Safer North Tyneside
Community Safety Partnership

Domestic Homicide Review

‘Maxine’

Died October 2018

Review Chair: Lesley Storey

Author: Lynsey Eglington

Date: 28 January 2025

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Foreword from the Chair of the Safer North Tyneside Partnership

Firstly, I would like to offer my sincere condolences to Maxine's family. It is clear that Maxine was loved deeply and that her loss is felt profoundly. The family's grief at the loss of Maxine is palpable in their very moving and honest elegy.

Their elegy sets an important tone for this review and report. It tells us, through their eyes, their shock, their devastation and their questions in the aftermath of Maxine's death.

Reading this line in particular *"the scene we were left with when forensics were done"* gave me chills. It is a stark reminder to us all about what a family is left with when a loved one dies in tragic circumstances. Agencies and professionals come in and do their jobs, but then they leave. And the family then has to navigate lots of formal processes; registering a death, arranging the personal affairs of the person they loved, dealing with housing issues, sorting through belongings, the Police investigation, the post-mortem examination, the Coroner's Inquest...all while grieving their loss. It reminds us that during all these processes, which absolutely must be done, we should always remember that there are people at the heart of it. There is a devasted family who need our collective support.

Whenever there is an unexpected death, families are left with lots of unanswered questions. It is the view of our Safer North Tyneside Partnership that the Domestic Homicide Reviews we undertake should help to answer some of those questions clearly and with compassion. The importance of this should never be underestimated; it can bring enormous comfort to families.

There is a lot of learning to take from this review and I know that agencies have committed to fully implementing and embedding the learning and recommendations in this report. The Safer North Tyneside Partnership will take ownership of the action plan to ensure that we make changes to safeguard more people in the future.

Finally, I would like to pay tribute to the family's tenacity in both their love and support for Maxine throughout her life and in their extensive endeavours after her death to seek out answers to their questions. Their determination led the Safer North Tyneside Partnership to commission this review. The family have been absolutely integral to the review process and on behalf of the Partnership I offer my sincere thanks for helping us to hear Maxine's voice and theirs.

Councillor Karen Clark

Chair of the Safer North Tyneside Partnership

Foreword by the Chair and Author of the Review

This Report outlines the findings and future learning recommendations following the Domestic Homicide Review into the death of Maxine in October 2018. The Panel wishes to express their sincere condolences to Maxine's family and to thank them for the valuable information they have provided to the review process, which they secured through their commitment and perseverance. Without doubt Maxine is deeply missed everyday by those that knew and loved her.

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.

DHR Chair, Lesley Storey

DHR Author, Lynsey Eglington

Glossary Summary:

ASC	Adult Social Care
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
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
SII	Serious Incident Investigation
AAR	After Action Review
DWP	Department Working Pensions
ICB	Integrated Care Board
DAP	Domestic Abuse Partnership

1 Introduction

1.1. This statutory Domestic Homicide Review (DHR) examines agency responses and support given to Maxine, a resident of North Tyneside, before her death in October 2018.

1.2. The DHR seeks to adopt an open-minded, thorough, inquisitive approach whilst examining past agency involvement with Maxine, her intimate partner, and her family to help identify any relevant trail of abuse before Maxine's death, whether support was provided and taken up and whether there were any barriers to accessing support. The review seeks to identify appropriate key recommendations to make the future safer. The recommendations agreed upon by the panel members and their respective agencies strive to improve future access to services and professional multi-agency practices to ensure that lessons are learned from Maxine's experience.

1.3. The DHR, in addition to agency information, collaboratively sought views from Janine and Linda, which was crucial in securing a personal insight into Maxine's life and the reality that she faced from the very people who loved her dearly and were heavily involved in trying to support and safeguard Maxine.

1.4. The DHR Panel feels it is essential to stress at the beginning of this review that it is about Maxine and her lived experience. Maxine was 39 years old and, at the time of her death, was unemployed; however, she had previously worked for many years as a care worker and was warmly regarded by her employers, colleagues, and the people she cared for. Below is an extract from Maxine's work colleague that Janine kindly provided the DHR with:

"Maxine was well loved and was an excellent worker. Max would always come into work with an all-year-round tan, super bright lipstick and outrageous eyeliner raring to go.

The residents thought the world of Maxine and her infectious smile and laughter brightened up their day.

One of the residents has bought themselves a bracelet with Max's name engraved on it – with a message – Always remembered".

1.5. The DHR Panel acknowledges that the review could not conclusively link Maxine's death to the domestic abuse that she had alleged during the scoping period (March 2018 to October 2018), nor was it the intention of the DHR to enquire into how Maxine died. That matter had been examined by Northumbria Police, who commenced and conducted an investigation in October 2018 into Maxine's death, resulting in no person or persons being held responsible or

criminally charged with offences causing or attributing to Maxine's death and no criminal proceedings were brought before the Criminal Justice System (CJS).

1.6. The DHR Panel and Janine and Linda agreed that Thomas, Maxine's intimate partner, is pertinent to the review because he was the only person present at the time of Maxine's death and resided with Maxine at her home address.

1.7. Police arrested Thomas in connection with Maxine's death in October 2018, the offence being Rape. There was a history of domestic abuse reported to the Police during the scoping period, identifying Thomas as the perpetrator and Maxine as the victim of physical and emotional abuse, including coercive controlling behaviour, which was evident by the information Janine and Linda kindly provided the review with. Their method of securing this information is commendable and is a testament to their love for Maxine and their sheer tenacity.

1.8. During the DHR review, it was learnt that Thomas was deceased from a drug-related death. Therefore, the DHR review could not independently obtain and incorporate Thomas's perspective into the review. A summary of what Thomas said during his police interview was provided through the information that Janine and Linda had obtained from Northumbria Police**,** documented within Chronology Table 2.

1.9. The DHR wishes to highlight complexities surrounding Maxine's cause of death: October 2018, Post-Mortem documented opinion as to the cause of death was *'the effects of a combination of verapamil and cocaine'*, and the coroner's certificate of the fact of death was recorded *'Cardiorespiratory Arrest'* in October 2018. On 31 May 2019, Maxine's death certificate (date of registration 13 May 2019) documented conclusion of cause of death as '*Abuse of Drugs'.* Janine and Linda stated that the coroner verbally stated to them both that there had been *'systematic failings*' in Maxine's care, however this has not been documented in any of the coroner's documentation.

1.10. There were no professional medical opinions or facts identifying or attributing Maxine's physical injuries to the cause of her death or to homicide or suicide, which impacted upon a Domestic Homicide Review (revised statutory guidance dated December 2016[1]) being

[1] Domestic Homicide revised statutory guidance December 2016 it is now expected that such reviews will also take place 'where a victim took their own life and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship'.

considered and/or a referral submitted by the primary agencies: Northumbria Police, Northumberland Tyne and Wear NHS Foundation and Mental Health and Primary Care and Cumbria, who had been supporting and had interactions with Maxine during the scoping period. It is worth noting that any professional or agency may refer such a homicide or suicide to the North Tyneside Community Safety Partnership (CSP) in writing for a DHR to be considered if it is believed that there are important lessons for inter-agency working to be learned. The chair of the CSP holds responsibility for establishing whether a homicide or suicide is to be the subject of a DHR.

1.11. Janine and Linda state that in April 2019 the Coroner stated that they were struggling to determine a cause of death.

1.12. The main reason a DHR was considered was through the grit and determination of Janine and Linda's campaign for justice, supported and guided by Advocacy after Fatal Domestic Abuse (AAFDA) Service[2], which involved a summary and a family statement being presented before the North Tyneside CSP.

2 Timescales for the DHR process

2.1 In August 2021, a summary of Maxine's case and a statement from the family were reviewed by the North Tyneside CSP, which felt it might meet the DHR criteria; a core group panel of local statutory agencies with an understanding of the dynamics of domestic violence and abuse was held to review the relevant information against the Home Office criteria. The group made a unanimous decision that this met the criteria for a DHR following the Home Office 2016 multi-agency guidance for the conduct of DHRs; Maxine's death was that of a person aged 16 or over who has, or appears to have, resulted from violence, abuse or neglect and involved *'a person who was related or with whom she was or had been in an intimate relationship'*. The decision to conduct a DHR was welcomed and supported by Janine and Linda.

2.2 The group did consider, under the DHR Office 2016 guidance, the expectation that DHRs will also take place '*where a victim took their own life and the circumstances give rise to concern,*

This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)1 .The Act states: (1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. https://assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf

[2] Advocacy After Fatal Domestic Abuse (AAFDA) is an independent and unique organisation offering specialist and expert Advocacy and peer support after fatal domestic abuse.

for example, it emerges that there was coercive controlling behaviour in the relationship', however, Maxine's cause of death was not documented as suicide (that she did the act which ended her life and intended by that act that her life would end) and nor were the events and circumstances surrounding Maxine's death suggestive of suicide, which Janine and Linda agreed with.

2.3 Following the decision by the Chair of the CSP, the Home Office was notified in writing on 23 September 2021 of the intention to undertake a DHR.

2.4 An Independent Chair and Author were subsequently appointed, and the Initial Review Panel meeting occurred on 16 March 2022 where terms of reference were discussed. The full terms of reference were circulated to panel members with the Individual Management Review template on 23 March 2022.

2.5 Following this, a subsequent meeting took place with the Individual Management Reviews (IMR) authors and Panel members on 17 February 2023 to review all IMRs and discuss key learning identified for inclusion in this overview report.

2.6 In conjunction with the agreed ToRs, there was encouraging emphasis placed upon the relevant agencies to produce a comprehensive and well-structured IMR of their full involvement with Maxine and Maxine's intimate partners and any other information considered pertinent to the DHR, including pre and post scoping dates.

2.7 The draft overview report was circulated on 6 December 2023, and a further Panel meeting to review this took place on 12 December 2023.

2.8 When establishing the initial terms of reference for the Domestic Homicide Review, the decision was collectively made not to pursue information about Thomas. This decision was based on the unlikelihood of obtaining his consent and the fact that sharing his information would violate GDPR rules.

2.9 Upon reviewing the initial draft of the DHR report, the panel confirmed on 12 December 2023 that Thomas, the alleged domestic abuse perpetrator, passed away in April 2022. Panel members unanimously agreed that assessing his offending behaviour in the context of the review concerning Maxine is crucial. Consequently, the DHR ToR was modified to identify Thomas as a vital subject of the DHR. All panel members were tasked with completing an IMR

concerning Thomas within the scoping period from March 2018 to October 2018. The IMRs concerning Thomas were submitted to the DHR chair and author on 16 February 2024. The draft DHR report was then shared with Maxine's family members, Janine and Linda, as well as their advocate from the Advocacy After Fatal Domestic Abuse on 21 March 2024. To ensure inclusivity, the author extended an invitation to Janine and Linda to share their comments and provide feedback on the DHR draft.

2.10 The amended DHR report was circulated on 17 June 2024 to all Panel members, requesting final comments by 5 July 2024.

3 Confidentiality

3.1 The findings of this review are confidential until the report is published; it is marked Official Sensitive (Government Security Classifications May 2018) and is only available to those professionals involved, their line managers and members of the Review Panel until after the Home Office Quality Assurance Panel approves the report. It is usual and recommended practice to protect the identities of all the review subjects using pseudonyms; however, Janine had consented to the DHR not using pseudonyms but her real name, Maxine, which the DHR has respected. Thomas who was identified as Maxine's intimate partner and a suspect in the initial police investigation into Maxine's death is deceased. With that in mind, the following names have been adopted and used throughout the report:
Maxine – deceased, aged 39 years old.
Thomas – Maxine's partner at the time of her death

3.2 Maxine's family was/were keen to contribute and be involved in the review. Their contributions appear at various stages within the report as Janine and Linda (names they decided they wanted to be referred to in the report), and the additional information they kindly provided included professionals by name and names of previous intimate partners that Thomas had with several women. To ensure that the DHR protects individuals' identity, the work role will be referred to only for professionals, and intimate partners will be referred to as Partner 1, and Partner 2, in the report.

4 Terms of Reference, Timescales and Methodology

4.1 In addition to the standard areas for consideration outlined in the Statutory Guidance for the undertaking of DHR, the Panel agreed the following areas for specific consideration by agencies in this case:

- Were Maxine and/or Thomas known to local domestic abuse services and if so, were any concerns or warning signs identified? Where Maxine was not known to DA 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 specially relate to DA? How was professional judgment used? What action was taken as a result? If risks were identified what safeguarding measures were in place?
- Were agencies aware of a history of domestic abuse with regards to Maxine and/or Thomas? If so, were any safeguarding/prevention measures invoked with particular consideration to Clare's Law, DVPN's & DVPO's and multi-agency safeguarding arrangements such as MARAC/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 difficult 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 which prevented the sharing of information?
- What information is available for families to enable them 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?

4.2 The period for consideration within the Review was agreed to be from March 2018 to the date of Maxine's death, in October 2018. The Panel agreed that this period reflected the issues identified: accessing services for support regarding drug misuse, reporting domestic abuse, Janine and Linda expressing concerns to statutory agencies, Maxine and Thomas meeting

one another through accessing support and starting an intimate relationship, and Thomas moving into Maxine's property. The Panel agreed that any information from agencies that fall outside the timeframe that has an impact or can impact the issues identified above should be included and provided to the DHR process.

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

4.3 The DHR panel chair sought the involvement and inclusion of Maxine's family by considering the family's wishes to be involved as lead members and to identify other people they think are relevant to the DHR process. The family was invited to participate in the panel discussion setting the terms of reference and agreeing upon a communication strategy that keeps the family informed. The DHR review will be sensitive to the family's wishes and need for support, ensuring that the family can respond to the DHR without undue pressure.

4.4 The author mentioned Maxine's childhood friend and a friend and colleague who worked with her as a care worker during the review process. Janine and Linda had already provided much information, so the author decided not to investigate these connections further. This allowed the author to create a warm and loving portrayal of Maxine, capturing her essence beyond mere professional, impersonal descriptions.

Contributors to the review and Panel members

4.5 Lesley Storey was appointed as the independent chair, and on 16 March 2022 the first of four DHR panel meetings determined the period the review would cover. The review panel identified which agencies needed to submit written information and stipulated the format. The Panel found Maxine, during the review period, had frequent and consistent interactions in the form of face-to-face appointments, telephone contact and written correspondence with four primary agencies:

- Maxine's General Practice (GP) surgeries
- Cumbria, Northumberland Tyne and Wear NHS Foundation, Mental Health CNTW and North Tyneside Recovery Partnership (NTRP)
- Northumbria Police
- Northumbria Health Care NHS Foundation Trust (NHCFT), including-North Tyneside Talking Therapies (NTTT)

4.6 The majority of the agency information was ascertained from the above four primary agencies, which had interacted with Maxine professionally on multiple occasions. The DHR panel are

grateful for their cooperation and supply of detailed information on their respective agencies' interaction with Maxine.

4.7 *Table one* shows the agencies (***contributors to the review and panel members***) who provided information to the review:

Agency	IMR[3]	Chronology	Panel member
North Tyneside Adult Social Care (ASC)	Yes	Yes	Ellie Anderson Assistant Director
Northumbria Police	Yes	Yes	Detective-Constable 2121 Taryne Cooke Detective Sergeant 3752 Lisa Harrison Detective-Inspector 7577 Ian Callaghan Detective Inspector 118 David James
Northumbria Health Care NHS Foundation Trust (NHCFT), including-North Tyneside Talking Therapies (NTTT)	Yes	Yes	Paula Shandran Head of Service-Safeguarding Children and Adult Yvonne Lawrence Named-Nurse Safeguarding Children
Northeast Ambulance Service NHS Foundation Trust (NEAS)	Yes	Yes	Jane Stubbings, Named Professionals Safeguarding Lead.
The Department for Work And Pensions (DWP)[4]	Yes	Yes	Jackie Butson
Cumbria Northumberland Tyne and Wear NHS	Yes	Yes	Dawn Gauld Reviewing Officer

[3] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

[4] The Department for work and pensions (DWP) is responsible for welfare, pensions and child maintenance

Foundation Trust (CNTW), which includes. North Tyneside Recovery Partnership-(NTRP),			
North Tyneside Integrated Care Board (ICB)	Yes	Yes	Dr Riaan Swanepoel, General Practitioner GP
Harbour	Yes	Yes	Katie Hewitt, Service Manager
North Tyneside Community Safety Partnership (known as Safer North Tyneside Board)	No	No	Lindsey Ojomo and Lisa Warke

4.8 **North Tyneside Council Adult Social Care (ASC)** work to support people over 18 years of age who are vulnerable or at risk, by providing personal and practical support to help them live their lives independently and to safeguard people with care and support needs from harm in line with statutory duties under the Care Act 2014.

4.9 **Northumbria Police** is responsible for the geographic area covering North Tyneside. They serve a population of 1.5 million people and covers an area of more than 2,000 square miles in the Northeast of England, from the Scottish border down to County Durham and from the Pennines across to the North East coast. Northumbria Police is one of the largest forces in the country. The force takes the lead on Multi-Agency Tasking and Co-ordination (MATAC)[5] and Multi Agency Risk Assessment Conferences (MARAC)[6] and is responsible for its functioning, including administrative support and chairs.

4.10 **Northumbria Health Care NHS Foundation Trust (NHCFT) –** delivers care from sites across Northumberland and North Tyneside including an emergency care hospital, general and

[5] **MATAC** - refers to the Multi-Agency Tasking and Coordination process of identifying and tackling serial perpetrators of domestic abuse perpetrators. Each Police Force has responsibility for identification of MATAC subjects, screening, and facilitated and coordination of management.
[6] **MARAC** is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf https://safelives.org.uk/practice-support/resources-marac-meetings/marac-videos

community hospitals, an outpatient and diagnostic centre, an elderly care unit and an integrated health and social care facility. The Accident and Emergency (A&E) unit and The Community Learning Disabilities Team are part of this Trust. NHCFT also includes NTTT which provides an approachable service that helps adults who live in North Tyneside and are registered with a North Tyneside GP who are experiencing problems like anxiety, depression, stress and phobias.

4.11 **Northeast Ambulance Service NHS Foundation Trust (NEAS) –** The North East Ambulance Service NHS Foundation Trust is an NHS foundation trust responsible for providing NHS ambulance services in North East England.

4.12 **Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW) -** was formed in 2019 when the mental health and learning disability services in North Cumbria were transferred to Northumberland, Tyne and Wear NHS Foundation Trust. Northumberland, Tyne and Wear NHS Foundation Trust was created back in 2006. This was through the merger of three different NHS trusts: Newcastle, North Tyneside and Northumberland Mental Health NHS Trust; South of Tyne and Wearside Mental Health NHS Trust; and Northgate and Prudhoe NHS Trust. Within CNTW includes North Tyneside Recovery Partnership (NTRP) is a dedicated service for anyone in North Tyneside, who is experiencing problems with drugs and/or alcohol.

4.13 **North Tyneside Integrated Care Board (ICB*)*** is made up of the Clinical Commissioning and Contracts Committee who manage the day-to-day running, the governing body who meet in public and the council of practices who are nominated General Practitioners (GP's). These are the clinically led statutory NHS bodies responsible for the planning and commissioning of health care services. All 25 GP practices in North Tyneside are members of the ICB. NHS North Tyneside ICB has overall responsibility for the development and planning of healthcare services for the borough, covering a population of 222,116 (based on the 2020 NHS England allocations).

4.14 **Harbour -** Domestic Abuse Specialist Service that works with families and individuals who are affected by abuse from a partner, former partner or other family member.

4.15 **North Tyneside Community Safety Partnership (known as Safer North Tyneside Board)** is a statutory body consisting of North Tyneside Council, Northumbria Police, North East and North Cumbria Integrated Care Board, Probation Service and Tyne and Wear Fire and Rescue

Service. The purpose of the Partnership is to work together to develop and deliver the Community Safety Strategy to help reduce crime and disorder problems across the borough. One of the statutory duties of the CSP is to commission DHRs.

Author and Chair of the overview report

4.16 The chair and author of the DHR was selected after careful consideration by North Tyneside Community Safety Partnership. The partnership was satisfied that the chair's and author's independence from direct line management of those involved in the DHR was essential and afforded practical and objective challenges to individual agencies and enabled an appropriate independent analysis of the relevant information.

4.17 The 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.

4.18 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 2021 and the training session on the 2016 statutory guidance update.

4.19 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. The author has delivered Multi Agency Risk Assessment Conference (MARAC) training to six appointed Northumbria Police MARAC Chairs 2021 this was deemed not a conflict of interest for the purpose of being the author for the DHR.

Parallel reviews and concurrent processes

4.20 During the timeframe in which this DHR took place, there were no review processes parallel or concurrent to the DHR. It is pertinent to highlight that the following reviews were conducted and concluded prior to the DHR process commencing.

4.21 No criminal charges and no criminal proceedings were brought before the Criminal Justice System in relation to the investigation that Northumbria Police had conducted regarding Maxine's unexpected and sudden death.

4.22 There was an inquest in which the coroner provided a verdict of cause of death as 'Drug Abuse' May 2019.

4.23 Janine and Linda submitted a formal complaint to the Northumbria Police Professional Standards department whereby a failure in safeguarding Maxine was upheld surrounding the management of a Domestic Violence Protection Order which Northumbria Police had secured following a reported domestic abuse incident; Maxine identified as the victim and Thomas as the perpetrator. The DHR had full access to Northumbria Police Professional Standards investigation report, which was provided by Janine, including a copy of the Domestic Violence Protection Notice submitted to the courts by Northumbria Police 10 July 2018.

4.24 Linda and Janine submitted a formal complaint to the NHS in England to the Health Service Ombudsman.

4.25 Upon learning of Maxine's unexpected death, CNTW NHS Foundation Trust (including NTRP) activated its established procedures. In November 2018 the clinical risk and investigations department requested that the service leads for NTRP complete an initial report and an after-action review (AAR)[7]. This procedure is standard protocol when a death occurs in addiction services, especially if preliminary findings suggest that it may be drug-related.

[7] An After Action Review is a meeting of clinicians and allied support staff held with the aim of facilitating a reflective discussion of an event, incident or near miss. It is designed to enable the individuals involved to learn for themselves. It looks at:
• What happened, including care and treatment and events leading up to the incident being reviewed
• Compliance with Policies and Standards
• Key Learning Points

4.26 After completing the AAR report, it was reviewed and approved by the relevant Group Nurse Director. In accordance with Trust policy, an AAR was conducted with all professionals involved in Maxine's care. The aim of this review was to identify what happened, assess Maxine's care package leading up to the incident, and determine any lessons learned from the situation.

4.27 CNTW confirmed that a full Serious Incident Investigation (SII) regarding Maxine's unexpected death was not carried out.

4.28 "NHS SII Framework (March 2015) stipulates *"Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. This Framework describes the circumstances in which such a response may be required and the process and procedures for achieving it, to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again".*

"Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services".

"The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients and their families/carers and victims' families must be involved and supported throughout the investigation process".

Equality and Diversity

4.29 Section 4 of the Equality Act 2010 defines protected characteristics such as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

4.30 Section 6 of the Act defines 'disability' as:

- (1) A person (P) has a disability if -
- (a) P has a physical or mental impairment, and
- (b) The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[8].

4.31 Maxine was a female, white British national aged 39 years old. The Panel specifically examined their agencies' procedures to ensure compliance with the Equality Act. The DHR identified no form of Direct Discrimination, Indirect Discrimination, Harassment or Victimisation. The DHR considered the issues of gender, age, and mental health throughout the review process in terms of Maxine's experience of domestic abuse, drug misuse and mental health; the review recognised that these factors placed Maxine in a demographic group of heightened risk of repeat victimisation of domestic abuse.

4.32 No agency held information that indicated Maxine lacked capacity. However, the material reviewed suggests through professional interpretation that Maxine had been subjected to domestic abuse, possibly involving coercion. In cases where a person has no impairment of their mind or brain but is subjected to high levels of coercive control, professionals' consideration needs to focus on the impact of coercive control on the recipient's decision-making, thus prompting professionals to consider a formal assessment of capacity. However, no information was secured in this review confirming that professionals considered conducting a formal capacity assessment with Maxine.[9]

4.33 No further information was available on any other protected characteristics. To ensure the review process considered issues around domestic abuse, the Panel included representatives of agencies specialising in domestic abuse, as well as a Chair and Overview Author with backgrounds within this field.

Dissemination

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

- Maxine's family

[8] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[9] Mental Capacity Act 2005, Cases relating to unwise decision in relationships often make reference to Sheffield City Council v E (2004) EWHC 2808 (Fam) (2005) 1 FLR 965. https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Guidance_sheet_two_Mental_capacity_and_coercion.pdf

- Members of the Safer North Tyneside Partnership
- DHR Panel
- Domestic Abuse Commissioner
- Northumbria Police and Crime Commissioner
- Home Office

5. Factual Background, Chronology of Significant Events

5.1 This part of the report combines the background, overview and chronology sections of the Home Office DHR Guidance overview report template. The DHR author did this to avoid duplication of information. The narrative is told chronologically. It is built on Maxine's life. The data is drawn from documents provided by agencies (IMRs) for both Maxine and Thomas, Janine and Linda and material gathered by Northumbria Police during the investigation following Maxine's death and their response to the three reported domestic abuse incidents to Maxine's home address, during the scoping period (March 2018 to October 2018).

5.2 The author of the DHR wishes to acknowledge the detailed information regarding the Domestic Violence Protection Order (DVPO) and the rationale documenting the risk level grading of the several domestic abuse incidents, that Northumbria Police attended in July 2018, and October 2018 was provided by Janine and Linda; including a summary of what Thomas stated during his police interview following his arrest in October 2018, on suspicion of raping Maxine. This information proved to be invaluable and enabled the DHR process to delve deeper, which was fundamental in gaining an in-depth perspective of the risk that agencies knew Maxine was at whilst evoking a reflectiveness in how agencies responded, supported and safeguarded Maxine with the emphasis being firmly placed upon "*what lessons can be learnt"*. This level of detail was omitted from Northumbria's Police IMR.

5.3 Two detailed chronology tables were created to provide information before, during, and after the scoping period of March 2018 to October 2018. The first table, labeled as Table 1, contains agency information obtained solely from the Panel discussions and the IMRs regarding Maxine and Thomas. Information pertaining to Thomas secured from the IMRs is highlighted with chronology table 1 in yellow. The second chronology table provides information from Janine and Linda. The author of the DHR deemed this to be the most appropriate way to present the chronologies, enabling comparisons to be made, considering the distinct differences in perspective, professional interaction, and personal experiences and recollections of Maxine's family.

Chronology Tables

5.4 The following table contains important events which help with the context of the domestic abuse homicide review. It is composed from material provided by agencies that contributed to the review in the form of IMR and discussion within Panel.

Information obtained from Agencies (Table 1)

Date	Event
20.11.2009	Adult Social Care North Tyneside Council (ASCNTC): Request for information for MARAC -Thomas identified as MARAC perpetrator
2009	CNTW – records show that on 24/11/2009 and 25/11/2009 was discussed at MARAC meetings as a perpetrator of high-risk domestic violence
2009	Thomas's GP record - It is unclear from the GP records whether the GP shared information to the MARAC process, but this was unlikely because the MARAC pathway and systems of response for primary care was not yet embedded properly in North Tyneside. This happened after 2009. The fact that it was coded in the GP practice, was good practice, and had information been requested by MARAC the GP would respond to that request.
2015	Northumbria Police's first interaction with Maxine related to a report of a domestic abuse incident whereby Maxine was identified as the victim and her ex-husband section 39 Common Assault. ***Outcome -*** *The perpetrator was not spoken to regarding the offence section 39 Common Assault. Maxine is not able to support a prosecution. Reason not documented for not pursuing evidence lead. Outcome no further action taken against the perpetrator.*
Between 2015 and October 2018	Maxine reported a further five domestic abuse-related incidents from her ex-husband and partner Thomas who she was with until Maxine sadly died. The above incidents related to assault, unwanted text messages and requests of Maxine seeking advice
Between 16 June 2014 and 15 July 2019	Probation Services information: Maxine was not known to Probation Services. Thomas was not known to probation services during the scoping period from March 2018 to October 2018. Thomas's involvement with probation services before and after the death of Maxine is as follows: On 16 June 2014, Thomas received a 12-month custody sentence for the production of Class B drugs. This sentence ended on 23 January 2016. After that, there was a gap in his involvement with

	probation, until 15 July 2019, when he received a suspended sentence order for 18 months for the possession of an offensive weapon. An analysis of the Probation Services' risk assessment conducted prior to Maxine's death in October 2018, was dated 18 February 2016, and it confirms that it makes no mention of Maxine.
November 2016	*Thomas's GP record confirms that he attended a face-to-face appointment with GP 'Thomas told GP what was wrong the last time'.* ***He said he felt like killing someone****.* The GP explained that acting on these feelings would have legal consequences and pointed out that there was no medical justification for such actions. The patient's speech was slurred but coherent enough to argue. He admitted to smashing his coffee table and causing discord with friends due to his short temper. Although he denied consuming alcohol and stated that he was only taking prescribed Subutex, the GP suspected that he could be using a combination of drugs and alcohol based on his presentation. The GP decided that there was no clear indication for prescribing Selective Serotonin Reuptake Inhibitors (SSRI) due to potentially harmful interactions and instead referred the patient to the Improving Access to Psychological Therapies (IAPT) service.
05.07.2017	Maxine moved to a new GP surgery. New patient questionnaire.
02.08.2017	Letter from addiction services - The perpetrator was not spoken to regarding the offence section 39 Common Assault. Maxine is not able to support a prosecution. Reason not documented for not pursuing evidence lead and no further action was taken against the perpetrator
08.08.2017	Print out received from Maxine's previous GP surgery
10.08.2017	Appears to have been a request for medication, however records suggest it was dispensed on 27/7/17 therefore not due. ***Outcome*** *–The patient (Maxine) was contacted re request – she just said, 'fine I don't need any'.*
16.08.2017	Advised of key worker details for NTRP and noted their request not to prescribe Diazepam or Pregabalin for the patient. At the time the patient (Maxine) was being prescribed Pregabalin.
24.08.2017	GP appointment- new patient screening. The Patient (Maxine) reported feeling great now. History of codeine addiction for few years and alcohol 1-2 bottles vodka daily but under NTRP and off alcohol all together. Reducing Buprenorphine. Works as a care assistant. Sister nearby
09.11.2017	Seen by GP. Patient (Maxine), known anxiety and depression since age 18. Has tried several anti-depressants over the years, no benefit. Separated, marriage (with domestic abuse) 2 years ago – symptoms controlled since with Duloxetine and Pregabalin. Works as carer. Overdose 2/52 ago, seen at hospital; Bullied at work last week doesn't want to go back. HR aware of

	planning grievance. Crying, low mood, No suicidal thoughts. Requested sick note.
14.11.2017	Further sick note supplied
27.11.2017	Review GP. The Patient (Maxine) feels supported by sister, dad and step mum. No suicidal thoughts. Not drinking to excess. Feels lost confidence, husband was controlling. ***Outcome** - Increase Pregabalin and self-refer to talking therapies.*
5.12.2017	GP admin GP informed that Maxine has made a self -referral to talking therapies and will receive an initial assessment 15.12.17
14.12.2017	Review GP. Patient (Maxine) missed Buprenorphine pick up reports feeling anxious and struggling to leave house. ***Outcome** - Some side effects of Pregabalin, so reduced dose can increase Duloxetine*
	GP admin **Outcome** – Patient (Maxine) GP to submit a referral to North Tyneside Talking Therapies (NTTT) and includes information about historic domestic abuse and: 'Patient took an overdose in late October. She has recently started to work in Care Home as a care assistant and feels bullied by work. She previously had a difficult marriage with a controlling husband'
14.12.2017	NTTT contact NTRP to inform them Maxine is being considered for their service and to enquire what involvement Maxine has with NTRP. NTRP worker summarised that Maxine has been struggling with mood and anxiety over the last few weeks particularly and seeing the GP around this. Seeing NTRP monthly and reducing her Buprenorphine, not known to be using other drugs at that point. NTRP were informed that if NTTT accept Maxine the waiting list mean it's unlikely she will be seen until March/April.
19.12.2017	Initial screening appointment between NTTT and Maxine – Maxine would like support around anxiety and panic attacks which she felt had been worse for past 3 weeks. Unclear of trigger but left a previous job due to bullying form a manager and wonders if this set her back. Currently working as a support worker. Outcome- accepted onto waiting list.
20.12.2017	Letter received from NTTT- Informs GP that Maxine. has attended an introductory appointment with psychological therapies, after a self -referral. She is on the waiting list for further treatment.
24.12.2017	Letter from Emergency department stipulating that Maxine had taken an overdose of Pregabalin. Left before seeing Psychiatric team. **Outcome** – No action taken by GP

02.01.2018	Face to face review appointment with GP: Patient (Maxine), and sister present. Struggling with mood. Still under NTRP. Not been able to pick up Buprenorphine that day. Keyworker's name identified and mentioned during conversation. Duloxetine had been increased to 60mg three times a day but not sure how much this has helped. Due to start a new job but not able to start at present. No specific trigger over recent weeks. Has had an initial assessment from NTTT and awaiting further assessment from them. Used Diazepam before with good effect. No suicidal ideation recently. ***Outcome*** *- Agreed to short course of Diazepam to control acute anxiety symptoms.* *GP mentions might be appropriate to refer Maxine to Community Mental Health Team (CMHT).* *Depression medication review done.*
04.01.2018	Face to face appointment with GP: The patient (Maxine) came with neighbour /friend who is very supportive but also bears the effects of patient's moods at times - friend of sister of patient. GP documented that patient's moods are labile and one day can be busy cleaning from 5am and next in bed crying. Has been back for Buprenorphine and saw the key worker. Diazepam helped but understands risks - anxiety symptoms are a struggle and reports feelings of agoraphobia. GP adds note about her taking Pregabalin overdose on Christmas eve. Mental health has been difficult since teenage years. Mother died from motor neuron disease when she was 11 years old. Family has mental health problems. Family tree added. Has stopped drinking as much and will try and have days without it. On waiting list for Talking Therapies. Still getting the feeling of clashing cymbals in head? related to medication or anxiety. ***Outcome*** *- Agreed GP to refer to CMHT however GP thinks the cause is likely to be unstable personality disorder.* *GP advises her to try and have days without drinking alcohol.* *Mood disorder questionnaire result =11 suggesting moderate problem*

08.01.2018	GP admin - ESA form completed, and referral letter sent to CMHT
17.01.2018	GP admin - Letter from A&E- presentation of self-harm.
17.01.2018	Northumbria Police: On 17/1/18 Maxine called her neighbour making threats to self-harm, he went to see her, and she had taken a quantity of tablets. Her neighbour rang the police at 0053hrs. She was conscious however appeared confused. Officers arrived at 0105hrs. Police officers stayed at the address until the ambulance arrived, whilst at the address they found some cannabis. They created a crime for possession of cannabis, and this was closed as the update was it was not in the public interest to pursue the matter.
17.01.2018	Note from GP after telephone contact with sister of patient (Maxine): Janine called to say Maxine is heavily drinking every day and sister can't get access to house as Maxine won't let anyone in. Sister supports her financially and is worried she might harm herself again - the GP agreed that it was a high risk and happy to see if the patient will engage. Patient's sister will call emergency services if there was any evidence that patient had harmed herself. Is having daily contact - waiting to see if collects Buprenorphine as missed collection the previous day. ***Outcome*** *- GP agreed to see if sister can get her to come in; sister agreed to call emergency services if has self-harmed. Didn't collect NTRP script previous day – check if collects today.*
18.01.2018	GP admin - Letter from psychiatry (CMHT) - Oxford Centre to GP informing GP that Maxine was seen by psychiatric liaison officer and found to have poor coping strategies and no bipolar disorder. They didn't feel she needed their service after a Multi Discipline Team (MDT) triage meeting, so have discharged her.
Date was missing	Face to Face appointment with GP with sister present: The patient (Maxine) 'Struggling', and everything became too much for her. Locked herself in the house - over the last few days has drunk 3x70cl bottles of Vodka and a bottle of Amaretto. Also took an overdose of tablets - cannot recall how many and what she took. Now staying with sister. Not picked up Buprenorphine as cannot go - not had for 2 days now. Anxiety is through the roof. She was shaking and constantly vomiting, not eating. Drinking a small amount of alcohol is controlled by my sister. No suicidal ideation. Awaiting talking therapies review. Just not coping well at the minute Doesn't feel she can attend NTRP to pick up this script - next one due Tuesday

	On examination: Shaking tremor, retching, and vomiting during consultation. mood low. ***Outcome*** *- One off script of Buprenorphine but must attend NTRP next Tuesday for pickup.* *Diazepam for anxiety and alcohol withdrawal.* *Restart other medication - sister will look after all medication.* *Cyclizine for vomiting - may need buccal or injection if not settling with Cyclizine* *review GP Monday.*
22.01.2018	Patient (Maxine) face to face appointment with GP: GP reported that her alcohol problem was slightly more under control since living back at sisters. Key worker back in 2 days – patient requesting 1 day more of Buprenorphine. On examination appeared calm and not obviously intoxicated. The GP mentioned that she was not clear if medication was helping – the GP decided 'leave be for now'. GP documents that CMHT doesn't feel that it's appropriate to assess patient, so perhaps GP made this comment after viewing a response from CMHT.
01.02.2018	Face to face consultation with GP: The patient (Maxine) informed GP she has an appointment for Oak trees, for 12 weeks of rehabilitation the following week. Feels very positive though needs to also reduce Buprenorphine in addition to remaining abstinent from alcohol. The GP documented that she was up for the challenge and was also attending Alcohol Anonymous (AA) and finding that helpful. Seemed bright and positive that day and wanted to continue with current medication. Smelt of heavy perfume. Review of a previous diagnosis from 2006 -Supraventricular tachycardia. She complained of very occasional palpitations that are not long lived and settle easily. Medication review completed. ***Outcome*** *- Fit note for work issued: anxiety with depression Duration 29.01.18 – 28.02.18.* *Agreed to be reviewed in 1 month.* *See as and when/if needed if any worsening of mental health.* *No action taken regarding palpitations.* *Await rehabilitation outcome.*
21.02.2018	Department for Work and Pensions (DWP) - Maxine attended her Work Capability Assessment (WCA) and was awarded Limited Capability for Work-

	and Work-Related Activity (LCWRA) based on this assessment for a period of 18 months. Information established during the assessment: • Maxine has a history of self-harming with alcohol inducement. • Maxine has attempted suicide twice with an overdose and has been hospitalised twice. • Maxine has been referred by her GP to Psychiatrists. • Maxine has been given Crisis Team numbers however has not felt she needed to contact them as she has just two weeks ago entered a 12-week Alcohol rehabilitation program with psychological support as standard. • Maxine GP is aware of her mental health deterioration and subsequent overdose attempts. • Maxine attended Alcoholics Anonymous 3 times a week. • Maxine attended Oaktrees daily. • Maxine is in touch with her GP every month. There was no disclosure of any Domestic Abuse.
	Scoping March 2018 to October 2018 Chronology starts here.
05.03.2018	Cumbria, Northumberland Tyne and Wear NHS Foundation, Mental Health (CNTW) NTRP addiction worker - Maxine states her sister and partner want to be involved in her treatment, but she stated she did not want them involved. Maxine had a blip and had been drinking vodka since Wednesday. Consent was updated. Urinary drug screen (UDS) tested positive for Marijuana (THC), prescription given, Next appointment for 12/03/2018.
08.03.2018	GP admin - Document received Capable of work capability assessment criteria
12.03.2018	CNTW, NTRP addiction worker, review appointment - Maxine attended appointment and reported increased anxiety levels and used cannabis. She was given a one-off script of diazepam from GP.
12.03.2018	Patient (Maxine) face to face consultation with GP and sister present: Has been smoking cannabis at nighttime and feels very anxious today and doesn't know what to do. Hasn't heard back from NTTT and CMHT don't think suitable for their service. Discussed importance of coming off alcohol so can be ready for psychological treatment however Cognitive Behavioral Therapy (CBT) may be more appropriate in future. On examination: agitated

	Said she can get back onto Oak trees course when this group finishes. Still engaged with NTRP and AA. Keen for sick note as overdue and money an issue according to sister. **Outcome** - *Agreed Diazepam and could consider an increase in Pregabalin.* *Fit note for work Diagnosis: Anxiety with depression- worsening; Duration 28.02.18 – 30.04.18*
22.03.2018	CNTW, NTRP addiction worker, review appointment - Maxine reported drinking cider on Monday and had a 'joint' the day before.
23.03.2018	CNTW, Recovery Group - Maxine attended recovery group. She reported drinking alcohol and smoking 'skunk' cannabis and going to see GP as her anxiety was overwhelming
23.03.2018	GP admin - Note inserted to say Psychology appointment arranged for 05.04.18 at 11am at Wallsend Health Centre to see practitioner.
26.03.2018	Patient (Maxine) face to face consultation with GP: Remains abstinent from alcohol but using cannabis day and night to control anxiety symptoms - NTRP aware. Due to see psychology early next month. Managed to make the last Diazepam script last from 12th March 2018. Taking Pregabalin which helps. Not sure how much benefit getting from Duloxetine. ***Outcome*** *- Note inserted to say Psychology appointment arranged for 05.04.18 at 11am at Wallsend Health Centre.*
03.04.2018	CNTW: telephone call to Maxine to encourage attendance at Women's group the following day. Maxine said she had relapsed and wouldn't commit to any groups. Maxine was encouraged to access support offered at NTRP as well as utilizing Alcohol Anonymous.
05.04.2018	NTTT, Patient record: Initial face to face appointment with NTTT. Concerns around anxiety and low mood. Previous involvement 2014/15 noted. Maxines relationships were explored, and within this, details of domestic abuse in her relationship with the ex-husband were discussed. Maxine reported having suffered physical and emotional abuse throughout their marriage but reported that she has no contact with her ex-husband now and does not feel at any risk from him. Maxine did not report to be in a new relationship at this time and had been living alone with her cat. Maxine was open about her alcohol and substance use and input from NTRP. Please note previous involvement with NTTT in 2014/2015.
06.04.2018	CNTW, NTRP addiction worker, review appointment – Maxine reported no alcohol over last couple of weeks and cannabis: sometimes two joints daily, but every day. Maxine hasn't been going to meetings and the plan was to discuss a reduction at the next appointment.

	Outcome *- Prescription was provided and next appointment was organised for 20/04/2018.*
09.04.2018	Patient (Maxine) face to face consultation with GP: No major problems with having stopped the Duloxetine - and now off it. Managed to increase the pregabalin but not yet gone up twice daily - going to start from tonight. Still abstinent from alcohol. Still smoking cannabis - NTRP want her to cut down and stop. Had first appt with NTTT recently as well - probably will do 6-8 sessions on a weekly basis. Has used 9 diazepam in last 2 weeks. Both her ankles were uncomfortable and swollen for several months. left more marked than right. ***Outcome*** *- GP issued more Pregabalin twice daily and put on repeat.* *GP performed a medication review.* *GP agreed that she could request more Diazepam on acute prescription, when gets down to last couple of tablets.* *Agreed a further medication review in 3 months but to see her sooner, if struggling.*
12.04.2018	NTTT- Maxine turned up late to session so full appointment not possible, Maxine shared that her change in medication impacted on her ability to concentrate- agreed between practitioner and Maxine that they would wait a couple of weeks to plan more sessions so that the impact of changes to Maxine's medication had hopefully settled.
16.04.2018	Telephone consultation with GP: Stopped Duloxetine 1 week ago. Maxine reports feeling okay in herself but has been a lot more tearful. Now on a higher dose of Pregabalin and it is helping with the anxiety but making her a bit jittery and feeling very tearful. Not keen to restart Duloxetine - would *'prefer to ride out the storm'*. Has used most of Diazepam since last Thursday. ***Outcome*** *- Issued further prescription for 14 Diazepam and asked Maxine to phone back on Thursday with update, sooner if worse*.
17.04.2018	Patient (Maxine) face to face appointment with practice nurse Very tearful throughout the appointment, feels it's due to stopping the Duloxetine. ***Outcome*** *- Informed she will need to have old style doppler examination for safety, appointment arranged.*

	Will buy support tights or flight socks until the doppler is done.
19.04.2018	Patient (Maxine) face to face consultation with GP: GP documented that Maxine has used 10 out of the 14 Diazepam tablets that were issued previously. She feels a bit more settled than when GP spoke to her the last time, She took four Diazepam tablets the day before and a further two that day. ***Outcome*** *- Agreed to issue further supply of Diazepam and will continue to try reducing dose.* *Agreed to speak telephonically the following week.* *Could order more Diazepam as needed.* *Been on higher dose of Pregabalin so still a bit soon to fully assess this.*
23.04.2018	CNTW, NTRP addiction worker, review appointment – Maxine attended appointment and reports altercation with sister, feels her sister is checking up on her all the time. Maxine was very tearful and reports the GP took her off the anti-depressants. Maxine had a glass of 'Bella' that morning but did not appear intoxicated. Maxine reported having a man in her life, but she says it is early days. She has been for a scan for fluid retention in her legs.
25.04.2018	NTTT - Maxine called and stated she feels better to attend appointments. She agreed to attend tomorrow's appointment. NTTT - Telephone call to GP to explain that Maxine struggled with her second appointment and assumed it was due to a change in medication. Clinician checking whether GP feels she is able to engage whilst changes of medication in place of her diazepam. GP agreed the timeframe of 2-4 weeks for adjustment of medication.
25.04.2018	NTTT contacted GP and shared that Maxine had struggled with 2nd appointment which they had discussed and felt it was possibly related to changes in medication- NTTT due to see Maxine tomorrow and GP feels things should have settled enough for Maxine to be able to engage. If continuing side effects to try again in 2 weeks. Call to Maxine from NTTT to confirm tomorrow appointment- Maxine felt able to attend.
25.04.2018	GP spoke with NTTT: GP was informed that they are planning to review patient tomorrow but aware she had been a bit up and down with medication changes. GP suggested it was okay for Maxine to be seen by NTTT the next day. It was agreed that if Maxine was still struggling, they will push back appointment for a couple of weeks for review.
26.08.2024	NTTT received a call from Maxine to say she is struggling with mood and anxiety again and that she was waiting for her GP to call her back so won't be attending NTTT today. Letter sent to Maxine and GP.
Date needs confirming	Patient (Maxine)Telephone consultation with GP: Maxine feels her mood is much more stable and the Diazepam is lasting well.

	Maxine mentioned that GP mentioned previously the possibility of increasing her Pregabalin. She was feeling better generally although she had fallen out with her sister. ***Outcome*** *- GP issued further Diazepam script and agreed that it was ok for patients to order more at the end of the following week on acute, if required.* *To continue current dose of Pregabalin.* *GP suggested face to face appointment with AG or DL. Continuing to see SH from talking therapies as planned that day.*
Date needs confirming	Seen face to face by PN (JA): Doppler studies show ABPI = 1.04 right leg and 1.05 left leg. O/E - blood pressure reading 112/83 mmHg ***Outcome*** *- Measured for stockings.*
04.05.2018	CNTW, NTRP addiction worker – Raised concern - Worker expressed concern re Maxine's low mood and symptoms of depression and anxiety, and that she reported the GP had recently stopped her anti-depressant. She is prescribed buprenorphine and the worker is concerned regards her illicit use of substances. Routinely the service asks GPs not to prescribe any opiate-based medication without contacting service first. Outcome – Letter to Maxine's GP
04.05.2018	GP Admin - Letter from NTRP to GP. They are concerned about her anxiety and mood and inform GP that her antidepressants had recently been stopped. They inform GP that they continue to prescribe Buprenorphine. Template note to not prescribe Benzodiazepines/ Pregabalin or Gabapentin.
09.05.2018	Maxine has a telephone consultation with GP: Doing a bit better, generally. Managing OK without Duloxetine now. However, continue with Pregabalin. Due to see her key worker from NTRP the following week and GP references the recent letter from the addictions service. Patient hasn't ordered Diazepam since 26.04.18 ***Outcome -*** *GP agreed to issue a further seven Diazepam tablets.* *The GP agreed to write to key worker to update her with recent events.* *GP explained that they wouldn't issue more Diazepam until they are aware of plan from key worker NTRP*
10.05.2018	NTTT - Maxine phoned and cancelled her appointment as she had a sore throat and cold.
15.05.2018	CNTW, NTRP addiction worker review appointment - Maxine tested positive for cocaine, marijuana, benzodiazepines, buprenorphine, and opioids. Pregabalin dose is too high and intends to speak with her GP.

	Maxine is drinking two cans daily. The worker addressed concerns with Maxine about chaotic lifestyle'. Changed collections to 3x weekly and increased to 2mg after consultation with nurse prescriber. 2/52 script given and next appointment 29.05.18.
17.05.2018	Maxine called NTTT re appointment as feels unable to attend and has not been able to leave the house for 3 days. Feeling anxious and is being supported by NTRP key worker and GP who has increased diazepam. Discussion around difficulties being able to engage with service so no further appointments made. NTTT told Maxine that they would be happy to see her in the future when she was feeling more stable. Maxine reported she has a friend she had met at NTRP and had gone to see him but left because he was drinking alcohol.
25.05.2018	25.05.18: Practitioner supervision- plan to contact GP and advise Maxine was no longer seeing NTTT and that they have some concerns about her self-care and vulnerability (including within any future relationships given the DA she suffered in her marriage). Information shared with GP by telephone and letter. Maxine can self-refer in or be re-referred in by GP at any time.
25.05.2018	NTTT - Message left for GP to pass on information and advised that Maxine has been unable to attend any of her appointments so is not appropriate for the service at present. Passed on concerns about Maxine's self-care and that she remains vulnerable.
25.05.2018	GP admin - Letter from psychological therapy services informing GP that MS attended an appointment on the 05.04.18 (very high PHQ9 and GAD scores), then was late for a further appointment and then was unable to attend a further appointment due to anxiety with leaving the house. XX from psychological therapies informed GP that Maxine didn't fit the criteria for further support from CMHS (secondary care) and was signposted to get further support from MIND.
30.05.2018	CNTW, NTRP addiction worker – Telephone call from Maxine's partner the previous day and reported that Maxine is unwell, and they would both be attending today. Maxine rang and she reported that they had no money to get to Wallsend. Maxine stated that she would walk and hoped to get here. Maxine requested a prescription to be delivered to the pharmacy for her and her partner. The worker discussed this with the nurse prescriber, and it was suggested to Maxine that she does walk down to Wallsend. She seemed most put out at this suggestion.
31.05.2018	CNTW, Thomas attended NTRP and was advised anymore hostile behaviour between him and anyone else will result in the police being called as reflected in his records. Medical records do not indicate who Thomas had been hostile towards.
31.05.2018	CNTW, NTRP addiction worker - Unscheduled appointment - Maxine attended without an appointment.

	Maxine reported that she and her partner had been arguing. He locked her in his flat yesterday. Maxine reported that she has used cocaine and cannabis but none that day. Maxine stated that she has been passive smoking as her partner smokes heroin. Changed pharmacy to Boots North Shields. 13-day prescription given next appointment 13.6.18
10.06.2018	CNTW, NTRP addiction worker Maxine did not attend scheduled appointment and prescription was retained to facilitate attendance.
12.06.2018	CNTW, NTRP addiction worker: Telephone call from Maxine reporting that she did not collect her prescription on Friday. Maxine reports that she has been ill all weekend coming off pregabalin. Maxine states that she had bought buprenorphine to cover her over the weekend. The worker advised Maxine that she is on a low dose and to attend her appointment tomorrow as planned. She will then be 4 days off prescription.
13.06.2018	CNTW, NTRP addiction worker: Arranged appointment - Maxine attended appointment and was four days off prescription. Maxine stopped pregabalin the previous Wednesday and felt ill. Maxine reported that she bought 10mg of buprenorphine. Maxine tested positive for cocaine, marijuana, benzodiazepines, buprenorphine. Took diazepam when withdrawing from pregabalin, then had none left. Maxine stated that she had a couple of lines of cocaine a few days ago. Maxine stated she had been speaking to her dad and is still not talking to her sister. Worker discussed prescribing with Nurse Prescriber SG It was agreed that Maxine could have her usual dose and begin reducing 0.4mg fortnightly. next appointment 17.6.18
14.06.2018	Patient (Maxine) face to face consultation with GP: Three-week numbness ring and little fingers of right hand, feels can move them properly, feels weaker, rest of hand ok but thumb feel weaker, left hand ok. Tearful and upset as mum had Motor Neuron Disease (MND) and concerned it is this or Multiple Sclerosis (MS).

	No obvious reason, no neck pains. Has cut down alcohol a lot, new partner who does drink and now drinking couple times a week. Has been drinking today though. Previously up to 1l vodka a day, a few months ago, not been on thiamine. Under NTRP on Buprenorphine, reducing. Stopped Pregabalin completely 1w ago. Tearful and low since then, didn't think at the time was helping my mood but feels it was. Hand grip seemed reasonable, subjective Numbness of ring and little fingers.
17.06.2018	Northumbria Police: On 17/06/18 police attended Maxine address following a call of a taxi bilking, males were dropped off there and did not pay for the taxi. Maxine was spoken to by officers, and she did not have any knowledge of the incident, a crime was committed and closed as the suspects could not be identified. A proportionate investigation was completed in respect of the crime.
17/6/2018	Thomas- Patient Record. Emergency Department attendance. Thomas brought in by ambulance following a reported assault by 3 men. Punched, knocked across the head, ribs, and abdomen. Found unconscious. Facial swelling, fractures to ribs, small pneumothorax, injury to spleen and orbital fracture. Initially admitted to critical care for observation. Thomas abusive to staff and leaving unit for cigarettes and to make calls, stating anxious about housekeys, partner and his dog. Transferred to ward and self-discharged 20/06/2018 around lunch time. Risks explained regarding significance of injuries and potential for life threatening deterioration if further trauma suffered.
17.06.2018	Thomas GP Practice record – Administration following notification of Multi-trauma information received. Admitted to Critical care, then ward.
18.06.2018	External entry and admin by GP GP adds to records at 2pm: 'Says has lost script for Pregabalin -plan to discuss with NTRP and then needs a plan for weeklies' GP adds to records at 6pm: 'Called to say had lost pregabalin -there is an alert on notes re prescribing this so i need to discuss with NTRP but missed key worker today - issue a short supply and will need to communicate plan after that as an abusable medication'. ***Outcome*** *- GP asks administrator to contact patient:* *'Please call patient and say I am concerned about this as they are a risky medication - we need to discuss this further so I have issued a 1-week script and will get back to her about ongoing plans for Pregabalin scripts'.* *GP intention to discuss further prescribing with NTRP.* *GP issues a week's supply of Pregabalin as a temporary measure.*

23/06/2018	Thomas- Patient Record. Emergency department attendance. Thomas brought in by ambulance. Pain post rib fractures on the 17 June 18. Discharged with analgesia and safety netting.
23/06/2024	Thomas's GP record – admin-Seen in A&E post rib fractures, analgesia issued-codeine, paracetamol and ibuprofen.
25.06.2018	Telephone discussion between GP and addiction worker: GP contacted NTRP to check re Pregabalin and key worker (A) said patient told her that she had stopped pregabalin on 06.06.18. ***Outcome*** *- GP documents: needs to come in for a review due to various concerns that she is giving it away or selling it.*
25.06.2018	Thomas had contact with GP. Outcome of GP was Thomas was referred to A&E pneumonia as difficult to assess (due to drug history) and may need CXR and further management. Refused to go to hospital- agreed antibiotics and safety net. GP documents Thomas is 'with partner – a woman half recognises and seems to have good knowledge re opiates'.
27.06.2018	Patient (Maxine) face to face consultation with GP: Patient says she had spoken to Maxine's addiction worker and aware of her view of Pregabalin but stopped for 10 days and felt far more anxious and so back on them and wants to stay on them. Happy with partner despite sister's views. She seemed bright and didn't appear intoxicated. Discussed that if it happened again then GP may not be able to issue a replacement. ***Outcome*** *- Advised if lost again replacement may not be given* *GP codes medication review.*
27.06.2018	CNTW, NTRP addiction worker: Scheduled appointment - Maxine reported being back on pregabalin due to anxiety. Maxine stated that she needed a replacement script as she had left one on the bus. The worker informed Maxine she had spoken with Dr L and understood she had stopped taking it and detoxed herself. Maxine said she had an appointment that day and was sticking with the prescription. UDS for BZO/BUP/OPI and she denies any diazepam use. Maxine reported taking tramadol for period pain, her periods have returned, and she has been using co-codamol. Maxine stated she had seen her sister, but this hadn't gone well. Maxine stated that she had seen her dad on Father's Day. Maxine stated she could not remember the last time she had cocaine. Prescription given and next appointment 11.06.8.

28.06.2018	Patient (Maxine) face to face phlebotomy appointment with practice nurse (SR) **Outcome** - Bloods taken. Results indicate cause to be excess alcohol intake - raised Mean Corpuscular Volume (MCV).
04/07/2018	NHCFT - Thomas- Patient Record. Emergency Department attendance. Thomas brought in by ambulance. Girlfriend has reported that he has taken diazepam, heroin and pregabalin, became unsteady and collapsed. Aggressive in department, police present. Admitted to critical care and discharged 05.07.2018. Girlfriend, not in department to obtain history.
05.07.2018	Thomas's GP surgery received a letter confirming drug overdose
07.07.2018	Northumbria Police: On **07/07/18** at 1423hrs Maxine rang police to report a domestic assault of which she named Thomas as the perpetrator. He punched her in the face and was attacked by his dog. This incident was correctly assessed as a grade 1 which required a 15-minute response as it was an ongoing domestic. Officers arrived at the address at 1423hrs which was 6 minutes after the initial call was made and within the 15-minute required response time. Thomas was arrested for assault and officers in attendance created a crime for common assault. Maxine did not want to provide a statement and would not support a prosecution against Thomas. Outcome - The update on the crime was, the offender has been arrested and interviewed and denied the offence, due to lack of evidence he was released no further action and a DVPN was issued and DVPO obtained through the courts by the Police
11.07.2018	CNTW, NTRP addiction worker: Maxine contact NTRP by telephone - Maxine reported being assaulted yesterday by a female service user. She said she is sore with a black eye. Maxine's prescription was due today. One day will be missed due to her being unable to collect. Next appointment 12.07.18
13.07.2018	CNTW, NTRP addiction worker, Maxine contacted NTRP by telephone - Maxine reported she was physically unable to attend. Maxine missed two days' prescription and requested it be delivered to a New York Pharmacy. Maxine had previously been collecting from Boots on Bedford Street. Worker contacted pharmacy and they reported Maxine had not collected since 27 June 18. This would make Maxine 14 days off script if true. The worker contacted Maxine who was adamant she had been collecting. Worker contacted Boots and it was established that Maxine had missed collection on 6 June 2018 but had collected on 7 June 2018. No other issues with collection. 2/7 off prescription only.
17.07.2018	Probation Service information - Although Thomas was not currently in probation services, within the time frame specified, a court officer entered the probation system on 17 July 2018. It is noted as information from a third party

	stating that a DVPN was issued. A DVPO substantiated the case at a court on 10 July 2018, with Maxine as the protected person. There are no further entries during this time, and as the DVPN is a civilian order, probation will not be involved in the case.
18.07.2018	CNTW, NTRP addiction worker, scheduled appointment - Maxine reported using cocaine on one occasion following her altercation in North Shields. Maxine stated that she had co-codamol from a neighbour to try and ease the pain and had also had some cannabis. Maxine is speaking to her sister and Dad and reports not drinking to excess. prescription given and next appointment in 4/52.
08.08.2018	CNTW, NTRP addiction worker - scheduled appointment - Maxine reported life being ok and quiet. Maxine stated that she had a couple of co-codamol for headache and was advised on poly drug use. Maxine reported having some cocaine but not recently and having a joint a couple of weeks previously. Tested positive for cocaine, marijuana, benzodiazepines, buprenorphine. Prescription given and next appointment 04.09.18
29.08.2018	CNTW, NTRP addiction worker: Maxine contacted NTRP by telephone reporting having been to see her GP and they refused to prescribe without speaking to worker. Maxine reported partner is still in hospital and she is still very worried about him. Her mood has dipped, and she is feeling anxious. Worker advises the feelings are normal when a loved one was in hospital. The worker advised Maxine she would express her fluctuating mood to GP if they contacted the service.
29.08.2018	Maxine face to face consultation with GP: GP documents that patient's partner had a head injury 1 week ago. He was found in North Shields and airlifted to hospital, so no one knew what happened. Patient told GP that he was quite confused still. This had made her anxiety worse. She was asking for an increase in Pregabalin. Has used diazepam before but wants to avoid this. GP documents that she is under NTRP for previous codeine addiction and on Buprenorphine 2mg currently and that her key worker (A) doesn't want her to be prescribed Diazepam/ Pregabalin. GP discussed treatment of anxiety with patient: Noted that it was difficult as has asthma so not for propranolol. Noted she had been on Duloxetine but stopped as not helping.

	GP suggested a different SSRI, but patient told GP she had tried everything and was not helpful. ***Outcome*** *- GP agreed to call key workers for advice. Tried, but no reply.* *GP documented that she will try to call key worker again the next day.*
30.08.2018	Thomas's GP received a letter confirming subdural haemorrhage and temporal fracture
Undated	Thomas had face to face appointment with GP, post head injury, Thomas requesting diazepam for sleeping and tramadol for pain. Examination completed The GP declined Tramadol. Diazepam issued (4 only). Safety net
Undated	Thomas's GP received letter highlighting Thomas Falsifying a Diazepam script from 4 to 14 – Thomas was confronted by pharmacist and then tried to snatch prescription from GP
03.09.2018	MDT discussion at GP practice following script issue where it was agreed to remove Thomas from practice. Letter sent to patient.
06.09.2018	CNTW, NTRP addiction worker: Maxine contacted NTRP by telephone - Maxine reported she could not attend due to her anxiety. Agreed to have script taken to pharmacy and for her to attend tomorrow.
12/09/2018	Thomas's GP surgery received a letter confirming Thomas was admitted to NSECH 21/08/2018 and discharged home 29/08/2018. Traumatic brain injury after a fall backward, hitting head. Lost consciousness, responded to Naloxone, intubated and ventilated because GCS remained low. CT scan brain showed a Subdural Hemorrhage
12/09/2018	NHCFT - Thomas- Patient Record Emergency Department attendance. Thomas brought in by ambulance. Headache and a little drowsy following a serious head injury (skull) which was recently treated at RVI. Requesting diazepam to help him sleep. Advised to keep upcoming appointment with concussion service at RVI.
14.09.2018	CNTW, NTRP addiction worker review appointment -Maxine reported she had 2x5mg diazepam on Wednesday as well as cocaine. Effects of cocaine on mood were discussed. Keyworker contacted the surgery for an appointment for her mood. Maxine was given an appointment.
20.09.2018	CNTW, NTRP On 20 September 2018 Maxine had an appointment. Maxine reported really struggling with her partner now and that since the head injury he is different. A food parcel was ordered for Maxine to collect.
20.09.2018	CNTW, NTRP records show that Thomas attended his appointment at NTRP accompanied by Maxine and was described in clinical records as his partner
20.09.2018	Patient (Maxine) face to face consultation with GP: Patient informs GP that she would like to try an anti-depressant. She informs GP that both her and her keyworker feel she is low. GP documents that

	boyfriend is now home and that she has lost weight with worry. She informed me that she was up for a reduction in Pregabalin as she and key worker acknowledge that it wasn't ideal given addictions. GP also reviewed patient's left elbow: She reportedly fell 3 weeks ago and her elbow was swollen. GP examined the elbow and documented a small healing laceration 1cm above elbow and 4cm diameter. It was swollen but non tender, non-red or hot swollen bursa over left olecranon. GP diagnosed a left olecranon bursitis and noted the following: No signs of infection but to seek advice if red /heat worse pain or injection at next review. **Outcome** - *GP added Mirtazapine as wants nighttime sedation and hasn't found usual meds helpful.* *Review 4 weeks.* *Possible injection if left elbow not improved.*
03.10.2018	CNTW, NTRP addiction worker -scheduled appointment - Maxine appeared well and talked about her partner. Urine drug screening is positive for THC/BUP/BZO. Maxine reported she could not remember the last time she had diazepam. Maxine confirmed GP had started her on mirtazapine 15mg. Maxine described feeling her mood had lifted a little. Maxine stated that the plan with the GP was to reduce the pregabalin. Prescription given and next appointment was arranged 31.10.18.
October 2018	Northumbria Police: In October 18 Maxine rang police at 1955hrs to report she was having problems with Thomas as she wanted him to leave her address and he refused to leave. He did leave her address when he heard her making the call to the police. She was given advice and said she no longer needed police because he left. ***Outcome*** - A scheduled appointment was made for a date in October 2018 for officers to see her. This was initially assessed as a grade 2 incident, however the risk reduced as Thomas had left the address and MS told police she no longer required their attendance, thus making an appointment appropriate in these circumstances. Unfortunately, Maxine died prior to the scheduled appointment which meant officers did not get the chance to speak with her and complete the Domestic Abuse, Stalking Honour based violence (DASH) risk assessment.
October 2018	Northumbria Police: On a date in October 2018 at 2147hrs a neighbour of Maxine rang police after hearing sounds of a domestic coming from Maxine address. This was correctly assessed as a grade 1 incident and required a 15-minute response as it was an ongoing domestic related incident, officers arrived at the address at 2156hrs which was 9 minutes following the initial call.

October 2018	NHFCT – On a date in October 2018 at 2300hrs Thomas- Patient Record Emergency Department attendance. Thomas brought in by ambulance intoxicated with superficial dog bites to face and arms. Reported to have been drinking, got into a domestic dispute with partner and his dog attacked him. Police on scene. Thomas' partner was not named, or in attendance and Thomas was not co-operative with staff in the Emergency Department. Left department before discharge and before antibiotics could be given. No successful exploration around domestic abuse / offer of a risk identification checklist took place prior to Thomas leaving the department before his treatment was complete and he was cleared for discharge.
October 2018	Medical Records: Attendance at A&E – brought in by ambulance. Probably overdose of Verapamil. Cardiac Arrest. Lives with partner. Alcohol dependency. The patient had multiple bruises all over her body of variable ages. Police present were concerned about a lack of response from partner. Apparently, she had fallen last night.
October 2018	Northumbria Police: Concern for female; incident in which relates to the death of Maxine, the initial call was made to police from Ambulance service, this was rang in at 0923hrs on a date in October 2018, it was reported Maxine had taken an overdose, the ambulance service received a report from a neighbour. The information passed on from the neighbour related to concerns around domestic abuse and drug use within the address. This incident was correctly assessed as grade 1 as it was ongoing and this required a 15-minute response, officers arrived at 0930hrs which was 7 minutes following the initial call. ***Outcome*** *– Northumbria Police investigated Maxine's death because it was deemed sudden and unexpected which prompted the police to request a Home Office Postmortem.* *Thomas was arrested on suspicion of rape, section 47 assault and drug supply. He was interviewed and gave an account that he and Maxine were taking cocaine and had sex the night before her death. He was later released with no further action.* *Northumbria Police also confirmed that at no point from October 2018 until receiving the Home Office Pathologist's Postmortem findings they did not deploy a Family Liaison Officer (FLO) in the investigation into Maxine's sudden and unexplained death.* *FLOs are specially trained Officers who provide a two-way flow of information between bereaved families and investigation teams.*
October 2018	GP record sudden death – cause unknown
	End of Scoping period October 2018
2019	Thomas's GP provided in IMR Background information from a mental health assessment completed with Thomas in 2019: Thomas was born and brought up in North Shields.

	'Both parents were alcoholics and died from complications of excess alcohol, so his childhood was marred by experiencing both his parents drinking'. He had a half-brother who did not live locally and he was estranged from Thomas had significant losses in his life- parents, friends, partners and relatives. All three ex-partners have died)- this was information he provided when assessed for his mental health in 2019.
05.02.2019	Adult Social Care North Tyneside Council: Thomas claiming benefit being paid into friend's bank as he has no account. In a conversation he claimed that his benefit used to be paid into Maxine's bank account – she is described as his ex- partner.

5.5 The following table contains important events established from additional material that Janine and Linda had provided the domestic homicide review following formal complaints and grievances with Northumbria Police and Northumberland, Tyne and Wear NHS Foundation Trust.

The Family's Chronology (Table 2):

Date	Source and type of document	Summary of information in document
17/01/2018	Janine and Linda	On 17 January 2018, Janine visited NTRP's premises to express her concerns directly. This was after Maxine had locked herself in the house and refused to let Janine in. Janine was worried about Maxine's deteriorating condition and was desperately seeking help and support from NTRP, with whom Maxine had been working for her alcohol and drug misuse. Janine was saddened and disappointed that no one from NTRP would engage with her. Janine stated that she felt like she was going out of her mind with worry, which prompted her to contact the police, who could not assist. Janine then contacted Maxine's GP, who subsequently contacted Maxine by telephone.
		Scoping March 2018 to October 2018 Chronology starts here.
10/07/2018	Copy of the DVPN application to the courts for a DVPO 10/07/2018	Domestic Violence Protection Notice [10] (DVPN) by Northumbria Police described the domestic abuse that Maxine was subjected to by Thomas, including a summary of Thomas's serial domestic abuse perpetrating behaviours as: *"He (Thomas) has used violence/threatened violence against the victim, namely Maxine. The grounds for this DVPN are found in this recent report and supported by history where on this occasion Maxine has disclosed, he has punched her to the face and then pushed her causing her to fall to the ground.* *Officers attending the scene spoke to Maxine with Body worn video activated. There were no visible injuries to her face although there was a bruise to her elbow. Content with the verbal statement of Maxine that violence has been used on this occasion.* *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. In addition, this is the first reported DV*

[10] A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support, they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

		incident between the two, but Maxine has been involved with another volatile/violent person previous to Thomas. *This clearly shows Thomas's propensity for violence. Both Maxine and Thomas do not support a DVPN. Evidence-led prosecution will be sought from CPS.* *A DVPN/DVPO is the only way to safeguard the immediate safety of the victim, there is a need to protect the injured party (IP) given her reluctance to safeguard herself from harm and to give her the time and space to consider her welfare and future choices around Maxine and work with agencies.* *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.* *Understand that both parties want to continue their relationship and this DVPN and any subsequent DVPO will be policed through regular patrols to the address to ensure it is not being breached.* *There is a clear duty of care to mitigate Maxine against further risk as she appears not to be giving herself time and space away from Thomas where she can access support services and make informed choices away from any influence he may have.* *Reasonable grounds for believing the issuing of this DVPN and the conditions requested are necessary to protect the victim from further violence or threats of violence".*
October 2018	Police statement from Maxine's neighbour	Neighbour confirmed that she knows Maxine. Maxine in summer (2018) started mixing with the wrong people and appeared to be drinking heavily and she would often see Maxine taking alcohol into the flat. In the last couple of months Maxine started a relationship with Thomas. Since Maxine started her relationship with Thomas, she would hear numerous arguments between them both which mostly happened on weekends at various times, shouting and swearing at each other. At that time the neighbour was not aware of any physical fighting between Thomas and Maxine. Between 1700hrs and 1800hrs in October 2018 she heard raised voices which she recognised as Maxine and Thomas arguing. She heard Maxine shout "Go away, don't come back". She then seen Thomas walk away.
Undated	Report by Northumbria Police DC involved in	0930hrs - Police officers dispatched and arrived at Maxine's home address whereby paramedics identified Maxine was in cardiac arrest and was transported to NSEC, Cramlington where

	the investigation to Maxine's death	attempts to revive her were made. Maxine's partner, Thomas, was at the address. At 1018hrs on a date in October 2018 - Lead consultant confirmed Maxine's time of death. Initial Police Actions: • Scene secured. • Contact and liaise with crime scene manager. • CCTV enquiries. • Witness enquiries. • Maxine's body was formally identified by her sister. • Statements obtained from the caller (neighbour of Maxine) of the original police incident 19/10/2023. • Maxine's body was removed to the mortuary at Rake Lane Hospital, North Tyneside. • A Home office postmortem was arranged and took place in October 2018. • House search arranged and conducted following postmortem. • Toxicology requested. • Interview Maxine's partner, Thomas.
Undated	Report by Northumbria Police DC involved in the investigation to Maxine's death	Points extracted from summary of Thomas's police interview in October 2018: Thomas was Maxine's partner and lived with her at her home address. Thomas stated that Maxine took Subutex, inhalers, sleeping tablets, and anti-depressants due to drug use, heart palpitations and depression. Maxine was alcohol dependent and consumed at least 4 liters of 'Bella Brusco' daily. Maxine took crack cocaine and street valium. Thomas stated on a date in October 2018 Maxine had fallen over in the kitchen drunk, causing bruising to Maxine's left side in particular a big bruise to Maxine's upper arm and thigh. Thomas stated that Maxine bruised easily. On a date in October 2018 Thomas and Maxine started drinking round teatime at their home address. Maxine left the address at some point for 30 minutes to go and buy crack cocaine. Maxine

returned with £20 worth of powder form and both Thomas and Maxine consumed this using the crack pipe.

At around 2030hrs on a date in October 2018 Maxine left the address to buy more crack cocaine. Maxine returned approximately 45 minutes later with rock instead of powder. Both Thomas and Maxine consumed the crack cocaine by using the crack pipe.

Maxine wanted to engage in sexual intercourse with Thomas. Maxine performed oral sex on Thomas, and they then had consensual sexual intercourse.

Maxine wanted sexual intercourse a second time, but Thomas declined. Thomas stated that Maxine 'kicked off' because he wouldn't have sex with her.

Thomas stated that he fell asleep but noticed Maxine got up during the night, which is not unusual for Maxine.

Thomas stated that he got up in the morning on a date in October 2018 at 0900hrs. He went to the kitchen to make a cup of tea and noticed blister packs on the kitchen work top.

Thomas stated that he went to check on Maxine and stated that she was on her back and cold to touch. Maxine was wearing only a pair of black knickers, which was what she was wearing when Thomas had gone to sleep.

Thomas heard a car outside and looked out of the window to see a neighbour who he alerted he could not get a response from Maxine.

The neighbour contacted the ambulance service. Thomas started chest compressions on Maxine who was lying on the bed. Thomas continued with the chest compressions until the ambulance arrived. Thomas stated that he assisted the paramedics in moving Maxine from the bed to the floor by lifting both of Maxine's legs.

In the police interview the officer referred to neighbour statement dated October 2018 whereby she had heard another neighbour, talking to Maxine and Thomas. The neighbour heard Maxine say, "You should see the bruises he's done me". Neighbour stated that she heard a smashing sound and contacted the police as she feared Thomas was assaulting Maxine. Thomas denied assaulting Maxine and stated Maxine's bruises were caused from falling over when drunk.

Thomas denied in the interview being responsible for any of the bruises on Maxine.

- Thomas, when being interviewed, had several injuries to his face. He stated these injuries were from his 15-year-old Staffordshire terrier dog that had attacked him after

		Thomas tried to take the dog's food away. Thomas stated that his dog had never attacked him before but left bite marks on his arm and face. Thomas stated that he went to the hospital for treatment following the dog attacking him. • Thomas denied that Maxine had set his dog on him.
Undated	Report by Northumbria Police DC involved in the investigation of Maxine's death. Summary of Body worn footage attending officers October 2018	Within the Body worn footage Thomas is in the living room and has told the police officers every time he gets close to someone they die. Thomas stated that the night before Maxine was full of drink and was asking how she was going to take all of her tablets (verapamil). Thomas stated that Maxine had fallen in the kitchen and banged the back of her head and when he went to help her the dog bit him on the lip. Thomas stated that Maxine's phone was broken so he had to get the attention of the neighbour to ring 999 for the ambulance. Thomas stated that he tried to wake Maxine up, but she was stone cold to touch. Thomas stated that Maxine had said she was going to take the tablets, but he didn't think that she was going to do it. Thomas states that between 2330hrs and 0000hrs Maxine told him she had taken the tablets but that he had not seen her. When police asked why Thomas had not contacted 999 he stated that Maxine showed no signs of her having taken an overdose and described Maxine as being 'rosie'. Thomas stated that he had said but, in the morning, she was stone cold. Thomas stated that he had tried CPR (cardiopulmonary resuscitation) and shaking Maxine but there was no response. Thomas then stated that Maxine had Subutex and pregabalin the morning before.
Undated	Report by Northumbria Police DC involved in the investigation to Maxine's death	Findings and the information that was available at the time 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 into the death.
Undated	Statement of the Pathologist who	The Home Office Pathologist carried out a Home Office post-mortem examination in October 2018. Below are extracts from the Home Office registered Pathologist's statement:

	conducted Home Office Post-mortem	*"From these examinations were:* 1. *Numerous bruises to the limbs and torso.* 2. *Blood verapamil of 5.5mg/L* 3. *Cocaine, benzoylecgonine and cocaethylene in the blood.* 4. *Contraction band necrosis of the heart* 5. *Blood alcohol of 46mg/100ml* 6. *Rib Fractures* *Thus, the post-mortem examination has shown no injuries to account for Maxine's death. There were large numbers of bruises to the arm's, limbs and torso but these would not have caused death. Many of the bruises are likely to be as a result of a number of falls and Maxine being somewhat unsteady on her feet. The bruising to the upper arms and around the armpits is likely to be the result of gripping but it is not possible to determine where this was as a result of some form of restraint or whether it was, instead, during attempts to render assistance to Maxine. However, it has been caused, it has not played a role in her death".*
21/07/2020	Letter from Northumbria Professional Standards Department CO/574/19 Investigation into appeal	The report focussed on 7 areas raised by Janine and Linda which were the family's basis of submitting a formal complaint regarding Maxine not being safeguarded appropriately by Northumbria Police: 1) Why was Maxine not assessed as High Risk following the reported Domestic abuse incidents in July and October 2018? 2) Was Maxine discussed at MARAC? 3) What did officers do to safeguard Maxine following each domestic abuse incident? 4) Why was Thomas not charged with assault in July 2018? Was the file of evidence taken to the Crown Prosecution Service (CPS)? If it was not taken to CPS, then why? 5) Was a DVPO granted at court? If so, how long was it granted for? 6) Has the suspect ever used any other name? If so, would this affect the safeguarding that was offered to Maxine? 7) Why has Thomas not been convicted of anything based on his extensive background of violence towards vulnerable women? **DVPN/DVPO Northumbria Police conclusion documented on the report sent to Janine and Linda:**

		"Conducted a thorough investigation into your upheld appeal and sought advice from those more suitably placed than I to provide a professional opinion to the questions you have raised. *It is my opinion as investigator that Police Constable (XXXX) did everything that would be expected of him as a police officer until the point he obtained a DVPO. Northumbria Police Policy and procedure around the policing of a DVPO states both the victim and the subject should be visited on a daily basis for the duration of the order. This was not done, and lessons should be learnt from this.* *Your complaint was that your sister was not afforded the necessary safeguarding or support as ought to have been expected following a DVPN, to which I agree.* *Therefore, on the balance of probabilities I* ***uphold*** *your complaint with words of advice to be given to both PC XXX and his supervision regarding the management of the DVPO once obtained in line with force policy. Furthermore, I will be recommending that in light of this investigation, a review of force policy into the management of DVPOS be conducted by the Safeguarding Department".* **Risk assessment regarding domestic abuse incidents that the police attended during the scoping period, whereby Maxine was the victim and Thomas identified as the perpetrator.** The internal police investigation examined the risk assessment that initial responding officers completed following the domestic abuse, stalking and 'honour'-based violence DASH risk assessment after attending reported incidents of domestic abuse whereby Maxine was identified as the victim and Thomas as the perpetrator. Below are extracts from the internal police investigation report: *"**7 July 2018** the attending officer highlighted concerns in 4 of the available 27 sections of the DASH form. Those highlighted areas were in response to questions 1, 21, 23 and 24 which relate to:* *1) Evidence of an injury caused to Maxine as a result of the incident.* *21) That the abuser was suspected of mental health and drugs or alcohol dependency.* *23) That the abuser was suspected of breaching either bail or previous orders against him and;* *24) That the abuser may have had a criminal history* *Summary recorded on this DASH form was as follows: IP (injured Party) has called after her partner has punched her in the face*

		earlier in the morning and then pushed her against the living room wall, bruising her left arm" The DASH Risk identification checklist relating to the domestic abuse incident **in October 2018** was examined also as part of the internal police investigation. Below is an extract from the internal police investigation report: *"The uploaded DASH form, only one area was highlighted, at question 21 which related to the abuser being suspected of mental health and or drug or alcohol dependency. The update provided on the DASH form was as follows: third party report of a loud verbal argument from the address with the female being heard to tell the male to get out. On police arrival only Maxine present and she was more concerned that she had lost her phone. Maxine was saying that Thomas had left the property and was under the influence of drink and drugs, hence the argument. Maxine provided a signed pocket notebook entry stating that she had not been assaulted and was not making any complains and was wanting Thomas out of the address only".* Below are extracts from the report that give **conclusion regarding the DASH risk assessments** completed which resulted in Maxine being graded as *'standard'* risk: "It is clear that Maxine was not willing to assist police or support a prosecution. With reference to the first incident (7 July 2018), Maxine refused to provide police with a witness statement which would have outlined the incident and the allegation of assault. The second incident resulted in Maxine refusing to engage in the DASH process. Admittedly, this makes it more difficult for the officers to engage with the victim and provide necessary support to ensure her safeguarding. Nonetheless, positive action was taken in respect of the first incident due to the alleged assault" "For Maxine to have been assessed as high risk there would have been a requirement for at least 4 incidents of domestic abuse in 4 months, or repeat MARAC victim within the last 12 months, or at least 14 ticks highlighted on the DASH form. In addition to this, the attending officer can provide professional judgement if they had significant concerns which were not part of the DASH assessment, which would then override the DASH risk assessment. The Officers who attended both incidents, having used their professional judgement deemed that the incidents involving Maxine did not fit the 'high risk' criteria". The author of the internal police investigation report sought guidance and opinion from a senior serving Northumbria Police Officer with additional specialist knowledge within domestic abuse and safeguarding. Below is an extract documenting their opinion: "States having reviewed the first incident dated 7 July 2018 and the domestic abuse violence records, as well as the completed

		DASH form, based on the number of ticks, considers this was the correct assessment by attending officer". "Having reviewed the second incident dated October 2018 which was also assessed as standard with only one tick being recorded states given the circumstances were based on a third-party report and the lack of cooperation by Maxine, the assessment on this occasion was also correct". "Risk levels within Northumbria Police procedure are made on the following basis. ***High risk*** – 14 or more ticks in the relevant fields or 4 incidents in 4 months or repeat MAARC victim within the last 12 months. ***Medium risk*** – 8 - 13 ticks in the relevant fields or 3 incidents in 4 months. ***Standard risk*** – incidents falling outside of the above. **Senior Northumbria Police Officer's Professional judgement and opinion regarding the risk levels identified by attending officers retrospectively was extracted from the report below:** **"***States neither case is treated in isolation, nor even if taken together (looking at the wider impact of known domestic abuse), would have resulted in Maxine being assessed as medium risk, let alone high risk, and therefore the risk levels were appropriate in their view"* *"Police officers are expected to look at the history of domestic abuse but that includes questioning the victim to see if there has been an unreported history as well as the incidents that have been reported. This is where coercive control could potentially be identified. However, as you will appreciate, Maxine refused to engage with police on both occasions"* *The internal police reports examined and gave consideration to managing Thomas and looks at Multi-agency Public Protection Arrangements (MAPPA)[11], Potential Dangerous Person (PDP)[12] and 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" "In taking into account both incidents involving Maxine, Officers would not have thought the risk was so great that a referral would have been made to the MAPPA Process"*

[11] MAPPA The purpose of MAPPA is to help to reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm - https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

[12] Potential Dangerous Person (PDP) – College of Policing - https://www.college.police.uk/app/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/potentially-dangerous-persons

		"Reviewing information held on the police computer system in respect of Thomas incident offences and convictions. There are 3 categories within MAPPA and PDP which range from category one, which would include the management of sex offender and serious violent offenders, to category two in which someone would have to have been convicted of a relevant offence and sentenced to 12 months or more imprisonment, and then category three refers to anyone with a conviction sentenced to less than 12 months. Once the category is identified, the screening panel will establish which level the perpetrator could be managed at. Level 3 refers to the most serious of offenders, level 2 refers to those offenders that need to be managed on a multi-agency level and level 1 would be managed by that referring agency i.e police or probation. Thomas was already being 'managed' by police on level 1 (the DVPO process), the next level being level 2 would be the consideration for the screening Panel". *"Due to the restrictions by the Data Protection Act, I am unable to share the rationale; however, having reviewed all information held by the police, Thomas would not have been eligible for MAPPA/ PDP referral for level 2 consideration".*
undated	Janine and Linda	At various stages following Maxine's death in October 2018, Janine and Linda liaised directly with multiple people in the community to establish an understanding of Thomas's background, which, on the information collated, would categorise Thomas as a serial perpetrator of domestic abuse.[13] Information provided by Janine and Linda has been summarised below: *"Thomas had changed his name (2007/2008), and under his previous name, there were 'rumours' that he had raped a female".* ***Partner 1 (deceased):*** *Thomas entered a relationship with a female. There was alcohol and drug misuse and domestic abuse in this relationship. Partner 1 was found deceased. Thomas was in a relationship with her at the time. Incidents of domestic abuse alleged that Thomas subjected Partner 1 to physical and emotional abuse.* ***Partner 2 (deceased):*** *Thomas entered a relationship with a female. Thomas had an on-off relationship with Partner 2, involving alcohol, drug misuse, domestic abuse, physical and described as controlling and jealous. When Partner 2 ended the relationship Thomas harassed her.* *Other rumours which have been circulating within the local community regarding Thomas were on Facebook suggesting that he had been linked to a death of a female and a male.*

[13] The term 'Serial perpetrators' is usually used to refer to individuals who have used or threatened violence or abuse against two or more victims who are unconnected to each other.

6 Analysis of agencies involvement, key issues and themes

6.1 Analysing chronology tables 1 and 2, the author has provided a factual overview that identifies crucial points, compares them, and puts them in chronological order, affording valuable information from sources like Janine, Linda, and agencies to be linked together, providing an accurate picture of Maxine's experiences. The interlinked overview and analysis also highlight Maxine's struggles, vulnerabilities, and risks to agencies, which she may not have been aware of during the scoping period, particularly about her intimate relationship with Thomas.

6.2 Maxine had been a repeat victim of domestic abuse. She was in a long-term abusive and violent relationship with a male for 16 years. The emotional and psychological abuse that she was subjected to during this relationship had long-term effects, affecting her physical and mental health. Understandably, Maxine used coping strategies which were self-protecting in nature and included addiction in the form of alcohol and prescribed drugs.

6.3 Maxine left the abusive relationship and with the support of her sister, Janine and Linda moved into a flat in August 2016 near her sister, whom was a protective and supportive factor in her life, helping her regularly with meals, transportation and encouraging Maxine to attend various addiction groups like Alcoholics Anonymous (AA)[14], Narcotics Anonymous (NA)[15] and Project Answer. Janine believes that the self-help groups exposed Maxine to persons with more severe drug and alcohol addictions, making Maxine vulnerable to being exploited and targeted.

6.4 **20 November 2009** Adult Social Care North Tyneside Council were invited to provide information to the North Tyneside Multi-Agency Risk Assessment Conference (MARAC), identifying Thomas as the MARAC perpetrator.

6.5 Between **2015 and 2018**, Northumbria Police identified Maxine as a repeat victim of domestic abuse with Maxine's previous partner (2015 – 2017) and Thomas (2018).

6.6 **5 July 2017**, Maxine moved GP doctor surgeries, resulting in a new patient questionnaire being completed.

[14] https://www.alcoholics-anonymous.org.uk/members/regional-&-local-websites/North-East-Region/Tyne-&-Northumbria-Intergroup/Meetings Alcoholics Anonymous is a fellowship of people who come together to solve their drinking problem

[15] https://ukna.org/ - We are Narcotics Anonymous in the United Kingdom & Channel Islands. If you have a problem with drugs, we are recovering drug addicts who can help you get and stay clean.

6.7 **2 August 2017,** New GP surgery was made aware by NTRP, that Maxine had been subjected to Domestic Abuse in the form of a physical assault by her previous partner.

6.8 **8 August 2017,** Maxine's new GP surgery had received notes from Maxine's previous GP surgery.

6.9 **16 August 2017,** A keyworker from NTRP contacted Maxine's GP surgery requesting that the GP doctor does not prescribe Maxine Diazepam or Pregabalin. At the time, Maxine was being prescribed Pregabalin by her GP surgery.

6.10 Between **November and December 2017**, there was frequent interaction between Maxine and her GP surgery, specifically noting that on **9 November 2017**, Maxine was seen by her GP doctor, expressing a history of anxiety, depression and taking anti-depressants feelings of low mood and crying, no suicidal thoughts. Maxine discussed being subjected to domestic abuse resulting in separation from her previous partner and mentioned a historical overdose. During this appointment, Maxine disclosed work-related stresses causing her not to wish to return to work and that she was seeking a sick note, which her GP provided. There was no documentation of a discussion taking place between Maxine and her GP regarding Maxine being prescribed Pregabalin or Diazepam, which NTRP had on 16 August 2017 explicitly requesting the GP not to prescribe Maxine those two medications.

6.11 **27 November 2017**, the GP doctor conducted a review documenting that Maxine feels supported by her sister, dad and step mum has no suicidal thoughts and is not drinking to excess; she feels she lost confidence as her previous partner was controlling. The outcome of the review appointment was to increase Maxine’s medication of Pregabalin and self-refer to NTTT. This contradicts the request NTRP had made directly to the GP on 16 August 2017, which was not to prescribe Maxine Pregabalin or Diazepam. From Maxine’s GP notes, there was no communication or documentation confirming that the GP has sought clarification or liaised with NTRP regarding their request on 16 August 2017 or that this had been discussed with Maxine. There was no documentation in Maxine’s notes regarding how the GP had responded to the domestic abuse that Maxine had self-reported during GP consultations (9 and 27 November 2017). There is an expectation, and it is considered best practice following a patient's disclosure of domestic abuse that the patient becomes part of the designated person’s caseload if they are a specialist domestic abuse practitioner themselves. Or a referral to an appropriate local specialist domestic abuse service if the patient consents. Or signposting to domestic abuse resources and provision of a basic safety plan if the patient is unwilling to

engage with services currently. The review has not been able to determine the exact reasons for the GP not exploring Maxine's support needs surrounding the domestic abuse that she had willingly disclosed.

6.12 **5 December 2017***,* the GP doctor informed that Maxine had made a self-referral to talking therapies and would receive an initial assessment on **15 December 2017.**

6.13 **24 December 2017**, Maxine's GP surgery received a letter from the Emergency Department confirming Maxine had attempted to overdose on Pregabalin and had left before seeing the Psychiatric team. After receiving this correspondence, the GP doctor took no action at that time.

6.14 **4 January 2018**, Maxine had a face-to-face appointment with her GP doctor. Linda was also in attendance. The GP documented during the appointment that Maxine's moods are labile, and one day can be busy cleaning from 5 am and next in bed crying. Maxine's GP doctor discussed her medication with her, noting that Diazepam helped, but understands the risks. Maxine disclosed that anxiety symptoms are a struggle, and she is feeling agoraphobic. Maxine explains that her Mental health has been complex since her teenage years following the death of her mother from Motor Neuron Disease (MND) when she was 11 years old. Maxine stated that she has reduced her alcohol intake and tries to have days without any alcohol. Maxine confirmed that she is on the waiting list for NTTT. The GP doctor completes a mood disorder questionnaire with Maxine scoring 11, suggesting a moderate problem.

6.15 **8 January 2018**, the GP doctor submitted a referral to CMHT.

6.16 **17 January 2018,** Janine visited NTRP's premises to express her concerns about Maxine locking herself in the house and refusing to let Janine in. Janine said she was deeply disappointed that no one from NTRP would engage with her. Janine contacted the police, who were unable to assist. Janine then contacted Maxine's GP, who subsequently contacted Maxine by telephone.

6.17 **17 January 2018**, Northumbria Police and Emergency Services reported an incident regarding Maxine's self-harming following Maxine contacting her neighbour, threatening to self-harm. Maxine's neighbour went to check on her welfare, discovering that she had taken a quantity of tablets. Maxine's neighbour rang the police, who attended. Maxine was conscious; however, she appeared confused.

6.18 There was a history whereby Maxine had on three previous occasions taken overdoses in **December 2017 and January 2018**, which is when Janine and Linda became aware of the full extent of Maxine's alcohol addiction, debt, and a deterioration in her physical and mental health. Janine describes how Maxine was desperate for help and support, acknowledging that NTRP had not been aware of the extent of her drinking problem. With Maxine's agreement, her sister and Linda adopted a supportive handheld approach in promoting self-help and advocating Maxine's needs to her GP doctor on **22 January 2018**.

6.19 Towards the **end of January 2018**, Maxine felt optimistic about starting the 12-step recovery programme from self-help literature. Maxine and her GP doctor decided that Janine and Linda would become part of her care team due to Maxine historically omitting the extent of her alcohol addiction and the impact that this was having on her. During this proactive discussion among Maxine, her GP, Janine and Linda, it was confirmed that NTTT and NTRP were the other agencies actively supporting Maxine then. Maxine had also requested an increase in medication, but the GP doctor refused, explaining that she could not properly assess the effects of the medication on her until she stopped drinking heavily.

6.20 Janine described how Maxine had informed her and Linda that her key worker at NTRP disagreed with the self-help 12-step programme that Maxine had been positive in starting and gave her various leaflets and literature on alternative methods. Maxine also advised her sister that her NTRP key worker believed that she was not alcohol dependent and that she had the power to give up at any time, suggesting that she start immediately reducing her alcohol intake. Janine noted that in **February 2018**, Maxine did start a course with Oaktrees[16]; however, she stopped attending after three weeks.

6.21 Maxine also relayed to her sister on **26 February 2018** that she had asked her key worker at NTRP about meeting with Janine. However, she had been advised that her sessions were confidential, and her key worker did not understand why she needed to speak with her.

6.22 Thomas made multiple visits to the GP practices at various times, primarily for substance misuse and mental health issues. He also faced challenges related to housing, isolation, and physical health. His symptoms were consistent with those of someone struggling with drug

[16] **Oaktrees abstinence Programme** you will participate in group therapy and develop life skills and techniques to prevent relapse. This programme is suitable for those who wish to live a life free from drugs and alcohol and can commit to a daily treatment programme on weekdays. The staff team and your peers will also support you to structure your evenings and weekends to help with your recoveryhttps://www.cntw.nhs.uk/services/northumberland-recovery-partnership/oaktrees-programme/

addiction. The GP practice and the community substance misuse team shared responsibilities for his care, while his mental health support fell between the two services. Thomas expressed frustration about the lack of clarity regarding who was managing his care.

6.23 At times, Thomas displayed anger, expressed frustration, and behaved threateningly during his visits. Such behaviour is common among patients struggling with substance abuse. The GPs involved in his care understood and managed these outbursts as part of their work. Being a GP often requires addressing the challenges faced by patients grappling with substance abuse. These patients frequently find themselves in vulnerable situations and exhibit complex behaviours that need substantial support.

Scoping period March 2018 to October 2018

6.24 Janine stated that on **3 March 2018**, she found Maxine unconscious at home with the door to her flat open, and Maxine remained unconscious for some time. Following this incident, Maxine went and stayed at her sisters for support, where discussions regarding Maxine's alcohol addiction and relapsing took place.

6.25 Janine and Linda started a seven-week course with Props North Tyneside[17], a family recovery service improving the lives of families affected by alcohol and drug use.

6.26 On **05 March 2018**, CNTW, NTRP, addiction worker stated that during an appointment with Maxine, she had advised her that her sister and partner wanted to be involved in her treatment, but stated that this was something that she did not wish for them to be involved in. Maxine also disclosed that she had a relapse and had been drinking vodka since Wednesday (several days ago).

6.27 On **12 March 2018**, NTRP, addiction worker conducted a review appointment with Maxine, whereby Maxine had self-reported an increase in anxiety levels and used cannabis and that her GP had provided one-off prescription Diazepam. The GP records provided as part of the review confirm that Maxine had a face-to-face consultation with her GP and that her sister was in attendance. The GP records refer to Maxine having no communication from NTTT, and that CMHT does not believe that Maxine is suitable for their service. During this consultation, the GP described Maxine's presentation as agitated. The GP reiterated the need for Maxine to

[17] **Props North Tyneside** We help you to understand your situation and ensure you and your family stay safe. We offer support to help you cope with difficult situations and behaviours. We ensure you look after your wellbeing whilst also helping your family member. https://props.org.uk/

abstain from alcohol in preparation for psychological treatment and documented that Cognitive Behavioral Therapy (CBT)[18] would be more appropriate due to anxiety with depression worsening, which was written on Maxine's fit note. Janine confirms that she was present during this appointment and was keen for Maxine to seek support and help following a significant relapse due to Maxine binge drinking.

6.28 **22 March 2018**, NTRP, addiction worker, conducted a review appointment with Maxine and documented Maxine's self-reporting of drinking cider and smoking cannabis.

6.29 **23 March 2018**, CNTW, case file from a recovery group session, stated that Maxine attended recovery group and reported drinking alcohol and cannabis whilst disclosing that her anxiety was becoming overwhelming. She intended to seek support from her GP. Maxine's GP notes confirm that a Psychology appointment had been arranged for **5 April 2018** for Maxine. Maxine had attended a face-to-face appointment with her GP on **26 March 2018**, whereby Maxine stated that she had remained abstinent from alcohol but is using cannabis day and night to control her anxiety symptoms and that NTRP is aware of this and that Pregabalin that she was taking was helping, which is contradictory of NTRP's request on 16 August 2017 for Maxine not to be prescribed Pregabalin.

6.30 On **3 April 2018**, CNTW contacted Maxine by telephone to encourage her attendance at the women's group. It was during this telephone call that Maxine said she had relapsed and would not commit to any group work. Following this disclosure, Maxine was advised to access support offered at NTRP as well as utilising Alcoholics Anonymous.

6.31 On **5 April 2018**, NTTT conducted a face-to-face appointment with Maxine and noted that the service had previous involvement with Maxine in a support capacity in 2014/2015.

6.32 On **6 April 2018**, NTRP, an addiction worker, conducted a review appointment documenting that Maxine reported no alcohol over the last couple of weeks, would use cannabis daily and that she had not been attending support group meetings. The abstinence from alcohol and smoking cannabis was also self-reported by Maxine in a GP face-to-face consultation on **9 April 2018**, whilst relaying that NTRP had encouraged her to reduce her cannabis use and confirmed that she had her first appointment with NTTT and was hopeful of continuing to engage with NTTT every week. During this appointment, Maxine and her GP discussed her

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painful swollen ankles, which had been problematic for several months, and her increased dosage of Pregabalin was discussed. Both the GP and Maxine agreed she could request more Diazepam on acute prescription, and a medication review would be conducted in 3 months. There is no recording or documenting in Maxine's GP notes regarding NTRP request not to prescribe Pregabalin and the dangers of taking Pregabalin whilst drinking alcohol/using illegal drugs. Whether taken intentionally or without realising the risks, the effects of Pregabalin and alcohol mixing can be very serious. These effects include a range of physical, cognitive and psychological issues including slowed reaction time, memory loss, confusion, loss of coordination, depression, suicidal thoughts and increased risk of addiction to both substances.

6.33 On **23 April 2018**, NTRP, addiction worker, conducted a review appointment where Maxine reported that she had an altercation with her sister and felt that her sister was checking up on her all the time. Maxine's presentation during the appointment was described as very tearful, and she reported that the GP took her off the anti-depressants. Maxine implied that she had started a relationship with a male by saying she had a "new man in her life and it was early days". Maxine also confirmed that she had been drinking alcohol, and the addiction worker noted that she did not appear intoxicated during the appointment.

6.34 The NTRP, addiction worker was aware that Maxine had been subjected to domestic abuse by her previous partner and the abuse had had long-term effects on her physical and mental health, including Maxine adopting coping strategies in the form of alcohol, prescribed drugs and illegal misuse of drugs, making Maxine increasingly vulnerable prompting a need for professional curiosity and exploration of new relationships, which would potentially mitigate the risk of being taken advantage of or exploited whilst safeguarding Maxine. The review has noted that there was no documentation regarding Maxine's review appointment on 23 April 2018 that her NTRP addiction worker had explored Maxine's 'new man in her life'. The review has not been able to establish if this comment made by Maxine was referring to Thomas.

6.35 On **25 April 2018,** NTTT contacted Maxine by telephone, seeking confirmation that she would be attending the appointment on **26 April 2018**, which she did.

6.36 On **26 April 2018**, NTTT received a telephone call from Maxine cancelling her appointment due to waiting to discuss medication change with her GP. This prompted NTTT to contact Maxine's GP on **26 April 2018** to explain that Maxine struggled in attending her appointment and that they were seeking an opinion if Maxine's GP feels she can engage whilst changes to

her medication, Diazepam, are taking place. The GP agreed on the timeframe of between two to four weeks for adjustment of medication.

6.37 During **April 2018** Janine describes how, during the following weeks, Maxine continued consuming alcohol, and her behaviour was becoming increasingly erratic, causing her to appear highly emotional and weepy whilst withholding information from her sister about where she was and who she was socialising with. Maxine advised her sister that around this time, following medical reviews, she was taken off her anti-depressant medication, and a couple of weeks later, Maxine's daily Pregabalin dose was doubled by her GP. Janine was becoming increasingly concerned for Maxine as she was describing the impact of the withdrawal, she was experiencing from her anti-depressants openly on Facebook and she was becoming reclusive and not getting out of bed. Janine describes how she saw a deterioration in Maxine's physical appearance. She described Maxine as having a disheveled, unkempt look and that the swelling was worsening in her legs. Janine and Linda would express their concerns to Maxine, who responded defensively, suggesting that she was handling things fine and did not need to answer to them anymore. Janine noted that this was an unexpected change in Maxine's behaviour which coincided with Maxine starting a relationship with Thomas and an increase in Maxine's prescription of Pregabalin.

6.38 On **4 May 2018**, the NTRP addiction worker raised concerns regarding Maxine's low mood and symptoms of depression and anxiety, and she reported that the GP had recently stopped her anti-depressant and was prescribed Buprenorphine. Maxine's addiction worker was concerned due to Maxine's continued use of illicit substances and documented that the service routinely asks GP doctors not to prescribe any opiate-based medication without contacting the service first. The addiction worker followed up on the above concerns with Maxine's GP in written correspondence; this was referenced in the GP's information, and a template note not to prescribe Benzodiazepines/Pregabalin or Gabapentin was documented. The concern raised prompted the GP to conduct a telephone consultation with Maxine.

6.39 On **9 May 2018** the GP has a telephone consultation with Maxine to discuss the letter they had received from Maxine's addiction worker. The GP established that Maxine reported managing without Duloxetine and would continue with Pregabalin. The agreed outcome between Maxine and the GP was for the GP to issue seven Diazepam tablets and for the GP to liaise with the addiction worker and provide an update. The GP advised Maxine that no more Diazepam would be given until they had been advised of the plan by her addiction worker. The review has noted that the GP has responded promptly to the NTRP request on 4 May 2018 regarding

Maxine's prescribed medication to mitigate potential risks regarding specific medicines like Benzodiazepines. However, it omits to document any consideration or mitigation of the increased risk of Pregabalin continued to being prescribed, which the combination of Pregabalin and opiates taken together can slow down breathing further.

6.40 On **15 May 2018**, a CNTW, NTRP, addiction worker held a review appointment with Maxine whereby Maxine tested positive for Cocaine, Marijuana, Benzodiazepines, Buprenorphine, and Opioids. The addiction worker felt that Maxine's Pregabalin dose was too high and intended to liaise with Maxine's GP. During this meeting with Maxine, the addiction worker documented that they had addressed concerns regarding Maxine's "chaotic lifestyle", but there was no elaboration upon that term or how the addiction worker had come to that professional conclusion regarding Maxine's lifestyle.

6.41 On **17 May 2018**, Maxine contacted NTTT and cancelled her appointment, stating that she could not attend due to experiencing anxiety. Maxine stipulated that her GP had prescribed her Diazepam and disclosed that she had met a friend whom she met at NTRP, but she left because he was drinking alcohol. Maxine disclosed that she had not been out for three days, which prompted NTTT to document a note of concern about self-care. NTTT during this interaction with Maxine did not use professional curiosity, exploring who Maxine's male friend was that she had met at NTRP.

6.42 On **25 May 2018**, NTTT conducted a clinical supervision regarding Maxine, which confirmed no specific safeguarding or risk issues were identified; an action was agreed upon for the NTTT worker to contact the GP and share concerns about Maxine's presentation, which was completed that same day by a message being left for the GP advising Maxine had not attended NTTT appointments and concerns referencing Maxine's self-care expressed and that Maxine remains vulnerable. NTTT also suggested to the GP that Maxine was unable to attend her appointments and that NTTT's service is currently not appropriate for Maxine.

6.43 NTRP, addiction worker received a telephone call from Maxine's partner (no name documented) the previous day and reported that Maxine was unwell and that they would be attending together on 30 May 2018. Maxine then contacted, stating that she had no money for transportation, and neither did her partner. Maxine suggested that she walk, or they deliver her prescription to a pharmacy for her and her partner to collect. The addiction worker enquired if this could be facilitated; however, she was advised for Maxine to walk instead. The addiction

worker perceived and described Maxine's response to this as being *'most put out at this suggestion'.*

6.44 On **31 May 2018**, Maxine had an unscheduled appointment with a NTRP addiction worker. The addiction worker documented that Maxine had disclosed that she had used cocaine and cannabis but none that day and that Maxine stated that she had been passively smoking as her partner smoked heroin. During this appointment, Maxine disclosed*, "She and her partner had been arguing and that he had locked her in his flat yesterday".* No further information was documented or recorded by the addiction worker regarding Maxine's disclosure of domestic abuse. The addiction worker had not recorded any professional exploration or risk assessment being considered or safety plan completed following Maxine's disclosure of domestic abuse by her partner, which contradicts the professional responsibility that the addiction worker has under the CTNW Domestic Abuse policy, NTW(C) 54, dated January 2017 to be reviewed January 2020.

6.45 The author of this review purposely considered the response from the addiction worker against the above Domestic Abuse policy, which was in place at the time that the addiction worker received a disclosure of domestic abuse from Maxine. The purpose of the policy is to; "*raise awareness as to the nature of domestic abuse, guide staff through their responsibilities when a disclosure of abuse is made, to ensure that as domestic abuse is disclosed, the immediate action is to protect the victim (and children if living in the same household) to prevent further abuse from taking place, provide a clear framework of actions should the indicators of risk necessitate a referral through the Multi Agency Risk Assessment Conference (MARAC) process, to ensure people who disclose that they are perpetrating domestic violence or abuse are offered a referral to Specialist Services".* It was apparent from Maxine's detailed disclosure during the impromptu appointment that she was a victim of domestic abuse. This should have prompted the addiction worker to establish who the perpetrator was, evaluate the risk level (low, medium, or high), and consider involving other agencies like MARAC for further assessment. It was imperative to collaboratively devise a safety plan with Maxine, seek her consent for referrals to specialised domestic abuse agencies, and offer information about support services if she did not consent to a referral. It is worth noting that NTRP is a service that falls under the umbrella of CNTW, and as such, Thomas would have had a MARAC perpetrator flag on his CNTW record, as he did with Adult Social Care North Tyneside Council and Northumbria Police (MARAC Perpetrator 2009).

6.46 The author has considered third party reporting regarding this specific disclosure from Maxine of Domestic Abuse, which is documented within the trusts Domestic Abuse Policy, NTW(c) 54 as follows:

"The Trust has signed the Northumbria Police MARAC information Sharing Protocol using the principles of the Section 115 Crime and Disorder Act 1998. Permission should always be sought before sharing information. If, however, you feel a victim is at immediate risk of serious harm permission should be overridden and the Police contacted"

"Whilst personal information held by NHS organisations should be properly protected there is a growing expectation that information will be shared between Health Bodies, Public and Local Authorities and the Police Service where it is appropriate to do so. Sharing information is a key element in the delivery of high-quality cost effective and seamless public services. Please refer to the Trust's Information Sharing Policy - NTW(O)62"

6.47 The review has concluded that Maxine's disclosure of domestic abuse was not shared with any other agencies, and no referrals were submitted. However, the review was unable to establish why no action was taken after her disclosure. The author has classified this as a significant missed opportunity. In retrospect, had a risk assessment been conducted and the perpetrator's name - which the review believes was Thomas - been identified, then the significant risk he posed to Maxine may have been identified earlier and a multi-agency (MARAC) response considered.

6.48 Between **April and May 2018** Janine stated that Maxine was introduced to Thomas by a friend. Thomas locally was known to use heroin and deal illegal drugs and he had been offered support by NTRP, resulting in both Maxine and Thomas being open to the same NTRP addiction worker. Quickly following Maxine and Thomas's introduction they began a relationship and Thomas moved into Maxine's home in **June 2018**. Janine believes during this period Maxine became distant from her. Janine attributes Maxine's distance to their relationship with Thomas and mixing and associating with people who were open drug users.

6.49 It was in **May 2018** Janine noted that Maxine's behaviour became more erratic, she was unsteady on her feet, concealing her alcohol use further, and presenting in a dazed state. Maxine's engagement with her GP, NTTT and NTRP became intermittent due to Maxine missing several appointments.

6.50 Janine in **June 2018** expressed concerns to Maxine's GP that she was worried about Maxine in general and more so because of the relationship Maxine had entered with Thomas.

6.51 On **10 June 2018**, NTRP, addiction worker documented that Maxine did not attend the scheduled appointment and that the prescription was retained to facilitate attendance. On **12 June 2018**, Maxine's addiction worker received a telephone call from Maxine confirming that she had been ill all weekend due to coming off Pregabalin and that she had bought Buprenorphine to manage over the weekend. An appointment was arranged for Maxine to attend on **13 June 2018**, making Maxine four days off prescription.

6.52 On **13 June 2018**, Maxine attended her appointment with CNTW, addiction worker, where she disclosed that she had felt ill due to withdrawing from Pregabalin and that she had bought 10mg of Buprenorphine and had taken Diazepam when starting to experience withdrawal from Pregabalin; then had no Diazepam left. Maxine stated that she had a couple of lines of cocaine a few days ago. Maxine stated she had been speaking to her dad but was still not communicating with her sister.

6.53 On **14 June 2018**, Maxine had a face-to-face consultation with her GP, whereby she presented as tearful and upset as her mum had MND and was concerned that the numbness in her hands was possibly MND or Multiple Sclerosis (MS). During the consultation, Maxine stated that she had reduced her alcohol consumption and made reference to her new partner (no name obtained) drinking alcohol, causing her to drink a couple of times a week. Maxine stated that she had ceased taking Pregabalin approximately a week ago and that she had felt low in mood and tearful since, and due to this, she believes that Pregabalin had been helping. No exploration was documented in Maxine's GP notes regarding her new partner.

6.54 On **17 June 2018**, Northumbria Police attended Maxine's address in search of males who had been dropped off but had not paid for the taxi. Police Officers spoke to Maxine at the address, and she advised the Police Officers that she did not know about the incident. No additional information was provided to the DHR process describing Maxine's physical presentation or confirmation of Thomas residing at the address, and that Police Officers at this time were aware he was.

6.55 On **18 June 2018**, Maxine's GP made an entry on her medical record that Maxine had contacted the surgery, stating that she had lost her prescription for Pregabalin and planned to discuss this with NTRP. Later the same day, the GP made another entry confirming that they had received another call from Maxine, who was stating that she had lost her Pregabalin. The GP also referenced an alert on Maxine's notes advising against Pregabalin being prescribed and that the GP was to liaise with an NTRP worker. The GP documented an attempt to contact

the NTRP key worker but was not successful. GP decided to issue a week's supply of Pregabalin for Maxine.

6.56 On **25 June 2018,** Thomas had a consultation with his GP. During the appointment, Thomas mentioned that he had a partner, who is believed to be Maxine, and she seems to have good knowledge about opiates. Unfortunately, the GP did not demonstrate any evidence of considering contextual safeguarding, which is a crucial oversight. The DHR suggests that the GP was aware of Thomas's aggression and violent outbursts and had historic notification that Thomas had been identified as a MARAC perpetrator with a previous partner.

6.57 On **27 June 2018**, Maxine had a face-to-face consultation with her GP. During this appointment, Maxine stated that she had spoken to her NTRP key worker and was aware of her view regarding Maxine being prescribed Pregabalin. Maxine noted that when she stopped taking Pregabalin for ten days, she had felt more anxious, so she wished to continue taking Pregabalin. The GP documented that Maxine seemed '*bright'* and did not appear to be intoxicated during the appointment, with no further elaboration on Maxine's presentation. The GP advised Maxine during this appointment that if she lost her Pregabalin again, they may not be able to prescribe and replace the Pregabalin.

6.58 On **27 June 2018**, NTRP, addiction worker, conducted a scheduled appointment with Maxine, who reported she was taking Pregabalin due to anxiety and that she had misplaced her prescription by leaving it on the bus. Maxine was advised that they had spoken with her GP and understood she had stopped taking it and detoxed herself. Maxine stated that she had an appointment that day with her GP and had requested that she continue to be prescribed Pregabalin. During this conversation, Maxine confirmed that she had also been taking Tramadol and Co-codamol as pain relief. During the appointment, Maxine disclosed that she had seen her sister but that their interaction had not gone well. Maxine stated that she had seen her dad on Father's Day. Maxine stated she could not remember the last time she had cocaine.

6.59 On **7 July 2018**, Maxine contacted Northumbria Police to report a domestic assault. Maxine disclosed to the Police that her partner, Thomas, had punched her in the face and that her dog attacked him. Thomas was arrested for the assault. The Officers in attendance noted that Maxine did not want to provide a statement and was not supportive of a prosecution against Thomas. The Police confirmed that Thomas was interviewed under caution and that he denied physically assaulting Maxine; due to the lack of evidence, Thomas was released with no further

action. The domestic abuse incident had been graded a risk level of 'standard' through the officer completing a DASH risk identification checklist. The Police Officer issued a Domestic Violence Protection Notice (DVPN) and later obtained a Domestic Violence Protection Order (DVPO) at the Magistrates court. The DHR process recognises this as a proactive response to domestic abuse cases where the criminal evidential threshold is not met to pursue an evidence-led prosecution. In such cases, where the victim is not able to support a criminal prosecution, a DVPO is a necessary measure to ensure the victim's safety.

6.60 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 posed by Thomas to Maxine other than securement of a DVPO. It is also unclear how the conditions imposed upon Thomas by the DVPO would be monitored and managed. This is in contrast to Northumbria Police's Domestic Abuse Improvement Action Plan which was implemented in April 2018. The Action Plan focuses on the Forces' response to domestic abuse, with four key areas (4Ps); PREPARE, PREVENT, PROTECT and PURSUE:

PREPARE - These are actions designed to prepare the Force to respond to Domestic Abuse effectively and in partnership with other agencies.

PREVENT - These are actions designed to prevent Domestic Abuse and reducing reoffending by perpetrators.

PROTECT- These are actions designed to protect those at risk from Domestic Abuse and reduce the threat of harm.

PURSUE -These are actions designed to ensure an effective investigation and appropriate outcome for every report of Domestic Abuse.

6.61 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. This lack of monitoring was further confirmed by Northumbria Police in a letter from their Professional

Standards Department (CO/574/19) which detailed an investigation into Janine's appeal following Maxine's death.

"It is my opinion as the investigator that Police Constable (XXXX) did everything that would be expected of him as a police officer until the point he obtained a DVPO. Northumbria Police Policy and procedure around the policing of a DVPO states both the victim and the subject should be visited on a daily basis for the duration of the order. This was not done, and lessons should be learnt from this".

"Your complaint was that your sister was not afforded the necessary safeguarding or support as ought to have been expected following a DVPN, to which I agree".

6.62 The DHR process revealed that the Police Officer's failure to monitor the DVPO conditions was not widely known within the force. This led to different departments, such as those managing PDP and 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 and stated:

"Level 2 refers to those offenders that need to be managed on a multi-agency level and level 1 would be managed by that referring agency i.e police or probation. Thomas was already being 'managed' by police on level 1 (the DVPO process), the next level being level 2 would be the consideration for the screening Panel".

6.63 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 or whether Thomas being managed at level 1 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 in October 2018) risk level of ‘standard’ attributed to that decision.

6.64 The DHR author offers a more detailed analysis of the initial grading of risk made by attending officers in relation to the three incidents (7 July 2018 and two in October 2018) of domestic abuse. All of these incidents were classified as 'standard' risk, with Maxine being identified as the victim and Thomas as the perpetrator of the abuse. As part of their investigation, the Professional Standards Department (CO/574/19) requested senior police officers with specialist knowledge of safeguarding and domestic abuse to review the initial attending officers' risk assessment. The senior officers agreed with the initial attending officers' assessment of 'standard' risk. However, during the DHR process, it was found that the risk to Maxine was much higher than the 'standard risk'. This conclusion was drawn based on information provided by Northumbria Police directly from the IMR and indirectly by Janine, who kindly offered the DHR author a copy of the letter produced by Northumbria Police Standards (CO/574/19), which the *‘standard risk review’* has been heavily considered and documented. The information directly and indirectly secured from Northumbria Police suggests that the Domestic Abuse, Stalking Honour Based Violence (DASH) Risk Indication Checklist (RIC) assessments completed were, in fact, incomplete, casting doubt that the risk level identified was a true and accurate risk assessment of the risk that Thomas posed Maxine. Furthermore, the supporting information provided by the Police Officer seeking the DVPO on professional judgement contradicts their initial risk level of 'standard risk'.

6.65 The DASH-RIC is a list of evidence-based questions used to identify risk factors present in a domestic abuse incident. Answering yes to 14 or more questions indicates the risk is 'High' of serious injury or harm. However, it is important to note that a lower score doesn't necessarily mean there is no risk. It could indicate that the victim is too scared to disclose certain aspects of the abuse. Therefore, professional judgement is crucial when considering the score from the DASH-RIC, particularly when it results in a lower score than expected, which when applying this to the Police Officer’s justifiable reasons for requesting a DVPO the professional judgement risk was higher.

6.66 The DHR process has noted that because of the risk grading being classified as ‘standard risk’ this has negated and prevented referrals being submitted to MARAC by the police. MARAC cases are identified as "high-risk" by using a completed DASH-RIC, which also includes

professional judgment. A coordinated safety plan is then developed to protect each victim, as well as an action plan to consider a multi-agency collaborative approach in managing and reducing the perpetrator's offending and risk they present.

6.67 The DHR process also noted that both the initial attending officers regarding the two reported incidents of domestic abuse in October 2018, resulting in receiving two calls hours apart, the first being Maxine's neighbour expressing concerns of domestic abuse and the second from Maxine, had not been considered collectively, but rather in isolation.

6.68 Within all three incidents of domestic abuse DASH-RIC assessments that the initial attending police officers completed suggests that Maxine's vulnerabilities regarding her mental health (police were aware of Maxine's historical overdoses and incident of self-harm) and reduced ability to seek help possibly when under the influence of alcohol was not considered as a risk. Regarding the incident of domestic abuse reported on 7 July 2018, the fact that domestic abuse in the form of physical abuse was reported at the early stages (within two to three months) of Maxine's and Thomas's relationship was not considered an additional risk factor under professional judgement. There was clear evidence supporting that there was an increase in frequency of the abuse being reported and there was an escalation.

6.69 Northumbria Police at each reported domestic abuse incident between Maxine and Thomas (7 July 2018 and two in October 2018) were aware from checks on their police systems that Thomas had previously been identified as a MARAC perpetrator with another partner, historically and that he was a serial perpetrator of domestic abuse with several other previous partners.

6.70 The DHR process through securing detailed information from Janine and Linda specifically pertaining to the DVPN/DVPO, the risk level identified by the attending police officer and the risk Thomas posed to Maxine should have triggered Northumbria Police making a disclosure to Maxine under Clare's Law[19] 'Right to Know'. The 'Right to Know' refers to an obligation the

[19] **Domestic violence disclosure scheme (DVDS) -** The DVDS, often referred to as "Clare's Law", was implemented across all police forces in England and Wales in March 2014.The scheme has two elements: the **"Right to Ask"** and the **"Right to Know".** Under the scheme an individual or relevant third party (for example, a family member) can ask the police to check whether a current or ex-partner has a violent or abusive past. This is the **"Right to Ask"**. If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the police will consider disclosing the information.

The **"Right to Know"** enables the police to make a disclosure on their own initiative if they receive information about the violent or abusive behaviour of a person that may impact on the safety of that person's current or ex-partner. This could be information arising from a criminal investigation, through statutory or third sector agency involvement, or from another source of police intelligence.

police must disclose information to individuals, without it being requested, if they consider that information suggests the individual is at risk of harm from domestic violence or abuse.

6.71 The police officer was aware of the potential harm that Thomas posed to Maxine, as evidenced by the DVPN that the officer had secured. The officer had submitted the necessary documentation to the Magistrates Court, requesting that a DVPO be imposed. Here is an excerpt from the completed documentation that the police officer submitted to the court which confirms the significant risk the police officer believed Thomas posed 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".

6.72 During the Domestic Homicide Review (DHR) process, it was revealed that Northumbria Police failed to provide Maxine with information about the risk of harm posed by Thomas, due to his 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 to consider the risk of abuse on 7 July 2018 or following the other two reported incidents of Domestic Abuse in October 2018.

6.73 Thomas was not current to the Probation Service during the DHR scoping period, but Probation did receive a court officer entry on their probation system on 17 July 2018. It is noted as information from a third party stating that a DVPN was issued. A DVPO substantiated the case at a court on 10 July 2018, with Maxine as the protected person and Thomas as the perpetrator. The DVPN is a civilian order, Probation would not be involved in the case.

6.74 The author noted reassurance from Probation which outlined the process for conducting domestic abuse checks, from the court stage throughout the person's sentence, has been updated in the Domestic Abuse Policy Framework. This update occurred on 2 February 2020 and was reissued on 26 September 2022. As per the updated policy, domestic abuse checks are now routinely completed for all cases at court. Staff are required to follow the Domestic Abuse and Child Safeguarding guidance when writing reports. This guidance specifies that

staff need to request a framework of information related to any case where concerns about domestic abuse are noted, including historical information or convictions. If a response is not received within five days, the court will issue an adjournment and request the necessary information to ensure well-informed risk assessments concerning domestic abuse are obtained.

6.75 The identification of domestic abuse is an ongoing process throughout the entire sentence, not just a one-time activity at the start of the sentence. Probation staff are expected to adopt an investigative approach, being vigilant and inquisitive in seeking information from various sources to inform a continuous assessment of the presence of domestic abuse in current or previous relationships, going beyond the index offence and approaching the issue with professional curiosity.

6.76 Furthermore, a spousal assault risk assessment (SARA) is completed by probation practitioners if there is evidence of present or historical domestic abuse. SARA helps determine the level of risk to intimate partners and is designed to structure practitioners' professional judgment. To support practitioners in completing SARA in cases involving domestic abuse, a digital learning package has been developed, guiding them on the necessary points to consider and ensuring appropriate training to complete accurate evaluations.

6.77 On 11 July 2018, four days after 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.

6.78 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 disclosure of being a victim of domestic abuse led to a need for a review

of the FACE risk assessment to be conducted. For instance, when Maxine reported being locked in her flat (31 May 2018), or when Thomas May 2018 received a warning regarding his offensive and abusive behaviour from the service due to the risks he posed to others, including the 20 September 2018 when Maxine attended Thomas's NTRP appointment and was identified as his partner, was not captured or assessed in a FACE risk assessment format. Furthermore, the assault on Maxine by a female service user on 11 July 2018 was also not reported in a FACE risk assessment.

6.79 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.

6.80 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 rumors, which Maxine and Thomas did not appreciate, resulting in both of them shouting abuse at her. This was the last time that Janine had contact with Maxine.

6.81 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 (Multi-Agency Risk Assessment Conference) 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.

6.82 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.

6.83 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 documented on the record. It was documented in the medical records by A & E that Maxine had multiple bruises all over her body, variable ages and that Northumbria Police attended A & E, 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.

6.84 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.

6.85 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.

6.86 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 previous acknowledgements 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 primacy in the investigation, and in such cases, best practice is for a Home Office Postmortem to be conducted (appx c).

6.87 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.

6.88 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 below 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, detailed comprehensively in Chronology Table 2, and the authors in depth knowledge and experience of police powers, processes and procedures regarding arrest and post arrest for suspects.

6.89 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. What Thomas stated in the interview is detailed in Chronology Table 2. Thomas was released with no further action.

6.90 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.

6.91 The Home Office Pathologist who conducted the Home Office Postmortem on 20 October 2018 in their statement stated:

"Thus, the post-mortem examination has shown no injuries to account for Maxine's death. There were large numbers of bruises to the arm's, limbs and torso but these would not have caused death. Many of the bruises are likely to be as a result of a number of falls and Maxine being somewhat unsteady on her feet. The bruising to the upper arms and around the armpits is likely to be the result of gripping but it is not possible to determine where

this was as a result of some form of restraint or whether it was, instead, during attempts to render assistance to Maxine. However, it has been caused, it has not played a role in her death".

6.92 Northumbria Police, following this finding, did not pursue a Homicide investigation from that point.

6.93 The DHR 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 suggest 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. She had fallen last night.".*

6.94 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.

6.95 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.

6.96 The Police must meet the Crown Prosecution Service's (CPS) charging codes to try 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.

6.97 The author of the DHR report considered Janine'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 was 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 into the immediate communications between Northumbria Police Investigation Team and Maxine's family. It is worth noting that these unanswered questions surrounding Thomas's arrest has had a profound negative impact on Maxine's family. Janine and Linda expressing that it is the not knowing that has caused immense distress.

6.98 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 in a sensitive and compassionate manner, ensuring that family members are given timely information in accordance with the needs of the investigation. It was established that a FLO was not deployed in Maxine's investigation.

7 Maxine's sister, Janine's, lived experiences and comments on the review:

My little sister, Maxine Freeth (Max) came into this world on 31 October 1978 weighing 10lb 2oz. From the moment I met her I was so protective of her. Max was a lovely, funny, lively little girl, very strong-willed and with a mind of her own. She grew into such a beautiful sensitive girl, always wanting to help with everything. Her caring side was prominent when our mam was diagnosed with a terminal illness in 1988 – motor neurone disease. At the age of nine and a half she was always there to help me with our mam's care. Sadly, when mam died in 1990 Max (who was only 11 years old) began to struggle with depression. Things were not easy; I had to leave school and take on the role of running our home and being a mother. Max left school at the age of 16 years and tried several jobs – hairdressers, retail etc. but they weren't for her. She found her vocation as a care assistant and progressed to Senior Care Assistant. She loved her job, where she worked for many years, and she loved the difference she made to the lives of others.

Max had a couple of long-term relationships that didn't work out. Sadly, she became trapped in an abusive violent relationship with a man she later married. I had warned her about him – he was a lot older; he had been married twice before; he had older children; he was a club man; a drinker, but NO, Max could not see wrong in anyone and always gave them the benefit of doubt. She became more and more isolated over the years and not really herself. I still saw her occasionally but there were no invites to her home or "get togethers" on birthdays and Christmas. We drifted apart. Eventually (after 16 years) she realised that enough was enough and made the break in 2016. He did not take the breakup well and there were a few incidents of domestic violence while the house was up for sale. She moved into a small, privately owned, flat close to me and Linda. She said she felt safe beside us. I wanted to protect her.

Max was very vulnerable and depressed. She told Linda and I how bad things had been. She admitted she had become addicted to codeine following an injury to her shoulder. She agreed to seek help and signed on with the North Tyneside Recovery Programme (NTRP). She had some ups and downs but was on the final stages of her treatment for codeine in late 2017 when we discovered she was also secretly abusing alcohol. She gave up her job and became even more depressed. We tried to help her through this, but she insisted that she did not want us involved and wanted to do it through her support worker at NTRP and her new friends she met through the programme. She started avoiding us; she had 3 failed overdose attempts; she spent more and more time with them and in April 2018 she started a new relationship with a well-known drug addict nicknamed "Tommy Tablets". She wouldn't listen to us …. She didn't want to hear anything bad about him. She said they were soulmates … they understood each other. She was besotted and like putty in his hands. We were desperate and sought help through PROPS (help for families affected by alcohol and drug abuse) and we enrolled on a 6-week course. We didn't see much of Max during that time or over the next few months, and we never got to meet her new boyfriend.

She never made it to her 40th birthday. The police knocked on our door at 9.25 am on a date in October 2018 to tell us that Max had been found unresponsive, "cold", in bed at 09.10 hours on that morning by her partner Tommy. Police officers had arrived at the scene at 09.30 hours where paramedics identified that Max was in cardiac arrest, and she was transported to hospital. She was confirmed dead at 10.18 hours. He was arrested on suspicion of rape and possible homicide but was released the following morning with no charges. We tried to get answers from the police over that weekend, but we were just told to call 101. The police did not seem very concerned once Tommy had been released.

Once the scene had been investigated and I had access, Linda and I went to the flat to clean up. It was during the initial check that we discovered some paperwork and evidence that had been left/missed by the police. There was also a copy of a Domestic Violence Protection Order from July 2018 issued against Tommy following an assault on Max on 10 July 2018. Max had been assessed as "Standard Risk". We discovered from this paper that he was well-known by the police – he was a previous offender with a series of offences behind him: Fifty-Four for domestic violence against women, including GBH. He was a serial perpetrator. We found this all very worrying as we were totally unaware of this incident or the extent of his violent background. We were concerned and felt that Max had not been assessed or safeguarded properly following the assault. Each time we approached the police with our concerns, we were brushed aside. We were being treated like "just another case of druggies on a council estate". They were ignoring the evidence we had found. We were not happy at all with the way things were being handled so we decided to investigate things ourselves. I was completely devastated and broken and couldn't comprehend how this could have happened to my beautiful kind and loving sister. Linda started a log of events, wrote to the Police Commissioner's office about how the case was being handled and I filed an official complaint to the police. I also began trawling the local areas for answers.

During our search we found letters from 'Talking Therapies to Max and her GP advising that, despite their concerns, and a failure to reach her doctor, they were discharging Max from their care. We delved a little further and discovered that there had been a failure/lack of communication within, and between, these agencies and ourselves (her carers) resulting in her medication being increased/changed; a failure in engagement with Talking Therapies and a lack of follow-up action overall. We were concerned - this all raised some serious questions about the risk assessments and safeguarding processes and practices.

We shared our findings with the Coroner as we went along. Although Max's funeral was held on 14 November 2018, there was still no death certificate and he admitted, in April 2019, that they were still struggling to determine "cause of death". There was a pre-inquest into her death and then the final Inquest was held on 9th May 2019. The coroner outlined the background and findings. Despite "numerous bruises to the limbs and torso", "bruising to left side of jaw" and "Rib fractures to the 3rd and 4th ribs on left side". none of the injuries on Max could be attributed to her death and the conclusion was "the effects of a combination of verapamil and cocaine" (NB Verapamil was a prescribed drug for her heart). The Coroner also noted "systemic failings in her care" and spoke to us afterwards, encouraging us to tell her story and seek answers. We then approached Advocacy After Fatal Domestic Abuse (AAFDA) in September asking if they could help us in seeking a Domestic Homicide Review and the process slowly began.

My complaint to the police was rejected. However, during final discussions with them, the DCI made a statement that, based on his experience, the DVPO was "not worth the paper it was written on". We were even more angry and decided to lodge a second complaint to Northumbria Police about the risk assessments carried out on Max and subsequent safeguarding. (FYI: This was filed in September 2019; rejected in January 2020; appealed against and then partially upheld in April 2020 and following further investigation, was finally upheld in July 2020, concluding that Max was not afforded the necessary safeguarding under the terms of the DVPN/DVPO.

At the same time, we also decided to seek answers from the care services involved in Max's care and Linda approached the Northeast Independent Complaints Advocacy (ICA) for assistance in putting in a complaint to the various agencies involved. These were: New York Doctors Surgery, Project Answer (which is part of North Tyneside Recovery Partnership, managed by Northumberland Tyne and Wear NHS Foundation Trust) and the Talking Therapies Service (part of Northumbria Healthcare NHS Foundation Trust). Our complaint was submitted and there was a lot of correspondence over several months, but we were very unhappy with the responses received and did not feel our questions and concerns had been fully addressed. We then submitted our case to the Parliamentary and Health Ombudsman (PHSO) in September 2020. The Ombudsman was dealing with the case but ended their involvement after confirmation was received from North Tyneside Council in September 2021 that a Domestic Homicide Review (DHR) would be held.
Tommy Tablets was found dead of a drug overdose in 2022.

It has been a long 6 years since this tragedy. It has been a long six years of waiting but it is now over and the DHR Report is being finalised. I feel a huge sense of relief that the DHR found, what Linda and I suspected all along, that the risk to Maxine from Thomas was much higher than the 'standard risk' decision reached by Northumbria Police. This effectively ruled out any multi-agency response (MARAC) being considered. We are disappointed and angry at the overall response from Northumbria Police during this Review. Furthermore, it should be noted that not only did they fail to participate in the first meeting of the Panel, but they added insult to injury when sending a representative to the final meeting who was totally unfamiliar with the case. We can only hope that lessons have been learned and that they are incorporated into ongoing training.

The review also revealed several "missed opportunities" (or what we would call failings) by the other agencies involved in Max's care which are reflected in the recommendations. All of them held information, which was crucial to Max's safety, but it was not always shared or referred onwards. We are pleased that the agencies have accepted the findings of the Review and responded

positively to the recommendations. However, in the case of NTRP, we stress that we do not feel that they handled the aftermath of Maxine's death in a professional matter. We do not believe that a fair and comprehensive investigation was undertaken but rather the completion of a series of tasks was done behind closed doors. It begs the question of how an 'After Action Review' was held only a month after her death when the inquest was not held until the following year and cause of death had not been established? In conclusion, we sincerely hope that the recommendations will be acted on; that lessons will be learned from Max's death and that her story will be shared with the relevant organisations and agencies with the aim of trying to prevent this kind of tragedy happening again.

Thank you to AAFDA (especially Tricia) for all the amazing support along the way; thank you to NTC (Lindsey and Lisa) for facilitating this Review and making us feel welcome; thank you to the Chair, Lesley, and the Author, Lynsey, for the thoroughness of the investigation and their patience and determination in seeing things through to the end. And thank you all for the compassion you have shown us throughout. It has been a journey for all of us but, if any of the lessons learned here can save a life, it was worth it. Rest in Peace our beautiful Maxine.

8 Conclusions

8.1 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.

8.2 Within the Review, Maxine has been identified as a vulnerable woman, with several stress factors attributing to her vulnerability, including having witnessed the loss of her mother at a young age and having been subjected to bullying at work and identified as a repeat domestic abuse victim. The Review has heard, through Maxine's self-reporting to agencies, Maxine's account describing being subjected to levels of control and physical abuse during her long-term intimate relationship with her ex-partner and in her recent intimate relationship with Thomas, who was identified as a serial and prolific perpetrator of domestic abuse, impacting significantly upon Maxine's mental health and ability to make informed choices and engagement with agencies supporting her with alcohol and drug addiction and her mental health.

8.3 Maxine's repeated reports of anxiety, low mood, depression, suicidal ideation and overdose attempts indicated a deterioration in Maxine's mental and emotional well-being. The Review has found it challenging to measure the impact that domestic abuse has had on Maxine's

deterioration in her mental health and increased need to use illicit drugs and prescribed drugs as a self-coping strategy to manage her life stressors and the domestic abuse she was sadly subjected to up until her death in October 2018.

8.4 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.

8.5 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.

8.6 While good practice has been observed in responding to Maxine's presentation, there is still room for learning. Specifically, it is important to have a comprehensive understanding of domestic abuse and its impact on mental health. A trauma-informed approach should be adopted, and professional curiosity exercised to fully identify the risk posed by individuals such as Thomas. This will help to accurately identify risks and support professionals in utilising their professional judgment to identify non-obvious signs of risk. Additionally, it is crucial to consider Maxine's capacity to identify the risk posed by Thomas.

9. Summary of Lessons Learned and Recommendations

9.1 Based on the chronology, analysis and conclusions of the Overview Report, the DHR Panel agreed a series of recommendations for national, regional and local bodies to help prevent future domestic homicides.

9.2 The DHR review has identified collective and individual agencies' recommendations which are outline below.

	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.***

Appendix A – Government definition of domestic abuse

Definition of Domestic Abuse

Domestic violence and abuse: new definition[20]

The new definition of domestic violence and abuse now states:
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." *
This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

[20] Domestic violence and abuse new definition: https://www.gov.uk/government/news/new-definition-of-domestic-violence

Appendix B – Coercive and controlling behaviour

Controlling or Coercive Behaviour in an Intimate or Family Relationship (extract from Statutory Guidance Framework):[21]

- The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- This guidance is issued as statutory guidance under section 77 of the 2015 Act. A person investigating offences in relation to controlling or coercive behaviour under section 76 must have regard to it.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.
- Controlling or coercive behaviour should be dealt with as part of adult and/or child safeguarding and public protection procedures.

Types of behaviour[22]

The types of behaviour associated with coercion or control may or may not constitute a criminal offence in their own right. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
  depriving them of their basic needs;
- monitoring their time;

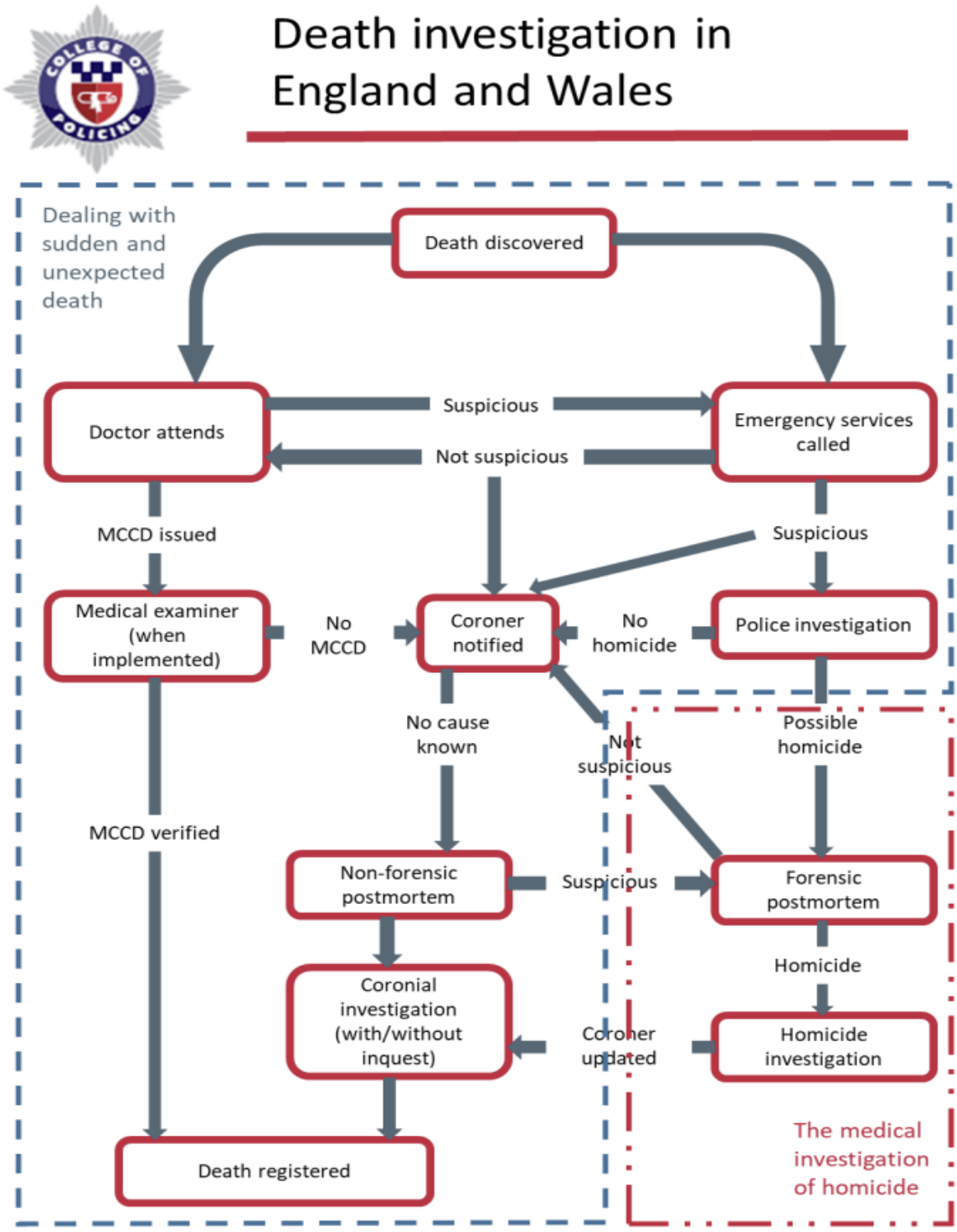
[21] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework Home Office 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

[22] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework Home Office 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services; • repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information (e.g. threatening to 'out' someone).
- assault;
- criminal damage (such as destruction of household goods);
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C – College of Policing, Sudden and Unexpected Deaths



Appendix D – Agreed Terms of Reference

Agreed Terms of Reference (ToR)

The IMRs were asked to focus on the following specific questions:

- Were Maxine and/or Thomas known to local domestic abuse services and if so, were any concerns or warning signs identified? Where Maxine was not known to DA 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 specially relate to DA? How was professional judgment used? What action was taken as a result?

- If risks were identified what safeguarding measures were in place?

- Were agencies aware of a history of domestic abuse with regards to Maxine and/or Thomas. If so, were any safeguarding/prevention measures invoked with particular consideration to Clare's Law, DVPN's & DVPO's and multi-agency safeguarding arrangements such as MARAC/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 difficult 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 which prevented the sharing of information?

- What information is available for families to enable them 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?

Appendix E - MAPPA Levels of Management

(https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance)

Introduction

There are three levels of MAPPA management designed to ensure resources are focused on those that require the greatest level of multi-agency co-operation. The MAPPA level is determined by a robust level setting process and should be regularly reconsidered throughout the MAPPA management period.

The three levels of MAPPA management are:

- Level 1 – Multi-Agency Support
- Level 2 – Multi-Agency Management
- Level 3 – Enhanced Multi-Agency Management

Regular formal MAPPA meetings must be held for offenders managed at Level 2 or 3. The lead agency may arrange professionals' meetings for offenders managed at any level. The MAPPA meeting may establish a core group for any offender managed at Level 2 or 3. See Chapter 13a – MAPPA Meetings for more details of MAPPA meetings, professionals' meetings and core groups.

Level 1 management is where the risks posed by the offender can be managed by the lead agency in co-operation with other agencies but without the need for formal multi-agency meetings. Responsible Authority and Duty to Co-operate agencies have a statutory obligation to engage with MAPPA at all levels, including Level 1, and will be involved in the management of the offender as necessary. Offenders will only be managed at Level 1 where the lead agency is confident that their Risk Management Plan (RMP) is sufficiently robust to manage the identified risks, the circumstances of the case do not require the formal multi agency oversight offered by level 2 or 3 meetings and there are no barriers to the implementation of agreed multi-agency actions. See below for further information on Level 1 management.

Level 2 - Cases should be considered for Level 2 management where:

- Formal multi-agency meetings would add value to the lead agency's management of the risk of serious harm posed;

and one, or more, of the following applies:

- The offender is assessed as posing a high or very high risk of serious harm;

- Exceptionally, the risk level is lower, but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm;
- The case requires oversight at a more senior level;
- The case has been previously managed at Level 3 but no longer requires Level 3 management.

Level 3 management is for cases that meet at least one of the following criteria:

- Meet the criteria for Level 2 and require senior representation and oversight by the Responsible Authority and Duty-to-Co-operate agencies to commit significant resources at short notice,
- Meet the criteria for Level 2 and require senior representation and oversight in order to maintain public confidence in the criminal justice system. This may be due to high levels of current national media scrutiny or public interest in the management of the case as a result of the nature of the offence or the identity of the offender or victim,
- Have a national security dimension and require senior oversight by Counter-Terrorism Police (CTP) or the Probation Service National Security Division (NSD). Cases will be identified in line with lead agency case allocation policies relating to CTP and NSD. Discretionary Category 4 offenders, like Category 3 offenders, must be managed at Level 2 or 3,
- Involve high risk offenders involved in serious organised crime.