East Riding COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

## 'Elizabeth'

Date of death: July 2022

EXECUTIVE SUMMARY

March 2025

Chair and Author: Carol Ellwood-Clarke QPM
Support to Chair and Author: Ged McManus

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## 1. The Review Process

1.1 This summary outlines the process undertaken by East Riding Community Safety Partnership [the statutory Crime and Disorder Partnership] in reviewing the death of 'Elizabeth', who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator, and children.

| Name | Relationship | Age | Ethnicity |
|---|---|---|---|
| Elizabeth | Victim | 37 | White British female |
| Paul | Perpetrator | 46 | White British male |
| Ira | Child of Victim | Secondary school age | White British |
| Taylor | Child of Victim | Secondary school age | White British |
| Lee | Child of Perpetrator | Secondary school age | White British |

1.3 Elizabeth and Paul had been in a relationship since 2015. Both had children from previous relationships. In March 2018, Paul moved from York, North Yorkshire into a property in Beverley, East Riding of Yorkshire. In 2019, Elizabeth moved to Beverley to live with Paul.

1.4 Elizabeth and EP1[1] shared care of Taylor until around 2020, after which Taylor then lived with their Father (EP1). Elizabeth and a former partner, EP2[2], shared the care of Elizabeth's youngest child, Ira. Paul's child, Lee, lived with their Mother, (PP1), during the week and stayed with Paul on weekends and during other agreed times.

1.5 In July 2022, the police attended at Paul's address. Elizabeth was found with multiple stab wounds and a serious head injury. Elizabeth was taken by ambulance to hospital, where

[1] Pseudonym for Elizabeth's former partner and father of Taylor. [2] Pseudonym for Elizabeht's former partner and father of Ira.

she later died from her injuries. Elizabeth's youngest child and Paul's child were present at the address when the police arrived. The criminal investigation established that they had not witnessed the murder.

1.6 A Home Office post-mortem determined that Elizabeth died as a result of:

1a – Hypovolemic shock (blood loss)

1b – Multiple stab wounds

2 – Blunt force trauma

1.7 After Elizabeth's murder, Paul was involved in a road traffic collision in which he sustained serious injuries. Paul died at the scene of the collision. The police investigation established that the collision occurred when Paul deliberately drove into the path of another vehicle. The driver of that vehicle sustained life-changing injuries.

1.8 The first meeting of the DHR panel was held on 11 May 2023. Thereafter five further meetings were held, and a draft report written. The Review Panel met using online and face-to-face meetings.

1.9 The final overview report was agreed by East Riding Community Safety Partnership on 1 July 2024.

## 2. Contributors to the review

2.1 Contributors to the review/agencies submitting Independent Management Reviews (IMRs).

| Agency | IMR | Chronology | Report |
|---|---|---|---|
| North Yorkshire Police | | | |
| City of York Children's Social Care | | | |
| City of York Education | | | |
| IDAS[2] | | | |
| York Health and Care Partnership | | | |
| York and Scarborough NHS Foundation Trust | | | |
| Healthy Child Service – City of York Council | | | |
| East Riding of Yorkshire Health and Care Partnership | | | |
| East Riding Children's Social Care | | | |
| City of York – Housing Options | | | |
| | | | |

[2] https://idas.org.uk/

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

## 3. Review Panel Members

3.1 The Review Panel Members were:

| **Review Panel Members** | | |
|---|---|---|
| **Name** | **Job Title** | **Organisation** |
| Dr. Elisabeth Alton | Named Doctor Safeguarding Adults, North Lincolnshire Health and Care Partnership and East Riding Health and Care Partnership | NHS and North Yorkshire Integrated Care Board (ICB)<br><br>Humber and North Yorkshire Health and Care Partnership |
| Vicky Anderson | Area Manager | York and North Yorkshire IDAS |
| Joanne Atkinson | Team Manager | Domestic Violence and |

| | | |
|---|---|---|
| | | Abuse Partnership[3] |
| Nicki Bloor | Communities Manager | East Riding of Yorkshire Council |
| Jemma Cormack | Safeguarding Manager | North Yorkshire Police |
| Carol Ellwood-Clarke | Independent Chair and Author | |
| Shelley Goodinson | Domestic Abuse and Safeguarding Partnerships Manager | East Riding of Yorkshire Council |
| Jess Markwart | Head of Service MASH, Assessment and Targeted Intervention | City of York Children's Social Care |
| Ged McManus | Support to Chair and Author | |
| Rachel Parsons | Community Safety Partnership Administrator | East Riding of Yorkshire Community Safety Partnership |
| Christine Pearson | Designated Nurse Safeguarding Adults | Humber and North Yorkshire Integrated Care Board, York Health and Care Partnership |
| Catherine Slaughter | Detective Inspector | Humberside Police |
| Maxine Squire | Assistant Director, Education and Skills | City of York |
| Matthew Temperton | Community Safety Partnership Manager | East Riding of Yorkshire Community Safety Partnership |

3.2 The Panel Chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

[3] The Domestic Violence and Abuse Partnership is a confidential service supporting victims of domestic abuse and providing services dedicated to preventing domestic abuse.

## 4. Chair and Author of the Overview Report

4.1 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.

4.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – Humberside Police) in 2017, after 30 years' service. Humberside Police are a contributor to this review. The commissioners of the review were satisfied of her independence, given the length of time since she had any involvement with Humberside Police. Prior to leaving the police, she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to safeguarding and family liaison. In addition, she is an Associate Trainer for SafeLives.[4]

4.3 Carol was supported in her role by Ged McManus. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in East Riding of Yorkshire or an adjoining authority). Ged served for over 30 years in different police services (not in Humberside Police or North Yorkshire Police) in England. Prior to leaving the police service in 2016, he was a Superintendent with particular

responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

4.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have both completed accredited training for DHR Chairs, provided by AAFDA.

[4] https://safelives.org.uk/

## 5. Terms of reference

5.1 These were set as -

**The purpose of a DHR is to**:

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

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

- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

- 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;

- contribute to a better understanding of the nature of domestic violence and abuse; and

- highlight good practice.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

## 5.2 Specific Terms

1. What indicators of domestic abuse were your agency aware of that could have identified Elizabeth as a victim of domestic abuse, and what was the response?

2. What knowledge was your agency aware of that indicated Paul might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Paul?

3. How did your agency assess the level of risk faced by Elizabeth? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. How effective was inter-agency information sharing and cooperation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider crossborder information sharing.

5. How did your agency assess the impact of the domestic abuse on the children, and what was your response?

**6.** How did your agency capture the voice of the children, including their wishes and feelings, in relation to their lived experiences? Did your agency experience any barriers in gathering this information?

**7.** How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Elizabeth and Paul?

**8.** What services did your agency provide for Elizabeth and/or Paul; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

**9.** When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions?

**10.** Were the subjects of the review signposted to other agencies, and how accessible were these services to the subjects? Were there any barriers that may have prevented access and/or engagement with services?

**11.** What action has your agency undertaken to raise awareness of services available to victims of domestic violence and abuse?

**12.** Were single and multi-agency policies and procedures followed, including the MARAC? Are the procedures embedded in practice, and were any gaps identified?

**13.** Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.

**14.** What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?

**15.** Are there any examples of outstanding or innovative practice arising from this review?

**16.** What learning has emerged for your agency?

**17.** Does this learning appear in other Domestic Homicide Reviews commissioned by East Riding of Yorkshire Community Safety Partnership?

5.3 **Timescale**

The covers the period from 1 February 2014 to the date of Elizabeth's murder in July 2022. The start date was chosen to capture relevant information held by agencies in North Yorkshire in relation to the subjects of the review, which was prior to the start of Elizabeth and Paul's relationship. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

## 6. Summary Chronology

### 6.1 Elizabeth

6.1.1 Elizabeth was the oldest of three children born to her mother. Her father died when Elizabeth was seven years old. Elizabeth achieved good academic grades, including A Levels in Media Studies, Theatre Studies, and Psychology. Elizabeth went to university to study English and Drama.

6.1.2 After leaving university, Elizabeth worked in local retail outlets in York.

6.1.3 Elizabeth had two children, Taylor and Ira, to EP1 and EP2, respectively. Custody of the children was shared with their respective fathers.

### 6.2 Paul

6.2.1 Paul was the youngest of two children, born to his parents. Paul attended mainstream schools in York. Paul had been close to his paternal grandmother, who died whilst he was at secondary school. It was reported that Paul took her death badly, and his school work suffered.

6.2.2 After leaving school, Paul started on an Art and Design course, but left this after six months. Paul then started to work on making stage props and models for museums. Paul completed an evening course and qualified as a personal trainer and sports masseur.

6.2.3 Paul worked at a local stadium as a sports masseur, before setting up his own business in York.

### 6.3 Elizabeth and Paul's relationship

6.3.1 Paul met Elizabeth online in December 2015. Elizabeth's mother stated that they seemed very happy. Elizabeth had a good relationship with Paul's family. In 2018, Paul purchased a house and moved to Beverley, East Riding of Yorkshire.

6.3.2 In 2019, Elizabeth moved to Beverley to live with Paul. Elizabeth continued to commute to York for work. After moving to Beverley, Elizabeth was offered a place at university to study Physics.

6.3.3 In the month prior to Elizabeth's murder, Elizabeth and Paul became engaged. The date of the engagement was Paul's birthday.

6.3.4 The exact timeline of when relationships (described within this review) ended and new relationships started is unknown. It is highly likely that there was some crossover in the relationships that Paul had with PP1 and Elizabeth.

## 6.4 The Children

6.4.1 Elizabeth had two children, Taylor and Ira. Elizabeth and EP1 shared care of Taylor until around 2020, after which Taylor then lived with their Father. Elizabeth and EP2 shared the care of Ira.

6.4.2 Elizabeth had not had contact with Taylor several years prior to her murder. Information provided to the review, documented that Taylor had lived with their father since 2010 and had limited contacted after this time.

6.4.3 Paul had a child, Lee, from a previous relationship with PP1. Lee stayed with Paul regularly.

## 6.5 Events prior to the timescales of the review

6.5.1 In December 2013, Elizabeth approached Housing Options, City of York.

Elizabeth, Taylor, and Ira were provided with temporary accommodation. There was no mention of domestic abuse during contact with Housing Options.

## 6.6 2014

6.6.1 On 8 February 2014, Elizabeth attended hospital with facial injuries following an assault. Elizabeth told hospital staff that she had been assaulted by an ex-partner. Hospital records identified this person as EP2. Elizabeth sustained bruises to her sternum and neck. Elizabeth was seen by the police but declined to provide the name of the person responsible and stated that she did not want the police to be involved. The hospital and the police submitted a referral to York Children's

Social Care for Taylor and Ira. A DASH was not completed by Health or the police.

6.6.2 York Children's Social Care completed an initial assessment. A social worker spoke with Elizabeth, EP1, and EP2 about the impact of domestic abuse on children. On 13 February, following management oversight, the case was closed. None of the children had been present during the incident. The incident had occurred outside of the home. The social worker completed a referral to IDAS

6.6.3 On 14 February, a health visitor received information about the incident from 8 February. It was documented that Elizabeth was staying in a local hostel. The Review Panel has identified that this was accommodation provided by City of York Housing.

6.6.4 On 20 February, Elizabeth was seen by a health visitor. Elizabeth told the health visitor that she had been placed in a hostel because of domestic

abuse. Elizabeth was informed about local support available through Besom.[5]

6.6.5 On 27 February, a health visitor completed an assessment of Ira's needs.

6.6.6 On 15 April, Elizabeth moved into permanent accommodation provided by City of York Housing. There was no further contact with Housing Options and Support Team.

6.6.7 On 23 June, Elizabeth contacted the police and reported that a burglary had occurred at her house. The police arranged for the locks to be changed. The perpetrator was not identified.

6.6.8 On 5 October, Elizabeth contacted the police and reported that EP2 had assaulted her and taken their child, Ira. Elizabeth and EP2 were not in a relationship at this time. EP2 was arrested by the police and issued with a caution for the assault. A DASH was completed with Elizabeth, and the risk was graded as medium. Elizabeth did not consent for a

[5] https://www.thebesominyork.co.uk/about/
The Besom exists to be a bridge between those who want to give their time, skills, money, or things to those who are in need. The Besom is a national charity with bases all around the country.

referral to IDAS. The police submitted a referral to York Children's Social Care.

6.6.9 York Children's Social Care completed an initial assessment. A social worker spoke with Elizabeth and EP1. Contact was also made with Elizabeth's GP and Ira's nursery. On 14 October, following management oversight, the case was closed. There were no concerns identified, and Elizabeth stated that she did not need further support.

## 6.7 2015

6.7.1 On 2 May, Elizabeth contacted the police and reported that EP2 had tried

to assault her. Elizabeth and EP2 were not in a relationship at this time. Elizabeth had been at EP2's address with their child, Ira, and left the house, leaving Ira asleep. Elizabeth had telephoned the police after she had returned to her own home. The police established that no assault had taken place. Elizabeth asked the police to return Ira to her care. A DASH was not completed.

6.7.2 Sometime during 2015, Elizabeth and Paul's relationship commenced.

## 6.8 2016

6.8.1 On 18 October, Elizabeth telephoned the police and reported concerns over forthcoming child access contact with EP2. The police provided Elizabeth with advice in regards to seeking a court order and asking family or friends to be present or assist with handover of Ira. It was documented on police

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records that a referral would be made to York Children's Social Care. There is no record that this referral was made.

6.8.2 On 21 October, Elizabeth contacted the IDAS helpline for support over child contact issues with EP2. Elizabeth described controlling behaviours during the relationship, and post breakup, with EP2. Elizabeth also disclosed receiving numerous messages the day before from EP2. Elizabeth was provided with advice, including reporting to the police and legal orders. Elizabeth was referred to outreach support.

6.8.3 On 24 October, IDAS telephoned Elizabeth and discussed further support.

6.8.4 On 3 November, the police received an abandoned call from Elizabeth. Contact was made with Elizabeth, who stated that EP2 had been banging on her door but had since left the area. Elizabeth was provided with safety advice.

6.8.5 On 4 November, IDAS held a face-to-face appointment with Elizabeth.

6.8.6 On 4 November, Elizabeth saw a GP and reported feeling stressed, anxious, and struggling to eat and sleep. Elizabeth had attended at her GP on the advice of IDAS. Elizabeth was prescribed antidepressants.

6.8.7 On 5 November, Elizabeth telephoned IDAS helpline to discuss that EP2 had not returned their child. Elizabeth was advised to contact the police. During the call, Elizabeth described assaults that she had suffered during their relationship plus controlling behaviour. Elizabeth disclosed that EP2 had become increasingly difficult after finding out that she had been seeing someone else. On the advice of IDAS, Elizabeth telephoned the police and discussed the child contact. Elizabeth stated that she would ask a family member to check on their child.

6.8.8 On 7 November, Elizabeth telephoned IDAS helpline and reported fears around child contact. Safety advice was provided. A DASH was completed, and the risk was graded as medium.

## 6.9 2017

6.9.1 On 17 February, Elizabeth had a face-to-face appointment with IDAS. Elizabeth stated that she felt unable to be in the same room as EP2, as she found him intimidating. A support and safety plan was completed**.**

6.9.2 On 21 February, Elizabeth telephoned IDAS helpline to discuss issues over child contact. During the call, Elizabeth disclosed that mediation was taking place in the next few days.

6.9.3 On 3 March, Elizabeth had a face-to-face appointment with IDAS. Elizabeth reported positive changes over child contact. IDAS commenced work on domestic abuse awareness.

6.9.4 On 20 October, PP1 telephoned IDAS helpline and asked for support around housing and finances. PP1 was in a relationship with Paul at this time. PP1 stated that Paul had given her notification to leave the property. PP1 reported previous emotional and financial abuse in her relationship with Paul. PP1 was referred to outreach support.

6.9.5 On 3 November, IDAS completed an initial assessment with PP1. PP1 stated that her relationship with Paul had ended after 17 years, and she and their child, Lee, had to vacate the family home. Support and guidance were offered around housing, finances, and legal support. PP1 was provided with the helpline telephone number for further support, and the case was closed.

**6.10 2018**

6.10.1 On 8 March, Paul was recorded in council tax records as residing in Beverley.

6.10.2 On 5 August, Paul contacted the police and reported an incident with his car: whilst it was parked outside Elizabeth's address in York.

**6.11 2019**

6.11.1 No information held.

**6.12 2020**

6.12.1 On 26 March, Elizabeth was recorded in council tax records as residing at Paul's address in Beverley.

6.12.2 In December, Elizabeth and Paul's GP records in York were closed: both later registered with a GP in Beverley.

**6.13 2021**

6.13.1 In September, Elizabeth started a foundation degree course at university.

**6.14 2022**

6.14.1 In April/May, Elizabeth started work at a local pub in Beverley.

**The below information has been taken from statements made as part of the coronial investigation.**

6.14.2 In June, Work Colleague 3 recalled an incident where Paul approached

them in the workplace and asked where Elizabeth was. Paul stated: 'I'm

[redacted] partner, she told me she finished at eleven, where is she?' Paul was told that Elizabeth had already left. Paul stated: 'Ye, I meet her every time she works on a night-time, where is she, why are you lying to me?' Work Colleague 3 described Paul as being quite abrupt and rude. Work Colleague 3 stated that after this incident, Paul was seen a couple of times standing outside the work place with a child, apparently waiting for Elizabeth to end her shift.

6.14.3 On 30 June, Paul and Elizabeth became engaged. After this date, Paul's family stated that Paul and Elizabeth had been looking at wedding venues.

6.14.4 On 1 July, Work Colleague 3 saw Elizabeth and Paul sitting at a table in a pub. Work Colleague 3 described that they appeared to be having a 'heated argument', there was lots of shouting from Paul, and he was waving his arms. Elizabeth was trying to calm things down, and she appeared to be embarrassed and worried and looked uncomfortable. Work Colleague 3 asked a couple of door staff to keep an eye on Elizabeth. Another work colleague told Work Colleague 3 that they had seen Paul screaming at Elizabeth and grabbing/shaking her. Work Colleague 3 approached Elizabeth and Paul and asked if everything was OK. Elizabeth told Work Colleague 3 that everything was fine, and she left with Paul.

6.14.5 The following day, Work Colleague 3 spoke with Elizabeth. Work Colleague 3 told Elizabeth that if she needed to talk, she could talk to them, or she could speak to the Wellbeing Manager.

6.14.6 Throughout July, Paul's father stated that Paul had told him that he had suspicions that Elizabeth had started to become friendly with another male and may have been having an affair. Paul's father told him to ask Elizabeth to leave.

6.14.7 In the weeks prior to her murder, Elizabeth had told Work Colleague 2 that she was 'splitting up' with Paul and that they had agreed to live separate lives but live in the same house because of the children.

## 7. Key issues arising from the review.

**7.1** Knowledge, understanding and recognition of the dynamics of domestic abuse, and in particular coercive control amongst family and friends, and what to do with this knowledge.

**7.2** Opportunities to proactively ask about domestic abuse during health care appointments.

## 8. Conclusion

**8.1** Elizabeth was murdered by Paul. Following Elizabeth's murder, Paul was involved in a traffic collision in which he died, and a driver of another vehicle sustained life changing injuries.

**8.2** Elizabeth and Paul met online. They had been in a relationship for seven years, and both had children from previous relationships. In the three years prior to her murder, Elizabeth moved in to live with Paul. Elizabeth and Paul's children visited and stayed over.

**8.3** Not long after Elizabeth and Paul had started living together, the country was placed under a national lockdown due to the Covid-19 pandemic. When restrictions were lifted, Elizabeth commenced a degree course and gained employment in a local hospitality venue. Elizabeth's youngest child and Paul's child continued to visit their home.

**8.4** Elizabeth and Paul's relationship was not known to agencies. Elizabeth and Paul's contact with agencies was limited to health matters. There were no reports or concerns raised to agencies about domestic abuse.

**8.5** The review covered an eight-year time frame. In addition to changes in legislation, there have been changes to policies and procedures for all agencies, which have addressed the learning identified during their early contacts with Elizabeth and Paul.

**8.6** The review highlighted the complexity of coercive control in terms of recognition and evidence gathering. Furthermore, that how when events are reviewed in their entirety, it can provide a pattern of behaviour that identifies indicators of domestic abuse.

**8.7** Elizabeth's family were involved in the review process. The Review Panel extends its thanks for their contribution to the review.

## 9. Learning

**9.1** The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

| **Learning 1 [Panel recommendation 1]** |
|---|
| **Narrative** |
| The case identified the challenges faced by family and friends who have concerns over the way an individual acts or engages with another person, and that those concerns may not been recognised as an indicator of domestic abuse. |
| **Lesson** |
| Perpetrators who exert coercive control over a victim can do so in a way that individual acts may not be seen as domestic abuse. When those acts are reviewed in their entirety, it can start to identify a pattern of behaviour that is coercive control. Raising awareness on the complexity of coercive control can lead to identification of domestic abuse. |

| **Learning 2 [Panel recommendation 2]** |
|---|
| **Narrative** |
| The review identified opportunities for health professionals to engage in further questioning and exploration, in accordance with NICE guidance, when a potential indicator of domestic abuse had been identified. |
| **Lesson** |
| Compliance with guidance will provide health professionals with the opportunity to identify the presence of domestic abuse, and for appropriate responses and referrals to be undertaken to safeguarding any identified victim. |

## 9.2 Agencies Learning

9.2.1 <u>York Health and Care Partnership</u>

- Coding of domestic abuse in primary care.

- Professional curiosity in further exploring around an individual's presenting issues.
- Recording of the names of individuals – partners, professionals, children, those bringing children to appointments for crossreferencing purposes, and identification of risk factors.

**Actions taken to address this learning –**

- Annual training on domestic abuse.
- Safeguarding lead within each GP practice.
- Coding on domestic abuse cases.
- Links between MARAC process, MARAC co-ordinator, and GP practice.
- Protected Learning Time (PLT)[6] events to share learning from reviews.
- In October 2023, IDAS delivered two workshops to promote their service.
- Implementation of Standing Together – 'Crossing Pathways' project.

9.2.2 York Healthy Child Service

- Recording standards.

**Actions taken to address this learning –**

- Six-weekly caseload supervision for health visitors.
- In 2021, the introduction of safeguarding team and lead safeguarding nurse.
- Annual thematic audits of caseloads, which includes record-keeping.
- Embedded links to other multi-agency review meetings.

9.2.3 East Riding of Yorkshire Health and Care Partnership

- Recording of MARAC and safeguarding information recorded on System 1.

**Actions taken to address this learning –**

- GP practices to set up a 'safeguarding' group on their system so that the information is seen immediately by the relevant personnel within

[6] The Protected Learning Time event is where each GP practice closes for the afternoon for staff to attend an event promoting particular topics of learning.

the practice. This will be discussed at a strategic safeguarding level and, if felt appropriate, rolled out to all practices in the area.

- The GP practice will be informed of the learning from this review in the delivery of a feedback session to ensure that learning can be embedded into practice.

## 10. RECOMMENDATIONS

### 10.1 Panel and Agency Recommendations

10.1.1 Panel Recommendations

| Number | Recommendation |
|---|---|
| 1 | That East Riding Domestic Abuse Partnership produces a document that details the learning on this case – to be then shared to all agencies involved in this review – to disseminate the learning from this case, within their agency, and to raise awareness of the complexity and subtlety when identifying indicators of coercive control. This could be achieved by embedding the learning into a case study, or other form of training materials, and the production of a briefing document. |
| 2 | That East Riding of Yorkshire Health and Care Partnership provides a report to East Riding Community Safety Partnership, detailing how GP practices are embedding selective enquiry into practice, in compliance with NICE guidance – 'Domestic Violence and Abuse: Multi-Agency Working'. |

10.1.2 Agency Recommendations

There were no single agency recommendations arising from this review.

# DOMESTIC HOMICIDE REVIEW

## 'Elizabeth'

Date of death: July 2022

FINAL VERSION

March 2025

Chair and Author: Carol Ellwood-Clarke QPM
Support to Chair and Author: Ged McManus



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## Family Tribute

Elizabeth's family asked for the tribute written by her sister, read at Elizabeth's funeral, to be included in this report.

'Elizabeth

One of my earliest memories is going to the cinema with my sister to see the film Aladdin, it had just come out so we would have been about 6 and 7 at the time. I remember coming out of the cinema with her and we were already arguing about who was going to be princess Jasmine. We loved Disney, watched all the films, we had all the toys and all the merchandise. But Disney was more than just a passing phase for Elizabeth, her love of princesses and everything pink continued into her adult life. I think one of the reasons she loved Disney so much was because she could relate. Take any Disney princess and you'll find something about her that makes her different, a reason why she stands out from the crowd, they are not who you expect them to be. This was Elizabeth. There was something about my sister which was so completely different from anyone else you had ever met. She was totally unique. This is why people fell in love with her; it is why we are all here today to celebrate her life.

Growing up with Elizabeth, as you can imagine, was never boring. I learned early on that my sister was full of mischief. I remember how, after being told repeatedly that she was not allowed a hamster, she somehow secretly accrued, piece by piece, all the necessary equipment and set it up in her wardrobe. The empty cage, all the toys, the water bowl, ready for her new pet. Her plan was discovered before she acquired the hamster, on reflection this was for the best, but on that day, I realised my sister was a genius.

Elizabeth was always testing boundaries, which worked well for me as her younger sister because then I knew where they were and managed to keep myself out of trouble.

This mischievous side is what made Elizabeth so much fun to be around, she wasn't afraid to take risks, and people loved being around her because of how carefree she made them feel. Probably one of her best qualities was her ability to get you in trouble. When she visited me once at University, I had signed us up for one of our formal dinners. By the time the dessert was being served, she managed to start a food fight. I'd never been in trouble before and was utterly mortified but I can still see Elizabeth now, her face covered in lemon meringue pie, cackling with laughter. In the end it was one of my most memorable nights from University. Elizabeth had that ability to make fun out of any situation. She knew that life was short, and because of this she lived her life exactly how she wanted to with no regrets.

But, beneath this wonderfully defiant exterior my sister was one of the most generous people I knew. I think this is something she learned from our mum. When she loved someone, she would do anything for them. A memory that comes

up often within our family was the year she bought so many Christmas presents they literally wouldn't fit in the house. We had to use the garage as temporary overflow car park, another space to try and contain her generosity. If you went out for coffee with her, you'd never be allowed to pay. And god help you if you ever visited the bakery she worked at, you'd come out with a sandwich so full it was impossible to eat, my brother can attest to that.

But, she was generous in other ways too. When I started at secondary school, she took me under her wing and showed me the ropes. Not that I'm convinced she knew them herself, I can still see her clear as day running for the bus with her ankle length pleated skirt and her blonde curls bouncing in her face. And when I had my first heart break, it was Elizabeth who scooped me up and watched Julia Stiles films with me until I was put back together again. She stood up for me, encouraged me to do what I loved and was my biggest cheerleader. I always felt like she was proud to be my sister, she'd tell anyone she could about my achievements. I even remember once on a night out how she accosted a total stranger to tell them my Alevel results. She thought I was the clever one, but in reality, she was smarter than she realised.

Elizabeth's childlike sense of fun and her warm, open generosity were always going to make her a special mum. And she was blessed with two children, Taylor and Alex. I remember going to see Elizabeth not long after Taylor was born, we went to a coffee shop. It was the happiest I had ever seen her.

There was no doubt that my sister's spirit was in her two children. I saw it one year on Boxing Day when the whole family were at our mum's house. Taylor and Alex were just as free spirited and fun loving as Elizabeth was. Though, I did raise a smile when Elizabeth sat Alex on the naughty step, a seat she had practically taken up residence in years before. Elizabeth's unique sense of fun lives on in her children and I hope, more than anything that they continue to have a relationship with Elizabeth even though she is gone.

There is a saying 'listen to anyone long enough and you'll hear their true intentions'. If this is true then the most important thing in my sister's life were her two children. She talked about them all the time, to anyone who would listen. In recent years, my sister and I had not been as close. I moved up to the Lake District and we both got busy with our own lives. But, when I heard from her friend, who worked with her, I could see Elizabeth hadn't lost any of the qualities I loved about her. He told me how much he enjoyed working with her and how much fun they would have playing games like 'hide the llama'. He told me about her inimitable sense of humour, recounting a story about a time she greeted a new starter with the words 'welcome to hell'. He also spoke of how she worked harder than anyone and how when the time came that he needed her, she was there for him. None of this surprised me. Elizabeth worked in quite a few customer-facing roles like this. She was always well liked because of her sense of fun and successful because she had such a strong work ethic. But, she was also always destined for more.

In the last few years, Elizabeth had gone back to school; she recently started at University studying Physics. It seemed like she had finally found what she was always meant to do. She did so well in her first year that she was made a finalist for the Foundation Year Prize. The Head of Physics described her fierce commitment to the pursuit of her dream and also told us about her passion to support and nurture underrepresented groups. She was working with him on some ideas for equality and diversity initiatives. And this was the Elizabeth I knew, her defiant nature which caused so much mischief when we were younger, finally put to use to challenge something of real importance. Whilst she now won't get to see these projects through, that work will continue without her and will carry a little bit of Elizabeth with it.

I will miss Elizabeth most when I watch those Disney films we loved as little girls. Even though she has been taken from us before she could finish her story, she did live her life like the princesses in those fairy tales. When I watch them with my own little girl this is what I will tell her.

Elizabeth was just like princess Jasmine from Aladdin, strong, determined and unafraid to stand up for the people she cared about.

Elizabeth was just like Belle from Beauty and the Beast, her head always buried in a book, far smarter than she knew.

Elizabeth was just like Ariel from the Little Mermaid, a little mischievous but ready to give up everything she had for the person she loved.

And finally, Elizabeth was just like Pocahontas, leaping defiantly from the cliff edge into the waters below, a truly free spirit.

Goodbye to Elizabeth, our sister, our daughter, our mother, and our friend. May she rest in eternal peace'.

1. **INTRODUCTION**

1.1 The Review Panel offers its sincere condolences to Elizabeth's family.

1.2 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported, Elizabeth, a resident of East Riding of Yorkshire, prior to her murder in July 2022. The review follows the principles within the Home Office Domestic Homicide Review statutory guidance (2016).[7]

1.3 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse, 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.

1.4 Elizabeth and Paul had been in a relationship since 2015. Both had children from previous relationships. In March 2018, Paul moved from York, North Yorkshire into a property in Beverley, East Riding of Yorkshire. In 2019, Elizabeth moved to Beverley to live with Paul.

1.5 Elizabeth and EP1[8] shared care of Taylor until around 2020, after which Taylor then lived with their Father (EP1). Elizabeth and a former partner, EP2[3], shared the care of Elizabeth's youngest child, Ira. Paul's child, Lee, lived with their Mother, (PP1), during the week and stayed with Paul on weekends and during other agreed times.

1.6 In July 2022, the police attended at Paul's address. Elizabeth was found with multiple stab wounds and a serious head injury. Elizabeth was taken by ambulance to hospital, where she later died from her injuries. Elizabeth's youngest child and Paul's child were present at the address when the police arrived. The criminal investigation established that they had not witnessed the murder.

1.7 A Home Office post-mortem determined that Elizabeth died as a result of:

1a – Hypovolemic shock (blood loss)

1b – Multiple stab wounds

2 – Blunt force trauma

1.8 After Elizabeth's murder, Paul was involved in a road traffic collision in which he sustained serious injuries. Paul died at the scene of the collision.

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[7] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-StatutoryGuidance161206.pdf

[8] Pseudonym for Elizabeth's former partner and father of Taylor. [3] Pseudonym for Elizabeth's former partner and father of IRA.

The police investigation established that the collision occurred when Paul deliberately drove into the path of another vehicle. The driver of that vehicle sustained life-changing injuries.

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1.9 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.10 It is not the purpose of this DHR to enquire into how Elizabeth died: this is determined through other processes.

## 2. TIMESCALES

2.1 On 26 July 2022, Humberside Police notified East Riding Community Safety Partnership of the murder of Elizabeth. A meeting was held on 23 August 2022, which considered initial information held by agencies across East Riding. This meeting identified the need to gather information from

agencies in North Yorkshire: where the subjects of the review had previously lived and where their children were currently residing.

2.2 On 12 September 2022, a further meeting was held, which considered information known by East Riding of Yorkshire and North Yorkshire. The outcome of the meeting, based on the information provided, was that the case did not reach the criteria for a DHR. On 14 September 2022, the Home Office was notified of the decision.

2.3 On 13 December 2022, the Home Office informed East Riding Community Safety Partnership that the Quality Assurance Panel, in accordance with paragraph 26 Home Office Statutory Guidance, had considered the circumstances of the case and agreed that the case would benefit from a DHR. This decision was made on the basis that the Quality Assurance Panel felt there was a history of domestic abuse known to the victim and perpetrator, in addition to potential information held by family and friends, which would be relevant to a DHR and produce learning; hence, the reason for the extended timeline reviewed and the focus upon previous relationships.

2.4 East Riding Community Safety Partnership considered the correspondence from the Home Office and agreed to undertake a DHR. Work then progressed to commission an Independent Chair.

2.5 The first meeting of the Review Panel took place on 11 May 2023. The Review Panel met using online and face-to-face meetings. In between meetings, contact was maintained with the panel via email and telephone calls. In total, the panel met six times.

2.6 The DHR covers the period from 1 February 2014 to the date of Elizabeth's murder in July 2022. The start date was chosen to capture relevant information held by agencies in North Yorkshire in relation to the subjects of the review, which was prior to the start of Elizabeth and Paul's relationship. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

2.7 The Domestic Homicide Review was presented to East Riding Community Safety Partnership on 1 July 2024, and concluded on 23 Aug 2024 when it was sent to the Home Office.

## 3. CONFIDENTIALITY

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

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim,

perpetrator, and children: these were identified by the panel and agreed by the victim's family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

| Name | Relationship | Age | Ethnicity |
|---|---|---|---|
| Elizabeth | Victim | 37 | White British female |
| Paul | Perpetrator | 46 | White British male |
| Ira | Child of Victim | Secondary school age | White British |
| Taylor | Child of Victim | Secondary school age | White British |
| Lee | Child of Perpetrator | Secondary school age | White British |

## 4. TERMS OF REFERENCE

4.1 The Review Panel settled on the following Terms of Reference at its first panel meeting on 11 May 2023.

4.2 **The purpose of a DHR is to**:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local Professionals and organisations work individually and together to safeguard victims;

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

- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

- 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;

- contribute to a better understanding of the nature of domestic violence and abuse; and

- highlight good practice.
  (Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

4.3 **Specific Terms**

1. What indicators of domestic abuse were your agency aware of that could have identified Elizabeth as a victim of domestic abuse, and what was the response?

2. What knowledge was your agency aware of that indicated Paul might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Paul?

3. How did your agency assess the level of risk faced by Elizabeth? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. How effective was inter-agency information sharing and cooperation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider crossborder information sharing.

5. How did your agency assess the impact of the domestic abuse on the children, and what was your response?

6. How did your agency capture the voice of the children, including their wishes and feelings, in relation to their lived experiences? Did your agency experience any barriers in gathering this information?

7. How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Elizabeth and Paul?

8. What services did your agency provide for Elizabeth and/or Paul; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

9. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions?

10. Were the subjects of the review signposted to other agencies, and how accessible were these services to the subjects? Were there any barriers that may have prevented access and/or engagement with services?

11. What action has your agency undertaken to raise awareness of services available to victims of domestic violence and abuse?

12. Were single and multi-agency policies and procedures followed, including the MARAC? Are the procedures embedded in practice, and were any gaps identified?

13. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.

14. What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?

15. Are there any examples of outstanding or innovative practice arising from this review?

16. What learning has emerged for your agency?

17. Does this learning appear in other Domestic Homicide Reviews commissioned by East Riding of Yorkshire Community Safety Partnership?

## 5. METHOD

5.1 On 16 March 2023, Carol Ellwood-Clarke was appointed as the Independent Chair and Author for the review; she was supported in her role by Ged McManus. There was a delay in the review starting, as detailed in Section 2.

5.2 The first meeting of the Review Panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews (IMR)[9]: the other agencies were asked to produce short reports. The Chair provided training to Individual Management Review authors, to assist in the completion of the written reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information was sought.

5.4 The Chair liaised with the panel members to identify family members or friends to help inform the DHR process. Engagement with family and friends is covered within Section 6.

5.5 H.M. Coroner for East Riding of Yorkshire and Hull provided access to information gathered as part of the coronial investigation. This has been captured in the report where relevant.

5.6 Thereafter, a draft overview report was produced that was discussed and refined at panel meetings before being agreed. The draft report was shared with Elizabeth's family, who were invited to make any additional contributions or corrections. The family declined to attend a panel meeting.

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

### Elizabeth's Family

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

6.1 The Chair of the review was introduced to Elizabeth's mother by her Victim Support Homicide Worker. The Chair held an initial meeting online to introduce herself and explain the purpose of the review. The Chair shared the Terms of Reference and agreed timescales for the completion of the review.

6.2 The Chair visited Elizabeth's mother in person. The Victim Support Homicide Worker was present during the meeting. Elizabeth's mother provided the Chair with valuable information, which has been captured in the report where relevant.

**Elizabeth's Former Partner (referred throughout the report as EP1)**

6.3 The Chair wrote to EP1, who is the father of Taylor (Elizabeth's eldest child). The Chair informed him of the purpose of the review and included the Home Office DHR leaflet for families.

6.4 EP1 informed the Chair that he did not want to engage in the review process and did not want any contact to be made with any member of his family. EP1 stated that Taylor had not had any contact with Elizabeth since around 2020. The Review Panel accepted the view of EP1 and made no contact with Taylor, either directly or through any professional working with them.

**Elizabeth's Former Partner (referred throughout the report as EP2)**

6.5 The Chair wrote to EP2, who is the father of Ira (Elizabeth's youngest child). The Chair informed him of the purpose of the review and included the Home Office DHR leaflet for families.

6.6 EP2 agreed to be contacted. The Chair spoke with EP2, who provided information for the review. The information focused on Ira's contact with Elizabeth, and information about when they stayed with Elizabeth and Paul. This has been captured in the report where relevant.

6.7 EP2 did not agree for direct contact to be made with Ira, either by the Chair or through another professional working with them. The Review Panel respected EP2's wishes.

**<u>Children</u>**

6.8 None of the children were seen or spoken to as part of the review process, in accordance with the wishes of their parents.

6.9 All of the children were in receipt of bereavement and emotional support. The Review Panel recognised that not engaging with the children could be a potential barrier to gather information and identify learning; however, the Review Panel agreed that the children's welfare was their primary concern.

6.10 The Review Panel reflected on how they could capture any information known by the children to inform the review, as none of the children were spoken to, nor information gathered, by the police as part of their investigations. The panel member from City of York Children's Social Care informed the Review Panel that work by a social worker had been undertaken with the children after the murder of Elizabeth, which captured the children's wishes, feelings, and information. It was agreed that this information would be released to the DHR to inform the review process.

## Paul's Family

### Paul's Former Partner (referred throughout the report as PP1)

6.11 The Chair spoke to PP1. PP1 had been in a relationship with Paul for over 17 years. The relationship started prior to 2000 and ended around 2014/2015, when Paul started a relationship with Elizabeth. PP1 is the mother of Paul's only child, Lee.

6.12 PP1 told the Chair about their living and financial arrangements with Paul. PP1 stated that she moved into Paul's house in 2006, and they remained living as a couple until the end of the relationship. During this nine-year period, PP1 described how Paul had told her that she was not allowed to have her name on any of the utility bills, including the mortgage. PP1 stated that they did not have a joint bank account, that Paul paid for all the household bills, and that she had to pay him cash for her 'share' of these bills. PP1 stated that she was not allowed to send money via bank transfers, as Paul had told her that he did not want any record of her link to the house.

6.13 PP1 stated that she bought the food for the house, but this had to be paid for in cash. PP1 stated that if she wanted to buy goods (other than food or toiletries) for the house, such as furniture and furnishings, she had to show Paul what these were. He would then buy them, putting his name on any warranty, and then she would pay him in cash for the item.

6.14 PP1 described that when the relationship ended, she had returned to the home after work and found a letter from a solicitor advising her that she had 28 days in which to find alternative accommodation and leave the house with their child, Lee.

6.15 PP1 stated that Paul was never physically abusive towards her, but he would shout and raise his voice. PP1 stated that there was not a door or

wall in the house that did not have a 'punch' mark that had been caused by Paul when he had been arguing. PP1 provided further information about their relationship, which has been captured throughout the report.

**The following information has been gathered from statements gathered as part of the coronial investigation: it has been provided to the review with the consent of H.M. Coroner. The Chair did not speak to anyone who had provided these statements due to the coronial processes that were taking place at the time of the DHR.**

**The Review Panel acknowledges that some of the below information could be seen as 'victim blaming' but have included this in the report to gather contextual information.**

**Paul's Parents**

6.16 Paul's mother stated that Paul was besotted with Elizabeth and that he would do everything around the house for Elizabeth, including cooking, cleaning, and looking after the children. Paul's mother described that Paul was always buying Elizabeth gifts and spoiling her.

6.17 Paul's mother described a change in Elizabeth after she had gained employment, insomuch as that she was not as attentive towards Paul, and it seemed as if she was becoming distant. Paul's mother stated that this had put a strain on their relationship.

6.18 Paul's father stated that around June/July 2022, Paul had told him about concerns about his relationship with Elizabeth. Paul said that Elizabeth may have started becoming friendly towards another male. Paul's father stated how Paul had told him that Elizabeth was always on her phone, laughing and giggling. Paul's father stated that he had told Paul to ask Elizabeth to leave, but Paul had told his father that he loved her.

6.19 Following access to the report, Elizabeth's family asked for the review to record their disappointment at the 'hearsay' evidence listed at 6.16 – 6.18 and further entries being included in the report.

**<u>Work Colleagues</u>**

**Work Colleague 1**

6.19 Work Colleague 1 had known Elizabeth for a couple of months and described Elizabeth as a lovely girl, who was a quiet girl but chatty when she wanted to be. Work Colleague 1 stated that everyone got on well with Elizabeth, and that they did not know anyone who had a bad word to say about her.

6.20 Work Colleague 1 stated that Elizabeth was a totally different person outside of work and that she was happy when she was in work. Work Colleague felt that Elizabeth did not want to go home and would always find an excuse to stay at work, where it felt to Work Colleague 1 that Elizabeth could have more fun.

**Work Colleague 2**

6.21 Work Colleague 2 had known Elizabeth since she started work around April/May 2022. They described Elizabeth as being unhappy in her relationship with Paul. Elizabeth had described Paul as being very jealous, and that if they were out together and anybody looked at her, then Paul would go mad.

Work Colleague 2 stated that Elizabeth would come to work and say that Paul and herself had had a fight (this was not expanded on further). Work Colleague 2 had formed the impression that Paul did not like Elizabeth going to work.

**Work Colleague 3**

6.22 Work Colleague 3 was an assistant manager at Elizabeth's place of work. Elizabeth was described as a bubbly person, who could also be quiet. Elizabeth carried out her work tasks with little fuss but was fairly private; therefore, Work Colleague 3 did not know much about her personal life.

**University**

6.23 The Chair spoke to the Head of Physics Department at the university attended by Elizabeth. The Head of Physics has responsibility for outreach and engagement, which includes work to improve the engagement and representation from diverse communities within the world of physics. In early 2022, Elizabeth had worked with the Head of Physics as part of a small group of students to develop strategies and processes on engagement with diverse members of the community. The Head of Physics described Elizabeth as an active and valued member of the university and work stream.

6.24 The Chair was informed that within the university there is an active student wellbeing unit that promotes all areas of support, including domestic abuse. The university has a dedicated website and has undertaken an extensive campaign (through various methods of communication) to raise awareness of support, both at the university and locally.

6.25 Paul had been self-employed for many years; therefore, there was no employer or work colleagues for the Chair to contact.

## 7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

| Agency | IMR | Chronology | Report |
|---|---|---|---|
| North Yorkshire Police | | | |
| City of York Children's Social Care | | | |
| City of York Education | | | |

| | | | |
|---|---|---|---|
| IDAS[10] | | | |
| York Health and Care Partnership | | | |
| York and Scarborough NHS Foundation Trust | | | |
| Healthy Child Service – City of York Council | | | |
| East Riding of Yorkshire Health and Care Partnership | | | |
| East Riding Children's Social Care | | | |
| City of York – Housing Options | | | |
| | | | |

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 The following agencies were written to, as part of the review process, but held no information:

East Riding of Yorkshire

- Adult Social Care
- Humberside Police
- Domestic Violence and Abuse Partnership (DVAP)[11]
- Housing
- Probation
- Humber University Teaching Hospital Trust
- Humber NHS Foundation Trust

[10] https://idas.org.uk/

[11] https://www.eastriding.gov.uk/living/crime-and-community-safety/domestic-violence/domestic-violenceadultservices/

North Yorkshire

- Adult Social Care
- Probation

7.4 Below is a summary of contributors to the review:

7.4.1 **North Yorkshire Police**

North Yorkshire Police is the territorial police force covering the unitary authorities of North Yorkshire and the City of York in northern England.

7.4.2 **City of York – Children's Social Care**

Children's services are responsible for supporting and protecting vulnerable children. This includes providing children and their families with extra help.

7.4.3 **City of York – Education**

City of York Council provides a range of education support services to schools and academies to discharge statutory duties to ensure that children and young people are able to access high quality education in the local area and to promote the well-being of children and young people. This

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includes providing advisory support on safeguarding duties, outlined in Keeping Children Safe in Education statutory guidance.

7.4.4 **IDAS**

IDAS is the largest specialist charity in the North, supporting people affected by domestic abuse and sexual violence. IDAS provides services in the community for anyone subjected to domestic abuse, irrespective of their age, sex, gender identity, ethnicity, disability, or immigration status.

7.4.5 **York Health and Care Partnership**

The Health and Care Act 2022 placed the Integrated Care Board (ICB) and Integrated Care Systems (ICS) onto a statutory footing from 1 July 2022. The Humber and North Yorkshire ICB brings together six former Clinical Commissioning Groups (CCGs) from across the Humber and North Yorkshire region. The six former CCG teams now work at place in Health and Care Partnerships, the borders of which are the local authority areas. York Health and Care Partnership is the system of organisations that are responsible for planning, paying for, and providing health and care services for the population of York: this includes primary care and general practice services.

### 7.4.6 York and Scarborough NHS Foundation Trust

York and Scarborough Teaching Hospitals NHS Foundation Trust provides services for a population of around 800,000 people living in and around York, North Yorkshire, North East Yorkshire, and Ryedale.

### 7.4.7 East Riding of Yorkshire Health and Care Partnership

Primary care serves all members of the community and looks after any medical need, be that physical or psychological, as well as being aware of social needs of their patients.

### 7.4.8 East Riding of Yorkshire – Children's Social Care

Children's services are responsible for supporting and protecting vulnerable children. This includes providing children and their families with extra help.

### 7.4.9 City of York – Housing Options

The Housing Options Team provides advice on any matters related to housing, including for people who are homeless or people threatened with homelessness.

### 7.4.10 Healthy Child Service – City of York Council

In 2014, health visiting services were provided via York Teaching Hospitals NHS Foundation Trust. The majority of services were provided on a locality basis. In 2017, the provision of health visiting services, as part of the wider Healthy Child Service, moved from York Teaching Hospitals NHS Foundation Trust to City of York Council, where it is located today.

## 8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

| **Review Panel Members** | | |
|---|---|---|
| **Name** | **Job Title** | **Organisation** |
| Dr. Elisabeth Alton | Named Doctor Safeguarding Adults, North Lincolnshire Health and Care Partnership and East Riding Health and Care Partnership | NHS and North Yorkshire Integrated Care Board (ICB)<br><br>Humber and North Yorkshire Health and Care Partnership |
| Vicky Anderson | Area Manager | York and North Yorkshire IDAS |
| Joanne Atkinson | Team Manager | Domestic Violence and Abuse Partnership[12] |
| Nicki Bloor | Communities Manager | East Riding of Yorkshire Council |
| Jemma Cormack | Safeguarding Manager | North Yorkshire Police |
| Carol Ellwood-Clarke | Independent Chair and Author | |
| Shelley Goodinson | Domestic Abuse and Safeguarding Partnerships Manager | East Riding of Yorkshire Council |
| Jess Markwart | Head of Service MASH, Assessment and Targeted Intervention | City of York Children's Social Care |
| Ged McManus | Support to Chair and Author | |

[12] The Domestic Violence and Abuse Partnership is a confidential service supporting victims of domestic abuse and providing services dedicated to preventing domestic abuse.

| | | |
|---|---|---|
| Rachel Parsons | Community Safety Partnership Administrator | East Riding of Yorkshire Community Safety Partnership |
| Christine Pearson | Designated Nurse Safeguarding Adults | Humber and North Yorkshire Integrated Care Board, York Health and Care Partnership |
| Catherine Slaughter | Detective Inspector | Humberside Police |
| Maxine Squire | Assistant Director, Education and Skills | City of York |
| Matthew Temperton | Community Safety Partnership Manager | East Riding of Yorkshire Community Safety Partnership |

8.2 The Chair of East Riding Community Safety Partnership was satisfied that the Review Panel Chair/Author was independent. In turn, the Review Panel Chair believed that there was sufficient independence and expertise on the panel to safely, and impartially, examine the events and prepare an unbiased report.

8.3 The Review Panel met six times, and the circumstances of Elizabeth's murder were considered in detail, with matters freely and robustly considered to ensure all possible learning could be obtained. Panel meetings were held virtually. Outside of the meetings, the Chair's queries were answered promptly via email or telephone call, and in full.

## 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.

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – Humberside Police) in 2017, after 30 years' service. Humberside Police are a contributor to this review. The commissioners of the review were satisfied of her independence, given the length of time since she had any involvement with Humberside Police. Prior to leaving the police, she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to safeguarding and family liaison. In addition, she is an Associate Trainer for SafeLives.[13]

9.3 Carol was supported in her role by Ged McManus. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in East Riding of Yorkshire or an adjoining authority). Ged served for over 30 years in different police services (not in Humberside Police or North Yorkshire Police) in England. Prior to leaving the police service in 2016, he was a Superintendent with particular

[13] https://safelives.org.uk/

responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have both completed accredited training for DHR Chairs, provided by AAFDA.

## 10. PARALLEL REVIEWS

10.1 H.M Coroner for East Riding of Yorkshire and Hull opened and adjourned an inquest. At a later inquest hearing, H.M. Coroner concluded that the cause of Elizabeth's death was: unlawful killing.

10.2 H.M. Coroner for East Riding of Yorkshire and Hull opened and adjourned an inquest in to the death of Paul. At a later inquest hearing, H.M. Coroner concluded that the medical cause of death was –

1a – multiple injuries
1b – road traffic collision

The conclusion of the jury as to the cause of death was recorded as - accident.

10.3 Humberside Police undertook a criminal investigation into the circumstances surrounding the death of Elizabeth and Paul. The findings of these investigations have formed the basis for the coronial processes.

10.4 The review was not aware of any other investigations that have taken place since Elizabeth's murder.

## 11. EQUALITY AND DIVERSITY

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

- **age** [for example an age group would include “over fifties” or twentyone-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or

national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].

- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a 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.[9]

11.3 There is nothing in agency records that indicated that any subjects of the review lacked capacity[10] in accordance with the Mental Capacity Act 2005. Professionals applied the principle of the Mental Capacity Act 2005: ‘A person must be assumed to have capacity unless it is established that he lacks capacity’.

**Elizabeth**

11.4 Elizabeth had limited contact with health professionals. The majority of the contacts were for routine health matters, which are not relevant for the review.

11.5 In November 2016, Elizabeth saw a GP. Elizabeth reported feeling stressed, anxious, and struggling to sleep and eat. Elizabeth stated that these symptoms were due to matters in her personal life with a previous partner (details not recorded) around child access. Elizabeth was prescribed sertraline (antidepressant), with a further appointment to review the medication in 3 – 4 weeks. Elizabeth did not attend the review appointment.

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

[10] The Mental Capacity Act 2005 established the following principles:
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.
Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
(Mental Capacity Act Guidance, Social Care Institute for Excellence)

11.6 Elizabeth had a condition called Ectodermal dysplasia[14] which affected her hearing. Elizabeth did not use hearing aids and was known to lip read. Elizabeth's hearing condition was not commonly known. The Review Panel has seen no evidence that this had an impact on Elizabeth's ability to carry out day to day activities. The Review Panel noted that Elizabeth was able to work in a busy pub/restaurant without any adjustments.

**Paul**

11.7 Paul had limited contact with health professionals. The majority of the contacts were for routine health matters, which are not relevant for the review.

11.8 Towards the end of 2011, Paul was seen by a GP. Paul reported 'low mood' for approximately one year, and cited difficulties in his then relationship. Paul stated that he was separating from his partner. Paul was prescribed antidepressants for a period of four months.

11.9 In March 2021, Paul consulted with a GP about a headache and 'stress'. The stress was not explored. In December 2021, Paul saw a GP regarding multiple minor symptoms. During this contact, Paul described himself as a 'stress-head'. The stress was not explored. Later that month, Paul was seen by a practice nurse. The practice nurse asked Paul about the stress, and he stated that this encompassed both 'work and home'. Paul told the practice nurse that he was coping.

**Children**

[14] Ectodermal dysplasia occurs when the outer layer of tissue (ectoderm) of the embryo does not develop normally. If two or more body structures derived from the ectoderm are affected, a person is considered to have ED. ED is a rare disease, defined in the USA as a condition that affects fewer than 200,000 people.

11.10 All children saw health professionals as part of their routine health appointments and programme of immunisation.

11.11 All subjects of the review are white British nationals. English is their first language.

**Intersectionality**

11.12 **Sex**: Domestic abuse is a gendered crime which is deeply rooted in the societal inequality between men and women. It is a form of gender-based violence. Women are more likely than men to experience multiple incidents of abuse, different types of domestic abuse (intimate partner violence, sexual assault and stalking) and in particular sexual violence. Any woman can experience domestic abuse regardless of race, ethnic or religious group, sexuality, class, or disability, but some women who

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experience other forms of oppression and discrimination may face further barriers to disclosing abuse and finding help.

**Research**

11.13 The number of domestic abuse crimes recorded by the police in England and Wales in the year ending March 2021, increased by 6% – from 798,607 (in the year ending March 2020) to 845,734.[12] This continues the trend of increases seen over previous years.

11.14 Domestic homicide and particularly domestic abuse, are predominantly crimes affecting women – with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

11.15 In November 2022, the Office for National Statistics published the 'Domestic abuse in England and Wales overview'.[13] The following data was recorded:

- 'The Crime Survey for England and Wales (CSEW) estimated that 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).
- 'Approximately 1 in 5 adults aged 16 years and over (10.4 million) had experienced domestic abuse since the age of 16 years.

12 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021

13 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

- 'There was no significant change in the prevalence of domestic abuse experienced by adults aged 16 to 59 years in the last year, compared with the year ending March 2020; a year largely unaffected by the coronavirus (COVID-19) pandemic and the last time the data were collected.
- 'The number of police recorded domestic abuse-related crimes in England and Wales increased by 7.7% compared with the previous year, to 910,980 in the year ending March 2022; this follows increases seen in previous years and may reflect increased reporting by victims.
- 'The Crown Prosecution Service (CPS) domestic abuse-related charging rate in England and Wales increased for the first time in four years to 72.7% in the year ending March 2022 but remains below the year ending March 2018 (75.9%).
- 'The National Domestic Abuse Helpline delivered 50,791 support sessions through phone call or live chat in the year ending March 2022, a similar number to the previous year'.

## 12. DISEMMINATION

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

- The family
- East Riding of Yorkshire Community Safety Partnership
- Safer York Partnership
- All agencies that contributed to the review
- Humberside Police and Crime Commissioner
- North Yorkshire Police and Crime Commissioner
- Domestic Abuse Commissioner

## 13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, information from Elizabeth's family, and information provided for the coronial investigation.

### 13.1 **Elizabeth**

13.1.1 Elizabeth was the oldest of three children born to her mother. Her father died when Elizabeth was seven years old. Elizabeth achieved good

academic grades, including A Levels in Media Studies, Theatre Studies, and Psychology. Elizabeth went to university to study English and Drama.

13.1.2 After leaving university, Elizabeth worked in local retail outlets in York.

13.1.3 Elizabeth had two children, Taylor and Ira, to EP1 and EP2, respectively. Custody of the children was shared with their respective fathers.

13.2 **Paul**

13.2.1 Paul was the youngest of two children, born to his parents. Paul attended mainstream schools in York. Paul had been close to his paternal grandmother, who died whilst he was at secondary school. It was reported that Paul took her death badly, and his school work suffered.

13.2.2 After leaving school, Paul started on an Art and Design course, but left this after six months. Paul then started to work on making stage props and models for museums. Paul completed an evening course and qualified as a personal trainer and sports masseur.

13.2.3 Paul worked at a local stadium as a sports masseur, before setting up his own business in York.

13.3 **Elizabeth and Paul's relationship**

13.3.1 Paul met Elizabeth online in December 2015. Elizabeth's mother stated that they seemed very happy. Elizabeth had a good relationship with Paul's family. In 2018, Paul purchased a house and moved to Beverley, East Riding of Yorkshire.

13.3.2 In 2019, Elizabeth moved to Beverley to live with Paul. Elizabeth continued to commute to York for work. After moving to Beverley, Elizabeth was offered a place at university to study Physics.

13.3.3 In the month prior to Elizabeth's murder, Elizabeth and Paul became engaged. The date of the engagement was Paul's birthday.

13.3.4 The exact timeline of when relationships (described within this review) ended and new relationships started is unknown. It is highly likely that there was some crossover in the relationships that Paul had with PP1 and Elizabeth.

13.4 **The Children**

13.4.1 Elizabeth had two children, Taylor and Ira. Elizabeth and EP1 shared care of Taylor until around 2020, after which Taylor then lived with their Father. Elizabeth and EP2 shared the care of Ira.

13.4.2 Elizabeth had not had contact with Taylor for several years prior to her murder. Information provided to the review, documented that Taylor had lived with their father since 2010 and had limited contacted after this time.

13.4.3 Paul had a child, Lee, from a previous relationship with PP1. Lee stayed with Paul regularly.

## 13.5 Events prior to the timescales of the review

13.5.1 In December 2013, Elizabeth approached Housing Options, City of York. Elizabeth, Taylor, and Ira were provided with temporary accommodation. There was no mention of domestic abuse during contact with Housing Options.

## 13.6 2014

13.6.1 On 8 February 2014, Elizabeth attended hospital with facial injuries following an assault. Elizabeth told hospital staff that she had been assaulted by an ex-partner. Hospital records identified this person as EP2. Elizabeth sustained bruises to her sternum and neck. Elizabeth was seen by the police but declined to provide the name of the person responsible and stated that she did not want the police to be involved. The hospital and the police submitted a referral to York Children's Social Care for Taylor and Ira. A DASH was not completed by Health or the police.

13.6.2 York Children's Social Care completed an initial assessment. A social worker spoke with Elizabeth, EP1, and EP2 about the impact of domestic abuse on children. On 13 February, following management oversight, the case was closed. None of the children had been present during the incident. The incident had occurred outside of the home. The social worker completed a referral to IDAS

13.6.3 On 14 February, a health visitor received information about the incident from 8 February. It was documented that Elizabeth was staying in a local hostel. The Review Panel has identified that this was accommodation provided by City of York Housing.

13.6.4 On 20 February, Elizabeth was seen by a health visitor. Elizabeth told the health visitor that she had been placed in a hostel because of domestic abuse. Elizabeth was informed about local support available through Besom.[15]

13.6.5 On 27 February, a health visitor completed an assessment of Ira's needs.

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[15] https://www.thebesominyork.co.uk/about/
The Besom exists to be a bridge between those who want to give their time, skills, money, or things to those who are in need. The Besom is a national charity with bases all around the country.

13.6.6 On 15 April, Elizabeth moved into permanent accommodation provided by City of York Housing. There was no further contact with Housing Options and Support Team.

13.6.7 On 23 June, Elizabeth contacted the police and reported that a burglary had occurred at her house. The police arranged for the locks to be changed. The perpetrator was not identified.

13.6.8 On 5 October, Elizabeth contacted the police and reported that EP2 had assaulted her and taken their child, Ira. Elizabeth and EP2 were not in a relationship at this time. EP2 was arrested by the police and issued with a caution for the assault. A DASH was completed with Elizabeth, and the risk was graded as medium. Elizabeth did not consent for a referral to IDAS. The police submitted a referral to York Children's Social Care.

13.6.9 York Children's Social Care completed an initial assessment. A social worker spoke with Elizabeth, EP1 and EP2. Contact was also made with Elizabeth's GP and Ira's nursery. On 14 October, following management oversight, the case was closed. There were no concerns identified, and Elizabeth stated that she did not need further support.

13.7 **2015**

13.7.1 On 2 May, Elizabeth contacted the police and reported that EP2 had tried to assault her. Elizabeth and EP2 were not in a relationship at this time. Elizabeth had been at EP2's address with their child, Ira, and left the house, leaving Ira asleep. Elizabeth had telephoned the police after she had returned to her own home. The police established that no assault had taken place. Elizabeth asked the police to return Ira to her care. A DASH was not completed.

13.7.2 Sometime during 2015, Elizabeth and Paul's relationship commenced.

13.8 **2016**

13.8.1 On 18 October, Elizabeth telephoned the police and reported concerns over forthcoming child access contact with EP2. The police provided Elizabeth with advice in regards to seeking a court order and asking family or friends to be present or assist with handover of Ira. It was documented on police records that a referral would be made to York Children's Social Care. There is no record that this referral was made.

13.8.2 On 21 October, Elizabeth contacted the IDAS helpline for support over child

contact issues with EP2. Elizabeth described controlling behaviours during the relationship, and post breakup, with EP2. Elizabeth also disclosed receiving numerous messages the day before from EP2. Elizabeth was provided with advice, including reporting to the police and legal orders. Elizabeth was referred to outreach support.

13.8.3 On 24 October, IDAS telephoned Elizabeth and discussed further support.

13.8.4 On 3 November, the police received an abandoned call from Elizabeth. Contact was made with Elizabeth, who stated that EP2 had been banging on her door but had since left the area. Elizabeth was provided with safety advice.

13.8.5 On 4 November, IDAS held a face-to-face appointment with Elizabeth.

13.8.6 On 4 November, Elizabeth saw a GP and reported feeling stressed, anxious, and struggling to eat and sleep. Elizabeth had attended at her GP on the advice of IDAS. Elizabeth was prescribed antidepressants.

13.8.7 On 5 November, Elizabeth telephoned IDAS helpline to discuss that EP2 had not returned their child. Elizabeth was advised to contact the police. During the call, Elizabeth described assaults that she had suffered during their relationship plus controlling behaviour. Elizabeth disclosed that EP2 had become increasingly difficult after finding out that she had been seeing someone else. On the advice of IDAS, Elizabeth telephoned the police and discussed the child contact. Elizabeth stated that she would ask a family member to check on their child.

13.8.8 On 7 November, Elizabeth telephoned IDAS helpline and reported fears around child contact. Safety advice was provided. A DASH was completed, and the risk was graded as medium.

13.9 **2017**

13.9.1 On 17 February, Elizabeth had a face-to-face appointment with IDAS. Elizabeth stated that she felt unable to be in the same room as EP2, as she found him intimidating. A support and safety plan was completed**.**

13.9.2 On 21 February, Elizabeth telephoned IDAS helpline to discuss issues over child contact. During the call, Elizabeth disclosed that mediation was taking place in the next few days.

13.9.3 On 3 March, Elizabeth had a face-to-face appointment with IDAS. Elizabeth reported positive changes over child contact. IDAS commenced work on domestic abuse awareness.

13.9.4 On 20 October, PP1 telephoned IDAS helpline and asked for support around housing and finances. PP1 was in a relationship with Paul at this time. PP1 stated that Paul had given her notification to leave the property. PP1 reported previous emotional and financial abuse in her relationship with Paul. PP1 was referred to outreach support.

13.9.5 On 3 November, IDAS completed an initial assessment with PP1. PP1 stated that her relationship with Paul had ended after 17 years, and she and their child, Lee, had to vacate the family home. Support and guidance were offered around housing, finances, and legal support. PP1 was provided with the helpline telephone number for further support, and the case was closed.

13.10 **2018**

13.10.1 On 8 March, Paul was recorded in council tax records as residing in Beverley.

13.10.2 On 5 August, Paul contacted the police and reported an incident with his car: whilst it was parked outside Elizabeth's address in York.

13.11 **2019**

13.11.1 No information held.

13.12 **2020**

13.12.1 On 26 March, Elizabeth was recorded in council tax records as residing at Paul's address in Beverley.

13.12.2 In December, Elizabeth and Paul's GP records in York were closed: both later registered with a GP in Beverley.

13.13 **2021**

13.13.1 In September, Elizabeth started a foundation degree course at university.

13.14 **2022**

13.14.1 In April/May, Elizabeth started work at a local pub in Beverley.

**The below information has been taken from statements made as part of the coronial investigation.**

13.14.2 In June, Work Colleague 3 recalled an incident where Paul approached them in the workplace and asked where Elizabeth was. Paul stated: 'I'm [redacted] partner, she told me she finished at eleven, where is she?' Paul was told that Elizabeth had already left. Paul stated: 'Ye, I meet her every time she works on a night-time, where is she, why are you lying to me?' Work Colleague 3 described Paul as being quite abrupt and rude. Work Colleague 3 stated that after this incident, Paul was seen a couple of times

standing outside the work place with a child, apparently waiting for Elizabeth to end her shift.

13.14.3 On 30 June, Paul and Elizabeth became engaged. After this date, Paul's family stated that Paul and Elizabeth had been looking at wedding venues.

13.14.4 On 1 July, Work Colleague 3 saw Elizabeth and Paul sitting at a table in a pub. Work Colleague 3 described that they appeared to be having a 'heated argument', there was lots of shouting from Paul, and he was waving his arms. Elizabeth was trying to calm things down, and she appeared to be embarrassed and worried and looked uncomfortable. Work Colleague 3 asked a couple of door staff to keep an eye on Elizabeth. Another work colleague told Work Colleague 3 that they had seen Paul screaming at Elizabeth and grabbing/shaking her. Work Colleague 3 approached Elizabeth and Paul and asked if everything was OK. Elizabeth told Work Colleague 3 that everything was fine, and she left with Paul.

13.14.5 The following day, Work Colleague 3 spoke with Elizabeth. Work Colleague 3 told Elizabeth that if she needed to talk, she could talk to them, or she could speak to the Wellbeing Manager.

13.14.6 Throughout July, Paul's father stated that Paul had told him that he had suspicions that Elizabeth had started to become friendly with another male and may have been having an affair. Paul's father told him to ask Elizabeth to leave.

13.14.7 In the weeks prior to her murder, Elizabeth had told Work Colleague 2 that she was 'splitting up' with Paul and that they had agreed to live separate lives but live in the same house because of the children.

## 14. ANALYSIS USING THE TERMS OF REFERENCE

### 14.1 Term 1

**What indicators of domestic abuse were your agency aware of that could have identified Elizabeth as a victim of domestic abuse, and what was the response?**

14.1.1 No agency involved in this review held information that Elizabeth was a victim of domestic abuse, perpetrated by Paul. Elizabeth had been a victim of domestic abuse, perpetrated by EP2.

14.1.2 In February 2014, Elizabeth attended at hospital with injuries caused by EP2. Elizabeth and EP2 were not in a relationship at this time. The police spoke with Elizabeth, but she declined to name who had caused the injuries. A referral was made to York Children's Social Care for Ira.

14.1.3 Details of this incident were shared with Elizabeth's GP practice. Elizabeth had not been seen by her GP practice since 2011. The notification was not coded on the system as domestic abuse, as coding of domestic abuse was not usual practice at that time. The Review Panel was informed that this practice has since changed, and coding does now take place.

14.1.4 An entry on 14 February 2014, recorded that Elizabeth had told a health visitor that she had had fled domestic abuse and had been placed in a hostel. The Review Panel identified that in December 2013, Elizabeth had presented as homeless and been placed in temporary accommodation. There was no record that Elizabeth's homelessness was due to domestic abuse.

14.1.5 There was no record, by the health visitor, about how either Elizabeth or her children presented at this visit. The Review Panel was informed that this was below expected practice at that time and that the member of staff who dealt with the matter was no longer in employment. The Review Panel has been informed that there has been extensive training and information sharing around recording and expected practice in response to domestic abuse. This is captured in Term 16.

14.1.6 In October 2014, there was an entry in Elizabeth's GP records following a call from a social worker that Elizabeth had a new partner and that there was 'some inflammation' in the relationship. The name of the social worker nor the names of the involved parties were recorded. Those names should have been recorded which has been identified as learning as detailed at 14.16.1. The use of the term 'some inflammation' was not helpful and did not allow risk assessment or any future escalation of issues to be determined. No further action in relation to this was documented in the health record.

14.1.7 In November 2016, Elizabeth attended an appointment with a GP. It was recorded that a support worker had suggested to Elizabeth to see a GP. The support worker was from IDAS. Elizabeth reported to be struggling with her ex-partner and that he had been physically abusive, it was documented that their relationship had ended three years ago, and that she was now in a new relationship. Details of the partners, to whom Elizabeth was referring, were not recorded. The Review Panel concluded that it was likely that the ex-partner was EP2, and Elizabeth's new partner was Paul.

14.1.8 Elizabeth was prescribed antidepressant medication. There was no evidence that the information (shared by Elizabeth) was further explored by the GP in terms of the impact on her child and herself, and who else was involved in supporting them. There was no record that referrals for supportive services had been discussed or provided. The consultation was

coded on the health record as a depressive episode and not a history of domestic abuse.

14.1.9 Between 2014 and 2016, Elizabeth called the police on five occasions. On each occasion, Elizabeth was seen and spoken to by police officers. The response was in line with policies and procedures at that time. Elizabeth was afforded the opportunity to speak to police officers in a safe environment. DASH risk assessments were completed on three occasions, and appropriate safeguarding referrals were made. On one occasion, EP2 was arrested and cautioned.

14.1.10 Elizabeth's contact with the police was after her relationship with EP2 had ended and related, in the main, to issues around child contact. Elizabeth also sought engagement with IDAS and was provided with advice and support around legal proceedings and court orders.

14.1.11 Between 21 October 2016 and 3 March 2017, Elizabeth accessed IDAS services. Elizabeth called the helpline on four occasions and had a further nine face-to-face or planned telephone contacts. Elizabeth's initial contact with IDAS was around concerns about EP2 and contact with Ira. During further contacts, Elizabeth disclosed to her outreach worker, controlling behaviour, verbal abuse, and previous assaults perpetrated by EP2. Elizabeth was provided with advice, and a support and safety plan was completed.

14.1.12 In 2014, York Children's Social Care responded to two referrals that detailed concerns around domestic abuse perpetrated by EP2. Contact was made with Elizabeth, EP1, and EP2, and discussions were held around the impact of domestic abuse on children. The cases were closed following management oversight. There was no evidence within these contacts that York Children's Social Care was required to instigate child protection processes.

14.1.13 The Review Panel was clear in their discussions that Elizabeth had been a victim of domestic abuse, and that the abuse had been perpetrated by EP2. The Review Panel acknowledged that domestic abuse could continue or intensify after separation and that perpetrators of domestic abuse will use child contact to exert power and control.

14.1.14 In 2016, Women's Aid published a report – 'Safe not sorry'[16] – which documented key issues raised by research on child contact and domestic abuse. Whilst the main focus of the report is in relation to child contact arrangements through the family court, it does document that domestic abuse occurs in all forms of child contact arrangements.

14.1.15 During contact with IDAS, Elizabeth spoke about the controlling behaviour that was being perpetrated by EP2. Elizabeth and EP2 were not in a

relationship at that time. These incidents were not reported to the police, as Elizabeth did not provide her consent.

14.1.16 The Review Panel discussed legislation that was in place at this time that could have responded to the abuse: had Elizabeth consented to information being shared. On 29 December 2015, Section 76 Serious Crime Act introduced the offence of coercive and controlling behaviour in intimate or familial relationships. Whilst the introduction of this piece of legislation closed a gap in the law around patterns of controlling or coercive behaviour, it did not cover cases of coercive control in relationships that had ended: as was the situation at that time between Elizabeth and EP2.

14.1.17 This gap in the law has since been amended by the introduction of the Domestic Abuse Act 2021, which now allows for post-separation abuse and familial domestic abuse to be covered by the legislation.[17] Section 68 Domestic Abuse Act was enacted on 5 April 2023. The Act removed the

requirement that the victim and suspect must be cohabiting when controlling and coercive behaviour occurs.

**Term 2**

14.2 **What knowledge was your agency aware of that indicated Paul might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Paul?**

[16] https://www.researchgate.net/profile/Christine-Harrison/publication/291341994_Thiara_RK_and_Harrison_C_University_of_Warwick_Safe_not_sorry_Supporting_the_campaign_for_safer_child_contact_Bristol_Women's_Aid_2016/links/56a0dc5108ae21a5642d5693/ThiaraRK-and-Harrison-C-University-of-Warwick-Safe-not-sorry-Supporting-the-campaign-for-safer-child-contactBristolWomens-Aid-2016.pdf

[17] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/amendment-tothecontrolling-or-coercive-behaviour-offence

14.2.1 Paul had no previous convictions or contact with the police as a perpetrator of domestic abuse.

14.2.2 Prior to the murder of Elizabeth, Paul and Elizabeth were not known by any agency to have been in a relationship.

14.2.3 IDAS was the only agency to hold information that Paul was a perpetrator of domestic abuse. This abuse was perpetrated against PP1. This information related to a self-referral from PP1 at the end of 2017. PP1 shared information in relation to child contact, separation abuse, and previous emotional and financial abuse.

14.2.4 IDAS was involved with PP1 for a few weeks. The contact focussed on support and guidance around housing, finances, and legal support. PP1 was not in a relationship with Paul at the time of contact with IDAS, and as detailed in Term 1, Paul's behaviour was not covered by Section 76 Serious Crime Act.

14.2.5 York Health and Care Partnership had information from 2011, when Paul referenced low mood and feeling stressed. Paul attributed this to his work and home circumstances, including difficulty in his relationship. The review has established that these comments were not explored further. There was nothing in these contacts where Paul stated that this was linked to domestic abuse. The Review Panel acknowledged that these comments could be indicators of domestic abuse.

14.2.6 The Review Panel was informed that anyone requesting a GP appointment with a GP practice within North Yorkshire, who are presenting with symptoms of low mood and feelings of stress, will first complete an online form that immediately offers signposting to relevant agencies for support,[16] advice links, and the local Improved Access to Psychological Therapies number. There are also mental health practitioners – based in GP practices in North Yorkshire and York – who can be accessed without an appointment with a GP.[17]

14.2.7 The review identified information, not known to agencies, which indicated that Paul had been a perpetrator of domestic abuse towards PP1 and Elizabeth. This information is analysed under Term 14.

## Term 3

[16] https://www.yorkmedicalgroup.co.uk/mental-health/

[17] https://www.valeofyorkccg.nhs.uk/your-health-and-local-services/mental-health/mentalhealthpractitioners1/#:~:text=Mental%20health%20practitioners%20are%20accessible,with%20the%20mental %20he alth%20practitioner.

14.3 **How did your agency assess the level of risk faced by Elizabeth? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?**

14.3.1 In February 2014, Elizabeth attended at hospital with facial injuries. Elizabeth told hospital staff that she had been assaulted by an ex-partner (EP2). A DASH was not completed. The reason why a DASH was not completed was not recorded. The Review Panel have seen evidence from all agencies involved in this review that since 2014, there has been changes to policy and processes, supported by training to front line staff around the completion and submission of DASH risk assessments.

14.3.2 Between 2014 and 2016, North Yorkshire Police completed DASH risk assessments during contact with Elizabeth in relation to EP2. Elizabeth was not in a relationship with EP2 during these contacts.

14.3.3 In October 2014, the risk assessment was graded as medium. Elizabeth reported that EP2 had entered her home, uninvited, and assaulted her, by grabbing her by the throat. The DASH was completed with a score of 4, which would usually indicate 'standard risk'; however, professional judgement determined that the circumstances indicated 'medium risk'. The DASH question regarding strangulation/suffocation was marked as 'No'. EP2 denied grabbing Elizabeth by the throat but admitted to hitting her with the back of his hand. EP2 was arrested and later issued with a caution. Referrals were made to York Children's Social Care.

14.3.4 In June 2022, non-fatal strangulation was made a specific offence – following the introduction of the Domestic Abuse Act 2021. The offence was introduced because concerns had been raised that perpetrators were avoiding punishment as the act often left no visible injury, making it harder to prosecute under existing offences. The introduction of the legislation was linked to research,[18] which showed that victims are seven times more likely to be murdered by their partner if there had been non-fatal strangulation beforehand.

14.3.5 The Review Panel was informed that within North Yorkshire Police, the introduction of this legislation and improved understanding and training around domestic abuse, including DA Matters training (delivered by Safelives), has led to changes to the policing response to such incidents. The IMR author for North Yorkshire Police has informed the Review Panel that the strangulation element of the assault reported by Elizabeth, would, if reported today, lead to the risk being graded as 'high risk'.

[18] Non-fatal strangulation is an important risk factor for homicide of women - PMC (nih.gov)

14.3.6 The Review Panel was informed that in North Yorkshire Police, high risk cases are now identified at the point of triage and allocated to domestic abuse officers within 24 hours. These cases are subject to research, whereby opportunities for safeguarding measures can be identified, including the Domestic Violence Disclosure Scheme (DVDS), Domestic Violence Protection Notice/Orders (DVPN/O), and referrals into MARAC.

14.3.7 In November 2016, IDAS completed a DASH with Elizabeth. The risk was assessed as medium. Over the following months, Elizabeth engaged with IDAS – during telephone and face-to-face contacts.

14.3.8 The Review Panel considered the DASH risk assessments that had been completed. The panel agreed that, based on the information known at that time, the assessment of risk was appropriate.

**Term 4**

14.4 **How effective was inter-agency information sharing and cooperation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider cross-border information sharing.**

14.4.1 North Yorkshire Police made two referrals to York Children's Social Care in 2014 and 2016. This was in relation to Ira. In October 2016, it was documented by the police that a referral was to be sent: this did not take place. North Yorkshire Police have informed the Review Panel that processes have now changed to ensure that where it is documented that referrals are to be sent, this action is followed up.

14.4.2 Since this time, the Review Panel has been informed that North Yorkshire Police processes – around information sharing in domestic abuse cases – have developed. In March 2019, North Yorkshire introduced Public

Protection Notifications (PPNs). The PPN is a form that can be used by any police officer/staff member within North Yorkshire Police to raise a safeguarding concern, and this is the preferred route for submitting referrals to external agencies for welfare and safeguarding concerns, as well as notifying the Domestic Abuse Team of domestic abuse incidents, stalking and harassment, and honour-based abuse. Police officers are expected to complete and submit a PPN for every domestic abuse incident they attend. The PPNs are screened by two separate teams:

- The Domestic Abuse Team reviews the PPN, alongside information on Niche,[19] and determines the risk grading. This results in a number of safeguarding actions based on the grading, including referrals to support services such as IDAS.
- Where there are children in the household, or belonging to the victim or perpetrator, the PPNs are reviewed by MAST/MASH,[20] and referrals are made. PPNs are routinely shared with 0-19 services (health visitors and school nurses), and with schools as part of Operation Encompass.

14.4.3 North Yorkshire Police had no requirement to share information across Force areas; however, information on domestic abuse incidents and other safeguarding concerns from North Yorkshire Police are recorded on the Police National Database, to which all Forces in England and Wales have access.

14.4.4 During contact with North Yorkshire Police, Elizabeth did not consent to information being shared with IDAS, and in accordance with her wishes, information was not shared. The level of risk to Elizabeth from EP2 was not assessed as high; therefore, consent was not overridden. The Review Panel was informed that incidents of standard and/or medium can only be shared with the victim's consent.

14.4.5 The GP practice in York documented that a social worker contacted the GP practice to discuss domestic abuse between Elizabeth and EP2, and the welfare of their child Ira. At that time, it was not routine practice for domestic abuse to be coded in primary care. This has been analysed in Term 1, and changes to practice have been included in Term 16. This practice has since changed.

14.4.6 None of the children's schools held information in the children's file about domestic abuse. The only contact with an education establishment occurred at the end of 2016: this was made by York Children's Social Care to a nursery where Ira attended.

14.4.7 The Review Panel concluded that information was shared in accordance with policies and procedures at that time. There were no incidents that gave rise to share information across local authority boundaries.

[19] IT System

[20] Multi Agency Safeguarding Team/Multi Agency Safeguarding Hub

**Term 5**

14.5 **How did your agency assess the impact of the domestic abuse on the children, and what was your response?**

14.5.1 North Yorkshire Police and IDAS only had Ira recorded as being the child of Elizabeth. They had no information regarding Taylor.

14.5.2 There was evidence on North Yorkshire Police systems that appropriate checks were made, in relation to Ira, on the two occasions that the police attended in 2014 and 2015. Ira was seen by police officers, although Ira was asleep on one of the incidents. Whilst no safeguarding concerns were noted, these entries were in the context of practice in 2014 and 2015, together with a potential lack of any understanding of the impact of domestic abuse.

14.5.3 Since this time, significant work has been undertaken to improve how North Yorkshire Police safeguard children. The IMR author for North Yorkshire Police informed the Review Panel that the police response would be considerably enhanced now in 2023. Staff have received training in relation to understanding and recognising the children's lived experiences.

14.5.4 The Domestic Abuse Practitioner from IDAS discussed with Elizabeth, the effects of domestic abuse on children. It was documented that Elizabeth advised that she did not feel that Ira needed any support. IDAS had no contact with Taylor and Lee.

14.5.5 During the engagement with Elizabeth, EP1, and EP2 in 2014, York Children's Social Care discussed the impact of domestic abuse on children. There was no direct work undertaken with the children. York Children's Social Care had no information about domestic abuse between PP1 and Paul.

14.5.6 Following Elizabeth's murder, York Children's Social Care has undertaken direct work with Taylor, Ira, and Lee: this is captured within Term 6.

14.5.7 York Education has no record of domestic abuse prior to the murder of Elizabeth. Following Elizabeth's death, the children were offered pastoral support in school, and responses were needs led. The Review Panel was informed that each child's needs were different in terms of impact.

14.5.8 The Review Panel acknowledged the impact that domestic abuse has on children: this has been reflected in the introduction of the Domestic Abuse Act 2021, which recognises children as victims of domestic abuse if they 'see, hear, or otherwise experience the effects of abuse'.

**Term 6**

14.6 **How did your agency capture the voice of the children, including their wishes and feelings, in relation to their lived experiences? Did your agency experience any barriers in gathering this information?**

14.6.1 There was no evidence on North Yorkshire Police systems that the voice of Ira was elicited or captured by the police during the contact they had with them between 2014 and 2016. North Yorkshire Police had no contact with Taylor and Lee.

14.6.2 In March 2022, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service published a report in response to North Yorkshire Police's National Child Protection Inspection.[21] Within the report there were two recommendations:

- To improve the quality and submission of Public Protection Notifications; and
- To obtain children's wishes, feelings, demeanour, and views, as well as the voice of the child.

The Review Panel was informed that significant work has been undertaken to improve how North Yorkshire Police capture the voice of the child and their wishes and feelings in relation to their lived experiences. This has included the development of a new pro forma to aid the completion of the 'Officer Observation' section of the PPN that prompts important areas for police officers to comment on and was developed in consultation with frontline staff and colleagues within Children's Social Care. The pro forma was launched alongside the AWARE document, which is a guide for all frontline staff to use when observing children at incidents and what they should be recording. A Voice of the Child training programme has been developed and launched across the Force.

14.6.3 The Review Panel was informed that the action taken, in response to the recommendations, has seen a considerable improvement in how North Yorkshire Police capture the voices and lived experience of children, which has been recognised by partner agencies. The Review Panel was satisfied that this area of learning for North Yorkshire Police has been addressed; therefore, this negated the requirement for any further recommendations.

14.6.4 The Review Panel was provided with extracts from direct work that had been undertaken with the children following Elizabeth's murder. The

[21] https://hmicfrs.justiceinspectorates.gov.uk/publications/north-yorkshire-national-child-protection-inspection/

Review Panel reviewed these as part of their analysis to understand wishes, feelings, and lived experiences.

## Term 7

14.7 **How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Elizabeth and Paul?**

14.7.1 There was no evidence that Elizabeth and/or Paul had any issues with substance misuse or self-neglect.

14.7.2 Elizabeth had contact with a GP in 2017 and was prescribed a short course of antidepressants. This was the only agency record of any mental health issue for Elizabeth.

14.7.3 As part of the coronial investigation, Elizabeth's mother stated that Elizabeth had accessed therapy for borderline personality disorder and that this had been suggested by Paul, due to his perceived lack of Elizabeth's empathy for others. Elizabeth's mother stated that this had been prior to Elizabeth moving in to live with Paul. There was no record held by agencies that Elizabeth had been diagnosed with borderline personality disorder or that she accessed therapy.

14.7.4 The Review Panel discussed the information from Elizabeth's mother and concluded that Paul's suggestion and view of Elizabeth was 'gaslighting'[22]: a terminology used to describe a form of emotional abuse, and an indicator of coercive and controlling behaviour. This is analysed further under Term 14.

14.7.5 In August and September 2011, Paul was seen by a GP: this was in reference to difficulties that he had in his current relationship (not with Elizabeth) that led him to access help for low mood, which Paul had indicated had been present for about a year. The name of Paul's partner at that time was not recorded. Whilst this incident was outside of the review's time frame, the Review Panel agreed that it was relevant for inclusion.

14.7.6 Paul was prescribed antidepressants for a period of four months. There was minimal recording in relation to any exploration of what the reported difficulties/stress at home were or what impact that might be having on the child and partner who were living in the household. During the second

[22] https://16days.idas.org.uk/stories/gaslighting/

appointment, Paul stated that he was separating from his partner. There was no record about the impact or consideration of signposting for support.

14.7.7 The Review Panel agreed that the absence of further recorded exploration of the relationship breakdown did not enable the GP to consider the symptom of low mood holistically in the context of the family situation. The Review Panel was informed that changes have been made within the GP practices in North Yorkshire and someone with Paul's presentation would be signposted to emotional wellbeing services, such as IAPT and local voluntary organisations.

14.7.8 In March 2021, Paul saw a GP due to headaches and stress. The stress was not explored during the consultation. In a further contact with a GP in December 2021, Paul identified himself as a 'stress-head'. This 'stress' was not explored further. There was some evidence that the stress was discussed with Paul by a practice nurse, and Paul stated this was due to 'work and home'. The Review Panel was informed that the lack of exploration of Paul's stress was part of him presenting with multiple physical symptoms and a short consultation time of 10 minutes. The IMR author for East Riding of Yorkshire Health and Care Partnership informed the review that the physical symptoms were not 'medically unexplained', which meant that a physical cause was evident and that if the symptoms had been 'medically unexplained' then a more holistic assessment may have been indicated.

14.7.9 National Institute for Clinical Excellence (NICE) guidance – 'Domestic Violence and Abuse: Multi-Agency Working'[23] – does not expect primary care to 'routinely' ask about domestic abuse but to 'selectively' ask about it. The conditions that NICE list as being relevant to domestic abuse, include psychological conditions such as 'stress'.

14.7.10 The Review Panel discussed Paul's contact with his GP practice in 2021, and that he had presented with stress. This was not explored within the context of domestic abuse. The Review Panel concluded that further exploration should have taken place. This has been identified as an area of learning, and a relevant recommendation has been made.

**Term 8**

[23] https://www.nice.org.uk/guidance/ph50

14.8 **What services did your agency provide for Elizabeth and/or Paul; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?**

14.8.1 Elizabeth communicated with her keyworker from IDAS, via text, phone, and face to face. Elizabeth was provided with emotional support, advice on child contact issues, signposted to a solicitor, and advised on protective orders. Elizabeth completed work on domestic abuse traits of a perpetrator. Elizabeth's safety plan was reviewed verbally during telephone calls and face-to-face appointments.

14.8.2 The Review Panel was informed that since involvement with Elizabeth and PP1, IDAS has made changes to the management and delivery of initial assessments and the helpline they provide. Since 2017, IDAS has undertaken training on helpline calls, which has moved to a central hub, to ensure continuity with designated workers who are overseen, and case managed by a hub manager.

14.8.3 At the end of 2017, IDAS changed their assessment model to incorporate a single point of access Hub model, as the outreach workers were often undertaking assessments in a community setting. The Hub model introduced a manager to oversee and ensure quality and consistency in all assessments and ensure regular case management.

14.8.4 York and Scarborough NHS Foundation Trust informed the Review Panel that since 2014, there have been changes to processes that include the introduction of the secondary coding system and an Emergency Department Safeguarding Liaison Nurse (EDSLN) in post.

14.8.5 In February 2014, the health visitor undertook a thorough assessment of Ira's health and needs at that time. The assessment considered both Elizabeth and Ira's immediate health and support needs, which established that Elizabeth was receiving support through IDAS. The health visitor discussed and supported accessing nursery provision for Ira. Also, practical considerations were discussed, such as Elizabeth's need for furnishing her new home. Ira was reported to be having contact with their father, and the health visitor discussed their safety in relation to the domestic abuse. This contact met all required standards.

14.8.6 There was no record that Paul accessed any services.

**Term 9**

14.9 **When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions?**

14.9.1 IDAS completed an initial assessment with Elizabeth. This was completed by a Domestic Abuse Practitioner, and the decision-making was reached in an informed and professional way. The assessment was holistic and considered each area of Elizabeth's life, including safety, health, housing, finance, and her relationship with EP2. The assessment was centred around Elizabeth's wishes and feelings, and she co-produced a support and safety plan with the Domestic Abuse Practitioner.

14.9.2 North Yorkshire Police records show that on two separate occasions, they revisited Elizabeth to ensure that she had the opportunity to make full disclosures about any abuse that she was experiencing. On the first

occasion, Elizabeth had declined to tell the police who had assaulted her. The police went back the following day and spoke with Elizabeth to discuss safeguarding options and to see if she had changed her mind regarding the case. This contact related to incidents with EP2.

14.9.3 In October 2016, North Yorkshire Police provided Elizabeth with advice regarding court orders for child contact arrangements, which included asking family or friends to be present or assist with the handovers of the child. Elizabeth was advised to call 999 if she felt her safety was being jeopardised in any way. This contact related to incidents with EP2.

14.9.4 It was the view of the panel that those agencies who had worked with the subjects of the review, informed them of the options/choices that were available to them.

**Term 10**

14.10 **Were the subjects of the review signposted to other agencies, and how accessible were these services to the subjects? Were there any barriers that may have prevented access and/or engagement with services?**

14.10.1 North Yorkshire Police made two referrals to York Children's Social Care following incidents of domestic abuse with EP2.

14.10.2 In October 2014, North Yorkshire Police responded to a domestic abuse incident with Elizabeth and EP2. Elizabeth did not provide consent for information to be shared with IDAS.

14.10.3 On other occasions in which North Yorkshire Police responded to incidents

with Elizabeth, there was no record on police systems about discussions with Elizabeth regarding referrals to domestic abuse services. The Review Panel was informed that as these events occurred between 2014 and 2016, Elizabeth may have been signposted to services; however, these discussions are not recorded. The Review Panel has been informed that records are now documented of referrals made and offered to victims of abuse.

14.10.4 IDAS provided Elizabeth with information on how to seek legal advice in relation to child contact. IDAS also advised Elizabeth to see a GP after she informed them about feeling stressed and struggling to sleep and eat. The Review Panel has seen evidence that Elizabeth followed this advice and spoke with a GP on these matters.

14.10.5 The Review Panel considered whether there were any barriers that would have prevented Elizabeth engaging with services. The Review Panel recognised that Elizabeth's contact with IDAS had been through a

selfreferral. The Review Panel acknowledged that there are many reasons why victims of domestic abuse do not report the abuse or contact agencies to receive support. The Victim Support report 'Survivor's Justice'[24] contains the following statistical data as to why victims may not report abuse:

**Barriers to reporting, as cited by Victim Support caseworkers**

| Barriers to reporting | Percentage of respondents citing barrier |
|---|---|
| Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger | 52% |
| Fear that they would not be believed or taken seriously | 42% |
| Fear, dislike, or distrust of the police/criminal justice system (CJS) | 25% |
| Concern about their children and/or the involvement of social services | 23% |

[24] https://www.victimsupport.org.uk/wp-content/uploads/documents/files/VS_Survivor%E2%80%99s%20justice.pdf

| Barriers to reporting | Percentage of respondents citing barrier |
|---|---|
| Poor previous experience of the police/CJS | 22% |
| Abuse normalised, not understood, or believed to be deserved | 15% |
| Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator | 14% |
| Cultural or community concerns | 9% |
| Financial concerns | 7% |
| Housing concerns | 4% |
| Embarrassment | 3% |

14.10.6 The Review Panel considered whether Elizabeth's move to live in the East Riding of Yorkshire in 2019, having lived and worked for most of her adult life in York, could have been a barrier to her accessing services. The Review Panel also discussed that not long after Elizabeth moved in to Paul's house, the Covid-19 pandemic had started, which resulted in restrictions being put in place around travel and contact/engagement with services.

14.10.7 The Review Panel discussed that Elizabeth had self-referred to IDAS in 2014. The Review Panel member from IDAS stated that had Elizabeth contacted them whilst living in East Riding of Yorkshire, they would have provided her with advice and referred her to local domestic abuse services.

14.10.8 An internet search of domestic abuse services in Beverley, produced a direct link to East Riding of Yorkshire Council's webpage[25] on domestic

[25] https://www.eastriding.gov.uk/living/crime-and-community-safety/domestic-violence/domestic-violenceadultservices/

abuse and Humberside Police and Crime Commissioners webpage[26] on domestic abuse services in East Riding of Yorkshire.

14.10.9 The Review Panel also acknowledged the information provided by the Head of Physics at Elizabeth's university on the awareness raising and information available through the student wellbeing hub, which included information on domestic abuse services, how to report abuse, and the information from a work colleague around support available to Elizabeth in the work place.

14.10.10 The Review Panel discussed that Elizabeth's previous contact with agencies had related to physical abuse and child contact arrangements. The Review Panel discussed if Elizabeth may not have known that coercive control is a form of domestic abuse. Whilst the Review Panel could not reach a definitive answer on this point, they did agree that this was an area of learning, which has been linked to a recommendation for the review.

**Term 11**

14.11 **What action has your agency undertaken to raise awareness of services available to victims of domestic violence and abuse?**

North Yorkshire Police

14.11.1 North Yorkshire Police have a service directory to assist police officers and staff in signposting victims to support. The Force has undertaken internal and external communications, including via social media to promote the service of IDAS and to raise awareness around the Domestic Violence Disclosure Scheme. In addition, the Force has worked in conjunction to support IDAS at community events.

IDAS

14.11.2 All staff at IDAS actively campaign to raise awareness of their service and domestic abuse. IDAS has a far-reaching website that gives information and advice on domestic abuse, sexual violence, child support, family court, mental health well-being, and safeguarding. The website is also available

[26] https://www.humberside-pcc.gov.uk/Help-and-Advice/Domestic-Abuse-You-Are-Not-Alone/EastRidingDomestic-Abuse-Services.aspx

to be translated to any language. Self and professional referrals can be made through the website. Attached to the website is a live chat facility that can be accessed via phone or computer. IDAS runs a helpline that is available seven days a week (including bank holidays) and has an active social media standing, including Twitter, Facebook, and Instagram.

14.11.3 IDAS undertakes regular liaison with partner agencies and teams regularly attending MARAC, MATAC,[27] Crown Prosecution Service, and police scrutiny panels. Training is undertaken with professionals and other agencies. A regular programme of awareness raising is undertaken with schools, colleges, universities, health professionals, police, social care, and local businesses such as hairdressers, barbers, banks, and supermarkets. IDAS has a team of champions that engage with community groups and businesses.

York and Health Care Partnership

14.11.4 The former North Yorkshire and Vale of York Clinical Commissioning Groups put support in place for safeguarding in primary care. This was from 2015, when a nurse consultant for safeguarding adults and children in primary care was recruited into post and subsequently four named GPs were recruited. The following actions have been undertaken to raise awareness of domestic abuse and how to respond in practice:

- Hot topics training 2019/20 – monthly delivery of session to primary care practitioners, which covered the Domestic Homicide Review and learning from DHR 'Julie' – awareness of DASH risk assessment and referral to MARAC.
- Hot topics training 2020/21 – monthly delivery of session to primary care practitioners, which covered Domestic Abuse: stalking and harassment, inc. the Alice Ruggles film, impact on victims, actions for primary care and advice for victims, SPOs, and awareness of national stalking helpline.
- February 2022 – domestic abuse policy written and shared for use by primary care/GP practices. This is a new document that details the standard guidance for general practice in North Yorkshire and York and provides clear guidance for staff in dealing with cases of domestic abuse. The policy has been sent to all GP practices in North Yorkshire and York .

[27] MATAC refers to the Multi-Agency Tasking and Coordination process of identifying and tackling serial perpetrators of domestic abuse. The overarching objectives of the MATAC are to safeguard adults and children at risk of domestic abuse and to reduce the offending of domestic abuse perpetrators.

- Hot topics training 2022/23 – monthly delivery of session to primary care practitioners, which covered key points of Domestic Abuse Act for primary care: coercive control; potential indicators; targeted clinical inquiry based on presentation; how to respond; DA services; and resources.
- Hot topics training 2023/24 – included learning from the DHR 'Mary'[28] (not yet published), with reference to those individuals who may lack the capacity to identify or understand an abusive relationship for themselves and the accessibility of the information available for support. Delivery of these sessions commenced in April 2023. Final session will be in March 2024.
- June to September 2023 – both the safeguarding adults policy and the safeguarding children's policy for primary care have been revised.

- In addition, there is currently an ongoing comprehensive programme of domestic abuse training being delivered by IDAS for all practitioners. Dates are shared with primary care practitioners and uptake is encouraged through safeguarding leads meetings.

York and Scarborough NHS Foundation Trust

14.11.5 Domestic abuse is included in adult and children safeguarding statutory and mandatory training, with the addition of single one-off modules offered. The Trust intranet provides resources to support staff and there is an upto-date domestic abuse policy to support staff. The safeguarding teams also offer office hours support. York Emergency Department (soon to be Scarborough) has in post, an emergency department safeguarding liaison nurse who also provides whole family support for incidents of domestic abuse.

14.11.6 Where an attendance is of concern, emergency department clinicians can code the attendance for a secondary safeguarding review. This is carried out daily by the safeguarding team, and MARAC referrals are made as a result of this. The adult and child team also share a 'Adult attendance affecting child' work list so that a holistic safeguarding approach can be made for an attendance.

[28] Not published at time of completion of review.

East Riding of Yorkshire Health and Care Partnership

14.11.7 The GP practice has assigned a member of the administration team to be the practice's domestic abuse champion. The training for this role is in September 2023 and is being delivered at a multi-agency event in person.

14.11.8 The GP safeguarding lead for the practice, attends the 'GP leads meeting': this is hosted (monthly) by the named doctors for safeguarding adults and children. Domestic abuse is a frequent topic at these meetings. The role of the GP lead is to relay this knowledge back to the GP practice. Minutes from the meeting are emailed to all the GP partners and taken to the partners' practice meeting as an agenda item for discussion. The Health IDVA and Prevention of Domestic Abuse Services (PODAS)[29] have delivered short sessions about domestic violence at these meetings.

14.11.9 The GP practice has DVAP information posters in all waiting areas. The DVAP telephone number is on the practice telephone list in all rooms, which means that clinicians and staff have easy access if needed. The GP practice website has DVAP signposted on the front page.

14.11.10 The City of York Safeguarding Children Partnership has promoted local training opportunities and services offered by IDAS, which has been commissioned jointly for North Yorkshire and York by Office of North Yorkshire Police, Fire and Crime Commissioner.

14.11.11 Whilst Elizabeth had no contact with Humberside Police and domestic abuse services in East Riding of Yorkshire, the Review Panel was keen to understand what awareness raising had taken place.

DVAP and Domestic Abuse and Safeguarding Partnership Team (DASP)[30]

14.11.12 Provided the Review Panel with a comprehensive source of information in relation to the work that they have undertaken on raising awareness across communities. The Review Panel agreed to include a summary of some of these to highlight the work that has commenced and is planned to take place:

[29] https://www.eastriding.gov.uk/living/crime-and-community-safety/domestic-violence/prevention-ofdomesticabuse-service/

[30] Domestic Abuse and Safeguarding Partnerships Team (DASP) are responsible for Strategic Domestic Abuse and the communications and engagement alongside DVAP. This is a team who manages the Strategic Domestic Abuse Board and oversees implementation of learning from Domestic Homicide Reviews. They provide coordination of Communications and Engagement across the area and have been consulted on in relation to an independent view of Domestic Abuse and also in relation to the Communications and Awareness of the East Riding Domestic Violence and Abuse Partnership.

- East Riding of Yorkshire Council social media campaign on domestic abuse 2019 – 2022.

- Office Police and Crime Commissioner communication strategy 2020 – 2022.
- Public consultations to inform Domestic Abuse Strategy.
- Domestic abuse awareness month, with online events and press releases.
- Domestic abuse support awareness campaign 2020 – 2022 (now a reoccurring event).

Humberside Police

14.11.13 Humberside Police have completed a number of events and campaigns to raise awareness. The Review Panel has seen a detailed list of the actions taken and planned by Humberside Police and have included some of these below to highlight the work undertaken and ongoing:

- 2021 – joint campaign with Humber NHS Foundation Trust, City Health Care Partnership, and DVAP to raise awareness on domestic abuse, focusing on coercive control, honour-based abuse, diversity, and how children are affected by domestic abuse.
- White Ribbon campaign.[31]
- You are Not Alone campaign.[32]

- My Community Alert[35] to distribute information on domestic abuse, links to partner agencies, available support, and how to report domestic abuse.
- Visual publicity campaigns in the community, including workplaces and places of worship, which include a QR code linking to local websites for support.

14.11.14 The Review Panel concluded that there had been extensive evidence of awareness raising across North Yorkshire and East Riding of Yorkshire which did not identify any learning on this area for this case.

**Term 12**

[31] https://www.whiteribbon.org.uk/

[32] https://justbeverley.co.uk/articles/east-riding-of-yorkshire-council-supports-you-are-not-alone-campaign

[35] https://www.mycommunityalert.co.uk/

My Community Alert is a new way to be updated from Humberside Police and Humberside Fire & Rescue Service about the issues that matter to you. My Community Alert is a specialist and secure messaging system that allows you to receive the messages of interest to you.

### 14.12 Were single and multi-agency policies and procedures followed, including the MARAC? Are the procedures embedded in practice, and were any gaps identified?

14.12.1 During the timescales of the review, none of the incidents of domestic abuse were either risk assessed as high or reached the criteria from professional judgement to refer to MARAC. The Review Panel has seen that MARAC processes are embedded into practice within agencies involved in the review.

14.12.2 The Review Panel recognised that policies and procedures had changed since the commencement of this review period, and that practice that was deemed acceptable in 2014 – 2016, will now seem unsatisfactory in comparison as to how it would be dealt with in 2023.

14.12.3 There were opportunities in 2014, when Elizabeth attended at hospital with injuries sustained from an assault, when a DASH should have been completed. This did not occur. The Review Panel has been assured from those agencies that systems are in place for DASH risk assessments to be completed in these circumstances.

14.12.4 In October and November 2016, North Yorkshire Police attended three calls from Elizabeth where she expressed concerns about EP2. It was documented that Elizabeth was worrying about potential escalations, particularly around child contact. Elizabeth was provided with safety advice by the call handler in the control room, but the police were not deployed to attend. As part of this review, these three occurrences were discussed with a deployment manager in the force control room of North Yorkshire Police. The Review Panel was informed that the policing response and deployment would be different today, in relation to two of the calls:

- 18 October 2016 – A police officer would be deployed to obtain more information and to complete a Public Protection Notification, which would include a DASH.
- 3 November 2016 – This would now be categorised as a domestic incident, and a police officer would be deployed.

14.12.5 The Review Panel was informed that the attendance of police officers today, would result in a greater understanding and awareness of domestic abuse. A DASH would be completed as part of the PPN, details of all children would be obtained, their voice and lived experience captured, and opportunities to discuss and make partner agency referrals would be undertaken.

14.12.6 Since a pilot in 2019, there has been an established MARAC process linking primary care within York and Health Care Partnership. Safeguarding adults and children single and multi-agency policies and procedures are embedded in primary care. In 2022, a stand-alone domestic abuse policy was developed and shared for use.

14.12.7 There were a small number of occasions where safeguarding practice could have been enhanced by the GP having a safeguarding discussion about concerns. These episodes would not necessarily have met the threshold for any intervention but would have presented an opportunity to share information and gain assurance that wider concerns were not being missed.

14.12.8 The GP practice (East Riding of Yorkshire) has a domestic abuse policy and established systems in place for MARAC notifications. The MARAC is coded appropriately and discussed at the practice meeting so that all clinicians are aware of the issue. Minutes are kept of practice meetings and circulated to absent clinicians. Practice minutes are shared with all staff of the practice.

14.12.9 The IMR author from East Riding of Yorkshire Health Care Partnership has identified learning in relation to MARAC and safeguarding information recording, which is captured in Term 16.

**Term 13**

**14.13 Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.**

14.13.1 There were no issues in relation to capacity or resources that affected agencies' ability to provide services to the subjects of the review, or in working with other agencies.

**Term 14**

**14.14 What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?**

14.14.1 Elizabeth's family were not aware of any incidents of domestic abuse in her relationship with Paul.

**The below information was provided to the Chair through information shared with the consent of H.M. Coroner. The Chair has not spoken to individuals due to the ongoing coronial investigation.**

Work Colleague 1

14.14.2 Work Colleague 1 had only seen Elizabeth and Paul together on two occasions, although they did not know his name was Paul, as Elizabeth never mentioned it in conversation. The first time Work Colleague 1 had seen Elizabeth with Paul was when they were walking in Beverley town centre together. Work Colleague 1 described how they heard Paul having a 'go' at Elizabeth, saying: "What the fuck do you think you are wearing?" Paul's voice was raised, and he had hold of her upper arm with his arm wrapped around her arm, in what Work Colleague 1 stated was not a loving way. Elizabeth was described as looking uncomfortable and had put her head down.

14.14.3 Work Colleague 1 spoke to Elizabeth – either the next day or the day after that incident – and asked if Elizabeth was OK. Elizabeth replied: "Ye, I'm fine". Work Colleague 1 told Elizabeth that if she ever needed to talk, then she could talk to them.

14.14.4 Around mid-June 2022, Work Colleague 1 was in a local pub at around 10 pm, having recently finished work. Work Colleague 1 described seeing Paul, with a young child, outside of the pub. Paul was looking through the window. Work Colleague 1 did not know where Elizabeth was, or if she was still at work. Work Colleague 1 described this incident as if Paul had come to look for, or check on, Elizabeth.

14.14.5 The second time that Work Colleague 1 had seen Elizabeth with Paul was on 1 July 2022. This was in the pub where Elizabeth worked. Work Colleague 1 described seeing Elizabeth sat with Paul, and that he had one of his hands on Elizabeth's shoulder and his other hand on her upper leg, which was described as not being in a loving way. Work Colleague 1 stated that it appeared as if Paul was angry with Elizabeth, so much so that it made them pay attention, as they were concerned. Work Colleague 1 heard Paul say to Elizabeth: "This is not acceptable. I don't think so". Work Colleague 1 spoke to a member of staff, and later that day, they spoke to a supervisor. The supervisor assured Work Colleague 1 that they had spoken to Elizabeth and confirmed that they had offered some reassurance.

Work Colleague 2 and 3

14.14.6 Both Work Colleague 2 and 3 provided information for the coronial investigation in relation to incidents of concern between Elizabeth and Paul. These have been captured at 13.4 and will not be repeated here.

14.14.7 In response to one such incident on 1 July, Work Colleague 3 told Elizabeth that she could speak with them or the Wellbeing Manager about the events that had occurred.

**The Review Panel acknowledges that some of the below comments can be seen as victim blaming but have included them to provide context for the review. In reaching this decision, the Review Panel took cognisance that the information was provided to the police in the days after the murder of Elizabeth and the death of Paul and following the discovery of Elizabeth by Paul's mother and father. The Review Panel acknowledges that these**

**events will have had a significant emotional impact on all involved.**

Paul's Mother

14.14.8 Paul's mother stated that after Elizabeth started at university, they felt that Elizabeth was not as attentive towards Paul, and that after Elizabeth started to work, she became more distant with Paul. Paul's mother stated that Paul would offer to pick Elizabeth up when she finished work and that Elizabeth would tell him not to, as she could walk home. Paul's mother stated that Elizabeth would often stay behind after work for a drink and that this had put a strain on Paul and Elizabeth's relationship. Additional information provided by Paul's mother is captured in Section 6.

Paul's Father

14.14.9 Paul's father stated that in the month prior to Elizabeth's murder, Paul had spoken to him about his relationship with Elizabeth, which included concerns that Elizabeth may have been having an affair.

14.14.10 Paul's mother and father were not aware of any domestic abuse in Elizabeth and Paul's relationship.

**The following information was provided by PP1 during contact with the Chair.**

14.14.11 PP1 provided the Chair with detailed information about her relationship with Paul. This included information in relation to their finances, home circumstances, emotional and verbal abuse, and criminal damage within the home. These are detailed in Section 6 of the report.

14.14.12 PP1 stated that throughout their relationship, Paul had affairs. PP1 stated that when these ended, Paul would withdraw into himself and become morose and that this would last for a few weeks. PP1 stated that, in her opinion, Paul did not like rejection.

14.14.13 PP1 stated that after their relationship ended, her only contact with Paul was in relation to Lee, and handover of care. PP1 stated that the conversation was limited – to the odd word or two. PP1 stated that in the weeks prior to Elizabeth's murder, she had had a lengthy telephone conversation with Paul. The telephone call had been instigated by Paul, during which he spoke about his relationship with Elizabeth. PP1 stated that Paul told her that he believed Elizabeth may have been seeing another male and that he had taken a day off work and followed Elizabeth, without her knowledge, to see if he could find out if his concerns were true. During the conversation, Paul spoke about having 'nothing to live for' and that he 'had lost Elizabeth'.

14.14.14 PP1 stated that she was surprised when she heard the news that Paul had proposed to Elizabeth and that they were engaged. PP1 told the Chair that it was her belief that the engagement had been an act of desperation by Paul, as a means of maintaining their relationship.

Review Panel Analysis

14.14.15 The Review Panel held a lengthy discussion about the information that had been gathered during the DHR and the coronial investigation. None of this information was known to agencies until after the murder of Elizabeth, and the Review Panel recognised that their analysis of this information was taking place in hindsight and with the collective information being considered in its entirety. The Review Panel was conscious not to analyse these events with hindsight bias.

14.14.16 The Review Panel concluded that the information demonstrated indicators that Paul had been a perpetrator of domestic abuse, including coercive control, in his relationship with PP1 and Elizabeth. The Review Panel recognised that some of these acts were subtle, and if seen in isolation, may not have been recognised in the context of domestic abuse.

14.14.17 The Review Panel discussed the complexity of recognising and understanding domestic abuse, in the context of coercive control. The information held by families, friends, and work colleagues, whilst causing them concern, had not resulted in those concerns being reported to agencies. The Review Panel considered whether the nature of the abuse, in particular coercion and control, may not have been recognised as a form of domestic abuse.

14.14.18 The Review Panel discussed the individual accounts of family and friends, that had been gathered by the police as part of the coronial process following Elizabeth's murder, against research undertaken by Dr MoncktonSmith in 2018.[33] In the research, Dr Monckton Smith reviewed domestic violence killings in the United Kingdom, which showed an eight stage timeline of events before a homicide takes place. To conduct the study, 575 homicide cases involving women killed by men were identified using the Counting Dead Women database,[34] which then identified 372 cases from 2012 to 2015. Every case was reviewed using published media and homicide reviews, to establish the history and circumstances of the homicide, and to identify common and consistent themes. In almost all of the murders that were studied, the following eight stages were identified to be present:

1. A pre-relationship history of stalking or abuse by the perpetrator.
2. The romance develops quickly into a serious relationship.
3. The relationship becomes dominated by coercive control.
4. A trigger threatens the perpetrator's control – for example, the relationship ends, or the perpetrator gets into financial difficulty.
5. Escalation – an increase in the intensity or frequency of the partner's control tactics, such as stalking or threatening suicide.
6. The perpetrator has a change in thinking – choosing to move on, either through revenge or by homicide.
7. Planning – the perpetrator might buy weapons or seek opportunities to get the victim alone.
8. Homicide – the perpetrator kills his or her partner and possibly hurts others, such as the victim's children.

14.14.19 The Review Panel considered the evidence that had been available to them, as part of the review, against Dr Monckton Smith's eight stages. In undertaking this piece of work, the Review Panel was clear in their deliberations that they focussed on evidence and not speculation. The Review Panel was conscious that they were undertaking this analysis in hindsight, with the collective knowledge and expertise of domestic abuse – the level of which was not known, nor expected to be known, by family and friends.

[33] https://core.ac.uk/download/210991723.pdf

[34] https://kareningalasmith.com/counting-dead-women/

| **Dr Monckton's Stages** | **Facts of this case** |
|---|---|
| A pre-relationship history of stalking or abuse by the perpetrator. | The review has seen evidence of this from IDAS and PP1. |
| The romance develops quickly into a serious relationship. | The review has seen no evidence to support that the romance developed quickly. It was understood that Paul was still in a relationship with PP1 when he met Elizabeth in December 2015. |
| The relationship becomes dominated by coercive control. | The Review Panel has seen information from family and friends that indicated examples of coercive control, including Paul's behaviour towards Elizabeth. |

| | |
|---|---|
| A trigger threatens the perpetrator's control – for example, the relationship ends, or the perpetrator gets into financial difficulty. | The review has seen no evidence that their relationship ended or that there was financial difficulty. The Review Panel agreed that it was reasonable to say that Elizabeth had a number of things in her life that may have increased her independence from Paul. She was working in hospitality and had a brief relationship, and she had started a new course at university that she seemed to be committed to and enjoying. All of those things would have taken up her time and |
| | potentially reduced the time that she was able to spend on her relationship with Paul. |

| | |
|---|---|
| Escalation – an increase in the intensity or frequency of the partner's control tactics, such as stalking or threatening suicide. | The review has seen information that could indicate control, such as waiting for Elizabeth to finish work, and Paul's physical presence and demeanour towards Elizabeth. The panel discussed whether the couple's engagement could have been a way of Paul strengthening the relationship with Elizabeth, and potentially his control over her, but was unable to come to a conclusion. |
| The perpetrator has a change in thinking – choosing to move on, either through revenge or by homicide. | The review has seen no evidence to support this stage. |
| Planning – the perpetrator might buy weapons or seek opportunities to get the victim alone. | The review has seen no evidence to support this stage. |
| Homicide – the perpetrator kills his or her partner and possibly hurts others, such as the victim's children. | This stage is met through the murder of Elizabeth. |

14.14.20 The Review Panel concluded that this case demonstrated the challenges faced in recognising and understanding coercive control and agreed that this case could be used to further inform learning and awareness raising.

**Term 15**

## 14.15 Are there any examples of outstanding or innovative practice arising from this review?

14.15.1 Whilst the Review Panel did not identify examples of outstanding or innovative practice, they did want to acknowledge the process in place within the GP practice in East Riding.

14.15.2 The GP practice has a 'notes summariser' who is a member of the administration team and attends the practice safeguarding meetings. The

note summariser brings to the attention of clinical staff, including the Lead GP, relevant safeguarding information.

14.15.3 Safeguarding and domestic abuse are a fixed agenda item on weekly meetings. The GP practice manager and reception manager have defined roles in safeguarding within the GP practice.

**Term 16**

**14.16 What learning has emerged for your agency?**

14.16.1 Agencies learning is captured at Section 16 and is not included here to avoid duplication.

**Term 17**

**14.17 Does this learning appear in other Domestic Homicide Reviews commissioned by East Riding of Yorkshire Community Safety Partnership?**

14.17.1 The Review Panel considered the learning that had been identified in two previous DHRs[35] commissioned by East Riding of Yorkshire Community Safety Partnership, both of which were with the Home Office for quality assurance purposes at the conclusion of this DHR. The Review Panel identified similarities in this DHR, in terms of learning for health professionals and around the implementation of 'selective enquiry', in accordance with NICE guidelines.

[35] DHR – 'Suzanne' and DHR – 'Coleen'

## 15. CONCLUSIONS

15.1 Elizabeth was murdered by Paul. Following Elizabeth's murder, Paul was involved in a traffic collision in which he died, and a driver of another vehicle sustained life changing injuries.

15.2 Elizabeth and Paul met online. They had been in a relationship for seven years, and both had children from previous relationships. In the three years prior to her murder, Elizabeth moved in to live with Paul. Elizabeth and Paul's children visited and stayed over.

15.3 Not long after Elizabeth and Paul had started living together, the country was placed under a national lockdown due to the Covid-19 pandemic. When restrictions were lifted, Elizabeth commenced a degree course and gained employment in a local hospitality venue. Elizabeth's youngest child and Paul's child continued to visit their home.

15.4 Elizabeth and Paul's relationship was not known to agencies. Elizabeth and Paul's contact with agencies was limited to health matters. There were no reports or concerns raised to agencies about domestic abuse.

15.5 The review covered an eight-year time frame. In addition to changes in legislation, there have been changes to policies and procedures for all agencies, which have addressed the learning identified during their early contacts with Elizabeth and Paul.

15.6 The review highlighted the complexity of coercive control in terms of recognition and evidence gathering, and, when events are reviewed in their entirety, it can provide a pattern of behaviour that identifies indicators of domestic abuse.

15.7 Elizabeth's family were involved in the review process. The Review Panel extends its thanks for their contribution to the review.

## 16. LEARNING IDENTIFIED

### 16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The Review Panel identified the following lessons. Each lesson is preceded by a narrative that seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross reference is included within the header.

| **Learning 1 [Panel recommendation 1]** |
|---|
| **Narrative** |
| The case identified the challenges faced by family and friends who have concerns over the way an individual acts or engages with another person, and that those concerns may not been recognised as an indicator of domestic abuse. |
| **Lesson** |
| Perpetrators who exert coercive control over a victim can do so in a way that individual acts may not be seen as domestic abuse. When those acts are reviewed in their entirety, it can start to identify a pattern of behaviour that is coercive control. Raising awareness on the complexity of coercive control can lead to identification of domestic abuse. |
| **Learning 2 [Panel recommendation 2]** |
| **Narrative** |
| The review identified opportunities for health professionals to engage in further questioning and exploration, in accordance with NICE guidance, when a potential indicator of domestic abuse had been identified. |
| **Lesson** |
| Compliance with guidance will provide health professionals with the opportunity to identify the presence of domestic abuse, and for appropriate responses and referrals to be undertaken to safeguarding any identified victim. |

### 16.2 Agencies Learning

16.2.1 <u>York Health and Care Partnership</u>

- Coding of domestic abuse in primary care.
- Professional curiosity in further exploring around an individual's presenting issues.

- Recording of the names of individuals – partners, professionals, children, those bringing children to appointments for crossreferencing purposes, and identification of risk factors.

**Actions taken to address this learning –**

- Annual training on domestic abuse.
- Safeguarding lead within each GP practice.
- Coding on domestic abuse cases.
- Links between MARAC process, MARAC co-ordinator, and GP practice.
- Protected Learning Time (PLT)[36] events to share learning from reviews.
- In October 2023, IDAS delivered two workshops to promote their service.
- Implementation of Standing Together – 'Crossing Pathways' project.

16.2.2 York Healthy Child Service

- Recording standards.

**Actions taken to address this learning –**

- Six-weekly caseload supervision for health visitors.
- In 2021, the introduction of safeguarding team and lead safeguarding nurse.
- Annual thematic audits of caseloads, which includes record-keeping.
- Embedded links to other multi-agency review meetings.

16.2.3 East Riding of Yorkshire Health and Care Partnership

- Recording of MARAC and safeguarding information recorded on System 1.

**Actions taken to address this learning –**

- GP practices to set up a 'safeguarding' group on their system so that the information is seen immediately by the relevant personnel within

[36] The Protected Learning Time event is where each GP practice closes for the afternoon for staff to attend an event promoting particular topics of learning.

the practice. This will be discussed at a strategic safeguarding level and, if felt appropriate, rolled out to all practices in the area.

- The GP practice will be informed of the learning from this review in the delivery of a feedback session to ensure that learning can be embedded into practice.

## 17. RECOMMENDATIONS

### 17.1 Panel Recommendations

| Number | Recommendation |
|---|---|
| 1 | That East Riding Domestic Abuse Partnership produces a document that details the learning on this case – to be then shared to all agencies involved in this review – to disseminate the learning from this case, within their agency, and to raise awareness of the complexity and subtlety when identifying indicators of coercive control. This could be achieved by embedding the learning into a case study, or other form of training materials, and the production of a briefing document. |
| 2 | That East Riding of Yorkshire Health and Care Partnership provides a report to East Riding Community Safety Partnership, detailing how GP practices are embedding selective enquiry into practice, in compliance with NICE guidance – 'Domestic Violence and Abuse: Multi-Agency Working'. |

### 17.2 Single Agency Recommendations

17.2.1 There were no single agency recommendations identified for this review.

17.2.2 All identified learning has been addressed, as detailed in Term 16.

**Appendix A – Action Plans**

| Review Panel Recommendations | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | That East Riding Domestic Abuse Partnership produces a document that details the learning on this case – to be then shared to all agencies involved in this review – to disseminate the learning from this case, within their agency, and to raise awareness of the complexity and subtlety when identifying indicators of coercive control. This could be achieved by embedding the learning into a case study, or other form of training materials, and the production of a briefing document. | Local | The Strategic Domestic Abuse Board to:<br>1. Produce a briefing document on the learning from this case and disseminate to all agencies involved in the review.<br>2. The SDAB to ensure that agencies disseminate learning within to raise awareness of the complex nature of domestic abuse | Strategic Domestic Abuse Board (SDAB)<br>Domestic Abuse and Safeguarding Partnerships Manager<br><br>Domestic Abuse Training and Development Officer | 1. Learning brief completion<br>2. Dissemination of learning brief across the partnership and within agencies own internal organisations<br>3. Embedding of a case study within the DAPS and agencies own Domestic Abuse Professionals and Internal DA training. | Jan 2025 | |

| **Review Panel Recommendations** |
|---|

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | and coercive control<br>3. To develop the anonymised case into a case study to be embedded into domestic abuse training in the Local Authority Area. This will be embedded within the DAPS multi agency training package (Domestic Abuse Practitioner Standards) which is available to all professionals in the LA area, and made available to agencies own | | | | |

**Review Panel Recommendations**

| No | Recommendation | Scope local or regional | Action to take | Lead Agency | Key milestones achieved in enacting recommendation | Target Date Completion | Completion Date and Outcome |
|---|---|---|---|---|---|---|---|
| | | | professional / internal DA training | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2 | That East Riding of Yorkshire Health and Care Partnership provides a report to East Riding Community Safety Partnership, detailing how GP practices are embedding selective enquiry into practice, in compliance with NICE guidance – 'Domestic Violence and Abuse: Multi-Agency Working'. | Local | Yorkshire and Humber ICB (integrated Care Board) to roll out selective enquiry into East Riding GP Practices in accordance with the NICE Guidance, including development of training and practice briefings to facilitate this.<br><br>To monitor this practice across ER GPs and produce an audit | Yorkshire and Humber ICB (ER DA Leads) | Y&H ICB roll out selective enquiry to GP practices in the ER including training / learning practice briefs<br><br>Audit programme developed to monitor the success and areas of improvement for this and report back to the SDAB<br><br>Report from the ICB to the ER CSP on the success and areas of learning to this following implementation | Jan 2025<br><br>March 2025<br><br>Oct 2025 | |

**Review Panel Recommendations**

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | programme to facilitate this<br><br>To produce a report to the ER CSP detailing the embedding of this across ER GPS and the success and areas of learning to improve this practice / embedding of, beyond implementation | | | | |

End of overview report

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Shelley Goodinson
Domestic Abuse and Safeguarding Partnerships Manager
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Beverley
HU17 9BA

26th February 2025

Dear Shelley,

Thank you for submitting the Domestic Homicide Review (DHR) report (Elizabeth) for East Riding Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd January 2025. I apologise for the delay in responding to you.

The QA Panel felt that the family tribute at the beginning of the report, along with the inclusion of statements from friends and work colleagues provided an insight into Elizabeth as a person. The timeline was well explained and well-informed research is provided throughout. The lessons and recommendations were also noted to be relevant and SMART.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published. **Areas for final development:**

- Whilst the names used for the children are gender neutral, the sex of 'Ira' is revealed at 14.61 and 14.66 and should be amended to ensure anonymity.
- The Home Office data collection form records family declined attending a panel meeting. This is not stated within the report itself and should be noted.
- Section 11 defines the protected characteristics but does not currently address how these are relevant to the review – specifically the victim's sex and that she had a condition that affected her hearing and how these could have been considered in relation to her individual experience of and response to domestic abuse.

- The inclusion of detail of the children's conversations with social workers following the deaths at 14.65 -14.68 seems somewhat unnecessary and intrusive to their privacy. The Panel therefore suggests removing this.
- The review would be enhanced by some consideration given within the analysis of the increased vulnerability of women when they have just left a domestically abusive relationship, to being targeted by perpetrators as vulnerable.
- The report currently feels weighted to perpetrator's voice, and more consideration could therefore be given to how the victim's voice can be made more central to the report.
- The lessons identified by each agency are set out in section 14.6, alongside the actions taken to address the learning. As these are not then repeated in section 16 (learning Identified). It would be helpful to bring all of the learning together in one section.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review. Yours sincerely,

Home Office DHR Quality Assurance Panel