



**Safer North Tyneside
Community Safety
Partnership**

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of 'Maxine' in October 2018

Report produced by Author, Lynsey Eglington

28 January 2025

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Executive Summary

An elegy prepared by Maxine's sister, Janine, and dear family friend, Linda:

What happened on that fateful night, Maxine? So many different scenarios have gone through my mind; your body was so bruised and battered, and your last months of life were so unkind. The scene we were left with when forensics were done – A jigsaw of different clues scattered around. Notes on calendars and scraps of paper, crumpled balls of paper stashed away not meant to be found. Were you reading that story, the one in the magazine left open on your chair? About another loss of life to domestic abuse and a grieving sister left in despair. Did you notice all the similarities? Did you see all the same traits? Were you beginning to realise the truth? That his whole life was full of hate.

We found all the letters, too, stuffed away in the drawers from the police and other agencies. They were all aware, but a change in medication and a communication failure led to you being discharged from their care. The Domestic Violence Protection Order was issued only a few months before. There were no arrests made, or restraining order issued. No follow-up or police checks at your door. You were only assessed as Standard risk, and the repercussions of that were immense. He had fifty-four previous offences against women. This decision just did not make sense.

Fifty-four previous offences of domestic violence against women, including grievous bodily harm. You had only known him for seven months. The police knew about him all along. They didn't care; they left you there. No one checked to see if you were safe. They said you didn't engage with them, so they left you to your fate.

They arrested him for rape at first then there were reports of homicide. There was talk of drug abuse and lifestyle and then some suggestions of possible suicide. None of your injuries could be attributed directly to your death. They

said there was no evidence of foul play. The Post-mortem supposedly confirmed this, and he walked free the very next day.

Time seemed to stand still for a while; the coroner seemed to be having difficulties with your case. Some of the evidence was contradictory, and things were not falling neatly into place. It was May 2019 before the inquest was held. We knew the score. It was not being held to apportion blame, just to answer the questions: who, where when and how? The last one being the one driving us insane.

And then it was over in the blink of an eye: conclusion, drug abuse. So many questions left unanswered and issues unresolved. The missed evidence we found didn't seem to be of any use. The coroner was kind and encouraged us to tell your tale. He knew there had been failings in your care. We went through the complaint procedures and started looking at his background, ex-girlfriends and those close to his lair.

Section 1: The Review Process

- 1.1 This summary details the process undertaken by the North Tyneside Community Safety Partnership (CSP) and the Domestic Homicide Review (DHR) Panel in examining the unexpected and sudden death of Maxine, a resident of the area.
- 1.2 It is common practice to protect the identities of all individuals involved in reviews by using pseudonyms. However, Maxine's sister, Janine, specifically requested and consented to the DHR using first names. The CSP sought legal advice regarding this decision and found no legal barriers to using first names, as the deceased's family had consented, and the perpetrator had since died. Janine and Linda supported the review's decision to use first names. With that in mind, the following names have been adopted and used throughout the report:

Maxine was aged 39 years old at the time of her death.

Thomas was aged 42 years old at the time of Maxine's death.

They were both White British.

- 1.3 There were no criminal proceedings related to Maxine's death. Northumbria Police began an investigation in October 2018, which concluded without holding any one responsible or charging any one with offences linked to her death. Consequently, no criminal proceedings were initiated within the Criminal Justice System (CJS).
- 1.4 The primary catalyst for considering a DHR was the unwavering determination of Janine and Linda, who campaigned tirelessly for justice. Their efforts, supported by the Advocacy After Fatal Domestic Abuse (AAFDA) Service, included presenting a summary of Maxine's case and a family statement to the North Tyneside CSP, making their contributions integral.
- 1.5 In August 2021, the North Tyneside CSP reviewed Maxine's case summary and the family statement, determining that it might meet the criteria for a DHR. A core group panel, composed of local statutory agencies familiar with the dynamics of domestic violence and abuse, convened to evaluate the relevant information against the Home Office criteria. The group unanimously agreed that the case met the requirements for a DHR, as per the Home Office's 2016 multi-agency guidance for conducting DHRs. Maxine's death was categorised as that of a person aged 16 or older which appeared to have resulted from violence, abuse, or neglect involving someone related to her or with whom she had been in an intimate relationship. This decision to conduct a DHR was welcomed by Janine, and Linda.
- 1.6 The group also considered the expectation under the DHR 2016 guidance that reviews should occur even when a victim has taken their own life, mainly if there are concerns about coercive controlling behaviour in the relationship. However, Maxine's cause of death was not classified as suicide, as she did not intend for her life to end, and the events surrounding her death did not suggest suicidal intent, a view agreed upon by Janine and Linda.
- 1.7 The Home Office was notified in writing on 23 September 2021 of the intention to conduct a DHR. Subsequently, all agencies that potentially had contact with Maxine and Thomas before her death were contacted and asked to confirm whether they had involvement with them.

Section 2: The Review Panel Members

Name	Position and organisation
Ellie Anderson	Assistant Director North Tyneside Adult Social Care (ASC)
Taryne Cooke Lisa Harrison Ian Callaghan David James	Detective Constable 2121 Detective Sergeant 3752 Detective Inspector 7577 Detective Inspector 118 Northumbria Police
Paula Shandran Yvonne Lawrence	Head of Service-Safeguarding Children and Adult Named-Nurse Safeguarding Children Northumbria Health Care NHS Foundation Trust (NHCFT),including-North Tyneside Talking Therapies (NTTT)
Jane Stubbings	Named Professionals Safeguarding Lead. Northeast Ambulance Service NHS Foundation Trust (NEAS)
Jackie Butson	The Department for Work And Pensions (DWP) ¹
Dawn Gauld	Reviewing Officer Cumbria

¹ The Department for work and pensions (DWP) is responsible for welfare, pensions and child maintenance

	Northumberland Tyne and Wear NHS Foundation Trust (CNTW), which includes. North Tyneside Recovery Partnership-(NTRP),
Dr Riaan Swanepoel	General Practitioner GP North Tyneside Integrated Care Board (ICB)
Katie Hewitt	Service Manager Harbour
Lindsey Ojomo Lisa Warke	North Tyneside Community Safety Partnership (known as Safer North Tyneside Board)

Section 3 Author of the Overview Report and DHR Chair

- 3.1 The author, Lynsey Eglington, has a wealth of knowledge and understanding of domestic abuse from various perspectives within statutory and non-statutory disciplines and advocacy, both frontline and strategic. Her knowledge is current, having completed the accredited DHR Chair training provided by AAFDA in 2024, 2021 and the training session on the 2016 statutory guidance update. The author has delivered Multi Agency Risk Assessment Conference (MARAC) training to six appointed Northumbria Police MARAC Chairs in 2021 this was deemed not a conflict of interest for the purpose of being the author for the DHR.
- 3.2 The DHR Chair, Lesley Storey, has extensive experience in domestic abuse and has completed the Home Office's comprehensive online training on Domestic Homicide Reviews, including specialised modules on chairing reviews and producing overview reports. She has also undergone accredited DHR Chair training provided by AAFDA, ensuring her knowledge is up to date. She actively participated in the AAFDA Annual Conference in March 2017 and training sessions on the 2016 statutory guidance update, further enhancing her expertise. The chair has not worked for any agency providing information for this review. The chair has previously undertaken a DHR In North Tyneside during 2022.

Section 4: Terms of Reference

4.1 The Initial Review Panel meeting took place on 16 March 2022, during which the terms of reference (ToRs) were discussed. When establishing the initial terms of reference for the DHR, the decision was made collectively not to seek information about Thomas. This decision was based on the unlikelihood of obtaining his consent and the potential violation of GDPR rules by sharing his information because Thomas's death had not been established at this time. This decision was made to ensure fairness and transparency in the review process, as it would have been unfair to include information about Thomas without his consent or without his death being confirmed.

4.2 Upon reviewing the initial draft of the DHR report, the panel confirmed on 12 December 2023 that Thomas, a domestic abuse perpetrator against Maxine and who was present at the time of Maxine's death, passed away in April 2022. The panel members unanimously agreed that assessing his offending behaviour in the context of the review concerning Maxine was essential. As a result, the DHR terms of reference were modified to include Thomas as a key subject of the review. All panel members were tasked with completing an Individual Management Review (IMR) regarding Thomas for the scoping period from March 2018 to October 2018.

4.3 In conducting the DHR into the death of Maxine, the Panel shall have regard to the following agreed ToRs:

- Establish the facts that led to the death in October 2018 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Maxine.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what these lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the DHR process.

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity.
- The scoping period covered by the review will cover events from March 2018. The Panel agreed that this period reflected the issues identified through scoping and contact with agencies until October 2018.
- Agencies with records before the start date above summarise their involvement. Any information from agencies that falls outside the timeframe that impacts or can impact the critical lines of enquiry should be included.
- If the Panel considers it necessary to use evidence and reflection to extend or shorten the period, the terms of reference may be amended accordingly. Authors of independent management reviews will provide, in any event, as part of the IMR, a summary of any relevant information before that date.
- Consider the period March 2018 to October 2018, subject to any information emerging that prompts a review of relevant earlier incidents or events.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the DHR.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Take account of the coroners' inquest regarding timing and contact with the family.
- Produce a report summarising the chronology of the events, including the actions of involved agencies, analysing and commenting on the actions taken, and making any required recommendations regarding safeguarding families and children where domestic abuse is a feature.

4.4 The review will also specifically consider:

- Were Maxine and Thomas known to local domestic abuse services, and if so, were there any concerns or warning signs identified? Where Maxine was not known to domestic abuse services, were there opportunities to refer, signpost or raise awareness of support services? Had services known/received a referral, what action would they have taken?
- Were any risk assessments completed, and if so, what was the nature of that assessment, and did it especially relate to domestic abuse? How was professional judgment used? What action was taken as a result?
- If risks were identified, what safeguarding measures would be in place?
- Were agencies aware of a history of domestic abuse about Maxine and Thomas? Were any safeguarding/prevention measures invoked with particular consideration to Clare's Law, Domestic Violence Protection Notice (DVPN) and Domestic Violence Protection Order (DVPO) and multi-agency safeguarding arrangements such as Multi Agency Risk Assessment Conference (MARAC) and Multi-Agency Tasking and Coordination (MATAC) ?
- Had Maxine accessed support for any previous relationship, and did this affect her decision to access support in her new relationship?
- Do the agencies involved have domestic abuse policies? If so, are they considered robust enough?
- Were there opportunities for professionals to routinely enquire about domestic abuse which were missed?
- What information was held or known by family, friends, colleagues or neighbours? Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse?
- How do agencies manage risks related to people who find it challenging to engage with services? If a person disengages, what actions are taken to understand why and to mitigate outstanding risks?
- What support was available for the family? How did agencies engage with Maxine's family, and were there any barriers preventing information sharing?

- What information is available for families to proactively advocate for their family members?
- Are practitioners clear about what to do with information from family once received? What barriers prevented appropriate information sharing or action?

Section 5: Summary Chronology and Key Issues Arising from the Review

- 5.1 On 20 November 2009, Adult Social Care from North Tyneside Council was invited to provide information at the North Tyneside Multi Agency Risk Assessment Conference (MARAC), identifying Thomas as a MARAC perpetrator.
- 5.2 In August 2016, Maxine left the abusive relationship. With the support of her sister Janine and Linda, she moved into a flat near them. Janine and Linda both played a protective and supportive role in Maxine's life, regularly helping with meals and transportation and encouraging Maxine to attend various addiction groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Project Answer (PA). Janine was concerned that these self-help groups exposed Maxine to individuals with more severe drug and alcohol addictions, making her vulnerable to exploitation.
- 5.3 In November 2016, Thomas told his GP he felt like "killing someone." The GP warned him of the serious legal consequences of such feelings. Although Thomas's speech was slurred, he could converse and admitted to breaking his coffee table and having conflicts with friends due to his temper. The GP suspected he might be mixing substances.
- 5.4 From 2015 to 2018, Northumbria Police identified Maxine as a repeat victim of domestic abuse, first with a previous partner and then with Thomas in July and October of 2018.
- 5.5 Maxine changed her GP on 5 July 2017 and completed a new patient questionnaire.
- 5.6 On 2 August 2017, her new GP was informed by the North Tyneside Recovery Partnership (NTRP) about a past physical assault by Maxine's previous partner, not Thomas, whom she began dating in April or May 2018.

- 5.7 On 6 August 2017, the NTRP requested that Maxine's GP not prescribe her Diazepam or Pregabalin, even though she was currently prescribed Pregabalin.
- 5.8 On 8 August 2017, Maxine's new GP received notes from her previous GP.
- 5.9 On 9 November 2017, during a GP visit, Maxine discussed her history of anxiety, depression, and past domestic abuse but denied suicidal thoughts. Despite the NTRP's earlier request, the GP increased her Pregabalin dosage and recommended a self-referral to North Tyneside Talking Therapies (NTTT) without addressing her support needs or the domestic abuse disclosures.
- 5.10 On 5 December 2017, Maxine self-referred to NTTT for an assessment scheduled for 15 December.
- 5.11 On 24 December 2017, her GP received a letter stating Maxine had attempted to overdose on Pregabalin and had left the Emergency Department before seeing a psychiatric team.
- 5.12 On 4 January 2018, Maxine's GP noted her mood fluctuations, anxiety, and reduced alcohol intake. She scored 11 on a mood disorder questionnaire, indicating a moderate problem.
- 5.13 On 17 January 2018, after Maxine locked herself in her house, concerns were raised to the police and her GP. The police found her conscious but confused after she threatened self-harm.
- 5.14 Maxine's history of overdoses was addressed by her supportive friends, Janine and Linda, during their collaborative care with her GP.
- 5.15 By late January 2018, hopeful about a 12-step recovery program, Maxine's GP agreed to have Janine and Linda assist her but would not increase her medication until her alcohol consumption decreased.
- 5.16 Janine learned that Maxine's NTRP key worker disagreed with the recovery program, asserting that Maxine could quit drinking at any time.
- 5.17 On 5 March 2018, an NTRP addiction worker reported that Maxine did not want her sister and partner (believed to be Thomas) involved in her treatment and had relapsed, drinking vodka since the previous Wednesday. During a review on 12 March 2018, Maxine expressed increased anxiety and had used cannabis, with her GP prescribing Diazepam. The GP noted that Maxine

appeared agitated and stressed the need for abstinence from alcohol before psychological treatment.

- 5.18 On 22 March 2018, Maxine self-reported drinking cider and using cannabis, and on 23 March 2018, she indicated her anxiety was overwhelming while seeking support from her GP. By 26 March 2018, Maxine stated she had remained alcohol-free but was using cannabis to manage her anxiety.
- 5.19 CNTW contacted Maxine by telephone on 3 April 2018 to encourage her to attend a women's group, Maxine disclosed she had relapsed and was advised to seek support from NTRP and AA.
- 5.20 On 6 April 2018, Maxine reported being alcohol-free but using cannabis daily and not attending support meetings. During a GP visit on 9 April 2018, she confirmed her ongoing cannabis use while expressing optimism about engaging with NTTT. Discussions about her swollen ankles and increased Pregabalin dosage occurred, with an agreement for a medication review in three months.
- 5.21 Maxine attended a review appointment with her addiction worker from CNTW, NTRP. During the appointment, she mentioned an altercation with her sister and expressed that she feels her sister is constantly checking up on her. Maxine was very tearful and reported that her GP had stopped her anti-depressants. While she had a glass of 'Bella' that morning, she did not appear intoxicated. Maxine also mentioned that she has a *"new man in her life and it was early days."* Additionally, she has undergone a scan for fluid retention in her legs.
- 5.22 On 26 April 2018, Maxine cancelled her appointment with NTTT to discuss a medication change with her GP. NTTT then contacted the GP to express concerns about Maxine's ability to engage in treatment during her adjustment to Diazepam, and the GP agreed on a timeframe of two to four weeks for this.
- 5.23 Throughout April 2018, Janine observed Maxine consuming alcohol and exhibiting erratic behaviour, becoming emotional and withdrawn. Maxine informed her that she had stopped taking her anti-depressants, and her GP had increased her Pregabalin dosage. Janine became increasingly concerned as Maxine discussed withdrawal symptoms on Facebook and appeared reclusive.
- 5.24 On 4 May 2018, the NTRP addiction worker expressed worries about Maxine's mental health to the GP, noting her use of illicit substances and advising against prescribing opiates without consultation. The GP subsequently spoke with Maxine on 9 May 2018, confirming she was

managing without Duloxetine and agreed to prescribe her seven Diazepam tablets, stating no further Diazepam would be issued until a plan was discussed with the addiction worker.

- 5.25 On 15 May 2018, Maxine tested positive for multiple substances, leading the NTRP addiction worker to believe her Pregabalin dose was too high. The addiction worker noted concerns about Maxine's "chaotic lifestyle" but did not provide details or context as to what led them to use the term "chaotic".
- 5.26 On 17 May 2018, Maxine called NTTT to cancel her appointment due to anxiety and disclosed that her GP had prescribed Diazepam. She mentioned meeting a friend, believed to be Thomas, at NTRP but left due to his alcohol consumption. NTTT documented concerns about her self-care.
- 5.27 During a clinical supervision on 25 May 2018, no specific safeguarding issues concerning Maxine were identified, and it was agreed that the practitioner would inform her GP about the concerns regarding her well-being.
- 5.28 The NTTT practitioner left a message for Maxine's GP, noting her missed appointments and ongoing vulnerability due to past domestic abuse.
- 5.29 The GP received a letter stating that Maxine had missed several appointments due to anxiety about leaving home. Psychological therapy services informed the GP that Maxine did not qualify for additional support from Community Mental Health Service (CMHS) and suggested she contact MIND.
- 5.30 An addiction worker at NTRP was informed by Thomas that Maxine was unwell, and they planned to attend together on 30 May 2018. Maxine later expressed frustration about transportation, as they lacked money.
- 5.31 On 31 May 2018, during an unscheduled appointment, Maxine disclosed drug use and mentioned being locked in her partner's flat. However, the worker failed to document follow-up actions or safety plans.
- 5.32 The review assessed the worker's response according to CNTW's domestic abuse Policy, which emphasises victim protection and risk assessments. Maxine's situation indicated domestic abuse, necessitating identification of the perpetrator and a safety plan.
- 5.33 The review found that Maxine's disclosure was not shared with other agencies, resulting in a missed opportunity for intervention. A risk assessment could have identified the risks posed by Thomas earlier.

- 5.34 Between April and May 2018, Janine noted that Maxine became distant after Thomas moved in, likely due to their drug use association.
- 5.35 In May and June 2018, Janine expressed concerns about Maxine's erratic behaviour and her relationship with Thomas to her GP.
- 5.36 After missing multiple appointments, Maxine contacted NTRP on 12 June 2018 about withdrawal symptoms. An appointment was scheduled for 13 June.
- 5.37 During the appointment on 13 June 2018, Maxine reported using various substances and having limited communication with Janine.
- 5.38 On 14 June 2018, Maxine met with her GP, appearing tearful due to concerns about her deceased mother's health and her own symptoms. Maxine stated that she had reduced her alcohol intake but noted that her new partner's drinking influenced her alcohol consumption. She mentioned that she had stopped taking Pregabalin a week prior, the details of Maxine's partner were not obtained and there was no professional curiosity.
- 5.39 On 17 June 2018, Northumbria Police responded to a report of taxi fare evasion at Maxine's address. Males were dropped off but did not pay the taxi fare. Officers spoke with Maxine, who stated that she had no knowledge of the incident. Since the suspects could not be identified, the case was closed.
- 5.40 On 18 June 2018, Maxine contacted her GP about losing her Pregabalin prescription. The GP noted an alert against prescribing it and attempted to contact Maxine's NTRP worker without success, the GP decided to issue a week's supply of Pregabalin.
- 5.41 On 25 June 2018, Thomas consulted his GP and mentioned having a partner, believed to be Maxine, who is knowledgeable about opiates. The GP overlooked contextual safeguarding despite being aware of Thomas's past aggression and his identification as a MARAC perpetrator.
- 5.42 On 27 June 2018, Maxine met with her GP and expressed a desire to continue taking Pregabalin for anxiety. The GP noted that she appeared "*bright*" and not intoxicated, advising her that losing the prescription again might prevent a replacement.
- 5.43 During another appointment on 27 June 2018, an addiction worker from NTRP learned that Maxine misplaced her Pregabalin prescription. She confirmed that she also took Tramadol and Co-codamol for pain and discussed family interactions.

- 5.44 On 7 July 2018, at 14:23, Maxine contacted Northumbria Police to report a domestic assault, identifying Thomas as the perpetrator. She stated that he had punched her in the face and that his dog had subsequently attacked him.
- 5.45 Officers arrived at the scene and arrested Thomas for assault against Maxine. They created a report for common assault. Maxine indicated she did not wish to provide a statement and would not support prosecution against Thomas. No documentation has been presented to the DHR, which shows that the attending officer explored the reasons or barriers that led to Maxine's decision not to support the prosecution.
- 5.46 During the police interview, Thomas denied assaulting Maxine. Due to insufficient evidence, he was released with no further action taken. A DVPN was issued, and a DVPO was obtained through the courts by the police.
- 5.47 The DHR process did not receive any information from Northumbria Police regarding any additional safeguarding and protective measures implemented or considered to mitigate the risk Thomas posed to Maxine, aside from securing a DVPO. It is also unclear how the conditions imposed on Thomas by the DVPO were monitored and managed. This lack of clarity contrasts Northumbria Police's domestic abuse Improvement Action Plan, which was implemented in April 2018. The Action Plan focuses on the force's response to domestic abuse and encompasses four key areas known as the 4Ps: PREPARE, PREVENT, PROTECT, and PURSUE.
- 5.48 It is widely recognised that proactively securing DVPN and DVPO would be considered best practice under the PREVENT arm of the Action Plan. However, there was no evidence that the police were monitoring Thomas to ensure he was adhering to the DVPO conditions put in place to safeguard Maxine, which significantly impacted upon the DVPO's effectiveness.
- 5.49 The DHR process revealed that the police officers failure to monitor the DVPO conditions was not widely known within the force. This led to different departments, such as those managing Potentially Dangerous Persons (PDP) and Multi Agency Public Protection Arrangements (MAPPA), genuinely believing that Thomas's offending behaviour was being managed at level one, which is what DVPO is categorised as. This impact was evidenced in the letter from their Professional Standards Department (CO/574/19) to Janine, which made specific reference to this issue.
- 5.50 During an investigation by the Professional Standards department, it was determined whether Thomas was eligible to be referred internally by the police to MATAC, which manages domestic abuse perpetrators only. The

inquiry found that certain criteria needed to be met before consideration of referring a domestic abuse perpetrator to MATAC was made. These criteria included the perpetrator being named as a suspect or offender, listed on more than one domestic abuse incident record, and listed against two or more different victims within the last two years. To conclude on the MATAC matter, the Northumbria Police MATAC manager was consulted for their opinion on whether Thomas would have been eligible for MATAC. The MATAC manager stated that each application for MATAC is considered on its own merits. Additionally, they would assess any application from an officer who had concerns for a victim of domestic abuse. After reviewing Thomas's criminal history retrospectively, the MATAC manager confirmed that Thomas would not have been eligible to be managed under MATAC, *"Having reviewed Thomas's offending and the potential of the MATAC process in these circumstances, please be assured Thomas does not fit the criteria for MATAC"*. However, no explanation was given as to how this conclusion was reached, whether Thomas being managed at level one due to a DVPO being secured had any impact on that decision or whether the three reported domestic abuse incidents (7 July 2018 and two on 17 October 2018) risk level of 'standard' attributed to that decision.

- 5.51 The DHR author provides a detailed analysis of the initial risk grading conducted by attending officers regarding three incidents (7 July 2018 and two on 17 October 2018) of domestic abuse. All incidents were classified as 'standard' risk, identifying Maxine as the victim and Thomas as the perpetrator. The Professional Standards Department (CO/574/19) requested a senior police officer with expertise in safeguarding and domestic abuse to review the risk assessments carried out by the initial attending officers. The senior officer agreed with the assessment of 'standard' risk. However, during the DHR process, it was revealed that the actual risk to Maxine was significantly higher than categorised. This conclusion was based on information from Northumbria Police and insights provided by Janine, who shared a letter from Northumbria Police Standards (CO/574/19) which heavily documented that the risk in each domestic abuse incident that Thomas subjected Maxine to was assessed as standard risk.
- 5.52 The information obtained suggests that the Domestic Abuse Stalking Honour Based Violence (DASH) Risk Indicator Checklist (RIC) assessments were incomplete, raising questions about whether they accurately reflected the risk that Thomas posed to Maxine. Additionally, the professional judgment exercised by the police officer requesting the DVPO contradicted the initial 'standard risk' evaluation.

- 5.53 The DASH-RIC comprises evidence-based questions designed to identify risk factors present in domestic abuse incidents. A score of 14 or more "yes" responses indicate a 'high' risk of serious injury or harm. However, a lower score does not necessarily imply that there is no risk; it might suggest that the victim is too afraid to disclose certain aspects of the abuse. Thus, professional judgment is crucial, particularly when the scoring does not align. This was particularly relevant in the police officer's justification for requesting a DVPO, which suggested a higher risk level.
- 5.54 The DHR process noted that classifying the risk as 'standard' prevented referrals to the MARAC being submitted by the police. MARAC cases require a completed DASH-RIC and professional judgment to identify them as "high-risk." A coordinated safety plan is then developed to protect victims while creating an action plan that involves a collaborative multi-agency approach to manage and reduce the perpetrator's offending behaviour and associated risks.
- 5.55 In reviewing two reported incidents of domestic abuse on 17 October 2018, one from Maxine's neighbours expressing concerns and the other from Maxine herself, it was noted that the initial attending officers considered these incidents in isolation rather than collectively.
- 5.56 In all three incidents of domestic abuse (7 July 2018 and two on 17 October 2018), the DASH-RIC assessments completed by the initial attending officers indicated that Maxine's vulnerabilities—particularly regarding her mental health (including historical overdoses and self-harm incidents) and her reduced ability to seek help while under the influence of alcohol—were not adequately considered as risks. Specifically, during the incident reported on 7 July 2018, the fact that physical abuse occurred early in Maxine's relationship with Thomas was also overlooked as an additional risk factor. Clear evidence indicated an increase in both the frequency and severity of the abuse.
- 5.57 Northumbria Police were aware from their systems that Thomas had previously been identified as a MARAC perpetrator with another partner and had a history of being a serial domestic abuse perpetrator with multiple prior partners.
- 5.58 Obtaining detailed information from Janine and Linda regarding the DVPN, and the DVPO, the risk level determined by the attending police officer, and the risk Thomas posed to Maxine should have prompted Northumbria Police to disclose information to Maxine under Clare's Law, also known as the 'Right to Know.' This legislation obligates the police to inform individuals about potential risks of harm from domestic violence or abuse, even if such information is not explicitly requested.

5.59 The police officer attending the domestic abuse incident on 7 July 2018 was aware of the potential danger Thomas posed to Maxine, as indicated by the DVPN that had been issued. The officer submitted the required documentation to the Magistrates Court, requesting that a DVPO be imposed. Below is an excerpt from the completed documentation submitted to the court, which highlights the significant risk that the officer believed Thomas posed to Maxine:

“Of concern is that Thomas is down on police systems as being a domestic violence suspect against several women, 54 times since 2000 and has various offences on his record for differing degrees of assault against person ranging from common assault to grievous bodily harm.”

“This clearly shows Thomas’s propensity for violence. It is necessary therefore to invoke this DVPN to ensure the safety of Maxine from Thomas due to this clear extensive DV history and current incident. The conditions requested are necessary to protect the victim from further violence or threats of violence”.

- 5.60 During the DHR process, it was revealed that Northumbria Police did not provide Maxine with crucial information about the risk of harm posed by Thomas, who had a history of serial domestic abuse and violent crimes against others. This information was not shared with Maxine under the 'Right to Know' policy, which prevented her from making an informed decision about her relationship with Thomas and assessing the risk of abuse on 7 July 2018, as well as following two other reported incidents of domestic abuse on 17 October 2018.
- 5.61 At the time of the DHR scoping period, Thomas was not under the supervision of the Probation Service. However, on 17 July 2018, Probation received a court officer entry on their system, which noted information from a third party indicating that a DVPN had been issued. Additionally, a DVPO was substantiated in court on 10 July 2018, with Maxine identified as the protected person and Thomas as the perpetrator. Since the DVPN is a civilian order, the Probation Service was not involved in the case.
- 5.62 On 11 July 2018, four days following Maxine's reporting being physically punched in the face by Thomas to Northumbria Police, Maxine contacted her addiction worker at NTRP by telephone. She reported being assaulted yesterday by a female service user, which she had sustained a black eye, reporting that it was sore. The addiction worker noted that Maxine's prescription was due that day, resulting in one day missed due to Maxine not

being able to collect her prescription. There were no recordings confirming that the addiction worker had explored who the female service user was or the circumstances surrounding the assault, which coincided three days after Thomas had assaulted Maxine. The review has not been able to determine if a female service user assaulted Maxine or if Maxine was concealing the physical assault Thomas subjected her to from her addiction worker out of fear or control that Thomas exerted over her.

- 5.63 The CNTW NHS noted in their IMR that the Functional Analysis of Care Environment (FACE) risk assessment needs to be updated whenever there is a change in risk. Maxine's increasing substance misuse and her disclosure of being a victim of domestic abuse necessitated a review of the FACE risk assessment. However, a FACE risk assessment was not conducted when Maxine reported being locked in her flat on 31 May 2018, nor when Thomas received a warning in May 2018 regarding his offensive and abusive behaviour due to the risks he posed to others. Additionally, a FACE risk assessment was not conducted on 20 September 2018, when Maxine attended Thomas's NTRP appointment and was identified as his partner, nor after Maxine was assaulted by a female service user on 11 July 2018.
- 5.64 In August 2018, Maxine's addiction worker from NTRP continued to have sessions with Maxine, and it was during this period that Maxine was suffering domestic abuse from Thomas. In August 2018, following Thomas being assaulted and suffering a brain injury, Maxine acted as Thomas's carer following his release from the hospital. During this period, Janine would receive constant telephone calls from Maxine, who sounded extremely distressed and found it challenging to cope with Thomas's behaviour; on several occasions during these telephone calls, Thomas was heard shouting in the background.
- 5.65 In early September 2018, Janine was informed by a neighbour that there were rumours that Maxine was now using cocaine and heroin. Janine contacted her by telephone, expressing concern regarding the rumours that Maxine and Thomas did not appreciate, resulting in both shouting abuse at her. This was the last time that Janine had contact with Maxine.
- 5.66 On 20 September 2018, Maxine attended a clinical appointment for Thomas at the NTRP. During this appointment, the practitioner noted that Maxine was Thomas's partner. At that time, the practitioner had access to Thomas's patient record, which indicated that he had been identified as a perpetrator in the MARAC in 2009. The record also documented that, in May 2018, Thomas received a warning regarding his offensive and abusive behaviour due to the risks he posed to others. As a precaution, it was recommended that Thomas

should not meet alone with practitioners during appointments to ensure safety.

- 5.67 Unfortunately, during the appointment on 20 September 2018, the practitioner failed to exercise professional curiosity or consider that if Thomas posed a significant risk to staff, he could also be a danger to Maxine as his partner. This oversight raises serious concerns about the practitioner's understanding of the risks that Thomas presented to others. Consequently, this diminished the opportunity to identify the risk he posed to Maxine and limited the protective measures that could have been implemented to support and safeguard her.
- 5.68 In October 2018, medical records confirm Maxine was transported to Emergency Department (ED) by Ambulance following being found at her home address unresponsive by her partner, Thomas. Maxine's medical records suggest the reason is 'probably an overdose of verapamil'; however, there is no source or evidence-based reasons documented in the record explaining why it was 'probably an overdose of verapamil'. Cardiac arrest and alcohol dependency are reported on the record. It was noted in the medical records by ED that Maxine had multiple bruises all over her body, variable ages and that Northumbria Police attended ED, who had expressed concerns at the lack of response from Maxine's partner, Thomas, who was also present. A statement was made that Maxine had fallen last night, but no elaboration or where that statement had come from.
- 5.69 In October 2018 Northumbria Police: received a report of a concern for a female. The Police were contacted by the Ambulance Service at 0923hrs, reporting that Maxine had taken an overdose; the Ambulance Service received a report from a neighbour confirming the information passed on from the neighbour related to concerns around domestic abuse and drug use within the address. police officers were dispatched to Maxine's address within 7 minutes of receiving the call.
- 5.70 In October 2018 Northumbria Police commenced an investigation into Maxine's death because it was deemed sudden and unexpected, which resulted in Thomas's arrest on suspicion of raping Maxine in October 2018. A Home Office Postmortem was undertaken as part of the investigation in October 2018.
- 5.71 The DHR process has made multiple inquiries with Northumbria Police to secure details and an understanding of Thomas's arrest on suspicion of raping Maxine to objectively assist the DHR process further by providing additional information relating to the violence, abuse, or neglect that it appears Maxine has been subjected too. The author wishes to reiterate that it

is not the intention of the DHR to enquire into how Maxine died but to explore relevant trails of abuse explicitly. As a result of the DHR process adopting an inquisitive thinking approach and securing valuable additional information from Northumbria Police, it identified good practice by Northumbria Police in requesting a Home Office Postmortem be undertaken. The College of Policing: Death Investigation in England and Wales, Sudden and Unexpected Deaths - stipulates that where the outcome of the police investigation is that the death is suspicious, the Police take on priority in the investigation, and in such cases, best practice is for a Home Office Postmortem to be conducted.

- 5.72 A report published by the Forensic Science Regulator 1 in December 2015 highlights the potential to 'miss' a homicide. To reduce the likelihood of such a miss, the police service must deal with death systematically and professionally. A Home Office Postmortem is considered a systematic arm to assist the Police in determining where homicide is suspected. Forensic Pathologists are registered on a list held by the Home Office. These are known as 'Home Office Registered Pathologists', and the Home Office Registered Pathologists can only conduct Home Office Postmortems.
- 5.73 The DHR report's author wants to clarify that despite making additional inquiries with Northumbria Police to obtain information specifically related to the abuse and violence trail, the information secured regarding Thomas was limited. The analysis presented in the report is based solely on Northumbria Police information obtained indirectly through the DHR process from Janine, who kindly provided the author with original Northumbria Police documentation, confirming its authenticity, and the author's in-depth knowledge and experience of police powers, processes and procedures regarding arrest and post-arrest for suspects.
- 5.74 Thomas was interviewed under caution and gave an account that he and Maxine were taking cocaine and had consensual sex the night before her death and denies ever assaulting Maxine in their relationship. Thomas was released with no further action.
- 5.75 The Home Office Postmortem documented the preliminary cause of Maxine's death as cardio-respiratory arrest, and the summary of findings were:
- no injuries to account for death,
 - no natural disease to account for death,
 - no evidence of significant assault,
 - no pathological evidence to indicate third-party involvement in the death.

5.76 The Home Office Pathologist who conducted the Home Office Postmortem in October 2018 in their statement stated:

"Thus, the postmortem examination has shown no injuries to account for Maxine's death. There were large numbers of bruises to the arms, limbs and torso, but these would not have caused death. Many of the bruises are likely to result from a number of falls and Maxine being somewhat unsteady on her feet. The bruising to the upper arms and around the armpits will likely result from gripping. Still, it is impossible to determine where this was due to some form of restraint or whether it was during attempts to render assistance to Maxine. However, it has been caused; it has not played a role in her death".

5.77 Northumbria Police, following the findings from the Home Office Pathologist, did not pursue a Homicide investigation from that point.

5.78 The author aims to provide context and insight for Maxine's family and the reasons why Thomas was arrested for rape instead of murder. The author, after consulting with multiple Northumbria Police DHR panel members and drawing from her extensive experience, has formed the professional opinion that the evidence secured within the review suggests that police officers who attended the scene and hospital in October 2018 were suspicious of Thomas's behaviour surrounding Maxine's death. This suspicion was noted in Maxine's A&E medical records, which stated, *"The patient had multiple bruises all over her body of variable ages. Police present were concerned about a lack of response from the partner (Thomas) who stated she had fallen last night."*

5.79 The author is confident that the Police evaluated all the evidence they had at that point and made the decision to arrest Thomas on suspicion of rape because they reasonably suspected that Maxine could not consent to sexual intercourse with Thomas due to being affected by drugs. Although Thomas was not arrested for murder, the Police expedited vital, urgent lines of inquiry, including lawfully detaining, forensically examining, and interviewing Thomas, preserving and forensically examining one of the primary scenes (Maxine's home), and requesting a Home Office Postmortem to be conducted in October 2018.

5.80 Arresting Thomas for rape and not murder demonstrates creative professional thinking within the narrow confines of policing laws and powers. The author is confident that the Police were unable to progress criminal matters further against Thomas due to the Home Office Pathologist's findings: *"no natural disease to account for death, no evidence of significant assault, and no pathological evidence to indicate third-party involvement in the death"*.

- 5.81 The Police must meet the Crown Prosecution Service's (CPS) charging codes to secure an authorised charge from CPS. The charging codes determine whether there is enough evidence to provide a realistic prospect of conviction against each defendant on each charge and, if so, whether a prosecution is needed in the public interest. The criminal threshold is beyond all reasonable doubt, placing a higher burden of proof.
- 5.82 The author of the DHR report considered Janine's and Linda's experience described in the elegy, detailing a feeling of discombobulation. In October 2018, Maxine's family was aware that professionals were contemplating Maxine's death potentially because of Homicide, Suicide or Overdose through drugs, and they were aware that Thomas had been arrested on suspicion of rape. Maxine's family's confusion and understandable alien experience of processes surrounding such matters prompted the DHR process to explore further the immediate communications between the Northumbria Police Investigation Team and Maxine's family. It is worth noting that these unanswered questions surrounding Thomas's arrest have had a profound negative impact on Maxine's family. Janine and Linda expressed that not knowing has caused immense distress.
- 5.83 The author of the DHR contacted Northumbria Police to inquire about the deployment of a Family Liaison Officer (FLO) during their investigation into Maxine's death. FLOs are specially trained officers who act as a bridge of communication between bereaved families and investigation teams. They are usually assigned to incidents such as fatal accidents, murders, unexplained deaths, or disasters involving multiple fatalities. The primary role of a FLO is to gather evidence and information from the family to contribute to the investigation while preserving its integrity. The FLO also provides support and information sensitively and compassionately, ensuring that the needs of the investigation give family members timely information. It was established that a FLO had not been deployed during the investigation into Maxine's death.

Section 6: Conclusions

- 6.1 This case is deeply sad, and when all the information is considered together, it reveals an escalating situation in which Thomas poses a significant risk to Maxine. It's important to note that not all the details presented in this report were known to any one agency at the time.
- 6.2 In the review, Maxine has been identified as a vulnerable woman facing several life stressors that contribute to her vulnerability. These include the traumatic loss of her mother at a young age, bullying at work, and a history of domestic abuse. The review reveals that Maxine sought help from various agencies, describing her experiences of control and physical abuse in her long-term relationship with her ex-partner and in her recent relationship with Thomas, who has been identified as a serial and prolific perpetrator of domestic abuse. The domestic abuse that Maxine was subjected to has significantly impacted Maxine's mental and physical health, hindering her ability to make informed choices and engage effectively with agencies that support her with alcohol and drug addiction, as well as her mental health.
- 6.3 Maxine reported feelings of anxiety, low mood, depression, suicidal thoughts, and previous attempts at overdose to her GP, the NTRP, and the NTTT. She disclosed to her NTRP worker that '*she and her partner had been arguing. He locked her in his flat yesterday*' was not explored, risk assessed or communicated to other statutory services. The review emphasises the difficulties in effectively measuring the profound impact that domestic abuse had on Maxine's mental health. This abuse led to an increased reliance on illicit drugs and prescribed medications as coping strategies for managing the stressors in her life and the domestic abuse she experienced until her death in October 2018.
- 6.4 In summary, the analysis reveals that mental health issues, along with alcohol and substance abuse experienced by both Maxine and Thomas, significantly contributed to Thomas using these issues to strengthen and exert control over Maxine, escalating to physical abuse, during their relationship.
- 6.5 The review highlighted the essential importance of assertive outreach, especially for individuals dealing with issues like domestic abuse, mental illness, or substance abuse. By taking this proactive and hands-on approach, agencies can better support and protect the individuals they engage with while also gaining a clearer understanding of the risks they may face.
- 6.6 Although some good practices were observed in responding to Maxine's situation, there is still room for improvement. A thorough understanding of domestic abuse and its profound effects on mental health is absolutely

essential. Adopting a trauma-informed approach is crucial, as is fostering professional curiosity among practitioners to fully evaluate the risks presented by individuals like Thomas. This proactive mindset will lead to better identification of potential threats and empower professionals to discern subtle signs of domestic abuse. By triangulating risks and exploring supportive measures, we can greatly reduce these dangers. Additionally, we must prioritise Maxine's ability to recognise the risks that Thomas poses, ensuring she is safeguarded effectively.

Section 7 Recommendations from the Review

	Recommendations
1	All agencies to implement policies and training that incorporate the six trauma-informed principles: Safety, Trustworthiness, Choice, Collaboration, Empowerment, and Cultural Consideration to recognise and address the barriers that victims of domestic abuse face.
2	All agencies to ensure that effective measures are in place to assist victims and ensure that safeguarding practices are integral to responses to abuse disclosures.
3	The Chair of the Community Safety Partnership Board to write to the Chair of the Domestic Abuse Partnership Board to request the Domestic Abuse Partnership Board to lead on developing and implementing an awareness campaign for "Findaway" as part of the Board's overall communications plan. The goal of the campaign is to empower families, friends, and communities to recognise early signs of domestic abuse, take decisive action, promoting strong collaboration between communities and agencies to address domestic abuse and ensure the safety of victims together.
4	The ICB to develop training sessions for GP practice safeguarding leads and GPs to inform them about the services provided by NTRP, including the referral process.
5	The ICB to ensure training is available and completed by all identified staff to ensure they are fully compliant within the roles and competencies of Adult Safeguarding.
6	The ICB to reinforce the importance of identifying any persons at risk of domestic abuse and signposting is reinforced in all domestic abuse training.
7	The ICB to undertake audits to ensure GP practices are referring and signposting to relevant specialist services.
8	CNTW and NTRP to review their processes for patients who Do Not Attend (DNA) particularly when there is a safeguarding concern or there is a presence of domestic abuse.
9	NTRP and CNTW to identify and manage domestic abuse risk within the context of continuous professional development for frontline practitioners and supervisors. This should focus on enhancing their competency and exercising professional curiosity.
10	NTRP and CNTW to review procedures identifying domestic abuse risks and patients whose behaviours may post a threat to others.
11	CNTW to highlight the importance of historical information as a key indicator of potential future risks as part of risk assessment training.
12	CNTW to review their consent and confidentiality policy and take into account the importance of establishing clear communication with the patient's family or caregivers.
13	CNTW and NTRP to reflect and adopt a debrief learning approach with frontline practitioners embedding a consistent response to disclosures of domestic abuse by patients and the term professional curiosity is embedded in the debrief learning.
14	Northumbria Police to review the internal procedures related to the disclosure of information under Clare's Law, which grants individuals the "Right to Know".

15	Northumbria Police to review the internal procedures and processes that pertain to the deployment of Family Liaison Officers (FLO) in cases of fatal accidents, murders, unexplained deaths, or disasters involving multiple fatalities. Ensure that there is consistency in the consideration of using a FLO, and if one is not to be utilised, communication with bereaved family's needs to incorporate the six Trauma-informed principles: Safety, Trust, Choice, Collaboration, Empowerment, and Cultural consideration.
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Section 8: Glossary

A&E	Accident and Emergency
ASC	Adult Social Care
ICB	Integrated Care Board
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DVPN	Domestic Violence Protection Notices
DVPO	Domestic Violence Protection Order
ED	Emergency Department
ESA	Employment and Support Allowance
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MARAC	Multi Agency Risk Assessment Conference
NFA	No Further Action
NHCFT	Northumbria Health Care NHS Foundation Trust
NHSE	National Health Service England
NTRP	North Tyneside Recovery Partnership
CNTW	Cumbria Northumberland, Tyne and Wear NHS Foundation Trust
CMHS	Community Mental Health Service
PDP	Potential Dangerous Person
MAPPA	Multi - agency Public Protection Arrangement
MATAC	Multi-Agency Tasking and Coordination
FLO	Family Liaison Officer
NTTT	North Tyneside Talking Therapies
NTRP	North Tyneside Recovery Partnership
CSP	Community Safety Partnership
CJS	Criminal Justice System
CPS	Crown Prosecution
AAFDA	Advocacy After Fatal Domestic Abuse
ToR	Terms of Reference
AA	Alcoholics Anonymous Project Answer
NA	Narcotics Anonymous
PA	Project Answer