.65 Later in June 2023, a friend and colleague of Ellie telephoned the police. Ellie had not turned up for work and had been very upset with herself about the arrest of Mary. The colleague had attended Ellie's address and could

see Ellie unconscious on the stairs. Police forced entry. Ellie was found deceased, with a ligature around her neck.

Section 15: Overview

15.1 There were several emerging themes identified that affected Ellie, Mary and their relationship.

15.2 Ellie had suffered violence and abuse at the hands of a former partner. This male was subsequently prosecuted and Ellie obtained a restraining order.

15.3 Mary was a serial perpetrator of domestic abuse. She had perpetrated violence and exercised coercion and control over several of her former partners.

15.4 Ellie experienced bereavement which resulted in her taking an overdose around the anniversary of her former partner's death.

15.5 Both Mary and Ellie consumed alcohol to excess. They also took controlled drugs.

15.6 Mary coercively controlled Ellie by isolating her from her family, taking her mobile phone and threatening self-harm if Ellie ever said the relationship should end.

15.7 Ellie was in permanent employment and worked long hours. Mary gave up work as she wanted to spend more time with Ellie. When Ellie was at work, Mary would text her constantly.

15.8 Police were called to two incidents involving the couple. Both incidents were assessed as high risk.

15.9 Non-fatal strangulation was a part of the abuse being perpetrated.

15.10 Ellie took her own life. There was no direct third party involvement in her death. However, the death immediately followed a domestic abuse incident involving her partner, Mary.

Section 16: Analysis

16.1 The DHR panel reviewed a five year time frame to analyse the life experiences of Ellie and Mary. For most of that time frame, the two were not in a relationship. The individual Terms of Reference highlighted specific questions that could illuminate experiences, interactions, missed opportunities or good practice carried out by professionals across a variety of agencies. Each Term of Reference is now addressed in detail.

16.2 **Were practitioners sensitive to the needs or vulnerabilities of the victim?**

16.2.1 Although eleven agencies took part in the DHR, only six had direct contact with the victim. These were:

- GP Practice
- York & Scarborough Hospitals NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- North Yorkshire Police
- Yorkshire Ambulance Service
- Independent Domestic Abuse Service (IDAS)

16.2.2 The victim was registered with the same GP practice from 2005 until her death. Her partner was also registered at the same practice.

During the five year timeframe being considered by the DHR (June 2018 – June 2023), Primary Care had eight contacts with Ellie. The only face-to-face contacts were for general routine health appointments with the Practice Nurse. The remaining six were all via the telephone. Two of the telephone contacts were for unrelated minor ailments. Four telephone consultations (between April and August 2021) were regarding anxiety and mental health issues.

16.2.3 On 1st April 2021 Ellie rang the '111' service, reporting she had taken 60 paracetamol tablets, as a self-harm attempt. During the telephone assessment she stated it had crossed her mind to end her life but this had quickly passed. Ellie said she now felt 'stupid' for taking them. She was transported by ambulance to York District Hospital. Ellie told the ambulance crew the reason for the overdose was due to it being the anniversary of her partner's death. She was admitted to Ward 24 at the hospital for further observations, where she reported 'low mood'. Prior to her discharge, Ellie was reviewed by the Psychiatric Liaison Team (part of the Tees Esk & Wear Valleys NHS Foundation Trust -TEWV) where Ellie again shared that the overdose was triggered by the upcoming anniversary of her partner's death (seven years previously), by working excessive hours and due to

alcohol consumption. TEWV professionals found no evidence of acute mental illness. Ellie had sought her own rescue, identified her children as protective factors and was 'future planning'.

16.2.4 Actions were agreed to reduce the current stressors. There was also appropriate signposting to other agencies. TEWV staff recorded on their safety summary that Ellie was not at risk of harm from others. There is no record of Ellie referring to any current partner at that time.

A plan was agreed with Ellie:

- Advised to contact Cruse Bereavement Counselling and the contact number was provided (no subsequent contact was made).
- Provided with the crisis team and 'Haven' contact numbers (Haven provides out of hours mental health support. Ellie did not make contact with them).
- Ellie was advised and agreed to remain abstinent from alcohol when she was feeling emotionally vulnerable.

16.2.5 The referral was closed on 7th April 2021 and a summary of the assessment was sent to Ellie's GP.

16.2.6 Two weeks after her hospital admission, Ellie had a telephone consultation with her GP. The call was for an unrelated medical issue (a skin condition). However, following the receipt of the TEWV report, the GP also proactively asked Ellie about her mental health. This is good practice and demonstrated ongoing wraparound support. Ellie told her GP that she was feeling better and had no thoughts of self-harm or intention to overdose.

16.2.7 One week later, (on 23rd June) Ellie had a further telephone consultation with her GP around anxiety. She reported working long shifts (60 hours per week), drinking six cans of beer per night and occasional cocaine use. Ellie said she had no thoughts of deliberate self-harm.

Ellie was given a prescription for propranolol, given advice on ways to reduce anxiety and advised to cut down significantly on her alcohol intake. She was warned about taking a beta blocker with cocaine due to the toxicity. Ellie agreed to this and a two week review was planned.

16.2.8 On 7th July 2021 the review took place (again via telephone). Ellie advised she was feeling a little better; her anxiety and 'shakes' had improved. Her working hours had reduced and she was only drinking on two nights a week. She had taken cocaine once but added she didn't take a beta blocker that day. The GP strongly advised Ellie against cocaine due to toxic interaction, regardless of whether the beta blocker was taken that same day. (Ellie's blood pressure and ECG were taken by the practice nurse on 9th August – the readings were normal).

16.2.9 A further telephone consultation took place with a GP on 28th August. Of note Ellie spoke to three different GPs during her four telephone consultations between April and August 2021.

Ellie requested propranolol as she found the medication helpful. She told the GP she was trying to cut down her alcohol intake and had reduced her recreational drug use.

16.2.10 North Yorkshire Police dealt with five incidents or occurrences involving Ellie during the five year timeframe of the DHR. Incidents either involved her partner Mary, relatives of Mary and one was a request for support from Ellie's family.

16.2.11 The first incident occurred on 12th October 2022 when a concerned member of the public called '999' reporting two women fighting (Ellie and Mary). Officers established that an initial argument had taken place over Mary's jealousy and not liking Ellie talking to her own sons. There were allegations from both of pushing, shoving, escalating into Mary punching Ellie and Ellie headbutting Mary. Both were under the influence of alcohol. Ellie attempted to drive her car away but Mary had got in and continued punching Ellie while she was driving. The car had then crashed into a hedge.

Both were arrested. Body-worn camera footage showed Ellie was upset but compliant and Mary to be aggressive, upset and obstructive. The custody records show that both women had injuries including bruised eyes and bloody lips.

16.2.12 In terms of any vulnerability, Ellie's custody log recorded she disclosed 'taking tablets a few months earlier'. Mary was seen in police custody by the 'Liaison and Diversion' service (L&D) but declined any support. Ellie was not seen by L&D.

As part of the DHR process, further enquiries were made regarding why Ellie was not seen.

The answer appears to be that several police 'systems' are in use plus there is a separate IT system used by the L&D staff (who are NHS employees, not police). Police do not have access to the L&D system and some L&D staff do not have access to the relevant police system. The police Custody Sergeant is ultimately responsible for the prisoner's welfare. A prisoner can decline to be seen by the L&D service but there may be gaps when the actual custody record is not completed with sufficient detail or not accessed by L&D staff.

The Liaison & Diversion service employ 'navigators'. They review who is in custody each morning and identify any vulnerabilities that may indicate L&D assessment is required. This is also based on what the individual has disclosed during 'booking in' to police custody. The navigator uploads the details onto their own system. Issues include substance misuse,

homelessness and mental health. L&D hold a morning meeting which includes the custody health care practitioner who will note if there is anyone missed that is of concern. Further checks are undertaken such as mental health notes on those identified in custody, to get more context to their vulnerabilities. They are then visited by either a navigator or a nurse/mental health practitioner dependant on need. The service and assessment are explained and the areas covered for support. Practitioners explain it is a voluntary service and the confidentiality of the contact. It is bespoke for each client and they will spend as long as they need with the individual.

The DHR has been unable to fully verify why Ellie was not seen by L&D. It may be she simply declined to see them when she arrived at the police station. It may be that she had no recorded vulnerabilities (though she did disclose 'taking tablets' on a previous occasion to the custody staff when she first arrived at the police station). This issue forms part of the recommendations of the review.

Many of Mary's vulnerabilities were already noted from numerous previous detentions at the police station. In this case, neither party was recorded as the victim or the perpetrator of this incident, though police did record it as a 'highly volatile' relationship.

16.2.13 It was good practice that a specialist 'Domestic Abuse Officer' (DAO) visited Ellie while she was in custody. She disclosed to the DAO that she had stopped speaking to some of her family due to Mary and that she was now also losing touch with her friends as they don't like Mary's behaviour. She added that Mary would 'kick off' if Ellie contacted her own friends. Ellie also told police that Mary would take her phone from her, go through her private messages and then start an argument.

These levels of jealousy and control were reflected in the police assessment that this was a 'high risk incident'. Ellie's vulnerability was clear and this resulted in the case being referred to the MARAC (Multi-Agency Risk Assessment Conference) which meets regularly to exchange information and formulate action plans to protect high risk victims of domestic abuse.

16.2.14 During interview, Ellie stated to police she acted in self-defence. Mary denied the assault allegation. The member of the public who reported the incident described both women as 'equally aggressive'. A police supervising officer recorded that Mary was more likely the perpetrator (when noting her behaviour at this incident and her repeated abuse of her former partners) but the investigation was finalised as 'no further action' as the evidential threshold for a prosecution was not met.

16.2.15 Two days after the violent domestic abuse incident, Ellie's (adult) daughter contacted North Yorkshire Police requesting a disclosure for her mother under the Domestic Violence Disclosure Scheme (DVDS or 'Clare's Law'). Ellie's daughter stated she was aware of Mary having a history of perpetrating domestic violence.

Clare's Law was introduced across England and Wales in March 2014. It followed the case of the murder of Clare Wood. Clare was a 36 year old woman with a 10 year old daughter. She had met a male named George Appleton on 'Facebook' and they had formed a relationship. Unknown to Clare, Appleton had a long history of violence towards women which included harassment and kidnapping a former partner and holding her at knifepoint for several hours. When Clare had ended the relationship with Appleton, he had threatened to kill her. These threats were not taken seriously by the police and no officer warned Clare about Appleton's background. In February 2009, Clare was murdered by Appleton. He had raped and strangled her, then set her body on fire. A subsequent campaign by Clare's family and friends resulted in the introduction of 'Clare's Law'. The Domestic Violence Disclosure Scheme is an option for professionals to consider, to protect victims of domestic abuse.

16.2.16 The application for disclosure was subsequently authorised. Officers noted that the relationship between Ellie and Mary had resumed. As Mary was noted as a serial perpetrator, Ellie's vulnerability was recognised and a physical attendance at the property which Mary and Ellie shared was deemed inappropriate. A DAO therefore made arrangements to see Ellie at her place of work. The disclosure was then made. The DAO documented that it appeared Mary was actively isolating Ellie from her friends and family and that Ellie's adult son had now moved out of Ellie's home, thus increasing her isolation.

16.2.17 Officers referred the case to IDAS (the Independent Domestic Abuse Service). However despite numerous attempts, IDAS staff could not make contact with Ellie and so were unable to offer her support.

16.2.18 The next incident reported to North Yorkshire Police involving Ellie was reported by Mary in January 2023. Mary alleged her nephew had logged into her iCloud and distributed naked images of Ellie to her contacts on her phone. Officers obtained a statement from Ellie when she confirmed that explicit images of her had been shared. She supported a police investigation.

When officers interviewed Mary's nephew, he stated he only 'screen shot' them and that they had already been shared on the phone's WhatsApp function.

16.2.19 It is unknown if Ellie believed Mary that it was the nephew who had shared the naked photographs or if she suspected Mary may have been responsible for sharing the images herself. In any event, this episode is likely to have caused Ellie embarrassment and so increased her vulnerability.

16.2.20 The last call to police was made in June 2023. This was only days before Ellie's tragic death and so this whole period of contact from 11th June is analysed in detail at paragraph 16.7.

16.3 Were professionals knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim?

16.3.1 Domestic abuse was never disclosed by Ellie to health practitioners at York District Hospital, Yorkshire Ambulance Service, the GP Practice or TEWV.

16.3.2 Ellie's attendance at hospital in April 2021, following an overdose, was clearly (and correctly) recorded as 'low mood' at the anniversary of her partner's death. Subsequent discussions with her GP included the anniversary of the death plus her excessive working hours.

16.3.3 There was an earlier occurrence in October 2018. This was not connected to Ellie but involved Mary. Opportunities for further potential interventions by professionals were missed.

Mary had been admitted to York District Hospital experiencing chest pains after consuming large quantities of alcohol and amphetamines. Hospital notes record Mary disclosed she had recently split up with her partner and this was why she had taken drugs and consumed large quantities of alcohol. Although practitioners signposted Mary to counselling and alcohol services, there are no entries in the hospital records that suggest staff explored any current issues within the relationship or considered completing a DASH (Domestic Abuse, Stalking & Harassment) risk assessment.

Mary was seen by professionals from TEWV during the same attendance. Although Mary reported she had been aggressive in all of her previous relationships, there was again no DASH risk assessment completed nor any recorded consideration of a referral to a domestic abuse perpetrator programme.

16.3.4 Further attendances by Mary at York Hospital in December 2018 and February 2019 also have no recordings showing staff considered domestic abuse may be occurring. Both attendances involved violence, injuries and alcohol.

In one instance, staff suspected a human tooth had caused an injury but Mary denied this. Hospital staff were proactive in noting Mary had attended hospital five times in eight months with injuries to her hands but did not link this to potential domestic abuse.

16.3.5 In February 2022, Mary attended the hospital with multiple abrasions and a contusion to her head 'following an alleged assault by her partner' (this was before Mary met Ellie). But hospital practitioners did not complete any domestic abuse risk assessment nor consider a MARAC referral. Prior to discharge, Mary told staff, she 'will contact the police'. Police records show no such report was made to them.

16.3.6 In most contacts with North Yorkshire Police, domestic abuse was recognised. The incident was then dealt with accordingly. However, there was an incident in March 2020 when a cousin of Mary alleged Mary was 'kicking off' at their flat. Mary left prior to police arrival, but officers did not subsequently submit a domestic abuse report. This is not compliant with Force policy as incidents between family members falls within the definition of a domestic abuse incident.

16.3.7 During North Yorkshire's Horizons (NYH) contact with Mary in June 2018, for support with her alcohol abuse, Mary disclosed she had recently been arrested for an assault on her partner. This was not explored further. Horizons staff did not confirm this information with the police. Her audit score for alcohol use was high and so may have affected the level of risk related to domestic abuse.

16.3.8 The following month, NYH were notified by the MARAC that Mary was listed as a perpetrator (i.e. this was a high risk domestic abuse case). The lack of consideration for exploration or further referrals linked to Mary's disclosure was a missed opportunity for intervention.

16.3.9 A further disclosure was made by Mary in August 2018 when she described drinking one litre of vodka per day plus taking cannabis. Mary was open with North Yorkshire Horizons staff and told them she had previously assaulted her partner. Again this was not explored and no domestic abuse risk assessment tool was utilised.

NYH have a domestic abuse policy in place which has a clear procedure for staff dealing with disclosures of domestic abuse. NYH staff are competent at completing a DASH risk assessment form with victims and referring into MARAC. Training is provided. However, there is not currently a tool available for professionals to complete with a perpetrator to assess further risks they may pose. If a referral is received from a statutory agency, this would usually include any risks listed by the referrer. However when it is a self-referral, NYH practitioners are purely reliant upon the individual informing them they have committed abuse. Often, individuals are reluctant to disclose this. It is therefore likely NYH staff are less confident having conversations with perpetrators around the abuse or harm they may have caused. North Yorkshire Horizons staff do make referrals to 'Positive Choices' (a local perpetrator programme) but this is usually done when information has been received from a partner agency.

16.3.10 The victim's GP practice received no disclosures or suggestions of domestic abuse from the victim in this case.

The DHR cannot be certain whether or not domestic abuse was disclosed or suspected regarding Mary. Unfortunately, as Mary was not convicted of an assault or exercising coercive control over Ellie, the GP Practice felt unable to share Mary's confidential Primary Care records. This legal advice to the Integrated Care Board was challenged by the DHR Independent

Chair (noting several previous abusive relationships involving Mary) but the ICB legal team still felt unable to share their records.

16.3.11 West Yorkshire Police had no direct contact with the victim, Ellie. However, their officers did attend incidents with other victims of Mary. On each occasion, domestic abuse was recognised and appropriate action taken to safeguard the victim.

16.3.12 The Probation Service managed Mary (though in 2018-2019 this management was by a separate organisation; the Community Rehabilitation Company). Agency records clearly show domestic abuse was actively considered as this was the index offence (assault on her ex-partner) for which she was being managed.

16.4 Did the agency have policies and procedures in place relating to domestic abuse? Were these policies complied with?

16.4.1 At the time of the victim's death in June 2023 her GP practice did not have a domestic abuse policy in place. However, contacts for the Independent Domestic Abuse Service (IDAS) and child/adult safeguarding were accessible to staff through the Care Navigation folders.

16.4.2 The practice has since implemented its own domestic abuse policy based on the Integrated Care Board Primary Care Safeguarding template. The current policy is available on the GP practice's intranet library. The importance of completing the mandatory safeguarding training is emphasised within the policy. As part of this review process the GP practice manager has confirmed that all their staff have completed the training modules.

16.4.3 West Yorkshire Police management of domestic abuse incidents is directed by the Force Domestic Abuse Policy which covers all aspects of the police response; including initial call, risk assessments and provision of specialist services. The policy is routinely amended to take account of new legislation and procedures.

16.4.4 IDAS are a specialist domestic abuse support agency. Their policies and procedures reflect this as the core business of the organisation.

16.4.5 The Probation Service have a comprehensive policy relating to all aspects of domestic abuse. However, at the time Mary was being managed for a suspended sentence order, this was carried out by the Community Rehabilitation Company (CRC). The (former) National Probation Service (NPS) has since merged with the CRC to form the Probation Service. Not all CRC records were available to this review.

16.4.6 TEWV have a comprehensive stand-alone domestic abuse policy in place. This covers all aspects of the Trust's contact with victims or perpetrators, disclosures and advice on referrals. The policy was first introduced in April 2017 and the latest revision and updates were added in May 2024.

16.4.7 North Yorkshire Horizons have a domestic abuse policy along with an adult and child safeguarding policy. There is also a 'did not attend' policy which advises that any referrals will be closed following three failed attempts to make contact. As part of the policy, a seven day closure letter is sent to individuals providing them with contact details should they need to get back in touch and seek support.

16.4.8 York and Scarborough NHS Foundation Trust have a stand-alone domestic abuse policy. This policy requires regular compliance checks (Trust-wide) on a regular basis.

16.4.9 North Yorkshire Police have a domestic abuse policy in place. This provides comprehensive guidance to staff on all aspects of domestic abuse from an initial call, to safeguarding, risk assessment, crime investigation and continued support. The need to take positive action is highlighted and there are links to 'Authorised Professional Practice' from the College of Policing. Domestic abuse is a Force priority. There were some deviations from policy (for example delayed attendance by police at an incident in June 2018 or lack of progress in an investigation in September 2019). However, these were some time ago and appear to be poor individual practice rather than a failing of Force protocols or systems.

16.5 Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

16.5.1 Contacts from York Hospital with the victim in this case were infrequent. The only incident relevant to the DHR was in April 2021 following an overdose. The documentation does not indicate a formal risk assessment was carried out. However, the hospital clinicians did refer Ellie to the Psychiatric Liaison Service (part of the TEWV NHS Trust) for further support. This indicates a risk assessment process as Ellie was medically fit for discharge prior to the referral. The TEWV risk assessment for Ellie is clearly documented on her patient safety summary.

16.5.2 There were gaps in the risk assessment process in relation to Mary by staff at York Hospital. Mary had several attendances at the hospital during 2018 and 2019. Records were clear she had attended five times in an eight month period with hand injuries. On one occasion she stated she had recently split from her partner. The links between repeated injuries and potential domestic abuse do not appear to have been considered.

16.5.3 In February 2021 and February 2022 Mary attended with injuries and on both visits alleged these injuries were caused by her partner. On the first occasion, clinicians submitted a MARAC referral which included a risk assessment. But on the second visit in 2022, Mary told medical staff that she would contact police. However, no professional subsequently checked with the police. No risk assessment was completed by the hospital staff. As there had been a MARAC referral by the hospital the year before, this suggests a lack of consistency or knowledge of individuals rather than a systemic problem.

16.5.4 During both of Mary's contacts with TEWV practitioners an exploration of risks and safeguarding actions were carried out. However, no formal domestic abuse risk assessment was conducted, even though at the first contact, Mary discussed the fact she was being managed by the Probation Service following a conviction for assaulting her partner.

16.5.5 At the second contact, Mary declined an assessment but practitioners were aware that the referral to TEWV had been made by the police who were risk managing the case.

16.5.6 North Yorkshire Horizons contact was with Mary, not Ellie. Although staff are aware they can make MARAC referrals (including a risk assessment) this is a victim-led process. There is a gap when their contact is with an alleged perpetrator. During a triage, Mary confirmed she had recently been arrested for an assault on her partner so the police were involved. This is a gap in procedures if police are not involved. (see Section 18 - Recommendations).

16.5.7 North Yorkshire Police attended two domestic abuse incidents involving Ellie and Mary (October 2022 and June 2023). Both of these incidents were correctly graded as 'high risk' by the attending officers. These risk gradings were agreed and ratified by supervising officers and by specialist Domestic Abuse Officers (DAOs). They were then subsequently listed at the MARAC.

16.5.8 Mary was also involved in many domestic abuse incidents with her former partners. During the five year timeframe of this review there were seven incidents of domestic abuse reported to North Yorkshire Police and two incidents reported to West Yorkshire Police – one of these incidents was later transferred to North Yorkshire Police as the incident occurred in their area.

The first of those (June 2018) was initially assessed under the recognised DASH model as 'standard risk' by the attending officer. This was the incorrect assessment to the presenting circumstances. However, following a review by a DAO the risk level was raised to 'medium'.

This is good practice and demonstrates an active review process in operation. But the actual 'score' (i.e. positive responses by the victim to the 'DASH' questions) was 14/24 which indicates a 'high risk'. The rationale

appears to be simply because there was no physical violence on this occasion. This is wrong. Even if there is no reported physical violence, high risk of harm can remain. In addition, the case had been listed at the MARAC within the previous twelve months and so should have been listed at the MARAC (where all high risk cases are discussed) as a 'repeat' incident.

16.5.9 At the next domestic abuse incident between Mary and a former partner (July 2019) the reporting person was Mary who stated she was the victim. But counter allegations were made by Mary's partner who said Mary was the aggressor. This incident was assessed as 'medium risk'. This risk was ratified on review by a DAO. Although this grading matched the 'score' on the DASH, the incident did include allegations of strangulation. Of note, North Yorkshire Police policies have been amended since this date. All incidents involving non-fatal strangulation are now graded as 'high risk'.

16.5.10 The case reported to West Yorkshire Police and then transferred to North Yorkshire Police was assessed as 'medium risk'. It remained at this level following a review by a North Yorkshire Police DAO.

16.5.11 In March 2020, the Yorkshire Ambulance Service called North Yorkshire Police as they were attending an incident at a club where a female had bitten off part of the ear of her partner. The victim was Mary. There was a substantial injury to her ear but the ear was still attached. Her partner had left the scene. Mary was intoxicated and declined to go to hospital. She would not engage in conversation with the officers. This included not responding to any questions within the DASH risk assessment process. Nevertheless, officers completed a 'skeleton' DASH risk assessment based on the circumstances, witnesses and their own observations. This is good practice. The incident was assessed as 'medium risk'.

16.5.12 A further separate call was made to police later the same day. The caller was Mary's cousin. Mary and her partner were reported to have 'kicked off' at the cousin's flat. Both parties had left before police arrived. Mary's mother was contacted and she stated Mary was fine and that Mary and her partner had travelled back to Dewsbury (in the West Yorkshire Police area). It appears no DASH risk assessment (nor indeed any domestic violence report) was completed. This is contrary to Force policy.

16.5.13 During a call to North Yorkshire Police in November 2020 Mary's partner (a different partner to the incident that occurred in March) reported Mary had assaulted her and been abusive. Mary was not present but they did give her partner a lift home. She was heavily intoxicated, but officers still completed a 'skeleton' DASH risk assessment, which is good practice. The incident was graded as 'medium risk'. (The partner had changed her account to say she was not physically assaulted). This grading was ratified by a DAO.

16.5.14 In January 2022, an eleven year old child rang police at 3.30am upset that there was a fight in their home. Officers had to force entry to the property.

Mary was arrested for assaulting her former partner (Chloe). Four children had witnessed the incident. The victim was intoxicated but a 'skeleton' DASH was completed (assessed as 'medium risk'). The officer had updated the police incident log that 'the victim can be seen later when she is sober' but also noted she was not incapacitated. Hence the risk assessment was completed as per Force policy.

16.5.15 The final incident reported to North Yorkshire Police involving Mary and her partners prior to her relationship with Ellie was reported in February 2022. Mary's partner (Chloe) stated Mary had attacked her and that she had locked herself in a room as she feared further violence from Mary. However, when police attended, neither Mary nor Chloe would speak with them. Both were described by police as obstructive. Mary was arrested but Chloe would not provide a statement. A DASH risk assessment was completed but only 'scored' 5 due to Chloe's reluctance to comply with the assessment. Most responses were recorded as 'refused'. The incident was graded as 'medium risk'. This means there must have been an element of 'professional judgment' by the officer, probably linked to minimisation concerns. This is good practice.

16.5.16 The case was referred to IDAS who conducted a DASH risk assessment with Chloe. She scored 17 on the DASH and was therefore assessed as 'high risk'. Some of Chloe's positive responses to questions within the assessment included allegations of strangulation. The case was then referred to the MARAC.

16.5.17 West Yorkshire Police dealt with two incidents reported by Chloe, an ex-partner of Mary (in September 2020 and January 2021). On the first occasion officers were proactive in gaining entry to the property. Despite reluctance of the victim to assist police, positive action was taken and Mary was arrested, as the incident was assessed as 'high risk'. The case was then listed at the MARAC. The second incident was assessed as 'medium risk' and again Mary was arrested for assault. This was with the same victim. The case was discussed at the DRAM meeting but not progressed to the MARAC. This is not in compliance with Force policy as this was a 'repeat' case.

16.5.18 At the time of her assessment with probation (CRC) in 2018, Mary was assessed as a medium risk to partners. The DHR Panel consider this to be the appropriate level of risk pertaining to her circumstances at that time. When Mary's attendances with her probation officer became sporadic, this was challenged and enforcement action taken.

In January 2019, when Mary reported she was in a new relationship, the probation practitioner advised her that risks can increase when circumstances change. The practitioner discussed contingency plans to address potential risks within the relationship. This included discussions about what a positive relationship looks like, though records indicate Mary

appeared to have little motivation to address previous concerns about her relationship issues.

16.6 Did the agency adhere to information sharing protocols agreed with partners?

16.6.1 There is evidence of good information exchange throughout the contacts between various agencies.

16.6.2 In April 2021, when Ellie was admitted to hospital following an intentional overdose, the clinicians at York District Hospital liaised with colleagues from the Psychiatric Liaison Team at TEWV. This enabled a support plan to be put in place. TEWV then sent a letter to Ellie's GP so that Primary Care were aware of the issue. This was then followed by proactive enquiries by the GP to check on Ellie's welfare at future GP appointments.

16.6.3 There was contact between the Probation Service (who were managing Mary after an assault against a former partner Lucy) and IDAS who were supporting the victim. Although the victim did not take up the offer of further support, there were regular updates provided by IDAS back to the Probation Service.

16.6.4 Again, with requests via the Probation Service for Mary to receive support from North Yorkshire Horizons, there was an exchange of information. However, Horizons records suggest they did not know if the attendance was voluntary or part of a court order. There was also a delay in feeding back information about Mary's lack of attendance or engagement in any substance misuse programme.

16.6.5 Both North Yorkshire Police and West Yorkshire Police (Mary spent time living in both police areas) exchanged information with key partners via referrals and as part of the MARAC process. On most occasions this worked effectively. However there were two incidents which lacked clarity or confirmation of actions taking place:

In February 2021, clinicians at York Hospital treated Mary for injuries (a bleeding nose and multiple abrasions). She told staff that she had been assaulted by her partner (Lucy). The clinician was concerned and so submitted a MARAC referral to Kirklees in West Yorkshire (at that time Mary was living in West Yorkshire and therefore this was the correct location as MARAC convenes in the locality where the victim resides). Kirklees MARAC rejected the referral as in their assessment the circumstances did not reach a 'high risk' criteria. They ascertained the criminal offence took place in North Yorkshire and so West Yorkshire Police forwarded details to North Yorkshire Police so that a crime report could be

submitted. North Yorkshire Police have no record of receiving the report and it appears therefore that no investigation took place. Lucy was never interviewed so we cannot know if she would have made counter allegations against Mary.

In April 2022 North Yorkshire Police requested colleagues in West Yorkshire conduct a 'Clare's Law' disclosure to a partner of Mary (Chloe). The disclosure was carried out in a timely manner in line with Force protocols, but there appears to have been confusion about providing an update that the disclosure had actually been completed. West Yorkshire Police records show the update was sent. North Yorkshire Police records do not show any receipt of this information. Of concern, during the same incident, the recipient of the disclosure (Chloe – a victim of Mary) told West Yorkshire officers she was concerned about a female in North Yorkshire with whom Mary had recently started a relationship. The female was Ellie. Once again, the West Yorkshire Police records state this intelligence was forwarded to North Yorkshire but North Yorkshire Police records have no receipt for this intelligence and so no disclosure to Ellie about Mary was made by officers at that time.

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

16.7.1 Ellie tragically took her own life in June 2023. An incident occurred on 11th June which was reported to the police. The events over the following week require an in-depth analysis to understand the occurrences, developments and above all the thought processes, pressures and considerations of Ellie during this period.

16.7.2 North Yorkshire Police received an abandoned '999' call at 4.35am on 11th June 2023. When a police operator called the number back a female voice could be heard asking for the police before clearing the line. Police systems showed the number was linked to Ellie. Subsequent attempts to call the number back went straight to voicemail. Police attended Ellie's property approximately 20 minutes later.

Police spoke with Ellie. Mary was asleep upstairs. Ellie told the officers that Mary had now calmed down, but they had been arguing and Mary had thrown something at the television causing it to break. The police notes record that the television was Mary's property so there was no criminal damage offence.

16.7.3 Ellie was taken to her workplace by police. Officers recorded that this was so they could speak in private without waking Mary. Officers completed a DASH risk assessment. During the discussion, Ellie disclosed behaviours that were consistent with coercive and controlling behaviour and an assault which had occurred two or three weeks earlier. The 'score' on the DASH risk assessment was 15/22 (i.e. fifteen positive responses by the victim to the questions posed by the assessment) indicating this was a 'high risk' incident. The definition of a 'high risk' domestic abuse incident is:

"*There are identifiable indicators of serious harm or death. The potential event could happen at any time and the impact would be serious."*[10]

Positive answers given by Ellie included:

- Strangulation
- Previous separation
- Threats to kill
- Substance misuse
- Threats to others

16.7.4 Ellie gave consent for sharing the information with IDAS (Independent Domestic Abuse Service) whose service provision can include the allocation of a trained support worker or Independent Domestic Violence Advocate (IDVA).

Ellie gave the police officer a full account of the incident. She described that Mary had friends round, but Ellie had gone to bed as she had an early start for work the next day. Mary entered the bedroom in the early hours and began arguing. Ellie believed this was because she had started speaking with her family again and Mary did not like this. When Ellie turned the television on, Mary had thrown something at it. Mary then passed out on the bed.

While the officers checked on Mary, they saw she was upstairs and fast asleep. Ellie told police Mary would 'kick off' if they woke her.

16.7.5 During the risk assessment, Ellie disclosed Mary can be controlling and is very jealous. She stated that a few weeks ago (possibly around 25th May) Mary had become violent due to Ellie talking to her (adult) son. Mary had punched a photo frame. Ellie had then left the property and gone for a walk while Mary calmed down. When Ellie returned, another argument started and Mary began strangling Ellie. Ellie had pushed Mary away, then Mary hit her round the head with a bag of broken glass (from the picture frame she had punched earlier). Ellie then punched Mary to the side of the face several times. Ellie said she had wanted to leave, but the doors were locked and she couldn't phone the police as Mary had taken her phone.

[10] Safe Lives Guidance 2015

16.7.6 Other coercive behaviours were described by Ellie to the police:

- Mary had made threats to Ellie's family (including threats to kill her adult son and burn his flat down with him and his new baby inside).
- Mary controlled Ellie's use of social media. She described that Mary had to 'approve' her contacts.
- Mary contacted Ellie while she was at work. Ellie had to respond or Mary would become upset. Ellie had to call Mary on her lunch break.
- Mary had timed how long it takes Ellie to get to and from work (with and without traffic), indicating monitoring of her time and movements.
- Mary had breached her bail conditions in October 2022 by turning up at Ellie's work. She kept contacting her until Ellie agreed to meet.
- Mary takes Ellie's phone from her.
- Mary is violent and causes damage.
- When Ellie arrives home, Mary insists the door is locked and keys removed 'for security reasons'. This means that Ellie cannot leave when there is an argument.
- Mary insisted Ellie changed her phone number to prevent support services engaging with her (she described Mary did not want others to interfere).
- Mary buys alcohol and cocaine with Ellie's money (though this does not appear to have been recognised as possible economic abuse).

Ellie told officers that 90% of the time the relationship with Mary was good, but that she is always mindful of trying to 'keep the peace'.

Ellie said she was not frightened of Mary and did not want to make any complaints. She just wanted support for Mary. She described the assault a few weeks earlier as a 'blip' and Ellie said she was not worried or in fear. Ellie did consent to receiving support but gave the officers specific times when she would be at work. Those would be the times when they could contact her.

16.7.7 As part of the DHR process, the body worn video of the officers attending Ellie's address was viewed. It is clear that Ellie left loud music playing in the house while she came outside, she gently closed the door, and spoke quietly to the officers outside. This is why Ellie agreed for the officers to take her to work (where she was due to start a couple of hours later).

The police officers spent over an hour talking with Ellie about her relationship with Mary. Ellie disclosed Mary had now given up her job. They were working opposite shifts so Mary resigned from her job so that she was at home with Ellie every time Ellie had a day off. She added that when she was at work, Mary would text her 50-60 times during her working day. Ellie expressed to the officer that she knew this was controlling but that she just 'goes along' with it as Mary needs reassurance. Ellie added that she had

asked Mary to get help with her drinking but Mary always made an excuse not to do so.

Further review of the body worn camera footage confirms the officer let Ellie talk at her own pace. She spoke about her relationship with Mary and the officer went through the 27 questions on the DASH risk assessment. When Ellie appeared to accept Mary's abuse, the police officer interjected to challenge this. The questions (as part of the DASH assessment) included 'Are you depressed or having suicidal thoughts?' The answer given was 'no'.

16.7.8 The officer advised Ellie that her disclosures were serious and that the incident would be formally recorded as a crime. Ellie stated that she did not want to support a police investigation as she didn't want Mary to get into trouble. Ellie then signed the officers note book that she didn't want any police investigation and that she believed 'things will settle down'.

The officer reiterated that they must record a crime has occurred and that they would have to speak with their supervising officer for advice on what will happen next. The officer added that positive action may have to be taken and then asked Ellie what she thought would happen if Mary was arrested. Ellie replied that Mary will not keep to any bail conditions and that the last time this happened Mary took an overdose. She said she didn't want Mary to hurt herself. The police officer advised Ellie that if action was going to take place then they would call Ellie first.

The next day a review of the incident and connected information about the previous incident was reviewed by a DAC (Domestic Abuse Co-ordinator). The Domestic Abuse Co-ordinator's core role is to supervise the Domestic Abuse Officers, triage and allocate the work to safeguard and support victims. All DACs have attended 'Domestic Abuse Matters' training. All DACs have prior experience as either Domestic Abuse Officers, Stalking Officers or IDVAs. The DACs are embedded within various Command areas in North Yorkshire Police and attend the morning management and tactical meetings. The DAC noted the 'high risk' grading of the case and also the 'high risk' from a previous incident. The case was allocated to a DAO to review.

The DAO noted:

- Escalation
- Various elements of coercive and controlling behaviour
- Non-fatal strangulation
- Previous attempts at separation
- Previous referrals for Mary's abuse of alcohol had not managed her consumption

The DAO agreed with the attending officer's assessment that this was a 'high risk' case and submitted a referral to the MARAC.

The same day the DAO spoke with Ellie, who was at work. Ellie told the DAO that Mary had since apologised for her behaviour and was unaware that Ellie had called the police. Ellie said she was 'trying to keep the peace' and did not want to provide a statement. She also said tensions were high after the recent strangulation. Ellie told the DAO that at the time of the incident occurring, she feared Mary may kill her and that was why she had called the police - to prevent escalation.

The DAO and Ellie also talked about the relationship in general. Ellie disclosed that Mary was no longer working so she would ask Ellie for money to go to the pub and then arguments started. But Ellie said she did feel safe and she would call the police if needed.

The DAO discussed the cycle of abuse and the high risk factors with Ellie. Ellie told the DAO she was willing to engage with IDAS and talk about how to end the relationship safely. Ellie repeated that Mary needed help and asked the DAO for advice about this. The DAO suggested Mary visit her GP. As part of this review, GP records were reviewed. Mary did not attend her GP Practice around this time.

16.7.9 The same day IDAS received a referral from North Yorkshire Police.

16.7.10 The next day, a supervising police officer (patrol Sergeant) reviewed the case. They recorded on the police computer system that the Officer in the Case (OIC) should confirm with Ellie if she supported a prosecution and to consider an 'evidence led prosecution' if she did not. However, the OIC was not on duty that day (having started a bloc of rest days). Due to the risks involved, the supervisor reallocated the case for another officer to make contact with Ellie as a priority, to obtain her wishes. The supervisor added that positive action needed to be taken due to the high risk indicators such as strangulation.

Later the same day an officer contacted Ellie to enquire if she would provide a witness statement and to inform her of the police intention to arrest Mary. Ellie confirmed she still did not want police to take any action and she declined to make a written statement. Ellie told the officer she and Mary were now engaged and she did not want to get Mary into trouble, adding that she believed Mary's behaviour was due to alcohol. The police officer recorded that they emphasised to Ellie that this was not an excuse for Mary's behaviour, Ellie said she felt like she was wasting police time. The officer assured her she was not. They also told Ellie that they (the police) needed to be open and honest with her. Their intention was to arrest Mary due to the risks identified in the case. They also explained that North Yorkshire Police do try to take victim's wishes into account where possible, but that their Force policies and procedures are clear on taking positive action.

The officer recorded in their notes that although Ellie again stated she did not want police to take action against Mary, she also understood the police perspective. However the officer also noted Ellie said she believed that

police taking action would have more of a negative impact on her than on Mary. Ellie explained her family had distanced themselves from her due to previous incidents within the relationship. Ellie believed if they were to learn of these incidents, they may distance themselves again. It is not documented if the police considered seeking consent from Ellie for officers to contact her family to provide support to her.

The conversation ended with the police officer reassuring Ellie that she would be kept informed of any decisions made or actions taken.

It should be noted that this conversation with Ellie was on the telephone. Previous police notes recorded the update should be provided during a revisit. The officer who rang Ellie cited ongoing other police incidents, the time of day they were allocated the task and information they had received that Ellie was safest (and free to speak) at her workplace rather than at home as the rationale for a telephone call instead of a personal visit.

16.7.11 That same day IDAS attempted to contact Ellie. There was no reply on her phone. A voicemail was left and a text message was sent leaving the IDAS contact number. (As part of this review, the DHR panel have confirmed police did provide the most up to date, current telephone contact number).

16.7.12 Mary was arrested for assault and coercive and controlling behaviour against Ellie the next day (nearly 24 hours after the telephone call from the police and four days after the incident was reported).

The arrest and custody procedures can be summarised:

- 1.41pm Mary was arrested at the home address she shared with Ellie. There were no unsolicited comments made by Mary. Ellie was not present during the arrest.
- 2.50pm Mary was ‘booked’ in to police custody at York Police Station.
- Ellie was contacted at 7.03pm and she was informed of Mary’s arrest. The entry on police systems reads ‘I have spoken to Ellie on the phone…’ To provide greater clarification, the officer who updated Ellie was interviewed as part of this Domestic Homicide Review. They report they received a message from their Force Control Room that Ellie had rang the police switchboard for an update. Ellie told the officer she had been made aware from neighbours that the police had been outside her house. Ellie expressed her concern as she had been advised she would be kept updated before any action took place. Ellie went on to say that she wanted Mary back home as soon as possible, she did not want bail conditions imposed and she did not want a Domestic Violence Protection Notice (DVPN). She expressed her reasons for this were that any conditions in place would be worse for her than Mary as her family had shut her out of their lives after they asked her to

choose between them and Mary, but she refused to do so. She also told the officer she was due to meet her grandchild for the first time at the weekend. The officer explained that police had a duty of care. They confirmed to Ellie that her views would be passed on, but that police intended to put bail conditions in place, together with a DVPN.

- Mary was interviewed at York Police Station between 8.42pm and 9.13pm. She confirmed she had anger issues when she drinks and that these were directed at Ellie. She stated she and Ellie had been using cocaine for the last four weeks when Ellie was not working. Mary said she couldn't remember very much about the incident but did confirm she had smashed a photo frame by punching it. She also said they had both 'strangled each other'. She did not think she had strangled Ellie hard or restricted her breathing. Mary denied various aspects of controlling and coercive behaviour that were put to her during the police interview. Finally, Mary said she was not addicted to alcohol or drugs but she had wanted help for a while but didn't know how to go about it (note: this is not true. Mary had several contacts with the 'Horizons' substance misuse service and with TEWV NHS Trust).
- There is no record of the 'Liaison & Diversion' service seeing Mary while she was in custody nor of any signposting to other agencies.
- At 11.50pm Mary was released from police custody pending a referral of the file to the Crown Prosecution Service for a charging decision. Police bail conditions were imposed not to contact Ellie for any reason whatsoever, including via third party or social media and not to enter the road where they lived together (unless accompanied by police to collect belongings).

As part of this DHR, enquiries were carried out to check if police seized Mary's mobile phone. It was not seized. This is surprising as the allegations included coercive control and in particular controlling messages and being 'bombarded' with hundreds of texts at all times. Her telephone could have provided valuable supporting evidence.

16.7.13 The police supervisor recognised the risk of unreported breaches of bail. Therefore a DVPN was authorised by a Superintendent. This is good practice and can assist in protecting a victim by stopping the perpetrator from contacting the victim or temporarily barring them from the home.

16.7.14 Police records show an attempt was made to contact Ellie at 11.12pm with an update on the enquiry but there was no reply so a text message was sent with the OIC's details. A further attempt was made at 8.48am the following morning. This included a message being left of the time of the DVPN hearing, if Ellie wished to contest it.

As part of this review, the DHR Panel enquired about methods of updates to victims. The Force policy records that victims should be updated in a 'timely manner' but no mention is made of the method. Clearly, it would be more suitable to update a vulnerable victim in person, but there are resource implications. North Yorkshire is the largest county in England and officers would need to travel considerable distances. (See Section 18 - recommendations).

16.7.15 It is now known (though not at that time) that Mary breached the DVPN almost immediately when she was released from police custody by attempting to call Ellie only two minutes after she was released. Further enquiries conducted after Ellie's death show that Mary again breached the DVPN by attending Ellie's home the day after her release (at 5.30am). She did not gain entry to the property.

16.7.16 It is not clear if officers considered the risks to Ellie from her own actions. The case was referred to the MARAC but sadly, Ellie had taken her own life before the multi-agency meeting convened. We know of a previous overdose two years previously. This was unconnected to Mary and related to Ellie's low mood on the anniversary of the death of her former partner. Police were not involved in that incident. In 2021, Ellie had sought help after taking a large quantity of tablets. She was taken to hospital by ambulance where she was admitted. Prior to her discharge, she was seen by the Psychiatric Liaison Team. This information was not known to police at the time that it occurred in April 2021, but it was shared by the GP Practice at a MARAC in October 2022 when Mary and Ellie's case was listed.

16.7.17 A summary of police and other agency actions during this period in June 2023 immediately prior to Ellie's death is contained in the conclusions & learning section of this Domestic Homicide Review.

16.8 Did the victim or partner access services while living elsewhere in the UK?

16.8.1 The victim lived all of her life in North Yorkshire.

16.8.2 Mary spent time living in both West Yorkshire and Humberside. This was when she was involved in an intimate relationship with former partners. Humberside Police and West Yorkshire Police were both called to domestic abuse incidents involving Mary. The details of these incidents are contained within the chronology section and analysed in other terms of reference.

16.9 How were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

16.9.1 When Ellie was admitted to hospital in April 2021 following her overdose on prescription drugs she received treatment in accordance with her wishes. Ellie had regretted her actions and sought help by calling the ambulance service. She agreed to be seen by the Psychiatric Liaison Service in accordance with her wishes and together a plan was agreed with Ellie.

16.9.2 Due to lack of clarity of messages between two separate Police Forces, an opportunity was missed to consider a 'Clare's Law' disclosure to Ellie about Mary's previous abusive behaviour. Such a full disclosure was given to Ellie in October 2022 but this delivery could have taken place six months earlier when West Yorkshire Police recorded they submitted intelligence about the relationship to colleagues in North Yorkshire. But North Yorkshire Police records have no such information on their systems.

16.9.3 The police DAO discussed the cycle of abuse and the high-risk factors with Ellie. Ellie told the DAO she was willing to engage with IDAS and talk about how to end the relationship safely. Ellie repeated that Mary needed help and asked the DAO for advice about this." This illustrated that Ellie was receptive to engaging with IDAS and was planning to end the relationship (her wishes were known and as a victim she was given choices and appropriately signposted to IDAS).

16.9.4 The events in June 2023 are analysed in detail at paragraph 16.7. The actions of North Yorkshire Police were not in accordance with Ellie's expressed wishes. She reported a domestic abuse incident and police attended. Further details were provided by Ellie of earlier occurrences within the violent relationship. The police assessed the incident as 'high risk' and therefore assessed Ellie was at risk of serious harm or death. Ellie's partner was arrested which was not what Ellie wanted to happen. However, police have a duty of care and are bound by Article 2 of the European Convention on Human Rights ('the right to life'):

> '*Everyone's right to life shall be protected by law. No one shall be deprived of his/her life intentionally.'*

For further details see the conclusions section of this review.

16.10 How did misuse of alcohol or other substances impact on this case?

16.10.1 Alcohol was a regular feature of both Mary and Ellie's lives. It featured on every single occasion where violence was perpetrated. Agency records also contain several references to cocaine use by both.

16.10.2 Ellie had twice been arrested for drink driving offences and subsequently disqualified from driving. During contact with her GP, she was strongly advised about using cocaine while she was taking beta blockers to assist with her low mood.

16.10.3 No alcohol support was offered to Ellie from North Yorkshire Police DAOs. Ellie had highlighted Mary had issue with substances and so a referral was made after speaking to Mary and gaining consent. Ellie did not indicate an issue with alcohol for herself when speaking to DAOs. However, the MARAC minutes from October 2022 record shared GP information as 'history of previous alcohol excess.'

Mary is recorded on police systems at many domestic abuse incidents involving several different partners. Alcohol and Mary being intoxicated is noted at nearly all of these incidents. Her offending is predominantly linked to alcohol use. There are examples provided in agency records after dealing with incidents:

- In June 2018 she had consumed three quarters of a bottle of vodka before assaulting two people at a party.
- In September 2020 she had drunk four glasses of vodka before assaulting a victim.
- During her attendance at York District Hospital in February 2021 after disclosing an assault involving an ex-partner, hospital notes state that she was intoxicated.
- During an incident involving Ellie in October 2022, both women are described as intoxicated.

16.10.4 Prior to the five year timeframe for this review, Mary was also given a DAR (Drug and Alcohol Referral) which required engaging with Horizons. The DAR is an informal out of court disposal and is viewed as a restorative approach where a suspect has an acceptance of guilt, suitability for the scheme and willingness to participate in the scheme. There should be a limited criminal history to be eligible.

16.10.5 Mary's problems with alcohol feature as part of her pre-sentence report completed by the Probation Service in June 2018 following Mary's conviction for assault and battery against her partner at that time. The Probation Service referred Mary to specialist support with the North Yorkshire 'Horizons' substance misuse service.

16.10.6 Mary's first contact with Horizons was that same month. She reported drinking 3-4 litres of cider per day. After the initial call, Mary attended the

following week for a triage assessment. She was accompanied by her mother. During the appointment she reported she had been advised by her GP to access Horizons for support. She described herself as going on ‘benders’ and drinks until she is highly intoxicated. She also disclosed she had recently been arrested for an assault on her partner.

16.10.7 The next appointment with Horizons was scheduled for 19th June but Mary did not attend. The next contact was from Mary’s probation officer on 21st August, who stated that although Mary did not attend her appointment with Horizons in June, Mary had told her probation officer she now felt more motivated and would like another appointment. Attempts were made by a Horizons worker to contact Mary without success Therefore a letter was sent out requesting she contact Horizons if she required further support. Mary replied via text and an appointment was made for 5th October but Mary did not attend. The appointment finally took place on 23rd October 2018.

16.10.8 A few weeks before her scheduled appointment with Horizons, Mary was admitted to York District Hospital with chest pains. She was seen by the Psychiatric Liaison Team from TEWV and disclosed drinking alcohol to excess, linking this to a recent break-up with her partner. A plan was agreed with Mary and a copy shared with her GP.

16.10.9 On 23rd October, Mary reported to Horizons staff that she was drinking one litre of vodka daily for the last month along with two grammes of cannabis each evening plus occasional amphetamine use. Mary stated the trigger for this was a recent break-up from her partner. A further appointment was made for two days later but Mary did not attend. A closure letter was sent out requesting Mary to get in touch if she required support. As a result of the letter, Mary did get in touch and made an appointment for 14th November. However, she also failed to attend that appointment. She did attend the Horizons office as a ‘walk in’ during December but stated she no longer required support. She stated she was now working and so was only drinking at weekends. Her alcohol audit was completed which showed a ‘score’ of 18 at that time. This did not meet the threshold for entering treatment. As her planned appointments were not part of a court order (i.e. not mandatory) there were no other options for staff to maintain contact. Mary was advised her case would be closed but that she could re-access Horizons at any time in the future if she felt her drinking had increased or was becoming problematic.

16.10.10 Further contact with Horizons occurred in February 2022 when Mary contacted their ‘Single Point of Contact’ line. The basic information gathered was that Mary was ‘binge drinking’. However, when the Horizons professional rang the number provided the next day to arrange a triage assessment the number was ‘out of service’.

16.10.11 Finally, there was a referral to Horizons relating to Mary from North Yorkshire Police in October 2022. The referral stated that Mary was using cocaine on a daily basis and that she was recorded as a domestic abuse perpetrator. Despite several attempts to make or re-schedule appointments to meet Mary's needs, Mary did not engage any further and her case was closed.

16.10.12 Several of Mary's former partners, plus Ellie, all told professionals that Mary was violent 'when in drink'.

16.11 Was the victim or partner ever listed at the MARAC?

MARAC is a Multi-Agency Risk Assessment Conference. It is a meeting of professionals to share information and formulate plans to protect the victim and their children in the highest risk domestic abuse cases (those cases where the victim is assessed as at risk of significant harm).

16.11.1 Mary was listed at the MARAC with several other partners as well as Ellie. The considerations about the MARAC function in relation to Mary's previous partners are addresses at paragraph 16.12.

16.11.2 Ellie's case had been listed at the MARAC on 28th October 2022. This was in relation to an incident involving Mary sixteen days earlier. A member of the public had dialled '999' and reported seeing two women in a violent confrontation in the street. Both women were arrested. A police DAO assessed the case as 'high risk' and so referred it to the MARAC for further exchange of information and safety planning.

16.11.3 The MARAC was attended by North Yorkshire Police, IDAS and Selby District Council. Apologies were received from TEWV and HDFT (Harrogate District Foundation Trust) but information was shared. Information was also provided by the GP Practice, York Hospital and Horizons.

The police (as the referring agency) gave an update of the full details of the incident that had resulted in the nomination as a MARAC case.

16.11.4 Although the information about Ellie's overdose (from April 2021) was shared by the GP, it was not shared by TEWV, York & Scarborough Hospital Trust or the Yorkshire Ambulance Service. The information from the GP is a one line entry stating, '*Ellie overdose mixed analgesia 1/4/21'*. The information sharing at that MARAC meeting was discussed at the DHR panel. It appears there were different reasons why the other agencies did not share the information:

- TEWV were advised that this was a 'repeat case' and so only shared information on incidents which had occurred since the last meeting -

that meeting involved Mary and a former partner, not Ellie (see Recommendations).

- York & Scarborough Hospitals policy is to share information to the MARAC about attendances or occurrences dating back 12 months. The overdose was 18 months earlier and so this information was not shared (see Recommendations)

- Yorkshire Ambulance Service do not have resources to forward information to all cases in the 15 MARAC areas that their service covers. They do supply information when requested to do so. No such request was received on this occasion (see Recommendations).

16.11.5 Clearly, if the information about Ellie's vulnerability, linked to the overdose had been shared by four agencies it would have been more impactive. It cannot be fully ascertained if it was factored into MARAC conversations but of note, Ellie did not have any 'warning marker' on the Police National Computer (PNC), yet Mary had 'warning markers' for 'self-harm' and 'suicidal'. The police were never involved in the overdose incident in April 2021 and so would not have such a marker in place as they were unaware. However, the marker could have been added as an action following the MARAC. It was not in place when officers made the decision to arrest Mary in June 2023. Existing protocols do not permit such markers to be placed on the PNC when the information was provided at multi-agency meetings such as MARAC (see Recommendations).

16.12 What information was known about the partner? Was the partner subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

MATAC is Multi-Agency Tasking and Coordination. It is a scheme rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse.

16.12.1 Mary has six criminal convictions dating back to 2015. These are for offences of criminal damage, assault and battery. Most of the offences relate to 'domestic' incidents against her ex-partners. In addition, she has

received a number of cautions, fixed penalty notices and reprimands for offences of theft, possession of controlled drugs and assaults.

16.12.2 Mary has been arrested on several other occasions (predominantly for domestic abuse related assaults) when no further action has been taken. The main reason for no further action appears to be that the victim was unwilling to provide a witness statement and hence the evidential threshold test was not met. The common theme for a victim declining to provide a statement was through fear; fear of further violence from Mary, or fear that Mary had threatened others, or fear that Mary would take her own life.

16.12.3 The DHR process has collated the number of previous victims of Mary. These were all intimate partners who suffered assaults, harassment, non-fatal strangulation and coercive & controlling behaviour from Mary. Agencies were aware of at least five previous partners who had experienced such abuse:

16.12.4 In 2014, Mary (who was then 21 years old) was in an intimate relationship with a 16 year old. Police received six reports of domestic abuse incidents (criminal damage, assaults and thefts) between 2014 and 2015. Mary received a caution for an assault on the child.

16.12.5 From 2017 to 2021 there were eight calls to police relating to domestic abuse incidents between Mary and her partner, Lucy. On all but one, Mary was the perpetrator. On the one incident where she stated she was the victim (February 2021), it does not appear that Lucy was ever spoken with to obtain her account or to check if there were any counter allegations against Mary. The incident occurred when Mary attended York Hospital for treatment relating to multiple abrasions. As the incident occurred in the North Yorkshire Police area, but the victim (Mary) was living at that time in West Yorkshire, the crime appears to have been ‘lost’ within the system.

In 2018, Lucy made allegations that Mary had shared intimate pictures of her on social media. She also reported assault and controlling behaviour by Mary.

The reports included non-fatal strangulation, criminal damage and disclosures from Lucy regarding Mary’s jealousy of Lucy’s family and Mary taking Lucy’s phone. The case was listed twice at the MARAC. During their relationship, Mary received one conviction (for assault on Lucy). During this time, Mary and Lucy moved to Mary’s home town, which Lucy stated further isolated her from her family.

16.12.6 In July and September 2019, Mary’s new partner, Sarah, reported Mary had strangled and assaulted her. In particular, when Sarah had tried to end the relationship, Mary used violence against her and threatened to kill herself if Sarah left. When the relationship did finally end, Sarah reported further harassment from Mary who was constantly texting her.

16.12.7 In November 2020, Mary's partner, Kirsty, called police to report she had been assaulted by Mary. Mary was not present. Kirsty later declined to prosecute and said the relationship was now over.

16.12.8 Mary was in a long term relationship with Chloe from 2020 to 2022. There were many calls to the police. These included reports of assault and coercion:

In November 2020 Chloe disclosed Mary would prevent her from leaving their flat.

In January 2021, Chloe reported non-fatal strangulation. She asked officers not to arrest Mary. However, due to the risks involved, Mary was arrested. But Chloe declined to provide a statement and no further action was taken. During that incident Mary had threatened to kill herself when she was released.

In February 2022, Chloe had to lock herself in a room to escape from Mary while she rang the police. Attending officers noted Chloe was extremely fearful of Mary. Mary was arrested and Chloe said she would hang herself. Chloe took an overdose when Mary was in custody. Chloe told officers Mary had made her change her surname to Mary's. She also commented that due to Mary she 'had nothing and no one'.

16.12.9 Mary was supervised by the Probation Service (then the CRC) for one year from July 2018 to July 2019. This followed her conviction at York Magistrates Court for assaulting her partner. She was sentenced to a Suspended Sentence Order with requirements to complete 100 hours unpaid work and engage in rehabilitation activities with the Probation Service. Mary completed her unpaid work and attended the majority of her office based appointments. The probation supervision also included referrals to alcohol support services (see paragraph 16.10) but Mary did not engage past initial assessments. At the conclusion of her period of supervision, it was noted she had completed work on emotional and physical regulation.

16.12.10 Ellie was Mary's 6th victim of domestic violence and abuse over an eight year period. Despite this, Mary was not identified as a serial perpetrator until her relationship with Ellie. At that point, 'flags' were placed on police systems. Mary was never nominated to any perpetrator programme by any agency. This includes her period of management by the CRC for domestic abuse related offences in 2018.

16.12.11 Mary was never nominated as a MAPPA nominal. MAPPA is a statutory process to manage the highest risk violent offenders and sexual offenders. There are three categories of offender within MAPPA:

1/. Registered Sex Offenders (category 1). Mary had no relevant convictions relating to sexual offences.

2/. Violent Offenders (category 2). All category 2 MAPPA nominals have been sentenced to a minimum of 12 months in custody. Mary never received such a sentence.

3/. Other / potentially dangerous persons (category 3). This category does not require a conviction for a specific offence or a sentence of any minimum term. Offenders can be nominated by any 'Responsible Authority' agency if a professional believes that person is a risk of serious harm to the public or a section of the public. Mary was never considered for such a nomination. Category 3 has a very high bar (i.e. the person is assessed as dangerous and they require active multi-agency management to reduce or mitigate the risks they pose).

16.12.12 Mary was not identified during the MATAC process. North Yorkshire Police and their key partners have adopted the MATAC scheme. This is a process of identification, monitoring and management of the most prolific perpetrators of domestic abuse. It involves the commitment of resources and so numbers in active management on the MATAC scheme are kept low. Otherwise, if the work is spread across many individuals the effect of proactive management is diluted. Police use a RFGV (Recency, Frequency, Gravity & Victims) matrix to assess and 'score' an individual who is abusive to more than one intimate partner. As well as this matrix, other professionals can also nominate an individual using 'professional judgement'.

16.12.13 As part of this Domestic Homicide Review, the matrix process has been scrutinised. Mary first appeared on the RFGV tracker in December 2018. At that point she was in the 'top 500' serial abusers within North Yorkshire. It was not until November 2022 (following the report of the domestic abuse perpetrated against Ellie) that Mary entered the 'top 100'.

16.12.14 The RFGV uses domestic abuse reports (criminal and non-criminal) to identify perpetrators. There are around 10,500 individuals on the system in North Yorkshire as the RFGV pulls in all individuals where a domestic abuse incident has been recorded. The 'top 100' does not necessarily mean that a person would be adopted as there are many variables, but they are reviewed. As a rule, analysts are reviewing who has 'scored' a significant increase within the month (and possibly the previous month). So there could be instances where a subject is quickly moved towards the top of the list. Professional judgement therefore also must be applied.

16.12.15 The MATAC in North Yorkshire has no current same-sex or female perpetrators within the MATAC cohort. There have previously been two same-sex perpetrators.

16.13 Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the partner and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

16.13.1 No issues were identified during the DHR process relating to ethnicity, culture, language, marital status or disability. Mary and Ellie were in a same sex relationship.

16.13.2 Mary and Ellie accessed a variety of services including health, policing (and in Mary's case probation and other specialist substance misuse services). These contacts were frequent and do not indicate any barriers to reporting.

16.13.3 The DHR panel posed the question to consider sexual orientation and how services responded. In terms of policing, this related to two incidents reported to North Yorkshire Police (in October 2022 and June 2023). On both occasions, there was a timely police response and assessment of risk. On the first occasion, both Mary and Ellie were arrested. On the second occasion (June 2023), Mary was asleep in bed. Police spoke with Ellie outside as she did not want Mary to wake and learn that she had called the police. Further discussions then took place at Ellie's workplace. Although it is positive that officers were sensitive and found a private place for Ellie to speak, she went on to make serious allegations about Mary (though expressed she did not want direct action taken against Mary). The officers left Mary asleep at the home address and it was in the coming days that arrangements were made to arrest Mary. The DHR panel discussed whether this would have happened if Mary were a male perpetrator. Ellie had alleged coercive control, strangulation and assault by Mary. The case was assessed as 'high risk'. Although Ellie was at her workplace when the full disclosures were made, she was still at risk from further attacks by Mary when she returned home from work.

16.13.4 Police did not recognise domestic abuse at an incident they attended in May 2018. It was recorded as 'noise nuisance' but clearly it was domestic abuse within a same sex relationship. Those involved (Mary and Lucy) had been listed at the MARAC (as a high risk relationship) the month before.

16.13.5 Similar issues occurred in June 2018 and July 2019 involving Mary and two former partners. On the first occasion there was a delayed police response. On the second occasion police attended a volatile situation, an allegation of assault was reported, but no arrest was made. Again, we should pose the question; would actions have been different if it was a male perpetrator?

16.14 Did any restructuring during the period under review have any impact on the quality of service delivered? Did the Covid-19 pandemic affect service delivery?

16.14.1 In common with all areas of the country, several services moved to telephone only contact during the Covid-19 pandemic. This included GPs, drug & alcohol services and domestic abuse specialist agencies. Though each had some flexibility to adapt contact depending on the circumstances. For example, TEWV adapted circumstances relating to that particular team's function. There is nothing to suggest this had any adverse impact on service delivery.

16.14.2 Emergency services such as North Yorkshire Police, West Yorkshire Police, Yorkshire Ambulance Service and York District Hospital retained face to face contact, though with additional safeguards and PPE in place.

16.14.3 There was no other restructuring during the applicable timeframe which impacted on services.

16.14.4 Neither restructuring nor the Covid-19 pandemic had any significant impact on this case.

Section 17: Conclusion and Lessons Learned

17.1 Mary is a serial perpetrator of domestic abuse. She was abusive, violent and controlling to at least five intimate partners before she met Ellie.

Mary displayed concerning similarities regarding her abusive behaviour to control and manipulate all of her intimate partners:

- Physical violence and threats including strangulation
- Threatening to take her own life
- Smashing/damaging property in the home
- Isolating her partners from their family and friends – making them choose between them and her.
- Monitoring their movements by constant texts and phone calls
- Following them about and accompanying them to appointments etc.
- Taking phones from her partners, thus preventing them contacting others
- Locking them in the house with her
- Posting naked images of partners on social media

There does not appear to have been sufficient proactive management of Mary, despite her abuse of at least six intimate partners. Several of these incidents were 'high risk' including episodes of strangulation and extreme control. Mary did not feature within the MATAC process (serial perpetrators) nor was she nominated as a 'Potentially' or 'Other' dangerous person under the MAPPA regulations.

17.2 Alcohol is a feature in every incident the police were called to involving Mary and Ellie. Alcohol was responsible for a deterioration in Mary's behaviour. She often agreed to reduce her drinking and seek support and treatment from agencies but this never progressed to full treatment.

17.3 During several contacts with North Yorkshire Horizons (drug and alcohol substance misuse service) there were partial disclosures to professionals indicating alcohol may be connected to domestic violence. This was not explored further.

17.4 Several of Mary's partners threatened or attempted to take their own lives.

17.5 Staff at the main hospital did not always consider domestic abuse as a reason behind hospital attendance. There were occasions in 2018, 2019 and 2022 when Mary attended hospital with various injuries. Staff were not proactive in considering domestic abuse as a potential cause. Indeed in 2022, although Mary alleged an assault by her partner, staff did not take action as Mary told them she herself would contact the police. She did not subsequently contact the police and so agencies were unaware of this incident.

17.6 There are examples when an IDVA offered to meet an ex-partner of Mary at their offices so that she was not being controlled by Mary. This is good practice as it makes it easier for the victim to speak openly about any concerns.

17.7 There are several examples during the timeframe of this review when no risk assessments were carried out by officers from North Yorkshire Police, even though the nature of the incident was domestic abuse. These occurred in April 2018, May 2018 and March 2020. This is contrary to Force policy.

17.8 Some incidents involving Mary and her ex-partners were assessed as 'medium risk' even though the victim made allegations of strangulation. North Yorkshire Police policies have been amended and all incidents involving non-fatal strangulation are now graded as 'high risk'.

17.9 On occasions when all of the information was not available, or a victim would not provide details of what had happened, police officers still completed 'skeleton' risk assessments containing the limited information they could gather. They were then able to use professional judgement to assess the level of risk. This is good practice. In addition, risk assessment grades were reviewed by supervisors and domestic abuse specialists. This reflects robust monitoring and review of assessments.

17.10 Professionals' actions at some incidents e.g. police not arresting the suspect at a high risk domestic abuse incident, *could* be perceived that female perpetrators and/or same sex relationships were treated differently to others i.e. would a male perpetrator be left asleep in bed after such serious disclosures were made?

17.11 There were some issues identified regarding the effectiveness of the MARAC process. When agencies could not attend the meeting to discuss a high risk incident involving Ellie and Mary in October 2022, they submitted apologies and sent their relevant information about that particular case to the MARAC Chair. However, some of the information shared was not accurate. Some agencies state they were advised this was a 'repeat' case (it was not - previous cases had involved Mary abusing former partners. This was the first time Ellie had been discussed as a high risk victim). Other agencies were either not asked for the information or only checked their agency records going back 12 months. The only agency that did correctly share information about Ellie's overdose in April 2021 was the GP Practice. Therefore it is likely that Ellie's vulnerability was not fully appreciated by the MARAC representatives. There were no 'warning markers' for Ellie (linked to suicide or self-harm) added to the Police National Computer (PNC) which meant officers may not have considered Ellie's vulnerability to suicide when they acted against her wishes and arrested her partner.

17.12 After Ellie's death, police were unable to access Ellie's phone. Mary's phone was not seized while she was in custody even though the allegations

were of significant coercive control and being texted 50-60 times per day. We therefore do not know if Mary's phone contained other threats. This lack of evidence gathering may have affected the outcome of the investigation.

Note: the Kellie Sutton case. Kellie had taken her own life in 2017 but the coroner ruled that this followed years of experiencing domestic abuse and coercive control. The finding at the inquest was that Kellie was unlawfully killed.[11]

17.13 Ellie's family were unable to speak directly to a GP or arrange a GP call-back for her after she climbed on to a bridge over a river in 2022. This incident followed an overdose attempt the previous year. Although the family made attempts to obtain an appointment for Ellie, they were advised by the GP Practice that close family could not make such appointments, nor would the GP Practice make a call to Ellie directly. The family were asked to call back with Ellie in the room or for Ellie to agree to the sharing of health information with her daughter, which wasn't possible at the time.

This issue was raised with the GP Practice by the Integrated Care Board representative from the DHR Panel. The GP Practice recognises the issues raised. They now operate a triage system where a GP is based in reception each morning. The GP is able to carry out initial screening and this could include speaking to third parties (though within the limits of the UK GDPR regulations). This system has been developed to now include an online form which can be submitted to assist with the triage process.

17.14 In two previous self-harm incidents, Ellie had sought help or was accompanied by friends.

In April 2021, when she took an overdose at home, she quickly telephoned an ambulance and immediately regretted her actions.

In June 2022 when she climbed onto a bridge over a river, her close friend who was with her and with other members of the public, talked her down.

However, by June 2023, she was isolated and alone at home. She made a determined effort and ended her life.

Her family strongly believe this was as a result of being worn down over many months of abuse and control by her partner.

17.15 The victim reported incidents of domestic abuse to the police. Following a thorough risk assessment officers determined this was a 'high risk' case. The victim was clear she did not want the police to take formal action

[11] Assistant Coroner Samantha Broadfoot KC Cambridge and Peterborough Coroner's Court 26 June 2023 – 6 July 2023

against her partner. The officer consulted with their supervisor and with specialist domestic abuse support staff.

Police made the decision that the partner should be arrested. The rationale is recorded to include incidents of serious violence, several episodes of strangulation, significant elements of control (including monitoring movements, taking away the victim's mobile phone, constantly texting her, locking the victim in her house with her, threats to take her own life and isolation from all of her family and friends).

The partner was subsequently arrested and interviewed about the offences. Ellie was updated about the arrest but this was done on the telephone and it was Ellie who instigated the conversation after learning of Mary's arrest from neighbours.

The DHR Panel is satisfied that the police actions were necessary to protect the victim. The violence and control disclosed by the victim were such that the police had concerns that Ellie may suffer serious violence in the immediate future. Indeed this concern is highlighted by Professor Jane Monckton Smith in her study[12] showing there are eight steps to look for in a progression to domestic homicide. Many of these behaviours were displayed by Ellie's partner. A pattern was developing:

1) A pre-relationship history of stalking or abuse by the perpetrator

2) The romance developing quickly into a serious relationship

3) The relationship becoming dominated by coercive control

4) A trigger to threaten the perpetrator's control - for example, the relationship ends or the perpetrator gets into financial difficulty

5) Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide

6) The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide

7) Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone

8) Homicide - the perpetrator kills his or her partner and possibly hurts others such as the victim's children

[12] Monckton Smith, J (2020). Intimate partner femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide

Professor Monckton Smith et al (University of Gloucestershire) has also developed a similar draft table linked to suicides[13] :

Stage	Alleged Perpetrator characteristics	Victim characteristics
1.History	History of domestic abuse, coercive control, stalking, routine jealousy and violence	History of vulnerability, previous domestic abuse, coercive control/sexual assault, previous Local Authority care
2.Early relationship	Speed and intensity	Speed and intensity
3.Relationships	Dominated by controlling patterns and violence	Subject to violence; drugs and alcohol; sexual violence.
4.Disclosure	Control escalating, violence may escalate	Tells others about the abuse. Persistent harassment
5.Help-seeking	Alleged perpetrator may use victim's mental health against them, may make threats to family or friends and counter allegations	Mental health services, GP for mental health, A&E, child services, social services, police
6.Suicidal ideation	Alleged perpetrator may encourage suicide, persistent contact, threats	Suicide attempts, sell-harm, may say they 'can't go on', may be convinced they will be killed.
7.Complete Entrapment	Stalking, threats, persistent contact, threats to others, violence	May say 'I'll never be free' or similar.
8.Suicide	Common for alleged perpetrator to find the body. In some cases abuse transferred to victim's family	Most common to be at home with ligature. Other methods also noted

It is clear from this table, that Ellie's relationship with Mary followed most of these characteristics.

17.16 Although the police action was necessary, there was insufficient support in place, late at night, when the victim learned of her partner's arrest. This left her extremely vulnerable. Officers, quite rightly, had assessed the significant harm that the victim may suffer from her partner. But they do not appear to have given sufficient consideration of the harm the victim may

[13] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide: Professor Jane Monckton Smith (University of Gloucestershire (2022)

suffer from her own actions. As the victim's close friend said to the DHR Chair:

"We know the police were really concerned about her and so they acted against her wishes, But they didn't protect her. They took action to protect her, but she is dead".

These powerful words by Ellie's friend illustrate what went wrong so succinctly.

Section 18: Recommendations

1. **There is a full implementation of 'routine and selective' enquiry within all Health agencies in the North Yorkshire area.**

   This programme is being rolled out nationally and requires health professionals to take positive steps when encountering potential victims of domestic abuse within health settings (See Homicide Abuse Learning Together – HALT- project sponsored by the Domestic Abuse Commissioner for England & Wales). Locally, in North Yorkshire the 'Safe Lives' charity is coordinating this work.

2. **The North Yorkshire MAPPA Strategic Management Board ensures all agencies involved in work with vulnerable people receive awareness raising of the MAPPA process.**

   MAPPA is much more effective when professionals are knowledgeable about the MAPPA process and how they as professionals, from a variety of agencies, can make a positive contribution in managing dangerous offenders.

   Category 1 MAPPA (Registered Sex Offenders) require a conviction for a relevant offence. Category 2 MAPPA (Violent Offenders) requires the offender to have been sentenced to 12 months imprisonment or more. However, a Category 3 MAPPA does not require a relevant conviction and any professional that is concerned about an individual can nominate them for consideration within the MAPPA process.

   Mary could have been considered as a Category 3 (Potentially Dangerous Person). A screening process would determine if she progressed into MAPPA.

3. **The MATAC Steering Group reviews the processes and protocols for identification and management of serial perpetrators of domestic abuse.**

   The DHR has recognised that many subjects are 'serial perpetrators' and that only limited opportunities for proactive management of these subjects is possible. To dilute the process by managing excessive numbers of subjects would not be effective. MATAC is a national system, adopted in most areas of the UK. Several DHRs have already highlighted some shortcomings in identifying the most appropriate subjects. This should be a multi-agency piece of work. Within the context of this Domestic Homicide Review, the work should also acknowledge that victims and perpetrators from an LGBT+ background are disproportionally affected by domestic abuse.

4. **All services, agencies and partners in North Yorkshire to commit to reducing the number of lives lost to suicide, through engagement with the local implementation of the cross-government suicide prevention strategy which seeks to achieve a reduction in suicides in England over the next five years.**

   Again, services should note that national data confirms the LGBT+ community are disproportionately affected by suicide and substance misuse.

5. **The North Yorkshire Community Safety Partnership should receive reassurances that professionals have up to date training to recognise the signs of abuse and what actions to take in these circumstances.**

   Some agencies did not always recognise domestic abuse. This includes hospital attendances, police incidents and contact with alcohol treatment services.

6. **Building on work progressing with the North Yorkshire Safeguarding Adults Board and Safeguarding Children Partnership, the North Yorkshire Community Safety Partnership should coordinate awareness raising and training in unconscious bias to acknowledge any nuanced behaviour by professionals, using this tragic incident as an example.**

   The DHR panel discussed concerns that at some incidents, professionals *may* have treated the victim or perpetrator differently as this was a same sex relationship (for example not arresting the named perpetrator at the time the 'high risk' incident was reported).

7. **The North Yorkshire Community Safety Partnership ensures professionals are aware of specialist charities and groups, such as Galop, who are able to offer support to LGBT+ victims of domestic abuse, in addition to existing local, tailored, commissioned services such as IDAS.**

8. **The MARAC Steering Group ensures agencies attending the MARAC and providing information, are confident the information is accurate and relevant to that individual victim or perpetrator. Protocols on how far back agencies search their records prior to the MARAC should be reviewed.**

9. **The MARAC Steering Group notes the conclusions and learning of this Domestic Homicide Review. They should cascade the findings of the DHR to all MARAC delegates to ensure a full understanding that in 'high risk' cases of domestic abuse, the risks of serious harm can come from the victims own vulnerability and not just from the perpetrator's actions. They should note this is not the responsibility of the victim.**

It is about professionals viewing Ellie's circumstances through an intersectional lens. This is particularly important in LGBT+ relationships where data confirms cases of suicide and mental health issues are more prevalent.

10. **The MARAC steering Group considers how information disclosed at operational MARAC meetings from trusted multi-agency partners can be added to the Police National Computer (PNC).**

    This may require liaison work at national level with the findings of this DHR utilised to show where gaps in information sharing can occur.

11. **The North Yorkshire Community Safety Partnership coordinates work on a 'pathway' that can be used by any agency, if a professional receives disclosures or partial disclosures from a perpetrator of domestic abuse. As this DHR progressed, it became clear that Mary's perpetrating of domestic abuse to so many partners was not known to several agencies.**

    There are established routes for victims of abuse (via the DASH risk assessment and MARAC referrals). But it is not clear how a perpetrator could be monitored without a proportionate exchange of information. There is no screening tool in place. In this case, Mary was open with practitioners that she had assaulted her partner. Guidance, including a flow chart, would assist professionals in assessing the risk involved and the most appropriate way forward to safeguard victims and / or get help for the perpetrator.

12. **The North Yorkshire Community Safety Partnership receives reassurance from North Yorkshire Police and the Liaison & Diversion Team from TEWV, that work has been carried out to explore any gaps that may occur relating to vulnerable people in police custody who are experiencing domestic abuse. There appears to be some liaison between Domestic Abuse Officers (DAOs) within the police and clinicians from L&D, but this should be formalised into a protocol that assists both agencies to provide the best possible service to victims.**

13. **The North Yorkshire Community Safety Partnership coordinates work across the private sector to ensure that companies have robust policies in place relating to their staff experiencing domestic abuse. This work should include services such as care homes that are commissioned by the Integrated Care Board or North Yorkshire Council.**

14. **GP Practice staff triaging the concerns of patient's relatives should always balance safety and GDPR compliance and when in doubt should have a process for escalation in place in order to maintain best possible outcomes.**

15. **North Yorkshire Police arrange training delivery to all operational staff on the risks of suicide linked to domestic abuse.**

The training should cite this Domestic Homicide Review as an example to highlight the learning. Although police needed to take action to protect the victim from her partner's violence, abuse and control, there was insufficient consideration of the victim's vulnerability. This included that she had previously taken an overdose. If an intimate partner in a high risk case is arrested against the victim's wishes, then it is crucial that support mechanisms are in place. This includes personal updates by the police officer, consideration of a joint deployment with a trained professional such as an IDVA and seeking the victim's consent to involve family or close friends.

16. **North Yorkshire Police remind all officers of the importance of seizing mobile telephones in cases of coercive control or stalking. Mobile phones can provide valuable evidence to support allegations.**

17. **North Yorkshire Police review their protocols linked to the Victim's Code of Practice. When a vulnerable victim requires updating on the progress of an investigation, officers should consider if such an update would be more effective and supportive if carried out in person rather than on the telephone.**

The resource implications for this are acknowledged, but in some instances this may be a much more appropriate method of delivery.

Glossary - Acronyms and Processes

BWV	Body Worn Video
Clare's Law	DVDS Domestic Violence Disclosure Scheme Clare's Law was introduced across England and Wales in March 2014. It followed the case of the murder of Clare Wood. Clare was a 36 year old woman with a 10 year old daughter. She had met a male named George Appleton on 'Facebook' and they had formed a relationship. Unknown to Clare, Appleton had a long history of violence towards women which included harassment and kidnapping a former partner and holding her at knifepoint for several hours. When Clare had ended the relationship with Appleton, he had threatened to kill her. These threats were not taken seriously by the police and no officer warned Clare about Appleton's background. In February 2009, Clare was murdered by Appleton. He had raped and strangled her, then set her body on fire. A subsequent campaign by Clare's family and friends resulted in the introduction of 'Clare's Law'. The Domestic Violence Disclosure Scheme is an option for professionals to consider, to protect victims of domestic abuse.
CPS	Crown Prosecution Service
CRC	Community Rehabilitation Company
DAC	Domestic Abuse Coordinator
DAO	Domestic Abuse Officer
DASH	Domestic Abuse, Stalking and Harassment This is a nationally recognised risk assessment model to assess the level of risk relating to an incident of domestic abuse. The professional carrying out the risk assessment may then determine if the incident is assessed as 'standard', 'medium' or 'high' risk: *Standard risk* – current evidence does not indicate a likelihood of serious harm. *Medium risk* - there are identifiable factors of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there are a change of circumstances *High risk* – there are identifiable indicators of risk of serious harm or death. The potential event could happen at any time and the impact would be serious. A high risk case may be taken to a MARAC meeting and the victim supported by an IDVA.
DRAM	Daily Risk Assessment Meeting
DVDS	Domestic Violence Disclosure Scheme (Clare's Law)
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Prevention Order
EDT	Emergency Duty Team
ICB	Integrated Care Board

IDAS	Independent Domestic Abuse Service
IDVA	Independent Domestic Violence Advocate. This is a professional who supports victims of abuse in a variety of ways. This includes updating the victim of any actions set at the MARAC and also supporting the victim through the criminal justice process.
IMR	Individual Management Review
L&D	Liaison and Diversion
LGBTQ+	Lesbian, Gay, Bisexuel, Transgender, Queer plus
MAPPA	Multi-Agency Public Protection Arrangements This is a statutory process used to manage Registered Sex Offenders (RSOs) or the most violent offenders. The police, HM Prisons and the Probation Service are the three 'Responsible Authorities' within the MAPPA process. MAPPA has different categories of offender and different 'levels' which determine the level of resources required to manage that dangerous individual. In addition to the three 'Responsible Authorities', other agencies (for example GPs, hospitals, local authorities or registered social landlords) may also be invited to participate within MAPPA.
MARAC	Multi-Agency Risk Assessment Conference These are meetings attended by several agencies who share information and formulate a plan to protect those victims of domestic abuse assessed at the highest risk of harm.
MAST	Multi-Agency Screening Team
MO	Modus Operandi
NYH	North Yorkshire Horizons
NMO	Non Molestation Order This is an order granted by the courts to protect a victim for further abuse by a named individual. It can restrict the movements of an offender and prevent a named individual from contacting a victim.
NPS	National Probation Service
OEL	Occurrence Enquiry Log
OIC	Officer In Case
OASys	Internal Probation Service system to determine assessed likelihood of reoffending and risk of harm to self or others
PCSO	Police Community Support Officers
PLT	Psychiatric Liaison Team (part of Tees, Esk & Wear Valleys NHS Foundation Trust)
PNC	Police National Computer

PND	Police National Database
RFGV	Recency, Frequency, Gravity & Victims - matrix to assess and ‘score’ an individual who is abusive to more than one intimate partner.
SARC	Sexual Assault Referral Centre
TEWV	Tees, Esk & Wear Valleys NHS Foundation Trust
VRI	Visually Recorded Interview

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