KIRKLEES COMMUNITIES PARTNERSHIP BOARD

[Incorporating the Statutory Community Safety Partnership]

DOMESTIC HOMICIDE REVIEW

Bethany

Died September 2019

EXECUTIVE SUMMARY

August 2024

Chair	David Hunter
Author	Paul Cheeseman
Support to Chair/Author	Sara Wallwork

Contents

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Kirklees Communities Partnership Board [the statutory Crime and Disorder Partnership] in reviewing the homicide of Bethany a resident of Leeds who was killed by her former partner Mr G in September 2019. The DHR panel extend their deepest condolences and sympathy to Bethany's parents Jim and Pauline, Pauline's partner Richard and all of Bethany's family and friends on their loss. The report examines whether agencies should have identified if Bethany was at risk from her former partner Mr G[1] and taken protective measures.

1.2 The table below provides details of the persons referred to in this executive summary. Bethany's family and some friends wanted their real names in the report.

Table 1 Family and Friends Names

Name	Relationship	Age	Ethnicity
Bethany	Victim	21	White British
Pauline	Bethany's mother	n/a	White British
Jim	Bethany's father	n/a	White British
Richard	Pauline's partner	n/a	White British
Mr G	Perpetrator	35	White British
Female 1	Mr G's first partner	n/a	n/a
Female 2	Mr G's second partner	n/a	n/a
Child 1	Mr G and Female 1's child	n/a	Unknown
Alice	Bethany's friend	n/a	White British
Mark	Managing director of a music studio and past employer of Bethany	n/a	White British
Daniel [2]	Bethany's partner after separating from Mr G	n/a	Unknown

[1] A pseudonym chosen by the DHR Panel in consultation with the victim's family and consistent with how he's referred to in the NHS England Mental Health Homicide Review. See paragraph 2.4.

[2] A pseudonym

1.3 Prior to forming a relationship with Bethany in 2017 Mr G perpetrated domestic abuse on at least two other partners. He met the definition of a serial perpetrator of domestic abuse[3], a fact unrecognised by agencies prior to Bethany's homicide. In June 2019 Bethany ended the relationship because of his abusive behaviour and his constant threats towards her and her friends.

1.4 Mr G had a history of mental health needs and at the time he killed Bethany had a diagnosis of emotionally unstable personality disorder [EUPD] and was under the care of mental health services [South West Yorkshire Partnership NHS Foundation Trust [SWYPFT]].

1.5 Mr G appeared before a Crown Court and pleaded guilty to the manslaughter of Bethany on the basis of diminished responsibility. At the time of sentencing Mr G had a confirmed diagnosis of schizophrenia, with evidence of a long-standing personality disorder. In describing Mr G's actions towards Bethany the sentencing judge's remarks included the following:

'I am quite sure you knew perfectly well what you were doing….Once you had made a decision to kill Bethany your actions in carrying out what must have been your purpose are characterised by entirely logical and rational actions with a view to carrying out the purpose that you had determined upon…It follows that for the purpose of the sentencing guideline you retained a high level of criminal responsibility'.

1.6 Mr G was sentenced to life imprisonment and must serve a minimum of 11 years before his case can be considered by the Parole Board. He was subjected to a Hospital Order under Section 45A Mental Health Act 1983 and a Restriction Order under Section 41 of the same act.[4].

1.7 Kirklees Communities Board met on 18 October 2019 and determined the death of Bethany met the criteria for a domestic homicide review [DHR]. The

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[3] Where a suspect has committed an act of domestic abuse against two or more different victims they should be considered a 'serial perpetrator' https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors

[4] Section 12[2] of the Mental Health Act 1983 makes provision for persons convicted of a crime who are suffering from a mental disorder to be detained in a hospital for medical treatment.

Home Office were informed, and an independent domestic homicide review was commissioned. All agencies that potentially had contact with Bethany and Mr G were asked to secure their files. The first meeting of the DHR panel was held on 13 November 2019. Because of the Covid 19 crisis, work on the review was delayed. Work resumed in August 2021. Seven further meetings were held before the panel concluded its work with the presentation of the overview report to Kirklees Communities Board on 14 September 2022.

1.8 The Independent Office for Police Conduct [IOPC] completed an independent investigation into the actions of West Yorkshire Police officers and staff that had contact with Bethany and Mr G. That report has yet to be published but the findings are included in this review.

1.9 NHS England commissioned a Mental Health Homicide Review under the NHS England Serious Incident Framework. A separate report was written for NHS England and can be found at https://www.england.nhs.uk/north-east-yorkshire/wp-content/uploads/sites/49/2022/05/mr-g-independent-investigation-may22.pdf

1.10 The Coroner determined that an inquest would not be held.

1.11 Pauline, Jim and Richard said:

"Bethany was beloved by family, friends and colleagues, too numerous to mention, all who had the privilege to have met and known her, in her, sadly, way too short a life. A life which was pure, decent, worthy and deserving of life.

Bethany, had she lived, would undoubtedly have gone on to achieve so much for humanity, nature and our planet.

Bethany touched people in a profoundly positive way, inspiring, lifting and boosting morale, self-esteem, by listening, motivating, and encouraging disadvantaged people to reach their full potential through music.

Bethany was a natural, genuine, honest, hardworking young woman, personable, graceful, dignified, and humorous, of a high moral compass, wise beyond her years, yet modest and humble with the unique gift of naturally being able to intuitively sense a person's emotions [empathetic].

Bethany was charismatic, witty, fun, totally loveable, reliable, charitable, giving, loyal and protective. Such beauty and depth of heart and soul. I

cannot even begin to describe on reading your report the crushing pain which is insuperable. She was our, 'Earth Angel'.

I [Pauline] firmly believe Bethany's life ended prematurely, that it was premeditated and totally preventable. Bethany's life ended needlessly, cruelly without justification, cause or reason other than gross failings, neglect, lack of duty of care, absolute lack of responsibility to protect the public, especially known victims of domestic abuse."

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Table 2 Agencies contributors to the review

Agency	Known	IMR[5]	Chronology	Report
Adult Safeguarding	No			
Brighton-Sussex Partnership Foundation Trust	Yes	✓		
Calderdale & Huddersfield NHS Foundation Trust	No			
Carers Leeds[6]	Yes			Email Telephone
CHART [Drug & Alcohol Service]	No			
Community Rehabilitation Company [CRC] Probation West Yorkshire	Yes	✓	✓	
Greater Huddersfield & North Kirklees CCG (Adults & Children) – supported the gathering of GP	Yes	✓	✓	

[5] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review which includes a chronology.

[6] 'Carers Leeds is an independent charity that gives support, advice and information to unpaid carers aged over 16. Established in 1996, our team of expert support workers are dedicated to improving the lives of the 72,000 carers in Leeds. We deliver confidential one to one and group support in Leeds city centre, local communities, over the phone and on-line.'

Agency	Known	IMR[5]	Chronology	Report
information[7]				
Housing Services	No			
Kirklees Neighbourhood Housing	No			
Leeds Clinical Commissioning Group [CCG]	Yes	✓	✓	
Leeds Domestic Violence Service	Yes	✓	✓	
Locala	No			
MARAC / DRAMM	No			
Mid Yorkshire Hospitals NHS Trust	Yes	✓	✓	
Pennine Domestic Violence Group	No			
Safer Kirklees	No			
Sussex Partnership NHS Foundation Trust	Yes	✓	✓	
University of Sussex	Yes			
University of York	Yes			
South West Yorkshire NHS Foundation Trust	Yes	✓	✓	
West Yorkshire Police	Yes	✓	✓	
Yorkshire Ambulance Service	Yes	✓	✓	

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[7] The CCG did not have any records as they are not providers. Instead they supported the delivery of the GP information. The CCG do not have an automatic right to look at patients' records.

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Table 3 Review Panel Members

Name	Role	Organisation
Clive Barrett Marie Gibb Angela South	Head of Safeguarding	The Mid Yorkshire Hospitals NHS Trust
Lindsay Britton-Robertson	Designated Nurse, Adult Safeguarding	Leeds York Partnership Foundation Trust
Lynn Chambers	Head of Safeguarding	Leeds Community Health Care NHS
Paul Cheeseman	Author	Independent
Emma Cox	Assistant Director of Nursing, Quality and Professions	South West Yorkshire Partnership NHS Foundation Trust [SWYPFT]
Maria Dineen	NHS England Independent Investigator	Consequence [UK] Ltd
Amanda Evans	Adults Service Director	Kirklees Council
Chani Mortimer	Service Manager, Domestic Abuse	Kirklees Council
Julian Hendy	Chief Executive	Hundred Families
Jacqui Stansfield	Manager Kirklees Safeguarding Adults Board	Kirklees Council
Clare Groves	Services Manager	CGL [Substance Misuse Provider]
Rebecca Hirst Kathryn Hinchliff	Chief Executive	Pennine Domestic Violence Group
David Hunter	Chair	Independent
Charlotte Jackson	Head of Service, Family Support and Child Protection	Kirklees Children's Services
Michelle Lowe	Senior Probation Officer	CRC Probation
Joanne Atkin	Head of Kirklees Probation Delivery Unit	Her Majesty's Prison and Probation Service [HMPPS]

Name	Role	Organisation
Bryan Lynch	Deputy Director of Social Work	Sussex Partnership Foundation Trust
Gill Marchant	Designated Nurse Safeguarding Children	NHS Leeds CCG
Alex Bacon	Detective Chief Inspector	West Yorkshire Police
Neil O'Byrne	Domestic Abuse Programme Manager	Leeds City Council
Nik Peasgood	Chief Executive of Leeds Women's Aid and Contract Lead of Leeds Domestic Violence Service [LDVS]	Leeds Women's Aid
Clare Robinson	Head of Nursing & Safeguarding	Greater Huddersfield and North Kirklees CCGs
Rebecca Strutt	Safer Kirklees Manager	Safer Kirklees [incorporating the Kirklees CSP]
Sharon Hewitt	Manager, Kirklees Safeguarding Children Partnership	Kirklees Council
Sara Wallwork	Support to Chair/Author	Independent
Agnieszka Wilstrop Vicky Lenihan	Administrative Support	Kirklees Council

3.2 The review chair was satisfied the members were independent and did not have operational and management involvement with the events under scrutiny. Due to the length of time the review took to complete some agencies changed their representation hence more than one name may appear as the representative for that agency.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 David Hunter was appointed as the Independent Chair and Author. He was supported by Paul Cheeseman who authored the report. Both are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. They were supported by Sara Wallwork. None of them has been employed by any of the agencies involved with this review nor are they connected to Kirklees Communities Board who judged they had the necessary experience, skills, and independence to undertake the review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 These were set as:

The purpose of a DHR is to:[8]

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

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

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

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

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

f) Highlight good practice.

Specific Terms

1. What knowledge or indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that could have identified Bethany as a victim of domestic abuse and Mr G a perpetrator and what was the response?

2. Did that response: e.g., contacts/care/treatment:
a] Comply with your agency's policies and good practice expectations?

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[8] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

b] Reveal opportunities for improvement in how contacts were managed, care was delivered or treatment formulated and/or delivered?

3. What was your agency's knowledge of the mental health needs of Bethany and Mr G and what consideration did your professionals give to any needs when responding to domestic abuse or signposting them to other services. This term will be primarily discharged through the independent assessment and investigation of the mental health care and management of Mr G commissioned by NHS England. However, non-mental health agencies are still required to respond to this term.
4. What consideration did your agency give as to whether Bethany or Mr G were adults in need of care and support[9] and what did it do?
5. What knowledge or concerns did Bethany and/or Mr G's families, friends or employers have about the domestic abuse, and did they know what to do with it?
6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Bethany and Mr G?
7. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Bethany and/or Mr G, or on your agency's ability to work effectively with other agencies, including sharing information and/or providing services across district boundaries??
8. What learning has emerged for your agency?
9. Are there any examples of outstanding or innovative practice arising from this case?
10. Does the learning in this review appear in other domestic homicide reviews commissioned and monitored by the Kirklees Communities Board?

Timescale

[9] Section 9 Care Act 2014

5.2 The review covers the period between 1 January 2014 [when Mr G appeared to be experiencing mental health concerns] and the date of Bethany's homicide.

6. SUMMARY CHRONOLOGY

6.1 Bethany

6.1.1 Bethany was an only child and was described by Pauline as intelligent, articulate, good hearted, loving, a caring person and wise beyond her years. Her father Jim, and mother Pauline separated when Bethany was 5 years old. Jim remained close to Bethany and had a loving relationship with her. Bethany was supportive of Pauline's partner Richard.

6.1.2 Bethany was educated in Leeds and after leaving secondary school gained a place to study English literature and psychology at Sussex University. For personal reasons Bethany did not finish the course and at the time of her death was studying at the University of York.

6.2 Background to Mr G

6.2.1 Mr G's mother said he had a lot of behavioural issues as a child and was admitted to a specialist child psychiatric unit when about 7, 8 or 9 years of age for a period of approximately 6-7 months. Mr G's elder sister said he had difficulties from being very young and would become angry and frustrated.

6.2.2 Mr G had three intimate relationships that were known about by some [although not all] agencies. Chronologically these were with Female 1, Female 2, and Bethany. Female 1 experienced domestic abuse by Mr G. His younger sister described how Mr G spoke of suicide following the breakdown of his relationship with Female 1. She said from then on, suicide notes became a constant feature and she got to the point at which she realised he needed help.

6.2.3 Between January 2012 and July 2015 Mr G was in a relationship with Female 2. She experienced an identical pattern of victimisation from him as that experienced by Female 1. This involved behaviour that was controlling and coercive and included constant abusive calls, text messages and Facebook messages.

6.2.4 Mr G had a history of mental health needs and was under the care of SWYPFT in respect these between 2015 and 2019. A strong factor in Mr G's life was a voice he reported hearing called 'Osiris'.

6.3 Bethany and Mr G's Relationship

6.3.1 Before leaving to University in Brighton, Bethany worked in a music studio where she met Mr G. In late autumn 2017 they formed a relationship. Mark [a friend of Bethany's] recalled her confiding in him that Mr G was behaving in a controlling manner. Bethany showed Mark a text from Mr G in which he wrote 'If you ever went back I'd kill all of you'.

6.3.2 Mark was so concerned about Mr G's behaviour towards Bethany that he sought advice from Women's Aid which he passed onto Bethany. Mark described a number of instances when Mr G made threats during conversations, emails and texts either to him, Bethany, or others. Bethany told Mark how Mr G was using graphic language which included cutting people.

6.3.3 Bethany also confided in Alice. She spoke about ending her relationship with Mr G and how he sent messages threatening suicide and harm to anyone who formed a future relationship with her. Bethany also told Alice about incidents in which Mr G had made suicide attempts and been admitted to hospital.

6.3.4 In September 2019 Bethany made Alice aware of a number of threats that Mr G made against her. These included references to harming Alice by 'cutting' her. Alice believes Mr G tried to manipulate Bethany by using events such as a mental health crisis, threats of suicide and threats against Alice to isolate Bethany.

6.4 Key Events

6.4.1 Agencies in the Kirklees area had a significant number of contacts with Mr G. These are detailed in Appendix A. The following paragraphs describe the most significant events.

6.4.2 A number of these related to mental health episodes and threats to harm himself. Mental health services had many contacts with Mr G during the period of this review. They had some contacts with Bethany and were aware

of their relationship and when it broke down. Bethany raised concerns with mental health services about Mr G's increasing paranoia in April and May 2019. She also disclosed to her GP in April 2019 that her partner [who she did not name] had a personality disorder and psychosis.

6.4.3 Bethany's GP was also aware in July 2019 [following a letter from another agency] that Bethany had caring responsibilities for the unnamed boyfriend and that he behaved in an abusive manner towards her. In August 2019 Bethany told her GP her boyfriend had a history of mental health issues and that she was his carer.

6.4.4 WYP held 15 safeguarding records relating to Mr G in respect of domestic abuse in which he was recorded as either the suspect, victim, or subject of the report. Five of these incidents occurred when Mr G was in a relationship with Female 1 [the mother of Child 1]. Mr G had Police National Computer [PNC] Warning Markers for violence, mental health, suicidal and self–harm.

6.4.5 There were a number of references in agency records [principally WYP and also mental health agencies and the CRC] concerning Mr G's possession and use of a knife. Mental health agencies were aware he kept a knife under his pillow although did not consider this was a threat as he did not take it outside. Consequently they did not share the information with other agencies. WYP records contained a number of references to Mr G having a knife. However, this information was not processed correctly and as a result Mr G did not have a warning marker on PNC for weapons.

6.4.6 From March 2015 onwards WYP had a number of contacts with Mr G concerning his relationship with Female 2 including threats by Mr G to harm himself. In May 2015 Female 2 reported to the police that Mr G had sent her unwanted messages following their separation. She told the police Mr G was very controlling. After being served with a harassment warning notice, his abusive behaviour towards Female 2 continued.

6.4.7 In August 2015 Female 2 reported to WYP that Mr G was harassing her. Mr G made a counter allegation that he was the victim [this was a tactic he had perpetrated before and would do so again in an attempt to cover his abusive behaviour towards female victims]. Mr G then made several threats to harm himself, another tactic he would repeat when his abusive behaviour towards his victims was reported.

6.4.8 In December 2015 Mr G was convicted of harassing Female 2 and received a sentence of a Community Order for 12 months and a restraining order for 2 years with a rehabilitation activity requirement. He was supervised during his sentence by Kirklees Community Rehabilitation Company [CRC]. As part of the process of preparing an OASys[10] risk assessment, the CRC recorded a disclosure by Mr G that he was expelled from school for stabbing someone when aged 16. That information was not shared with other agencies.

6.4.9 In January 2018 WYP first became aware of Mr G's relationship with Bethany when he telephoned the police saying he wanted to stab a paedophile. In February 2018 Bethany called Leeds Domestic Violence Service [LDVS] seeking information on how she could leave her partner in a safe way. She was given details of the drop-in session which she visited later that month. Bethany wanted to know what she could do in an emergency situation and what support could be offered.

6.4.10 Although Bethany said her partner had not threatened her, she said he had threatened to hurt other people including her friends and family. The LDVS worker completed a Domestic Abuse Stalking and Harassment [DASH][11] risk assessment. That concluded Bethany was at standard risk of harm from Mr G [the score was 9]. It is not clear on this occasion if Bethany was asked to provide information to identify Mr G.

6.4.11 In June 2019 Bethany made two reports to WYP that Mr G, who by then was her ex-partner, had made threats to kill himself. In the second call Bethany told police his behaviour had escalated over the previous 5 days and he had threatened to hurt himself and other people. Both calls resulted in Mr G attending hospital. In August 2019, Mark told the police Mr G was threatening suicide. Police officers located Mr G who denied any such intent.

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[10] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision.

[11] The DASH risk assessment tool has been developed to create a common tool for both police and non-police agencies when identifying and assessing victims of domestic abuse, stalking and harassment and honour-based violence. The risk to victims is assessed as either standard, medium or high. This then informs the range of protective measures offered to the victim.

6.4.12 WYP contacted an Approved Mental Health Practitioner [referred to as an AMHP][12]. The AMHP was informed of everything held on the WYP log. The AMHP told WYP they had no concerns and were content for Mr G to be left.

6.4.13 On 16 August 2019 Bethany reported that Mr G had made threats to her new partner. Bethany gave a statement to a WYP police officer on 19 August and described how from the start of their relationship Mr G had been threatening towards her former partner and manipulating towards her. Bethany described these threats towards others as intensifying to include threats against her. Since ending their relationship in June 2019 Bethany described receiving a barrage of abuse from him.

6.4.14 The police officer who spoke to Bethany recorded a crime against Bethany of harassment and completed a DASH assessment and recorded the risk level as medium. However, the information provided by Bethany in her statement did not mirror the DASH risk assessment. Had the correct responses been recorded then the risk to Bethany from Mr G would have been assessed as high and not medium. In addition, rather than a crime of harassment, the more serious crime of 'stalking and coercive and controlling behaviour'[13] should have been recorded.

6.4.15 Because the risk to Bethany was recorded as medium rather than high, it was not automatically referred into a MARAC[14]. Had that happened, it is

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[12] AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act.

[13] It is important to understand the difference between the offences of controlling or coercive behaviour and those involving stalking and harassment. Like controlling or coercive behaviour, offences of stalking and harassment can involve a course of conduct or pattern of behaviour which causes someone to fear that violence will be used against them on at least two occasions, or which causes them serious alarm or distress to the extent it has a substantial adverse effect on their day-to-day activities. Indeed, the behaviour displayed under each of these offences might be exactly the same. The offence of controlling or coercive behaviour has been introduced specifically to capture abuse in an ongoing relationship where the parties are personally connected, as defined in section 76[2] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

[14] The Multi-Agency Risk Assessment Conference [MARAC] is a regular meeting where agencies discuss high risk domestic abuse cases, and together develop a safety plan for the victim and his or her children.

likely mental health services and WYP would have become involved in jointly sharing information, assessing risk, and developing a plan to protect Bethany. That did not happen and hence a significant opportunity to protect Bethany was lost.

6.4.16 Because of the serious nature of the offence and the potential for escalation, had WYP policy on domestic abuse been followed, Mr G's name should have been circulated on police information systems and he should have been arrested and detained for questioning. There was a delay of seven days before Bethany's statement was uploaded to police systems. This meant that any other officers who dealt with her, or incidents connected to her, were not able to access her statement and compare it with her DASH risk assessment.

6.4.17 There followed a complex series of events, during which the risk assessment moved between various departments within WYP for review and allocation[15]. The net result of this was that the investigation was passed back for completion by the officer who originally spoke to Bethany on 19 August 2019. That officer was a probationary constable who was inexperienced in the investigation of domestic abuse. The evidence suggests the case should instead have stayed with the specialist Leeds Safeguarding Unit [SGU] or Domestic Abuse Team [DAT] to complete as there were heightened risk factors and this was not a low-risk case.

6.4.18 In parallel to these process shortcomings, there were also a series of intelligence failings related to historic information about Mr G. These were investigated in detail by the IOPC. It was found WYP failed to record some significant pieces of information on Mr G's intelligence profile including information in 2016 that he intended to stab people; in January 2018 that Mr G had a knife in his bedroom and wanted to stab a paedophile; in April 2017 that he wanted to be tasered by the police and hurt himself or someone else; in August 2017 that he wanted to kill a paedophile and had 'stabbed a copper in 2013'; and finally on 22 June 2019 information from Bethany that

[15] The DHR panel have not set out the detail of when, how, and why this process of reallocation was undertaken. They feel that to do so would unnecessarily complicate this report. The panel has ensured that the learning that explains why this process was not followed has been included within this report.

he was making threats to hurt himself and other people and making a suicide video for Child 1.

6.4.19 If that information had been uploaded to Mr G's intelligence profile, it may have provided WYP officers and staff who had contact with Bethany after 19 August 2019, with further information about the potential threat Mr G posed to her and other members of the public. Between the date Bethany provided a statement to WYP and the date of her homicide, the police went on to record several contacts either directly with or relating to Mr G.

6.4.20 These were all potential opportunities to join together historic intelligence about Mr G, both the information provided by Bethany on 19 August and new information provided by other persons. Doing so would have led to Mr G being arrested for one or more offences, including principally the offence of coercive and controlling behaviour committed against Bethany. The fact that did not happen led to there being no plan in place to protect Bethany from the risk presented to her by Mr G.

6.4.21 On the same day she provided a statement to the police, Bethany again called the LDVS helpline. She said her ex-partner had been making death threats to her, a colleague, and a friend and that Bethany was visiting a police station. A staff member at LDVS gave Bethany details of solicitors contact numbers should she need legal advice. Bethany was also told about the Independent Domestic Violence Advocate [IDVA][16] service should there be any criminal proceedings.

6.4.22 On 21 August 2019 Mr G visited a police station with concerns that something had been reported involving him. On 26 August WYP were informed of concerns for Mr G's safety and that a rope had been found and Mr G had suicidal ideation. Mr G had told a friend he was under investigation for threats. He was found later that day safe and well at Bridlington on the beach and told police officers he went there intending to take an overdose on the beach.

[16] The main purpose of independent domestic violence advisors [IDVA] is to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

6.4.23 On 27 August Mr G reported to WYP he had been assaulted by Bethany and she had caused damage at his house. Because of low staffing levels and operational demands his allegation was not progressed until 12 September 2019. A DASH risk assessment recorded the risk to Mr G as medium. Both the threats of suicide and the counter allegation by Mr G are further examples of the way he behaved towards his victims when his violent and abusive behaviour to them was reported to police.

6.4.24 On 7 September 2019 Bethany's father Jim contacted WYP to report Mr G had followed him around and threatened him. On 9 September 2019 Mark reported to WYP he had received multiple emails from Mr G and WYP recorded a crime of harassment. Neither of these matters had been investigated at the time of Bethany's homicide.

6.4.25 On 9 September Daniel made an online report to WYP saying he was aware Mr G had made threats to kill him. On 11 September 2019 Daniel attended a police station to provide further details. However, an officer incorrectly closed the log with no further police action. The rationale recorded was that the threats had been made to a 3rd party rather than directly to Daniel. No crime was recorded.

6.4.26 On 11 September 2019 Mr G contacted WYP and said he had reported Mark to various authorities for matters unrelated to this DHR and on 12 September 2019 he visited a WYP station at the request of a police officer and there provided a statement concerning his allegation that Bethany had assaulted him. This was the last contact Mr G had with any agency in Kirklees before he attacked and killed Bethany.

7. FINDINGS

7.1 Mr G was a serial perpetrator of domestic abuse before he met Bethany. He was under the care of mental health services from 2014 until the day he killed Bethany. The Mental Health Level Three Review [the review] of Mr G's treatment and care by mental health services found there were elements of Mr G's care and management between 2014 and 2019 that could and should have been different.

7.2 More careful consideration should have been given to Mr G's presentation and thus diagnosis. The review found a lack of contemplation of an additional diagnosis for Mr G was a significant missed opportunity that may have altered the chronology. The DHR review accepts this finding and recognises it is difficult to know how that may have impacted on the sequence of events.

7.3 The review also found the lack of integration of what was known about and should have been known about Mr G's abusive behaviours in 2015, towards an ex-girlfriend, was a serious miss in his risk profile, and represented a serious miss in risk management planning and mitigation.

7.4 During the time Bethany was in a relationship with Mr G mental health services also held information about Mr G's possession of a weapon. At the same time WYP also held information about Mr G's use and threats to use a knife. That information was not shared between those agencies either before or after Bethany entered into a relationship with Mr G. The review found mental health services had a clear duty of care to Bethany regarding her risks at the point of relationship breakdown.

7.5 WYP held a large amount of information about Mr G on different information systems. This included a history of perpetrating domestic abuse against other partners, concerns about his mental health, concerns for his safety and missing person reports. Gaps in the information that was recorded on Mr G's intelligence record were found. Particularly concerning his possession of weapons and threats he made to harm others. The fact this information was not recorded on Mr G's intelligence record meant opportunities may have been missed to accurately assess the risk he posed should a police officer or member of police staff have researched his intelligence record.

7.6 This became most relevant from the point at which Bethany provided a statement in August 2019 in which she alleged domestic abuse by Mr G. Had WYP domestic abuse policy been followed, and other relevant information

about Mr G have been considered, the risk recorded against him towards Bethany would have been assessed as high and not medium. That would have led to Mr G being circulated as wanted and arrested as soon as possible for the offences against Bethany. Whether that would in turn have led to his detention in custody, a custodial sentence or a restraining order is not known.

7.7 Had the risk Mr G posed to Bethany been assessed as high it would have led to a MARAC being held. That would most likely have led to the sharing of information between WYP and mental health services including the important information both agencies held concerning Mr G's history and use of weapons. Sharing information would have produced a much more complete picture of the risks Mr G posed.

7.8 There are a number of reasons why agencies did not deliver an appropriate response to the risk of harm Mr G posed to Bethany. They include features that have been seen in previous DHRs both locally and nationally and include inappropriate handling of important information, failure to correctly assess risk, a failure to follow policy and procedure in respect of domestic abuse, lack of adequate supervision and inadequate experience, training, and knowledge in relation to dealing with domestic abuse and assessing risk.

8. The Domestic Homicide Review Panel's Lessons

8.1 LESSONS IDENTIFIED

The following lessons were identified by the individual agencies that contributed to the DHR and collectively by the panel.

The following lessons were identified by the individual agencies that contributed to the DHR and collectively by the panel. The agency identifying the lesson is identified in each header.

1. Mental health awareness-Kirklees CRC [Probation]

At the time of managing this case it was identified within the organisation in Kirklees that there were gaps in Mental Health knowledge, sentencing and in regular links to community services.

2. Sentencing-Kirklees CRC [Probation]

It is questionable whether Mr G was suitable to be sentenced to a Community Order. The Court at the time were assisted in sentencing by a short Fast Delivery Report. The report author recommended a conditional discharge for this offence. Having reviewed the case file, it appears that at time of Sentence Mr G's Mental Health was under assessed.

3. Practice issues-Kirklees CRC [Probation]

There were issues with attendance during the management of this order, where in places frequency of expected attendance fell short of the organisational standards.

There was also a gap in the handover of this case between PO1 and PO2, followed by a significant period of non-contact with Mr G after this event.

There was also no formal review of this case in the 12-month period Mr G was managed by West Yorkshire CRC Probation.

4. Mental health-North Kirklees CCG

Whilst it is not directly related to the DHR in this case, it is good practice for GP practice professionals to record information relating to patients who have complex mental health issues, substance misuse issues or domestic abuse indicators relating to children they may have contact with or parenting responsibilities for.

5. Flagging risk-NHS Leeds CCG

In reference to the IAPT letter received by GP practice 1 on the 10/07/19 [point 8.1.4] which states that Bethany's boyfriend "can behave in an abusive manner" the author has identified that there was an opportunity for the reviewing GP practice to mark or flag the GP record that Bethany was at risk of domestic abuse.

6. Triggered enquiry-NHS Leeds CCG

It is the author's opinion that this action might then have encouraged subsequent practitioners at future consultations to consider completing, if safe and appropriate to do so, a triggered enquiry and enquire if Bethany was experiencing any abuse or violence in her relationships.

7. Support for victims-NHS Leeds CCG

It is the author's opinion that completing a triggered enquiry would have offered Bethany the opportunity to disclose if she felt that she was a victim of domestic abuse and subsequently receive support for any issues identified.

8. Good practice-Leeds Domestic Violence Service

Ensure good practice guidelines are followed and adhered to at all times across the LDVS service.

9. Ask the question-Leeds Domestic Violence Service

Gain suspects details where possible and if not achieved the reason why is clearly recorded.

10. Follow up call-Leeds Domestic Violence Service

Given the severity of the disclosures in the helpline call on 19 August 2019, an attempt to pre-arrange a follow up call the day after would have been appropriate.

11. Recording of intelligence-Independent Office for Police Conduct

Significant intelligence relating to allegations of domestic abuse was not recorded on police systems. This meant that this information was not available to other personnel and could not assist with decision making or the assessment of risk to the victim.

12. Standards-Independent Office for Police Conduct

A case was returned to a probationary constable because the minimum standards of investigation had not been met. The officer had not yet completed his probationary service and should not have led the investigation without supervision. When the minimum standards were met the investigation was not referred to the safeguarding unit or domestic abuse team who should have been responsible for investigating this incident.

13. Supervision-Independent Office for Police Conduct

A probationary WYP officer dealt with a serious domestic abuse investigation. The probationer was not supervised appropriately nor did he receive supervisory support and guidance.

14. Procedure-Independent Office for Police Conduct

This recommendation follows an IOPC investigation where a probationary officer failed to understand and adequately complete a domestic abuse risk assessment [known as DASH], failed to understand and complete incident logs or complete other investigative tasks.

15. Assessments-Independent Office for Police Conduct

A probationary officer failed to adequately complete a domestic violence risk assessment. This was not subject to any supervisory oversight.

16. Correction completion of Assessments-Independent Office for Police Conduct

An officer failed to fully understand and accurately complete a DASH risk assessment in respect of a victim. In addition, no PNC checks were completed, No explanatory notes were included when an answer was completed as 'other' and insufficient appreciation was shown about why certain questions were asked on the form.

Comprehensive completion of the form would have provided additional information which would assist when supervisors review and validate the risk posed to a victim.

17. Threats to life-West Yorkshire Police

Crimes should have been recorded and investigated in relation to the threats to kill made towards Daniel by Mr G.

18. Safe guarding unit secondary review of DASH risk assessments and domestic abuse occurrences-West Yorkshire Police

Safeguarding Clerks need to focus their research into incidents of domestic abuse and include previous domestic abuse incidents involving the victim, perpetrator and any previous partners.

19. Force domestic abuse policy when people report domestic abuse by appointment-West Yorkshire Police

WYP Domestic Abuse Policy provides clear and comprehensive guidance to Supervision, Call Takers and Police Officers attending ongoing incidents of domestic abuse. The process is not so clear when victims attend at the Police Station/Help Desk by appointment to report such incidents. The pending appointments need to be monitored, contact needs to be made with the victim and any escalation of risk needs to be actioned as a matter of urgency.

20. Primacy of investigations/information sharing cross border between agencies-West Yorkshire Police

Expected practice would direct that the district where the offence occurred would take primacy of the investigation, however, in this case there were reports in both Kirklees and Leeds Police Districts. WYP need to develop guidance to the Police Districts directing who takes ownership of such investigations, where the victim and suspect may live in different Policing Districts and counter allegations are made.

21. Identification of patterns of offending behaviour and controlling and coercive behaviour-West Yorkshire Police

Had WYP fully researched Mr G's previous offending history, notwithstanding Bethany's statement was not uploaded to the information system, the outstanding information would have escalated the initial risk that Mr G posed to high risk.

22. None recording of occurrences on WYP intelligence systems-West Yorkshire Police

The initial contact made to WYP reporting threats made by Mr G to Bethany, her father, friends' and colleagues were all recorded on individual logs. The incidents in the main were not cross referenced or linked to WYP intelligence systems. The wider risk was not considered.

23. Risk identification-DHR Panel

It is important to ensure all information that impacts upon the risk a perpetrator poses is accurately recorded and placed on the correct information system so as to ensure it can be found at any time in the future when an assessment of the risk a perpetrator poses needs to be undertaken.

24. Policies & Procedures-DHR Panel

Failing to follow domestic abuse policies and procedures undermines the accurate risk assessment of perpetrators and the development of plans to protect victims from those perpetrators.

25. Accuracy of assessments-DHR Panel

Accurate completion of DASH risk assessments is essential so to ensure the risks to a victim are fully understood and appropriate measures taken to protect the victim such as a referral to MARAC.

26. Supervision-DHR Panel

Effective supervision can support compliance, policy and procedure so staff are reminded of and understand their responsibilities.

27. Experience-DHR Panel

Practitioners who do not have the appropriate amount of domestic abuse training and also lack experience, cannot effectively comply with domestic abuse policy, nor accurately assess risk and develop robust plans to protect victims.

28. Safeguarding Issues-DHR Panel

Investigations and assessments into any incident should always consider whether there are any child safeguarding issues.

29. Recognition of faith issues-DHR Panel

Not recognising that people hold faith beliefs denies them the opportunity be signposted to their faith organisation for potential support.

30. Claire's Law-DHR Panel

Neither leg of Clare's Law was applied in Bethany's case. This denied her the opportunity of using the impartial information as part of her safety planning.

31. Action planning-DHR Panel

Not having a robust process for identifying serial perpetrators of domestic abuse and action planning thereafter can lead to victims, or potential victims, vulnerable to domestic abuse.

9. Recommendations

9.1 The recommendations appear within the Action Plans at appendix B post.

Appendix A: Chronology of Key Events

Table 4 Chronology of Key Events

Date	Event
September 1997	Mr G received a juvenile caution for criminal damage. This was in respect of an incident in which he slashed the jumpers of two school pupils.
Jan 2000	WYP records show police attendance when Mr G was asked to leave the house by his mother.
Feb 2004	Mr G reported to WYP that he was victim of abuse after he alleged his father assaulted him following a disagreement over board. No further action on advice of CPS.
28 August 2004	Mr G has a verbal disagreement with Female 1 over who should babysit. WYP are called and Mr G left before officers arrived.
6 July 2005	Female 1 reports Mr G sending her threatening messages. Female 1 pursuing injunction against Mr G. WYP send domestic abuse warning letter to Mr G.
Jan 2012	Mr G enters into a relationship with Female 2.
6 April 2013	Former PCSO reports having being in a fight with Mr G and that he may have stabbed him in the leg. Police log records that injury caused by a fall not stabbing. Incident reviewed as a result of the homicide of Bethany and victim repeats allegation Mr G stabbed him.
16 Oct 2014	Mr G disclosed to GP that he was having paranoid thoughts. GP referred him to SWYPFT for access to mental health services.
12 March 2015	Mr G reports Female 2 has been abusive to him. He claims this caused him paranoia. He did not want action taking. DASH completed and standard risk recorded.
13 March 2015	Mr G receives his first clinical psychologist assessment. Suspected he is psychotic.
17 March 2015	Medical review of Mr G who has diagnosis of EUPD confirmed.
8 May 2015	Mr G telephones WYP saying he is suicidal. Found by police near a swimming pool and taken to ED of hospital. Referred to his former partner [not Bethany] causing him problems. He had taken overdose of tablets and alcohol.
16 May 2015	Female 2 reports to WYP that Mr G has sent her unwanted messages following separation. She says he is controlling. DASH completed recorded as medium risk. Subsequently Mr G is served a harassment notice by the police. Mr G tells the officer about his mental health

Date	Event
	issues. The officer contacts mental health crisis team who state they will contact Mr G that evening.
15 June 2015	Mr G's housemate contacts WYP with concerns for his safety believing he has suicidal ideation. Mr G located by police with noose and taken to hospital and detained under Section 136 mental health act then released for home-based treatment.
30 July 2015	Mr G's sister reports him missing and is concerned because of suicidal ideation. He later returns home.
1 August 2015	Female 2 reports to WYP that Mr G was sending threatening and abusive text messages. Mr G was in hospital and was told by police he would be reported for harassment. DASH risk assessment completed.
2 August 2015	Mr G reports to WYP that he was victim of abuse by Female 2. WYP take no action against her.
28 August 2015	Mr G's housemate reports him missing after police tell Mr G of NFA in respect of his complaint about Female 2. He is detained under Section 136.
July 2015	Mr G's relationship with Female 2 ends.
13 Oct 2015	Mr G visits a WYP station saying it was 'Osiris' and not him that committed the crime he is appearing in court for. He is seen by a doctor.
2 Dec 2015	Mr G contacts WYP saying he is going to harm himself. He is located outside a leisure centre.
7 Dec 2015	Mr G convicted of harassing Female 2. Sentenced to community order and rehabilitation activity requirement. Later that day his flat mate reports concerns for his safety saying he took the court appearance badly and has suicidal ideation.
Autumn 2017	Bethany and Mr G's relationship starts.
9 Jan 2018	Mr G telephones WYP saying he wants to stab a paedophile. Bethany speaks to the police saying he has knife and is unwell. Police and ambulance attend and Mr G is taken to ED of hospital accompanied by police and was reported to be aggressive wanting to kill someone. Reviewed and transferred to Section 136 suite of Fieldhead Hospital. He was discharged with intensive home treatment support.
17 Feb 2018	Bethany contacts LDVS asking for advice on a safe way to leave her partner. LDVS gave her details of a drop-in service.
22 Feb 2018	Bethany visits LDVS drop-in session asking for advice on what to do in an emergency. She was concerned about her partner's behaviour. Bethany was given advice about available services including MARAC and safety planning.

Date	Event
27 April 2018	Mr G attends ED of hospital with a partner [name nor recorded] with hearing loss and pain in ear. Discharged and referred to specialist.
30 April 2018	Mr G tells a GP he is experiencing disturbed sleep. GP noted he was under the care of a CPN.
Summer 2018	Pauline receives telephone call from Bethany who asks her mum to collect her from Mr G's house.
24 Oct 2018	Mr G seen by GP asking for more medication and admitted being erratic with taking medication. Said he was having paranoid thoughts and his mood was worse.
28 Dec 2018	Mr G's GP received letter saying his CPN was absent from work.
14 Jan 2019	Mr G visits GP practice and tells pharmacist he is missing medication and it was poisoning him. Pharmacist noted Mr G was awaiting an appointment with his CPN.
28 Feb 2019	Mr G seen by a GP who he tells he has stopped taking his medication and has not seen his CPN since Sept 2018.
6 March 2019	The GP sends fax to SWYPFT to escalate matters in respect of Mr G's poor compliance and possible decline in mental health.
11 April 2019	Bethany told her GP in Leeds that she was in a low mood and struggling with university. Bethany said her partner [who she did not name] had a personality disorder and psychosis.
24 April 2019	Bethany contacted mental health services with concerns for Mr G. She did not feel there was an urgent threat however she felt his care team need to be aware and requested someone contact him the next day. Contact did take place between Mr G and his lead health professional and Mr G declined a home visit.
1 May 2019	Bethany spoke to Mr G's lead health professional by telephone while they were visiting him. She outlined concerns for Mr G and his increasing paranoia. The plan was for him to engage with the emotional stabilisation group, which he did on 7, 14 and 21 May.
16 June 2019	Bethany contacts WYP stating Mr G is her ex-partner and has made threats to kill himself. Mr G is located and taken to hospital.
22 June 2019	Bethany contacts WYP saying Mr G is threatening to kill himself after breakdown of their relationship. He was found by police and taken to hospital after attempting to hang himself. He sent a video recording of the rope to Bethany who called the police.
10 July 2019	Bethany's GP receives a letter from IAPT stating Bethany has caring responsibilities for her unnamed ex-boyfriend who behaves in an abusive manner towards her although she did not feel at risk.

Date	Event
30 July 2019	Mr G's last face to face contact with a GP for a routine matter. Communications with SWYPFT reviewed and GP notes Mr G is having a difficult time because of his child's health. GP discusses with Mr G concerning his contact with CPN for mental health support.
1 August 2019	Bethany disclosed to her GP she was feeling better, she said her boyfriend had a history of mental health issues and had tried to kill himself. Bethany said she was his carer.
May 2019	Mr G asks Mark to meet him in a car park and accused Mark of being a threat and wanting Bethany.
Summer 2019	Bethany and Mr G's relationship ends.
12 August 2019	Alice took Bethany to a WYP station and says Bethany was given advice about leaving Mr G and was told to ring 101.
14 August 2019	At a medical review, Mr G reported he had plans for his own suicide and had got his affairs in order. He was calm and reasoned regarding his intent throughout the meeting. The psychiatrist noted medication increase was discussed but was refused. Also noted was the need for a Mental Health Act assessment.
14 August 2019	Mr G contacted the home treatment team to report that his ex-partner had been telling people he had hit her. He said he was annoyed about this claim and denied it. He said he felt angry and would like to take revenge and knew that he should not. He continued to vent his feelings and said that he planned to take his own life the following week.
15 August 2019	Mark had a conversation with Mr G who said he had separated from Bethany. Mr G was vengeful and threatening. Mark contacts WYP after Mr G threatened suicide. Police locate Mr G.
15 August 2019	An AMHP met with Mr G to conduct an assessment. The AMHP felt his presentation did not justify assessment under the Mental Health Act with a view to compulsory admission to hospital. It was very different to how he had presented to the previous consultant. A plan was made regarding contact with his lead health professional, the removal of the noose in his garage, and that he would recommence his medication.
16 August 2019	Mark excludes Mr G from the music studio. Mark calls the police and attempts to contact Mr G's CPN with concerns for Mr G's safety.
16 August 2019	Bethany contacts Derbyshire Police and informs them Mr G is threatening her new partner Daniel. Details passed to WYP who record Mr G as suspect and Bethany as victim.

Date	Event
16 August 2019	Alice says Bethany made a telephone call to WYP reporting further threats by Mr G.
18 August 2019	Mr G contacted the home treatment team reporting that he had made threats to Beth's new partner. The records show that he said that he had no intention of acting on the threat and had advised that if he did any harm it would be to himself. He went on to say, however, that he had no plans to end his life.
19 August 2019	Mr G received a home visit from his lead health professional where the occurrences over the previous few days were discussed. This home visit ended with Mr G agreeing that a referral for 1:1 psychology would be made as this may be more suitable for him than group work. Also recorded in the records is a claim by Mr G that he had received a conviction for violence in 2013 following threats to kill. [There is no known validation of this by the independent team]
19 August 2019	Mr G visits WYP station. States he was going to 'smash a males head in'. WYP liaise with mental health nurse. They have no concerns for him. They advise Mr G should keep engaging with his mental health worker and NFA required.
19 August 2019	Bethany contacted LDVS seeking support and said she was going to a police station to make a report about threats from ex-partner. Bethany visits a WYP station and makes a statement of complaint against Mr G for domestic abuse. This includes allegations of manipulation, threats to harm others. DASH completed and risk recorded as medium.
20 August 2019	Mr G contacted his named healthcare professional reporting that he had received information that his ex-partner had raised safeguarding concerns about him and his friend who is disabled. He was advised to contact the police to make his own statement regarding the allegations.
21 August 2019	Mr G visits a WYP station and says he is concerned someone may have reported him. Police take a contact number from him.
24 August 2019	Mr G reported he felt in crisis and wanted to end his life. Because of this, he was discussed at a multi-disciplinary meeting on 27 August.
26 August 2019	Report to WYP from a friend of Mr G rope found in his garage and Mr G has suicidal ideation as he is under investigation by police. HE is found on the beach at Bridlington. Same day Bethany contacts WYP seeking an update on her complaint against him and expressing concern he may be looking for her.

Date	Event
27 August 2019	Mr G was visited at home by mental health services. He presented less stressed than previous contacts but stated things had not gone well for him over the weekend. He had decided to get away and give himself some space but had not given thought to how he did this or the effect he had on some others. [this was a reference to him posting his keys, wallet, and phone through his next door's letterbox] He did not realise that he had been reported as a missing person. He had no thoughts of self-harm, no suicidal intent, and no current plans.
27 August 2019	Mr G reports to WYP that he is victim of historic assault by Bethany in May 2019. Because of staffing issues the investigation is not progressed until 12 September.
Early Sept 2019	Alice says Bethany told her Mr G was making threats against Alice. Bethany asked Alice to report these threats to WYP.
3 Sept 2019	Mr G not available for a scheduled visit from mental health services. This was re-arranged for 11 September.
3 Sept 2019	Mr G visits WYP station asking for an update on the investigation into his allegation. He was told the matter had not yet been allocated for investigation.
4 Sept 2019	Mark starts to collate information concerning Mr G's threats and sends an e mail to the police officer dealing with Bethany's complaint against Mr G.
7 Sept 2019	Mr G makes a further visit to a WYP station requesting an update. He is told to be patient as WYP are short staffed.
7 Sept 2019	Bethany's father contacts WYP stating Mr G has followed and threatened him. Because of other demands the log in not progressed.
9 Sept 2019	Mark reports to WYP multiple e mails from Mr G alleging sexual assault.
9 Sept 2019	Mattieu makes on line report to WYP that Mr G had threatened to kill him. Log closed in error because rationale was that reports had been made to a 3rd party rather than to Daniel.
11 Sept 2019	Mr G contacts WYP saying he has reported Mark to various other authorities for matters unrelated to the DHR.
11 Sept 2019	Mr G was not available for a scheduled home visit from mental health services.
12 Sept 2019	Mark contacts Bethany saying he wanted to contact Mr G's CPN. Bethany asked him not to do that as it would be unethical.
12 Sept 2019	Mr G attends a WYP station by request in relation to his complaint against Bethany. A statement is obtained and a DASH risk assessment completed that is graded as medium risk.

Date	Event
Autumn 2019	Mr G attacks Bethany in the street armed with a knife and kills her.

Appendix B: Action Plans

West Yorkshire Police

Table 5 West Yorkshire Police Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
1 2	Training for all frontline officers / police staff in respect of threats to life Policy. To reiterate that all reports of Threats to Kill to be brought to the immediate attention of an Inspector to assess whether they meet the criteria for a threat to life assessment / safeguarding strategy.	Local	Force to develop new Threats to life policy Training to be delivered to all those affected	West Yorkshire Police	Policy developed for all TTLs to be reviewed by an Inspector who will undertake an initial assessment utilising the national matrix. Training will include:- 1. Face to face training on all training courses involving Inspectors and Crime investigators. 2. An online set of resources that will be accessible 24/7 to include a Bitesize symposium, YouTube educational video and	June 2023	Action completed – Implemented by Protective Services Crime not SCGU. The Safeguarding Central Governance Unit has recently undertaken an audit on the use of the threats to life policy in domestic abuse reports of threats to kill which has generated a recommendation to further

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					advice and guidance documents. 3. A series of online workshops and training events to incept the new policy.		strengthen the guidance within the policy. This work is ongoing with the policy holder.
3	Remind Staff and Police Officers that intelligence related to Domestic Abuse / Mental Health is submitted on Niche.	Local	Force policy to be updated	West Yorkshire Police	Force policy has been updated to include the following: West Yorkshire Policy will ensure that all officers and police staff record intelligence gained from incident reports on individual Niche intelligence reports at the earliest opportunity.	December 2021	Completed and Domestic Abuse DI's continue to embed learning in Districts.
4	West Yorkshire Police to ensure the Safeguarding Clerks are fully aware of what systems need to be researched in the secondary review of the DASH risk assessment. This needs to include the previous domestic/offending history of	Local	Review force policy and establish mechanisms for compliance	West Yorkshire Police	The force policy provides for staff within the SGUs/DATs to be responsible for: Completing a secondary risk assessment to ensure the correct risk	December 2021	Completed. Domestic Abuse DI's continue to monitor compliance in Districts.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	the victim, perpetrator and domestic related incidents with previous partners which could identify patterns of offending, controlling and coercive behaviour.				grading. This review should take into account the previous domestic/offending history of the victim and perpetrator, information on PNC, PND or other intelligence reports, and any domestic related incidents with previous partners which could identify patterns of offending. Compliance checks will be maintained through thematic domestic abuse audits		
5	West Yorkshire Police need to ensure that all Front-Line Supervisors are aware of the significance of cumulative risk indicators when endorsing/signing off the DASH risk assessment.	Local	To monitor compliance with existing DASH ilearn	West Yorkshire Police	The force has a dedicated DASH ilearn which reinforces that the information on the DASH must be combined with professional judgement to identify risk and safeguard victims from		Completed. Domestic Abuse DI's are embedding this recommendation through dip sampling and

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					serious by taking into account the history and bigger picture. Compliance checks will be maintained through thematic domestic abuse audits		further training.
6	West Yorkshire Police to develop guidance directing who takes ownership of cross District/Force safeguarding investigations, including cases where counter allegations of crime are reported and the victim and suspect live in different Police areas.	Local	Force policy to be updated	West Yorkshire Police	Force policy was updated in February 2022 to include a section on 'Safeguarding a victim living outside of West Yorkshire' Where a report of domestic abuse has occurred in West Yorkshire and the victim resides in another Force area, officers, and staff in WYP are responsible for: •Investigating the crime in line with the domestic abuse policy.	February 2022	Completed and Domestic Abuse DI's continue to embed learning in Districts.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					•Communicating with the other Police Force, in which the victim resides, to ensure that safeguarding responsibilities are agreed and are clear between Forces. •Recording on the OEL what action has been agreed and who is taking responsibility. •West Yorkshire districts should afford other Police Forces the same assistance where a victim of DA crime resides in the West Yorkshire area.		
7	West Yorkshire Police to review the Force Common Interventions Framework and assess whether it is fit for	Local	To review framework and determine if further analytical	West Yorkshire Police	The Power BI tool has been developed to capture live time information on domestic	December 2021	Completed as part of a programme of

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	purpose or needs to be updated or replaced with new guidance on safeguarding interventions.		tools are required		abuse, and can be used to identify those victims or repeat suspects who require increased interventions. A standard operating procedure has been developed for Districts on the use of Power BI. The Common Interventions Framework should be used alongside the Power BI tool whilst still ensuring that officers and staff use professional judgement in their decision making. Further Update: The DA Tactical Plan has a specific action as below: Using the analytical capability of Power BI, embed a bespoke multi-		continuous improvement.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					agency problem solving approach to those who are repeated victims of high harm crimes where a traditional prosecution/criminal justice approach has not proved effective. The mechanism for identifying victims is embedded, however following a recent audit, there is still further work ongoing in relation to repeat DV Management occurrences and ensuring that as a minimum top 10 victims are reviewed to consider any further safeguarding interventions. It is documented within force policy that where a DV Management		

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					occurrence is recorded for increased interventions it must be monitored and supervised. If the parties do not engage with the plan, District Safeguarding Unit must ensure that it is discussed with partners through existing partnership arrangements.		
8	West Yorkshire Police to remind to all staff the importance of creating separate Niche Occurrences for each victim reporting incidents for example Threats to Life, harassment and domestic related incidents/crimes at the earliest opportunity.	Local	To improve crime recording through training, communications, audit and ongoing process improvement	West Yorkshire Police	Training provided to all new Police Officers, the PCSO upskill training and all transferees into WYP; regular training packages to Contact staff and supervisors; series of training programmes to Neighbourhood Support Officers.	December 2021	Completed as part of a programme of continuous improvement. HMICFRS latest inspection of WYP graded our Force as Outstanding as a result of our compliance with

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					Forcewide communications to ensure all officers are aware of any changes to the Home Office Counting Rules. The Office of the Force Crime Registrar provides a permanent audit function for the Force, ensuring that all rape and serious sexual offences crimes are recorded in line with standards. Process improvement – following successful pilot, all Domestic Crime and Non-Crime occurrences pushed to Niche at first point of contact.		crime recording rules
9	West Yorkshire Police to review the Domestic Abuse Policy to encompass the appropriate	Local	To develop new mechanisms to improve response	West Yorkshire Police	The Investigations Review team led on a pilot to use a DA	June 2023	Complete

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	response to non-immediate reports of domestic abuse [dealing with reports of domestic abuse by appointment].		time to non-immediate DA reports		Appointment Car pilot in Kirklees. In addition, SCGU worked with Demand Reduction on piloting the use of GoodSAM for Domestic Abuse incidents in Kirklees. The Rapid Video Response (RVR) Process is intended to target calls for service that have recently come into WYP. The aim is to obtain best evidence and provide improved service by delivering a rapid response <15mins of receipt of call. Officer will assess logs based on initial grading and THRIVE. The initial pilot of GoodSAM was evaluated and a further pilot has commenced in		

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					Wakefield. This will also be subject to internal evaluation and then considered for wider roll out. The force has conducted pilots in relation to using GoodSAM as a rapid video response. Rapid Video Response (RVR) is a new digital policing model which uses GoodSAM technology to provide an immediate video link between consenting victims of domestic abuse, if their offenders are not present and following an eligibility assessment, with a uniformed police officer rather than wait for face-to-face Police attendance. RVR will be available at the point of		

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					a victim's call for help, rather than waiting for conventional resources to become available. Following these initial pilots, a centralised RVR team within Contact is being set up to improve the timeliness of the initial response to DA. Recruitment of the team is ongoing.		

Leeds CCG: This organisation has been replaced with Leeds Health and Care Partnership

Table 6 Leeds CCG: This organisation has been replaced with Leeds Health and Care Partnership Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
10	The Head of Safeguarding/ Designated Nurse Safeguarding Children and Adults from NHS Leeds CCG will write to all GP	Local		Leeds Health and Care Partnership	Recommendation shared with practice managers and safeguarding leads		Recommendation and all key milestones

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	practices highlighting the recommendation as described in 11.1.1 of the IMR The author recommends that as part of the learning from this review, that GP practices are encouraged to flag the GP record when a patient has been identified in GP incoming correspondence as a potential victim of domestic violence or abuse so that trigged enquiry can be considered at future contacts				Learning was discussed in GP peer meeting New template on GP electronic records systems that allows for DVA, either current or historic, to be recorded and this would create a clear flag on the records		achieved by March 2020 Recommendation and all key milestones achieved by March 2020
11	The recommendation detailed above will be added to all NHS Leeds CCG safeguarding training sessions from March 2020.	Local		Leeds Health and Care Partnership	DVA and related training updated to include recording of information and the flagging of records.		Recommendation and all key milestones achieved by March 2020
12	NHS Leeds CCG will develop and send a learning briefing out to all GP practices highlighting the	Local		Leeds Health and Care Partnership	Leeds GGC produced and disseminated learning briefings that include recording information accurately, including		Recommendation and all key milestones achieved by March 2020

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	recommendation detailed above				when received from external sources and the flagging of records, the importance and need for routine and triggered enquiry. In addition the records now have a reminder on the system that encourages a practitioner to ask about DVA at least yearly to all female patients over 16 years old. This reminder continues to pop up when entering the individual's records each time until the request is completed and documented		

Leeds Domestic Violence Service [LDVS]

Table 7 Leeds Domestic Violence Service [LDVS] Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
13	Review of LDVS Protocol and Procedure for maintaining Quality Assurance in delivery of the service.	Local	Team Leaders and Head of Service to review and implement.	LDVS	Ensuring that expected practice and standards are adhered to.	Immediate and ongoing.	Completed
14	oduction of case work nitoring documents.	Local	Team Leaders to implement and monitor.	LDVS	Ensuring case recording is succinct and accurate.	Immediate and ongoing.	Completed
15	Check that all LDVS staff are fully compliant in recognising/assessing and managing risk and safety planning incorporating professional curiosity.	Local	To identify any additional or training needs across staff teams.	LDVS	A maximum level of knowledge and understanding across the LDVS teams and to embed values around professional curiosity in this process.	Immediate and ongoing.	Completed
16	Review of how one-off contacts are linked together for the same clients.	Local	Team Leaders and DPL1 to review, make recommendations of how to link together short-term work records.	LDVS	STW for the same client are linked together to make identification easier and assessment more accurate.	Feb 27th 20 meeting to agree process and suggested timetable.	Completed

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
17	Consider ways of following up calls in appropriate cases and documenting this as procedure/protocol.	Local	Team leaders to review how to follow up/engage in specified cases.	LDVS	Cases meeting certain criteria have follow up calls when required.	Feb 27th 20 meeting to agree process and suggested timetable.	Completed

Pennine Domestic Abuse Partnership

Table 8 Pennine Domestic Abuse Partnership Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
18	Ensure PDAP helpline, triage and intake processes are pro-active in engaging clients into our service in line with our values.	Local	Complete review of staff induction and staff training Additional case audits of short	PDAP	Consultation with staff currently taking place to improve induction and training plans. Monthly case audits in place for our triage service that specifically	Jan 2023 Quarterly	Complete – a new learning and development programme for staff is being implement across the organisation. Complete – regular auditing

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			term work clients		looks at initial engagement attempts		is in place across the organisation. PDAP recently re-accredited by Safelives
19	Review PDAP helpline, triage and intake processes to ensure where appropriate a risk assessment is carried out as soon as possible	Local	Dip sample case audits take place quarterly. Ensure helpline calls/ Live chat & short term work is included in auditing	PDAP	Quarterly auditing in place across services Review auditing processes with management team	Quarterly Oct 22	Completed Completed
20	Review of case recording for clients who do not access full support but receive initial advice and guidance to ensure cases are linked and information is easily accessible	Local	Full Review of case recording for Live chat, helpline calls and short term work clients	PDAP	Embed within auditing processes	Oct 22	Completed
21	Check that all PDAP staff are fully compliant in recognising/assessing and managing risk and safety planning and in line with our	Local	To identify any additional or training needs across staff teams.	PDAP	Embed within induction, supervision, training and monthly case management with all staff	Sept 22	Completed

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	values being pro-active and responsive.						
22	Ensure PDAP services are publicised widely, and that friends and family are aware they can access support and guidance through our helpline and live chat service	Local	Review of website, social media and publicity materials to ensure friends and family is included	PDAP	Embed in PDAP strategic action plan	Sept 22	Completed

Kirklees Probation Delivery Unit (PDU) - Probation Service (former organisations - CRC and National Probation Service)

Table 9 Kirklees Probation Delivery Unit (PDU) - Probation Service (former organisations - CRC and National Probation Service) Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
23	Liaison and Diversion to continue to offer support in the Court to assist with sentencing and information sharing at assessment stages.	Local	Review current arrangements, to identify and address any gaps.	Probation Service	Meetings held by Court Senior Probation Officer with L&D May and July 22:	July 22	July 22 - arrangements running smoothly.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					Refreshed guidance issued to Court team re referral pathway; Process agreed to track requests for information via central mailbox; Escalation route clarified. Additional Court Liaison Worker from CHART re substance misuse (part of PHE Criminal Justice Project.)		Probation Court SPO in regular contact with L&D Manager and invited to L&D Board.
24	Continue to promote and sustain the services of the Seconded Mental Health Nurse to support Case Managers to work with Services Users with Mental Health needs whilst being supervised by the Probation Service.	Local	Seconded MH Nurse resigned February 2022 and has not been replaced – work with MH services to establish future of this role and maintain best practice.	Probation Service	During secondment of MH Nurse, pathways were improved: L&D in place at police station and court -short interventions/signposting; Probation Practitioners use Single Point of Access; Triage tool agreed;	April 2023 re future of seconded role. Sept 22 for other actions.	Sept 22- pathways clarified and probation practitioners understand referrals routes / available support. Good use of Ingeus

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					PHE Criminal Justice Project includes role for Forensic MH Nurse, and Dual Diagnosis Worker, but recruitment to date has not led to appointments. Probation Service has Offender Personality Disorder Pathway (formerly a NPS service.) All supervised individuals are screened for eligibility. Psychologist linked to PDU provides formulations and case surgeries to support Probation Practitioners in working with people with traits of PD. Probation Service commission a Personal Wellbeing Service from Ingeus, which addresses emotional wellbeing, lifestyle		commissioned service and the Personality Disorder Pathway.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					& associates, family & significant others, and social inclusion. Includes mentoring service, with some prison-in reach. Can support access to MH services and compliance with treatment and programmes. Head of Probation has met with General Manager, SWYT, to discuss proposal to replace MH Nurse and locate the post in Probation Community Integration Team, to address barriers for CJS entering into specialist and secondary MH Services. Under consideration by SWYT. Further meeting requested by Probation.		
25	The Kirklees Reducing Re-Offending Strategic Group to continue to have a focus on	local	Probation Service to work with police to	Probation Service	Group co-chaired by IOM Police Sergeant and Senior Probation Officer of	September 2022 and ongoing.	September 2022.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	Mental Health and continue to drive forward innovation, service development and sustaining good links for community partners in Kirklees.		refresh membership and focus of this group, in line with Kirklees Communities Plan and Probation Reducing Reoffending Plan.		Community Integration Team. Well attended by most partners but still need a representative from mental health. To be progressed in meeting with SWYT General Manager re action 2.		Terms of reference refreshed. Multi-agency action plan agreed with partners and in progress.
26	Continue to promote the use of minimum standards, review and transfer of cases guidance and be aware of these in case audits/training sessions.	regional/ local	Embed understanding and application of practice standards in Probation Service	Probation Service	All probation staff have access to electronic process map, EQuiP, which sets out expectations and process to follow against Case Transfer Policy Framework. EQuAL framework established – Quality Development Officers leading peer audits of cases in each PDU. Every practitioner expected to attend one p.a. and learning disseminated in teams, to	September 2022 and ongoing.	September 2022. All staff aware of framework and where to access guidance.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					embed understanding of all quality standards. 2 Senior Probation Officers take lead in managing transfers and 2 take lead in case allocations, to provide closer oversight.		

North Kirklees CCG: Now part of West Yorkshire Integrated Board

Table 10 North Kirklees CCG: Now part of West Yorkshire Integrated Board Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
27	GP practices in Kirklees will receive written communication from the CCG safeguarding team reminding about the importance of the 'think family' approach when delivering care to adults who may have caring responsibilities, specifically when complex mental health issues, substance misuse and	Local	Local	Provide a briefing document to disseminate to GP practices.	CCG Safeguarding team	'Think family' was shared as part of a newsletter in August 2019. 7 Minute briefing on Domestic Abuse July 2021	March 2020

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	domestic abuse issues are identified.					Revisited in March 2022 with a further briefing on 'Caring Responsibilities' Briefing paper on Bethany DHR to share learning, again revisiting caring responsibilities.	
28	The CCG safeguarding team will highlight the importance of the 'think family' approach when delivering care to adults who may have caring responsibilities, specifically when complex mental health issues, substance misuse and domestic abuse issues are identified, via the CCG newsletter that is sent out to the GP practices via the CCG communication team.	Local	Newsletter to be shared	CCG Safeguarding team	'Think family' was shared as part of a newsletter in August 2019.	April 2020	August 2020

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
29	GP practice leads in Kirklees have regular safeguarding lead GP meetings and it will be discussed at each of these regarding the importance of the 'think family' approach when delivering care to adults who may have caring responsibilities, specifically when complex mental health issues, substance misuse and domestic abuse issues are identified.	Local	Repeat agenda item	CCG Safeguarding team/Named GP for Safeguarding	Safeguarding lead GP meetings in 2020/21 changed focus due to Covid19. Revisited 25 April 2022 presentation by Named GP including 7-minute briefing Revisited 19 July 2022 presentation for a local children's case relating to think family and caring responsibilities. Planned dedicated session 29 November 2022 to share specific learning from this DHR.	December 2020	November 2022

DHR Panel

Table 11 DHR Panel Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
30	Kirklees Communities Board works with all the agencies that have contributed to this DHR and have developed individual agency action plans to address the lessons identified. That work should ensure a single overarching multi-agency process or body is in place which holds each agency to account for the delivery of their action plans including the implementation of the NHS Mental Health Homicide Review and the IOPC investigation.	Local	The DHR Standing Panel will hold each agency to account for the delivery of their action plan	Communities Service	October 2022 – all agencies to have established individual agency action plans June 2023 – all agencies to have completed action plans	June 2023	Complete
31	Within 12 months of Kirklees Communities	Local	The DHR Standing panel will host an audit style event for	Communities Service	May 2023 – challenge event scheduled to allow the DHR panel,	November 2023	Complete – a challenge event 2023 highlighted how

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	Board accepting the DHR report it must: Require all agencies to report to the Board in writing the progress they have made in implementing their agency's DHR recommendations and those of the NHS Mental Health Homicide Review and IOPC investigation. State in writing, to the Board Chair, the progress the Board has made in implementing the DHR Panel's recommendations. Prepare an overarching written report for the Board Chair detailing the progress agencies and the Board have made in implementing the DHR, NHS Mental Health		agencies to submit evidence of progress in implementing recommendations		including the family advocate, to provide constructive challenge to agencies regarding improvements made as a result of this DHR. Event postponed given pre-inquest hearing on 31st May. Pre-inquest hearing – Coroner requested that key agencies provide a report to the coroner advising on how these findings have been implemented - submitted by 28th July. Meeting postponed until Coroner has made a final decision on the inquest (tentatively scheduled for October		improve-ments have been made, in sustained in key partner agencies

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	Homicide Review and IOPC investigation recommendations. A copy of this written report should be shared with Bethany's family on its completion.				2023 pending advice from the coroner). November 2023 – event for agencies to present evidence of progress. Family advocate in attendance to provide challenge.		
32	Agencies ensure that whenever an investigation or assessment is being undertaken into an event or incident consideration is always given as to whether there are any child safeguarding issues to address.	Local	Evidence to be collated as part of a West Yorkshire wide Organisational Safeguarding Assessment	Kirklees Safeguarding Children Partnership	An Organisational Safeguarding Assessment was completed by the Communities Service and relevant partner agencies in October 2022 and demonstrates compliance with relevant legislation (e.g. Working Together 2018, Keeping Children Safe in Education, Early Years Foundation Stage Statutory Framework); provides	October 2022	Complete

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					evidence of reflective practice; and identifies areas of good practice and improvement for participating agencies to safeguard and promote the welfare of children.		
33	Agencies have processes in place that ensure people who have faith beliefs are recognised and provided with an opportunity to be signposted to their faith organisation for potential support.	Local	Partner agencies to submit evidence of their processes to signpost people to faith organisations as appropriate	Communities Service	May 2023 – learning event scheduled to allow agencies to highlight progress. Event postponed given pre-inquest hearing on 31st May. Pre-inquest hearing – Coroner requested that key agencies provide a report to the coroner advising on how these findings have been implemented -	November 2023	Complete – a challenge event 2023 highlighted how partner agencies have implemented this learning

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					submitted by 28th July. Meeting postponed until Coroner has made a final decision on the inquest (tentatively scheduled for October 2023 pending advice from the coroner). November 2023 – event for agencies to present evidence of progress. Family advocate in attendance to provide challenge.		
34	That all Kirklees Community Board constituent agencies should: 1. Have a Domestic Violence Disclosure Scheme policy. 2. Review their Domestic Violence Disclosure Scheme policy and	Local	DVDS policy to be included in DRAMM-MARAC operational protocol and signed up to by all agencies Info on DVDS to be included in relevant agency training & leaflets		Jan-23 - West Yorkshire Police reviewed DVDS information available to the public Monthly oversight of DVDS requests/ disclosures and targeted work to	July 23	Complete and will continue to be embedded. Kirklees has the highest rate of DVDS disclosures in West Yorkshire

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	practice to ensure it properly supports victims and potential victims of domestic abuse. 3. Review the opportunities for including details of the Domestic Violence Disclosure Scheme in the domestic abuse leaflets they give to victims and potential victims of domestic abuse.		Monitoring of requests/ disclosures and work with targeted agencies to improve		increase disclosures within MARAC and with key partners i.e. probation and children's services July 2023 – Agency training on domestic abuse updated to include reference to DVDS and training delivered to 2,166 people in the community		
35	That West Yorkshire Police review it policies and practices around identifying and responding to serial perpetrators of domestic abuse.	Local	Review existing policies and practices for serial perpetrators of domestic abuse Consider multi-agency arrangements for responding to serial perpetrators	West Yorkshire Police	June 2022 - new domestic abuse specific Integrated Offender Managers in place to manage serial/repeat DA perpetrators in the community. IOM coordinate regular multi-agency meetings to identify and manage risk	November 2022	Complete

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					Nov 2022 - new domestic abuse coordinator in place to coordinate a multi-agency response to reducing the number of repeat victims, including through targeted work with serial perpetrators		
36	That Kirklees Community Board considers whether partner agencies have separately identified the risk to victims of technology facilitated abuse and whether partner agency policy and practice needs to be revised so as to ensure such risks are identified and measures are in place to respond to them and protect victims.	Local	Info on tech related abuse to be included in relevant agency training & leaflets Information on Kirklees Domestic Abuse pages to be updated with links to tech abuse related support	Communities Service	July 2023 – Agency training on domestic abuse updated to include tech related abuse and training delivered to 2,166 people in the community WY Police webpages include online safety guides Links to tech abuse support on Kirklees	November 23	Complete Tech abuse is a regular part of domestic abuse training and links to support available through professional webpages

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					Safeguarding Children Partnership website Kirklees Council pages have been updated		