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SAFERNORTHUMBERLAND

A Domestic Homicide Review of the death of Mary

March 2022

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Section 1: Introduction

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Mary, a resident of Northumberland, prior to her tragic death in March 2022.

1.2 In addition to agency involvement, the review will also examine the past, to identify any relevant background or indicators of harm or of potential abuse before her death. It will consider if support was accessed and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify lessons that can be learned from this incident.

1.3 The circumstances of the death were initially provided by Northumbria Police via email to the Chair of the Safer Northumberland Partnership (SNP) on 7th April 2022.

1.4 To protect the identity of those involved, pseudonyms were used for both adult subjects in the review. The victim will be referred to throughout as Mary. There is no other person directly involved in the death in this case. However, Mary did have an ex-partner. Initial scoping suggested an abusive relationship which resulted in the launch of a Domestic Homicide Review (DHR). The ex-partner will be referred to throughout the review as Kyle. Mary's family were consulted and agreed to the use of these pseudonyms.

1.5 Mary and Kyle had a child together. The baby was removed from their care and child protection procedures will also be considered as part of this review.

1.6 The review will consider all agencies' contact and involvement with Mary and Kyle from January 2019 through to the date of Mary's death. This three year period was agreed as appropriate in order to give a full picture of Mary's life and vulnerabilities. However, to fully understand Mary's experiences and see life through her eyes, the panel agreed to consider any significant event or pattern of events spanning her lifetime. These are also documented within the review.

1.7 The key purpose for undertaking DHRs is to enable lessons to be learned where a person is killed as a result of domestic violence and abuse or takes their own life and suffering domestic abuse or experiencing coercive control may have been a significant factor. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Section 2: Timescales

2.1 The review began in September 2022 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 23rd November 2022. The panel met again on 15th March 2023 and on 24th May 2023.

2.2 The DHR was concluded in September 2023 following presentation to the Safer Northumberland Partnership, who agreed with the conclusions, learning and recommendations.

Section 3: Confidentiality

3.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

3.2 The victim, Mary, was 19 years old at the time of her death. Her ex-partner, Kyle, was 21 years old at that time. Their child will only be referred to in general terms to protect their identity. We can summarise that the child was still a baby at the time of their mother's death. All subjects of this review are British citizens who reside or did reside permanently in the UK. Their ethnicity is white / British.

Section 4: Terms of Reference

4.1 The terms of reference were agreed at the convening of the first DHR panel:

- Were practitioners sensitive to the needs of the victim? Were they knowledgeable about potential indicators of domestic violence or abuse?

- Did the agency have policies and procedures in place relating to domestic abuse? Were these policies complied with?

- Were risk assessment and risk management processes for domestic abuse victims or ex-partners correctly used in this case?

- Did the agency adhere to agreed information sharing protocols?

- What were the key points or opportunities for assessment and decision making?

- How were the victim's wishes or feelings ascertained or considered? Is it reasonable to assume the wishes of the victim should have been known? Were they informed of options/choices to make informed decisions?

- Was the victim or ex-partner ever listed at the MARAC?
  MARAC is a Multi-Agency Risk Assessment Conference. It is a meeting of professionals to share information and formulate plans to protect the victim and their children in the highest risk domestic abuse cases (those cases where the victim is assessed as at risk of significant harm).

- How were mental health support services accessed by the victim or ex-partner? What were the outcomes of these contacts?

- Was the ex-partner known to agencies for previous domestic abuse incidents? Were there any injunctions or protection orders in place?

- Were nationally and locally agreed child protection procedures correctly implemented?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim and ex-partner? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Did any restructuring during the period under review have any impact on the quality of service delivered? Did the Covid-19 pandemic affect service delivery?

4.2 As the DHR progressed, further information came to light which suggested the victim may also have been subjected to financial abuse. Therefore, an additional term of reference was set by the Independent Chair to consider this aspect:

Was the victim subjected to economic or financial abuse?

4.3 Initial scoping gave a very brief indication of the victim suffering a sexual assault. Further enquiries were carried out which showed the victim had suffered several episodes of sexual violence. The Independent Chair therefore added a further term of reference to consider the impact of sexual violence and the agencies' response to this:

Consider the incidents of sexual violence and abuse disclosed by the victim. How were these investigated and what support measures were put in place?

4.4 It also became apparent, as the review progressed, that the victim had complex needs and this required support from agencies. In particular, the actions and decision-making of professionals following the start of child protection procedures required further scrutiny. To focus fully on this issue a further term of reference was added to pose the question:

How were the support needs of a vulnerable young mother considered and reviewed in this case?

Section 5: Methodology

5.1 The Safer Northumberland Partnership (SNP) was formally notified of the circumstances of the death by the police in April 2022. A briefing was then delivered to all members of the Safer Northumberland Partnership. On 12th May 2022, SNP members agreed that a Domestic Homicide Review should be convened. All agencies likely to be involved in the review were notified in writing, to secure records and begin an initial scoping exercise to determine the level of agency involvement.

5.2 The aim of the DHR Panel was to deliver the review as soon as practicable. There were some delays, as the ex-partner had never been charged or convicted of any offences. This meant detailed consideration and specialist legal advice was necessary to comply with the requirements of the UK GDPR (2018) regulations regarding access to his personal data. However, the DHR Panel Chair is confident the review maintained focus and the final report was completed in good time.

5.3 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide or death and to determine whether a review is required. In accordance with the provisions of Section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

a) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
b) A member of the same household as himself / herself."

5.4 For this review, the term domestic abuse is in accordance with the statutory definition of domestic abuse contained within the Domestic Abuse Act 2021:

'Definition of "domestic abuse"

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

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

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

(b) the behaviour is abusive.

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

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

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

(e) psychological, emotional or other abuse;

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

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

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

(b) obtain goods or services.

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

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

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

2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

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

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

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

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

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

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

(g) they are relatives.

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

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

(b) the person has parental responsibility for the child.

(3) In this section—

- *"child" means a person under the age of 18 years;*
- *"civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004;*
- *"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);*
- *"relative" has the meaning given by section 63(1) of the Family Law Act 1996.*

3 Children as victims of domestic abuse

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

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

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

(b) is related to A or B.

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

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

(b) the child and the person are relatives.

(4) In this section—

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

5.5 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

5.6 The Safer Northumberland Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review. Although the victim took her

own life, the Partnership were concerned there may have been domestic abuse and elements of coercive control within her relationship with her ex-partner.

The statutory guidance states the purpose of the review 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 upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

- Contribute to a better understanding of the nature of domestic violence and abuse.

- Highlight good practice.

Initial scoping suggested that several agencies in Northumberland had involvement with the subjects of the review. Chronologies were requested and nine organisations were required to submit an Individual Management Review (IMR) of their agency's involvement. Other agencies submitted summary reports of their limited involvement. The Independent Chair made enquiries to confirm the independence of the IMR authors.

Section 6: Involvement of family, friends, neighbours and wider community

6.1 Mary's family were approached at the start of the Domestic Homicide Review. The Independent Chair telephoned Mary's mum and explained how the DHR would be conducted and progressed. He also clarified that although the title was 'Domestic Homicide Review', this was not an accurate description of the process. The Chair explained there was no third party involved directly in Mary's death and that nationally matters were being reviewed to explore a more suitable title for this type of review. However, he noted that initial scoping suggested Mary had been a victim in an abusive relationship.

6.2 The Chair then wrote formally to Mary's parents to set out the process and that the family were invited to take part. This was followed by another telephone call to clarify a timetable. The parents were thanked for their agreement to take part during that difficult time. The Independent Chair also explained the role of independent advocacy services. Mary's mum declined additional support and was happy that she had her partner, her sons and also a very good close friend who were supporting her.

6.3 Further periodic calls took place and then the Independent Chair travelled to Mary's home town and met her family face to face. Mary's parents both attended as did Mary's mum's close personal friend. The meeting lasted several hours and discussions included Mary's early life together with her relationship history, the involvement of services and a review of each individual incident recorded by agencies. The parents assisted by providing valuable clarification of events and also their own personal views of how Mary's issues and contacts had been handled.

6.4 Mary experienced bullying at school. There were extended periods of school absence. This led to her first incidences of self-harm. Her parents also described how Mary was deeply affected by the death of her grandad and this too resulted in incidents of self-harm. However, by her final school year, Mary did attend school and sat her school examinations.

6.5 Despite it being a difficult subject, Mary's mum bravely provided the Independent Chair with background details of her daughter suffering sexual violence. The details of these discussions are included within that specific term of reference.

6.6 Mary met Kyle when they were both at college. Mary's parents state he treated their daughter badly. He was jealous and controlling. They reported two separate occasions when they had each heard the way he spoke to her. Mary's mum was chatting with her daughter on a lap top computer via 'FaceTime' one afternoon when Kyle arrived back at his flat. He did not know Mary's mum was on the screen and she heard him being abusive to

her, demanding to know where she had been and saying things like 'you're a fruit loop'. He stopped once he realised Mary's mum could hear him.

6.7 The family gave other examples of controlling behaviour perpetrated by Kyle towards Mary. He was heard by Mary's father 'timing' her for how long she had been out of the flat and again demanding to know where she had been. He asked her who she had in the flat. Mary's mum recalls how she stopped taking pride in her appearance. Mary disclosed to her mum that Kyle insisted she wore her pyjamas and not her leggings. He wouldn't let her wear make-up.

6.8 Mary's parents (supported by their close friend) wanted the review to explore why Kyle had not been prosecuted for stalking Mary and why she had not been allowed to live at home with her parents with the baby.

6.9 The parents confirm they now have a Special Guardianship Order for the child. But they are unhappy at how the child protection case was handled by Children's Services. As far as they are concerned, Mary living elsewhere and out of the family home was unnecessary.

6.10 When talking about Mary and Kyle's unhealthy relationship, Mary's dad stated of Children's Services;

'*They pushed them together. She wasn't allowed to live at home and so she was miles away in Blyth, living in the same block of flats as him. She had no family there to support her.'*

6.11 Mary's parents believe Children's Services made their mind up that Mary was neglecting the baby and that they wouldn't reconsider this. They state that the baby was examined by a paediatrician who told them there was no medical reason why the baby was not gaining weight. But they state that now they are two years old, the child is diagnosed with a number of disabilities; brain damage to their left hand side, cerebral palsy, epilepsy and has to be 'PEG fed'[1]. The parents are absolutely convinced that if the paediatric examination had picked up on these problems, including the baby refusing the bottle and having to be fed by a tube, then the social services assessment would have been quite different.

6.12 Mary's parents cannot understand why Mary was not allowed to live at home with them. As well as the challenge to the paediatric examination, they report that the actions of Children's Services 'blamed' her for neglecting her child and had a detrimental effect on her mental health.

6.13 Mary's parents are of course, still grieving the loss of their daughter. They take comfort in having care of their grandchild. The young child has extensive disabilities and may never be able to walk. But they adore their grandchild and cherish the memories of Mary through the baby.

[1] Fed through a Percutaneous Endoscopic Gastronomy (PEG) tube.

6.14 Mary's family will remember her as a loving daughter and sister. They describe a young woman who was cheerful and friendly. Mary's mum believes Mary was only just starting to realise how complex her mental health needs were. She didn't hide these away but remained outgoing. They miss Mary so much and hope that any learning from this review can be shared to prevent other families experiencing such a tragic loss.

Section 7: Contributors to the Review

7.1 Eleven agencies have contributed to the Domestic Homicide Review by the provision of summary reports or chronologies. Nine agencies then provided Individual Management Reviews (IMRs) to outline and analyse their own single agency actions, contacts and decision-making. The review chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author.

7.2 The following organisations were required to produce an Individual Management Review:

- North East and North Cumbria Integrated Care Board
- Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust
- Northumbria Health Care NHS Foundation Trust
- Northumberland County Council Children's Services
- Northumbria Police
- Northumberland Domestic Abuse Service
- North-East Ambulance Service
- Northumberland County Council Homelessness and Housing Options Team
- Northumberland County Council Housing Team

7.3 Other agencies provided scoping, summaries and chronologies:

- Talking Matters (then part of South Tyneside & Sunderland NHS Trust)
- Northumberland County Council Adult Social Care

Section 8: The Review Panel Members

8.1 The Independent Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

8.2 The Domestic Homicide Review panel comprised of the following people:

- Chris Grice – Northumberland County Council (NCC), Strategic Community Safety Officer & DHR Lead
- Jim Kilgallon - North East Ambulance Service (NEAS)
- Sharron Pearson, Senior Manager, Children's Services, NCC
- Lesley Pyle - NCC, Domestic Abuse & Sexual Violence Lead
- Ian Callaghan -Northumbria Police, D/Inspector, Strategic Safeguarding
- Leesa Stephenson - Northumberland Integrated Care Board (ICB), Designated Safeguarding Adults Nurse
- Yvonne Lawrence -Northumbria Healthcare NHS Foundation Trust, Acting Head of Safeguarding
- Sheona Duffy -Cumbria, Northumberland and Tyne & Wear NHS Trust (CNTW), Acting Named Nurse, Safeguarding & Public Protection
- Julie Stewart - NCC, Strategic Housing Manager
- Andrea Cross - NCC, Head of Service, Safeguarding Adults & Social Care
- Patrick Boyle, Senior Manager, Children's Services, NCC
- Shlomi Isaacson - NCC, Information Governance & Data Protection
- Sharon Brown- CEO, Northumberland Domestic Abuse Service (NDAS)
- Nici Dodd - NDAS, Office Manager
- Lisa Harrison - Northumbria Police, D/Sergeant, Strategic Safeguarding
- Davina Blake - NCC, Community Safety Support Officer
- Pam Lee - Public Health (specialist in suicide prevention)
- Sue Pearce - CEO Rape Crisis, Northumberland and Tyneside

Following disclosures of sexual abuse, a specialist service; Rape Crisis, Tyneside & Northumberland (RCTN) were invited to join the panel after the second meeting. They provided valuable support and advice within this sensitive arena.

The panel members were completely independent and had no direct dealings with the subjects of the review nor management responsibilities to any front line worker involved with any of the subjects of the review.

Section 9: Author of the overview report

9.1 The appointed Independent Author is Mike Cane. He is completely independent of the Safer Northumberland Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and investigation of child abuse, rape and other serious sexual offences. He has extensive experience as a panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years and was also Chair of the Sexual Assault Referral Centre (SARC) management board. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as an Independent Chair/Author.

Mike completed accredited DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as taking part in AAFDA training on ‘involving children in Domestic Homicide Reviews’ in 2021 and ‘best practice in managing DHRs’ in 2022.

He has designed and delivered domestic abuse training (identification, risk assessment & risk management) to staff across the public/voluntary sector.

Section 10: Parallel Reviews

10.1 The inquest into Mary's death was opened and adjourned on 25th November 2022. HM Coroner will not make a decision in relation to resuming the inquest until after the outcome of the DHR is known. Contact was made with HM Coroner's office and agreement reached that a copy of the Domestic Homicide Review would be provided at the conclusion of the DHR process.

10.2 A young child was removed from parental care during the timeframe of this review. Children's Services were part of the Domestic Homicide Review Panel. There was no requirement for a separate Child Safeguarding Practice Review, but one of the terms of reference specifically considers how child protection procedures were managed. Another term of reference was developed during the review process, linked to support offered and accessed by a young mother when a child had been removed from her care. A copy of the completed overview report from the DHR will be shared with Children's Services and the Northumberland Children and Adults Safeguarding Partnership (NCASP).

10.3 Neither subject of the Domestic Homicide Review were accessing services under the Care Act 2014. There was no requirement for a Safeguarding Adult Review. However, vulnerabilities were identified relating to the victim and her ex-partner. Adult Social Care were part of the DHR panel and a copy of the DHR will be shared with Adult Social Care and the NCASP.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim and her ex-partner were not married at the time of her death. Their marital status did not affect any of the services provided.

11.3 No issues were identified during this review applicable to gender reassignment, sexual orientation, race or religion.

11.4 The victim was a vulnerable woman but was not registered as disabled, nor in receipt of statutory services.

11.5 The ex-partner was a vulnerable young man with a 'mild to moderate' learning disability but was not in receipt of services under the Care Act 2014.

11.6 With regard to sex, around three-quarters of suicides in England are males (4,129 deaths; 74.0%), consistent with long-term trends, and equivalent to 16.0 deaths per 100,000. The rate for females taking their own life is 5.5 deaths per 100,000.

Females aged 24 years or under have seen the largest increase in the suicide rate since detailed recordings began in 1981.

Of note, at the time of concluding this Domestic Homicide Review, HM Coroner's Inquest is adjourned. The ruling and the reasons behind Mary's death are still to be established.

The North East region also had the highest suicide rate in England.

Data also shows that females were the victim in 73% of domestic-abuse related crimes in England in the year ending March 2021.[2]

The Domestic Homicide Project states:

'*Across the two-year period 1 April 2020 to 31 March 2022 there were 470 deaths in total which took place in a domestic setting or following domestic abuse, including 43% intimate partner homicide, 24% suspected victim suicide, 22% adult family homicide, 8% child death, and 3% 'other'. Police are identifying more suspected victim suicides with a history of domestic abuse – up 28% to 64 cases in year two.'*[3]

Section 12: Dissemination

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

- HM Coroner
- All organisations within the Safer Northumberland Partnership
- Northumberland Children and Adults Safeguarding Partnership
- Northumberland DHR Panel
- Office of Police and Crime Commissioner for Northumbria
- Home Office DHR team
- The Domestic Abuse Commissioner for England & Wales
- Mary's family

[2] Office for National Statistics 2021

[3] The Domestic Homicide Project is a Home Office funded research project led by the National Police Chiefs' Council (NPCC) and delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing.

Section 13: Background information

Case specific background

13.1 The victim, Mary, was born in the UK. She had some challenges with her education attendance but was not diagnosed with a learning disability. Records confirm Mary was supported on a Child Protection Plan in 2008 (at the age of 6 years). She met Kyle in 2019 and became pregnant. She gave birth in 2020. The relationship fluctuated with the couple splitting up, resuming the relationship and then splitting up again.

13.2 Mary had self-harmed and taken overdoses of prescription drugs on many occasions during her teenage years.

13.3 Mary's child had been removed from her care due to a failure to thrive and an assessed lack of capacity for the parents to care for a young baby. The relationship with the baby's father was also noted to be abusive and controlling. These issues caused Mary a great deal of anxiety and distress.

13.4 Mary's ex-partner, Kyle, was born in the UK. He was 21 years old at the time of Mary's death. He had been taken into care as a Looked After Child and remained within the social care system for many years. From the age of 18 years, he was supported by the Northumberland County Council 'Leaving Care Team'. This support remained in place until the age of 21. He also had some involvement with Adult Social Care. Kyle has a mild to moderate learning difficulty.

13.5 Mary made allegations of physical and sexual abuse perpetrated by Kyle. She also reported she was suffering coercive control and harassment. Several incidents were reported to the police.

13.6 In March 2022, Mary's mother called at her daughter's home address and found her lifeless body. Mary was in bed. Police and ambulance services were called but Mary was deceased. Medication and a note were found at her bedside. Mary was only 19 years old.

13.7 A subsequent post mortem examination revealed the levels of propranolol in Mary's body were 20 times that which would be expected from a therapeutic dose.

13.8 An inquest into Mary's death was opened and adjourned on 25th November 2022.

Section 14: Chronology

14.1 The Domestic Homicide Review Panel agreed to review agency records going back three years before Mary's death. In some instances, earlier records were also checked as they could provide an insight into the life experiences of both Mary and Kyle.

14.2 On 27th June 2017, Kyle's carer telephoned for an ambulance. He had been smoking marijuana and felt dizzy and unwell. The call was passed to a District Nurse to provide advice and Kyle was left in the care of his guardian (he was 16 years old at this time).

14.3 During March and April 2019, there are several entries within the 'Leaving Care Team' (part of Northumberland County Council Children's Services) that indicate behaviour of concern regarding Kyle (then aged 18 years). There were issues of Kyle and other young people congregating at Kyle's cousin's flat. The property was described as 'not in good condition' and young people were smoking cannabis and drinking alcohol. Kyle had been evicted from his supported accommodation and there were concerns about his safety at his cousin's flat where the windows had been smashed several times. When a support worker visited Kyle, he was in bed. There were cigarette butts covering the floor and mattress.

14.4 On 22nd May 2019, Mary attended her GP. She disclosed having unprotected sex and thought she might be pregnant. The test was negative.

14.5 On 23rd May 2019, Kyle's support worker contacted the Homelessness department at Northumberland Council to support a tenancy for supported accommodation.

14.6 On 12th June 2019, Mary again attended her GP for a pregnancy test. She was accompanied by her mum who wanted Mary to start taking contraceptives. Mary is described in the notes as less concerned about the contraception.

14.7 On 1st July 2019, Mary contacted the 'Talking Matters' service (at that time provided by South Tyneside and Sunderland NHS Trust). It was a self - referral. Mary described engaging in self-harm the day before and was experiencing negative thinking.

14.8 On 27th July 2019, Mary had her initial assessment with 'Talking Matters'. The appointment was conducted over the telephone. Mary shared an incident of deliberate self-harm two months ago. She described it as 'cutting' and the wounds were superficial. She advised she had been engaging in deliberate self-harm from the age of 14 or 15 years. Mary also disclosed one previous suicide attempt in 2018 which was an overdose in

response to a relationship break-up. She denied any active suicidal thoughts at that time. No risk to or from others was declared. Mary was offered Cognitive Behavioural Therapy (CBT) and moved to the appropriate waiting list. Mary's GP was sent a letter confirming the initial assessment had taken place and the planned CBT appointment.

14.9 On 23rd September 2019, a support worker from the Leaving Care Team accompanied Kyle to enrol at Northumberland College. The enrolment was not successful. Kyle felt anxious about college and no tutor was available to explain the processes to him.

14.10 On 24th October 2019, Kyle's mother reported to his support worker that his girlfriend was pregnant.

14.11 On 28th October 2019, Kyle met with a social worker and his support worker (together with his mother) to discuss his accommodations needs. He was encouraged to meet with 'Horizons' (supported accommodation providers). Kyle stated he did not wish to access this service. His mum pointed out he needed to move out of his grandmother's home as they had been arguing. Kyle needed to find his own place. Also during the meeting Kyle disclosed his girlfriend (Mary) was pregnant. He wasn't clear on the actual relationship status at that point, though his mother shared that Kyle and Mary had been arguing. Kyle would not give Mary's full name.

14.12 On 6th November 2019, Mary attended a maternity appointment with Northumbria Healthcare Midwifery Team. It was her first pregnancy. The notes record she was 17 years old and had a history of self-harm. The notes also describe she was engaging with 'Talking Matters' and was waiting to see the CBT (Cognitive Behaviour Therapy) service for anxiety. Kyle was named as the baby's father and a history of social care involvement was identified. Mary said she was happy about the pregnancy but the Kyle was 'mixed' about it. Mary reported that Kyle could be jealous, play 'mind games' and be quite controlling. Mary stated that they were separated and had no contact.

14.13 On 12th November 2019, a housing officer from the 'Homefinder' team tried to contact Kyle. There was no response so in turn they contacted Kyle's grandmother (where Kyle had been staying on a temporary basis). She advised Kyle did not want the properties his mum had been making bids for on his behalf. The housing professional advised that they would take over the bidding for Kyle and would update each week on progress. The same day, Kyle's housing band changed from Band 2 to Band 1 as he was staying in temporary accommodation (i.e. his grandmother's) and could be potentially homeless in the near future.

14.14 On 25th November 2019, the housing officer contacted Kyle's support worker from the Leaving Care Team. The support worker reported that

Kyle's mother was becoming increasingly concerned about him living with his grandma. She alleged Kyle had been in his grandma's purse and that he was coming in late, not locking the door.

14.15 On 4th December 2019, the support worker from the Leaving Care Team made a referral to Children's Social Care for Mary and Kyle's unborn baby. The concerns listed were:

- In the past Kyle has struggled to manage his own finances and home.
- Kyle had previously lived at an address of concern, where young people who had been reported missing had been found.
- Kyle has a learning difficulty and it is not always clear what he understands about looking after himself and to what extent he prioritises this.
- Kyle is a care leaver. He may struggle to form an attachment with the child.
- Kyle has limited to no experience of looking after a child.
- There have been arguments and conflict between Kyle and Mary.

14.16 On 10th December, a discussion took place between Kyle's support worker and a member of the homelessness team. Kyle had a viewing on 12th at a flat in Blyth. Apparently he did not seem keen on the move but his family have said he will be homeless if he does not take it. The tenancy was approved two days later.

14.17 On 19th December, the support worker from the Leaving Care Team supported Kyle in obtaining a fit note review by his GP. The support worker explained Kyle's learning difficulty to the GP. Kyle wasn't able to talk about his mood during the appointment. The previous fit note had been for low mood. Kyle disclosed he and Mary were not speaking and that she had 'blocked' him on social media. Kyle also reported that Mary's brother uses cannabis and cocaine and that he had hit Mary when under the influence of controlled drugs. The support worker shared this information with Children's Services.

14.18 On 7th January 2020, Kyle signed for his tenancy and was given the keys to his flat.

14.19 On 10th January, Kyle's support worker reported to the homelessness officer that the relevant support will be put in place for Kyle and this included a £2000.00 grant from social services to assist with furnishings, decorating etc.

14.20 On 13th January, Kyle's support worker accompanied him to the Job Centre where he handed in a fit note declaring him not currently fit for work due to his low mood and learning difficulty.

14.21 On 16th January, Mary's mother called the police to report Kyle making threats to harm Mary and to have the baby 'taken off her'. He also apparently demanded Mary's current boyfriend and her father fight him. Her mother also stated Kyle knew where Mary lived. Police established there had been no direct threats. Mary did not want any action taken. A domestic violence report was completed and the incident assessed as 'standard risk'. Police also submitted a Child Concern Notice (CCN) for the unborn baby, plus a 'Victims First Northumbria' referral. Kyle was given advice by police regarding further contact with Mary.

14.22 On 30th January, Mary had her first treatment appointment with the Talking Matters service. The professional was a High Intensity Psychological Therapist (HIPT). Mary was accompanied by her mother and the appointment was face to face. Mary disclosed she was 28 weeks pregnant. She declined consent for the HIPT to contact her midwife as Mary stated she believed 'the midwife had taken the side of her ex-partner'. Therapeutic goals were established. There were no risks to self or others disclosed and no risk from others were disclosed.

14.23 On 6th February 2020, a housing officer conducted a 'new tenant' visit at Kyle's new property. This applies to all new tenants. The visit included checks that Kyle was settling in, there were no rent arrears and that any claims for universal credit or other allowances had been submitted.

14.24 On 13th February, Mary had her second treatment appointment with the Talking Matters service. This was a face to face appointment with the HIPT and Mary was accompanied by her mother. Mary stated she wanted to end the therapy. She described feeling better due to housing and college matters being resolved. Mary also described how she wanted to focus on her pregnancy and not talk about issues that made her feel anxious. She was offered the opportunity to work on relaxation and mindfulness but declined this in favour of being discharged from the service. Again, no risk to herself or others and no risk from others were disclosed.

14.25 Only six days later, on 19th February, Mary submitted a self-referral to the Talking Matters web site. She stated she was 'in a really bad dark place'. Mary received an initial assessment by telephone contact the next day. She reported going through a recent relationship break-up, which at times she blamed herself for due to being pregnant. Mary also reported fleeting suicidal thoughts but without planning or intending to act. She described one incident of self-harm on 18th February (the day before her self-referral) when she cut herself with a 'Stanley' blade. Mary went on to report she had no current or past risks from others. She was offered Cognitive Behaviour Therapy (CBT) and moved to the appropriate waiting list.

14.26 On 4th March 2020, Kyle's Leaving Care Team support worker met with a social worker from Adult Social Care to review and assess Kyle's needs. All information regarding Kyle's vulnerabilities were shared.

14.27 On 19th March, Mary sent a message online to the Talking Matters service. She stated she was getting worse and that being on the waiting list was not helping so she would like to withdraw from the service. The HIPT professional telephoned Mary a week later to advise they could book in a first treatment appointment, but Mary asked to be discharged and stated she did not require support at that time.

14.28 On 8th April 2020, Mary had a maternity appointment at the hospital. Staff noted 'love bites' on her neck. The midwife discussed this with Mary who acknowledged her relationship with Kyle had resumed. This information was shared with Children's Services.

14.29 On 21st April 2020, the health visitor made a referral to Children's Services as she had concerns about Mary and Kyle reconciling their relationship, as there had been previous reports of the relationship being abusive.

14.30 Mary had two lengthy telephone conversations with a social worker; on 24th and 29th April. Mary was aware of the concerns raised by the health visitor. Mary did not share the concerns about the relationship resuming. Mary stated her relationship was 'on/off' with Kyle and that she and the new baby were living at home with her mother. Mary said she 'wanted to give Kyle a chance'. She also disclosed that she had a problem overthinking things and this affected her. She told the social worker Kyle was 'putting her down', telling her 'you are getting paranoid'. However, Mary also stated that some people in her college had said similar things about her being paranoid.

14.31 On 1st May 2020, the social worker carried out a home visit with Mary and her baby. Mary, Kyle and the baby were all living at Mary's mother's house. Mary and her mother were advised not to leave Kyle with the baby on his own as social workers were worried about him being able to care for the baby alone. The notes state the family were not happy about the supervised care plan in place during the social care assessment phase.

14.32 On 6th May there was a strategy meeting held regarding the baby failing to thrive and parental capacity to meet the baby's needs. The notes state a paediatrician was due to see the baby later that day and that this would help to inform the plan (the paediatrician's examination subsequently showed no medical reason for the baby having low weight gain).

14.33 On 16th May 2020, Mary's baby was admitted to the Children's Assessment Unit at Northumbria Hospital, Cramlington. Mary reported low mood and arrangements were made for her to see the Psychiatric Liaison Team (from

Cumberland, Northumberland, Tyne & Wear NHS Trust -CNTW). Mary consented to an assessment.

14.34 CNTW professionals spoke with Mary and reported that the anxiety she was feeling was appropriate within the context of being a first time mother. She was not presenting as depressed and she had been prescribed sertraline by her GP two days earlier. She said she was not suffering abuse. She agreed to follow up care with the Universal Crisis Team after baby's discharge from hospital.

14.35 On 19th May, a professional from the Universal Crisis Team rang Mary as agreed. Mary reported improved mood on returning home and support from her parents and brothers. She shared she had previously accessed support from 'Talking Matters' but she had found this unhelpful. Mary declined further support for her mental health, reporting that she felt some improvement with her medication and regular GP appointments in place. Discharge from mental health services was agreed and crisis and contingency planning were discussed.

14.36 On 20th May, Mary informed Children's Services that she was moving out and wanted to reside with Kyle. A safety plan was put in place. This included Mary and the baby staying at the paternal grandmother's home.

14.37 On 21st May as part of the Children & Families' assessment, a social worker visited the home. Mary showed the social worker messages from her brother calling her names such as 'slag'. There were also messages from Mary's mother telling Mary that she wanted to care for the baby over the weekend as she was not at work. The social worker strongly encouraged Mary to go back to her mother's address as this would be the preference of Children's Social Care. Mary was clear that she did not want to do this. She said she was uncomfortable there and it was impacting on her mental health. She also said that she, Kyle and the baby had not stayed at Kyle's mother's last night, as agreed. The social worker agreed that Mary, Kyle and the baby could stay there that night but that Kyle or his mother were not to have sole care of the baby (due to issues with one of Kyle's siblings).

14.38 On 24th May, Kyle rang the police to report he had been assaulted by Mary's brother. He reported that he, Mary and his own brother had attended Mary's mother's address to collect some of her belongings and there had been an altercation when Mary's brother had hit him in the face. A further call was then received from Kyle's brother to say Mary's brother had also pulled a knife on them. Finally, the call stated Mary was being prevented from leaving the address by her mother and her brother. When police attended, it was established that Mary's brother had threatened to get a knife and had gone into the address; however he had not come back outside and no knife was ever seen. Kyle, his brother and Mary were

escorted from the area. A crime report of assault was completed and finalised as undetected as Kyle had declined to support a prosecution. The baby was not present, but officers submitted a Child Concern Notice (CCN) due to the circumstances. However no domestic abuse report was submitted.

14.39 On 26th May, a Section 47 Child Protection enquiry was initiated.[4] The social worker explained to Mary that child protection enquiries were now being undertaken and that professionals were worried about the very young baby who had not been well and that the baby needed to be the priority. The child was not gaining sufficient weight and there was no apparent medical cause for this.

14.40 On 11th June 2020, an Initial Child Protection Conference (ICPC) was held. Attendees agreed that Mary and Kyle's baby would be placed on a Child Protection Plan under the category of neglect. The concerns were around the parent's ability to meet the basic care needs of the baby, without a significant amount of adult support. The child had been admitted to hospital three times due to not gaining or maintaining weight. Kyle had a learning difficulty and there had not been an assessment on what impact this had on his ability to parent. Mary was to remain living with her parents who would help her with the care and feeding of the child.

14.41 On the same date, Mary had an appointment with her GP. She reported her medication was making her feel dizzy. The GP agreed to start a different anti-depressant.

14.42 On 16th June 2020, during a telephone call with the social worker, Mary said she 'did not want to be here'. The social worker asked what she meant and Mary said that she wanted to kill herself. They had been discussing the baby needing regular feeds. Mary said she was upset that Children's Services were saying she was starving the baby and then hung up the phone. The social worker rang back and spoke with Mary's mum. She told the professional that Mary and her brother were arguing and that Mary was trying to hurt her own wrists. The social worker encouraged Mary's mum to help Mary and that she would call back tomorrow.

14.43 On 17th June, the social worker called back. They discussed Mary's medication and that she may wish to speak with her GP. The social worker asked Mary about her doing something to her wrists yesterday. Mary said she had been scratching at them yesterday when she argued with her brother, but that she was feeling more positive today.

14.44 On 1st July 2020, Mary's mum called '999' for an ambulance after Mary took an overdose of paracetamol, citalopram and propranolol. She was

[4] Section 47 Children Act 1989

conveyed to Accident & Emergency department at Cramlington Hospital where she was admitted. She reported to staff that it was her intention to end her life and that her mum was 'trying to take the baby away'. The medical notes record that Mary was known to have suffered from post-natal depression and that self-harm scars were noted on her wrists. The records also confirm staff knew about domestic abuse concerns and that there was a Child Protection Plan in place for the baby.

14.45 While at the hospital, Mary was seen by professionals from CNTW's Psychiatric Liaison Team. She told them that the overdose was impulsive. She had found messages which made her believe her mother was applying for paternal responsibility for her son. She reported continued anxiety and emotional dysregulation. The CNTW professional shared information with partner agencies including the GP and social worker. Mary agreed to a referral to perinatal services.

14.46 On 3rd July, after noting the referral about Mary's suicidal ideation, the Universal Crisis Team (UCT) followed up with a telephone call with Mary. The notes indicate Mary engaged well and was reframing her thoughts and feelings. She denied current intent or suicidal ideation. There was a second call that evening. Mary again engaged in the process and reported improved mood. Further contact was agreed.

14.47 On 4th July, there was a home visit by the UCT clinicians. Mary reported improving mood and planning to engage with perinatal services to improve coping and stabilise her mental health. Mary's mother was also present and reported she too could see an improvement in Mary's mood. She and Mary were agreeable to discharge from UCT.

During this visit, additional information was gathered, which was shared with Children's Social Care. The overdose occurred when Mary had care of the baby. The family acknowledged they had withheld the truth about Mary's lack of interest she has in caring for the baby. Mary admitted she had not yet bonded with the baby and that she was struggling to manage the responsibility of caring for the child when she was such a young age.

14.48 On 7th July, Mary cancelled her perinatal assessment appointment as she said she was busy with other professional's visit until after 4pm. She declined a video call, so the next appointment was agreed by telephone on 21st July.

14.49 During a telephone call with the social worker the same day, Mary reported that Kyle had told her that, in relation to Mary's overdose the week before, 'he hadn't called an ambulance as he didn't want her to take any more'. The social worker highlighted her concern that Kyle does not have the capacity to keep the baby safe.

14.50 On 21st July 2020, Mary's perinatal Community Psychiatric Nurse (CPN) contacted her. The contact was on the telephone as Mary had declined a video call. Mary reported low mood and stressors regarding the thoughts of others around her ability to care for her baby. She mentioned social services, family first team and the health visitor. Mary went on to say that she is not able to be alone with the baby since her overdose and that her mother is the main carer. She shared that Kyle had limited contact due to his history with statutory services. Mary denied she was experiencing any domestic abuse. She agreed to further telephone contact with perinatal services.

14.51 On 28th July, there was a further telephone contact between Mary and her CPN. Mary reported an improved mood. She made an appointment for further contact on 5th August.

14.52 On 4th August 2020, Mary made a request to her GP for anti-depressants.

14.53 On 5th August, there was planned telephone contact between Mary and her CPN. The health records note that Mary engaged well in the discussions. She shared that she had experienced difficulties throughout her life and challenges in her relationships with her parents and brothers. She also shared that her mother had suggested Mary moved in with her boyfriend and that it was planned that her mother would accept custody of the baby. Mary reported she had taken eight overdoses previously during her adolescence but had only sought help on one occasion. Risks of impulsive overdose were discussed with the CPN and alternative strategies suggested. It was agreed further work around emotional regulation may be of help.

14.54 On 11th August, a social worker from Children's Services spoke to Mary on the telephone. Mary disclosed she was in the process of moving in with Kyle. The social worker noted Mary was spending a considerable amount of time away from the baby which they recorded as further evidence of her lack of attachment to the child.

14.55 On 12th August, a Core Group meeting of professionals and family was held to review progress of the Child Protection Plan. Information shared was that the baby was in the care of grandparents and that Mary had minimal contact. Mary had requested unsupervised contact but this was not agreed. The notes from the meeting record that it was 'fractious and difficult throughout and difficulties with family dynamics'. Professionals noted Mary seemed unsure and was not fully onboard with the plan, reportedly changing her mind and seeming angry and frustrated about not being involved in decisions around the baby's care. The CPN raised the issue that the perinatal team input would be reviewed if Mary were not to have the baby in her care.

14.56 Repeated attempts were made by the perinatal CPN to contact Mary on 14th and 19th August but there was no response from Mary.

14.57 On 27th August, a child protection review meeting convened. Grandparents were to maintain full responsibility for the baby with supervised visits twice weekly to Mary and Kyle. Tensions in the family home persisted and professionals noted concerns around Mary's brother's convictions, temper and previous drug use. The CPN shared information that Mary felt overwhelmed by professional's involvement and at times appeared defensive and angry whilst being unable to decide if she wished for the baby to remain with her parents or pursue full caring responsibility.

14.58 On 28th August, advocacy was accepted by Kyle. This was provided by the 'participation team' within Children's Social Care. Mary could also access this support as she was also present. The referral to advocacy services was due to Kyle and Mary expressing their concerns that they were not being listened to, nor their feelings and wishes being taken into account in respect of their baby.

14.59 On 1st September 2020, there was a negative parenting assessment of both parents. This had been directed by the courts to consider if Mary and Kyle could look after the baby independently.

14.60 On 2nd September, the perinatal CPN was unable to make contact with Mary for their pre-planned appointment.

14.61 On 6th September, Mary was seen at hospital reporting a kidney infection and dehydration. The dehydration had been caused by the infection and was not assessed by the clinician as linked to any self-neglect.

14.62 On 12th September, Mary rang the police to ask for assistance in taking her to her parent's address as she no longer wanted to live with Kyle but said she was too scared to leave. She said he was smoking 'green' and had allowed his friend, who had previously raped her, to live with them. She stated this had previously been disclosed to police. A further call was received from Mary 20 minutes later, stating Kyle was shouting at her and acting aggressively. When police attended, officers recorded that no offences were disclosed. Mary wanted to leave and go to her parent's address, however she had no means to get there. Officers transported her to her parents and left her in their care. The incident was assessed as 'standard risk'. Police completed a Child Concern Notice (CCN) for the attention of the baby's social worker. Mary's mum also rang Children's Social Care to notify them of the incident. This incident will be reviewed fully at paragraph 16.11.

14.63 There were telephone calls between Children's Social Care, Mary and her mother on 13th and 14th September. On 13th, Mary's mum reported that

although Mary was back living with her, Mary and Kyle had been contacting each other via 'FaceTime'. She said Kyle had ended the relationship. She also disclosed Mary had used a kitchen knife to cut her left arm. She told the social worker there were five separate cuts which Mary's dad was dressing. Mary's mum said the cuts were superficial and that Mary did not require additional medical intervention.

The following day, Mary spoke on the telephone with the social worker to say her relationship with Kyle was over. She reported Kyle prioritised his friends over her and the baby. He had apparently told her to leave the flat.

14.64 On 15th September, a multi-agency strategy meeting was convened to discuss the concerns of the information gathered over the last few days. At the meeting, professionals raised concerns of the potential impact on the baby of Mary being back in the family home.

14.65 On 16th September, Mary's perinatal CPN managed to speak with her on the telephone (following several failed attempts to contact her). Mary told the CPN she had left her boyfriend's home and was living back with his mother. On the same day, the social worker carried out a home visit. They recorded *'Parents are now concerned for Mary and her mental health as she did not want to return to Blyth, both parents have received telephone calls from Mary crying.'*

14.66 On 30th September, Mary had an appointment with her new GP. She stated she felt isolated in Blyth. She was living with her partner Kyle. Her baby was living with her mother in Amble. She reported low mood but no suicidal ideation. The GP took blood tests and the plan was to continue with anti-depressants and review in two to three weeks' time.

14.67 On 8th October 2020, following several failed attempts at contact, Mary's CPN spoke with Mary. Mary shared that she remained living with her ex-boyfriend's mother and was seeking independent housing but was not eligible for homeless services. She also told the CPN that she had been informed she could not return to the family home. She reported there had been a change of the baby's social worker.

14.68 On 14th October, Mary had an appointment with her GP. She reported she was having a difficult time. She had issues with her accommodation and was supposed to be living with her partner's mum. Mary also said she only has limited contact with her baby and has just been informed the child has cerebral palsy and a learning difficulty.

14.69 On 15th October, Mary had a telephone call with the baby's social worker. She told the professional that she was thinking of moving back in with Kyle and enquired what would happen if she did. The social worker expressed

her concerns but informed Mary that as adults, she and Kyle must make that decision themselves.

14.70 On 27th October, Mary's CPN spoke with her on the telephone. Mary disclosed she was living back with Kyle as she felt he was the only person able to understand her situation at the minute. Mary was described as calm during the conversation and agreed with the CPN that their next discussion would be at Kyle's flat.

14.71 On 4th November 2020, two social workers visited Mary and Kyle at Kyle's flat. The home visit is described in the notes as 'chaotic'. Kyle and Mary stated they did not know why the baby was removed from their care. Social workers observed that both Mary and Kyle were continuing to involve themselves in their friend's issues and that this could jeopardise them having face to face contact with their child. This was linked to the Covid 19 restrictions in place at that time; Mary and Kyle were not complying with regulations linked to 'bubbles' etc.

14.72 On 6th November, the perinatal CPN visited Mary at Kyle's flat. The notes record that Mary was seen alone. Mary disclosed she had moved back in with Kyle a few weeks ago. She shared that she continued to experience emotional dysregulation to stressors and that she self-harmed at times, with superficial scratching and punching walls when she felt criticised. She also said she hoped to have the baby full time and felt able to care for the child even though there were ongoing tests related to a possible diagnosis of cerebral palsy. Mary agreed to making an appointment with a psychiatrist for a review.

14.73 On 11th November, Mary had a consultation with her GP. She was anxious and depressed. She reported her baby was with her mother and was requesting a sick note which was agreed by the GP.

14.74 On 14th November, Mary contacted the Crisis Team (at CNTW) to report she felt unable to cope as her mother had not brought her son for the planned visit. A clinician made multiple attempts to contact her but these were unsuccessful and eventually the referral was closed. However, three days later, Mary's perinatal CPN did manage to speak to her. Mary reported she had argued with her mother and other family members and felt overwhelmed. She was unclear on the future planning for the baby but had been told she could not have unsupervised care of the baby while she was living with her boyfriend. The CPN agreed to share information regarding the current stressors with Mary's family social worker.

14.75 On 18th November, Mary had a further appointment with her GP. She reported still feeling low, but no thoughts of suicide. She disclosed she had recently split from her partner so she could have access to her child. She also reported she was having contact with mental health services.

14.76 Also on 18th November, Kyle had a visit from his Leaving Care support worker. Mary was also present, which is at odds with her description to her GP that they had split up. Both Kyle and Mary outlined to the support worker that they didn't agree with the professional's worries about the baby.

14.77 On 19th November there was a planned appointment for Mary with her perinatal CPN. Mary reported she had recently had her antidepressant medication increased. Behavioural activation was discussed to improve her mood. She confirmed she had a planned review due with her consultant psychiatrist.

14.78 On 20th November, Mary attended the Urgent Care Centre at Wansbeck Hospital following an overdose of 21 citalopram. The notes record she was accompanied by her boyfriend's mother who said she was happy to take her to the main hospital at Cramlington.

14.79 On 23rd November, Kyle had a consultation with his GP. He requested a sick note. He stated he did not want to work at all as 'it wasn't for him'. He reported he had no issues with mood and no thoughts to harm himself. He described how his family cause him anxiety. He denied taking drugs or alcohol. The GP gave Kyle a number of support options including motivational actions and coping mechanisms. He was issued with a sick note for anxiety (and later with a repeat sick note).

14.80 On 24th November, Mary attended for a review with her consultant psychiatrist. The notes indicate Mary engaged well in the assessment. She shared she had recently taken an overdose of prescribed medication without an identifiable trigger. She had attended Wansbeck Hospital and been advised to attend NSECH but had declined to do so. On reflection she reported she was pleased the overdose had not killed her. She described ongoing mood difficulties that were very changeable – again with no identifiable trigger. She disclosed no periods of persistent mood states. Mary also shared that she was restricting her food intake and inducing vomiting to relieve stress. Mary went on to describe long standing difficulties with mood regulation, thoughts and acts of self-harm and relationship difficulties on the background of childhood adversity. She went on to say these included suffering sexual abuse when she was 13 years old (this had not been reported to the police). The psychiatrist reflected that these early life experiences could impact on her emotional development and described this cluster of symptoms as Emotionally Unstable Personality Disorder.

Given the recent overdose and history of overdoses, the consultant psychiatrist believed Mary was clearly at high risk of further self-harm, most likely a further overdose. The GP was advised it would be prudent to reduce and withdraw her anti-depressants (a letter was sent to the GP Practice and the dose of citalopram was stopped). Evidence for DBT

(Dialectal Behaviour Therapy) based interventions was discussed. Mary reported she would like to access counselling for her previous abuse. The psychiatrist and Mary agreed the follow up plan.

14.81 On 25th November, there was a LAC review (Looked After Child). Concerns were raised regarding the parent's ability to have face to face contact with the baby with respect to their non adherence to Covid-19 restrictions. The CPN advocated for Mary to be involved in some of the decision making linked to her baby.

14.82 On 27th November, the North East Ambulance Service received a '999' call reporting Mary had taken an overdose of prescription drugs. On attendance, Mary informed the ambulance crew she had ingested 470mg of citalopram following an argument with friends. Initially she stated she was suicidal, which was the reason for her taking the overdose. She shared that this had happened on numerous occasions. Mary explained that her mental health fluctuates wildly and that her mood can swing within a 30 minute period. She was transported to NSECH. Clinicians noted her declared diagnosis of Borderline Personality Disorder and that she took the overdose after an argument with flatmates when she felt she was not being listened to. She said her child was living with her mother.

The Psychiatric Liaison Team reviewed Mary prior to her discharge. She gave further details that her argument was with Kyle. She clarified she only had limited access to her baby as she maintained a relationship with Kyle. She mentioned a court case on 23rd December. The practitioner explored domestic violence but Mary denied this was an issue. She did disclose sexual assault and physical aggression in a previous relationship but declined to share details of the ex-partner. The GP was informed of this discussion.

14.83 On 30th November 2020, Mary signed for her tenancy and was handed the keys to her own flat. The flat was in the same block as Kyle's flat.

14.84 Also on 30th November, the perinatal CPN had a telephone conversation with Mary. Mary reported she continued intermittent suicidal ideation but had no further planning. She also outlined that she felt her mood difficulties would resolve if she had the baby back in her care. The practitioner revisited crisis and contingency planning with Mary.

14.85 On 3rd December 2020, a social worker conducted a second session with Mary as part of their parenting assessment. Due to the recent overdose, the session focused on Mary's mental health and what had triggered her into taking another overdose. There was a discussion on how she felt she could manage with the baby in her care with her ongoing mental well-being. Mary stated she didn't feel like she would have any mental health concerns if the baby was in her care.

14.86 On 4th December, police received an abandoned '999' call when a male and female could be heard arguing in the background. The telephone number was identified as Mary's. Officers attended Kyle's flat for a welfare check. Mary alleged that when she had attended to pick up some belongings, Kyle had assaulted her by pushing her into a fence. However, other witnesses at the scene stated to police that this had not happened. Both Kyle and Mary were now living in the same block of flats. Officers facilitated Mary collecting her belongings and advice was given to both parties. Mary was not willing to support a prosecution and the crime report was filed as undetected. A domestic violence report was completed and the incident was assessed as 'standard' risk. Mary declined any further support.

Later that day, Mary's mother rang Children's Services as she wanted to check if she was allowed to accommodate Mary as she had left Kyle's flat with the assistance of the police. Mary's mum stated something had happened at her daughter's property and the police had been involved. Mary's mother was informed by the social worker that she cannot accommodate her daughter at her home as the social work assessments were that Mary was putting her own needs above those of the baby.

14.87 Also on 4th December a support and vulnerability officer from the housing department contacted Mary as they had sourced furniture and white goods for her new flat.

14.88 On 5th December, police attended Mary's mother's home as part of ongoing enquiries to arrest Mary's brother. Mary and her baby were present and Mary's mum stated that she should not have been there and Children's Services were not aware she had slept there the previous night. A quantity of white powder, drug paraphernalia and knives were located in Mary's brother's room. Mary's mum stated she was in the process of applying for a Special Guardianship Order for the baby and was concerned how this incident would affect the application. A CCN was raised and forwarded to the allocated social worker via the triage process within the MASH (Multi-Agency Safeguarding Hub). This resulted in a strategy meeting. Legal advice was to be sought and the aim was to work with the family so that the older son (Mary's brother) would move out.

14.89 On 8th December, Mary had a planned appointment with her perinatal CPN. She reported that her relationship with Kyle had ended but that they remained friends. Mary disclosed she was living at Kyle's flat as her own property was not quite ready, but she planned to move into her own property by the end of the month.

14.90 On 10th December, there was a home visit by Children's Social Care (Kyle's 18+ social worker). The discussion included:

What was working well?

- Both were sticking to the Covid-19 guidance.
- Kyle had received a PIP letter confirming receipt of his application.

What were the concerns?

- Mary was defending her family and not appearing to understand the risks to the baby from her brother.
- Kyle did not seem upset about worries with his child. It was not clear whether he didn't understand or whether he did understand and is handling the concerns well.

14.91 On 12th December, police received a call from a male reporting Mary had made threats over the phone to 'smash his windows'. A further call was then received reporting Mary was now at his address and was trying to kick his door in. Mary had left prior to police attendance. The male was a friend of Mary's and the incident was not domestic abuse related. Kyle was not present. The male would not support a prosecution but did request officers spoke to Mary about her behaviour.

14.92 On 15th December, an estates officer from the Housing Team visited Kyle as part of a welfare visit. This was a periodic review carried out with all tenants.

14.93 On 23rd December, Adult Social Care received a referral from the CPN requesting support for Mary, who was described as vulnerable due to adverse childhood trauma. An assessment was required to see what support Adult Social Care could provide. This referral was not allocated. No action was taken until the CPN rang again on 14th January 2021 asking for an update.

14.94 On 4th January 2021, a support worker from the Leaving Care Team spoke with an adult social worker. The social worker (from Adult Social Care) advised that Kyle's needs assessment would be reviewed after she had visited Kyle.

14.95 On 13th January 2021, police received a call from a member of the public that Mary was on the wrong side of a bridge's safety railings and was threatening to jump. The caller then updated that she had subsequently climbed back over to the main side but was feeling despondent and hopeless. On police attendance, Mary confirmed she had not taken any overdose but she did have minor self-harm wounds. The Street Triage Team (part of CNTW) were contacted, who then spoke with Mary. She

disclosed she had recently split from Kyle and 'her baby had been taken from her'. Her care team were contacted and the perinatal duty officer also spoke with Mary. It was agreed the perinatal team would recontact Mary the following day with a plan of action. Mary's social worker was also contacted as Mary stated she had no furniture and no money for electricity. The social worker advised she would explore options including finding Mary a hostel placement. The Children's Social Care notes record that Mary's flat was unheated (it was January) and unfurnished. She had one blanket and had been sleeping on the floor.

14.96 On 14th January 2021, during a follow up contact, Mary disclosed to her CPN that she had slept the previous evening in a neighbour's caravan, with support from her mum. She did not intend to return to her flat or have contact with Kyle as the relationship had ended. She had collected her belongings from Kyle's home and had access to her own flat but was without heating or furniture. Mary stated if she had to remain in the flat overnight she would 'cut her throat with a broken mirror'. The CPN contacted the Emergency Duty Team at Children's Social Care and it was agreed she could sleep that night at her mother's home. Mary confirmed that due to this, her self-harm ideation had reduced.

14.97 Following the update request by the perinatal CPN (see paragraph 14.89), Adult Social Care noted Mary's situation had now changed. Mary had discovered Kyle had been 'cheating' on her. She had been provided with a council flat but this was only a few doors away from Kyle. The CPN describes the relationship between them as toxic, as they can be verbally abusive to each other. Mary was reported to be 'sofa surfing'. Children's Services had a safety plan in place that would not allow Mary to stay overnight at her parent's as they were caring for her baby. On 15th January 2021 a social worker from Adult Social Care telephoned Mary for an initial triage. They agreed to meet on 20th January to start her assessment.

14.98 On 20th January, Adult Social Care visited Mary who was staying at a friend's property temporarily. Mary asked for support with housing and benefits. She wanted to terminate her tenancy in Blyth and seek alternative accommodation nearer her parents. She reported she was only in contact with Kyle and his cousin as she had taken out a mobile phone contract for them. (See paragraph 16.12 for a full review of these circumstances). She then disclosed that the cousin had raped her when she was 16 years old and that he was due in court for this offence plus the rape of other females (see paragraph 16.11 for further consideration of this disclosure and subsequent actions). Mary told the social worker she was scared of Kyle as 'he gets in her face and shouts when he is angry'. The Homelessness & Housing Options Team were contacted regarding the domestic abuse allegations.

14.99 On 3rd February 2021, a social worker from Adult Social Care had a telephone conversation with their counterpart at Children's Social Care. The social worker from Children's Social Care disclosed that Mary and Kyle were back in a relationship and that she was staying back at Kyle's flat where his cousin was also staying.

14.100 On 5th February 2021, a social worker from Adult Social Care had a meeting with Mary. She confirmed she was not in a relationship with Kyle but is staying in his flat on the nights that his cousin does not stay there. The social worker completed her assessment. Mary did not have any eligible needs under the Care Act 2014 and so was informed her case would be closed. There was no signposting or referrals made relating to the rape. The social worker telephoned Mary's CPN to advise that Mary had refused supported housing options (this was an error as Mary did not qualify for supported housing). The CPN advised that Mary was not engaging with her.

14.101 On 8th February 2021, Mary had a planned appointment with her CPN. She reported she had been discharged from Adult Social Care. She also told the CPN she was finding the 'Decider Skills' training useful. She was planning to move to her flat in March and remained in the caravan. She also reported an improving relationship with her mother. The CPN discussed follow up support with mental health at the end of perinatal support in April 2021. Mary shared she did not think this would be needed as her mental health was improving.

14.102 On 26th February during another planned appointment with her CPN, Mary reported that she was staying with Kyle. She denied they were in an intimate relationship but remained friends. Mary shared that she had initially been upset regarding suggestions that the baby remained with her parents, however had been able to reflect and use coping strategies and not felt the urge to further self-harm. She reported stabilised mental health.

14.103 In February 2021, the support worker from the Leaving Care Team referred Kyle to the 'Young Dad's Service'. Kyle was given sexual health advice and access to condoms. Kyle shared he had been having unprotected sex with Mary. This is at odds with the account Mary was giving to professionals at this time who stated the relationship was over but they remained friends.

14.104 On 5th March 2021, the Children's Social Care notes record an email from Mary's CPN: that Mary attended and engaged well in two weekly appointments. She was working well with the 'Decider' work for emotional regulation and was doing some relapse prevention work. The email states Mary was getting her own flat and making it her own. This seems to have picked up her mood and given her a focus. She repeated what she had told other professionals; that she had been staying with Kyle but they are not in a relationship. She reported sleeping well and her appetite was good.

14.105 On 8th March 2021, Mary was sent a closure letter from Adult Social Care. Other professionals were updated via telephone.

14.106 On 26th March 2021, Mary had a planned appointment with her CPN. She reported she had not moved into her flat as she wanted to decorate and was saving for this. She remained in Kyle's home but denied they were in a relationship. She discussed ongoing support and accessing therapy or counselling to discuss past abuse.

14.107 On 20th April 2021, Mary had a planned discharge discussion with her perinatal CPN. Mary reported the court case for the baby had been delayed but she declined extended support from perinatal services and said she was comfortable with the proposed outcome. Mary also reported she was considering accessing the 'Talking Matters' service but declined a direct referral from the CPN. This information was shared with the GP.

14.108 On 7th May 2021, Mary had telephone consultation with her GP. She is recorded as 'chatty' on the phone. She informed the GP of services she was involved with. She reported she would be referring herself to the 'Talking Matters' service and requested an updated sick note.

14.109 On 14th May, Kyle had a discussion with his support worker from the Leaving Care Team. He shared that his maternal grandmother had taken an overdose and his brother had gone into care.

14.110 On 18th May, the Local Authority returned to court where proceedings concluded. The court granted a Special Guardianship Order to maternal grandparents and a supervision order for 12 months to the local authority to support, assist and befriend the family. The baby was then subject to a Child In Need Plan.[5] The professional from the Leaving Care Team noted Kyle seemed to have mixed feelings about this. At times he seemed upset that his child is not living with him. At others, he was happy the baby is with grandparents rather than in foster care. Kyle's time with the baby was supervised in a contact centre.

14.111 On 24th May, the 'Young Dad's' service stopped working with Kyle. They were not able to engage with him. Kyle had missed appointments or was in bed or was playing on his 'PlayStation' during visits.

14.112 On 14th July 2021, Mary had a consultation with her GP. She was concerned about weight loss. She agreed to a referral to a community dietician.

14.113 On 18th July, Mary had an eight month tenancy review. Her introductory period was extended due to rent arrears.

[5] Section 17 Children Act 1989

14.114 On 16th August 2021, Mary called the 'Talking Matters' service to make a self-referral (she had discharged herself from this service in March 2020). She stated she had been advised by her previous perinatal mental health nurse to get in touch with Talking Matters for further support. Mary also stated in her self-referral that she was trying to get her medication back from her GP, which had been taken from her due to an overdose the previous January. The referral was reviewed and Mary added to the assessment waiting list.

14.115 On 9th September 2021, Kyle had an eight month tenancy review. His introductory period was extended due to rent arrears.

14.116 On 10th September, Mary had a consultation with her GP for anxiety.

14.117 On 27th September, Mary had her initial assessment with a Psychological Wellbeing Practitioner (PWP) from the Talking Matters service. Mary told the practitioner she had been diagnosed with bipolar disorder, paranoia, borderline personality disorder, obsessive compulsive disorder and was previously bulimic. The practitioner noted that none of these apparent diagnoses had been shared previously. Mary described no suicidal ideation at that time though she did say she was experiencing self-harm in the form of voices encouraging her or commanding her to act. She also described a suicide attempt in January 2021 when her child was removed from her care. Mary went on to share that she had aspects of self-neglect. She reported a cycle of either barely eating at all or of eating a lot and that her weight would fluctuate. She also described being sexually assaulted at the age of 13 years by her then boyfriend (whom she did not name). The outcome of the assessment was for the PWP to seek further guidance on the appropriate care pathway.

14.118 On 29th September, Kyle was visited by his support worker from the Leaving Care Team. Having reached the age of 21 years, his time with Leaving Care was ending. The Leaving Care team notes record that 'Blyth Star' will be working with Kyle from this point and will be helping him with benefits, finances etc.

14.119 On 1st October 2021, Mary had a review consultation with her GP. She reported she was managing well, her medication appeared to be helping and she had a good relationship with her mum.

14.120 On 15th October, the Talking Matters 'low intensity' team leader called Mary to gather further information. Mary stated her diagnoses were from April 2021 but she could not provide any information on who had given them. Mary reported her weight was 8 stone 7 pounds and also stated her GP was weighing her and had told her she was on the borderline of anorexia. (Note: health professionals on the DHR panel advised a healthy BMI is 18-25. Mary was not anorexic). Finally, Mary reported she had a pending

appointment with the Community Treatment Team (CTT) but didn't know what this was for.

14.121 On 22nd October 2021, the Community Treatment Team (part of CNTW services) had contact with Mary. A CPN carried out a planned care assessment following a referral from her GP to the regional eating disorder service. The concerns were her low weight (BMI 18), with restricted intake and induced vomiting. Mary reported low mood and reduced appetite exacerbated by social circumstances, but some recent improvement in eating patterns since the GP referral. She shared that she had previously accessed CBT with 'Talking Matters'. However, due to college, housing and issues with access to the baby, she had disengaged. An onward pathway was confirmed with agreement the GP may access 'Consult Connect' for prescribing advice if necessary and Mary to consider resuming therapy with 'Talking Matters'.

14.122 On 26th October, the Talking Matters low intensity team leader telephoned Mary to inform her their recommendation was to discharge Mary from their service (due to her input from the CTT). Mary told the professional CTT had informed her that the two services would work alongside each other to support her.

14.123 On 8th November 2021, the low intensity team leader from 'Talking Matters' spoke with the assessing clinician from the CTT. The clinician confirmed there was no diagnosis of borderline personality disorder or bipolar disorder. The perinatal CPN had suggested some traits of emotionally unstable personality disorder but this was not formally diagnosed. (Note: this information was not correct. There had been a diagnosis of EUPD by a psychiatrist). Mary's body mass index was reported to be stable at 20. CTT noted there was no role for them and that Mary was open to the Talking Matters service. As a result of this liaison, the Talking Matters service discussed Mary's case a few days later in their internal care pathway meeting. It was agreed to offer Cognitive Behaviour Therapy (CBT) to Mary and to place her on the waiting list for that service. Mary was informed and she requested face to face contact. Talking Matters agreed to send Mary their 'Silver cloud' package (online computerised CBT) while her face to face appointment was pending.

14.124 On 31st January 2022, Mary had an appointment with her GP. She reported feeling a 'crawling sensation' and that someone is watching her just as she is falling asleep.

14.125 Mary had another appointment with her GP on 8th February 2022. She reported being 'panicky' and light headed. The GP gave her reassurance.

14.126 On 9th February 2022, Kyle had an appointment with his GP. He presented with his mum. He reported 'everything is getting on top of him'. He was

tearful during the consultation. He said he had split up with his girlfriend a week ago. He outlined his past history, including being a Looked After Child, use of alcohol and self-harm. The plan was to refer to the Crisis Team, prescribe anti-depressants and review in seven days. However, on 21st February, the GP received a message to say Kyle could not attend the planned appointments as he had an upset stomach. The message left said he is 'doing much better'.

14.127 The following day, 22nd February 2022, police were called by Kyle's mother. She and Kyle had been talking on a video call when Kyle showed his mother some self-inflicted injuries to his arms which had bled. Police attended Kyle's flat. He was cooperative and showed officers superficial cuts to both his lower arms. The blood had congealed. An ambulance was not required as Kyle had cleaned the wounds. He was left in the care of his grandmother and his mother was already enroute to offer support. He was provided with the contact details for the Crisis team and an Adult Concern Notice was submitted.

14.128 On 25th February, Mary had another appointment with her GP. She reported having a difficult time following a separation with her partner. He had apparently been trying to contact her, but she realised that the relationship was not healthy and he showed manipulative behaviours. She stated her mood was stable and was waiting for support from 'Talking Matters'. The GP agreed to a review in 3 - 4 weeks.

14.129 On 27th February, a friend of Mary rang the police to report Mary was being harassed by Kyle. They had broken up a few weeks before and he had been attending her address; shouting, screaming and putting letters through her door. It was also reported that they lived in the same block of flats. Officers attended and spoke with Mary. She disclosed that Kyle had assaulted her the previous October or November when he grabbed her by the arm and kicked her in the back. Kyle was arrested and subsequently released on conditional bail not to contact Mary by any means or attend her address. Mary was willing to support a prosecution but both were finalised as undetected due to evidential difficulties. No further action was taken against Kyle.

Police completed a domestic violence report. The incident was assessed as 'medium' risk. Mary was given advice regarding her personal safety and use of the '999' system. A safe telephone number was identified for her. An Adult Concern Notice was also completed due to Mary's vulnerability; she lived in close proximity to Kyle and her mental health issues. This report was triaged for further assessment and was subsequently discussed between professionals from police, Adult Social Care and CNTW. The next day, a social worker from Adult Social Care tried to contact Mary, but there was no response.

14.130 On 1st March, Adult Social Care made telephone contact with Mary. Mary was seeking to move home. She had her key returned from Kyle. She reported Kyle was on bail and is not allowed to contact her. She had also 'blocked' him on social media.

14.131 Also on 1st March, Kyle's GP telephoned him for a consultation. Kyle would not come to the phone so the GP spoke with his mother. Kyle's mood had dipped as earlier in the week he had been arrested for harassment of his ex-girlfriend. He felt his 'ex' had 'led him on' and he now believed it was safer for him to stay in bed. The GP agreed to review in seven days.

14.132 On 2nd March 2022, a police officer attended Mary's flat to return some property connected with the incident reported a few days earlier on 27th February. Mary disclosed that the previous month, she and Kyle had shared a bed. She reported Kyle had removed her shorts, had used bodily force and had sexually assaulted her. She stated she did not suffer physical injuries, but she had suffered emotionally and mentally as a result. Mary stated she was willing to support a prosecution. From that point, she said the only contact between her and Kyle was via their mothers.

A crime report was created. Kyle attended a police station voluntarily where he was interviewed under caution. He denied the offence. The crime was finalised as undetected due to evidential difficulties; there were no witnesses or independent evidence.

A domestic violence report was submitted and the incident was assessed as 'medium' risk. Mary was advised regarding safety planning. She reported she was seeking re-housing away from the area and that she had a good support network. The limits of the safeguarding arrangements were acknowledged by the police as in practical terms, Kyle and Mary lived in the same block of flats. Although 'medium' risk, the incident 'scored' 13 ticks on the DASH risk assessment (i.e. one more tick would have resulted in a 'high' risk assessment - and subsequent forwarding of the case to the MARAC). Professional judgement could also have been applied (when considering Mary's vulnerability) which could have overridden the actual 'score'. Further analysis of this incident is at paragraph 16.11.

14.133 On 7th March 2022, Kyle had approached Mary in the street wanting to talk, despite a clear warning not to contact her. He then followed her until she went into a sports centre to get away from him. Mary had then suffered a panic attack. Once she had calmed down she was happy to go to her home address. A domestic abuse report was completed and the incident was assessed as 'medium' risk. The risks identified also included stalking and harassment. The comments on the police message records state 'no offences disclosed'. This appears to have been a missed opportunity to intervene as Kyle had already been warned not to approach Mary.

14.134 The following day, 8th March, Mary rang police to report Kyle had put letters through her door. He had also posted a birthday card, even though her birthday was months away. Mary stated she had a friend staying with her so she was not alone in the house. She was advised to keep all windows and doors locked and contact police if he returned before officers arrived. When police attended, Mary stated she wanted Kyle spoken with and warned not to contact her. Officers did then speak to Kyle and warned him not to contact Mary directly or indirectly outside of the agreed channels for child contact. Kyle signed the officer's pocket note books to acknowledge this. The crime was finalised as undetected. A domestic violence report was completed and the incident was assessed as 'medium risk' including elements of stalking and harassment.

14.135 On 11th March, an Initial Response Officer from NDAS (Northumberland Domestic Abuse Service) rang Mary following a referral from 'Victims First'. Mary reported that she wanted to move but was on the Band 3 on the housing list. The NDAS professional advised she would send a letter of support to housing to increase this banding. An appointment was made for a courtesy call on one week later, while Mary was waiting for direct practitioner support. The Homelessness & Housing Options Team records confirm receipt of the letter of support the same day.

14.136 On 18th March 2022, a further telephone call took place from NDAS to Mary. Mary reported that Kyle had been speaking to her neighbours and she was considering moving down south and wanted advice on how to go about this. The support worker advised Mary to get in touch with the local 'Homefinder' of where she wanted to move. A further telephone call was scheduled but there was no further risk assessment carried out.

14.137 On 21st March, Mary had a telephone consultation with her GP. She reported she was having a difficult time and was feeling harassed by her ex-partner. She was awaiting victim support and was considering moving away. She described poor sleep. The GP noted her speech started to slur. Mary stated she had taken 2 x zopiclone the previous night. The GP advised her to take just one. Mary also reported occasional alcohol use though she did mention 'a bottle of vodka per night'. The GP prescribed a short course of zopiclone and made arrangements to review with Mary in 2-3 weeks.

14.138 On 23rd March, the Homefinder support officer recorded on their systems the decision to award Mary a Band 2 as she would benefit from a move from her current accommodation.

14.139 On 25th March 2022, the Housing Team received information from Northumbria Police. The referral listed the domestic abuse and sexual violence she had been suffering from her ex-partner. Mary was awarded a Band 1 priority.

14.140 At the end of March 2022, police and ambulance attended Mary's home address. Mary had been found by mother. Her body was cold and rigor mortis had set in. Mary was in bed. A note and medication were found next to her body.

Section 15: Overview

15.1 Mary and Kyle were both vulnerable individuals. Kyle had a learning difficulty. Mary had a diagnosis of Emotionally Unstable Personality Disorder . Both had been involved with Children's Services when they were children. At the age of 6 years, Mary was placed on a Child Protection Plan. Kyle was a Looked After Child within the care system and then supported as a 'care leaver' when he was18 years old.

15.2 There were several domestic abuse incidents reported to the police. However, although he had been warned by police and was interviewed under caution about one specific incident, Kyle was never charged or convicted of any offence. Kyle has no criminal convictions.

15.3 The couple briefly shared a flat. They had a child together. The abuse and tension within their relationship increased after the birth of their child.

15.4 Even when the couple split up, they lived in the same block of flats only a few doors apart.

15.5 Due to the documented concerns of Children's Social Care and other agencies, the child was removed from Mary and Kyle's care. This added to Mary's anxiety.

15.6 Mary had made several attempts to self-harm, take overdoses or threaten to take her own life.

15.7 Mary had frequent contact with a variety of mental health services.

15.8 Mary disclosed to professionals incidents of rape and sexual assault. No person was ever prosecuted for these allegations.

15.9 Mary took her own life. There was no direct third party involvement in her death. She left a note which was found by her family.

Section 16: Analysis

16.1 There were several pressures within Mary's life which may have contributed to her tragic death. The DHR panel reviewed agency records dating back three years before Mary took her own life. Professionals also documented other key events in childhood relating to both Mary and Kyle.

16.2 The DHR panel agreed a robust set of 'terms of reference' to explore and consider the actions and decision-making of professionals. This approach meant there was a focus on specific questions to be considered when identifying learning relating to this tragedy.

16.3 Were practitioners sensitive to the needs of the victim? Were they knowledgeable about potential indicators of domestic violence or abuse?

16.3.1 Mary had a number of issues which affected her mental health. These brought her into contact with several services.

16.3.2 Mary had four contacts with the North East Ambulance Service (NEAS) during the timeframe of this review. These were in May 2019, July 2020, November 2020 and November 2021.

May 2019: A call was received from Mary's college. Staff reported Mary had pain in her side. She believed she was pregnant and was worried as she had miscarried in the past. The agreed contact was with primary care. However, no GP appointments were available so Mary was advised to attend Wansbeck Urgent Care Centre.

July 2020: a call was received from Mary's mum. Mary had overdosed on propranolol. The crew noted she was suffering from post-natal depression and were informed by the family that Children's Services were involved with the new baby. Mary stated she had the express intention to take her own life and disclosed she had made a similar attempt two years earlier. Mary was taken by ambulance to Northumberland Specialist Emergency Care Hospital (NSECH). There was a verbal handover of safeguarding concerns to hospital clinicians and a safeguarding referral submitted to Adult Social Care. There was no suggestion of any domestic abuse during this incident.

November 2020: a friend reported Mary had taken an overdose. She was awake and crying. Mary told the ambulance crew she had an argument with 'friends'. The paramedics believed there was a complex mental health issue involved and Mary was taken to NSECH. After treatment for her overdose, Mary was also seen by the Psychiatric Liaison Team. She

confirmed to them the ‘friend’ was actually her partner, Kyle. This incident was not recognised as domestic abuse by the ambulance crew. However, this was an ongoing medical issue and the priority was to get Mary to hospital. With Mary stating it was an argument with ‘friends’ and several people as well as Kyle being present, it would have been difficult for the crew to have taken further action at that time. Once Mary was calm within the hospital she gave the further details of the incident.

November 2021: this was over a year since the last call to NEAS and was an unconnected medical issue with no relevance to this review.

16.3.3 Mary had regular contact with her GP. There was an early indication of relationship problems in January 2020 when the GP practice received a copy of a Child Concern Notice which had been submitted following a police attendance at a domestic abuse incident. This incident had been reported by Mary’s mother after Kyle had sent her daughter abusive messages. A few months later, the GP received a copy of a referral from the maternity unit, submitted to Children’s Social Care, when they were notified by Mary that the relationship with Kyle had resumed. But over the following two years, Mary’s GP appointments were related to issues of overdoses & self-harm, housing problems and her contact with Children’s Social Care relating to her baby. The GP acted according to the medical issues that were presented. There were no further disclosures of domestic abuse and Mary reported she was either living on her own or was with her own family. Mary changed GPs when she moved from her parent’s home to her own flat. The GP ensured Mary was being supported by mental health services. Only once, immediately before Mary took her own life in March 2022, did she disclose to the GP that she had been suffering harassment from her ex-partner. However, the context of this disclosure included that she was already being supported by a specialist domestic abuse service.

16.3.4 Northumberland Health Care Foundation Trust (NHCFT) midwifery services did display professional curiosity when they proactively asked Mary about relationships. She reported her partner could be ‘jealous, controlling and play mind games’. Staff did probe further but Mary stated the relationship had now ended.

16.3.5 CNTW had contact with Mary via several of their services. These are explored in paragraph 16.10.

16.3.6 There were no disclosures or suggestions of domestic abuse during all of Mary’s contacts with the ‘Talking Matters’ service. During her initial assessment in July 2019 the notes record ‘no risk to or from others declared’.

16.3.7 Police attended seven incidents of reported domestic abuse between Kyle and Mary during the period of this review. During each call to police, it is

clear that domestic abuse was recognised and that staff took positive action. However, there were instances, (notably in February and March 2022) when police action was not sufficiently robust. This is fully explored at paragraph 16.7.

16.3.8 There was also an omission (24th May 2020) of police not completing a domestic violence report relating to a wider family altercation involving Kyle's brother and Mary's brother and mother. It was not a domestic incident directly between Kyle and Mary (though both were present). Northumbria Police accept the incident should have resulted in a domestic violence report.

16.3.9 During the majority of domestic abuse incidents, police officers noted Mary's vulnerabilities and responded by a variety of means such as taking her to stay with family, making referrals to Adult Social Care, submission of Child Concern Notices, warning the ex-partner (in line with Mary's wishes) or contacting housing services.

16.3.10 More could have been done by the police to support Mary regarding action against her ex-partner (see paragraph 16.7) and in terms of her being a victim of sexual violence (see paragraph 16.11).

16.3.11 Northumberland Domestic Abuse service (NDAS) had very limited contact with Mary and all of this was in the last month of her life. NDAS received a referral from 'Victims First Northumberland' (VFN). The referral was accompanied by a DASH risk assessment with a 'score' of 12. VFN is a service offered to all victims of crime in the Northumbria Police area and is directly accessed by the police, who (with the victim's consent) will forward that victim's details to VFN. They are not a specialist domestic abuse support service. NDAS made telephone contact the same day they received the referral. This is good and effective practice as a prompt response is more likely to engage the victim. The staff member at NDAS gathered further information and informed Mary she would be added to their waiting list which was around eight weeks' time. Mary reported Kyle lived close to her own address and 'has signed something to say that he couldn't go near me'.

16.3.12 There was a further call to Mary from NDAS on 18th March 2022. The purpose was to maintain contact and offer support while she remained on the waiting list for an allocation of a DAP (Domestic Abuse Practitioner). Mary stated she was considering moving away to the south of England. There were no indications Mary would self-harm or take her own life.

16.3.13 Children's Social Care were aware of Mary's needs from an early stage of their involvement. As well as Mary's mental health history, the Children's Social Care notes record the tensions in her relationship with Kyle. This

informed their strategy meetings, Initial Child Protection Conference (ICPC) and subsequent planning around the care and welfare of Mary's baby.

16.3.14 There were problems due to other tensions at Mary's mother's home (predominantly linked to altercations between Mary and her brother). Although social workers clearly acknowledged Mary's vulnerabilities, the wider home circumstances did present challenges. There were occasions when Mary was wanting to move from her own flat (due to its proximity to Kyle's flat) but child protection planning meant she should not share her mother's home while her baby was living there. This is documented as both due to the tensions already described with her brother, but also as social care assessments indicated Mary's own needs would lose focus on the very young baby who needed a calm environment to thrive. This issue is explored in detail at paragraph 16.15.

16.3.15 The Housing Team and the Homelessness & Housing Options Team at Northumberland County Council were not initially aware of domestic abuse in the relationship at the time Mary was allocated a flat in the same block as Kyle. However, when notified by police and NDAS, they reacted positively by increasing Mary's housing 'banding' thus making her move to other accommodation a priority. The issue was the timing of this banding increase. Other agencies were aware of the abuse and Mary's regular contact with mental health services. If this information had been shared with housing services then a move (away from the vicinity of her abuser) could have taken place much sooner.

16.4 Did the agency have policies and procedures in place relating to domestic abuse? Were these policies complied with?

16.4.1 The GP practice and wider Integrated Care Board have safeguarding policies in place which include domestic abuse. These policies were complied with in this case.

16.4.2 NHCFT have policies in place relating to safeguarding children, safeguarding adults and domestic abuse. Procedures were followed. Staff noted tensions within the relationship and were proactive in asking probing questions. Controlling behaviour was disclosed, though Mary initially said the relationship had ended. Subsequent referrals were made to Children's Services.

16.4.3 CNTW have a detailed policy in place if domestic abuse is suspected or disclosed. Staff are expected to complete a 'safe lives' checklist and make appropriate referrals to MARAC if the case is assessed as 'high' risk. The policy gives guidance to staff on actions required when receiving disclosures (from victims and ex-partners). Advice and support is also

available from CNTW's safeguarding and public protection team. Mary denied abuse with practitioners from the Psychiatric Liaison Team, the Universal Crisis Team and the perinatal CPN.

16.4.4 NEAS have a comprehensive domestic abuse policy and this includes core annual training for staff. NEAS also maintain a network of 'DA champions'.

16.4.5 Northumbria Police have policies and procedures in place relating to domestic abuse. This includes guidance relating to positive action, call-handling, incident grading, risk assessment, crime investigation and referrals to partner agencies who may provide additional support. Force policy was complied with in the majority of incidents involving Mary and Kyle. A domestic violence report was completed on each police call-out except the wider family disturbance described at paragraph 16.3.8. All responses were graded appropriately with the exception of an incident in January 2020 when a call was received and a disturbance could be heard in the background. The call was graded as a 'priority 2' (priority response) when it (as an ongoing incident) should have been graded 'priority 1' (emergency response). Nevertheless, no harm resulted from this error, officers attended and a full risk assessment was completed (and in any event officers attended in nine minutes which met the Grade 1 response times).

16.4.6 NDAS are a dedicated specialist domestic abuse service. They have domestic abuse policies in place and these were complied with in their contacts with Mary.

16.4.7 Children's Social Care adhere to both Northumberland County Council's policy on domestic abuse and also the national 'Working Together to Safeguard Children' guidance (Children Act 2004).

16.4.8 Northumberland Housing also follow the Northumberland County Council policy on domestic abuse. Policy was complied with in this case.

16.5 Were risk assessment and risk management processes for domestic abuse victims or ex-partners correctly used in this case?

16.5.1 There was only one contact with the GP where the practitioner noted that Mary reported she 'feels harassed by her ex-partner'. This was not the core reason for her visit. The GP did not take further action. However, during the appointment Mary confirmed both that the relationship was over and the GP satisfied themselves that 'victim support' (it is believed they were referring to NDAS) were already supporting Mary.

16.5.2 Midwives at NHCFT noted in April 2020 that Mary had 'love bites' on her neck. Proactive questions confirmed that Mary's relationship with Kyle had resumed. Aware of this plus the increased risk to victims during pregnancy, they explored the relationship further and forwarded the risks to Children's Services.

16.5.3 There were no disclosures of domestic abuse to CNTW professionals. However, their risk assessments reflected Mary's childhood trauma and ongoing family network difficulties regarding Mary, Kyle and their baby. Risks to Mary and her baby were appropriately managed by close liaison with professionals from her GP and Children's Social Care.

16.5.4 Northumbria Police use the recognised 'safe lives' / DASH risk assessment for all incidents of domestic abuse. This involves officers discussing the incident with the victim and asking a number of questions relating to the incident. This produces a 'score' to indicate the level of risk (standard, medium or high risk). Professional judgement can also be used by an officer to assess the level of risk, especially when they are concerned about the vulnerability of a victim or they believe a victim may be minimising the circumstances. The three risk levels can be summarised:

Standard risk – current evidence does not indicate a likelihood of serious harm.

Medium risk - there are identifiable factors of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there are a change of circumstances.

High risk – there are identifiable indicators of risk of serious harm or death. The potential event could happen at any time and the impact would be serious.

An incident assessed by police as high risk is routed through the MASH (Multi-Agency Safeguarding Hub) and an IDVA (Independent Domestic Violence Advocate) assigned to support the victim.

No cases involving Mary and Kyle were assessed as high risk. Of the seven incidents reported to police, three were assessed as standard risk and four were assessed as medium risk. Each individual incident was scrutinised as part of this DHR process. The review found each was assigned the correct level of assessed risk. On four occasions, Mary agreed to officers making a referral to agencies that could offer further support. These referrals were then made (to agencies such as Adult Social Care, NDAS or Housing Services).

16.5.5 The Northumberland Domestic Abuse Service received a referral from Victims First Northumbria. Staff at NDAS contacted Mary via the telephone

the same day. VFN had completed a domestic abuse risk assessment but NDAS did not review the risks or complete their own risk assessment. As a specialist domestic abuse service this could have been a missed opportunity. Mary had some mental health problems, had been on a Child Protection Plan as a child and had suffered sexual violence. This was not recorded on the VFN risk assessment. If NDAS had known of the other risks involved, their response may have been upgraded. NDAS policy has since been amended to ensure all referrals are re-assessed by their own specially trained staff.

16.5.6 Risk assessments were carried out and regularly reviewed by social workers in Children's Social Care. Following the ICPC, both young parents were referred to NDAS to complete the 'Freedom' programme. Kyle was also referred to the 'Caring Dads' programme. Neither Mary nor Kyle engaged with the support being offered. Kyle (as a care leaver) also had a home visit from an Adolescent Support Worker to discuss healthy relationships.

16.5.7 Adult Social Care received a referral regarding Mary from her CPN in December 2020. As part of Adult Social Care's assessment, a social worker had a telephone call with Mary on 15th January 2021 and a home visit on 20th January. Despite the CPN describing Mary's relationship with Kyle as 'toxic' and further information being provided during the home visit that Kyle 'gets in her face and shouts when he is angry', there was no risk assessment carried out. Mary also disclosed to the social worker that she only maintained contact with Kyle as she had taken out a mobile phone contract for him in her name (and also a contract for his cousin). She went on to say that Kyle's cousin had raped her and was due in court for this matter and for raping other women. There was no further exploration of the rape or of potential financial abuse. This issue is explored at paragraphs 16.11 and 16.12.

16.6 Did the agency adhere to agreed information sharing protocols?

16.6.1 Records indicate that GP notes were accessed as part of the child protection processes. There were no 'high risk' domestic abuse assessments and so consent would have been required for a GP to share information regarding domestic abuse. Good practice is demonstrated when Mary's attendances at hospital (following overdoses) were clearly shared with her GP practice.

16.6.2 In January 2020, information had been shared (via a police referral into the MASH) with midwifery services of a police call-out relating to domestic abuse. This meant that midwives could tailor their approach and conversations with Mary.

16.6.3 CNTW practitioners were in regular communication with Mary's GP and Children's Social Care. Their contacts are recorded in the CPN or PLT notes. Information was also shared during the Looked After Child (LAC) Review.

16.6.4 Northumbria Police submitted Child Concern Notices and Adult Concern Notices to the Multi-Agency Safeguarding Hub on each police attendance that warranted such action.

16.6.5 Records within Children's Social Care confirm regular and effective exchange of information at formal strategy meetings and ICPCs /core group meetings. There are also several references to telephone conversations between social workers from Adult Social Care and Children's Social Care plus Mary's perinatal CPN. In addition, there were useful exchanges between Adult Social Care and the Leaving Care Team to ensure support was in place for Kyle.

16.6.6 Information was shared between housing officers, police and third sector organisations (i.e. NDAS) which ultimately increased Mary's housing band application. However, this information exchange could have taken place much sooner.

16.7 What were the key points or opportunities for assessment and decision making?

16.7.1 Pregnancy is recognised as an indicator of potential increased risk of domestic abuse. Staff at NHCFT followed existing protocols and were proactive in asking questions, exploring the nature of the relationship between Kyle and Mary. No opportunities were missed as all relevant information was shared with other agencies. This included the updated information about the baby's medical issues confirmed during hospital admission between 30th September and 10th October 2020.

16.7.2 CNTW practitioners completed an assessment of Mary's mental health at every contact. While building a therapeutic relationship with Mary, the perinatal clinician offered continuity of support and an environment whereby Mary would feel able to disclose details of her relationship or any other vulnerabilities.

16.7.3 The ICPC convened by Children's Social Care and attended by many agencies ensured a full parenting assessment was carried out. The assessment indicated the immaturity of both parents was a factor in the welfare of the child.

16.7.4 The majority of police contacts were positive. Mary was protected and actions ranged from officers taking her to her parent's address for support through to submission of Adult Concern Notices or Child Concern Notices. A domestic abuse report was completed on all but one occasion and this included a full risk assessment. However, there were some shortcomings which led to potential missed opportunities:

16.7.5 On 27th February 2022 officers were called by a friend of Mary who reported Mary was being harassed by Kyle. They had broken up a few weeks before and he had been attending her address; shouting, screaming and putting letters through her door. It was also reported that they lived in the same block of flats. Officers attended and spoke with Mary. She disclosed a further incident from several months earlier; Kyle had assaulted her the previous October or November when he grabbed her by the arm and kicked her in the back. Kyle was arrested and subsequently released on conditional bail not to contact Mary by any means or attend her address.

16.7.6 Only a few days later, on 1st March an officer attended Mary's home to return some property. She disclosed to the officer that the previous month, Kyle had sexually assaulted her. She stated she did not suffer physical injuries, but she had suffered emotionally and mentally as a result. Mary stated she was willing to support a prosecution. From that point, she said the only contact between her and Kyle was via their mothers. Kyle attended a police station voluntarily where he was interviewed under caution. He denied the offence.

16.7.7 The following week, on 7th March, Mary again called police. Kyle had approached Mary in the street wanting to talk. Despite a clear warning not to contact her, and already being on conditional bail for a similar incident, he then followed her until she went into a sports centre to get away from him. Mary then suffered a panic attack. Once she had calmed down she was happy to go to her home address. A domestic abuse report was completed and the incident was assessed as 'medium' risk. The risks identified included stalking and harassment. The comments on the police message records state 'no offences disclosed'.

16.7.8 The following day, 8th March, Mary again rang police to report Kyle had put letters through her door. He had also posted a birthday card, even though her birthday was months away. When police attended, Mary stated she wanted Kyle spoken with and warned not to contact her. Officers did then speak to Kyle and warned him not to contact Mary directly or indirectly outside of the agreed channels for child contact. Kyle signed the officer's pocket note books to acknowledge this. The crime was finalised as undetected. A domestic violence report was completed and the incident was assessed as 'medium risk' including elements of stalking and harassment.

16.7.9 Taken together, these incidents represent a missed opportunity to have intervened and taken formal action against Kyle. Over a period of ten days, there were four separate reports to the police. It is positive that when the (historic) offence of assault was reported, officers were proactive and arrested Kyle for assault. They also warned him regarding the original reason for the call (that Kyle had been harassing Mary). Then, on 1st March police were informed of the sexual assault allegation. They were called again on 7th March as Kyle had approached Mary in the street despite being warned by police not to contact her and already being on police conditional bail not to contact her. She sought refuge in a nearby sports centre. Then, on 8th March, Kyle had posted a card through Mary's door, despite already having been warned by police not to contact her.

16.7.10 The incidents on 27th February, 7th March and 8th March clearly show a 'course of conduct'.[6] Indeed, the officer's own risk assessments identify 'stalking and harassment' as one of the risk factors. There appears to have been sufficient evidence to consider criminal harassment offences and deal formally with Kyle (especially when considering Mary's vulnerability and the close proximity in which they were living). The police did take positive action in terms of a discussion with a housing officer to expedite a move to alternative accommodation for Mary (away from Kyle). But direct action against Kyle should have been taken.

16.7.11 There were other missed opportunities for a review of Mary's circumstances in 2021 relating to her being able access support at her parent's home (as part of the plans in place with Children's Social Care). This meant she was living in an unheated, unfurnished flat, in the same block as her abuser, over several months during the winter in 2020 to 2021. These opportunities are explored at paragraph 16.15.

16.8 How were the victim's wishes or feelings ascertained or considered? Is it reasonable to assume the wishes of the victim should have been known? Were they informed of options/choices to make informed decisions?

16.8.1 The GP practice listened to Mary's wishes regarding her general healthcare needs plus was able to signpost Mary to other medical services which she went on to access. These included NHCFT who listened to Mary's views and wishes, which were explored throughout her pregnancy and after the birth of her baby. NHCFT did not have any contact with Mary in the year prior to her death.

[6] Section 2 Protection from Harassment Act 1997

16.8.2 Information regarding Mary's wishes was sought at each contact with practitioners from CNTW.

16.8.3 Although NDAS had only brief involvement with Mary, they did ring her on the same day as they received the referral and established her priority was a move away from the area. They provided a letter of support to increase Mary's housing 'banding' application.

16.8.4 Notes within Children's Social Care record Mary could be outspoken during core group meetings which were held to monitor progress as part of the Child Protection Plan. Throughout parenting assessments, regular contact was maintained via face to face meetings or on 'MS Teams' virtual meetings. As a care leaver, Kyle was allocated an advocate, Mary also utilised the services of the advocate as she was frequently present at Kyle's flat. It was also documented during a LAC review that Mary retained decision-making in relation to several aspects of care linked to her baby.

16.8.5 Housing officers conducted new tenancy and review tenancy visits with Mary. Discussions during these visits included any problems or issues that Mary was encountering. None were disclosed.

16.9 Was the victim or ex-partner ever listed at the MARAC?

MARAC is a Multi-Agency Risk Assessment Conference. It is a meeting of professionals to share information and formulate plans to protect the victim and their children in the highest risk domestic abuse cases (those cases where the victim is assessed as at risk of significant harm).

16.9.1 Mary and Kyle's case was never assessed as high risk and so was not considered for inclusion within the MARAC process.

16.10 How were mental health support services accessed by the victim or ex-partner? What were the outcomes of these contacts?

16.10.1 The GP practice maintained accurate record keeping of services being accessed by Mary.

16.10.2 While an inpatient at NHCFT in May 2020, staff became aware of Mary's low mood. They arranged for her to be seen by the Psychiatric Liaison Team (PLT) prior to her discharge. The PLT subsequently arranged community follow-up and support.

16.10.3 Mary took four overdoses during the timeframe of this review. (July 2020, November 2020, November 2021 and March 2022). On two of these dates Mary's medical needs were assessed by the PLT prior to her discharge. But on one occasion (November 2020) she attended the Urgent Care Centre at Wansbeck. She was quickly triaged and advised she needed to attend the main Northumbria Hospital where emergency care was available. This was to provide further review and treatment. Medical records show she attended Wansbeck UCC with Kyle's mother who stated she would take Mary to the main hospital. However, it appears this attendance never took place. Sadly, on the fourth overdose Mary tragically died.

16.10.4 NEAS passed on verbal or written referrals to clinicians on the occasions when their crews had transported Mary to hospital. The ambulance crew noted Mary's complex mental health history.

16.10.5 Northumbria Police attended an incident in January 2021 when Mary was standing on the wrong side of the railings of a bridge. Members of the public had persuaded her to cross back over the railings before police arrived. The attending police officer contacted the Street Triage Team who in turn had a conversation with Mary. There was a further call arranged between Mary and her regular perinatal CPN. It was agreed further support would be provided by the perinatal team.

16.10.6 Police submitted an Adult Concern Notice in February 2022 due to ongoing harassment of Mary by Kyle. This led to a discussion within the MASH with colleagues from Adult Social Care and CNTW.

16.10.7 Mary accessed CNTW services via self-referral and referral at A&E. She was able to engage with the Universal Crisis Team, Psychiatric Liaison Team and Perinatal Services. Mary's engagement was erratic, with her regularly cancelling planned appointments. However, follow up was carried out assertively on every occasion in an attempt to maintain Mary in treatment.

16.10.8 Mary was referred to CNTW mental health services in May 2020, following concern from an A&E consultant on assessment of her very young baby and Mary's response whilst in the department, on hearing that her baby should be admitted. On contact with the Psychiatric Liaison Team clinician, Mary agreed to meet to discuss her presenting difficulties. Collateral information was sought from the acute trust clinicians and Mary's family contacts. Mary shared that she suffered from anxiety and depression but had always been reluctant to seek support. Mary denied she was subject to domestic abuse. Follow up care was agreed by the Universal Crisis Team (Young People's Pathway) on the baby's discharge from hospital.

16.10.9 On the infant's discharge from hospital and Mary returning home; she declined further contact with the Crisis Team clinicians reporting that her anxiety had improved and she felt that she had adequate support from her family. Discharge from mental health services was agreed and the GP was informed.

16.10.10 In July 2020, Mary was again assessed by the Psychiatric Liaison Team clinician following an overdose of prescribed medication. She shared that the overdose was impulsive and denied ongoing suicidal ideation. This review notes that her relationship with Kyle was not explored, despite information on the previous assessment indicating that Mary had a history of being a victim of abuse. A safeguarding referral was completed reflecting that Mary had taken the overdose whilst her child was in the family home. On information sharing between partner agencies, it was established that plans were in place for the parental responsibility of the baby to be transferred to Mary's mother. Follow up support for Mary was sought via referral to the Perinatal Team and Mary continued to access Crisis Team services at times of difficulty.

16.10.11 Perinatal Mental Health Services specialise in the assessment and short term treatment (up to one year) of women affected by a moderate to severe mental illness in the preconception, antenatal and postnatal period. The team offered a shared development of a care plan with Mary, to meet Mary's needs and the needs of her young baby. Mary accessed further support from the Universal Crisis Team prior to the planned Perinatal Team assessment. When Mary cancelled the priority appointment, information was shared with the GP and social worker.

16.10.12 Mary had a meeting with a consultant psychiatrist in November 2020. She described long standing difficulties with mood regulation, thoughts and acts of self-harm and relationship difficulties on the background of childhood adversity. It was reflected with her that her early life experiences could impact on her emotional development and this cluster of symptoms could be described as Emotionally Unstable Personality Disorder. This was subsequently recorded as a diagnosis.

16.10.13 In February 2021, Mary had a planned appointment with her CPN. The CPN discussed follow up support with mental health services at the end of perinatal support in April. Mary stated she did not think this would be needed as her mental health was improving. The planned discharge discussion took place in April. Although the court case for the baby had been delayed, Mary declined extended support from perinatal services but did say she was considering accessing the 'Talking Matters' service. She declined a direct referral from the CPN. This information was shared with the GP.

16.10.14 In October 2021, the Community Treatment Team (part of CNTW services) had contact with Mary. A CPN carried out a planned care assessment following a referral from her GP to the regional eating disorder service. The concerns were her low weight (BMI 18), with restricted intake and induced vomiting. Mary reported low mood and reduced appetite exacerbated by social circumstances. An onward pathway was confirmed with agreement the GP may access 'Consult Connect' for prescribing advice if necessary and Mary to consider resuming therapy with 'Talking Matters'.

16.10.15 Mary had extensive contact with the 'Talking Matters' service (at that time provided by a different health trust; South Tyneside & Sunderland NHS Foundation Trust (ST&SFT)). This began with a self-referral in January 2019 when she had self-harmed and was experiencing negative thinking. She was placed on the waiting list for Cognitive Behavioural Therapy. Issues related to the recent episode of self-harming and also a previous suicide attempt in 2018. Mary's first treatment session was not until January 2020 by which time she was pregnant. She decided to end the therapy as she wanted to focus on her pregnancy. However, she submitted another self-referral only a week later. She reported fleeting suicidal thoughts and a self-harm incident only two days earlier with a 'Stanley' knife. The following month Mary again withdrew from the waiting list.

16.10.16 Eighteen months later, Mary made another self-referral to the 'Talking Matters' service. She reported her perinatal mental health nurse had advised her to get in touch. She had an initial assessment the following month and Mary described no current suicidal ideation but described hearing 'voices' encouraging her to self-harm. She also described being sexually assaulted by her then boyfriend when she was 13 years old.

16.10.17 The following month (October 2021) Mary reported to the Talking Matters professional that her weight was 8 stone and 7 pounds and that her GP had told her this was borderline anorexia (of note; this is not recorded on the GP notes. It is Mary's account to another agency of her description of the conversation with the GP). Mary's BMI was 18. (Professionals advised the DHR panel that a healthy range for BMI is 18 to 25 so this did not put Mary within the parameters for anorexia). A referral was made to the Community Treatment Team (CTT); part of CNTW services.

16.10.18 When Mary was seen by the CTT clinician the following month. They confirmed a diagnosis of Emotional Unstable Personality Disorder. Mary's body mass index was reported to be stable at 20. CTT noted there was no role for them. Liaison followed between CNTW's Community Treatment Team and ST&SFT's 'Talking Matters' service. It was agreed to offer Cognitive Behaviour Therapy (CBT) to Mary and to place her on the waiting list for that service. Sadly, Mary took her own life before her first appointment.

16.10.19 Kyle has a moderate to mild learning difficulty. As a care leaver, a support worker from the Leaving Care Team referred him to Adult Social Care. This was to help him with managing his finances, attending appointments, opening his mail and other independent living tasks.

16.10.20 Kyle had much less contact with mental health services during the timeframe of this review. His mother contacted the Crisis Team in February 2022 following the breakdown of his relationship. However, Kyle declined to be seen by the team. The same month, he had an appointment with his GP. He presented with his mum and reported 'everything is getting on top of him'. He was tearful during the consultation. He said he had split up with his girlfriend a week ago. He outlined his past history, including being a Looked After Child, use of alcohol and self-harm. The plan was to refer to the Crisis Team, prescribe anti-depressants and review in seven days. However, on 21st February, the GP received a message to say Kyle could not attend the planned appointments as he had an upset stomach. The message left said he is 'doing much better'.

16.11 Consider the incidents of sexual violence and abuse disclosed by the victim. How were these investigated and what support measures were put in place?

16.11.1 This term of reference was added after the second DHR panel. From initial scoping at the start of the DHR process, there was a brief entry regarding a single incident involving one agency which required further exploration. However, as the review progressed, two other incidents were uncovered within agency records. Mary's parents were also asked about sexual abuse disclosed by their daughter. This term of reference will consider the response to each incident and the support offered to Mary.

16.11.2 The first brief reference of a sexual assault is within the CNTW agency records. In November 2020, a psychiatrist recorded Mary talking about suffering sexual abuse when she was 13 years old (Mary was 18 years at the time of this disclosure). The psychiatrist reflected that these early life experiences could impact on her emotional development. The psychiatrist did outline for the CPN to explore options for counselling, but there is nothing in the notes recording an outcome. There was no subsequent referral to specialist sexual abuse support services.

16.11.3 Another disclosure of this same incident was made three days later to the Psychiatric Liaison Team at the hospital, following Mary taking an overdose. Again, the notes do not elaborate on any actions taken.

16.11.4 There is another reference elsewhere to the incident involving sexual assault when she was 13 years old. These were made during counselling sessions with the 'Talking Matters' service in September 2021. There is no record of any further action.

16.11.5 The Independent Chair for the Domestic Homicide Review discussed these disclosures with Mary's mum during their meeting in April 2023. Mary's mother confirmed the incident took place. She stated it occurred when Mary had gone to a wedding function with her boyfriend when they were both 13 years old (the wedding was a relative of her boyfriend and Mary's own family were not present). Shortly after she had returned home, Mary told her mother she had sex with her boyfriend. Her mum had enquired if she was okay and Mary said that she was. It was several years later that Mary told her that she had disclosed the incident to professionals and that she had not consented to the sex. Mary's mum confirmed the incident had never been reported to the police.

16.11.6 The next incident of sexual violence involved a cousin of Kyle. Mary rang the police in September 2020. She reported her partner (Kyle) had been shouting at her. She was too scared to leave and requested police assistance to do so. When officers arrived she also reported that Kyle had allowed his friend to live there in the same small flat and said this 'friend' had previously raped her. She went on to tell the officers that this matter had already been reported to the police. The attending officers did not check on previous incidents. They did transport Mary to her parent's address as she had initially requested. But they did not check on the information disclosed regarding the rape allegation. No such allegation had ever been reported to the police. Therefore no crime report was recorded, so no subsequent investigation took place and no victim support was offered to Mary.

16.11.7 Another disclosure about Kyle's cousin and the rape offence was made four months later to a social worker from Adult Social Care in January 2021. They had attended as Mary asked for support with housing and benefits. She wanted to terminate her tenancy in Blyth and seek alternative accommodation nearer her parents. She reported she had maintained contact with Kyle and his cousin as she had taken out a mobile phone contract for them. (See paragraph 16.12 for a full review of these circumstances). She then disclosed that the cousin had raped her when she was 16 years old and that he was due in court for this offence plus the rape of other females. Mary went on to tell the social worker she is scared of Kyle as 'he gets in her face and shouts when he is angry'. The Homelessness & Housing Options Team were contacted regarding the domestic abuse allegations. There is no record of any action taken in relation to the rape allegation, no signposting to specialist domestic abuse services or of informing the police.

16.11.8 Two weeks later, on 3rd February, the social worker from Adult Social Care discussed Mary's case with a colleague from Children's Services. They confirmed Mary was back at Kyle's flat where his 'cousin' was also staying.

16.11.9 On 5th February, the social worker from Adult Social Care met with Mary. Mary confirmed she was not in a relationship with Kyle but was staying in

his flat on the nights that his cousin does not stay there. The social worker completed her assessment. Mary did not have any eligible needs under the Care Act 2014 and so was informed her case would be closed. There was no re-visiting of the rape allegation, no consultation with the police and no risk assessment carried out. This action does not meet with expected standards of service. Mary was a vulnerable young woman and more support should have been offered.

16.11.10 Police carried out further enquiries during this DHR. Records confirm that Kyle's cousin was never charged with any offence relating to Mary. No crime was ever recorded at that time of the rape allegation made by Mary. The named suspect has since been convicted of a rape against another young woman and he is currently serving a term of imprisonment for this offence. There are also other concerning incidents involving this male held on file. These include having sex with a 14 year old girl when this male was 17 years old. This offence was not proceeded with as the victim would not provide a formal statement and did not want to attend court as a witness.

16.11.11 A third incident involving sexual violence was reported by Mary, this time to Northumbria Police, in March 2022. An officer had attended Mary's home to return some property relating to an earlier incident. During the visit, Mary disclosed that the previous month, she and Kyle had shared a bed. She reported Kyle had removed her shorts, had used bodily force and had sexually assaulted her. She stated she did not suffer physical injuries but had suffered emotionally and mentally as a result. Mary stated she was willing to support a prosecution. From that point, she said the only contact between her and Kyle had been via their mothers.

Officers submitted a crime report and began an investigation. Kyle attended a police station voluntarily where he was interviewed under caution. He denied the offence stating that the sexual act was consensual. The crime was finalised as undetected due to evidential difficulties; there were no witnesses, no injuries nor any other supporting independent evidence.

16.11.12 As part of the Domestic Homicide Review, Northumbria Police were asked to review their actions during this investigation so that assessments could be made regarding adherence to Force policy on the investigation of sexual assault allegations and to consider if actions matched the expectations of identified best practice in these sensitive and complex cases:

16.11.13 The Sexual Assault Referral Centre (SARC) facilities were not utilised during this investigation as there were no potential forensic opportunities. Kyle had accepted there was sexual contact (but gave a legal defence that the sex was consensual). Therefore the SARC would not have added anything further to the investigation.

Northumbria Police policy on investigations and support linked to rape and sexual assault sets out areas of responsibility on the most appropriate department to investigate the offence. Although this was clearly a sexual assault allegation, the responsibility for the enquiry is with local officers, though with support from specialists. This offence should have included the deployment of a specially trained 'Sexual Offence Liaison Officer (SOLO). This did not take place. Likewise, the Rape Investigation Team did not have oversight of the investigation and so their expertise was not accessed.

An Independent Sexual Violence Advocate (ISVA) was not assigned. Mary was willing to support a prosecution but the support of an ISVA could have been beneficial. The arena of 'trauma informed practice' is still to be fully understood by many agencies.

Under the Victim's Code of Practice (VCOP) regulations, police have statutory obligations to keep victims updated with the progress of investigations. The DHR confirmed the VCOP requirements were complied with in this case.

A domestic violence report was submitted and the incident was assessed as 'medium' risk. Mary was advised regarding safety planning. She reported she was seeking re-housing away from the area and that she had a good support network. The limits of the safeguarding arrangements were acknowledged by the police as in practical terms, Kyle and Mary lived in the same block of flats. This was a missed opportunity as an increase in Mary's housing application banding at this point may have expedited a move elsewhere, away from Kyle.

16.11.14 Taken together, it is clear Mary had suffered several episodes of sexual violence and abuse. No person has ever been charged with any sexual offences perpetrated against her. The level of care and support given to Mary by several agencies was not of the standard expected. Medical notes show she had received counselling at previous periods in her life and these appear to relate to several issues including sexual abuse. But these incidents were never discussed between professionals in a formal setting or by a referral with consent, to ensure Mary received the best possible service in terms of investigation or support.

16.12 Was the victim subjected to economic or financial abuse?

16.12.1 Mary had her own source of income via her benefits. It is not believed she had a joint bank account with Kyle. For most of their relationship they lived apart, though her own flat was very close to Kyle's flat.

16.12.2 The only reference within the extensive records held by various agencies that may indicate potential financial abuse was a comment made by Mary to a social worker from Adult Social Care during a meeting in January 2021. The conversation related to mobile telephone contracts. During the conversation, it became apparent that Mary had taken out mobile telephone contracts in her own name and was paying for both her ex-partner Kyle's phone contract and also that of his cousin. The same meeting revealed Kyle had been abusive to Mary in the past and that she was afraid of him. During the conversation, Mary also disclosed that the other male whom she had taken the phone contract out for, had raped her and that this had been reported to the police. It appears that the issue of financial abuse was not recognised and therefore not acted upon.

16.12.3 This issue was explored during the meeting between the Independent Chair and Mary's parents. They confirmed that Kyle convinced Mary to put his mobile phone contract in her name. He apparently told her this was because his benefits went into his bank account a few days after the contract was due. Mary's benefits were paid into her account the day before the phone contract payment was due. At some point after this, Mary also put Kyle's cousin's phone contract in her name and the payment was taken directly from Mary's bank account. Mary's mum and dad state that eventually Mary realised she was being used and she cancelled the standing order for Kyle's cousin's phone but retained the one for Kyle. Her parents believe he rarely paid her back the money owed.

16.12.4 With the level of coercive control exercised by both Kyle and his cousin, it is clear that financial abuse was taking place.

16.13 Was the ex-partner known to agencies for previous domestic abuse incidents? Were there any injunctions or protection orders in place?

16.13.1 Kyle had not been involved in any other domestic abuse incidents with previous partners. The domestic abuse incidents between Mary and Kyle are documented. He has never been charged with any criminal offences and has no convictions. Kyle has never been subjected to any court orders or injunctions. He was warned several times by the police regarding his conduct towards Mary.

16.14 Were nationally and locally agreed child protection procedures correctly implemented?

16.14.1 The processes regarding Mary and Kyle's baby being removed from their care are already documented. The multi-agency strategy meetings, the

Initial Child Protection Conference and subsequent core group meetings were carried out within nationally recommended timeframes. The reasons for both the Child Protection Plan and then subsequently the removal of the child from the parent's care were sound and necessary at that time, to both safeguard the child and to ensure the baby's development. However, there may have been opportunities to review these decisions, including regarding Mary's access to her baby and to her family home support network (see paragraph 16.15).

16.14.2 The GP practice complied with information requests but there is no record of the GP being invited to any of the child protection meetings.

16.14.3 CNTW also provided information and attended strategy meetings. An example of partnership working was in July 2020 when Mary attended hospital following an overdose. She was assessed by the Psychiatric Liaison Team who submitted a safeguarding referral as the baby was in the family home at the time Mary took the overdose.

16.14.4 Police submitted a total of five Child Concern Notices related to incidents they had attended (both as an unborn baby and after the child's birth). This information was assessed and fed into the planning process.

16.15 How were the support needs of a vulnerable young mother considered and reviewed in this case?

16.15.1 When the child was removed from the care of their parents, Children's Services adopted the least intrusive option. The child was cared for by their maternal grandparent with Mary given regular (supervised) contact. Prior to this intervention the baby was not achieving expected developmental milestones. Nevertheless, the removal of the child had a detrimental effect to the fragile mental health of Mary as well as having another direct impact on her other personal needs linked to housing and family support.

16.15.2 There is no doubt that Mary's new born baby was not achieving expected weight gain. This was a serious issue which required intervention. The baby had been admitted to hospital three times. The timeline needs to be re-visited to explore all opportunities to make sure that as well as protecting the baby, the young vulnerable mother was also fully supported.

16.15.3 Information from Mary's family, plus other enquiries taken as part of this DHR, show that Mary's baby now has diagnoses of multiple disabilities and problems. These include:

- Brain damage
- Cerebral palsy

- Epilepsy
- All four limbs are impacted on function and range of movement

16.15.4 To examine the support given to Mary relating to the removal of the child from her care, we need to consider the **timeline of events** which impacted on both the environmental circumstances and the actions of professionals. **These events span a full year from May 2020 through to May 2021 (shortly after the baby's birth through to the SGO being granted to the grandparents):**

In May 2020, Mary and the new born baby were living at her mum's house in Amble.

On 16th May 2020, the baby was admitted to hospital due to no weight gain. Mary was also seen while at the hospital by the Psychiatric Liaison Team (PLT) due to her low mood.

On 20th May, Mary informed professionals she wanted to move in with her partner, Kyle. Children's Services agreed to this on the basis that all three (Mary, Kyle and the baby) lived with Kyle's mother.

The next day (21st May), Mary told the social worker they had not stayed at Kyle's mum's as agreed. The social worker strongly advised Mary to return to her own mother's address with the baby. Mary declined to do so.

On 24th May, Mary, Kyle and Kyle's brother attended Mary's mum's house to collect some belongings. There was an altercation between Kyle, his brother and one of Mary's brothers.

On 26th May, Children's Services began s.47 child protection enquiries.

On 11th June 2020, an ICPC was convened. The decision of the conference was to place the baby on a Child Protection Plan under the category of 'neglect'. The concerns listed were the parent's abilities to meet the basic needs of the baby, that the child had been admitted to hospital three times and that Kyle's learning difficulty may impact on his ability as a parent. The decision of the ICPC was for the baby to remain with Mary at Mary's parent's home. Mary's mum was to directly help with care and feeding of the baby.

On 1st July 2020, Mary took an overdose of prescription drugs.

On 11th August 2020, Mary told a social worker she would be moving in with Kyle.

On 12th August, Children's Services hosted a multi-agency core group meeting to check on the progress of the Child Protection Plan. At that point, the baby was being looked after by Mary's mum. Mary requested unsupervised contact but this was not agreed.

On 27th August, there was a child protection review meeting. The decision at that meeting was for the grandparents to retain full responsibility for the baby with supervised visits twice per week for Mary and Kyle. The records from this meeting indicate concerns listed included 'tensions within the home between Mary and her brother plus the brother's convictions and drug use'.

On 1st September 2020, there was a negative parenting assessment for both parents. This assessment had been directed by the courts to see if they could look after a baby independently. The assessment concluded they could not do so.

On 12th September, Mary rang the police. She told officers she was scared of Kyle as he had been shouting at her and she wanted to return to her mum's house. The officers transported Mary to her mother's home and submitted a Child Concern Notice (CCN). It was standard practice to submit the CCN as there had been a domestic abuse incident and the baby was on a Child Protection Plan.

On 15th September, a multi-agency strategy meeting was held. Professionals expressed concerns of the impact on the baby of having Mary back in the home (information shared at the meeting included Mary self-harming the day before by cutting her wrists). Although not unanimous, the consensus at the multi-agency meeting was that for the baby to thrive, Mary should not live there full time. Concerns included fractured family relationships, health risks to the baby from their parents not complying with Covid-19 'bubbles' and of Mary putting her own needs ahead of those of the child.

On 16th September, Mary told her CPN she was now living at Kyle's mother's home.

On 30th September, Mary informed her new GP that she feels isolated in Blyth (nearly 20 miles from her own family home). She was now living with her ex-partner's mother.

2nd October 2020– Mary's mum reports to Independent Chair that diagnosis relating to baby's disabilities took place on this date. (Northumberland Health Care Trust notes confirm it was during the hospital admission 30.9.20 – 10.10.20 that baby was diagnosed with cerebral palsy and other conditions resulting in PEG feeding (Percutaneous Endoscopic Gastrostomy – flexible feeding tube inserted through the skin and into the stomach through which liquid food and medicines can be given).

On 8th October 2020, Mary told her CPN she was still living with Kyle's mother. She also reported there had been a change of her baby's social worker.

On 14th October, Mary had an appointment at her GP. She told the practitioner she was 'supposed to be living at Kyle's mum's house'. It is

unclear whether she was actually living there or living with Kyle. Mary reported to the GP that her baby had recently been diagnosed with cerebral palsy.

On 15th October, Mary told a social worker she was thinking of moving back in with Kyle.

On 27th October, Mary told her CPN that she was living back with Kyle.

On 4th November 2020, two social workers visited Mary and Kyle at Kyle's flat. The home visit is recorded as 'chaotic'. They had several friends visiting and were not complying with any of the Covid-19 restrictions in place at that time relating to 'family bubbles'.

On 18th November, Mary told her GP that she had split from Kyle so that she could have access to her child. However, later that day, a professional from Kyle's 'Leaving Care Team' visited Kyle at his flat. Mary was also present in the flat.

On 20th November, Mary took an overdose of prescription drugs.

On 25th November, there was a LAC review. Professionals expressed concerns about Mary and Kyle having face to face contact with the baby due to breaches of the Covid-19 restrictions.

On 27th November, Mary took another overdose. She told clinicians this was because of an argument with Kyle and 'other friends'.

On 30th November 2020, Mary was given the keys to her new flat. The property was in the same block as Kyle's flat. A social worker offered to purchase Mary a bed for the flat. Mary declined the offer as she said she wanted to save for her own specific type of bed.

Checks carried out as part of this Domestic Homicide Review confirm it was Mary who had placed a 'bid' for that specific property. Housing staff were unaware of previously reported domestic abuse incidents. None of the incidents had been assessed as high risk and so information exchange had not taken place.

On 4th December 2020, there was an 'abandoned 999 call' to police. The telephone number was identified as Mary's. A male and female could be heard arguing. Officers attended for a welfare check. Mary stated she had attended Kyle's flat to collect some belongings and that Kyle had assaulted her by pushing her into a fence. Other people present gave a different account. Mary told the officers she only had some of her belongings but Kyle would not let her collect the rest of them. Police notes record that Kyle and Mary were living at the same block of flats. Officers assisted Mary in collecting her belongings. Mary was not willing to support a prosecution and so the crime was finalised as 'undetected'. Officers submitted a domestic violence report, which was assessed as 'standard risk'. She declined any further support.

Mary's mum discussed this incident with the Independent Chair during the Domestic Homicide Review. She stated she spoke with the social worker to ask if she could bring Mary home with her. Mary's mum also stated the social worker informed her that Mary could not return to live with them as social work assessments indicated Mary was putting her own needs above those of the baby.

Mary's mum was so concerned about her daughter's welfare that she took Mary home with her.

The following day, (5th December) police attended Mary's mother's home on an entirely unrelated matter. They searched the property and found drugs and weapons in Mary's brother's room at the house. Police submitted a Child Concern Notice as is standard practice. This CCN resulted in a multi-agency strategy meeting. The decision at the meeting was that legal advice should be sought. The strategy records that the aim was to work with the family so that the brother could move out of the property.

Although there is no specific entry in agency records, it appears Mary's brother did not move out of the family home.

On 8th December, Mary told her CPN she was back living at Kyle's flat as her own flat was not yet ready.

On 15th December, a housing officer conducted a 'new tenancy' visit for Mary. However, due to Covid-19 restrictions, the actual 'visit' was conducted over the telephone.

Mary's mother expressed to Independent Chair that Mary wanted to come home for the Christmas period but Children's Social Care said she was not 'allowed' home. Mary only visited for a few hours on Christmas Day.

Children's Services records have been checked as part of the DHR. A plan was in place to allow Mary to visit her family home between 11.00am and 3.00pm on Christmas Day to spend time with her family.

On 13th January 2021, police were called by a member of the public to a young woman (Mary) threatening to jump off a bridge. Mary was described as despondent and feeling hopeless.

Police contacted the 'Street Triage Team' who spoke with Mary. Mary's perinatal CPN was also contacted and spoke with Mary.

Finally, police also contacted Mary's social worker regarding Mary's housing situation as she had no furniture and no money for electricity. Children's Social Care notes record Mary has separated from her partner where she was living and has therefore gone to her flat which is unheated and unfurnished. She has one blanket and is sleeping on the kitchen floor. The social worker stated she would explore options in assisting her or finding Mary a hostel placement. Mary declined to go to a domestic violence refuge.

On 14th January, Mary told her CPN she spent the previous night sleeping in a caravan on a driveway of her parent's neighbours. She told the practitioner that if she had to go back to her cold, dark unfurnished flat she would 'cut her own throat with a broken mirror'. The CPN contacted the Emergency Duty Team at social care. A social worker agreed Mary could stay for that night at her parent's home. The CPN confirmed that the social services plan is that Mary cannot stay overnight at her parent's home.

On 15th January, a social worker from Adult Social Care spoke with their counterpart in Children's Services. This conversation followed a referral made the previous month by Mary's CPN. The notes of the conversation appear contradictory as they record 'no domestic abuse but there was one incident in December when Kyle pushed Mary into a fence'. (There was also another incident from September 2020 when police again submitted a referral regarding a domestic abuse incident between Kyle and Mary).

On 20th January, the social worker from Adult Social Care visited Mary. Mary was staying with a female friend. The notes do not record the actual address but Mary was not at Kyle's flat or her own flat. Mary said she wanted to terminate her tenancy in Blyth and look for a property nearer her parent's home (20 miles away).

The next meeting between the social worker from Adult Social Care and Mary was two weeks later on 5th February. Mary stated she is not in a relationship with Kyle but she does stay at his flat on the nights his cousin is not there. Mary was advised she did not meet the criteria for support under the Care Act 2014 and that therefore her case would be closed.

On 18th May 2021, Mary's parents were granted a Special Guardianship Order for her child.

This lack of support is below the standard of what should be expected by professionals. Although action was clearly needed to safeguard a very young baby who was not gaining weight, there was insufficient focus on the needs of a very vulnerable young woman. Mary was only 18 years old, had a long history of involvement with mental health services and had taken several overdoses or self-harmed.

16.16 Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim and ex-partner? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

16.16.1 No issues were apparent regarding age, ethnicity, language, religion, marital status or sexual orientation. Mary received support from a variety of agencies during her pregnancy.

16.16.2 Kyle had a diagnosed learning difficulty (diagnosed by a psychiatrist in 2015). This is described as 'moderate to mild'. Mary was assessed by a psychiatrist and had a diagnosed issue: Emotionally Unstable Personality Disorder. This was managed by a variety of professionals.

16.16.3 Although both could be described as vulnerable, neither Kyle nor Mary were in receipt of services under the Care Act 2014.

16.17 Did any restructuring during the period under review have any impact on the quality of service delivered? Did the Covid-19 pandemic affect service delivery?

16.17.1 Emergency services such as NEAS, NCHFT or Northumbria Police were unaffected and maintained services throughout the pandemic.

16.17.2 GP practices remained open, though most appointments were switched to telephone in line with national regulations. Face to face appointments remained an option.

16.17.3 Support from organisations such as CNTW or Children's Services continued but usually in the form of telephone or 'virtual' meetings on line.

16.17.4 The Covid-19 regulations relating to gatherings and 'bubbles' appear to have caused additional concerns to professionals as Mary and Kyle frequently breached these rules.

16.17.5 The national 'Domestic Homicide Project' found that Covid-19 acted as an 'escalator and intensifier of existing abuse' in some instances, with victims less able to seek help due to Covid restrictions. It also concluded that Covid had not 'caused' domestic homicide but had been 'weaponised' by some abusers as both a new tool of control over victims, and – in some cases – as an excuse or defence for abuse or homicide of the victim.[7]

[7] The Domestic Homicide Project (NPCC) and delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing.

Section 17: Conclusion and Lessons Learned

17.1 Mary was a vulnerable young woman with a long history of involvement with mental health services.

17.2 Mary was a victim of domestic abuse within a controlling relationship. The abuse included physical, sexual, financial and emotional abuse as well as coercive control.

17.3 Mary was a repeat victim of sexual violence. The disclosures she made of rape and other sexual abuse should have been managed more effectively, with a holistic approach and better coordination between agencies. Trauma informed practice is crucial if victims of sexual abuse are to be supported.

17.4 The disclosures of financial abuse were not recognised by professionals, so no advice was sought from the police regarding further investigation.

17.5 Mary had repeatedly self-harmed, taken many overdoses of prescribed drugs and threatened suicide before she tragically took her own life. Her complex mental health history was known to professionals supporting her.

17.6 Mary's ex-partner and the father of her child has a learning difficulty.

17.7 Mary's baby was removed from her care. Although action was clearly necessary to safeguard such a young child, there was no documented review of child protection arrangements following the sharing of the updated medical diagnosis. By October 2020, (during a hospital admission) the baby was diagnosed with cerebral palsy and was PEG fed (i.e. through a tube). This was the first indication of neurological issues affecting the child. Such a diagnosis is not possible in a very young baby, but by October this diagnosis was made and shared with Children's Social Care. By this point, there were other factors for professionals to consider; conflict between Mary and her brother, covid breaches, police finding drugs paraphernalia and weapons in Mary's brother's room and Mary's overdoses and self-harming. These were challenging, changing circumstances for practitioners to assess. But there does not appear to have been a detailed consideration of how Mary could be accommodated and managed in the family home; to both safeguard the baby but also ensure adequate support was in place for Mary.

17.8 There was insufficient focus on Mary's needs when the baby was removed from her care. She was a young (18 year old) new mother with a history of self-harming and taking overdoses. She found herself in an unfurnished, unheated flat, 20 miles away from the nearest family support, living in the same block of flats as her abuser(s). The decision for her not to remain

overnight in her parent's home was made at a multi-agency strategy meeting.

17.9 Opportunities were missed to secure Mary an earlier assessment for a higher 'banding' in her housing application to move away from the immediate locality, which was in the same block of flats as her abuser.

17.10 Mary experienced stalking and harassment from her ex-partner. Despite reports to police, the ex-partner was not prosecuted for these offences.

17.11 A note was found next to Mary's body by her mum. An excerpt read:

"I'm sorry, I really am. I tried but I can't. It's too much for me to deal with. Say sorry to xx (her baby) *for me but the only help I can hopefully get is this way. I'm really sorry. Just know it's no one's fault…….It hurts so much and I just want the pain to end. Remember the good things I did……xx* (baby) *I love you. Mam, dad, I love you, but I'm broken….."*

Recommendations

1. The contents and findings of this review should be shared with Northumberland Children & Adults Safeguarding Partnership.

2. Emotional wellbeing and mental health of parents should always be considered when a decision has been made to remove a child from their care, to ensure the necessary safety measures and support services are in place. In these circumstances there should be management oversight of the decision-making and review process.

3. The Safer Northumberland Partnership and the Northumberland Children & Adults Safeguarding Partnership should explore opportunities to engage with specialist providers who can support women whose children have been removed from their care.

4. Any professional who may encounter disclosures of sexual abuse should be briefed on how victims may be signposted to practitioners and organisations who are trained to offer direct, confidential, specialist support in these circumstances. Trauma informed practice is crucial if victims of sexual abuse are to be supported. The Safer Northumberland Partnership should consider commissioning a training package to give staff confidence within this sensitive arena.

5. The Safer Northumberland Partnership should review domestic abuse training packages being delivered to agencies in Northumberland. Training content should include a full understanding of financial and economic abuse so that professionals can recognise such abuse when it is taking place and take appropriate action to support victims.

6. The Safer Northumberland Partnership should liaise with the Northumberland Children and Adults Safeguarding Partnership, to confirm there are systems in place ensuring periodic reviews are carried out between NHS paediatric services and Children's Services when babies are not meeting developmental milestones. This is particularly important when children have been removed from their parent's care.

7. The Safer Northumberland Partnership should review its information sharing protocols linked to standard and medium risk cases of domestic abuse. In this case, the abusive nature of the relationship was known to several agencies but the housing department were not informed at an early stage. The victim was allocated a property in the same block of flats as her abuser.

8. The Safer Northumberland Partnership should receive reassurance from Northumbria Police that their training programmes have been reviewed relating to:

   (a) Stalking and harassment (all officers and operational staff are able to recognise a ‘course of conduct’ - Protection from Harassment Act 1997 - and take positive action to protect victims).

   (b) Investigation of rape and sexual abuse (ensuring compliance with Force policy and national best practice in relation to management, investigation and support within this complex and sensitive arena).

References

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

'Working together to safeguard children' (HM Government 2015, revised 2018)

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Vulnerability, Knowledge and Practice programme (Home Office, National Police Chief's Council, College of Policing 2020-2021)

Untangling the concept of coercive control (Sylvia Walby & Jude Towers 2018)

Crown Prosecution Service policy on domestic abuse cases and the VAWG strategy (2017)

Office for National Statistics (2021)