KIRKLEES COMMUNITIES PARTNERSHIP BOARD

[Incorporating the Statutory Community Safety Partnership]

DOMESTIC HOMICIDE REVIEW

Bethany

Died September 2019

OVERVIEW REPORT

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Support to Chair/Author	Sara Wallwork
Date	August 2024

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1. INTRODUCTION

1.1 The DHR panel extend their deepest condolences and sympathy to Bethany's parents Jim and Pauline, to Pauline's partner Richard and all of Bethany's family and friends on their loss. This report of a domestic homicide review examines whether agencies could have identified if Bethany, a resident of Leeds, was at risk from her former partner Mr G1 who killed her in September 2019 and whether agencies could have reduced that risk and protected her.

1.2 Before he met Bethany in 2017, Mr G perpetrated domestic abuse on at least two other partners. The quantum of his behaviour meant he met the definition of a serial perpetrator[2] of domestic abuse when they met, although this was not recognised by agencies until after he killed Bethany.

1.3 Bethany and Mr G lived together from March 2018. In June 2019 Bethany ended the relationship because of his abusive behaviour and his constant threats towards her and her friends. His pattern of abuse towards Bethany closely followed that experienced by his two other known victims.

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 Early one evening in September 2019 Bethany and colleagues, from a company providing musical services for persons with disabilities, were loading equipment into their van outside a club in Huddersfield. Mr G approached Bethany from a car park across the street and attacked her with a knife. One of Bethany's colleagues tried to intervene. Bethany was able to run a short distance before Mr G caught her and continued the assault.

1.6 Bethany's colleagues and bystanders administered first aid and the emergency services were called. Paramedics were unable to save Bethany and she died at the scene. By then Mr G had left in his car and made his way to a bridge over a motorway which he climbed onto and made threats to harm himself.

1.7 Police officers arrested Mr G and he was charged with Bethany's murder. In summer 2020 Mr G appeared before a Crown Court and pleaded guilty to the manslaughter of Bethany on the basis of diminished responsibility. His plea was accepted by the Court. At the time sentence was passed Mr G had a confirmed diagnosis of schizophrenia, with evidence of a long-standing personality disorder[3].

[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] See paragraph 16.1.9 for a definition of serial perpetrator of domestic abuse
[3] The issue of the difference between the two diagnoses is a key matter considered by the independent Level 3 Mental Health Homicide Review of the care and management of Mr G [see Appendix B].

1.8 Bethany was stabbed multiple times and the sentencing judge described Mr G as having carried out a targeted and sustained attack on Bethany. 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'.

1.9 The judge sentenced Mr G to life imprisonment and said he must serve a minimum of 11 years and 8 days before his case can be considered by the Parole Board. The judge also imposed a Hospital Order under Section 45A Mental Health Act 1983 and a Restriction Order under Section 41 of the same act.[4].

1.10 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer'.[5]

1.11 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person died because of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'.

1.12 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

[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.
[5] Home Office Guidance Domestic Homicide Reviews December 2016.

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. TIMESCALES

2.1 West Yorkshire Police [henceforth referred to as WYP] notified Kirklees Communities Partnership Board on 18 September 2019 of the homicide of Bethany. The Communities Partnership Board met on 8 October 2019 and determined the criteria had been met for a Domestic Homicide Review [DHR] to be undertaken. On 13 October the Chair of Kirklees Communities Partnership Board informed the Home Office by letter that a DHR was taking place.

2.2 David Hunter was appointed as the Independent Chair of the DHR on the same day. The first meeting review panel took place on 19 December 2019. The panel determined the timescale the review should cover as the period between 1 January 2014 [when Mr G appeared to be experiencing mental health concerns] and the date of Bethany's homicide.

2.3 The DHR review process was delayed because of the Covid pandemic. A further seven meetings were then held before the report and recommendations were accepted by the Kirklees Communities Partnership Board on 14 September 2022 and was sent to the Home Office later that month.

2.4 There is important information on parallel reviews in Section 10. Two of these were:

- 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. This report has not yet been published. The family have seen the final version and the DHR has received permission from the IOPC to quote from it.

- NHS England commissioned a Mental Health Homicide Review under the NHS England Serious Incident Framework. Appendix B of this DHR is the Executive Summary of that Mental Health Homicide Review. The published Extended Executive Summary can be found by using the following link. Independent review of the care and treatment of Mr G between 2014 and 2019

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of professionals providing services to Bethany and the perpetrator are anonymised using an agreed identifier.

3.3 This table shows the age and ethnicity of the victim, the perpetrator of the homicide and other key individuals.

3.4 Bethany's family and some friends wanted their real names in the report and this was agreed with the Home Office.

Table 1 Names of family and friends

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 former partner	n/a	n/a
Female 2	Mr G's second former partner	n/a	n/a
Child 1	Mr G and Female 1's child		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 [6]	Bethany's partner after separating from Mr G	n/a	Unknown
Address one	Scene of Bethany's homicide	n/a	n/a
Address two	Bethany's home in Leeds	n/a	n/a
Address three	Mr G's home in Kirklees	n/a	n/a

[6] A pseudonym

4. TERMS OF REFERENCE

4.1 It was agreed at the first meeting panel meeting that explicit Terms of Reference would be drawn up separately by NHS England and the DHR Review Panel. These were shared to ensure there was limited duplication and that the focus remained on sharing the joint learning.

4.2 Once the panel had drafted the Terms of Reference for the DHR they were shared with Bethany's family by the Chief Executive from Hundred Families[7], who is supporting them. The family were invited to comment on the Terms of Reference.

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.

[7] Hundred Families is a charity that aims to offer accurate information and practical advice for families bereaved by people with mental health problems along with evidence-based resources for mental health professionals and others interested in serious violence by the mentally ill.

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

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 as 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?

   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?

[9] Section 9 Care Act 2014

10. Does the learning in this review appear in other domestic homicide reviews commissioned and monitored by the Kirklees Communities Partnership Board?

5. METHOD

5.1 The DHR panel agreed the review would be conducted in parallel with a Mental Health Homicide Review under the NHS England Serious Incident Framework [see section 10 post].

5.2 At the first panel meeting members set the time period the review would cover. Draft terms of reference were agreed and the panel determined which agencies were required to submit written information and in what format. A timetable leading to the completion and submission of the overview report was also set.

5.3 As soon as possible a meeting was held with Bethany's family [see section 6]. They were able to provide a rich description of Bethany as a treasured person and shared important information about her relationship with Mr G. As well as talking to professionals who had provided services to them, panel members also held conversations with other people who had known Bethany and Mr G.

5.4 Unfortunately, before the panel could convene for its second meeting, the Covid pandemic occurred. This led to considerable delays amongst many agencies in providing the information necessary to allow the panel to complete its work. Bethany's family were kept informed of the reasons for these delays. The panel Chair consulted agencies and wrote eight briefing notes to the Chair of Kirklees Communities Partnership Board updating them with progress and including a revised timetable for completing the review. The Chair of the Communities Partnership Board's DHR Standing Panel agreed to the revisions and the Home Office were informed.

5.5 By August 2021 sufficient information was received to allow work to be resumed on drafting the overview report. When this work was completed the DHR panel resumed meeting on 5 November 2021[10]. Further meetings were held during which the panel discussed and refined the overview report. The panel then shared the draft report with Bethany's family and those supporting them and made additional changes.

5.6 The report was then presented to the Kirklees Communities Partnership Board before being sent to the Home Office for quality assurance.

[10] Because of national restrictions causes by the Covid pandemic all panel meetings from March 2020 onwards were conducted on line using appropriate software.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES NEIGHBOURS AND THE WIDER COMMUNITY

6.1 The DHR Chair wrote to Pauline inviting her to contribute to the review. The Chair also shared this letter with the Chief Executive from Hundred Families who is supporting her. The letter to Pauline included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse [AAFDA[11]] leaflet.

6.2 On 28 February 2020 the panel Chair met with Pauline, Richard, and the Chief Executive from Hundred Families. The Chair also met separately with Bethany's father Jim, her close friend Alice and Mark, the chief executive of the recording studio and Daniel who was Bethany's partner at the time of her death. The panel Chair gave the panel's condolences to Pauline, Jim, Richard, Alice, Mark and Daniel on the tragic loss of Bethany. He provided them with information about the DHR process and invited the family to meet with the panel.

6.3 Pauline and Richard identified a number of issues they wanted addressing within the DHR and the Mental Health Homicide Review. Jim offered a strong endorsement for these issues.

6.4 Pauline, Jim, Richard, Alice, Mark and Daniel provided information about Bethany which helped the panel build a picture of her life. The detail they provided is included within section 13 of this report.

6.5 In June 2022 some members of the DHR panel met with Pauline, Jim, Richard Alice and Mark who shared photographs of Bethany and made personal tributes. The meeting was impactive and identified Bethany as a much loved, selfless, intelligent and caring person.

1) Why did the mental health nurse not see Mr G in order to undertake an assessment and intervene with his behaviour, instead contacting Mr G over the telephone?
2) Was due consideration given by professionals in relation to the wider duty of care to safeguard Bethany and others in their management and care planning of Mr G?
3) Were any considerations given to Bethany being a carer for Mr G and were there any concerns from health care professionals that he was controlling, and/or Bethany felt obliged to say she was his carer?
4) Why did West Yorkshire Police not update Bethany following the three separate reports she made to them?
5) What safety measures were offered to Bethany by West Yorkshire Police?
6) Why did West Yorkshire Police not link the complaints made by other people, in relation to Mr G?

[11] https://aafda.org.uk/

7) What sharing of information occurred between police stations across West Yorkshire Police and indeed between agencies that had knowledge of Mr G concerning behaviour?

6.6 The answers to the questions can be found within this report and they are broadly summarised at Appendix A

6.7 The author of the independent Mental Health Homicide Review contacted Mr G's two sisters and a number of friends who knew Mr G and/or Bethany. They provided useful information which is included within both Section 13 of this report and the Mental Health Homicide Review [Appendix B].

7. CONTRIBUTORS TO THE REVIEW

7.1 Agencies were asked to search their records and establish if they held any information in respect of any of the subjects of this review. The panel scrutinised the information provided by these agencies and then asked those that held relevant information to provide further details. The table below shows each of the agencies that were contacted, whether any of the subjects were known to them and what information they then provided.

Table 2 Agencies contacted, and subjects known to them

Agency	Known	IMR[12]	Chronology	Report
Adult Safeguarding	No			
Brighton-Sussex Partnership Foundation Trust	Yes	✓		
Calderdale & Huddersfield NHS Foundation Trust	No			
Carers Leeds[13]	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 information[14]	Yes	✓	✓	

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

[13] '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.'

[14] 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.

Agency	Known	IMR[12]	Chronology	Report
Housing Services	No			
Kirklees Neighbourhood Housing	No			
Leeds Clinical Commissioning Group [CCG]	Yes	✓	✓	
Leeds Domestic Violence Service	Yes	✓	✓	
Locala[15]	No			
MARAC[16] / DRAMM[17]	No			
Mid Yorkshire Hospitals NHS Trust	Yes	✓	✓	
Pennine Domestic Abuse Partnership [PDAP]	No[18]			
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	✓	✓	

[15] Locala Health & Wellbeing is a not-for-profit community healthcare provider. We are proud to provide a variety of NHS services to .people of all ages.
[16] 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.
[17] Daily Risk Assessment Management Meetings.
[18] While Bethany and MR G were unknown to PDAP the organisation took the opportunity to review its practices and make recommendations' which appear in the DHR action plan.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

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

8.2 The chair of Kirklees Communities Board was satisfied the panel chair was independent. In turn, the panel chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met seven times and matters were freely and robustly considered. Outside of the meetings the panel chair's queries were answered promptly and in full.

*NOTE: 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.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

9.2 The chair completed forty-one years in public service [the military and a British police service] retiring, from full time work in 2007. Whilst in the police service he was responsible for developing domestic abuse policy and implementing the operational responses. To support him in this work he attended domestic abuse multi-agency training and seminars.

9.3 The author completed thirty-five years in public service [British policing and associated roles] retiring from full time work in 2014.

9.4 The chair and author have undertaken the following types of reviews: Child Serious Case Reviews, Safeguarding Adult Reviews, Multi-Agency Public Protection Arrangements [MAPPA] Serious Case Reviews and Domestic Homicide Reviews. They have not worked for any agency providing information to this review and have undertaken all the available Home Office training on DHRs as well as attending regional conferences for chairs, authors and other professionals involved with DHRs. They also attended regional events where families of domestic homicide victims have spoken.

9.5 They were supported by Sara Wallwork who completed 30 years in public service [British policing] and retired from full time work in 2019. Sara Wallwork has not worked for any agency contributing to this DHR and like the chair and author has completed the Home Office DHR training, AAFDA Chair Training, attends regional DHR seminars and is a member of the DHR Network.

9.6 The chair and author undertook DHR reviews in Kirklees in: 2014, 2017 and 2019.

10. PARALLEL REVIEWS

10.1 His Majesty's Coroner for Kirklees opened and adjourned an inquest into Bethany's death. Following the conclusion of the criminal trial, His Majesty's Coroner conducted a pre-inquest review and, on 6 October 2023, determined that there should be no inquest into Bethany's death.

10.2 West Yorkshire Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.3 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. The Chair of the DHR established contact with the investigating officer from IOPC and they shared a copy of their findings with the DHR panel.

10.4 NHS England commissioned a Mental Health Homicide Review under the NHS England Serious Incident Framework. This work was led by Maria Dineen from Consequence [UK] Ltd. A separate report was written by Maria for NHS England. This work was completed before the DHR overview report was finished and published on 11 May 2022. Because the mental health of Mr G was a key issue within the DHR, Maria was also a member of the DHR panel. The Executive Summary of her independent report is annexed to this DHR overview report. [See Appendix B] Page 7 above has the link to the published Extended Executive Summary.]

11. EQUALITY AND DIVERSITY

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

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

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

[1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[19].

11.3 Bethany and Mr G were born in the United Kingdom and their ethnicity is White British. English was their spoken and written language. Bethany was an articulate and well-educated person who had full capacity [that is, the ability and therefore the right, to make her own decisions] and she understood both the spoken and written word. Bethany did not suffer from any physical disability and did not have a mental impairment.

11.4 Mr G does not have a physical disability. There is nothing within Mr G's family background or medical history before the homicide to indicate he lacked capacity to understand either the spoken or written word. He was examined on a number of occasions between 2015 and 2019 by clinicians and other professionals qualified to assess mental capacity, who all concluded that he did not appear to lack capacity and did not qualify for detention under the Mental Health Act 1983.

11.5 Mr G had a diagnosis of emotionally unstable personality disorder [EUPD]. In addition the independent team that completed the Mental Health Homicide Review into Mr G's care stated, '… there are features in his clinical records which support a conclusion of long-standing schizophrenia and EUPD'.

11.6 The panel carefully considered the question of whether Mr G's condition of EUPD meant he had a disability as defined by the Equality Act 2010. Although Mr G was diagnosed as having a mental illness following his arrest, the panel felt it was important to consider what information was known about Mr G

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

before he killed Bethany. In so doing the panel considered the extensive guidance issued by government in helping to determine such questions[20]. However, the panel did not feel they had sufficient information to reach a consensus on this complex question.

11.7 However the panel were satisfied that, even if it had agreed Mr G had a disability that fell within the definition in the Equality Act 2010, they did not see any evidence of discrimination in respect of the services delivered by agencies to him because of it[21].

11.8 The panel recognise Bethany's sex was a significant factor in her abuse. Domestic abuse is a gendered crime which is deeply rooted in the societal inequality between men and women. Women are overwhelmingly the victims of domestic abuse and men the perpetrators.

'Women are more likely than men to experience multiple incidents of abuse, different types of domestic abuse[22]'

11.9 The World Health Organisation found that intimate partner violence can cause serious short and long-term problems for women including physical and mental issues. These forms of violence can lead to depression, post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, and suicide attempts[23]. Consequently the panel looked carefully at Bethany's presentation during her relationship with Mr G for evidence of these issues. While no records were found that Bethany had sought professional help for these conditions, the panel cannot discount the fact that, because of her sex, Mr G's appalling behaviour towards Bethany was starting to have an impact upon her health in a way that had not yet manifest itself to professionals.

11.10 Pauline felt that if the victims of domestic homicide were predominately men, more attention would be paid to the recommendations arising from domestic homicide reviews.

[20] Equality Act 2010: Guidance on matters to be taken into account in determining questions relating to the definition of disability.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/570382/Equality_Act_2010-disability_definition.pdf
[21] As defined by S29 [1-10] of the Equality Act 2010
[22] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/
[23] World Health Organization March 2021 'Violence Against Women' https://who.int

12. DISSEMINATION

12.1 The following organisations/people will receive a copy of the Home Office quality assured report.

- The Family
- Kirklees Communities Partnership Board and DHR Standing Panel
- Safer Leeds [the City's statutory Community Safety Partnership]
- Mayor of West Yorkshire [who is also the Police & Crime Commissioner]
- IOPC
- NHS England
- Domestic Abuse Commissioner
- The Member of Parliament for Pudsey, Horsforth and Aireborough
- Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

13. BACKGROUND

14. Bethany

14.1 Pauline said Bethany was an intelligent, articulate, good hearted, loving, caring person and wise beyond her years. She was an only child. Her father Jim, and mother Pauline separated when Bethany was 5 years old although they remained in contact after their separation and had Christmas dinners together. Jim remained close to Bethany and had a loving relationship with her.

14.2 Until Bethany was 11 years old, Pauline said they were on their own, as best friends and they had a lovely relationship. They shared cosy up nights, and Friday nights with Bethany were always special and fun said Pauline. Bethany was Pauline's priority and when Pauline met her partner Richard, Bethany was 11 years old. Pauline said she and Richard both trod carefully before gradually introducing Bethany to him. Bethany was supportive of Richard and pleased for Pauline.

14.3 Bethany was educated in Leeds and after leaving secondary school gained a place to study English literature and psychology at Sussex University in Brighton. She went there with her previous boyfriend. For personal reasons Bethany did not finish the course and left Brighton after completing her first year and one term of the second year. She then commenced a course at the University of York, studying environmental science.

14.4 Jim involved himself in Bethany's schooling and supported her with project work which she enjoyed and excelled at. Jim recalls praised being heaped on her by teachers for the depth and quality of the research she put into her work. They spent many happy days out together. Jim remembers with pride the way she developed while volunteering and then working alongside him at the music studio.

14.5 During the few months before her homicide Bethany moved most of her personal belonging into his home and stayed there on many occasions.

15. Mr G

15.1 The lead reviewer and author of the Level 3 Mental Health Homicide Review into Mr G's care, spoke to members of his family and friends. The details of these conversations and witness statements from Mr G's mother and one of his sisters are the source for the following paragraphs.

15.2 Mr G's mother said he had a lot of behavioural issues as a child. He was excluded from school as a result of 'going for a teacher'. His mother said he had 'meltdowns' and when he was young was violent towards one of his sisters. His mother says he 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 never forgave his mother for this.

15.3 Mr G's elder sister said he had difficulties from being very young and then through his whole life. She said he would become angry and frustrated and over the years there were a number of incidents in which he went missing, harmed or neglected himself. Into his adult life these got worse especially in the last 8-9 years. His younger sister said he would willingly help people with tasks such as gardening. He was also a very keen musician and played in a local band.

15.4 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. WYP recorded five incidents of domestic abuse involving Mr G and Female 1. The first of these was in August 2004. It involved a verbal disagreement over who acted as baby sitter for Child 1 when Female 1 was going out. The final domestic abuse incident involving Female 1 as the victim was when Mr G sent her threatening telephone messages.

15.5 Mark recalls that prior to Mr G's relationship with Female 1 he was in a substantial relationship with a named female. He told Mark the relationship was the best one he had and when he formed a relationship with Bethany often referred back to it. Mark knew the female and described how she 'escaped' from the relationship while Mr G was away. WYP do not have a record of any incidents between Mr G and this female.

15.6 Mr G's younger sister described how Mr G spoke of suicide following the breakdown of his relationship with Female 1. He left suicide notes for Female 1 and Child 1 and a note describing a funeral plan. His younger sister described how her brother went from being a happy person into a 'massive decline'. She said from then on suicide notes became a constant feature and she got to the point at which she realised he needed help. As well as suicide notes Mr G's younger sister also spoke about his paranoia. She says Female 1 told her how he would sleep under a window and kept a hammer with him believing people were coming to get him.

15.7 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. Female 2 reported that Mr G made threats towards her father and another male she formed a relationship with. Mr G sent her constant abusive calls, text messages and Facebook messages.

15.8 Mr G went on to make counter allegations against Female 2 when she reported his abusive behaviour. This repeated the experiences of Female 1 when she reported abuse. Mr G was convicted of harassing Female 2 [see section 15.3 where this is explored in more detail].

15.9 His younger sister says she told Mr G that he needed to tell his Community Psychiatric Nurse [CPN] what he was doing, although she does not know if he actually did. She was also concerned that Mr G might be displaying signs of schizophrenia. She knew about this condition as she had seen symptoms of it in another family member.

15.10 A longstanding male friend of Mr G's was aware that he heard a voice[24] and he was able to tell his friend when it was loud and constant.

15.11 When the voice got really strong his friend said that was the point at which Mr G would struggle and harm himself. His friend said, that while he did not know a great deal of detail about the voice, he knew the focus of Mr G's voice seemed to be people 'like paedophiles'. [See later references for context].

15.12 A male neighbour of Mr G, who knew him for 8-9 years, was also aware of the voice Osiris. They said it was a strong factor in Mr G's life and was the biggest threat he faced. While Mr G had always shown a keen interest in music he stopped as he believed Osiris had given him his talents. While this neighbour felt Mr G could be a little obsessive about other people, he had never witnessed Mr G being physically or verbally abusive.

16. Bethany and Mr G's Relationship

Pauline and Richard's Recollections

16.1 Bethany had known Mr G for six years. They met at a music studio in Leeds. This was where Bethany's father Jim had worked and as a teenager Bethany worked there with him. Pauline and Richard were first introduced to Mr G in March 2018.

16.2 Pauline said Mr G was more talkative than Bethany's previous boyfriend. He was more of a showman and liked to talk about himself. Mr G told her he had mental ill health issues and had telephoned the police in the past due to feeling suicidal. At the time Pauline felt he seemed to be open and honest about this. She felt he wanted her and Richard to accept him and wanted them to like him.

16.3 Pauline said Mr G was well known in the area and his openness may have been because he felt he had to tell them before someone else from the community did. After that first introduction, they found Mr G to be talkative, jolly, and lively. He went on days out with them as a family and they went to watch him perform his music and other members of Beth's family also met him. Pauline now believes Mr G had narcissistic tendencies and that his apparent openness was part of his manipulative behaviour. Had she known this at the time, Pauline would have been alert to dangers he posed and encouraged Bethany to treat him cautiously.

16.4 Mr G was 14 years older than Bethany. Pauline felt Bethany was looking for someone to be herself with; someone who understood her; her soul mate. Pauline said Bethany just wanted accepting for who she was. Pauline said she was concerned about the age gap but felt that mentioning it to Bethany would

[24] Mr G referred to the voice he heard as that of Osiris - the Greek mythical God of the dead.

not be helpful. Pauline thought the relationship would run into the sand and felt it was better to wait for that to happen.[25]

16.5 Most of Pauline and Richard's knowledge of Mr G's mental ill health is based on what Bethany told them. She said he had episodes every couple of years where he was aggressive and wanted to attack paedophiles. They were aware he had tried to self-harm and had attempted to take his own life. They had no knowledge whether he took medication. Pauline recalled an occasion when Mr G telephoned Bethany threatening to commit suicide in order to make her feel guilty.

16.6 Pauline said she did not see what happened to Bethany coming. In hindsight, she felt Mr G was very manipulative and controlling. Looking back Pauline said she used to think domestic abuse was violence and putting women down and isolating. Now she understands it is much deeper and that perpetrators are clever and control the other person.

16.7 Pauline described a telephone call she received from Bethany in summer 2018. Bethany was in tears and asked Pauline to go and fetch her from Mr G's address. When she arrived, Bethany did not want to go with Pauline anymore. She asked Bethany if she was alright, and if Mr G had made any threats or hurt her. Pauline said Bethany did not disclose anything.

16.8 Bethany told Pauline she wanted to talk with Mr G and asked Pauline to leave. Pauline and Richard left but went to a nearby public house in case there were any further calls. They did not see Mr G on that occasion although they believed he was in the house. Pauline felt Bethany was protecting Mr G by not telling her what was going on.

16.9 Pauline said she found a note book in which Bethany recorded issues relating to Mr G. She said Bethany had volunteered at a domestic abuse charity for six months and felt Bethany may have picked up the idea of writing things down from there. In the notebook Bethany listed personality traits of Mr G and commented on which ones she liked in him. This started off as a long list and towards the end of their relationship there were only a couple of things Bethany liked about Mr G.

16.10 Bethany acted as Mr G's informal carer. Pauline thought Bethany may have felt obligated to do so because Mr G controlled and manipulated her. This was particularly so when Bethany and Mr G split up

16.11 During summer 2019, the relationship between Bethany and Mr G was ending. Mr G said he realised he was holding Bethany back and he wanted to split so

[25] The following link refers to an article on why women should avoid relationships with older men. It talks of skewed power dynamics. Pauline felt that Bethany did not have the life experience to deal with a manipulative older man. https://lovefulmind.com/posts/9-reasons-why-young-women-should-avoid-significantly-older-men-at-all-costs The DHR panel offer this as a third party view without its endorsement.

that Bethany could move on with her life. However, Child 1 was ill and Mr G asked Bethany to hold off on the split until she was better.

16.12 At the same time Mr G was sending text messages to Pauline, Mark [Bethany's previous boss] and Jim causing problems. Pauline felt these were diversionary tactics to avoid the focus on his own behaviour towards Bethany. Pauline said she was worried about Bethany when she broke up with Mr G and advised her to do it gently with him because of the risk to him. Following the end of their relationship Pauline recalled a telephone call from Mr G. She felt he was fishing for information on Bethany and wanted to know where she lived. By this time Bethany had moved into accommodation in York: an address Mr G did not know.

16.13 Pauline said Bethany had gone to the police on three occasions [details of these contacts and what Bethany told the police are set out in the chronology at Appendix C and in the paragraphs beginning 15.3.46.] Pauline said that Bethany was not offered any protective measures by the police and received no contact from the police officer who took the reports before she was killed by Mr G. Pauline felt there was a lack of communication between police stations. She and Richard outlined a number of questions they wished to be addressed by the DHR and independent review into Mr G's care [see paragraph 6.4].

Friend's and Acquaintance's Recollections

16.14 Mark had known Mr G for about 20 years as he used the music studio Mark managed. Mark was aware Mr G suffered with mental health issues. Mr G's visits could be intermittent and when he returned after an absence he told Mark he had been 'locked up'. About 10 years ago Mr G was more open about his mental health issues and showed Mark a letter about his diagnosis and told him he had been released from psychiatric care. Mark recalled the letter described Mr G as having a diagnosis of border line personality disorder and that he would have difficulty in maintaining one-to-one relationships. Despite strenuous efforts by agencies the letter has not been found in any of their files. Mark summed Mr G up as someone who was loud and arrogant and would take everything he said with a 'pinch of salt'.

16.15 Mark had known Bethany for a number of years, through her father Jim who volunteered at the studio. For a period of time before leaving to go to Brighton to University, she worked in the studio and this is how she met Mr G. In late autumn 2017 Mark was aware Bethany had formed a relationship with Mr G.

16.16 Mark described a number of conversations he had with Bethany during which she confided in him that Mr G was behaving in a controlling manner. She showed Mark a text from Mr G in which he wrote 'If you ever went back I'd kill all of you'. Mark made Bethany aware that such behaviour was not healthy and was threatening and abusive.

16.17 He was so concerned about Mr G's behaviour towards Bethany that he sought advice from Women's Aid which he passed onto Bethany. He later took Bethany to their offices where she received personal advice and was offered a refuge and given an emergency contact telephone number. Before she moved in with Mr G she confided in Mark that she was nervous about going to live with Mr G.

16.18 Although Bethany moved to York to study at the University in 2018, Mark maintained contact with her. Mark also recalls a conversation with Mr G in which they discussed Mr G's relationship with Bethany being 'unhealthy'. Mr G indicated he would end the relationship. That did not happen, and in May 2019 Mark was asked by Bethany to meet with her and Mr G. This event took place in a supermarket car park. Mark says Mr G was crying, he said Mark was a threat and he accused Mark of wanting Bethany. Mark said he had no such intentions.

16.19 In August 2019 Bethany told Mark that Mr G had threatened her close friend Alice, other friends and a man called Daniel [a work colleague at the studio and a friend of Bethany's]. Mark advised Bethany to gather evidence of the threats and he believes Bethany and Alice reported the matter to the police.

16.20 On 15 of August 2019, Mark had a conversation with Mr G during which he said he and Bethany had separated. Mark said Mr G was vengeful, threatening and talked about putting things right. Mark covertly recorded this conversation and later gave it to the police as part of the homicide enquiry.

16.21 On 16 August 2019 Mark and Mr G had a conversation during which he threatened Daniel [a member of staff]. Mark told Mr G not to come into the studio in order to protect Daniel. Mr G reacted adversely intimating that he might harm himself and left in his car. Mark made an emergency call to the police and also tried to contact Mr G's CPN as he was concerned about his safety. Mr G was located safely at home by the police.

16.22 Mark described a series of conversations and exchanges of e mails and texts with Bethany in which she told him of threats Mr G made to him, her, and others. Bethany said Mr G was using graphic language which included cutting people. Amongst material sent by Mr G was an allegation that Mark 'groomed' Bethany.

16.23 On 4 September 2019 Mark said he started to collate information concerning Mr G's threats as he was aware of Bethany's report to the police and wanted to support it. Mark sent an email to the police officer dealing with Bethany's case in which he sought advice about the allegations Mr G made about him. That email was not answered. He was also aware that Bethany had sent an email that day to the same officer containing details of the threats Mr G had made about her and others.

16.24 Mark was aware that Mr G had also confronted Bethany's dad Jim in Leeds city centre. Because of this and concerns about the police response Mark, Jim, Daniel and Bethany met with a former police officer they knew. Mark says he

advised them to call '999' if Mr G approached them. He also advised Daniel to report Mr G to the police for threatening behaviour and advised Mark to make an adult safeguarding referral in respect of Mr G.

16.25 Mark made a safeguarding referral to the local authority in Bradford and was told the matter would be allocated and someone would be in contact with him. That contact was not made. The last contact Mark had with Bethany was on 12 September 2019 when he asked her if he should contact Mr G's CPN in relation to the threats Mr G had made. Mark says Bethany asked him not to do that as it was unethical.

16.26 Alice worked as a volunteer for a support group providing services to people caring for others with a personality disorder. They met when Bethany attended a course Alice was running. Bethany told Alice her partner Mr G suffered from a personality disorder, psychosis, and paranoia. They became friends and in a number of conversations Bethany told Alice about aspects of Mr G's behaviour. This included constant text messages from him and threats to take his own life.

16.27 During late 2018 and early 2019 they had a number of conversations in which Bethany spoke about ending her relationship with Mr G. Alice says Bethany told her she ended the relationship in June 2019 and as a result of this Mr G sent messages threatening suicide and threats of harm to anyone who formed a future relationship with her. Bethany also told Alice about further incidents that month in which Mr G had made suicide attempts and been admitted to hospital.

16.28 Even though they were no longer a couple Mr G insisted on holding hands and wanted affection in public. Bethany told Alice she could not face the consequences of what might happen if she did not go along with what Mr G said. She also expressed concerns that Mr G continued to visit the homes of her mother, stepfather and father. Bethany also told Alice that Mr G was making threats against Daniel that he would kill him if he discovered Bethany was in a relationship with Daniel.

16.29 On 12 August 2019 Alice took Bethany to a police station in Leeds to report Mr G's threats. Alice says Bethany was given advice about leaving Mr G and was told to telephone 101. Alice says Bethany called the police again on 16 August to report further threats made by Mr G. Alice says Bethany gave a statement to the police on 19 August. She says Bethany expressed a number of concerns to her about the pace of the police investigation and feared she might be killed by Mr G.

16.30 In early September 2019, Alice says that Bethany made her aware of a number of threats that Mr G made against Alice. These were in the form of messages that Mr G posted to Bethany and included references to him harming her by 'cutting' her. Although Alice had never met Mr G, he had searched the internet for pictures of Alice which he included in the messages he sent her.

16.31 Bethany asked Alice to report these threats to the police. Alice did this, although she was unaware when she made the report that Mr G had already killed Bethany. Alice says Mr G tried to manipulate Bethany. She feels he used events such as a mental health crisis, threats of suicide and threats against Alice to isolate Bethany.

17. CHRONOLOGY [THE FACTS]

17.1 The events that led to the homicide of Bethany by Mr G are set out in chronological order in a table at Appendix C. These facts are drawn from information provided by agencies, from statements provided during the homicide investigation, from conversations between panel members professionals and witnesses and from the recollections of Pauline, Jim, Richard, Alice and Mark.

18. OVERVIEW

19. Introduction

19.1 This section of the report provides detailed information on contact individual agencies had with either Bethany or Mr G. For reasons of brevity and clarity, not every contact is included, only those that are felt to be relevant to the domestic homicide review's terms of reference. This section of the report sets out contact agency by agency rather than chronologically, consequently there may be some overlap between the sequencing of events. Appendix C provides the reader with the chronological sequence of events.

20. Contacts Relating to Bethany

GP Services Brighton and Leeds

20.1 Bethany was a patient at a GP practice in Leeds between 1 January 2014 and 2 May 2017 [henceforth referred to as Practice 1]. She visited Practice 1 on 17 occasions during this period. The reasons for her appointments were routine matters unconnected to this DHR.

20.2 Bethany was then registered with a GP practice in Brighton between May 2017 and May 2018 [henceforth referred to as Practice 2]. She visited Practice 2 on 9 occasions. Most of the visits were for routine matters unconnected to this DHR.

20.3 Bethany returned to Leeds and re-registered for GP care at GP practice 1 in Leeds on 29 May 2018. She made 13 visits to Practice 1 between then and the date of her death. Some of these visits related to routine medical matters unconnected with this DHR.

20.4 Practice 1 received a copy of a screening consultation attended by Bethany at Leeds IAPT[26] on 10 July 2019. The letter referred to Bethany having caring responsibilities for her un-named ex-boyfriend. The letter states Bethany felt her ex-boyfriend could behave in an abusive manner although she could manage this and did not feel at risk. A GP at Practice 1 filed the letter after considering there were no specific GP actions within it and Bethany had an appropriate review appointment booked with her regular GP the following month.

20.5 On 1 August 2019, Bethany was reviewed by a GP from Practice 1. She said she was feeling better and was no longer taking medication. She was managing her condition and had started counselling through IAPT. During this review she disclosed to the GP that she had recently broken up with her partner.

[26] Adult Improving Access to Psychological Therapies programme.

20.6 Bethany said her former boyfriend had a history of mental health issues and it had been a difficult time for her as he had tried to kill himself a month ago. She said she had been his carer. Bethany asked the GP for a letter of support to take a year out of University due to her on-going issues. The GP provided this letter of support for the University. Bethany made two further presentations to Practice 1 before her death, both of these were unconnected to this DHR.

20.7 Although there are references to Bethany's partner/boyfriend in GP records from both Practice 1 and 2, there is no reference to his name.

Sussex Partnership NHS Foundation Trust

20.8 The Brighton and Hove Wellbeing Service [part of Sussex Partnership NHS Foundation Trust] provided adult mental health support between September 2017 and February 2018 to Bethany. She was assessed on 7 September 2017 and received treatment for the first time on 13 October 2017.

20.9 During this session she referred to past nastiness from her ex-boyfriend, following their separation. She did not name him [the DHR panel are satisfied the person she referred to was not Mr G]. After a gap in treatment Bethany said she was returning to live in Leeds with friends, one whom she said had a personality disorder. She did not say who this was although the DHR panel are satisfied she was referring to Mr G.

Leeds Domestic Violence Service [LDVS]

20.10 On 17 February 2018 Bethany called the service's out of hours helpline. She wanted information on how she could leave her partner in a safe way. Bethany said she was scared of him and he had a criminal record for threats to kill and hurting other people. Bethany said she did not want to go into a refuge, had somewhere to go and just wanted support with leaving him.

20.11 The service's helpline worker gave Bethany the details of the next available drop-in session so that she could go through the issues in more detail and in a secure environment. Bethany told the worker it was not safe to contact her until she had left her partner. She provided the worker with her mobile telephone number although she did not want to provide her address. Instead, she gave the worker Pauline's address. Bethany was asked to provide information to identify Mr G and this was not confirmed during the meeting. A risk assessment was not conducted by the helpline worker [see paragraph 16.1.6].

20.12 On 22 February 2018, Bethany visited a drop-in session run by the service. She told a worker she was staying in the relationship. She wanted to know what she could do in an emergency situation and what support could be offered. Bethany said she was becoming concerned with her partner's

behaviour: he had a border line personality disorder and became very aggressive when he had an episode.

20.13 Bethany said her partner had never been violent with her, although he did threaten other people. More recently he had made threats to Bethany about hurting her friends and family. The worker completed a Domestic Abuse Stalking and Harassment [DASH][27] risk assessment that concluded Bethany was at medium risk [the score was 9]. It is not clear on this occasion if Bethany was asked to provide information to identify Mr G.

20.14 Despite the medium score the worker was concerned for Bethany's safety so went through all the services that were available and could be offered to Bethany. This included the Multi-Agency Risk Assessment [MARAC] process and safety planning. LDVS only provide written safety plans for clients who formally access their service. However they did provide Bethany with a verbal safety plan which included: keeping her telephone charged and at hand; having a packed bag; keeping support information of friends and family handy and increased awareness of risk such as mental health. The worker encouraged her to come back or call the worker should anything change. She was also told to ring 999 in an emergency.

20.15 On 19 August 2019 at 16.08 hours, Bethany again called the helpline. She said she was seeking some support regarding her situation. Bethany said she was going to a police station at 21.00 hours that night with a colleague. She said her ex-partner had been making death threats to her, a colleague, and a friend. Bethany said he had a criminal record and had stabbed someone in the past. She said he had a fixation on the power of killing, had psychosis and suffered with paranoia.

20.16 Bethany told the worker that because of all this, they had broken up about two months ago and she did not want any more contact with him. The worker gave Bethany details of solicitors contact numbers should she need legal advice in respect of protective orders. Bethany was also told about the Independent Domestic Violence Advocate [IDVA][28] service should there be any criminal proceedings. Bethany asked if she could get access to her records should she need to and the worker confirmed she could.

20.17 Bethany had no further contact with the service after 19 August 2019.

20.18 LDVS respect the wishes of clients who do not want their information shared. However, in common with other agencies, there are exceptions. For example

[27] 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.

[28] 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.

if there is a child safeguarding issue or the risk to the client is so imminent that sharing information is judged to override their preferences. Maintaining a relationship with a client is important and needlessly sharing information can cause a breakdown and potentially increase the danger to the client.

West Yorkshire Police [WYP]

20.19 Bethany was a person of good character and was not known to WYP except as a person concerned for the safety of Mr G and as a victim of domestic abuse by him. WYP contact with Bethany is set out in section 15.3.46 et al.

21. Contacts Relating to Mr G

Mid Yorkshire NHS Trust [MYT]

21.1 MYT provide acute hospital services in the Wakefield and North Kirklees districts of West Yorkshire. It offers services in three main hospitals – Pinderfields [Wakefield], Dewsbury and District and Pontefract.

21.2 Mr G attended Dewsbury Emergency Department on 19 occasions between 17 February 2014 and 5 September 2019. Ten of the contacts were recorded as being of a mental health nature. These attendances included reports he had taken an overdose of prescribed medication in an attempt to end his life, was hearing voices or reported self-harm. It is clearly documented within his health record that he had a known history of mental health problems.

21.3 An attendance on 9 January 2018 accompanied by the police was the only occasion within the time frame of the DHR when he was reported to have been aggressive and wanted to kill someone. There is no record as to who he directed that intent towards. He was reviewed by staff and discharged from the hospital in to the care of the police and then transferred to the Section 136 Mental Health Suite at Fieldhead Hospital[29].

21.4 There are three references to Mr G's partner within MYT records. None of these references named Bethany as the partner. On 8 May 2015 Mr G attended the Emergency Department when he referred to an ex-partner as causing him problems. The DHR is satisfied this was not Bethany. On this occasion he had taken an overdose of paracetamol, codeine and wine. He was released home after treatment.

21.5 On 27 April 2018 Mr G attended the Emergency Department accompanied by a partner. There is no record of the partners name or other details from which this person can be identified. However, given what is known from the chronology [Appendix C] it is more than likely this was Bethany. On this

[29] A specialist place of safety used to assess persons detained under Section 136 of the Mental Health Act 1983. This Act means the police have the power to take someone they believe may be mentally unwell to a place of safety or keep them in a place of safety.

occasion Mr G presented with hearing loss and pain in his ear. He was discharged from hospital and referred to a specialist. He did not attend the appointment with the specialist.

21.6 On 22 June 2019 Mr G attended the Emergency Department after he had self-harmed in an attempted hanging. He said he had sent a video recording of a rope to his partner who called the police. There is nothing within MYT records to indicate who the partner may be, although from what Bethany told others it was almost certainly her that accompanied him. Mr G was discharged home on this occasion.

21.7 On all occasions Mr G attended at the Emergency Department either a 'Missing Patient Initial Risk Assessment' form and a 'Risk Assessment for Self-Harm' were completed as required. Referrals to, or consultation with, the Psychiatric Liaison Team [PLT] were made at each attendance and advice was sought prior to discharge. MYT state that Mr G's mental health problems were considered to be appropriately managed by specialist mental health services [SWYPFT].

Mr G's GP Service[30]

21.8 Mr G was registered with the same GP practice for general medical services throughout the period of this review and was seen on 25 occasions between February 2014 and September 2019 [henceforth referred to as Practice 3]. Many of these contacts related to routine medical issues that are felt to be unconnected to the DHR's terms of reference. In addition to these the GP received a large number of written contacts from other health providers [for example emergency departments] informing the GP of treatment services Mr G had accessed.

21.9 The following contacts between Mr G and Practice 3 are felt to be relevant to this DHR. On 16 October 2014 Mr G disclosed to a GP he was having all sorts of paranoid thoughts. For example, he thought people were following him and he was recording all car registration numbers on his telephone. He had a previous history of paranoia and self-harm and had tried to hang himself in the past. He said his partner and Child 1 lived in Leeds.

21.10 The GP made a referral the same day to the South West Yorkshire Partnership Foundation Trust [SWYPFT] single point of access [SPA] for mental health services. He was seen during further visits at practice 3 and his GP ascertained there was a plan in place for him to access SWYPFT services. Thereafter Practice 3 received regular written communication from SWYPFT with regard to the management of Mr G's medication regimes and summaries of the consultations when he was seen as a patient by that service.

21.11 As well as the incoming letters from SWYPFT, Practice 3 continued to see Mr G in relation to a range of other health care issues that are not relevant to the

[30] Information collated by North Kirklees Clinical Commissioning Group [CCG] from GP records

terms of this DHR. During these consultations, the GPs who had contact with Mr G noted his mental health issues and the fact he was receiving care from a CPN. There was also regular discussion about his medication.

21.12 On 30 April 2018 Mr G was seen by a GP at Practice 3 for a routine health care matter. During the consultation Mr G told the GP he was experiencing disturbed sleep. The GP noted Mr G was under the care of mental health services and his CPN was aware of these symptoms.

21.13 On 24 October 2018 Mr G was seen by a GP at Practice 3 for a routine health issue unconnected to this DHR. During the consultation Mr G told the GP he needed more Quetiapine [medication that was being prescribed for his mental health condition]. He admitted to the GP he had not been very compliant with his medication. He had been cutting the tablets in half taking them erratically. Mr G said he was getting some paranoid ideas about his medication. He said his mood had been worse since and acknowledged the medication was helping him and he was keen to continue with it.

21.14 The GP noted Mr G had a CPN who reviewed him regularly. The GP also noted a discrepancy in relation to the Quetiapine. A letter from the clinic mentioned an XL dose[31], however Mr G was currently taking a normal dose. Mr G said he was aware of that and said he was given the XL dose by a specialist. Mr G said he did not agree with him so he was advised to go back on to the normal dose. The GP offered Mr G a follow up review.

21.15 On 28 December 2018 Practice 3 received a letter from the doctor responsible for Mr G's mental health. The letter informed Practice 3 that Mr G's CPN was absent from work because of ill health.

21.16 On 14 January 2019 Mr G visited Practice 3 and saw the Pharmacist. They reviewed his medication and noted Mr G was not taking Quetiapine regularly [he was missing every third day]. Mr G told the Pharmacist he felt the medication was poisoning him. He said it was 'between him and God they will find a way to improve his health without taking regular medicines'. The Pharmacist noted Mr G was awaiting an appointment with a CPN for a review of his medication that would hopefully take place that week.

21.17 On 28 February 2019 Mr G was seen by a GP at Practice 3 as his repeat prescription for medication connected with his mental health had stopped on 14 January. Mr G told the GP he had not stopped taking the medication and he was cutting the tablets in half hence they lasted him longer. Mr G told the GP he had not seen his CPN since September 2018.

21.18 As a result of the information given by Mr G, the GP sent a fax on the 6 March 2019 to the mental health doctor at SWYPFT cited in the incoming letter of 28 December 2018. The GP did this to escalate issues in relation to Mr G's poor

[31] XL refers to an extended release dose of medication

compliance with medication, the apparent lack of a CPN for Mr G and the possible decline in his mental health.

21.19 Mr G's last face to face contact with Practice 3 was on 30 July 2019. On this occasion he presented with a routine medical issue. The GP who saw Mr G also reviewed communications with SWYPFT regarding Mr G's mental health. The GP noted that Mr G was having a difficult time because of Child 1's health and discussed with Mr G contacting his CPN for mental health support.

21.20 Bethany was not a patient at Practice 3. They hold no information about her. There are no direct or indirect references to Bethany in Mr G's Practice 3 medical records.

Yorkshire Ambulance Service [YAS]

21.21 YAS have 11 records of contact with Mr G during the review period of this DHR. The following calls are felt to be of relevance to the DHR. On 16 June 2019 the police requested ambulance assistance from YAS. They had received a call from Mr G's ex-partner reporting that he was suicidal. YAS did not have contact with him as the police cancelled the call and conveyed Mr G hospital instead.

21.22 On 22 June 2019 YAS received a call from the police requesting assistance as they had received information from Bethany that Mr G was going to hang himself. When YAS arrived at address 3 the police were also present, and an ambulance was used to convey Mr G to hospital for further assessment and care.

South West Yorkshire Partnership NHS Foundation Trust [SWYPFT]

21.23 Mr G was under the care of SWYPFT in respect of his mental health between 2015 and 2019. The independent report commissioned by the NHS [Appendix B] examines SWYPFT's care and treatment of Mr G in detail. That information is not duplicated in this section of the report. Key events from this period of treatment are included within the chronology of events [Appendix B] to assist the reader with gaining a holistic view of the sequence of his contacts with agencies.

West Yorkshire Police [WYP]

Police contact with Mr G that did not involve Bethany

21.24 WYP had some contact with Mr G that significantly pre-dates the period of this review. It is summarised in the following paragraphs so as to provide a rounded picture of his character and behaviour.

21.25 WYP hold 15 safeguarding records relating to Mr G in respect of domestic abuse in which he is recorded as either the suspect, victim, or subject of the report. Mr G had Police National Computer [PNC] Warning Markers for violence, mental health, suicidal and self–harm.

21.26 The earliest domestic abuse record dates from January 2000 and concerns an argument with his mother when she asked him to leave the house. He would have been aged 16 at the time. The incident involved verbal abuse by Mr G. Police officers attended and records contain partial information due to the limited recording facility of the records system that was in place at the time 20 years ago. It is not clear what, if any action, was taken against Mr G. The outcome did not result in a formal recorded caution or conviction.

21.27 In February 2004 Mr G reported he was the victim of abuse. He telephoned WYP saying his father assaulted him after a dispute over money he owed his father for living at home. The Crown Prosecution Service determined that his father would not be charged as he claimed to be acting in self-defence and there was no evidence of injury to Mr G.

21.28 Mr G was in a relationship with Female 1 [the mother of Child 1]. WYP hold records that show there were five incidents of domestic abuse involving Mr G and Female 1. The first incident was after they separated and on 28 August 2004 when Mr G discovered Female 1 was planning to go out with her friends and leave Child 1 with a babysitter. He was unhappy and visited Female 1's address to try and persuade her to let him look after Child 1 which neither Female 1 nor her mother wanted. The police were called however Mr G left before officers arrived.

21.29 The final domestic abuse record involving the couple relates to an incident on 6 July 2005. Female 1 reported that Mr G was sending her threatening messages by telephone and she said she was pursuing an injunction against him. Mr G was sent a domestic abuse warning letter by WYP[32]. Following receipt of the letter Mr G made a counter allegation to WYP saying he received messages from Female 1 although he had no proof, they were from her.

21.30 As a result of the homicide and IOPC investigation, a former WYP PCSO provided a statement in which he described being stabbed in the leg by Mr G on 6 April 2013. This person was a friend of Mr G who offered him somewhere to stay after Mr G separated from Female 1. During a dispute in a pub, the PCSO separated Mr G from his brother with who Mr G had started a fight. After being told he was no longer welcome to stay, Mr G made his way to the PCSO's address threatening to cause damage.

21.31 Here the PCSO confronted Mr G who it is alleged then stabbed him in the leg with a knife. The matter was reported to WYP. The PCSO was told Mr G had made a counter allegation of assault and had a facial injury. The PCSO did not

[32] The letter in use at this time could be adapted to three circumstances dependent on whether an allegation of domestic abuse had been made, whether the perpetrator had been bound over or is on bail.

wish to make a complaint as he was fearful of being arrested in respect of the counter allegation. A crime was not recorded nor was the matter referred to WYP Professional Standards. No further action was taken by WYP in relation to this matter.

21.32 On 12 March 2015 Mr G reported to WYP that his former partner Female 2 had been mentally abusive towards him. Specifically, he said she made references to her father 'sorting him out'. He claimed these incidents caused him to experience paranoia which was heightened by his long running mental health issues. Mr G said he did not want any action taken, nor did he want the police to speak to Female 2. A DASH risk assessment was completed and a standard risk recorded. No further action was taken.

21.33 On 8 May 2015 Mr G telephoned WYP saying he was suicidal. He was seen by police officers near a swimming pool. He was upset and told them he had cut himself, taken pain killers and drunk a bottle of wine. He said he was mentally unwell and had no credit on his telephone with which to contact the mental health Crisis Team. He voluntarily attended hospital for treatment.

21.34 On 16 May 2015 Female 2 reported to WYP that Mr G had sent her unwanted messages following their separation in March. Female 2 told the police Mr G was very controlling during the relationship, would not let her see her friends and watched what she was spending her money on. A DASH assessment was completed and the risk to Female 2 recorded as medium.

21.35 A police officer spoke to Mr G and served him with a harassment notice warning him not to contact Female 2 again. Mr G told the police officer he was suffering from mental health issues and had been diagnosed with psychosis. He told the officers about the incident on 8 May. He said he was angry and frustrated with Female 2. He said he had been in contact with the mental health Crisis Team and had been referred to a psychiatrist. The police officer subsequently contacted the mental health Crisis Team and they indicated they would contact Mr G that evening.

21.36 On 15 June 2015 Mr G's housemate telephoned WYP saying he was concerned about Mr G's safety. His behaviour and notes he left suggested he had suicidal ideation. Mr G telephoned the police to tell them where he was. Officers located Mr G in woods with a noose around his neck and semi-conscious. He was taken to hospital. Here he was detained under Section 136 of the Mental Health Act 1983. After assessment he was released for home-based treatment.

21.37 On 30 July 2015 Mr G's sister reported him missing to WYP. He indicated he was attracted to a female work colleague and had been upset when she told him they were just friends. His behaviour suggested suicidal ideation. He later returned home and it was established he was under the care of mental health services and had an appointment to see them shortly.

21.38 On 1 August 2015 Female 2 reported to WYP that Mr G was harassing her. Despite having received a harassment warning he had contacted her by text, had been threatening and abusive and these included threats towards others.

The police officer in the case spoke to his care coordinator who said they would check on his welfare. The police officer established Mr G was a patient in hospital after being admitted with suicidal ideation. The officer told Mr G he would be reported for the offence of harassment to which he became upset and made comments about ending his life. The officer advised the nurse in charge about what Mr G had said and was satisfied he was in a place of safety. A DASH risk assessment was submitted and the risk to Female 2 was recorded as medium.

21.39 On 2 August Mr G reported to WYP he was the victim of abuse perpetrated by Female 2. A DASH risk assessment was completed with the victim shown as Mr G. He said he had been assaulted on a number of occasions by her and she had threatened to involve her father if Mr G upset her. Female 2 told the police she had not assaulted him. She said he had behaved in a controlling manner towards her and she had suffered mental cruelty as a consequence of his behaviour. WYP did not take any action against Female 2 in respect of Mr G's allegations.

21.40 On 28 August 2015 Mr G's housemate reported he had gone missing after he said he received bad news from the police concerning Female 2. He intimated he was going to harm himself. WYP treated him as a high risk missing person and police officers located him. He said he could not go on after he had received news that WYP would not act against Female 2 in respect of his allegations. He said he intended to kill himself. He was detained under Section 136 of the Mental Health Act. He was assessed by the mental health Crisis Team and found not to be suffering from an acute mental health illness and was discharged.

21.41 On 13 October 2015 Mr G visited a WYP station. He said he was due to appear in court soon for a crime. However, he said it was not him and instead it was 'Osiris' who occupied his body and had committed the crime. He said he needed to hand himself in or else he would harm himself. The mental health Crisis Team attended the station and spoke to Mr G. He was taken by them to see a doctor.

21.42 On 2 December 2015 Mr G contacted WYP saying he intended to harm himself. He was located outside a leisure centre in the West Yorkshire area. WYP records show contact was made with a mental health nurse who did not have concerns for Mr G's safety.

21.43 On 7 December 2015 Mr G appeared before a Magistrates' court in West Yorkshire. He was convicted of harassing Female 2. He was sentenced to a Community Order for 12 months and a Restraining Order for 2 years with a rehabilitation activity requirement. The same day WYP received a call from Mr G's flat mate who was concerned for his safety. He said Mr G had taken the court appearance badly and had suicidal ideation.

21.44 The police spoke to a mental health nurse who then had a telephone conversation with Mr G. He said he would not harm himself and did not want to be seen by police officers for a welfare check. However, he then made a

telephone call later that night to WYP claiming he was frustrated with the mental health team. A police officer spoke to Mr G who said he was not going to do anything that night. He was in the hands of friends and was to be visited by the mental health Crisis Team the following day.

21.45 Between 7 December 2015 and 9 January 2018 WYP recorded 9 further contacts with Mr G. In summary they included threats to harm himself and others [paedophiles], suicidal ideation and concerns from others for his safety. On one of those occasions, he was arrested to prevent a breach of the peace and on two of the occasions he was detained under Section 136 of the Mental Health Act 1983.

Contact after Police became aware of Mr G and Bethany's relationship.

21.46 WYP hold no record of Bethany until 9 January 2018 when Mr G telephoned WYP saying he wanted to stab a paedophile. Bethany then spoke to the police and said Mr G had a knife, was unwell and she could not get the knife off him as he was too violent. Police officers and an ambulance attended. Mr G did not have a knife when the police attended and he was detained under Section 136 of the Mental Health Act 1983 and taken to hospital for assessment.

21.47 On 16 June 2019 Bethany made a telephone call to WYP. She explained Mr G was an ex-partner and he contacted her by telephone and made threats to kill himself. Bethany said she had broken up with him that day and rejection 'massively' triggered his personality disorder. She told the police Mr G had tried to harm himself before when he broke up with previous partners. Police officers were dispatched. Mr G was taken to hospital for a mental health assessment and then taken home by police officers.

21.48 On 22 June 2019 Bethany made a telephone call to WYP. She said Mr G was threatening to kill himself because their relationship had broken down. Bethany also told the police this had escalated over 5 days and he had threatened to hurt himself and other people. She said he visited her place of work and was making a suicide video for his child. Police officers attended address 3 and discovered Mr G had tried to hang himself. He was taken to hospital by ambulance.

21.49 On 15 August 2019 WYP received a telephone call from Mark. He said Mr G had been to his music studio. After being told he could not come in Mr G left making threats to take his own life. Police officers located Mr G at his home and he told them he had no intention of suicide. WYP contacted an Approved Mental Health Practitioner [referred to as an AMHP][33]. The AMHP was informed of everything held on the WYP log. This included the fact Mr G had a noose in his garage.

[33] 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. They are responsible for coordinating an assessment and admission to hospital if someone is detained under the Mental Health Act.

21.50 The AMHP told WYP they had no concerns and were content for Mr G to be left. They said there was no need for mental health services to attend Mr G that day and they would wait to see him at his next meeting the following Monday. Mr G declined to hand the noose over to the police officers and they left him in the company of a friend.

21.51 On 16 August 2019 Derbyshire Police contacted WYP to inform them Bethany had reported that Mr G had made threats to her new partner Daniel. WYP recorded this matter with Bethany shown as the victim and Mr G as the suspect.

21.52 In the late afternoon of 19 August 2019 Mr G visited a WYP station. He said he was going to "smash a male's head in". The male referred to was Daniel. WYP liaised with the HUB Mental Health Nurse who stated they had no concerns for Mr G's mental health as he was engaging with mental health services and contacting his worker regularly. The advice given was to tell Mr G to keep engaging with his worker and nothing further needed to be done. WYP advised Mr G to keep in contact with his worker and if he felt like harming himself or someone else to contact his worker immediately. No crime was recorded and the matter was finalised as a mental health episode.

21.53 Later the same night Bethany was seen by a WYP officer who recorded a statement from her. The statement described how Bethany had met Mr G in October 2017 and from the start of their relationship he had been threatening towards her former partner and manipulating towards her. Bethany described these threats towards others intensifying to include threats against her.

21.54 Bethany described moving in to live with Mr G in February 2018 and how the abuse towards her had continued. She described Mr G constantly self-harming and said she sought help for him from his CPN. Since ending their relationship in June 2019 Bethany described receiving a barrage of abuse from him. She said he made threats to cut the head off her friend and humiliated and embarrassed Bethany in an attempt to remove her support network.

21.55 The police officer who recorded the statement completed a DASH assessment and recorded the risk to Bethany as medium. Bethany did not consent for the information to be shared with other agencies. A letter giving Bethany advice about domestic abuse was sent to her. Because of other demands it was not possible to allocate the matter to a domestic violence coordinator [DVC]. The officer recording the statement was therefore asked to deal with any safeguarding interventions for Bethany. As will be seen later that officer was ill-equipped to deal with such a complex case.

21.56 On 21 August 2019 Mr G visited a WYP station with concerns that something had been reported to the police involving him. The officer that dealt with him took Mr G's contact number and advised him an officer would contact him if necessary.

21.57 On 26 August 2019 a friend of Mr G reported to WYP they had concerns for Mr G. They told the police they had found a rope in the garage and Mr G had

suicidal ideation. The friend told the police Mr G was under investigation for threats. He was found later that day safe and well at Bridlington. He told police officers he went there intending to take an overdose on the beach. While Mr G was missing, Bethany called WYP seeking an update when he was found as she was concerned he may be looking for her following the domestic incidents between them.

21.58 On 27 August Mr G reported to WYP he had been assaulted by Bethany and she had caused damage at his house. He stated he had a 'minor row' with her and she slapped him several times across the face telling him "I'm sick of you and your head". Mr G said Bethany punched the wall causing marks from her knuckles. He said the incident happened during May 2019 and he did not report then as he did not want it to affect their relationship.

21.59 Because of low staffing levels and operational demands his allegation was not progressed until 12 September 2019 when a police officer recorded a statement from Mr G and completed a DASH risk assessment. The officer recorded the risk to Mr G as medium. During the course of providing the statement Mr G showed the officer a screen shot from his mobile telephone. This was an exchange of messages between him and Bethany on 12 August 2019. In the messages Bethany told Mr G she acted the way she did because she was frustrated with him as he was strangling himself and she was desperate to stop him hurting himself.

21.60 On 7 September 2019 Bethany's father Jim contacted WYP to report Mr G had followed him around and threatened him. He requested the police contact him the following day. Because of significant operational demands on the police, that did not happen and the log was pending allocation at the time of Bethany's death. This is a matter of significant concern to Jim and was examined as part of the IOPC investigation.

21.61 On 9 September 2019 Mark reported to WYP he had received multiple emails from Mr G accusing him of grooming Bethany. He said he was aware of issues between Bethany and Mr G and as a result had banned him from the music studio. He said Mr G had been sending him and other employees' emails. WYP recorded a crime of harassment. However, the crime was not allocated to an officer for investigation until after Bethany's homicide[34].

21.62 Later the same day Daniel made an online report to WYP saying he was aware Mr G had made threats to kill him. These threats were made to a number of persons who were sufficiently concerned to advise Daniel to leave Yorkshire as Mr G was intent on killing him. On 11 September 2019 Daniel attend a WYP 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

[34] The reason for this was that the incident report was sent to the WYP Incident Management Unit [IMU]. The officer who dealt with the report would normally have contacted the victim by telephone to obtain full details. However, because of the lateness of the hour the officer made a decision that Mark should be contacted at a more sociable hour.

been made to a 3rd party rather than directly to Daniel.[35] A crime was not recorded.

21.63 On 11 September 2019 Mr G contacted WYP and said he had reported Mark to various authorities for matters unrelated to this DHR. The last contact WYP had with Mr G before he killed Bethany was on 12 September 2019 when 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 [see paragraph 15.3.58]

Kirklees Community Rehabilitation Company [CRC]

21.64 Following Mr G's conviction on 5 December 2017 for the harassment of Female 2 he was sentenced to a 12-month Community Order and made the subject of supervision by Kirklees Community Rehabilitation Company [henceforth referred to as CRC]. He told his probation officer he had an emotionally unstable personality disorder. He said he may also be schizophrenic and was prescribed quetiapine as an anti-psychotic medication. He described an unhappy childhood and had a lot of repressed anger. He said he was expelled from school for stabbing someone when aged 16.

21.65 The panel asked WYP and CRC for further information on this event. The self-disclosure Mr G made to the CRC was recorded as part of his OASys[36] risk assessment within the risk section. The record states Mr G had no previous convictions and had received a police caution from an incident when he stabbed a bully at school when he was aged 14-16. The emotional wellbeing section of the OASys notes that Mr G was hospitalised at the age of 7 years, due to his mental health condition.

21.66 WYP stated Mr G had no conviction relating to wounding or assault during the time he would have been a school pupil. A search of police systems disclosed Mr G had been involved in an incident in September 1997 in which Mr G [accompanied by others] was involved in an incident with pupils on their way to school. Mr G used a piece of glass to threaten these pupils and slashed the jumpers of two of the pupils causing damage. Mr G received a caution for criminal damage. The panel felt it was reasonable to conclude that the disclosure Mr G made related to the same event that WYP recorded as a caution.

21.67 Mr G told his probation officer he heard a voice called O'Sirus [sic] who told him to do things to himself and others. He said he fought hard against this instruction. The probation officer completed an OASys assessment for Mr G

[35] Section 16 Offences Against the Person Act 1861 Threats to Kill states: 'A person who without lawful excuse makes to another a threat, intending that that other would fear it would be carried out, to kill that other or a third person shall be guilty of an offence and liable on conviction on indictment to imprisonment for a term not exceeding ten years.

[36] 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.

and ~~a~~ comprehensive assessment of the risks of harm and reoffending that Mr G presented. This included an OASys assessment that assessed relationships as a criminogenic[37] area for Mr G. It was linked to both risk of serious harm and to re-offending, along with emotional wellbeing and thinking and behaviour. Instability of mental health was identified as a risk factor.

21.68 Mr G was assessed as posing a medium risk of serious harm to female partners. This was identified in nature as verbal abuse and harassing behaviour. The risk was assessed as likely to be greatest when Mr G was in a relationship and he perceived inequality in it, when a relationship broke down, during times of emotional difficulty [for example bereavement, loss, rejection or stress], when not complying with medication, when not engaging with mental health services and where he lost protective factors.

21.69 Using the OASys assessments, the CRC produced a risk management plan for Mr G. The key issue was a focus upon relationships. Probation officers had regular discussions with Mr G about his mental health. CRC records show Mr G's probation officers also shared information with other services including his CPN. However there is nothing within mental health records to show Mr G had received a caution or that he had made a self- disclosure to the CRC that he had stabbed a school pupil.

21.70 Mr G successfully completed the Order of the Court on 6 December 2016 and the CRC had no further contact with him. During the period the CRC engaged with Mr G there is no evidence from WYP domestic violence call outs that he re-offended. There is no mention of Bethany within any of the records held by the CRC [the DHR panel believe Mr G did not form a relationship with Bethany until after his supervision by CRC ended].

[37] Causing or likely to cause criminal behaviour.

22. ANALYSIS USING THE TERMS OF REFERENCE

23. Term 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 as a perpetrator and what was the response?

23.1 Two agencies held direct information that identified Bethany was a victim of domestic abuse. The first of these was Leeds Domestic Violence Service [LDVS]. The details of the information they held is set out within section 15.11 – 15.19 and is therefore not repeated here.

23.2 Although Bethany did not name Mr G, from the dates of her contact with the service and the information she provided the panel are satisfied the partner she was referring to was Mr G. The service completed a DASH risk assessment and also offered Bethany other information including details of MARAC and safety planning.

23.3 On the third contact she had with the service on 19 August it is clear there was an escalation in the situation with references to death threats, stabbing someone, a fixation on the power of killing and that her partner had psychosis and suffered with paranoia. The response of the service on this occasion was to provide Bethany with information about solicitors in respect of protective orders and also information about the IDVA service.

23.4 The panel discussed the role of LDVS. It was felt Bethany provided them with several significant risk factors. She received verbal advice and was told about the services LDVS provided, including details of MARAC. The panel also discussed whether an opportunity to risk assess and refer to MARAC in respect of the third contact on 19 August had been missed. The panel felt this was a difficult question on which to reach a judgment.

23.5 The Contract Lead for LDVS told the panel that advice and information was given to Bethany so she was equipped with this should she change her mind or need the information, and she knew how to come back to a drop-in session, access the helpline or access other LDVS services. The Contract Lead for LDVS said many service users do not want to be rushed into accepting support preferring drop-in sessions rather than accessing mainstream services. It is imperative that drop ins remain accessible to women in this way and that they do not feel forced to access services or give information that they do not want to. Should Bethany have wanted LDVS ongoing support she would have been referred there and then into LDVS services and support would have begun. The Contract Lead for LDVS said Bethany made it clear she did not want LDVS support and it was not safe to contact her.

23.6 The Contract Lead for LDVS also said that traditionally their helpline workers do not have the time or capacity to be able to conduct a SafeLives DASH due

to the huge number of calls [over 6,000 per year]. Also at that time they were only funded for one helpline worker, and often had to deal with multiple calls straight after each other. A DASH risk assessment was undertaken on the second occasion Bethany engaged with LDVS when she visited the drop in. Although the risk to her was assessed as medium, the Contract Lead for LDVS said the worker involved was concerned with Bethany's safety and therefore encourage her to access LDVS support.

23.7 The panel recognised one factor was that Bethany did not want her information shared and to some extent it could be that she just wanted advice. Another factor was that it was not clear to what extent some of the disclosures made by Bethany were explored [i.e. where she stated Mr G had stabbed someone in the past]. It was not clear on the second occasion Bethany contacted LDVS whether she was asked if she had used the service before and hence if this represented an escalation in the risk.

23.8 Learning for LDVS is identified in paragraph 18.1.4. The panel agreed that in the circumstances of its contact with Bethany, LDVS provided appropriate advice to her which met the expected standard for a drop-in service.

23.9 WYP knew of Mr G's previous domestic abuse history that pre-dated his relationship with Bethany by a number of years. The DHR panel are clear that from that information alone, Mr G met the definition of a serial perpetrator of domestic abuse[38]. However, this fact was only discovered during WYP's research when writing its IMR. This is an area that requires reviewing. The detail of these incidents has been set out earlier within section 15 of the report and within Appendix C the detail of which is not repeated here. In summary the incidents are as follows:

- On 25 January 2000 [when Mr G was 16] he offered violence to his mother after he refused to leave the house when asked. This was reported to WYP.
- Between 2004 and 2005 Mr G was involved in five domestic abuse incidents involving his former partner Female 1.
- 16 May 2015 Female 2, a former partner reported to WYP that Mr G was controlling towards her.
- 1 August 2015 Female 2 reported to WYP that Mr G was harassing her.
- On 7 December 2015 Mr G was convicted of harassing Female 2.

23.10 None of those incidents involved Bethany, and pre-date her relationship with Mr G. Their relevance to Bethany is that, when she reported to WYP that she was a victim of domestic abuse perpetrated by Mr G, the information about those earlier incidents would have been of value when assessing the risk Mr G presented to Bethany. Mr G's offending history was recorded on WYP

[38] 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

information systems as well as on the police national computer [PNC] and therefore would have been available to find when assessing the risk presented to Bethany. Without his full history being considered any risk assessment would have been incomplete.

23.11 The first direct evidence that Bethany was a victim of domestic abuse from Mr G was when Bethany made a report to WYP on 19 August 2019. That was not the first contact between Bethany and Mr G that was known to WYP. As described earlier Bethany had contact with WYP in relation to Mr G's behaviour and safety on three previous occasions. There is nothing in WYP records from those occasions to say she reported being a victim of domestic abuse.

23.12 The subject matter of the calls however does contain indicators of potential risk to Bethany. The call on 9 January 2018 concerned Mr G having possession of a knife, making threats to stab a paedophile and being mentally unwell. The call on 16 June 2019 contained information that Mr G was threatening to kill himself and that those threats were linked to the break-up of his relationship and his mental health. The final call on 22 June 2019 again related to Mr G threatening to kill himself and hurt other people. His behaviour appears to have been connected to his mental health and matters were said to be escalating.

23.13 All three incidents appear to have been dealt with as mental health matters. WYP did not link his behaviour with domestic abuse. The panel will comment further within term 2b below as to whether an alternative approach might have been appropriate to these events.

23.14 The first and only occasion on which WYP took direct action in response to Bethany disclosing she was a victim of domestic abuse by Mr G was on 19 August 2019. The response from WYP was to record a statement from Bethany and complete a DASH risk assessment. The appropriateness of that response is considered by the panel in detail within section 16.2a below.

23.15 Following Bethany's report to WYP on 19 August 2019 there were other events known to WYP that were potential indicators Mr G was continuing to try and exercise coercive and controlling behaviour upon Bethany. On 26 August 2019 Mr G was reported missing having threatened suicide and telling a friend he was under investigation.

23.16 Under some circumstances threatening suicide is a form of coercion and control. Many victims have reported such behaviour by their perpetrators as a means of trying to force them to withdraw their reports of victimisation or to stay or return to the relationship. On occasions when the perpetrator has then carried out their threat the victim has suffered emotionally, wrongly carrying feelings of guilt and blaming themselves for the perpetrator's death. In this way perpetrators are able to continue to exercise coercion and control[39].

[39] Men, suicide and family and interpersonal violence. A mixed methods exploratory study. Fitzpatrick-2022-Sociology of Health & Illness-Wiley Online Library

23.17 Mr G's threats of suicide on this occasion followed a similar pattern of behaviour when he abused Female 2 in 2015. On that occasion he went missing threatening to harm himself after Female 2 reported his abusive behaviour.

23.18 On 27 August 2019, Mr G reported to WYP that he had been assaulted by Bethany and she had caused damage. Again, these actions followed an identical pattern to his behaviour towards Female 2 when he made a counter allegation after she reported his behaviour to the police.

23.19 The following extract from advice to CPS prosecutors[40] is relevant and shows how some perpetrators behave when victims report their experiences.

'A perpetrator usually weighs up the relative benefits and costs of pursuing abusive actions. This may involve taking a number of steps to minimise the likelihood of detection and punishment. Given the nature of the relationship, and the access it affords the perpetrator to the victim, highly sophisticated tactics to control or coerce can be deployed which can be accompanied by physical violence. Prosecutors should also note that perpetrators may:

Be highly manipulative, taking steps to disrupt or mislead the investigation and prosecution. This can include making counter-allegations of abuse or arguing that actions were taken in self-defence, thereby making it difficult to distinguish between the primary victim and the primary aggressor'.

23.20 The fact that Jim was threatened by Mr G on 7 September 2019 may be seen as an example of the steps Mr G was prepared to take to try and disrupt or obfuscate any investigation into Bethany's report of domestic abuse. Similarly, the complaint made by Mr G to WYP on 11 September 2019, alleging criminal behaviour by Mark, may be viewed as a further example of manipulative behaviour by Mr G.

23.21 There is no doubt that the threats to kill made towards Daniel by Mr G, and reported by the former to WYP on 11 September 2019 are an example of Mr G continuing to try and exercise coercive and controlling behaviour over Bethany given that Daniel was now in a relationship with her.

23.22 The way in which these matters were dealt with by WYP and the extent to which they complied with policy and good practice is considered in term 2 below.

23.23 SWYPFT held information concerning Mr G's medical history and in particular his mental health. The issue of whether they held information that indicated Bethany was, or was at risk of becoming, a victim of domestic abuse and how they responded to that information has been fully considered by the Mental

[40]Controlling or Coercive Behaviour in an Intimate or Family Relationship Legal Guidance. https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

Health Level Three Review and a copy of the executive summary is at Appendix B.

23.24 The DHR panel do not feel it is necessary to rehearse the key issues in that report. However, the panel believe it is important to analyse one specific piece of information known to both mental health services and WYP that impacted upon risk. That is the carrying of, and/or threats to use, weapons by Mr G.

23.25 The first date on which WYP might have held information about Mr G carrying or using a knife was in April 2013 when a former WYP PCSO described being stabbed in the leg by Mr G. No crime was recorded at that time at the request of the victim. The log was closed and it noted the victim had not been stabbed, rather he had sustained injuries falling downstairs. There was no entry on the intelligence record for Mr G showing the allegation he had stabbed this victim.

23.26 The relevance of this event is that because the information was not recorded on Mr G's intelligence record, it was not available to be found by WYP officers when assessing any subsequent risk Mr G may have posed to others including Bethany. Because it was not recorded on Mr G's intelligence record, it was also not available to share with other agencies such as mental health had they requested information about him, or had the point been reached at which formal information sharing was taking place such as at a MARAC.

23.27 On 6 September 2016 Mr G's house mate called and stated that Mr G was going to 'stab' people tonight, specifically paedophiles. Mr G was arrested to prevent a breach of the peace. His custody record included references to his mental vulnerability and the risk of harm to himself was recorded as medium. He was seen in custody by a health care professional although there is no record that mental health agencies were involved nor whether the information about his arrest was passed to them. He was later released without charge. The information about the threat he made to stab someone was not recorded on his intelligence record. This non-adherence with policy meant the information was not available to be found if, or when, Mr G's WYP intelligence record was searched.

23.28 On 13 August 2017 Mr G made a telephone call to WYP stating he was drunk, had not taken his medication and wanted to stab a paedophile. He stated he had 'stabbed a copper in 2013'. No action was taken and he declined a lift from Police Officers saying he was going home to take his medication. There was no entry on Mr G's intelligence record of this event. This was a failure to recognise, record and assess significant risk factors.

23.29 It appears mental health agencies were not aware of the specifics of any of the above incidents, nor of the information Mr G self-disclosed to the CRC. In turn there is no record within WYP systems that show the police were aware of information held by mental health agencies. Specifically, that in 2018 Mr G's main healthcare professional was aware of Mr G's knife carrying and had spoken with, and counselled, him about this risky behaviour.

23.30 A panel member raised concerns about the information healthcare professionals may have had about Mr G being mentally unwell and carrying a knife and the way in which that information was handled. The author of the independent Mental Health Homicide Review told the panel that while it was known Mr G had a knife under a pillow at home there was no overt intelligence known to mental health services that he was carrying a knife in a public place and this was not known in his behaviour pattern. The most common method of killing, for both male and female victims, was by a sharp instrument [including knives; 40%]. Since the year ending March 2011, the proportion of homicide offences committed by a sharp instrument has fluctuated between 36% and 41%.[41]

23.31 The question for the DHR panel is whether these agencies should have shared the information they held and whether sharing that information may have led to an alternative assessment by any of those agencies of the risk Mr G posed. The DHR review concur with the findings reached by the IOPC and WYP, that all information concerning Mr G's use and threats to use weapons or to harm anyone else should have been recorded on his intelligence records. It should also have led to a 'Weapons' marker being placed on his PNC record. The fact that the intelligence was missing meant that any assessment of the risk he posed to others, including Bethany or any other person, would be incomplete. Mr G's disclosure to the CRC that he had stabbed someone at school when he was sixteen reinforces the point that accurate risk assessments rely on the assessor having full information.

23.32 Whether WYP should then have shared their information with other agencies or whether mental health agencies should in turn have shared the information they held with WYP is much less clear-cut and dependent upon a whole range of variables. While mechanisms exist for sharing information between statutory agencies [information sharing protocols for MARAC, MAPPA and the General Medicals Council's guidance on gunshot/knife wounds[42]] because of confidentiality, data protection and human rights issues there is no process for routinely doing so. Each and every occasion information is shared has to be justified and proportionate to the need. This makes information sharing a judgment-based process particularly for adults.

23.33 The DHR panel has carefully considered all the information in this case and have concluded that, up until the point at which Mr G entered into a relationship with Bethany, even if WYP held a complete intelligence picture about Mr G it is unlikely there were grounds for routinely sharing information they held with other agencies.

23.34 However, once that relationship commenced, and the more information that came to the attention of WYP concerning Mr G's abusive behaviour towards Bethany, the stronger the argument became for information sharing. However,

[41] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2021

[42] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---reporting-gunshot-and-knife-wounds/reporting-gunshot-and-knife-wounds

it was unlikely that before 19 August 2019 any of the events that had so far occurred would have triggered a multi-agency process that required WYP to formally review and share the intelligence they held about Mr G.

23.35 As will be considered further under Term 2, had WYP domestic abuse processes been followed correctly, and had all the intelligence about Mr G's history of violent behaviour and threats been recorded, then the risk he posed to Bethany should have been recorded as high. This would have automatically triggered a referral to MARAC and should have led to WYP, mental health and other agencies sharing the information they held. That would have enabled a more accurate risk assessment and associated risk management plan.

24. Term 2

Did that response: e.g. contacts/care/treatment:
a] Comply with your agency's policies and good practice expectations?
b] Reveal opportunities for improvement in how contacts were managed, care was delivered or treatment formulated and/or delivered?

24.1 The IOPC conducted an extensive investigation into the way in which WYP responded to reports made by Bethany and others involving Mr G which they shared with the DHR. The scope of those investigations and the analysis by IOPC of WYP processes are very detailed and lengthy. Repeating them in this DHR report may potentially obscure multi-agency learning and the detailed chronology is not set out here. However, the following paragraphs, which are relevant to multi-agency learning, summarise the main issues and findings in relation to compliance with WYP policy.

24.2 In summary a number of opportunities were missed to protect Bethany from the abuse perpetrated by Mr G. WYP have identified a number of lessons and recommendations to improve future services and these are set out in sections 18 and 19 of this report. In addition, IOPC identified a number of lessons and recommendations which are also set out in the same sections. The IOPC did not identify any misconduct or gross misconduct issues and management action for one officer was identified. The family believe that all agencies should have done more to protect Bethany. Agencies and the DHR panel have identified learning from the DHR and this is reflected in the recommendations and action plans.

24.3 The information provided by Bethany in her statement of 19 August 2019 did not mirror the DASH risk assessment that was then completed and there are significant inconsistencies. Several 'no' answers have been inserted when they should have read 'yes'. Experienced domestic abuse specialists from WYP revisited the DASH form as part of the IOPC investigation and it is clear that,

had the correct responses been recorded, then the risk to Bethany from Mr G would have been assessed as high and not medium.

24.4 Although WYP recorded a crime of harassment by Mr G against Bethany, the evidence indicates this should have been a more serious crime of 'stalking and coercive and controlling behaviour'[43]. Contrary to WYP policy the DASH risk assessment was not forwarded to a supervisor to be reviewed and signed off.

24.5 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 as BOLO [be on the lookout]. He should have been arrested and detained for questioning. That did not happen and there was a delay of seven days before Bethany's statement was uploaded to police systems which 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. The delay in uploading Bethany's statement was in part caused by the officer who took it being on leave and a failure to follow the correct WYP procedures.

24.6 There followed a complex series of events, during which the risk assessment moved between various departments within WYP for review and allocation[44]. 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. The evidence suggests the case should instead have stayed with the 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.

24.7 In parallel to these process shortcomings, there were also a series of intelligence failings related to historic information about Mr G. The exact nature of these is complex and again have been investigated in some detail by the IOPC. In summary, 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

[43] 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

[44] 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.

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

24.8 If that information had been uploaded to Mr G's intelligence profile, it will 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. The panel also felt Mr G's actions in making a suicide video for Child 1 to watch, was manipulative and abusive. The panel did not see any evidence that this information had been considered by agencies as a potential child safeguarding issue and whether it required a child safeguarding referral.

24.9 Although the DASH risk assessment was uploaded to WYP systems immediately after she spoke to the police on 19 August 2019, Bethany's statement was not uploaded until 27 August 2019. Once that happened police officers or staff then had the opportunity to interrogate WYP police systems, compare her statement to the DASH risk assessment, assess it in more detail, triangulate all the known intelligence and accurately assess the risk to Bethany. That did not happen.

24.10 The panel heard that Bethany's Niche intelligence profile was checked by police officers and staff a further 17 times and Mr G's a further 31 times between 27 August 2019 and 12 September 2019. The panel felt opportunities were missed to dynamically assess the risk to Bethany presented by Mr G.

24.11 WYP explained to the panel that force policy identifies that the previous domestic history of both the victim and suspect should be taken into account. Information on a number of police systems should be checked which could identify patterns of offending. However, much of the information and risk in this case was held within a system known as Storm[45]. Storm logs are not routinely searched when secondary risk assessments are undertaken. The rationale being that intelligence on the Storm log should be transferred to Niche.

24.12 Although Bethany and Mr G's Niche[46] records were accessed on a number of occasions as set out above, that did not necessarily mean each of these

[45] This is WYP Command and Control system and records the receipt of calls to the police, details of police attendance and the finalisation of the initial incident. Reports on this system are referred to by Log numbers. All calls made to WYP on either the 999 or 101 numbers are received by the centrally based Customer Contact Centre [CCC]. Operators create an electronic record of the call as a Storm log. The log is then passed to District Control Rooms where operators either despatch District staff to attend or pass to other District staff [for example Customer Contact Units who may telephone the caller and resolve the report without an officer physically attending].

[46] The Niche database is used to record all criminal investigations. It allows the scanning and electronic storing of case papers, for example witness statements, records of interview and Custody Records. It is also utilised to record a wide variety of police reports in respect of other non-crime incidents, for example motoring matters, lost/found property and intelligence reports. Digitally recorded suspect interviews are also available on the database. Reports recorded on the database are identified by Occurrence numbers. Records are locked by the user entering them on the system at the time of entry and cannot be subsequently amended. Free text entries can be made on the Occurrence Entry Log [OEL], and such entries are referred to as 'OEL entries'. These are timed and are locked by the user after entry and cannot be subsequently altered.

occasions represented a missed opportunity to understand the intelligence picture. This was because each of the occasions the Niche record was accessed would have been for a different policing purpose and they may not have all been related to the domestic abuse Bethany had reported.

24.13 For example, during this time Mr G had been reported as a high-risk missing person and these missing person enquiries would have generated multiple accesses to his Niche Record in the course of the missing person investigation. The WYP reiterated to the panel they would not expect staff searching Niche intelligence records to also routinely search Storm records. The issue in this case being that information from Storm records had not been transferred to the Niche intelligence records. The panel felt the explanation provided by WYP identified the problem.

24.14 On the following dates in 2019, between Bethany providing a statement and her homicide, either Mr G, or other persons contacted WYP to report offences he had committed.

- 21 August Mr G visited a WYP station and stated he was concerned someone had reported him to the police. He was told an officer would contact him;
- 26 August a friend reported concerns for Mr G. He was later found by Humberside Police officers safe and well in Bridlington;
- 27 August he visited the same police station and made an allegation he had been the victim of an assault perpetrated by Bethany;
- 3 September he visited the same police station asking for an update on the allegation he had made. He was told the matter had not yet been allocated to an officer and that he would be contacted when it had been;
- 7 September he again visited the same police station asking for an update. He was told WYP were short of staff and he would be contacted as soon as possible;
- 7 September Bethany's father contacted WYP expressing concerns for her, that she was being harassed by Mr G and that he had been threatened by Mr G. Bethany's father asked to be contacted by WYP the next day. That did not happen;
- 9 September Bethany's new partner contacted WYP and stated Mr G had made threats to kill him. WYP incorrectly closed the incident without further action because they wrongly thought that threats to kill made to third parties [Bethany] rather than the intended victim [Bethany's new partner] were not a crime;

- 11 September Mr G made an allegation to WYP that he was being harassed by a person he believed to be Bethany's ex-partner;

- 12 September Mr G visited a WYP station and provided a statement in relation to his historic allegation against Bethany made on 27 August. A DASH risk assessment was completed with him as the victim and a medium risk was recorded.

24.15 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.

24.16 In respect of information provided by other parties concerning Mr G and his threats, a key piece of information which should have impacted upon the assessment of risk he posed was that provided by Daniel. Crimes should have been recorded and investigated in relation to the threats to kill made towards him by Mr G. He was told these matters could not be recorded because they had been made to a third party.

24.17 That was not correct and was in breach of WYP threats to life policy. The Duty Inspector should have been notified of the Threats to Kill Offences to properly assess whether the threat was real and credible in order to implement a proportionate response and where appropriate [Person is in Real and Immediate Danger] conduct a threat to life assessment and implement control measures to mitigate risk.

24.18 The DHR panel have carefully considered all the information provided to them both by WYP and the IOPC. The DHR panel feel the key issues which led to WYP shortcomings were as follows;

- There was inappropriate identification, recording and recognition of historic information that was critical to assessing the risk Mr G posed to Bethany;
- Police officers and staff that dealt with Bethany and other victims and witnesses that held information about the risk Mr G posed did not follow the domestic abuse policy and procedure of WYP;
- Some police officers and staff that dealt with Bethany and other victims and witnesses that held information about the risk Mr G posed were either not supervised or were inadequately supervised. This meant opportunities were missed to identify noncompliance with WYP domestic abuse policy and the threats to life policy.

- Some police officers and staff that dealt with Bethany and other victims and witnesses that held information about the risk Mr G posed had inadequate experience, training and knowledge in relation to dealing with domestic abuse and assessing the risk that Mr G posed to Bethany.

24.19 Bethany's family wanted to know the mechanism by which Officer A, who took a statement from Bethany on 19 August 2019, was allocated the case. The family could not understand why Officer A, a probationary constable was asked to investigate such a complex case. They also remarked that there was nothing on Officer A's uniform to indicate they were a probationary constable. Had Bethany known that it would have allowed her to consider asking for a more experienced officer to deal with her case. WYP gave the following explanation to the IOPC in the form of statements. These appear in the IOPC report as follows. '…Officer A was not long out of tutorship. [They were] a young in service officer who did request assistance more than others. Officer A would request supervisors to review and offer support for jobs even before [they] had started to deal with them. I believe Officer A was going to be a fine officer [they were] finding [their] feet and learning [their] trade. [They were] being tasked with appointments so that [they] could develop in a slower more controlled environment the same as other student officers with [their] level of service. [They] would on occasion have to be told to actually speak with the victim and get the information, before requesting a supervisory review or to obtain further advice on how to proceed, this was to reduce the amount of contact between [them] and supervisors to allow [them] to gain confidence in [their] decision making. This was also because until [they] spoke with the caller we only had a minimal amount of information from a log, and this would be insufficient for a supervisor to review, and make live-time decisions on how to proceed. To me Officer A's struggles with certain aspects of [their] work were that of a young in service officer who wanted to do their best and get everything right. [They were] afraid of making mistakes, getting it wrong.' In simple terms Officer A was allocated the case as a matter of routine and as part of their ongoing development.

24.20 Thereafter their lack of experience and poor supervision failed to identify the real level of risk that Mr G posed Bethany. The family believe that nothing could have been more important than arresting Mr G and denying him the opportunity to continue stalking and harassing Bethany.

24.21 A number of learning points that flow from the issues above are set out later in this report within sections 18 and 19. In addition to the above, the DHR panel feel that one of the opportunities that was missed was to consider using Clare's Law to help protect Bethany. The Domestic Violence Disclosure Scheme [DVDS] enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

24.22 The scheme has two elements: the "Right to Ask" and the "Right to Know". Under the scheme an individual or relevant third party [for example, a family member or a professional from an agency] can ask the police to check whether a current or ex-partner has a violent or abusive past. This is the "Right to Ask". If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the police will consider disclosing the information to the person at risk.

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

24.24 Because Bethany's complaint against Mr G on 19 August 2019 was sent back to the originating officer to investigate, rather than a specialist domestic violence coordinator, a disclosure under Clare's Law was not considered.

24.25 16.2.25 Other agencies identified within their IMRs areas where service could be improved. The GP practice that dealt with Bethany has identified that she disclosed her-ex boyfriend who she cared for [although did not name] could behave in an abusive manner. This information was passed to the GP practice within a letter from IAPT. [see paragraphs 15.2.5].

24.26 The letter was filed and the GP practice did not take any action, having expected the IAPT service would have conducted a risk assessment and made any necessary onward referrals. The IMR author for the GP practice has identified a need to improve future practice in relation to how GP's respond to risk if recorded in correspondence.

24.27 That author has identified that during the specified time period practitioners at the GP practice did not have any systems and processes in place to enable them to make routine enquiries[47] in relation to domestic violence and abuse. The GP practice has now undertaken training to address this issue and is working to embed routine enquiry into clinical practice.

24.28 Although Bethany's relationship with Mr G post-dates his period of supervision by the CRC, that agency has still identified some areas for service improvement. While the CRC notified mental health services of their contact with Mr G, the CRC feel the case would have benefitted from a 3-way meeting between the probation officer responsible for Mr G's case, Mr G and his CPN. This could have led to agreement being reached concerning roles and responsibilities, frequency of contact and to formalise liaison arrangements. It would have also provided an opportunity to share information on Mr G's disclosure that he stabbed a school pupil. In this way practice would have been

[47] Routine enquiry involves asking all women at assessment about abuse regardless of whether there are any indicators or suspicions of abuse.

strengthened by more joint working with the CPN and Mr G and his mental health better understood.

24.29 LDVS identified that, while practice was followed in respect of the first two contacts with Bethany, LDVS did not record details of her partner Mr G, nor on the third occasion was Bethany asked whether she had contacted LDVS before. The DHR panel recognise that, for many reasons, some victims do not wish to disclose the identity of the perpetrator. However, it would have been helpful to have known whether Bethany had been asked this question.

24.30 The DHR panel believe that recognising whether a victim has contacted the service before is an important part of the process of helping to understand the victim's journey and their experiences of domestic abuse. It may all help in the identification of risk and the formulation of plans to protect the victim. LDVS has contributed lessons and implemented recommendations to improve future service as set out in sections 18 and 19.

24.31 The panel also identified that Mr G made two attempts to take his life using alcohol and medication and when arrested on one occasion he was noted to be drunk. The panel could not find any reference to alcohol consumption being considered as a factor in his worsening mental health needs, or it being explored and ruled out. CGL [CHART Kirklees Drug and Alcohol services] who were represented on the panel said they had no record that Mr G had been referred to them.

24.32 While the panel do not feel there were any missed opportunities by agencies to directly connect the abuse Bethany suffered and misuse of alcohol by Mr G, none the less, the panel felt it was important to highlight within this report the documented links between the misuse of alcohol and domestic abuse. For example, Alcohol Alert[48] report:

'Alcohol alone is not a cause of domestic abuse, and is never an excuse. There are, however, many ways in which alcohol and domestic abuse are related'

24.33 Alcohol Concern's Blue Light Project[49] looked at the links between resistant drinkers and domestic abuse and found:

'Alcohol use is a common theme among the initial sample of 39 DHR reports examined, with 27 [69%] featuring varying levels of alcohol related harm. Not all cases involve one or both of the partners having an ongoing alcohol problem, however alcohol misuse is commonplace within the sample: In 22 reports [56% of the 39] the perpetrator of the homicide is identified as experiencing problems with alcohol'.

[48] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-domestic-abuse

[49] Domestic abuse and change resistant drinkers: preventing and reducing the harm Learning lessons from Domestic Homicide Reviews June 2016 https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

25. Term 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].

25.1 There are well established links between domestic abuse and mental health. In research conducted by the Home Office into domestic homicides, it was established that mental health issues were present in 25 of 33 intimate partner homicides.[50] A number of high-risk factors have been identified as being associated with serious violence and murder through researching many cases and are considered within the DASH model when assessing risks. A specific question within the DASH risk assessment tool concerns mental illness.

25.2 Research elsewhere also supports this finding. For example, a paper published in Health and Social Care[51] found:

'…perpetrators' mental health was mentioned in 65% of DHRs; 49% of perpetrators had a mental health diagnosis. Healthcare services in particular, mental health services, were most likely to be involved with perpetrators…'

25.3 A paper published by Standing Together[52] found:

'Mental Health problems were identified in 64% of adult family homicide perpetrators [16/25 cases] and 44% of interpersonal homicide perpetrators [26/59 cases]'

25.4 The response of health agencies in respect of the mental health care and management of Mr G has been considered within the Mental Health Level Three Review and is therefore not repeated in this section. Instead this section of the report considers what other agencies knew about Mr G's mental health needs.

25.5 Prior to 9 January 2018 [the point at which WYP first knew Bethany was in a relationship with Mr G], WYP held a significant amount of information relating to Mr G's mental health. Details of these incidents are set out earlier in this report and within Appendix C. They include Mr G making threats to harm

[50] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf Paragraph 28

[51] Learning from Domestic Homicides in England and Wales: Chantler K, Robins R, Baker V, Stanley N. July 2019 Health and Social Care

[52] Domestic Homicide Case Review Analysis: Sharp-Jeffs N, Kelly L June 2016 Standing Together Against Domestic Violence

himself and others and occasions on which Mr G spoke openly to police officers about his mental health needs.

25.6 Information within the IMR provided to the panel by WYP show that on numerous occasions police officers and staff told mental health services about the contacts they had with Mr G. For example, on 1 August 2015, when reporting Mr G for an offence of harassment upon Female 2, a police officer contacted both Mr G's care coordinator and a nurse in charge of his care within hospital.

25.7 Another example of police contact with mental health services was on 28 August 2015 when an officer detained Mr G under Section 136 of the Mental Health Act in order that he could be assessed by the mental health Crisis Team. As well as direct contact between the police and mental health services, WYP also recorded information about Mr G's mental health on police information systems. These included records on PNC and Niche[53] and Warning Markers for Self-Harm, Mental Health Disorder and Suicide.

25.8 Between 9 January 2018 and 19 August 2019, WYP were contacted on four occasions relating to issues concerning Mr G which included his mental health. On 9 January 2018 Mr G threatened to stab a paedophile and was eventually detained under Section 136 of the Mental Health Act. On 16 June 2019 Bethany told WYP Mr G had threatened to kill himself and again he was taken to hospital for a mental health assessment.

25.9 On 22 June 2019 Bethany reported to WYP police concerns for Mr G's health and he was taken to hospital. On 15 August 2019 Mark reported concerns for Mr G to WYP and, after locating him, police officers contacted an AMHP who told the police there was no necessity for immediate mental health service input.

25.10 It appears to the panel that, up until to this point, WYP officers and staff did all they reasonably could do to bring episodes concerning Mr G's mental health condition to the attention of mental health professionals. Armed with that information, it was then the responsibility of mental health professionals to assess Mr G's condition and determine what action to take in respect of his care and treatment. At that point in time neither WYP nor mental health services had received any direct information that Bethany was at risk of domestic abuse from Mr G.

25.11 However, given the links between mental health and the risk of domestic abuse, the panel feel it would have been good practice for professionals experienced in dealing with domestic abuse to have considered the impact Mr G's behaviour might have been having upon Bethany. Bethany's identity was

[53] The WYP Niche database is used to record all criminal investigations. It allows the scanning and electronic storing of case papers, for example witness statements, records of interview and Custody Records.

known to both WYP and mental health professionals because she had spoken to both agencies in the past concerning Mr G and his behaviour.

25.12 The panel have not been able to accurately identify why professionals did not take the initiative and approach Bethany confidentially to assess the impact Mr G's behaviour was having upon her. The panel do not accept that confidentiality should have been an issue preventing this. They conclude the reason no professional took that initiative was most probably related to a lack of training and understanding about the links between mental health and domestic abuse.

25.13 On 19 August 2019 two significant events happened. The first was Mr G's visit to a WYP station. Here he told a police officer he suffered with mental health problems. Mr G told the police officer he had recently left his girlfriend because it was unfair to be with her with his mental health problems. He repeatedly said he wanted to hurt and kill himself because of the situation and asked for help.

25.14 The DHR panel believe the officer who spoke to Mr G then acted appropriately by seeking advice from a nurse located within the Mental Health HUB. In turn the nurse looked at Mr G's records and ascertained he had contacted his mental health worker earlier. They had told him to talk to the Police. It appears mental health services did not convey any concerns to that police officer and told the officer Mr G should keep engaging with his mental health worker and that nothing further needed to be done.

25.15 The second event later that day was Bethany's visit to another WYP station during which she made a statement outlining Mr G's threatening, manipulative behaviour towards her. Bethany told the police officer about Mr G's mental health and that she had sought help for him from his CPN. The significance of these two events is that they represent the first time at which there was a direct connection reported to an agency concerning Mr G's worsening mental health and the risk of domestic abuse from him towards Bethany.

25.16 That information was important to the police in respect of completing the DASH risk assessment concerning Bethany [this has been considered already within under Term 2 of this report and therefore is not repeated here]. That information was also important to mental health services who, up to this point, did not appear to be aware of any direct risk to Bethany of domestic abuse at the hands of Mr G.

25.17 A key issue for all DHR panels is to consider opportunities for multi-agency working. In this respect this DHR panel has carefully considered why the information WYP came into possession of from Bethany on 19 August 2019 was not passed to mental health services. While prior to 19 August it might have been good practice to consider the possibility that Bethany was at risk because of Mr G's mental health, from 19 August onwards it was irrefutably the case that such a link existed.

25.18 The primary reason this information was not passed to mental health services arises from the way in which WYP handled Bethany's complaint of domestic abuse against Mr G on 19 August 2019 and in the days that followed. As set out in section 16.2 there were significant inconsistencies in the way in which the DASH risk assessment was completed and a failure to follow the WYP standard operating procedure [SOP] in relation to domestic abuse.

25.19 Bethany's immediate wishes [as expressed in the DASH risk assessment] was that information should not be shared with other agencies. Had the SOP in respect of domestic abuse been followed, this would have led to a review of the risk Bethany faced being undertaken by a domestic abuse specialist. Had all the information held on police systems been reviewed, together with the information provided by Bethany in her statement, the risk she faced would have been raised from medium to high.

25.20 In turn, as a high-risk case it would automatically have been referred into a MARAC. At which point it is 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. These issues have been explored in depth by the IOPC and action is being taken by WYP to address the learning.

25.21 As well as WYP, Kirklees Community Rehabilitation Company [CRC] also held some information in relation to Mr G's mental health although this pre-dated his relationship with Bethany. This related to his conviction in 2017 for harassing Female 2, a previous partner. CRC knew details of Mr G's mental health because he told probation officers about his. In turn the CRC shared that information with mental health services including Mr G's CPN. It is not known if CRC shared Mr G's disclosure that he stabbed a school child.

25.22 The CRC are satisfied the level of service provided in respect of sharing information about Mr G's mental health met their standards and the DHR panel concur. The CRC held no information that Mr G presented any risk to Bethany as their contact predated the start of that relationship. Having formed contact with mental health services, the CRC provided information which should have alerted mental health services to the fact Mr G was a perpetrator of domestic abuse. In turn mental health services could have used that information in developing a risk assessment and plan in relation to Mr G. The extent to which they did has been considered in detail by the Mental Health Level Three Review.

25.23 The only other non-health agency that held information about Mr G's mental health was Leeds Domestic Violence Service [LDVS]. Bethany contacted them and made disclosures about her partner's behaviour and his mental health. For the reasons outlined earlier LDVS did not have Mr G's name. The Contract Lead for LDVS informed the panel that, even if they had that information, they would not have had the legal ability to share it with mental health services outside of a MARAC. The Contract Lead for LDVS stated that a MARAC had been discussed with Bethany and she asked that information was not shared.

25.24 Bethany had contact with three agencies in respect of her mental health needs. Between 2017 and 2018 she had contact with a GP Practice in Brighton and with Brighton and Hove Wellbeing Service. This contact related to 'nastiness' with a former partner. The partner was not Mr G and the panel are satisfied that agency did not hold any information which would have helped in protecting Bethany from Mr G's abuse.

25.25 While she was in a relationship with Mr G, Bethany had contact with her GP practice in Leeds following a presentation at hospital. Bethany disclosed that her ex-boyfriend [Mr G-who she did not name], was abusive towards her and had a personality disorder and psychosis.

25.26 Although GP services in Leeds could have improved the way they handled the disclosure of domestic abuse their IMR author believes there was no indication in the GP record that Bethany was either requesting support for, or struggling with, her partner's mental health.

26. Term 4

What consideration did your agency give as to whether Bethany or Mr G were adults in need of care and support and what did it do?

26.1 The following definition of care and support is taken from the UK Government web site[54]:

> 'Care and support' is the term used to describe the help some adults need to live as well as possible with any illness or disability they may have. It can include help with things like, getting out of bed, washing, dressing, getting to work, cooking meals, eating, seeing friends, caring for families, being part of the community. It might also include emotional support at a time of difficulty and stress, helping people who are caring for an adult family member or friend or even giving others a lift to a social event. Care and support includes the help given by family and friends, as well as any provided by the council or other organisations'.

26.2 The following definition of a carer is extracted from the NHS web site[55]:

> 'A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. When we refer to carers in this document, this is inclusive of both adult and young carers. Many carers don't

[54] https://www.gov.uk/government/publications/care-and-support-whats-changing/care-and-support-whats-changing
[55] https://www.england.nhs.uk/commissioning/comm-carers/carers/

see themselves as carers and it takes them an average of two years to acknowledge their role as a carer. It can be difficult for carers to see their caring role as separate from the relationship they have with the person for whom they care, whether that relationship is as a parent, child, sibling, partner, or a friend'.

26.3 Applying the definitions above, because of his mental health needs, Mr G was a person in need of care and support. This need appears to have been recognised by the agencies that had contact with Mr G and was primarily delivered through mental health services. The response of mental health services to Mr G's need for care and support and the quality of the services delivered are outlined in detail within the Mental Health Level Three Review [see Appendix B].

26.4 Again, applying the definition above it appears to the DHR panel that Bethany was acting in the capacity of carer to Mr G. Indeed, Bethany had told some agencies directly, for example her GP and WYP, that she was fulfilling this role. From the statements obtained from family, friends and colleagues as part of the homicide enquiry, it is apparent Bethany was a carer for Mr G. She assumed significant responsibility in managing his mental health and welfare. The DHR panel recognise this responsibility must have been a significant strain and impacted upon Bethany's ability to manage her own mental health and wellbeing in addition to the harm and fear she was suffering from as a victim of domestic abuse.

26.5 As the lead agency for delivering care and support to Mr G in respect of his mental health needs, it was the responsibility of mental health services to consider the needs of Bethany as his carer. This point has been specifically considered within the Independent Level Three Mental Health Homicide Review [see Appendix B]. The review concludes mental health services did not offer Bethany a carer's assessment and did not recognise Bethany fulfilled a care and support role for Mr G. The Mental Health Level Three report identifies learning and makes recommendations as to how mental health services can close this gap.

27. Term 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?

27.1 The information Pauline, Jim and Richard and friends held has already been considered in section 13 of this report.

27.2 When they first met with the Chair of the DHR, Pauline and Richard were asked whether [based upon their experiences of Bethany's abusive treatment by Mr

G], they had any advice for other victims of domestic abuse. They felt victims should go and get domestic abuse advice in secret. They should record all the events, dates, times and tell a trusted person about what is happening and victims should go to the police. However, Pauline felt in some cases this could act as a catalyst and make the situation worse. She felt that in Bethany's situation she was unsure what the best action would have been.

27.3 The panel felt it was important to reflect within this report the high levels of support Bethany had received from friends and family and how proactive they had been in trying to get Bethany the help she needed when she reported the abuse by Mr G. The Chief Executive from Hundred Families [who provided support to Bethany's family] said he felt that, despite Bethany reaching out for help and support, 'she was failed by the system'.

28. Term 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?

28.1 Neither Bethany nor Mr G appeared to have any specific racial, cultural, linguistic or faith needs. Using the definitions about diversity set out earlier on in the report [see section 11], it is clear Mr G had a disability within the meaning of the Equality Act 2010 by virtue of his mental illness, however he was not formally diagnosed until after his arrest for the homicide of Bethany. Mr G told a pharmacist in January 2019 that his medicine was poisoning him and said it was, "between him and God they will find a way to improve his health without taking regular medicines'. The reference to God was not used to see if Mr G had a faith and if so whether support for him could be sought through that avenue. This is a learning point.

28.2 All agencies that had contact with Mr G appeared to have acted appropriately and taken account of his disability when providing services to Mr G and the DHR review has not identified any learning in this respect.

28.3 The DHR panel recognised that Bethany's gender was a significant factor in her abuse as stated in paragraph 11.8 and this is a protected characteristic under the Equality Act 2010. The panel also recognised that Bethany was 21 years of age when she was killed and was acting as the carer for Mr G, a man of 35 years of age with significant mental health needs. In this respect Section 16.4 above has already considered the gap in the provision of a carer's service to Bethany.

29. Term 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?

29.1 WYP capacity and resources were significant issues highlighted both by the force in their IMR and by the IOPC in their report. At the time Bethany died there had been a significant increase in domestic abuse crimes and incidents reported in the Leeds District. The table below [extracted from the WYP IMR] details the increase of domestic abuse crimes and incidents reported between 2015 and 2019.

Table 4 Increase of domestic abuse crimes and incidents reported between 2015 and 2019

Incidents	2015	2016	2017	2018	2019
Leeds	15909	18473	20207	21833	21889

29.2 Because the officer that dealt with Bethany on 19 August 2019 had not completed the minimum standards of investigation required for the Leeds DAT to take responsibility for investigation, it was returned to that officer to complete. WYP state the DAT is reactive, it is responsible for dealing with high-risk domestic abuse cases. Because of the lack of capacity, the DAT cannot complete investigative actions that should be undertaken by the attending Officer.

29.3 Similarly, because of an increase workload due to Clare's Law requests and staffing and sickness within the Leeds District Domestic Violence Co-ordinator [DVC], increased safety interventions could not be undertaken by the DVC. An agreement was in place at the time Bethany disclosed her abuse to WYP that the DVC would only deal with BOLO and high-risk cases. Medium and standard risk domestic abuse crimes and incidents would be dealt with by the investigating officer, which in Bethany's case was the officer that spoke to her on 19 August 2019.

29.4 As outlined earlier, had the DASH risk assessment completed for Bethany on 19 August correctly mirrored Bethany's witness statement, then the risk to her from Mr G would have been assessed as high. Consequently, based upon the allocation criteria outline above, Bethany's case would have been allocated to a specialist within the DAT/DVC to deal with. As a high-risk case it would have been referred to a MARAC.

29.5 The police officer who spoke to Bethany on 19 August, and who was then allocated the case to investigate, was absent from work for a considerable period between 19 August and the date of Bethany's homicide. Working only

seven days in that period. That impacted on their capacity to progress the investigation and undertake any safeguarding interventions.

29.6 When Mr G made a counter allegation against Bethany on 27 August 2019, he was seen by another officer who was tasked with obtaining a statement and undertaking a DASH risk assessment from Mr G. Because of low levels of staffing and public demand for service, those tasks were postponed several times and were not completed until the day of Bethany's death.

29.7 The DHR panel did not identify resource issues in any of the other agencies that impacted upon the capacity of agencies to deliver services in respect of Bethany and Mr G. The Mental Health Level Three Review identified resourcing difficulties with SWYPFT providing services for all patients who met the criteria for Care Programme Approach. The details are within Appendix B of this report.

30. Term 8

What learning has emerged for your agency?

30.1 Learning identified by individual agencies and the DHR panel is set out within section 18 of this report post.

31. Term 9

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

31.1 The DHR panel did not identify any examples of outstanding or innovative practice.

32. Term 10

Does the learning in this review appear in other domestic homicide reviews commissioned and monitored by the Kirklees Communities Board?

32.1 There are similarities between the learning identified in this review and those of Adult V [2013] and William [2014] in respect of the recognition of domestic violence and abuse.

32.2 The Chief Executive of Hundred Families told the panel he felt there were lessons within this DHR report into the homicide of Bethany that have also appeared in previous reviews concerning homicides perpetrated by offenders who had been receiving treatment for mental health issues. He highlighted a case from 2002 in which a woman under the care of South West Yorkshire

Mental Health Trust stabbed and killed her boyfriend. A review[56] of the case identified no evidence of a formal risk assessment of any sophistication or value, beyond a simple statement of no risk and a description of behaviours.

32.3 Bethany's family believe that implementing recommendations should be compulsory otherwise they are pointless.[57] They say that domestic abuse is everyone's responsibility and that domestic homicides will continue unless DHR recommendations are relevant and implementation enforced. While it is too late for Bethany, other potential victims must be helped and supported. Bethany's life, and the lives of other victims, have to mean something.

32.4 They provided the following recommendation as an example [2018 Kirklees DHR 'Aadil'] and wonder what was done.

'Through the Domestic Abuse Strategic Partnership, Kirklees Communities Board undertake a review[58] to ensure partner agencies have good quality processes and systems in place for recording information on domestic abuse in Kirklees.'

32.5 The Kirklees Communities Partnership Board responded as follows.

"The Domestic Abuse Strategic Partnership commissioned an independent person to review our multi-agency risk assessment and safety planning processes. The purpose of the review was to assess the effectiveness of the current process, with particular emphasis on identification and responses to risk and the effectiveness of safety plans. The review found many positive examples where processes were working well, particularly in relation to immediate safeguarding and timely allocation of cases to victim support agencies. There were also areas for improvement, with recommendations in relation to systems for information sharing and producing data. Partnership agencies agreed to implement all recommendations and a new system is now in place to record information more effectively and produce more robust data".

[56] https://www.hundredfamilies.org/wp/wp-content/uploads/2014/10/JAYNE_COULTER_APR02.pdf

[57] Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. The Home Office's Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is issued as statutory guidance under section 9(3) of the 2004 Act. Section 109 of the Guidance states: 'Lessons learned and effective practice 109. DHRs are a vital source of information to inform national and local policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims. Publishing the DHR and completing the action plan is only the beginning of the process. To derive value from the DHR process and prevent further abuse and homicide, local areas should have governance mechanisms in place for monitoring delivery against DHR action plans. Community Safety Partnerships should satisfy themselves that an appropriate framework is in place.

[58] The unpublished review was undertaken after the Aadil DHR.

33. CONCLUSIONS

33.1 Mr G was a serial perpetrator of domestic abuse before he met Bethany. He had a history of violent and abusive behaviour towards others. That fact was unknown to WYP. He acted abusively towards at least two other female partners before he began to abuse Bethany. The significant weight of caring for Mr G placed upon Bethany's shoulders was not properly recognised by mental health who had a duty to consider a carer's assessment.

33.2 Mr G had a history of trying to manipulate partners and using tactics that are known to be favoured by other perpetrators to try and minimise their behaviour, raise counter allegations and obfuscate enquiries by agencies such as the police. There was a pattern to this behaviour toward at least two previous partners that could be seen in the way he behaved towards Bethany. Threatening suicide, going missing and making counter allegations against her and her friends. He exercised coercive and controlling behaviour towards Bethany and previous partners.

33.3 The panel recognised the significance of the age difference between Bethany and Mr G [14 years]. However the panel concluded that, because Bethany was not a child when the relationship began, the offence of grooming a child for sex was not applicable in this case[59].

33.4 However, once she was in the relationship, Bethany was certainly groomed by Mr G in the sense that, by reason of his abusive behaviour, his ultimate goal was to coerce and control Bethany.

33.5 While he had a diagnosis of emotionally unstable personality disorder [EUPD], which might have contributed to some of the excessive and irrational behaviour he demonstrated, it did not and could never have relieved him of the personal responsibility he bore for violent, abusive and manipulative acts towards Bethany and his other victims. The sentencing Judge was clear that Mr G '… knew perfectly well what you were doing…'. A fuller extract appears at paragraph 1.8.

33.6 Mr G was known to a number of agencies, although the principal relevant contact during the period covered by this review was WYP and mental health services. The CRC knew Mr G self-reported stabbing a school child. That disclosure was recorded in the OASys risk assessment. Neither CRC nor mental health records say whether that detail was shared. Because the event Mr G spoke about was actually recorded as criminal damage, it is unlikely its real relevance would have been identified to the MARAC. However, had the self-disclosure by Mr G been known by mental health services then it may have been a piece of relevant information that was then shared with the MARAC.

33.7 Mr G was under the care of mental health services from 2014 until the day he killed Bethany. The Mental Health Level Three Review of Mr G's treatment and care by mental health services has concluded there were many elements of Mr

[59] S14 Sexual Offences Act 2003

G's care and management between 2014 and 2019 that met and, at times, exceeded reasonable expectations. However, there are also elements that could and should have been different.

33.8 The first of those issues relates to his diagnosis. The mental health professionals involved do not accept they missed a diagnosis of psychosis in addition to his EUPD. However, the Independent Team that produced the Level Three report, based on the evidence it has seen and heard, considered that more careful consideration should have been given to Mr G's presentation and thus diagnosis. They also conclude 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 conclusion and recognises it is difficult to know how that may have impacted on the sequence of events.

33.9 WYP held information to show Mr G had a history of perpetrating domestic abuse between 2004 and 2015 against two female partners. Between 2012 and 2018 WYP held information concerning Mr G's mental health, concerns for his safety, missing person reports and detention under the Mental Health Act. As a result of the homicide of Bethany a review was carried out into information held by WYP and whether relevant and important information had been transferred to Mr G's intelligence record.

33.10 Gaps in the information that was recorded on Mr G's intelligence record were found. This included important information that Mr G had stabbed a former PCSO in 2013, and on other occasions had threatened to stab unnamed people such as paedophiles. 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.

33.11 This became most relevant from 19 August 2019, the date when Bethany provided a statement in which she alleged domestic abuse by Mr G. WYP incorrectly recorded this an offence of harassment, rather than the more serious offence of stalking and controlling and coercive behaviour. Bethany's risk assessment was incomplete in parts and did not match the information she provided in her witness statement. Had WYP domestic abuse policy been followed the risk recorded against Bethany by Mr G 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.

33.12 In fact Bethany's statement was not uploaded to WYP systems for another seven days. That meant the information she provided was not available to be checked and compared with her DASH risk assessment. Important information concerning Mr G's history including his use of weapons was not available to assist in developing the risk assessment. Had all of that been in place, WYP now conclude the risk Mr G posed to Bethany would have been assessed as high. That in turn would have led to a MARAC being held and most likely the

sharing of information between WYP and mental health services. Sharing information would have produced a much more complete picture of the risks Mr G posed.

33.13 Instead the investigation was returned to the officer that had first dealt with Bethany. Between the date of Bethany's complaint of domestic abuse and her homicide there were nine missed opportunities to arrest Mr G when either he visited WYP stations and made a counter allegation against Bethany, or other persons made complaints against him that he was harassing them or making threats.

33.14 Following the uploading of Bethany's statement to WYP systems there is no evidence that WYP undertook any dynamic risk assessment in respect of the potential risk to Bethany from Mr G. Consequently, there was no plan in place to protect Bethany. WYP also missed an opportunity to implement Clare's Law and consider using the Domestic Violence Disclosure Scheme to inform Bethany about Mr G's history of abusing others.

33.15 During the time Bethany was in a relationship with Mr G mental health services 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.

33.16 However, had WYP domestic abuse processes been correctly followed and had all the intelligence about Mr G's history of violent behaviour and threats been identified/located then the risk he posed to Bethany should have been recorded as high. This would have triggered a referral to MARAC and would have potentially led to both WYP and mental health agencies sharing the information they held. That in turn may have made a significant difference to the assessment of risk Mr G posed to Bethany and the production of a plan to protect her.

33.17 Abusers may use technology [for example messaging, e mails or mobile Apps] to control or harass their victims[60]. The panel recognise this was the case here in the way in which Mr G misused technology to harass Bethany, her family and his ex-partners. While the police addressed this as harassment, the panel felt there was a lack of connection between technology facilitated abuse and stalking and escalation. Accordingly the panel has made a recommendation that partner agencies review their policies to ensure the risk from technological abuse is adequately addressed [see recommendation 36 post].

33.18 The Mental Health Level Three review also concluded 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 represents a serious miss in risk management planning and mitigation.

[60] https://refugetechsafety.org/what-is-tech-abuse/

33.19 That review further concludes that the mental health service had a clear duty of care to Bethany regarding her risks at the point of relationship breakdown that encompassed, a duty to inform, a duty to check, a duty to raise a safeguarding alert/domestic abuse alert, a duty to counsel Mr G about his behaviour towards Bethany her friends and family when it was known that he and Bethany's relationship had ended and a duty to try to achieve complete information about any concerning behaviours that may have indicated domestic abuse was, or was becoming an issue. None of these duties were delivered. While the DHR panel concur with those conclusions they also recognise that WYP had similar responsibilities towards Bethany that they did not deliver.

33.20 There are a number of reasons why those duties were not delivered. 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.

33.21 In conclusion, the DHR panel repeat their deepest sympathy to Pauline, Jim and Richard and to their family and the many friends who loved Bethany. They urge all agencies to embrace the learning within this report so as to support and protect victims of domestic abuse.

34. LESSONS IDENTIFIED

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.

RECOMMENDATIONS

In the following table each of the recommendations is numbered corresponding to the order in which they appear in the action plan. The column headed 'Agency' identifies whether the recommendation has been made by a partner agency or collectively by the DHR panel.

Note:

Bethany's family believe that implementing recommendations should be compulsory otherwise they are pointless. [See footnote 56 page 77.] They say that domestic abuse is everyone's responsibility and that domestic homicides will continue unless DHR recommendations are relevant and implementation enforced. While it is too late for Bethany, other potential victims must be helped and supported. Bethany's life, and the lives of other victims, have to mean something.

Table 5 DHR Recommendations

Number	Recommendation	Agency
1	Training for all frontline officers / police staff in respect of threats to life Policy	West Yorkshire Police
2	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.	West Yorkshire Police
3	Remind Staff and Police Officers that intelligence related to Domestic Abuse / Mental Health is submitted on Niche	West Yorkshire Police
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 the victim, perpetrator and domestic related incidents with previous	West Yorkshire Police

Number	Recommendation	Agency
	partners which could identify patterns of offending, controlling and coercive behaviour.	
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.	West Yorkshire Police
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.	West Yorkshire Police
7	West Yorkshire Police to review the Force Common Interventions Framework and assess whether it is fit for purpose or needs to be updated or replaced with new guidance on safeguarding interventions.	West Yorkshire Police
8	West Yorkshire Police to review the Domestic Abuse Policy to encompass the appropriate response to non-immediate reports of domestic abuse [dealing with reports of domestic abuse by appointment].	West Yorkshire Police
9	West Yorkshire Police to review the Domestic Abuse Policy to encompass the appropriate response to non-immediate reports of domestic abuse [dealing with reports of domestic abuse by appointment].	West Yorkshire Police

Number	Recommendation	Agency
10	The Head of Safeguarding/Designated Nurse Safeguarding Children and Adults from NHS Leeds CCG will write to all GP practices highlighting the recommendations as described in 11.1.1.	Leeds Health and Care Partnership [formerly CCG]
11.	The recommendation made in 11.1.1. will be added to all NHS Leeds CCG safeguarding training sessions from March 2020.	Leeds Health and Care Partnership
12.	NHS Leeds CCG will develop and send a learning briefing out to all GP practices highlighting the recommendations made in 1.1.1.	Leeds Health and Care Partnership
13.	Review of LDVS Protocol and Procedure for maintaining Quality Assurance in delivery of the service.	Leeds Domestic Violence Service
14.	Introduction of case work monitoring documents.	Leeds Domestic Violence Service
15.	Check that all LDVS staff are fully compliant in recognising/assessing and managing risk and safety planning incorporating professional curiosity.	Leeds Domestic Violence Service
16.	Review of how one-off contacts are linked together for the same clients.	Leeds Domestic Violence Service
17.	Consider ways of following up calls in appropriate cases and documenting this as procedure/protocol.	Leeds Domestic Violence Service
18.	Ensure Pdap helpline, triage and intake processes are pro-active in engaging clients into our service in line with our values.	Leeds Domestic Violence Service
19.	Review Pdap helpline, triage and intake processes to ensure where appropriate a risk assessment is carried out as soon as possible.	Leeds Domestic Violence Service

Number	Recommendation	Agency
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.	Leeds Domestic Violence Service
21.	Check that all Pdap staff are fully compliant in recognising/assessing and managing risk and safety planning and in line with our values being pro-active and responsive.	Leeds Domestic Violence Service
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.	Leeds Domestic Violence Service
23.	Liaison and Diversion to continue to offer support in the Court to assist with sentencing and information sharing at assessment stages.	Kirklees Probation Delivery Unit
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.	Kirklees Probation Delivery Unit
25.	The Kirklees Reducing Re-Offending Strategic Group to continue to have a focus on Mental Health and continue to drive forward innovation, service development and sustaining good links for community partners in Kirklees.	Kirklees Probation Delivery Unit
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.	Kirklees Probation Delivery Unit

Number	Recommendation	Agency
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 domestic abuse issues are identified.	West Yorkshire Integrated Board [Formerly North Kirklees CCG]
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.	West Yorkshire Integrated Board
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.	West Yorkshire Integrated Board
30.	Kirklees Communities Board works with all the agencies that have contributed to this DHR and have	DHR Panel

Number	Recommendation	Agency
	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.	
31.	Within 12 months of Kirklees Communities 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 Homicide Review and IOPC investigation recommendations. A copy of this written report should be shared with Bethany's family on its completion.	DHR Panel
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.	DHR Panel
33.	Agencies have processes in place that ensure people who have faith	DHR Panel

Number	Recommendation	Agency
	beliefs are recognised and provided with an opportunity to be signposted to their faith organisation for potential support.	
33.	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 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.	DHR Panel
34.	That West Yorkshire Police separately review whether they are identifying the right cases for submission to the Domestic Violence Disclosure Scheme Panel.	DHR Panel
35.	That West Yorkshire Police review it policies and practices around identifying and responding to serial perpetrators of domestic abuse.	DHR Panel
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.	DHR Panel

Appendix A: Summary of Answer to Family Questions.

1) Why did the mental health nurse not see Mr G in order to undertake an assessment and intervene with his behaviour, instead contacting Mr G over the telephone?

   The answer forms part of the NHS Mental Health report. There are a number of references within that report to the mental health nurse contacting Mr G both in person and by telephone. The report concludes that these were appropriate means of contact.

2) Was due consideration given by professionals in relation to the wider duty of care to safeguard Bethany and others in their management and care planning of Mr G?

   These issues are covered in the NHS Mental Health Report which clearly concludes that mental health services had a duty of care to Bethany from the point of the relationship breakdown and they did not deliver that duty.
   The DHR reached a similar conclusion in respect of WYP.
   Both these issues in relation to the duty of care to Bethany are specifically covered within the conclusions of the DHR report.

3) Were any considerations given to Bethany being carer for Mr G and were there any concerns from health care professionals that he was controlling and Bethany felt obliged to say she was his carer?

   The DHR concluded that mental health services did not offer Bethany a carer's assessment because they did not recognise or consider that Bethany fulfilled a care and support role for Mr G. There is no evidence that health care professionals knew or suspected he was controlling Bethany.

4) Why did West Yorkshire Police not update Bethany following the three separate reports she made to them?

   Bethany was not updated because the officers and staff who handled her complaint did not follow the WYP domestic abuse policy; the reasons for which are set out in section 16.2.18 of the DHR report.

5) What safety measures were offered to Bethany by West Yorkshire Police?

   Bethany was not offered any safety measures because the officer who took the original report had not completed the minimum standards of investigation. The unit that should have dealt with safety measures returned the report to the originating officer to deal with [see

paragraph 16.7.2 and 16.7.3]. Additionally the risk was understated and Bethany should have been assessed as facing a high risk of harm from Mr G. Consequently the responsibility for safety measures in standard and medium risk cases rested with the investigating officer who did not follow the DV policy. He should have considered what measures were necessary to protect Bethany.

6) Why did West Yorkshire Police not link the complaints made by other people, in relation to Mr G?

   The reasons for the failure to link complaints is complex and is extensively covered in the IOPC report and within the DHR specifically within S16.2. In summary, information from the Storm system was not transferred to the Niche system [para 16.2.13] this meant that when officers searched Niche they were not aware of the other incidents involving Mr G.

7) What sharing of information occurred between police stations across West Yorkshire Police and indeed between agencies that had knowledge of Mr G concerning behaviour?

   Information is not shared between police stations rather it is recorded on common information systems that can be accessed by any officer irrespective of which station they work from. The issue is, there were failings in this system because information was not recorded when it should have been and neither was it transferred between systems when it should have been hence when police officers searched systems they were not aware all of the information concerning Mr G. Because WYP officers did not follow the domestic abuse policies of the force, the opportunity did not arise to share information with other agencies. That opportunity would have presented itself had the threshold for a MARAC been reached [see paragraphs 16.3.19 et al]. It was not reached because the risk Mr G presented to Bethany was not assessed correctly.
   In relation to other agencies, Maria's report concludes there was a duty to share information with the police about the fact Mr G carried a knife. However, at the time, there was insufficient evidence he posed a risk of harm to others which may explain why the information was not shared with other agencies.

Appendix B: Executive Summary

NHS Commissioned Independent review of the care and treatment of Mr G between 2014 and 2019 undertaken by:

The effective investigations company
PO Box 336, Malvern WR14 9GN
01684 572455 www.consequenceuk.com
Registered name: Consequence UK Ltd
Company number: 04574895 VAT 803218760

This Executive Summary was taken from the

Extended Executive Summary dated 29 October 2021

The full Extended Executive Summary was published in May 2022 and can be found at:

Independent review of the care and treatment of Mr G between 2014 and 2019

Acknowledgements and author's note

Following a conversation with the victim's mother and father, the report author was left with the conviction that their child would have wished for her full name to be revealed in this report. This was initially agreed on. However, the service user involved is now diagnosed with a severe mental health disorder and does not want his name used anywhere. This means it is not possible to state the victim's name in full in this report, as any Google search would reveal the identity of the mental health service user. The shortened name of the victim – Beth – is used. The service user is referred to as Mr G.

This review would not have been possible without the input and/or the support of the following:

- the parents of Beth
- several individuals close to Beth
- the advocate for Beth's parents
- the perpetrator of the attack that led to Beth's death, Mr G, and his current forensic care team
- the sisters of the perpetrator and two of his friends
- mental health professionals who had care contacts with Mr G between 2015 and 2019 and who provided information to the NHS England-appointed independent review team
- two mental health professionals involved in developing a specific personality disorder pathway in the trust who were responsible for Mr G at the time but had no contact with him between 2015 and 2019
- two senior managers within the trust who provided the independent review team with a range of information as and when it was requested
- the Chair of the Domestic Homicide Review panel commissioned by Kirklees Community Safety Partnership and panel members from all agencies involved in that review process, who each contributed their own assessment of their agency's involvement in the form of management reviews, which were available to the author of this report.

The independent review team were:

Maria Dineen – Director of Consequence UK Ltd
Dr Mark Potter – Consultant Psychiatrist, adults of working age
Sue Timms – Matron in community mental health services, adults of working age
Damien Kealy – Experienced mental health nurse, in intensive home treatment, and low secure forensic services. Currently service manager in community forensic services.

Executive summary

This executive summary sets out the key issues emerging from the independent review of the mental health care and management of Mr G, who was convicted of the manslaughter of Beth. She died following an unprovoked knife attack carried out by Mr G.

Before setting down key elements of this report, the independent review team express their condolences to the parents of Beth for the loss of their daughter under such tragic and shocking circumstances. It is important to acknowledge here that the attack was unprovoked and shocked an entire community. Everyone who knew Beth and Mr G was aware of his mental health issues. Following Beth's death, it has become clear that she was concerned, along with friends close to her, that Mr G posed a physical threat to her. A friend reported to this independent review that "one of our last conversations was that [Beth] would become another statistic, of yet another woman killed by her ex-partner". It is not within the scope of this independent process to explore how and why the concerns of near friends and family were either not communicated to, or not heard by, the range of agencies designed to take heed and act on such levels of concern.

The purpose of this independent review was to examine constructively and critically Mr G's mental health management from the time of his GP referral in 2014 to the time of Beth's death and the immediate post-incident assessment in the police cells in September 2019. This is the period agreed by NHS England, the Chair of the Domestic Homicide Review panel, involved agencies, the report author and the advocate for Beth's mother, given that Mr G was referred to local mental health services in 2014 and did not have a notable adult mental health history elsewhere.

Core elements included in the review are:

- Mr G's diagnosis of emotionally unstable personality disorder [EUPD]
- the quality of risk assessments conducted and their associated risk management plans
- Mr G's medication management
- whether or not the mental health service was aware of any domestic abuse risk posed by Mr G and/or domestic abuse issues in relation to him and Beth, and whether it acted on this knowledge
- the extent to which Mr G's family and friends, who acted in a friend/carer capacity, were engaged by the mental health service as partners in his care.

A core purpose of the review process is to deliver a report that facilitates learning and change by identifying necessary improvements in practice, process, quality and safety.

Finally, the independent review was asked to conclude regarding the predictability and preventability of the tragedy that occurred on 12 September 2019.

Conclusion

There were many elements of Mr G's care and management between 2014 and 2019 that met and, at times, exceeded reasonable expectations. However, there are also elements that could and should have been different. The most contentious element is Mr G's diagnosis. The mental health professionals involved do not accept that they missed a diagnosis of psychosis in addition to his EUPD. However, the independent team, based on the evidence it has seen and heard, considers that more careful consideration should have been given to Mr G's presentation and thus diagnosis. There are repeated examples in Mr G's clinical records that are suggestive of psychosis, notably the voice Osiris. Furthermore, information provided by Beth before her death, as well as by one of Mr G's friends, and concerns noted by the probation service in 2015 and 2016 also suggest psychotic elements to his presentation.

Had Mr G received a diagnosis of psychosis during the early period of his contact with adult mental health services, it is difficult to know how that may have impacted on the sequence of events. It is reasonable to conclude that Mr G may have been placed on the enhanced care pathway, making him subject to the Care Programme Approach. This would have resulted in more effective multidisciplinary reviews, longitudinal assessments, and further consideration of his medication management in line with NICE guidance.

The lack of contemplation of an additional diagnosis for Mr G was a significant missed opportunity that may have altered the chronology. Whether this altered chronology would have prevented Beth's tragic death will forever remain a matter of speculation.

The reasons the independent team cannot conclude with any certainty that Beth's death would have been preventable by modifications to Mr G's clinical assessment and management are:

- Mr G was never fully compliant with his prescribed medication and refused to tolerate the relatively mild side effects of the antipsychotics he was being prescribed. It is unlikely therefore that he would have been compliant with medicines that delivered more noticeable side effects.
- At no point was Mr G assessed as lacking capacity.
- At no point between 2014 and September 2019 was Mr G assessed as requiring detention under the Mental Health Act [1983]. He was assessed with a view to detention in August 2019, but the outcome of that assessment was that he was not detainable. Therefore, there was no scope to mandate and enforce treatment. This situation prevailed in the immediate aftermath of Beth's death.

Although the independent consultant psychiatrist has reservations regarding the mental health assessment of Mr G after his attack on Beth, Mr G was assessed in the police cells immediately after Beth's death by two mental health professionals, one of whom was an approved mental health practitioner. He was not considered psychotic and was considered fit to remain in police custody and fit for interview. This assessment therefore must stand. Furthermore, Mr G remained in custody for a month before consideration was given to a possible diagnosis of schizophrenia and the need for him to be cared for in a secure facility.

Regarding the assessment of Mr G's risks, although this was mostly in keeping with the expected local and national standards, there were two elements that deviated. These were in relation to Mr G's domestic abusive behaviour and his decision to carry a knife on his person.

Regarding the issue of keeping a knife nearby for self-protection, there was insufficient violent behaviour in Mr G's history for him to have been assessed as posing a high risk of harm to others. He had no convictions and no forensic history. The only reference to Mr G having a knife in a public place was on 12 September 2019, when he was threatening to harm himself, and had it to his own throat following a police car chase. Although the risk assessment documentation could and should have been more complete, the independent team is satisfied that Mr G's main healthcare professional was aware that Mr G reported hiding a knife at home and he had spoken with, and counselled, Mr G about this risky behaviour. Accepting that keeping a knife near to hand at home is risky behaviour, the independent team does not consider that mental health services could have predicted that Mr G posed a threat to Beth's life. He did not have a history of planning and carrying out acts of physical harm to others. That he is reported to have specifically purchased the weapon used to attack Beth, lain in wait for her and pursued her while she tried to escape has shocked an entire community, including the mental health professionals involved. This act was not predictable based on what was known and understood about him.

Mr G's past abusive behaviour, however, was a different matter. The lack of integration of what was known and what should have been known about Mr G's abusive behaviours towards an ex-girlfriend in 2015 was a serious miss in his risk profile and represents a serious miss in risk management planning and mitigation. It is not possible to say that had this happened, Beth would not have died as she did. However, better risk management practice in respect of domestic abuse presents the most tangible opportunity for a different narrative and therefore the potential for incident avoidance.

After the assessment of Mr G on 15 August 2019 and the Mental Health Act report compiled following this, which determined he was not detainable under the Mental Health Act, the mental health service had a clear duty of care to Beth given the domestic abuse risk Mr G posed to her. This duty encompassed:

- a duty to inform either Beth or another agency about the risk concern
- a duty to counsel Mr G about his behaviour towards Beth, her friends and her family when it was known that his and Beth's relationship had ended, and when he was articulating aggression including violence towards them
- a duty to try to achieve more complete information about any concerning behaviours that may have indicated domestic abuse was, or was becoming, an issue.

Although Mr G was counselled by his health professional about his threatening behaviours, and he was advised to go to the police to set down his own account, following a complaint about him made by Beth, these actions were not taken because of any domestic abuse awareness or concern. There was no situational

awareness in the mental health team of this risk. Therefore, they did not deliver their duty of care to Beth.

As above, it is not possible to determine the potential impact had any of these duties been delivered. However, it is reasonable to suggest that one possible consequence may have been the avoidance of the incident leading to Beth's death, or a mitigation of it.

Recommendations

The independent team is encouraged that the trust has already embarked on a substantial redesign of its approach to risk assessment. Its new approach has been piloted and has received significant support from senior clinicians across the trust. The new approach will help the trust overcome weaknesses in its historical approach, which has attracted criticism in previous independent reports. The trust is also committed to its development of a high-quality personality disorder pathway. Such a pathway would have applied to Mr G. The changes implemented and underway will reduce the likelihood of the modifiable factors in this case being repeated.

The recommendations by the independent team are intended to support the trust in the continuance of these activities and to ensure that they are complete so far as is reasonably practicable.

Recommendation 1: Learning event

The Director of Nursing and Quality at the trust is tasked with organising and facilitating an Oxford Model[1] learning event to ensure that the widest reflection and learning is achieved across adult services from this case.

Recommendation 2: The Care Programme Approach and care pathways

1: The trust must determine the extent to which there is a gap in service provision for those service users meeting Care Programme Approach criteria, to ensure that it is aware of its risk management position in relation to this gap, and to have a clear plan for mitigating its impact.

2: For all service users identified as meeting Care Programme Approach criteria, the trust must ensure that there is an auditable and defendable approach to determining which of them are accepted onto the Care Programme Approach as a matter of priority once capacity is released.

3: The trust has implemented a complex case forum, and other initiatives, for service users who may meet the threshold for enhanced care but cannot be accommodated on the enhanced care pathway, as well as service users who are presenting as more complex than the Core team can accommodate. The trust must audit the usage and effectiveness of the safety nets provided and provide assurance that the avenues to achieve a more enhanced and intensive package of support are being used as

[1] https://www.cambridge.org/core/journals/psychiatric-bulletin/article/six-years-experience-in-oxford/74A72AD39CBD0AC2F4A0958EF7059EDF

intended and to identify those service users for whom an enhanced care package must be achieved.

4: Where it is identified clinically that enhanced care must be delivered to a service user and the range of safety nets is not sufficient to deliver an effective or safe package of care, there must be tangible and measurable steps in the care pathway design to enable this to be escalated via the trust's risk/patient safety committees and brought to the attention of the commissioners.

5: The trust board should receive quarterly reports detailing the number of adult service users who meet the threshold for the Care Programme Approach but are not receiving this level of care package and explaining why not. Assurance regarding the delivery of safe and effective care will also be required.

Recommendation 3: Risk assessment

The development team for the trust's revised approach to risk assessment and the trust's Safeguarding Lead are tasked with ensuring that:

1: The revised FIRM model facilitates the consistent capture and consideration of information relating to the spectrum of domestic abuse [emotional, psychological, financial, physical]. This must encompass risk posed by the service user to others, not only risks to the service user. Reasonable expectations are that assessed risk will include known episodes of police and/or probation involvement in relation to such behaviours. A reasonable expectation is that the risk assessment process will triangulate what a service user reveals with these agencies where it is clear that the service user has had contact/involvement with them.

2: Information captured via FIRM that highlights safeguarding concerns for adults, adults at risk and vulnerable adults, such as domestic abuse, should trigger a force-field alert for the assessing professional to consider whether a referral to adult safeguarding, or a domestic abuse agency, is necessary. If it is determined that no action is required, the system must require the professional to record their rationale for this.

Recommendation 4: Carer's assessments

A situation must be achieved where individuals/informal carers providing significant emotional, physical, or day-to-day living support to a service user are routinely offered a carer's assessment, and are provided with a carer's passport, by the team responsible for the care and management of the service user.

Appendix C: Chronology of Key Events

Table 6 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 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

Date	Event
	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 partners behaviour. Bethany was given advice about available services including MARAC and safety planning.
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.

Date	Event
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.
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.

Date	Event
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.
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.

Date	Event
	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.
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.

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

Appendix D: Domestic Abuse Act 2021 – Definition of domestic abuse

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

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

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

(b) the behaviour is abusive.

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

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

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

(e) psychological, emotional or other abuse

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

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

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

(b) obtain goods or services

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

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

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

Section 2: Definition of "personally connected"

(1) Two people are "personally connected" to each other if any of the following applies —

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

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

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

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

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

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

(g) they are relatives

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

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

(b) the person has parental responsibility for the child

(3) In this section —

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

Section 3: Children as victims of domestic abuse

(1) This section applies where behaviour of a person ("A") towards another person ("B") is domestic abuse.

(2) Any reference in this Act to a victim of domestic abuse includes a reference to a child who –

(a) sees or hears, or experiences the effect of, the abuse, and

(b) is related to A or B.

(3) A child is related to a person for the purposes of subsection (2) if –

(a) the person is a parent of, or has parental responsibility for, the child, or

(b) the child and the person are relatives.

(4) In this section –

- "child" means person under the age of 18 years
- "parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act)
- "relative" has the meaning given by section 63(1) of the Family Law Act 1996

Appendix E: Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[61]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

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

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;

[61] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix F: Action Plans

West Yorkshire Police

Table 7 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 advice and guidance documents. 3. A series of online workshops and training	June 2023	Action completed - This was 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
					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 grading. This review	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.				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 serious by taking into		Completed. Domestic Abuse DI's are embedding this recommendation through dip sampling and further training.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					account the history and bigger picture. Compliance checks will be maintained through thematic domestic abuse audits		
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. •Communicating with the other Police Force,	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
					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 purpose or needs to be updated or replaced with new guidance on safeguarding interventions.	Local	To review framework and determine if further analytical tools are required	West Yorkshire Police	The Power BI tool has been developed to capture live time information on domestic 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	December 2021	Completed as part of a programme of 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
					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-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		

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					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 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.		

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
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. 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	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 crime recording rules

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					occurrences pushed to Niche at first point of contact.		
9	West Yorkshire Police to review the Domestic Abuse Policy to encompass the appropriate response to non-immediate reports of domestic abuse [dealing with reports of domestic abuse by appointment].	Local	To develop new mechanisms to improve response time to non-immediate DA reports	West Yorkshire Police	The Investigations Review team led on a pilot to use a DA 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	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
					evaluated and a further pilot has commenced in 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 a victim's call		

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					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 8 Leeds CCG 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 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	Local		Leeds Health and Care Partnership	Recommendation shared with practice managers and safeguarding leads 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		Recommendation and all key milestones 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

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
12	NHS Leeds CCG will develop and send a learning briefing out to all GP practices highlighting the recommendation detailed above	Local		Leeds Health and Care Partnership	Leeds GGC produced and disseminated learning briefings that include recording information accurately, including 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		Recommendation and all key milestones achieved by March 2020

Leeds Domestic Violence Service [LDVS]

Table 9 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	troduction of case work onitoring 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
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 10 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 term work clients	PDAP	Consultation with staff currently taking place to improve induction and training plans. Monthly case audits in place for our triage service that specifically looks at initial engagement attempts	Jan 2023 Quarterly	Complete – a new learning and development programme for staff is being implement across the organisation. Complete – regular auditing 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 &	PDAP	Quarterly auditing in place across services Review auditing processes with management team	Quarterly Oct 22	Completed 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
			short term work is included in auditing				
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 values being pro-active and responsive.	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
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 11 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: 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.)	July 22	July 22 - arrangements running smoothly. 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	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.

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			maintain best practice.		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 & associates, family & significant others, and social inclusion. Includes mentoring service, with		Good use of Ingeus 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
					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 Mental Health and continue to drive forward innovation, service development and sustaining good links for community partners in Kirklees.	local	Probation Service to work with police to refresh membership and focus of this group, in line with	Probation Service	Group co-chaired by IOM Police Sergeant and Senior Probation Officer of Community Integration Team. Well attended by most partners but still need a representative from mental health. To be	September 2022 and ongoing.	September 2022. Terms of reference refreshed. Multi-agency action plan agreed 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
			Kirklees Communities Plan and Probation Reducing Reoffending Plan.		progressed in meeting with SWYT General Manager re action 2.		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 embed understanding of all quality standards. 2 Senior Probation Officers take lead in managing transfers and 2	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
					take lead in case allocations, to provide closer oversight.		

North Kirklees CCG: Now part of West Yorkshire Integrated Board

Table 12 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 domestic abuse issues are identified.	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 Revisited in March 2022 with a further briefing on 'Caring Responsibilities'	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
						Briefing paper on Bethany DHR to share learning, again revisiting caring responsibilities. 0	
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
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	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	December 2020	November 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
	who may have caring responsibilities, specifically when complex mental health issues, substance misuse and domestic abuse issues are identified.				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.		

DHR Panel

Table 13 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	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

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	delivery of their action plans including the implementation of the NHS Mental Health Homicide Review and the IOPC investigation.						
31	Within 12 months of Kirklees Communities 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	Local	The DHR Standing panel will host an audit style event for agencies to submit evidence of progress in implementing recommendations	Communities Service	May 2023 – challenge event scheduled to allow the DHR panel, 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	November 2023	Complete – a challenge event 2023 highlighted how 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.				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.		
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 evidence of reflective practice; and identifies areas of good practice and improvement for	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
					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 - 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	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
					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 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.	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 Monitoring of requests/ disclosures and work with targeted agencies to improve		Jan-23 - West Yorkshire Police reviewed DVDS information available to the public Monthly oversight of DVDS requests/ disclosures and targeted work to 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	July 23	Complete and will continue to be embedded. Kirklees has the highest rate of DVDS disclosures in West Yorkshire
35	That West Yorkshire Police review it policies and practices around identifying and responding to serial	Local	Review existing policies and practices for	West Yorkshire Police	June 2022 - new domestic abuse specific Integrated Offender Managers in place to	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
	perpetrators of domestic abuse.		serial perpetrators of domestic abuse Consider multi-agency arrangements for responding to serial perpetrators		manage serial/repeat DA perpetrators in the community. IOM coordinate regular multi-agency meetings to identify and manage risk 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	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
			tech abuse related support		Safeguarding Children Partnership website Kirklees Council pages have been updated		