SHROPSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

into the circumstances

of the death of a woman aged 47 years

on 23rd-24th December 2014

Case No DHR1

Independent Chair and Author:

Ivan Powell

2016

CONTENTS

LIST OF ABBREVIATIONS

AAFDA	Advocacy After Fatal Domestic Abuse
ABE	Achieving Best Evidence (Investigating Interviewing Practice)
BBR	Building Better Relationships Accredited Programme
CPS	Crown Prosecution Service
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment Tool
DAU	Domestic Abuse Unit – West Mercia Police
DHR	Domestic Homicide Review
DVPN	Domestic Violence Prevention Notice
GP	General Practitioner
HAU	Harm Assessment Unit – West Mercia Police
HM Coroner	Her Majesty's Coroner
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
NOMS	National Offender Management Service
PVP	Protecting Vulnerable People (Department of West Mercia Police)
SIO	Senior Investigating Officer – Police
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SCSP	Shropshire Community Safety Partnership
WWMCRC	Warwickshire and West Mercia Community Rehabilitation Company

SHROPSHIRE COMMUNITY SAFETY PARNERSHIP

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1. Introduction

1.0 For the purposes of this review report in order to comply with the Home Office guidance[1] and to protect the identity of those involved, but to ensure it is personalised, pseudonyms have been used to identify each individual who had a personal relationship with the victim. These have been agreed with the family involved in this review. The people referred to in this report will therefore be known as:

1. Victim Jessica
2. Offender, victim's partner and person convicted of her murder – Richard
3. Victim's daughter Rebecca
4. Victim's sister Diana
5. Victim's mother Victoria

1.1.1 Additionally, there are three ex partners of the offender whose experience at his hands also have some relevance to this review. These have simply been identified by their initials (as below) as they are ancillary to the main individuals, and to ensure the victim, and her family, have the priority status in the report.

6. Ex-partner 1 (KF)
7. Ex-partner 2 (LMI)
8. Ex-wife (KB)

1.1.2 I would like to express my sincere condolences to the family and friends of Jessica.

1.1.3 I have endeavoured to place Jessica and her family, namely her daughter Rebecca, Sister Diana and her mother Victoria, at the centre of this review. Jessica's family are of course both integral to and a central part of the review process, but importantly are key to ensuring Jessica's voice is heard clearly. The author is genuinely grateful to all of the family for their honesty, openness and willingness to share very personal experiences to achieve this aim. Their resilience is remarkable in the circumstances and they have given of their best to represent Jessica and inform the review of what her life was like at the hands of Richard, and to ensure her voice is clearly heard.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

1.1.4 My gratitude is also extended to the professionals, agencies and panel members who dedicated their time, commitment and tenacious attention to detail throughout the Domestic Homicide Review.

1.1.5 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Jessica, a 47-year-old woman during the overnight period of 23rd-24th December 2014. The woman's long term partner, Richard, having been arrested and charged with her murder, appeared before Worcester Crown Court, where following a three-week trial was convicted of her murder on 11th March 2016 and sentenced to life imprisonment, with a recommendation that he serves 17 years.

2.0 Purpose of a Domestic Homicide Review

2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[2] on 13th April 2011. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"

2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.
It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

2.3 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

[2] Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

2.4 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

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

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

2.4.3 Apply these lessons to service responses including changes to the policies and procedures as appropriate;

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

3.0 Process of the Review

3.1 West Mercia Police notified Shropshire Community Safety Partnership (SCSP) of the homicide on 13th January 2015. The SCSP undertook a scoping exercise at the conclusion of which they met and agreed that the circumstances met the requirement for a DHR. Accordingly, the Home Office were informed on 9th October 2015 of the intention to commission a DHR.

3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.

3.3 Home Office Guidance[4] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

4. Independent Chair and Author

4.1 Home Office Guidance[5] requires that;

4.1.1 "The Review Panel should appoint an Independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on Individual Management Reviews and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should,
where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

4.2 The Independent Chair and Report Author, Mr Ivan Powell, was appointed at an early stage, to carry out this function. Throughout this report, where reference is necessary for contextual reasons he is referred to as the Report Author. He is a former Senior Detective Officer with West Mercia Police and formerly the Chair of the Herefordshire Strategic Domestic Abuse Steering Group. He retired from the police service in April 2014 and, since that time, has

[4] Home Office Guidance 2013 page 15
[5] Home Office Guidance 2013 page 11

had no contact with West Mercia Police in a supervisory capacity. Prior to this review process, he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it. Ivan Powell was appointed to the role of Independent Chair and Author by the Community Safety Partnership Board following a discussion at the Board where partners considered other possible 'candidates' for the role.

4.3 On the12th February 2016 SCSP wrote formally to the Home Office informing them of a delay in the review on the basis that the trial of Richard had been rescheduled on two occasions and was now due to commence on 29th February 2016, scheduled for three weeks. This meant a delay in arranging to speak to Jessica's work colleagues who were witnesses in the prosecution case, and affording Richard the opportunity to engage with the review.

4.4 Additionally the review panel had established a need to consider information which may be available in neighbouring county Police and Council Children's Services records appertaining to convictions from 2001and 2002, felt to be of potential relevance to the review.

5.0 DHR Panel

5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review.

5.2 Members of the panel and their professional responsibilities were:

George Branch	Assistant Chief Officer, Warwickshire and West Mercia Community Rehabilitation Company
Wendy Bulman	Shropshire Women's Aid Manager
Tom Currie	Assistant Chief Officer, National Probation Service, Head of Service for West Mercia
Alison Davies	Detective Chief Inspector West Mercia Police
Jan Frances	Chief Executive West Mercia Women's Aid
Lisa Kelly	Independent Review Officer, Shropshire Council Children's Services
Tony McGregor	Interim Internal Review Unit Manager Shropshire Council Children's Services
Adele McGuigan	Regional IDVA and Safeguarding Support Services Manager West Mercia Women's Aid
Teresa Tanner	Named Nurse for Safeguarding Children and Domestic Violence Lead, Shrewsbury and Telford Hospital NHS Trust
Claire Porter	Head of Legal and Democratic Services, representing Shropshire Council Children's Safeguarding Board.
Andrew Gough	Shropshire Council Community Safety Partnership (Business Manager)

5.3 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

5.4 The Panel was supported by the DHR Business Manager, Mr. Andrew Gough. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

5.5 The full Panel met on four occasions and the Author, and Business Manager met on an additional four occasions.

6.0 Parallel proceedings

6.1 The Panel were aware that the following parallel proceedings were being undertaken:

6.2 Her Majesty's Coroner opened and adjourned an Inquest on 17th February 2015. It was not reopened after the criminal proceedings.

6.3 The DHR Panel Chair advised HM Coroner on 17th March 2016 that a DHR was being undertaken. HM coroner has asked for receipt of a copy of this report on conclusion of this review.

6.4 The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with an awareness of the issues of disclosure that may arise. The review was suspended for a period from 12th February 2016 in the lead up to and during the crown court trial.

6.5 The early stages of this review revealed that a Probation Service Serious Further Offence Review should have taken place, but had not been instigated due to an administrative error. The necessary documentation was sent to the National Probation Service not the Community Rehabilitation Company as should have happened. This was corrected and a serious further offence review conducted. Following the serious further offence review following learning points will be implemented:

- Ongoing need to promote importance of home visiting where there have been/are concerns relating to domestic abuse. To be completed end of June 2016
- Assessments need to provide clear summary of current circumstances at point of actual review and not to be over reliant on historical information. To be completed end of September 2016
- Clarification required in relation to information that can be expected from Police partners (i.e. unrequested police call-out information; DASH assessments). To be completed end of September 2016
- Identified need for clarifying how additional court sanctions such as Restraining Orders will be managed and monitored. To be completed end of September 2016
- Offender engagement can result in too much reliance on offender self-reporting without corroborating evidence. To be completed end of September 2016

7.0 Time Period

7.1 The DHR review panel initially set the period of the review from the 12th April 2003, this being the date when West Mercia Police received their first complaint of domestic abuse from Jessica against Richard, to the date of the Jessica's death, which occurred sometime during the night of 23rd-24th December 2014. West Mercia Police were also specifically asked to consider a domestic incident which took place on 19th February

2002. (Exploration of this record revealed it was a domestic abuse incident between Richard and his brother and as such was removed from the scope of the review).

7.2 Between 1995 and 2003 Richard and Jessica had separated, and during this time, he had been involved in another relationship with KB whom he married. They had two children. As the review progressed, it was discovered that on 12th April 2000 and 18th December 2001 two separate incidents occurred where ultimately Richard was convicted for offences of assault on KB. As a consequence of the significance of these convictions the review panel agreed to include them within the terms of reference, being cognisant of the opportunity they presented for agencies to share key information.

7.3 For clarity the events leading to the convictions in 2000 and 2001 were not reviewed, nor the multi-agency decision-making and activity relating to the case.

8.0 Scoping the review

8.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with Jessica and Richard, the victim and perpetrator respectively prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

8.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period. As indicated above, West Mercia Police were asked to consider the domestic abuse incident which occurred on 19th February 2002, and Staffordshire Police and Staffordshire Council Children's Services were asked to provide details of records held concerning the incidents on 12th April 2000 and 18th December 2001.

8.3 The purpose of the extended period to consider the incidents in 2001 and 2002, was to examine and identify what opportunities were available for agencies to share relevant information and take action with Richard concerning his partner and their children. Additionally, to understand where this information should have been taken into account later and to identify whether this should have resulted in challenge and escalation by agencies.

9.0 Individual Management Reviews

9.1 The following agencies were requested to prepare chronologies of their involvement with Jessica and her family, carry out individual management reviews and produce reports:

- West Mercia Police
- Warwickshire and West Mercia Community Rehabilitation Company
- Shrewsbury and Telford Hospitals NHS Trust
- Shropshire Council Children's Social Services

9.2 The Crown Prosecution Service provided a report specifically dealing with the terms of reference for a review of the court appearance of Richard for assaults on Jessica and their daughter Rebecca committed on the 12th March 2013.

9.3 Also as part of the scoping exercise the following agencies were contacted but reported no previous contact with or involvement with the perpetrator or Victim:

- West Mercia Women's Aid
- West Mercia/Shropshire Victim's Support
- South Staffordshire and Shropshire Healthcare NHS Trust Foundation
- Clinical Commissioning Group on behalf of GP
- Severnside Housing Association
- Belvedere School, Shrewsbury
- School Nursing Service

10. Summary

10.1 Jessica was 47 years of age at the time of her death. She and Richard first commenced a relationship in 1990. They had one child together, their daughter Rebecca, who was 22 years of age at the time of her mother's death. Richard and Jessica separated when Rebecca was 3 years old, this would have been approximately 1995 and got back together when she was 10 years old, approximately 2002. They remained in a long-term relationship, with some periods of separation until Jessica's death. According to Rebecca, the couple split up again around Christmas 2013, but then began secretly seeing each other again before her father moved back into the family home in about July 2014.

10.2 The review was also informed by West Mercia Police of their enquiries into Richard's background during their murder investigation and in particular his previous relationships, one between 1988 and 1990, and two in the period 1995 – 2002 whilst living apart from Jessica. He had during each of these relationships, been violent to his partners.

10.3 Richard had a previous relationship with KF between 1988 and 1990. She was 16 at the time and he was a few years older than her (19-21years), the relationship lasted about 18 months. She described a life of violence at his hands, with him becoming increasingly dependent on alcohol. Although her mother witnessed one of the assaults on her daughter, neither she nor her daughter ever formally reported anything to Police or other agencies. As a young female in her first relationship, she put up with the violence thinking it would stop.

10.4 Ultimately she ended the relationship, although for a period of time Richard continued to contact her. A couple of months after the relationship had finished, she was diagnosed with a detached retina. She told her doctor at the time that she had been in an abusive, violent relationship and he told her that it had probably been caused by a blow to the head. She did not report the violence to the Police as she wanted to move on with her life.

10.5 LMI describes being in a relationship with Richard for about 9 months in 1995. She was aged 17 at the time; he would have been 26 years of age. During the relationship, he once grabbed LMI by both arms and pushed her against a stair gate during an argument. She stated this shocked her rather than injured her but this caused her to end the relationship.

10.6 During 1993 Richard was in what is described as an 'on/off relationship' with Jessica. They were living apart, him living at his parents' home address in Shropshire. At about this time he commenced the relationship with KB**.** They began living together in May 1995 and were ultimately married. They had two children together, a son born in 1996 and a daughter born 1999. The three have no contact with Richard now.

10.7 KB described to Police a relationship which steadily deteriorated into a life of violent attacks at Richard's hands, with him drinking heavily. Initially this victim did not report matters to the Police. In 1996, KB became pregnant and during the pregnancy, the domestic abuse continued, including one incident which resulted in her hospitalisation for two days because of the stress of her situation.

10.8 KB stated that following the birth of their son in September 1996 the violence continued. In February 1997 with the assistance of her father, she fled the relationship and secretly relocated to a neighbouring county.

10.9 By the summer of 1997 Richard had discovered where she was living and managed to convince her to resume their relationship, with the promise of an end to his violence. For a short period there was no violence, they married in June 1998 and their second child, a daughter was born in November 1999.

10.10 Ultimately the violence at his hands started again. On 12th April 2000 and 18th December 2001, this victim was the subject of assaults at the hands of Richard. On both occasions, she called the Police and on both occasions, he was later convicted. She commenced divorce proceedings which concluded in March 2003.

10.11 As two of these relationships had happened many years previously the review panel in full consideration of the circumstances as a whole did not feel they would add significantly to the review, however the panel did agree that the violent circumstances of Richards relationship with KB, and in particular the two convictions was likely to be of value to consider, and so was incorporated into the review.

10.12 Richard was 45 years old and the partner of Jessica at the time of her death. He was convicted of her murder on 11th March 2016 and sentenced to life imprisonment with the judge's recommendation that he should serve a minimum of seventeen years. At the time of the homicide subject of this review, they were living together with Rebecca at an address in Shrewsbury.

10.13 At the time of the offence Richard was the subject of a supervision order and being managed by Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC). This order was in respect of a conviction for an assault on his daughter Rebecca, committed on 2nd December 2012. The full sentence imposed was 5 months imprisonment, wholly suspended for 24 months, a supervision order with alcohol treatment requirement. He was also made the subject of a restraining order 'not to behave in a threatening or abusive manner towards Rebecca'.

10.14 Richard was unemployed, had no car and usually travelled on foot or using public transport.

10.15 Jessica had held a part-time job working for a local charity for a number of years as a finance officer; her normal hours of work were Monday to Friday, 9am to 4pm. Both Jessica and Richard were known to drink excessive amounts of alcohol.

10.16 West Mercia Police were involved with Jessica and Richard on a number of occasions between 2002 and the date of Jessica's death. Their daughter Rebecca was also the subject of assaults at the hands of the father for which he has three separate convictions. Richard also has a conviction for criminal damage to a television set belonging to Rebecca committed during a domestic argument.

10.17 Richard has one conviction for domestic abuse assault against Jessica, albeit it should be noted that the Police on many occasions did not manage to secure Jessica's engagement with the investigative process.

10.18 As a consequence of a domestic violence incident on 2nd December 2012 Richard was charged with offences of assault against both Jessica and Rebecca. The latter charge was a victimless prosecution, authorised by the Crown Prosecution Service (CPS) on the basis that whilst Jessica did not wish to engage with the investigation, their daughter Rebecca, had provided evidence of the assault on her mother.

10.19 On the 2nd March 2013 Richard appeared before the court, he offered a guilty plea and was convicted in respect of the charge relating to his daughter Rebecca, but not guilty to the offence against Jessica. The CPS offered no evidence in respect of the victimless prosecution against Jessica. The case was therefore dismissed by the court. Further commentary is provided later in the review document.

10.20 Jessica had one caution for a minor assault on Richard committed in 2005.

10.21 During the early morning of Wednesday 24th December 2014 West Midlands Ambulance Service were called by Jessica's employer to their place of work. The incident was so serious that West Midlands Ambulance Service requested the attendance of West Mercia Police. Jessica had been found slumped against an easy chair in the driver's kitchen area of her place of work. The scene had evidence of disruption, being described as 'in a mess and looking as if it had been burgled'. Paramedics pronounced Jessica deceased at the scene at 8.08 a.m.

10.22 On the morning of Wednesday 24th December 2014 Police officers attended the home address of Richard where they found him sat in his lounge, fully clothed and under the influence of alcohol. He made a comment to the officers amounting to what is known under the Police and Criminal Evidence Act 1984 as a 'significant comment'. The officers also noted the knuckles of both of his hands were swollen with a small graze on a middle knuckle finger and a bruise on his right hand below his index finger. He was arrested on suspicion of the murder of Jessica at 0940 a.m. that morning.

10.23 A subsequent post mortem of Jessica identified the cause of death as 1a haemorrhage with 1b being recorded as pancreatic laceration. (The terms 1a and 1b are used in the HM coronial recording process, 1a is the cause of death, 1b being the underlying cause). The autopsy revealed multiple blunt injuries to her body but in particular laceration to the pancreas. Multiple rib fractures of varying ages were also identified. The Forensic Pathologist recorded his professional belief that she had suffered a significant impact to her upper belly just below the breastbone, causing the pancreas to be forced back against her spine, and rupturing as a consequence. The examining pathologist also noted multiple rib fractures of varying age.

10.24 An osteoarticular pathologist later examined ten of Jessica's ribs. He found that each of those had at least one fracture and that they were caused in five different and distinct time intervals prior to her death. These were:

a) The oldest fractures were over 3 months old.
b) There were fractures aged 28 to 40 days old.
c) Some fractures had occurred 14 to 26 days prior to Jessica's death
d) A number of fractures were 7 to 12 days old.

10.25 The most recent fractures to her ribs were caused between 6 and 12 hours prior to her death.

10.26 In conclusion, the professor stated that Jessica had sustained five periods of injury during which ribs were fractured. They varied in age from a few hours to several months prior to her death.

10.27 Richard was initially released on Police bail whilst their investigations continued. On 3rd March 2015 he was charged with Jessica's murder at which time he was remanded into custody pending trial. The subsequent three-week trial concluded on 11th March 2016 when Richard was found guilty of Jessica's murder and sentenced to life imprisonment, with a recommendation that he serve a minimum of seventeen years.

10.28 HM Coroner for the County of Shropshire opened the inquest and adjourned until after the criminal proceedings. It was not reopened after the conclusion of the trial and conviction.

11 Terms of Reference

11.1 The Terms of Reference for this DHR are divided into two categories i.e.

- the generic questions that must be clearly addressed in all IMRs; and
- Specific questions which need only be answered by the agency to whom they are directed.

11.2 Time Period for the review

11.3 The time period of the review is detailed on page 8 of this report.

11.4 The generic questions are as follows:

1) Were practitioner's sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

2) Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3) Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?

4) Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

5) Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

6) Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

7) What were the key points or opportunities for assessment and decision making in this case?

8) Do assessments and decisions appear to have been reached in an informed and professional way?

9) Did actions or risk management plans fit with the assessment and the decisions made?

10) Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

11) When, and in what way, were the victim's wishes and feelings ascertained and considered?

12) Is it reasonable to assume that the wishes of the victim should have been known?

13) Was the victim informed of options/choices to make informed decisions?

14) Were they signposted to other agencies?

15) Was anything known about the perpetrator? For example, were they being managed under MAPPA?

16) Had the victim disclosed to anyone and if so, was the response appropriate?

17) Was this information recorded and shared, where appropriate? Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?

18) Was consideration for vulnerability and disability necessary?

19) Were Senior Managers or agencies and professionals involved at the appropriate points?

20) Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

21) Are there ways of working effectively that could be passed on to other organisations or individuals?

22) Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

23) How accessible were the services for the victim and the perpetrator?

24) To what degree could the homicide have been accurately predicted and prevented?

11.3.1 In addition to the above, the following specific questions are posed which need only be answered by the agency to which they are directed.

11.3.2 At the time the terms of reference were agreed the terms used were 'victim and perpetrator'. As the review progressed the pseudonyms, Jessica and Richard were agreed with the family. As such the pseudonyms have been placed within the terms of reference in the report, the terms of reference are accurately recorded other than this amendment.

11.4 **West Mercia Police**

11.4.1 It is known that Richard has convictions arising from a violent relationship he had with another partner, KB between 1995 and 2003. These convictions were secured following investigations by Staffordshire Police.

11.4.2 On the event of the first domestic incident/offence between Richard and Jessica, on 12th April 2003 (and indeed each and every subsequent occasion for incidents involving the combination of Richard, Jessica and Rebecca) there would have been an opportunity for West Mercia Police to conduct a Police National Computer (PNC) check revealing Richard's convictions in Staffordshire. Were these to have been conducted the information should have been shared with Shropshire Council Children's Services, were PNC checks made and were his convictions shared appropriately with statutory partners, notably Shropshire Council Children's Services?

11.4.3 West Mercia Police were first called to a domestic incident between Jessica and Richard on the 19th February 2002. The Police record suggests that neither party wished to make a complaint to the Police; the matter was dealt with by means of 'no further action'. As recorded above, at this time Richard was in fact the subject of a twelve-month conditional discharge for a common assault on KB. In reaching a decision to take no further action did West Mercia Police take into account Richard's conditional discharge? Did any risk assessment process take account of his conviction status, albeit from a neighbouring force area?

11.4.4 (As indicated earlier this was removed from the terms of reference when it was established that this is in fact an incident between Richard and his brother, it was elsewhere than at his home address, and did not involve Jessica or their daughter Rebecca)

11.4.5 At this time, their daughter Rebecca was seven years old was this fact noted by the officers and were appropriate referrals made to Shropshire Council Children's Services? (Again this was removed from the terms of reference as it no longer applies as explained above)

11.4.6 When conducting the DASH risk assessment process responding officers assessed the risk as standard on most occasions, with a smaller number of them being recorded as medium risk. Were these assessed levels of risk decisions in line with force policy and national guidance? It is noted that most MARAC referrals concern so called 'high risk' cases, but guidance does make it clear that other cases can also be referred, were attempts made to take the case to MARAC? If not should they have been?

11.4.7 Responding officers and investigating officer's decision-making are subject to scrutiny by their supervising officers. Were the supervising officer's interventions evident in consideration of the questions posed above?

11.4.8 Latterly harm assessment units have introduced a further level of scrutiny and opportunity for intervention in repeat domestic abuse cases, were harm assessment interventions evident and appropriate and indeed resultant in escalation activity in terms of risk assessment and risk level identification?

11.4.9 Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC), will have conducted their own assessment of risk (OASY), were West Mercia Police aware of this assessment, and was this taken into account by Police risk assessment processes?

11.4.10 In 12 of the 22 Police recorded incidents specific reference is made to the fact that either or both of Jessica and Richard had consumed alcohol. It must be noted that use or misuse of alcohol does not cause domestic abuse but it is a compounding factor. The use or misuse of alcohol is a disinhibiting factor likely to contribute to the severity of the abuse. In recognising this, particularly as the frequency of events increases was any form of assessment completed concerning the involvement of alcohol as a factor and were referrals made to appropriate agencies?

11.4.11 Was there an opportunity to explore with Richard whether alcohol consumption was having an adverse effect on his behaviour (in the context that alcohol is a disinhibition)

11.4.12 Is there any information to suggest that responding officers had become disengaged with the risk assessment process and as a result fell into conducting a form filling exercise rather than genuinely engaging in an informed conversation with Jessica?

11.4.13 The 'view previous incident process' undertaken by West Mercia Police's call takers seeks to inform officers of potential levels of risk and repeated nature of incidents. Was this applied appropriately in this case and should checks have resulted in the identification of the fact that Richard was the subject of a supervision order with West Mercia Probation Trust and latterly Warwickshire and West Mercia Community Rehabilitation Company?

11.4.14 What level of care plan was Jessica the subject of, was this appropriate and were appropriate interventions offered as a consequence of any care plan being in place?

11.4.15 It is believed that some information concerning the Richard's behaviour resulted in anti-social behaviour reporting between the housing association and West Mercia Police anti-social behaviour coordinator. Were the potential for these anti-social behaviour incidents to be recognised as in fact domestically abusive behaviour, and appropriate referrals and interventions invoked as a consequence?

11.4.16 Local policing teams often have a localised insight into activity on their respective areas, including anti-social behaviour and repeated crime and incident activity. As part of that local policing understanding of their community did the local policing team have these individuals and/or address within any form of patrol and support strategy? If so, did they endeavour to raise the level of risk with specialist colleagues?

11.4.17 Were opportunities to use Domestic Violence Protection Notices/Orders recognised and actively considered?

11.4.18 Was Jessica spoken to alone as part of any risk assessment?

11.4.19 Was there an opportunity to explore with Jessica whether or not alcohol consumption was having an impact on family life, home environment and/or her personal health?

11.4.20 Rebecca their daughter was the victim of an assault at the hands of Richard when she was 13 years old. She was also recorded by Police as being resident in the home at the time of four further domestic abuse incidents between her parents. Was her status as a very vulnerable child recognised, and was she ever spoken to alone as part of any risk assessment process?

11.4.21 During the periods of supervision by West Mercia Probation Trust and Warwickshire and West Mercia Community Rehabilitation Company Richard was involved in three domestic incidents with Jessica. Should West Mercia Police have shared relevant information with West Mercia Probation Trust and latterly West Mercia Community Rehabilitation Company?

11.5 Shrewsbury and Telford Hospital NHS Trust

11.5.1 Noting the prevalence of domestically abusive activity within the home environment did any of the presentations of any or all three parties in this case present an opportunity for Trust staff to engage in exploratory conversations concerning domestic abuse?

11.5.2 In particular, were any of the injuries presented suggestive of the incidence of domestic abuse and again were exploratory conversations held?

11.5.3 Richard attended the accident and emergency department on two occasions in 2012 where clear reference is made to his status as being suspected of domestically abusive behaviour against his family members. Was the significance of these presentations recognised and was information sharing undertaken appropriately? And due consideration given to other possible interventions e.g. MARAC?

11.5.4 With regard to all of the above, were any follow up appointments made and did these present a further opportunity to explore the prevalence of domestic abuse (and act accordingly)?

11.5.5 Was Jessica spoken to alone as part of any assessment?

11.5.6 Did Jessica ever present in company with her daughter, other family member (with the exception of Richard) or indeed other third party which may have presented an opportunity to explore the prevalence of domestic abuse? (Accepting the Jessica's consent may be an issue here).

11.5.7 Was there ever an opportunity for Rebecca to be spoken to alone to assess any level of risk to her as a child?

11.5.8 Did medical notes shared with GP practices reflect the actual or possible prevalence of domestic abuse? In consideration of this question, in particular where it was known that Richard was actively under Police investigation in respect of domestic abuse offending?

11.5.9 It must be noted that use or misuse of alcohol does not cause domestic abuse but it is a compounding factor. The use or misuse of alcohol is a disinhibiting factor likely to contribute to the severity of the abuse. Recognising the number of

occasions that Police noted alcohol consumption as a potential issue, in terms of presentation at accident and emergency were there opportunities to explore this and provide appropriate signposting to support services, either specifically or as part of a generic health assessment?

11.6 Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC)

11.6.1 The scope of this review covers the transition from West Mercia Probation Trust to the National Probation Service and Warwickshire and West Mercia Community Rehabilitation Company. The questions posed here should be considered with that understanding in mind.

11.6.2 The conviction leading to the imposition of the supervision order in respect to Richard referred to within this section arose from charges of assault against both the victim of the homicide Jessica and their daughter Rebecca. The charge in respect of Jessica was a so-called 'victimless prosecution'.

11.6.3 Richard pleaded guilty to the assault on Rebecca the daughter but not guilty to the charge against the Jessica, and as a consequence CPS offered 'no evidence' and the case in respect of the victim was dismissed.

11.6.4 As part of the delivery of the supervision order Richard undertook the 'Building Better Relationships Accredited Programme'. What policy framework was the service operating within?

11.6.5 What information and Rebecca's perspective was the women's safety worker able to obtain, of all that was discussed how much was recorded and were there any potential gaps if a difference exists between the two?

11.6.6 It must be noted that use or misuse of alcohol does not cause domestic abuse but it is a compounding factor. The use or misuse of alcohol is a disinhibiting factor likely to contribute to the severity of the abuse. During conversations between the women's safety worker and Rebecca was there an opportunity to explore with her the impact alcohol consumption was having an impact on her parent's behaviour, her life and family life.

11.6.7 Was there an opportunity for the women's safety worker to also obtain a perspective from Rebecca's mother Jessica, who herself had been the previous victim of assaults by Richard? (Acknowledging she did not wish to engage with the criminal justice process this may have been an opportunity to engage with her to discuss the risk posed to her)

11.6.8 Were home visits to Rebecca part of the process and might this have given a perspective on Richard's un-evidenced claim that he had moved back into the home (in breach of his supervision order)?

11.6.9 Was WWMCRC aware of the DASH risk assessment conducted by West Mercia Police and if so how did that inform the WWMCRC risk assessment process?

11.6.10 What protective measures were in place and should they/were they shared with West Mercia Police?

11.6.11 During the period of the Richard's supervision he was responsible for three reported incidents of domestic abuse involving Jessica. Was WWMCRC informed of this by West Mercia Police?

11.7 Shropshire Council Children's Services

11.7.1 On 24th March 2004 Jessica's 13 year old daughter was the victim of an assault by Richard who was also the father. This resulted in his conviction. Was the significance of the child being assaulted by her father recognised, and was consideration given to the fact that the mother (the victim in this review) may have been vulnerable to domestic abuse as a consequence? This presenting an opportunity for information sharing, possible case conferencing and discussion on appropriate intervention mechanisms, including keeping the case under review.

11.7.2 There are three further referrals when Rebecca was 14 and 15 years old respectively. In the light of the starting position of an assault, being committed by a father on his daughter, and then further domestic incidents was the likely cumulative effect on the child considered?

11.7.3 Did Shropshire Council Children's Services make proactive enquiries of principal partners in particular other health colleagues, school nursing and education, with focus on the child to assess the level of risk against her emotional and physical well-being?

11.7.4 Was any contact made with Jessica to establish her view on the level of risk posed to her daughter (if not herself as well)?

11.7.5 Was any direct contact ever made with Rebecca concerning her experiences living both as a direct victim of domestic abuse at the hands of her father, and then to assess the cumulative impact on her being exposed to further domestic incidents between her parents?

11.7.6 In reaching decisions on appropriate further action or not, did Shropshire Council Children's Services have further discussions with West Mercia Police and other agencies or were case decisions made on the basis of documented referrals in isolation?

11.7.7 There are a number of occasions where alcohol is reported as a factor. It must be noted that use or misuse of alcohol does not cause domestic abuse but it is a compounding factor. The use or misuse of alcohol is a disinhibiting factor likely to contribute to the severity of the abuse. In reaching decisions, did Shropshire Council Children's Services take into account this compounding factor?

11.7.8 These Terms of reference were a standing item on Panel Meetings agendas and were be constantly reviewed and amended according as necessary.

11.7.9 On 1st December 2015 the Report Author met family members where the terms of reference were discussed. The family had previously been supplied with the Home Office DHR guidance for families. On this occasion, they were also supplied with information on AAFDA (Advocacy after Fatal Domestic Abuse).
This meeting caused the Report Author to ensure that the terms of reference for the review paid suitable attention to ensuring that Rebecca's voice and views had been secured by professionals and agencies when dealing with domestic crimes, incidents and follow up work.

11.8. Throughout the review process the Women's Aid panel members greatly assisted the Report Author in providing balance, by advising both caution and challenge to ensure that whilst Rebecca's experiences were correctly recorded and addressed it did not have the impact of suppressing Jessica's voice.

12. Individual Needs

12.1 Home Office Guidance[6] requires consideration of individual needs and specifically:

12.1.1 *"Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Perpetrator and their families? Was consideration for vulnerability and disability necessary?"*

12.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

12.3 The review gave due consideration to all of the Protected Characteristics under the Act. The Protected Characteristics are age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation, each of which were considered and the panel felt there was no comment to be made about any of them.

12.4 The victim and perpetrator are white Europeans, Church of England.

13. Lessons Learned

13.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Safeguarding Adult Reviews and appropriate and relevant research.

14. Media

14.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the Shropshire Safer Communities Board.

15. Family Involvement

15.1 Home Office Guidance[7] requires that:

15.1.1 "Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in

[6] Home Office Guidance page 25

7 Home Office Guidance page 15

the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances", and:

15.1.2 "Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related Police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

15.2 The views of the family members and any family friends identified by the family were taken into consideration, and they were invited to participate in the review process. The Report Author met with the family on four occasions during the course of the review. (See section re Views of the Family pages 37-41).

15.3 The views of work colleagues were obtained by the Report Author meeting with Jessica's workplace manager. No other of her colleagues wished to meet with him. (See section on views of work colleagues pages 41-42)

15.4 The views of the perpetrator were obtained through a face-to-face meeting between him and Report Author. This occurred post-conviction and sentence. (Page 42).

16 Persons involved with the Review process

16.1 The following key identifies the family members in this case:

16.1.1

Victim – Jessica	Female – Aged 47 long term partner of the Perpetrator
Perpetrator- Richard	Male – Aged 45 partner of Victim
Daughter – Rebecca	Female – Aged 22 only child of Jessica and Richard
Sister – Diane	Sister of Jessica
Mother- Victoria	Mother of Jessica

17 Methodology

17.1.1 Some of the individual management report responses to the questions posed within the terms of reference have been limited due to the fact that both paper and electronic records have been subjected to individual agency weeding policies, and the information therefore remaining is limited.

17.1.2 In the case of West Mercia Police the remaining information prior to 2007 was confined to skeleton electronic crime and incident report records only.

17.1.3 For Shropshire Council Children's Services earlier records were paper records. On occasion not all-case information could be located.

17.1.4 Similarly staff interviews have been conducted where possible, but often staff members have left the organisation concerned.

17.1.5 This review has considered events which extend over a 12-year period. It is the nature of organisational policy that it evolves over time. In some cases, it has not been possible for the agency IMR author to identify which version of policy applied at a

particular moment in time; again, this has to some degree limited the analytical aspect of the review.

17.1.6 One particular aspect of this relates to the differing times at which West Mercia Police introduced risk assessments processes prior to their adoption of the DASH model in 2009 (page 46). Where the Police risk assessments documentation remains in existence it has been specifically reviewed.

17.1.7 The use of alcohol was a matter explored by each of the agencies as set out in their terms of reference. The panel sought to secure the support of specialist alcohol treatment provision, however, at this time the service was being recommissioned in Shropshire. The panel members from WWMCRC who have specialist knowledge of alcohol treatment programmes and Women's Aid, who have the experience of frontline domestic abuse cases, advised the panel on how alcohol could be used by victims as part of a coping strategy.

17.2 **Overview**

17.2.1 Richard was born in 1969. He met Jessica in 1988 and in 1992; they had their daughter, Rebecca, who was 22 at the time of her mother's death. Rebecca together with Jessica's mother Victoria and her sister Diana, have been engaged throughout the review, and their views are reflected within this report.

17.2.2 Jessica was a bubbly full of life character, who her family recall had her firm views on matters and would often openly share them. She was clearly an intelligent articulate woman who had much to offer. Her sister, Diana, recalls that her character was such that everyone knew when she was in the room. At the time of her death, Jessica worked for a local charity where she had been employed for a number of years.

17.2.3 In 1993 the relationship between Jessica and Richard had deteriorated to the degree that it was described as being 'on and off', and at this time he had moved back to live with his parents.

17.2.4 At about this time he met another partner, KB and they began living together in about May 1995. Richard was violent to KB during this relationship. In 1996 KB fell pregnant with their first child. The violence continued both throughout the pregnancy and after the birth of their first child. In February 1997, she fled the relationship to escape the violence and with the assistance of her father secretly moved to a neighbouring county.

17.2.5 By the summer of 1997 Richard had discovered where she was living. With the promise of an end to his violence, she allowed him into her home. In June 1998, they married, and in November 1999, their second child was born. Ultimately, the violence resumed and increased in severity over time. This violence did result in calls to the Police and convictions against Richard, further details are included later in this report.

17.2.6 In March 2003 divorce proceedings between the couple concluded, shortly after which Richard resumed his relationship with Jessica. The information concerning Richard's previous relationship is included as both the nature of the violence and the opportunities the convictions presented for information sharing between, and action by agencies is of relevance to this review. Having resumed her relationship with Richard in 2003, Jessica remained with him, albeit with some brief periods of separation, until her death in December 2014.

18. Summary of Key Events

18.1 Richard first came to the notice of the Police service for domestic violence in a neighbouring County. Full records are no longer held but there still exist two outline crime reports.

18.2 On 29th January 1988 and 13th February 1988 he was responsible for domestic abuse against his then partner KB. The first was recorded as an 'incident' (below the threshold of a substantive criminal offence being committed), the second was an assault by him on KB, but in view of the fact that no conviction is listed, it has to be assumed that for whatever reason the case was not pursued through the courts.

18.3 On the 12th April 2000 Richard was again arrested following an assault on his partner for which he was convicted on the 14th April 2000. Similarly, on the 18th December 2001 he assaulted his partner for which he was convicted on the 18th January 2002. On both occasions within the assaults, Richard grabbed his then partner around the throat. This fact is considered to be of particular relevance to informing the levels of risk he posed. The DASH risk assessment model introduced in 2009 and now used by the Police service, identifies that such action on the part of the perpetrator should be considered an indicator of high risk.

18.4 On the 12th April 2003 Jessica and Richard had spent the afternoon drinking at home when an argument occurred. Jessica called the Police via 999 at 2100 hours after she was punched in the face by Richard causing her minor injuries. The call was appropriately graded for an immediate response. Only the basic crime report still exists. It identified that Jessica was spoken to the following day by an officer during which she stated that she did not want Police to be involved and that she had in fact sustained the injuries following a fall not an assault. Further, follow up activity from the then family protection unit (domestic abuse officer) records that she was adamant she did not wish to pursue the allegation and specifically asked that the Police did not speak to Richard for fear of further problems.

18.5 It does not appear that Richard was arrested or spoken to by Police with regard to this matter. The matter was also correctly referred to Shropshire Council Children's Services as Rebecca their daughter, aged ten years at the time had been present during the incident. It is reported that although she was not involved in the fight she was quite upset by it. Shropshire Council Children's Services decision was that information would be held on record but they would not undertake any intervention. Their records do not make it clear at this first opportunity, or indeed on any other occasion, that the perpetrator, Richard was the father of Rebecca.

18.6 On 19th March 2004 at 23:00 hrs Jessica again called the Police via 999 because Richard had returned home drunk, an argument had ensued and he had punched her in the stomach. When Police attended, they could not see any injuries on Jessica. She again did not wish to pursue a formal allegation and signed a Police Officer's pocket notebook to this effect. This was Police practice at that time. Richard denied the assault. Again, their daughter Rebecca was present at the time of the incident. There is no information to indicate Rebecca was spoken to by Police Officers attending this incident. This was again referred in to the Police domestic abuse officer in accordance with the operating policy at that time.

18.7 On the 22nd March 2004 a supervising officer referred the matter to Shropshire Council Children's Services.

18.8 On the 24th March 2004 there is an entry on the Shropshire Council Children's Services electronic case record of 'first record – DV incident', there is no further detail recorded other than the decision to 'NFA', (take no further action).

18.9 On the 18th May 2004 having spent the day drinking together Jessica and Richard returned home. An argument followed during which he assaulted her by punching her in the stomach and pulling her across the lounge carpet. The Police were called at 2100 hours via 999 but it is not clear who by. Richard was arrested, but no further action was taken as the following day the Jessica made a witness statement to Police within which she withdrew her allegation of assault. There is no Police record of a referral to Shropshire Council Children's Services, which is a breach of Police policy, as the matter should have been referred.

18.10 On the 1st August 2004 Jessica and Richard having been recently separated went for a 'night out', which is recorded as 'not going well'. It resulted in them returning home and having an argument during which Rebecca, who was by now 12 years of age, called the Police at 0030 hours, as she was concerned for her mother's safety. The matter is recorded as a 'domestic incident', (beneath the threshold for a criminal offence to have been committed), as officers established that no offences had been committed or injuries apparent.

18.11 The Police report records a referral to Shropshire Council Children's Services on 4th August 2004, which is received by them on 6th August 2004. The decision taken by Shropshire Council Children's Services was that the information would be held on the case file, but that they would not be taking any action. This information was passed to them by fax, the fax containing a hand written note referring to the domestic incident, which had taken place on the 24th March 2004. Enquiry was made of the IMR author who was unable to clarify who had made the hand written note and indeed by which agency.

18.12 At 2330 hours on the 24th November 2004 Jessica called the Police, as she wanted Richard removed from the home as they had been arguing. Records do not provide detail as to how the Police response was graded. Police established that both people had been drinking alcohol and an argument happened. Again this matter was recorded as a domestic incident no substantive crime having been committed. Their daughter, Rebecca, was again present and so Police made an appropriate referral to Shropshire Council Children's Services. This referral was received by them on the 6th December 2004 when they took no further action and the notification was filed.

18.13 On the 3rd May 2005 Richard returned home having been out drinking alcohol. An earlier argument recommenced between him and Jessica. It is not clear who called the Police on this occasion but it is noted that an 'upset woman could be heard'. Police attended within minutes of receiving the 999 telephone call, which was made at 0130 hours. During this argument, Richard threatened Rebecca and told her to go to bed. Ultimately, he assaulted her by striking her three times with the metal buckle of his belt. He also struck Jessica's elbow causing reddening. He was arrested and charged with two offences of assault against Jessica and Rebecca. Richard was remanded to appear before the next available court and on that day was given bail conditions not to contact either Jessica or Rebecca as prosecution witnesses. Jessica provided a witness statement to the Police and Rebecca's evidence in accordance with the procedure at the time was captured in the presence of her mother by way of the form VW1, (VW referring to 'vulnerable witness'). Police sent letters to both Richard and Jessica confirming the details of the bail conditions. The case was not heard until 12th October 2005.

18.14 On the 4th May 2005 the matter was referred to Shropshire Council Children's Services by the Police, who actioned it that same day. The outcome recorded was for an 'initial assessment'. No record of the assessment could be found, however there was a case note confirming its completion. The referral detailed the fact that Richard should not have any contact with either Jessica or Rebecca. On 6th May 2005 Jessica and Rebecca both provided Police with retraction statements, stating that neither of them wanted to make any complaints against Richard. It is not clear whether the officer taking the withdrawal statements was a domestic abuse officer. Rebecca's statement of withdrawal was made in the presence of her mother as the appropriate adult. In the statement, Rebecca stated 'I've discussed it with my mother and we have decided to withdraw' interestingly despite the two statements of withdrawal, the matter did proceed through the criminal justice system. Enquiry was made from interest of the CPS to establish how this proceeded in the apparent absence of witness evidence but original case papers have been disposed in line with weeding procedures.

18.15 On the 9th May 2005 a Shropshire Council Children's Services team manager wrote to Jessica asking her to make contact, which in the event of no response was followed up by a second letter on 17th May 2005.

18.16 On the 3rd June 2005 with still no response a visit to Jessica's home was made by a children's services social worker. There was no one at home and a message was left asking again for her to make contact with the department.

18.17 On the 6th June 2005 a children's social worker made contact with Jessica by telephone. Jessica explained that she and her daughter 'were fine' and that she and Richard had separated with no plans to reconcile their relationship. The Shropshire Council Children's Services record stated that Jessica 'confirmed that both she and Rebecca (the daughter) have withdrawn their complaints against him'. Jessica declined to meet with the social worker but was given the contact details for Women's Aid, a local support charity for female victims of domestic abuse. Jessica also told the social worker that her daughter did not wish to speak to Shropshire Council Children's Services.

18.18 On the 7th June 2005 the social worker formally wrote to Jessica outlining the content of their telephone discussion. On this same date, the team manager closed the case recording 'no further action' to be taken.

18.19 On the 12th October 2005 Richard offered a guilty plea in respect of the offence against his daughter Rebecca, and was found guilty and convicted of the assault at magistrate's court, when he was sentenced to a six-month community punishment with supervision order. He pleaded not guilty to the assault on Jessica, and the records indicate he was found not guilty.

18.20 At 1130 hours on the 4th November 2005 Police were called to the address as Jessica and Richard had argued during which she had thrown a glass at him causing a cut to his face. Jessica was later arrested for this assault. She explained that she had thrown the glass recklessly and had not intended to hit him in the face. Interestingly Richard did not wish to pursue the matter; however, Jessica was arrested and was later cautioned for this offence.

18.21 On the 9th November 2005, the matter was referred to Shropshire Council Children's Services, Rebecca still being resident at the premises, however they do not have a record of receipt of this referral, and as such it has to be considered a missed opportunity for them to have made an assessment at that time. At that time Richard

was the subject of the community order imposed on 12th October 2005 following his conviction for the assault on Rebecca committed on 3rd May 2005.

18.22 At 0215 hours on the 26th March 2006 Police were called to their home address, during which a disturbance could be heard in the background. It is unclear who made the call. When Police arrived Jessica and Richard, both having been out drinking had ended up arguing over what are recorded as 'life issues in general'.

18.23 Shropshire Council Children's Services were duly informed. The referral was reviewed by them on 21st April 2006, where it was recorded that no further action would be taken, the rationale being 'this is almost a year on from the previous referral and no other information or concerns received from any agency during this time'. The apparent delay in taking action in response to this referral has been noted by the review; the Shropshire Council Children's Services IMR author has endeavoured to establish why there was this delay but has been unable to do so from the records that remain.

18.24 Again at that time Richard was the subject of the community order imposed on 12th October 2005 following his conviction for the assault on his daughter committed on 3rd May 2005.

18.25 At 0015 hours on the 27th January 2007 Police were called to a domestic incident at the home which had spilled into the street. Records no longer remain to identify who made the telephone call. Police attended within 30 minutes of receipt the call. Officers established that Richard had kicked a hole in the kitchen door of the home. He was arrested to prevent a breach of the peace, and was subsequently bound over by the magistrates to keep the peace for six months.

18.26 Police referred this to Shropshire Council Children's Services where it was actioned on 29th January 2007. The case had originally been managed by the duty team. The case was allocated to a social worker for an 'initial assessment' to be conducted'. It would be fair to state that there was initially some apparent difficulty in arranging a meeting with Jessica, but this did happen on 15th March 2007. Jessica stated she could not understand 'why children's services were involved as their daughter had not been involved in this most recent incident, that 'Richard' was not living at their home but only stayed on weekends and that she does not feel in danger and is capable of looking after 'Rebecca', (their daughter).

18.27 The initial assessment was completed on this occasion and a further meeting was held on 28th March 2007, between the social worker, Jessica and Rebecca to go through the assessment. Any knowledge of social work intervention in her life was a specific area explored by the Report Author and Rebecca. She is clear that she does not recall any conversations with a children's social worker nor was she ever informed she had an allocated social worker. There are entries on the social work system dated 29th March, 13th and 30th April 2007 where it is recorded that attempts were made to meet Richard but he failed to turn up.

18.28 On the 30th April 2007 Shropshire Council Children's Services sent a letter to Jessica confirming that the case would be closed, but indicating that 'action will be taken if further incidents of domestic violence'. The case was closed by Shropshire Council Children's Services on 4th May 2007, where the team manager records on case file notes 'Mr' ('Richard') does not reside in the home. Stays on a weekend. Ms 'Jessica', whilst acknowledging that 'Richard' can be aggressive, feels that she is not frightened of him. If there were any issues, she would not let him in the home. Contact numbers provided to the victim'. This case closure record would seem to be at odds with the content of the letter sent by Shropshire Council Children's Services to the victim which

stated 'Due to concerns for your own and the daughter's safety, (Shropshire Council Children's Services) would wish to complete a risk assessment prior to 'Richard' staying at your address'.

18.29 At 2240 hours on the 30th June 2007 Jessica called the Police. She and Richard had been drinking and trying to resolve their differences to enable them to resume their relationship, this ended up in an argument. Richard left prior to Police arrival. There were no criminal offences discovered and as such was closed as a domestic incident. A referral in respect of their daughter Rebecca was made to Shropshire Council Children's Services on the 4th July 2007.

18.30 From this point on within the Police IMR the IMR author has been able to report on Police risk assessment decisions. The risk assessment documentation from this earlier period until June 2009 was not available for review however, the decisions were recorded on the remaining electronic crime or incident record.

18.31 Police assessed the risk as standard, the rationale being that there were no injuries and this was a verbal argument only. The risk factors noted were the involvement of alcohol and the previous assaults on the daughter.

18.32 On 11th July 2007 Shropshire Council Children's Services decided to take no further action on the basis that the Police referral made it clear that the parties were not in a relationship.

18.33 On the 2nd May 2009 Jessica attended the local hospital emergency department (ED) with a head injury. The emergency department notes record that she had sustained a small laceration to her right scalp area having tripped over a box containing wallpaper and hitting her head on a hoover. It is also documented that she reported having consumed four glasses of wine. The review author has asked the family for their view on the account recorded. For a variety of reasons, most notably that they recall where both the wallpaper and hoover had been kept in Jessica's house, they conclude that the injury was most likely the result of a further assault by Richard. Of note is the fact that this was in the period between 2007 and 2010 where there was no reported abuse to the Police.

18.34 On 6th April 2010 Shropshire Council Children's Services were contacted anonymously concerning one of Richard's two children from his previous relationship with KB, and whilst separated from Jessica. The content of this referral is not relevant to this review, however it did present Shropshire Council Children's Services with an opportunity to reveal and understand his domestically abusive history with this previous partner within their home and the risk he presented to their children. It is known that later in the overall case history when offences of domestic abuse were being committed when Rebecca was present references to this were made on these second siblings' records, the children of Richard and KB. It should also have been that his previous history was updated onto the case file of his daughter Rebecca, being the victim of the current and ongoing abuse.

18.35 On the 8th May 2010 there was a domestic incident where Richard had been drinking and he and Jessica argued over whether their daughter was contributing to their household effectively. Jessica called the Police at 2340 hours, who arrived within 13 minutes of the call. Richard was arrested to prevent a breach of the peace. He was later released without charge, no further detail is available. The incident was assessed as being of standard risk. Police did not make a referral to Shropshire Council Children's Services.

18.36 On the 10th July 2010 the family had a barbeque at their home address. An argument occurred between Richard and Rebecca and at 2150 hours, the Police were called by Jessica via the 999 system. Police responded within 3 minutes of receipt the call. No criminal offence was found to have been committed but Richard left to spend the night elsewhere to prevent any further disturbance. The incident was assessed as being of standard risk. Police did not make a referral to Shropshire Council Children's Services.

18.37 Reflecting on discussions held at the review panel meeting on 14th June 2016 there is a strong possibility that the positive and welcome service responses to the assaults on Rebecca as she reached adulthood deflected agencies attention away from Jessica, in effect inadvertently silencing her.

18.38 A panel member from Women's Aid also rather astutely pointed out that from Jessica's perspective arguably none of her previous calls for assistance had made any difference to her life, and maybe she had given up asking for help.

18.39 On the 22nd August 2010 both Richard and Jessica had been drinking for an extended time, and argued which resulted in Jessica calling the Police via the 999 system, Police attended within two minutes of receipt the call. No substantive criminal offences were established however, Richard was arrested to prevent a breach of the peace from occurring. He was later released without charge (which would be normal practice once it is considered the likelihood of a breach of the peace has passed). This was assessed by the Police as being of standard risk, their rationale being that ''the incident concerned the father not getting on with his daughter, both Jessica and Richard had been drinking, there were no injuries observed and no allegations made'

18.40 On the 19th December 2010 Jessica returned home to find Richard confronting their daughter regarding her contribution to matters around the house. Richard had been drinking. This sparked an argument between Jessica and Richard. At 1800 hours, Jessica called the Police via the 999 system who attended within 3 minutes of receipt of the call. Again, no criminal offences were established but Richard was removed from the premises and taken to his mother's home address. This was assessed as a standard risk.

18.41 On the 12th June 2011 Richard, Jessica and Rebecca had been to a local air show. Richard and Jessica had been drinking heavily during the day. They later had an argument at their home address, which resulted in Jessica attending the local Police station at 2100 hours, with her mother and daughter. Jessica reported that she was concerned Richard was damaging the property, this was graded as a priority call and Police attended the address within 10 minutes. They found Richard at the address drunk but established that no criminal offences were found to have been committed. Richard remained at the property whilst Jessica went to stay with her mother for the night. The incident was assessed as being of standard risk.

18.42 On the 29th November 2011 Richard had been drinking and assaulted Rebecca during which he pulled a clump of hair out of her head. At 2310 hours, Jessica called the Police via the 999 system, who attended within 5 minutes of receipt of the call. Richard was arrested by Police and was charged with the assault the following day, 30th November 2011.

18.43 Richard was remanded to appear before the next available magistrate's court who imposed bail conditions not to contact Rebecca and for him to live and sleep at his mother's address.

18.44 The attending officer assessed the risk to be standard.

18.45 A DAU officer later conducted a review of the risk and assessed the risk to remain as standard because of the terms of Richard's bail conditions. This officer did make a referral for Rebecca to the Independent Domestic Violence Advisor (IDVA) service on 2nd December 2011, but Rebecca did not enter the service or was not contactable. The officer did not deem it necessary to make Rebecca the subject of a risk management plan.

18.46 West Mercia Women's Aid IDVA service is a regionally commissioned service that delivers support to women and men who are assessed as being at high risk of serious injury or death due to domestic violence. Victims who consent to having their details passed to the service will be contacted by the IDVA and offered support. If the victim is not reachable after three contact attempts, the referring agency will be notified so that they can find alternative contact methods. Victims who do not consent to having their details passed to the IDVA service will not be contacted by the IDVA. Consent is obtained by the agency who has contact with the victim, in most cases this is the Police, but a small number are referred by other agencies such as health or children's social care. For cases that do not reach the threshold for IDVA, there are alternative support packages and any agency can refer victims for support using West Mercia Women's Aid online referral form and 24-hour telephone helpline.

18.47 On the 21st December 2011 Richard was convicted at magistrate's court of the assault on his daughter Rebecca, which occurred on 29th November 2011. He was sentenced to 120 hours community service, with a 12-month community order and a 6-month alcohol treatment requirement. There was a supervision element to the alcohol treatment order.

18.48 The sentence was informed by a pre-sentence report prepared by the Probation Service in January 2012. The Probation Officer appropriately identified Richard's previous convictions for assaulting his previous partner in 2002 and a conviction for assault in 2005 on Rebecca. The report also accurately reflected the number of domestic incidents that occurred during 2010-11. The Probation Service employ the Offender Assessment System (OASY-page 68) to complete risk assessments informing the likelihood of risk of re-offending and risk of serious harm, and the Spousal Assault Risk Assessment (SARA-page 68), for risk factors for individuals being treated for spousal or family related assault. SARA helps to determine the degree to which an individual poses a threat to his spouse, children, family members or other people involved. On this occasion Richard was assessed as posing a low level of risk to his daughter Rebecca and Jessica his current partner. The Probation IMR author views this as a correct assessment given that this was the first conviction when a community order had been imposed. As reported above the Police assessment deemed the risk posed to be standard, reinforced by the reassessment by the DAU officer, on the basis of the terms of Richard's bail conditions.

18.49 At 2300 hours on the 16th January 2012 Police were called to the family home via the 999 system by Rebecca. The Police arrived within 2 minutes of receipt of the call. It was established that both Jessica and Richard had been drinking heavily and were described by Police as being drunk. During the incident, Richard had punched Jessica in the face. Rebecca had tried to intervene at which point Richard had gone into her bedroom and thrown her television to the floor causing it to smash. Jessica was unwilling to provide a witness statement; however, Rebecca provided two, one concerning the damage, the other outlining the events leading up to but not including the assault by Richard on her mother. Richard was charged with offences of assault against Jessica and the criminal damage to his daughter's television. He was remanded to appear before the next available court.

18.50 These were finalised by the courts on the 2nd April 2012.

18.51 Police conducted two 'initial 15 questions' DASH risk assessments and assessed the risk to be medium. The Probation Service raised the SARA risk level to medium following this further offence.

18.52 The Police records indicate that Rebecca provided detail about the extent of her parents drinking and how the relationship had been deteriorating. Jessica was given information regarding the differing support groups that were available to her with regard to alcohol dependency and a referral was also made to Women's Aid but records suggest she did not make contact. Jessica agreed that she would benefit from a visit by members of the local policing team.

18.53 On the 7th February 2012 Richard met with his Probation Officer for the first time. This meeting was concerned with the sentence imposed on 21st November 2011, by this time Richard had committed the further offences on 16th January 2012.

18.54 The time delay between Richard's conviction on 21st December 2011 and his first meeting with his Offender Manager falls well below national standards, which require that the first meeting, should take place within five working days.

18.55 During the discussion Richard also met with the allocated alcohol worker. During their discussion on family dynamics, Richard stated he felt he could return to the home provided he addressed his alcohol issues. There were a number of subsequent meetings; the following reporting is concerned with only the most significant of these.

18.56 On the 14th February 2012 Richard met his Probation Officer, where the Officer recorded that Richard no longer lived at the home address. The matter of his residence is recorded as a factor that reduced the level of risk (posed to Jessica and Rebecca).

18.57 On the 29th February 2012 a professional judgement entry on Probation case records highlighted the assaults on Jessica and Rebecca and the risk Richard presented to women. He was put on weekly reporting, with a requirement to see the alcohol worker fortnightly. There is clear reference to a need to understand the risk he posed to Jessica but no attempts were made to hear her voice within this process.

18.58 On the 2nd April 2012 Richard appeared before 'Shrewsbury and North Shropshire' magistrates court for the offences of assault on Jessica and criminal damage to Rebecca's television committed on the 16th January 2012. He offered a guilty plea, was convicted of both offences, and was sentenced to 24 months community order, with 24 months supervision. He was also required to complete the Integrated Domestic Abuse Programme (IDAP). These were in addition to the requirements of the existing order, imposed on 21st December 2011, (120 hours community service, 12 months community order and 6-month alcohol treatment requirement order). At the time of this sentence Richard was living with his parents, his address recorded as being monitored because of his domestic abuse. It was recorded Richard was complying with the current supervision order, was completing his community order and working with the alcohol counsellor.

18.59 During an appointment on 3rd April 2012 the Offender Manager recorded that Richard blamed Jessica for his violent behaviour. There was reference to Jessica and Richard intending to go to RELATE (for relationship counselling). The record indicated this did not in fact happen. When meeting with Richard the Report Author was told by him that, they did attend one appointment but did not have any others. Enquiries by the Report

Author with RELATE indicate that they would not be able to provide any information to help clarify this small area of discrepancy.

18.60 During an appointment on the 12th April 2012 Richard was subject to assessments against OASY and likelihood of reconviction assessment through the offender violent prediction process.

18.61 On the 11th May 2012 Richard self-presented at the emergency department of the local hospital having sustained lower leg injuries He told staff that he had kicked a UPVC door from the outside of his house following an argument with his partner. He told staff that he had drunk ten pints of beer.

18.62 On the 12th June 2012 recorded in the Probation case notes taken during an appointment Richard indicated he was spending more time at Jessica's home. The Offender Manager noted that Richard blamed alcohol for the dysfunctional relationship and showed very little insight in to his own behaviour and attitudes towards women.

18.63 On the 22nd July 2012 Richard had an argument with Rebecca and locked her out of the home. At 2030 hours Rebecca called the Police via the 999 system by her, they attended within two minutes of receipt of the call. No criminal offences had been committed. Rebecca explained she intended to move out of the premises in August 2012, and on this occasion left and went to stay with her boyfriend. The Police assessed the risk as standard. At this time Richard was still the subject of the community orders imposed on 21st December 2011 and the 2nd April 2012.

18.64 This was referred to Probation under Management of Police Information processes in that Probation made one of their periodic standard applications seeking notification of any relevant domestic abuse information.

18.65 On the 24th July 2012 the Probation case notes referred to the fact that Richard was now living at the home with Jessica as Rebecca had moved out and was living with her boyfriend.

18.66 On the 21st August the case notes record that Rebecca had moved back to the family home.

18.67 On the 1st September 2012 during a meeting Richard stated that he was no longer drinking heavily and that he felt his 'alcohol' was under control'. He also stated that his relationship with Jessica was good but acknowledged tension with Rebecca, their daughter.

18.68 On the 27th September 2012 the Offender Manager made a professional judgement decision that as Richard would be commencing the Building Better Relationships (BBR) programme on the 8th October 2012 then his supervision should be reduced to monthly meetings.

18.69 The BBR programme is part of a suite of programmes that are evidence based and is accredited by the Correctional Services Accreditation Panel, authorised by the National Offender Management Service (NOMS) and the Ministry of Justice (MoJ).The BBR programme is a 28-session programme for men who have been violent in their relationships and the aim is to:

- Reduce reoffending and promote the safety of current and future partners and children

- Work collaboratively with other agencies to assist offenders in managing their risk of intimate partner violence.

18.70 On the 6th November 2012 during supervision the Offender Manager noted that Richard was still living with Jessica and Rebecca but that he displayed a poor attitude towards his expectations of them.

18.71 On 2nd December 2012 Rebecca returned home to find both her parents drunk. An argument had followed during which she tried to prevent her father assaulting her mother. As a result of her intervention, Rebecca was assaulted on a number of occasions over the next three and a half hours by her father. She sustained bite marks to her hand, a bloody nose and soreness to her throat and neck when her father grabbed her around her throat. At 1900 hours, Rebecca went to the local Police station to report the assault on her by Richard. It was graded as a priority incident, Police attended within 16 minutes of receipt of Rebecca's report. The Police assessed the level of risk to be high.

18.72 Prior to Police arrival Richard had fled the scene. Although he was a 'wanted person' he was in fact recorded and treated as a 'missing person' by the Police. The review author questioned this practice on the basis that efforts to locate and trace either a wanted or a missing person should be equally robust and properly resourced. To have treated him as a missing person rather than a man evading capture could give the perception of the balance of judgement being in favour of the perpetrator. The supervising officer made this decision on the basis that he was concerned Richard was at high risk of coming to harm. It was in fact Rebecca who was asked by the Police to provide the details for the missing report, arguably not particularly empathetic of the organisation given the circumstances.

18.73 Richard was arrested on the 4th December 2012.

18.74 During his time in Police custody Richard was taken to the emergency department of the hospital complaining of chest pain. Police practice would be for him to be transported by ambulance accompanied by an escorting Police Officer.

18.75 The medical notes record that Richard had been in Police custody for one day following an assault by him, on his daughter. The daughter had not been admitted to the emergency department. The patient report form completed by the paramedic records that 'Richard' 'smelled of alcohol and that he had stated he had been drinking the night before'. The record confirms that 'Richard' was being escorted by a Police Officer. The medical records do not make clear what the terms of that escort were.

18.76 Richard was discharged after negative investigations regarding a possible cardiac event. Records are not wholly clear but it is a reasonable assumption that he was released from Police custody whilst in the hospital as he was bailed to return to the Police station on 5th December 2012, which he did. Again records are not clear but it is a reasonable assumption that he would have been interviewed by Police for the offence as he was subsequently re bailed to return to the Police station on 9th January 2013 whilst the Police investigation continued.

18.77 On the 18th December 2012 the Crown Prosecution Service, (CPS) authorised two common assault charges (section 39 Offences against the Persons Act 1861), for Richard in respect of the offences committed against Jessica and Rebecca. The CPS noted that Jessica had declined to make a statement to the Police. On this basis, the charge for the assault on Jessica was a so-called victimless prosecution, the charge

being authorised on the basis that Rebecca has provided evidence of the assault on her mother, within the content of her witness statement to Police.

18.78 On his return to the Police station on the 9th January 2013 Richard was charged with the two offences of assault. He was given bail conditions not to contact Jessica or Rebecca by any means. The CPS state it was their intention to pursue the prosecution without calling Jessica; that Rebecca's statement was very detailed and included a description of the assault by Richard on Jessica; but that the assault did not cause any injury to Jessica, in that she was pushed backwards causing her to fall over the back of a settee. In preparation for the trial, the CPS asked West Mercia Police to obtain a victim personal statement from Rebecca and to obtain her views on a restraining order. They also decided that it was not appropriate to apply for a witness summons to secure Jessica's attendance. Their rationale was that Jessica had not made a witness statement and there would be no material on which to cross-examine her (if as would be expected) she gave evidence hostile to the prosecution. This in their view would prejudice the prospects of securing convictions on the evidence of Rebecca. (The deputy senior investigating officer in the victim's murder investigation reports that in his review of the case file relating to this offence the victim repeatedly declined to support the investigation.)

18.79 On the 5th December 2012 Police made a referral to Shropshire Council Children's Services regarding the incident of the 2nd December. On this occasion, an entry is made on the record of one of the Richard's children from his previous relationship with KB. This would appear to be the first occasion that Shropshire Council Children's Service has formally noted, and recorded, the significance of Richard's domestically abusive behaviour and the impact it has on children. The Police did not share the information with the Probation Service.

18.80 On the 11th December 2012 Richard met his Probation officer and informed him that he was on Police bail for assaulting Rebecca, his bail conditions being that he was not to go home or have contact with 'Rebecca' or 'Jessica'. He stated he was living with his parents and his relationship with the victim was over.

18.81 On 8th January 2013 again during a visit to his Offender Manager Richard admitted to having contact with Jessica despite the bail conditions being in place.

18.82 On the 15th January 2013 Richard again informed his Offender Manager that he was in contact with Jessica.

18.83 On the 28th January 2013 Richard first appeared before Shrewsbury Magistrate's Court in respect of the two charges of common assault against Jessica and Rebecca committed on 2nd December 2013. He entered not guilty pleas to both charges and his trial date was fixed for 12th March 2013.

18.84 On the 12th February 2013 again during supervision with Probation Richard informed the Offender Manager that he was no longer in contact with the victim as they had argued on the telephone.

18.85 On the 12th March 2013 Richard appeared before magistrate's court for the offences of common assault against Rebecca and Jessica. Jessica did not attend court but, as the family explained, Rebecca was supported by her Aunty Diana and maternal grandmother Victoria. Diana reports that as a family, they were there to support Rebecca but in particular, to secure a court order, which would provide ongoing protection for her. The family recall having a discussion, which the Report Author concludes on the basis of their description of the discussion must have been with the

duty CPS lawyer. Their initial request was for a restraining order to prevent Richard from attending the family home. The family's understanding is that the lawyer declined this on the basis that as Jessica was the sole tenant of the property and was likely to continue to engage in the relationship with Richard any such restraining order would be unenforceable.

18.86 Ultimately the decision was to apply for a restraining order to prevent Richard from behaving in a threatening or abusive manner towards Rebecca. On that date, the CPS accepted a guilty plea from Richard to the common assault charge involving Rebecca and offered no evidence on the charge involving Jessica. During discussions with the family, it was apparent that they did not have a full understanding of the decision-making by the CPS with regard to this case. Given the detail and complexity of the response, the Report Author has included it in full within this report. The CPS Chief Crown Prosecutor has provided the following overview of the decision-making and rationale concerning this case, she reports as follows:

18.87 ''The guilty plea had been offered for the first time at court on the trial date. 'Rebecca' had attended court but 'Jessica' had not. The guilty plea was first offered on a more limited basis; namely, that excessive force had been used by 'Richard' in self-defence. The prosecutor made it robustly clear to the defence that a plea on this basis was not acceptable. The defendant then pleaded guilty on the basis of the full facts as described by 'Rebecca'.

18.88 In all of the circumstances of this case, the decision whether to accept this guilty plea was a difficult and finely balanced one. I am satisfied that the prosecutor took account of all relevant competing factors. In reaching this decision the prosecutor had due regard to paragraph 9 of the Code for Crown Prosecutors. The decision was made in consultation with a more senior lawyer. The prosecutor was fully aware of the history of the domestic violence committed by 'Richard' against both 'Rebecca' and 'Jessica'. The defendant's level of culpability was high given his relevant previous convictions for domestic violence. However, this had to be weighed carefully against other factors. By accepting the plea on the full facts basis, it avoided the need for 'Rebecca' to give evidence. Correctly, in my view, the prosecutor decided that a conviction for the assault on 'Jessica' was very likely to have made no difference to sentence; or to the ability of the court to make ancillary orders. The alleged assault on 'Jessica' was relatively minor when compared to the assault on 'Rebecca'. The court of appeal authorities make it clear that any sentence imposed for the assault on 'Jessica' would inevitably be imposed concurrently to the sentence for the assault on 'Rebecca'.

18.89 The CPS priority was to ensure that the court was in a position to make orders to protect both 'Rebecca' and 'Jessica' rom further domestic violence. The court still had the ability to make a restraining order to protect 'Rebecca' or 'Jessica' (or both) whether or not CPS pursued the second charge involving 'Jessica'. Section 5A of the Protection from Harassment Act 1997 provides a power for the court to make a restraining order on acquittal. Moreover, whether or not CPS pursued the second charge, the court was in the same position to make a community order or suspended sentence order aimed at rehabilitating 'Richard' in respect of his domestic violence offending''. The CPS report continues that the prosecutor spoke with 'Rebecca' in court. She was in a position to give her views on the acceptability of the plea. Concerning the matter of the restraining order the Chief Crown Prosecutor continues:

18.90 ''It was clear to the prosecutor that 'Jessica' did not support the prosecution. In response to a CPS request, a Police officer attended the home address (of Jessica)

on 28th February 2013. 'Jessica' refused to sign the witness warning notice and told the officer that she does not want to attend court.''

18.91 At court ''Rebecca' stated that 'Jessica' is the homeowner and she confirmed that 'Jessica' wanted 'Richard' there''. All of this information led the prosecutor ''to conclude that 'Jessica' did not want a restraining order to protect her from the defendant.''

18.92 ''In R v Brown (2012) EWCA 1152 the Court of Appeal held that in the absence of evidence of duress or fear it is not appropriate for a court to make a restraining order when it was contrary to the victim's wishes notwithstanding the seriousness of the offence and the violent history of the relationship.

18.93 For this reason, the prosecutor did not make an application for a restraining order on acquittal. The prosecutor's approach would have been the same if 'Richard' had been convicted of the charge involving 'Jessica'. In the absence of an application by the prosecutor, the court can still make a restraining order of its own volition.

18.94 The prosecutor was informed in court that 'Rebecca' wanted the prosecution to apply for a restraining order. However, it was deemed not appropriate for the prosecution to make such an application for an order prohibiting 'Richard' from any contact with 'Rebecca'. Such a condition would be unenforceable because in accordance with the wishes of 'Jessica', 'Richard, Jessica and Rebecca' were to continue to live together. Again, it was still open to the court to impose prohibitions of its own volition but it did not do so. The prosecutor made application for a restraining order in the terms ultimately imposed (not to behave in a threatening or abusive manner towards 'Rebecca')'.'

18.95 Richard was sentenced to 5 months imprisonment wholly suspended for 2 years, with a supervision order, fined £300 costs, placed on an alcohol treatment requirement order and made subject of the restraining order. The Report Author has spoken at length with the family members with regard to this case. Simply put they felt let down by the court process; they felt the court failed to properly protect Jessica and Rebecca and felt the sentence imposed was lenient. Moreover, in exploring the effectiveness of the restraining order as a protective measure for Rebecca she explained that her father continued to be abusive and intimidating towards her. She described him calling her names, continually accusing her of 'using the house', when she went out of the house for a cigarette he would lock her out and he would continuingly belittle and dehumanise her. He repeatedly threatened that he would throw her out of her home. Diana confirmed that on a number of occasions Richard telephoned her telling her she had to come and collect Rebecca from the home. Diana simply stood up to him telling him she was not prepared to have the conversation with him. He would also towards the 18-month point of the supervision order remark to Rebecca on how many months there were to go, clearly inferring that he intended to recommence his violent behaviour towards her, once the 24 months and term of the order had expired. Sadly, whilst all of the above would have constituted breaches of both the restraining order and therefore his supervision order, Rebecca believed them to be 'of a minor nature', in effect beneath the threshold at which the Police would 'take it seriously', and as a consequence continued to suffer abuse from her father. She never reported any of the matters to the Police.

18.96 On 21st March 2013 the following assessment was conducted using OASY. The Offender Manager referred to 'Jessica' living in constant fear as a result of an established pattern of behaviour. The Offender Manager recorded that 'Jessica' was also assaulted but refused to press charges and that her behaviour has been habitually collusive.

18.97 The IMR author identified here that the Offender Manager's assessment had not been based upon information from Jessica, but probably combined information from Richard together with the opinion of the Offender Manager based on his experience of domestic abuse working. The IMR author also took the time to indicate that the use of the terms 'habitually collusive' was not an acceptable term. It did not reflect current day working practices or policy.

18.98 The Offender Manager was of the opinion that there was a pattern of offending behaviour but not an escalation in seriousness. The WWMCRC IMR author disagreed with this assessment, 'given that this is his second conviction for the same offence within a short period and that there were possibly more assaults where he had not been charged'. The Offender Manager also contradicts his assessment by stating (in respect of Richard) that 'his violent behaviour towards family members appears to be escalating. Accommodation is linked to a risk of serious harm as the assaults have taken place at home. Risk is considered greatest when he is living in the same household as the victim and daughter and under the influence of alcohol. Offender Manager as part of the sentence plan to monitor living arrangements. Risk management plan included checks with 'S' Police domestic abuse unit. Assessed as medium risk to daughter and victim'. Again, the IMR author disagreed with the risk level, reporting it should have been high.

18.99 On the 26th March 2013 during supervision Richard confirmed his lack of responsibility for his behaviour when he stated he believed his daughter was to blame for his drinking and violence.

18.100 At 1830 hours on the 22nd September 2013 an anonymous third party made a 999 telephone call to the Police reporting a loud domestic argument at their home address. This was graded for an immediate response; Police officers arrived within 7 minutes of the call. They found that both Richard and Jessica were extremely intoxicated and involved in a loud domestic incident. Jessica asked officers to remove Richard from the house which they did, taking him to a relative's house 'to prevent a breach of the peace'. The incident was assessed as being of standard risk.

18.101 At 1620 hours on the 24th December 2013 Jessica attended the Police station in what is described as 'a highly intoxicated state'. Her mother Victoria and Rebecca were present. Victoria talked to the Report Author about this incident and stated 'after a very lengthy and traumatic period of time we managed to persuade a very distressed Jessica to go with them to the local Police station'. They reported circumstances to the Police after which it was mutually agreed that Jessica would spend Christmas Day and Boxing Day at her mother's home, which she did. It was also arranged for them to return to the Police station to resolve the matters. This was assessed as standard risk.

18.102 At this time Richard was still the subject of the 24 months' community order with 24 months supervision and the IDAP requirement imposed on 2nd April 2012.

18.103 Victoria explained that on their return to the Police station those two days later, as arranged with the Police, they were told that 'as the matter was more than 48 hours old there was nothing the Police could do', and indeed no further action was taken. In explaining this to the Report Author, the exact words Victoria used were 'we finally got her as far as the Police station but they let her down'. There is a police record of the first visit to the police station but no record of the second visit.

18.104 On 2nd April 2014 during a supervision meeting Richard disclosed to the Offender Manager that he was in contact with Jessica in that he visited the address to collect and exercise the dog.

18.105 At 2327 hours on the 4th September 2014 Police were again called by an anonymous caller via 999 reporting 'shouting, swearing and banging coming from the address'. This was graded for immediate response Police officers arrived within ten minutes of receipt the call. Richard was removed from the scene by Police officers and taken to a friend's house. Rebecca was present at the time but it does not appear that she was spoken to by officers. The risk was assessed as being standard with the rationale being recorded that Jessica had answered 'no' to all questions on the DASH, and that the last incident in December 2013 had been nine months previously. It would appear that officers took on face value the fact that Richard's presence was a 'one off' in that Jessica stated she had invited him there because his father had recently undergone an operation for a serious illness. It is unclear whether Rebecca was present and/or spoken to by attending officers. Police control room staff had identified that Richard at that time was the subject of management by the Probation Service (22.118 page 57).

19. **Views of the Family.**

19.1.1 Rebecca as the daughter of Jessica and Richard told a deeply moving story, concerning life from her perspective. She was as close to being able to tell Jessica's story as Jessica would have been herself had she not had her life taken in such tragic circumstances. Rebecca recounted first-hand what life was like for her mother Jessica. Equally as importantly Rebecca was able to give some insight into the way in which she and her mother were served by the agencies involved with their family during an extended period. Rebecca's accounts also helped to identify where gaps in service provision left her and her mother exposed to a life of domestic abuse for longer than should have been necessary. The Report Author was keen to explore with Jessica's family both the true extent of the domestic abuse, and the degree to which alcohol had an impact.

19.1.2 Rebecca considered both of her parents to be alcohol dependant, and both Jessica's sister Diana, and of their mother Victoria agreed. They quoted many examples of being sighted on Jessica's excessive drinking. Diana was of the view that some at least of her work colleagues must have on occasion smelled alcohol on her; she went as far as to say she strongly believed her sister would have been drinking at work, albeit it would be kept from her work colleagues.

19.1.3 The Women's Aid panel members offered the following helpful perspective on behalf of Jessica. They pointed out that Jessica, like many victims of domestic abuse do not self-identify as victims, as this further erodes their already compromised value of self-worth. Within such a dynamic alcohol is often part of a victim's coping strategy, and from their perspective this helps them to see themselves as 'being alright'.

19.1.4 Rebecca described her father as also being alcohol dependant, but he had greater resilience to the effects of alcohol as he was physically a big man, and much bigger than Jessica. Rebecca explained that the drinking got worse over time, to the extent that in the last few years of Jessica's life, her mother and father drank every day and would most often consume a 75cl bottle of vodka between them each day. She estimated that her mother would drink one third of the bottle, her father the remainder.

19.1.5 Rebecca explained that on the occasions she found bottles of alcohol she would either water them down or in some cases simply pour the contents away, sometimes in her parent's view and presence.

19.1.6 Rebecca explained that the domestic abuse and excessive drinking were inextricably linked, and increased in frequency and severity in the eighteen months to two years prior to Jessica's death. This coincided with her father becoming unemployed. For many

months he kept the loss of his employment hidden from both Rebecca and Jessica, hence she was unable to state accurately when he lost his job. After this, Jessica and Rebecca would return home from work to find Richard had been drinking during the day. Domestic abuse and arguments were a daily occurrence. Rebecca described the domestic abuse as being particularly bad at weekends.

19.1.7 Rebecca explained that she had no father/daughter relationship at all and that he would often pick arguments with Jessica and try to bring Rebecca into them. Rebecca was asked by the Report Author to reflect upon the incidence of domestic abuse against the frequency of Police call outs for help. She estimated that the Police were only called to 1 in 20 or even 1 in 30 incidents. The Police received 22 calls in respect of domestic abuse during their 12 years of involvement with the family, Rebecca's estimation of frequency of domestic incidents and calls to the Police for help arguably go some way to reveal the true extent of abuse by Richard.

19.1.8 In endeavouring to provide a qualitative view on behalf of Jessica and Rebecca it is suggested that based on Rebecca's estimation of frequency of events versus Police call outs over those 12 years there would have been in the region of 500 domestic abuse events committed by Richard, accepting that this is not support by empirical evidence, such as Police records.

19.1.9 In support of this contention, in respect of domestic abuse research shows that:

- On average high-risk victims live with domestic abuse for 2.6 years and medium risk victims for 3 years before getting help [8]

- On average victims experience 50 incidents of abuse before getting effective help [9]

19.1.10 Rebecca recalled that as a young girl she was frightened of the violence and would go and sit in her bedroom. On reaching a certain age, she estimated at being 16-18 years old, she described her changing mind set from being frightened to being one of determination not to tolerate the abuse. She would stand up to her father to try and protect her mother. She did however; continue, as she grew older to seek sanctuary in her bedroom often with her pets as comfort.

19.2 Diana, Jessica's sister is a professional with experience of safeguarding within the public sector. Both she and Victoria stated that it was obvious to them that Jessica was the victim of domestic abuse, but whenever they tried to hold a discussion with her about it, she would close the conversation down denying any violence was occurring. This happened even when Jessica had visible facial bruising.

19.2.1 The Report Author explored with the family the matter of them possibly trying to access support, but Diana explained that even if they as a family could have engaged some form of support Jessica would not have engaged herself because they had arranged it.

19.2.3 The Report Author explored with the family the aspect of the risk posed to Jessica and the degree to which she was frightened of Richard. They reasoned that she must have

[8] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.
9 Walby,S.and Allen,J. (2004), Domestic Violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office.

been frightened of him but it was more difficult to articulate how this fear masked for Jessica the potential severity of the risks she faced.

19.2.4 Diana felt that Jessica simply did not understand the likely severity of the risks she faced, even in the latter two years of her life where violence was almost a daily occurrence. She recalls specifically having a discussion with her sister where she remarked that the situation could not go on, she warned that either of Jessica or Richard would end up in prison, seriously harmed or worse. Even this approach could not engage her sister sufficiently to discuss the violence.

19.2.5 Diana explained that in her view Jessica was so disempowered and dehumanised by the abuse from Richard that she had lost the ability to make reasoned judgements. Diana continued this was exemplified by Jessica's decision not to attend the court case on 12th March 2013, when Richard stood charged with offences against both Jessica and their daughter, Rebecca. Diana went on to explain that in her view as her mother, Jessica ordinarily would have supported Rebecca in court, but on this occasion, she did not.

19.2.6 All three family members agree with this point, and Rebecca went on to explain that at the conclusion of the proceedings she returned home to find her mother and father at home together. This had a significant impact on Rebecca in that she felt her mother had chosen her father over her.

19.2.7 The Women's Aid members of the panel identified that from Jessica's perspective the decision not to attend court may well have been a conscious decision on her part, as she would feel that her attendance in court would result in increased violence as a consequence.

19.2.8 The Report Author was interested to know from Rebecca of her and her mother's experience and how they had been treated by the differing agencies involved. This review reports later on where Shropshire Council Children's Services and the WWMCRC ought to have done significantly more to engage directly with and provide support and intervention to Jessica and Rebecca. As a consequence Rebecca was only able to pass comment on her experience of policing in the main, and to a much lesser degree the CPS and magistrate's court service, based upon her experience of her specific magistrate's court case in 2013.

19.2.9 The Report Author specifically wanted to know of her experience as a child, and whether Police officers ever spoke to her as an individual. Rebecca explained that they did because she was most often the only one who was sober enough to explain what had happened within the incident under consideration. This goes some way to answering the obvious question under practice relating to safeguarding children as to whether the 'voice of the child' was secured sufficiently. A matter which draws comment later in this report, in particular within the analysis of activity by Shropshire Council Children's Services.

19.2.10 The subject of risk assessment was an area of particular interest and drew some insight from Rebecca from her perspective, concerning the Police DASH process. The Report Author has chosen to use the direct quotes from the conversation, as follows:

19.2.11 'You mean the tick list, where you're asked have you been threatened, is he suicidal, has he hurt any animals, are there any children involved?' and interestingly Rebecca states on one occasion she recalls the officer saying 'I know this is a silly question but have you been sexually abused?' Again, this draws later comment.

19.2.12 With regard to Jessica's engagement with the risk assessment process Rebecca stated that her mother only occasionally engaged in the conversation with officers. On some occasions where Jessica was not answering accurately Rebecca attempted to intervene but was told by the officers that it was her mother who needed to go through the risk assessment with them. Rebecca does not recall ever being asked by officers to inform the risk assessment process concerning her mother, nor indeed were Jessica's mother Victoria or her sister Diana. This report highlights later one direct opportunity in December 2013, for Police to seek information from them to inform the risk assessment.

19.2.13 Rebecca also explained that the risk assessment process was only conducted with the direct victim of the assault, as distinct from having separate conversations with each of her and her mother on each of the occasions they were called to their home.

19.2.14 It is known on one occasion the attending officers convinced Rebecca that a referral to Women's Aid would be in her interest and so she consented. It is also known that she did not pursue this avenue of support.

19.2.15 In explaining why she did not, Rebecca went on to state that 'it's the last thing they do, give you the leaflet and go', and then further that she did not feel comfortable or confident in 'phoning a stranger I don't know'.

19.2.16 The Report Author explored with the family the fact that there were no calls regarding domestic abuse during the period 2007-2010. The family agree that there was a period where 'things did settle down', but equally all agree that the violence did not fully stop. They were also of the view that this 'quieter period' was not 3 years in length. Considering Rebecca's view that the Police were only called on 1 in 20-30 occasions it seems inconceivable that there was no violence at all for this extended period. In reality, no explanation can be given for why this three-year period resulted in no calls to the Police.

19.2.17 Diana did take the time to point out the very positive aspects of a conversation between a female Police officer and Rebecca following the assault on her by her father, on 2nd December 2012. On this occasion having been at the Police station Rebecca went back to her aunty Diana's home, where she was visited by this officer. Both Diana and Rebecca recall the very personal discussion the officer had and they report that this had a very positive impact on Rebecca.

19.2.18 This report has already detailed the family's views on the police response to a domestic incident that occurred on 24th December 2013. Jessica's expectations of the police were that she wanted Richard removed from her home, however in view of it being Christmas she agreed to stay with her mother so Richard had somewhere to stay for Christmas. On her return to the police station 48 hours later, she simply expected the police to fulfil their commitment to assist in removing him from the home. They did not do so explaining that as 48 hours had expired they were unable to do so. There is no police record concerning this second visit.

19.2.19 The extent of Jessica's historical rib injuries as reported by the osteoarticular pathologist clearly indicate a number of months of her exposure to extreme violence during the last few months of her life. In view of this, the Report Author was interested to know from Rebecca why there had been no calls to the police.

19.2.20 Rebecca explained that from her perspective she often heard assaults taking place but rather than call the police her strategy was to intervene directly to protect her mother. She specifically did not call the police, as she knew Jessica didn't want them

called, and if she had done so she was concerned it would 'drive a rift between me and mum', she went on to explain 'I just did what I did to stop the here and now'.

19.2.21 Her personal judgement had also been significantly affected by the sentence imposed on Richard on 12th March 2013. Rebecca's view was that the sentence was 'pointless'. She articulated the point that in her view there was no longer any point in calling the police 'if that is all that is going to happen'. Consequently, her strategy was as described above as she no longer saw any value in calling the police.

20. Views of work colleagues

20.1.1 Jessica's work colleagues were offered the opportunity to contribute to the review but most declined to do so. Her manager however, did engage with the review, and was helpfully able to reflect matters not only from her perspective but also more generally from the workplace as a whole. She too recalls the very bubbly personality of Jessica, and describes the office as being noisy when Jessica was at work, but in a very positive way. It was clear that Jessica was well liked by all of her colleagues. She was also the longest serving of the members of staff at the charity.

20.1.2 The conversation regarding Jessica spanned over time where she had been in a relationship with Richard. It was known by her work colleagues that Jessica had previously been in an abusive relationship, and the manager specifically quoted their knowledge of one of the incidents of violence against Rebecca. This had obviously been the subject of extensive discussion with Jessica, and in particular about her decision not to go to court.

20.1.3 The manager specifically recalls Jessica saying 'it won't do any good; even if he is bound over it will make him mad, he will still come back'. This was particularly informative, as Jessica does not appear to have made such a significant and clear disclosure to any agency or indeed her family members.

20.1.4 During the Report Author's conversation with Rebecca, and as recorded within the section 'views of the family' Jessica's decision not to attend court had a profound effect on Rebecca (page 39 paragraph 19.2.6). It is hoped that this contribution from Jessica's manager, coupled with the experienced views offered by the Women's Aid panel members, (page 39 paragraph 19.2.7), goes some way to help Rebecca understand why Jessica made the decision she did.

20.1.5 The manager did explain that she had had an occasion to give Jessica a warning about repeated non-attendance at work after weekends. Jessica had reported to having had stomach upsets but the manager (because of previous experience with a different employee) did suspect 'binge drinking' at weekends.

20.1.6 She explained Jessica did acknowledge that she and Richard liked to drink, and conceded that if they drank to a certain level their relationship could become volatile. She did however say that Jessica always explained that she was a social drinker. There was no occasion at work where she had to be challenged or in fact even smelled of alcohol.

20.1.7 At a point in time Jessica led her work colleagues to believe that she had ended the relationship with Richard.

20.1.8 There were several occasions on which injuries were noted on Jessica's face. In the light of this, she was asked directly if she had resumed her relationship with Richard

and if he was being abusive. Jessica always categorically said to her colleagues that she was not in a relationship with him.

20.1.9 It was clear that work colleagues endeavoured to persuade and offer to support Jessica to seek help but she declined that anything was wrong either with her drinking levels or indeed a relationship (given that she continually denied having resumed her relationship with Richard).

20.1.10 One particular member of staff would often go with Jessica to a local supermarket for shopping, and on noting the number of bottles of vodka which she was purchasing, would gently but pointedly enquire about this and whether she needed help, even offering to go to support meetings or her Doctor, but again Jessica not only declined, but denied there was a need for her to seek such support.

20.1.11 During the last three months of Jessica's life her work colleagues became increasingly concerned for her health and welfare. It was visibly apparent to them that she was not well. Because for many years she had flatly denied being in a relationship with Richard, and therefore the victim of abuse, they concluded she may be suffering from a serious and perhaps life limiting illness, but again despite repeated attempts could not engage her to go to her GP.

20.1.12 It was clear that staff in the workplace and the manager in particular had good awareness of 'safeguarding' matters, most likely linked to the nature of the charity. This is an important factor, as many other local agencies or small business may not be as well informed on matters of safeguarding. In considering how the agency could take differing approaches, they often felt thwarted by the need to recognise and respect Jessica's wishes. The manager did feel that some form of support in the form of being able to discuss an anonymised set of circumstances for agencies and small businesses may have been beneficial.

21. Views of the perpetrator

21.1 The Report Author met Richard and had a discussion that ran to two hours. The conversation was structured to encourage open dialogue from Richard, there were occasions however, when to pursue a particular aspect the Report Author had to ask direct questions that drew short responses from Richard. These aspects of the conversation were not particularly helpful.

21.2 There were times within the conversation where it was apparent that Richard continued to blame Jessica and Rebecca for his violent behaviour. He was robustly challenged by the Report Author on these occasions.

21.3 Richard was asked if he could offer any suggestions on possible differing approaches by agencies. In response he suggested that the frequency of Police call outs perhaps should have caused them to intervene, even if only, in his view, to avoid wasting the Police's time.

21.4 At the time the interview occurred the Report Author had explored the possible changes in practice at the Emergency Department of The Royal Shrewsbury Hospital, and in particular, to empower staff to be more enquiring in circumstances where domestic abuse was suspected.

21.5 Asked if he had been engaged by hospital staff on either of the occasions of his attendance at the ED concerning his home life, Richard stated he would have simply told them to 'mind their own business'.

21.6 On reflection the conversation between Richard and the Report Author accorded with the narrative provided later by the Probation Service IMR author. Richard still largely blamed Jessica and Rebecca and his alcohol consumption for his violence.

22. Analysis and Recommendations

22.1 In examining the IMR's submitted by the differing agencies there are several areas which are worthy of mention, which indicate the services from agencies could have been better, but also revealed areas of effective practice which are to be commended and should continue.

22.2 It was identified within the review, and draws later comment, that Richard continually displayed an unwillingness to accept responsibility for his behaviour. During his time under probation supervision, in particular it is recorded that Richard felt that alcohol was the significant contributing factor to his violence.

22.3 This is simply not the case. Alcohol was not the reason for the violence he was. Alcohol has the impact of being a dis-inhibitor, in this case to his violent tendencies, and so the impact of alcohol was that the violence became more severe and frequent when alcohol was involved.

22.4 Police, probation and to a lesser degree SaTH noted on their records that alcohol was a factor when dealing with Richard. Richard was the subject of an alcohol treatment requirement on two occasions, the effectiveness of which draws later comment.

22.5 What is less clear is how robust Police and SaTH were in engaging with him regarding whether his alcohol consumption was something he should address and indeed in the case of Jessica how robust, the Police were, in encouraging her to consider referrals in respect of her alcohol consumption.

22.6 The panel held a discussion specifically on the issue of alcohol consumption and its prevalence within domestically violent relationships. All agencies were agreed that it was given due cognisance under current working practices, during their own interventions with victims and perpetrators, and indeed at the family level. The panel discussed but did not feel there was a need to undertake any communications activity with regard to alcohol across the multi-agency workforce as the matter has been embedded in working practice in recent years.

22.7 In consideration of the feedback given by Jessica's manager the Regional IDVA services manager did point out that they did offer an advisory service to professional agencies as part of their core function. The panel were of the view that this would fulfil the role articulated by Jessica's manager, but were also of the view that there was a need for raising awareness at the local level. It is left with the community safety partnership to review current local arrangements for raising awareness of domestic abuse, and how to signpost employers to support services.

Recommendation No.1

Shropshire Community Safety Partnership to review current local arrangements for raising awareness of the range and availability of domestic abuse support services.

22.8 The review also established that the MARAC coordinator who holds responsibility for oversight of the Princess Royal Hospital at Telford has a very effective quality assurance process to ensure the MARAC alerts on the patient system are up to date and reflective of the current position.

Recommendation No.2

SCSP to ensure that this effective quality assurance process is introduced for the patient alert process for the Royal Shrewsbury Hospital.

22.9 During the discussion on training the panel felt there would be significant value in conducting an audit on the level of multi-agency domestic abuse training available to and undertaken by agencies.

Recommendation No.3

SCSP to undertake an audit of multi-agency domestic abuse training.

Actions of the Police

22.10 In 2008 the then National Policing Improvement Agency (NPIA) issued guidance for all Police Officers attending incidents of domestic abuse. The NPIA has since been replaced by the new National College of Policing, however the NPIA identified priorities for the Police service in responding to domestic abuse still hold good, they are:

- To protect the lives of both adults and children who are at risk of domestic abuse;
- To investigate all reports of domestic abuse;
- To facilitate effective action against offenders so that they can be held accountable through the criminal justice system;
- To adopt a multi-agency approach in preventing and reducing domestic abuse.

22.11 The College of Policing Approved Professional Practice Domestic Abuse 2016 (CoP APP DA 2016) gives guidance on the Police service's duty of positive action as follows:

Senior managers are responsible for ensuring that their force fulfils its obligations under the Human Rights Act 1998, which includes taking positive action to protect victims of domestic abuse. Senior managers should ensure their staff are aware of the contribution they can make to victim safety by taking positive action at domestic abuse incidents.

22.12 The Human Rights Act 1998, incorporating the European Convention on Human Rights 1958 (ECHR), imposes positive obligations on the UK to actively protect individuals from acts which interfere with their rights, and to investigate effectively alleged breaches of those rights. Most relevant to domestic abuse are:

- Article 2 – right to life
- Article 3 – right not to be subjected to torture or to inhuman or degrading treatment or punishment, which includes ill-treatment
- Article 8 – right to respect for private and family life, which includes physical integrity.

22.13 Positive obligations under Article 2 require the UK to take 'appropriate steps to safeguard the lives of those within its jurisdiction' (L.C.B. v UK (1999) 27 EHRR 212), which includes 'preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual' (Osman v UK (2000) 29 EHRR 245). In practice, this means that where the victim is threatened in a real and immediate way and the authorities know, or ought to know, of the threat, they must take reasonable measures to counter that risk.

22.14 Police officers, as agents of the state, consequently have a positive obligation to take reasonable action, within their lawful powers, to safeguard the above rights of victims and children.

This includes the duty to:

- make an arrest where it is necessary and proportionate to do so;
- protect the victim and vulnerable people within the household from harm.

22.15 The requirement for positive action in domestic abuse cases incurs obligations at every stage of the Police response. These obligations extend from initial deployment to first response, through the whole process of investigation, and the protection and care of victims and children. Action at all of these stages should ensure

- effective protection of victims and children;
- criminal proceedings where appropriate;
- effective perpetrator management where criminal proceedings are not possible or unsuitable.

22.16 The following guidance is given in respect of breach of the peace arrests.

In cases where there are no apparent grounds for arrest, sometimes the victim just wants the perpetrator to leave the premises temporarily or the situation can be defused by removing the perpetrator from the location.

Where a breach of the peace is likely to occur or reoccur, officers should remove the perpetrator on this ground. They should take the perpetrator to an alternative location, preferably some distance away, and advise them to stay away for a period of time.

Officers should not choose this option because it appears the easiest and least time-consuming. A Police call-out to a breach of the peace that is domestic in nature, even if it appears low level, may be an indicator of underlying issues. It is an opportunity for officers to spot underlying problems, e.g. controlling or coercive behaviour, and prevent escalation, and may require follow-up investigation. Prior to leaving the address, officers should provide the victim with a point of contact and details of support agencies. They should carry out a risk assessment and discuss other follow-up options.

22.17 In response to an area of the terms of reference the Police IMR identifies that:

‘Patrolling Police officers are routinely trained in identifying signs of domestic abuse but are not expert neither do they receive the specialised training officers from the Domestic Abuse Unit receive. In many of the cases examined in this report, officers identified the domestic abuse and acted in accordance with Force Policy by arresting the offender, detaining him for a breach of the peace or removing him at the victim’s request. On each occasion they ensured the domestic abuse unit were aware of the incident. West Mercia Police maintain support for patrol officers dealing with such matters via specialist officers and units and specialist websites which are linked to external websites.

22.18 In view of the rather generic nature of this response further specific review work was requested and undertaken.

Police Positive Action

22.19 This section does not seek to detract from more detailed analysis but seeks to give a broad overview of the Police compliance with the requirements of their Domestic Abuse policy to undertake positive action when responding to domestic abuse. On the basis of initial reports to Police Richard was alleged to have committed criminal offences on seven occasions:

- 12th April 2003 when he assaulted Jessica. Richard was not arrested. Jessica subsequently stated to officers that she did not wish to support the investigation and further requested that she did not want the Police to contact Richard regarding the matter
- 19th March 2004 when he assaulted Jessica. Richard was not arrested. Jessica told Police that she did not wish to pursue a complaint and no injuries were visible. Jessica signed an officer's pocket note to book confirming she did not wish to pursue a complaint.
- 18th May 2004 when he assaulted Jessica.
- 3rd May 2005 when he assaulted both Jessica and Rebecca.
- On 29th November 2011 when he assaulted Rebecca.
- 16th January 2012 when he assaulted Jessica and damaged Rebecca's television set.
- On 4th December 2012 when he assaulted both Jessica and Rebecca.
- On the latter five of these occasions, Richard was arrested.

22.20 He was also arrested on three further occasions for Breach of the Peace on 27th January 2007, 9th May 2010 and 22nd August 2010, when domestic incidents were reported but no substantive criminal offences could be established.

22.21 On 8th May 2010, 10th July 2010, 19th December 2012, 22nd September 2013, 4th September 2014 and 2nd January 2015 Richard was removed from the premises by Police officers at Jessica's request and taken to alternative accommodation.

22.22 On the 30th June 2007 and 11th July 2007 following arguments Jessica called the Police but Richard had left the house before they arrived.

22.23 On the 12th June 2011 following an argument both Jessica and Rebecca left the home to spend the night at Victoria's home address.

22.24 On the 22nd July 2012 an argument occurred between Richard and Rebecca, following which Rebecca decided to leave the house and spend the rest of the evening at her boyfriend's home.

22.25 On the 24th December 2013 Jessica attended the Police station seeking advice. It was mutually agreed that Richard would remain at the property whilst she would spend the Christmas period at her mother's home.

22.26 The ability to analyse police action against their positive action requirement has been hampered by an ability to identify which version of relevant policy was in existence at any given point in time. In the view of the Report Author whilst positive action was not undertaken on the first occasion in 2003, officers were likely to have been influenced by Jessica's request for them not to do so. On the second occasion in 2004, officers did not make an arrest as Jessica stated she did not wish to pursue a prosecution. It cannot be confirmed in the absence of 'version control' policy but it is most likely that so called 'victimless prosecutions' were not an option for Police to pursue at that time.

Recommendation No 4

West Mercia Police to introduce version control for policy development and to secure outdated policies within the organisational corporate memory to assist in informing any future review processes.

22.27 On all other occasions where circumstances required that Richard was arrested such an arrest occurred.

Risk Assessment

22.28 In 2009 the Police service nationally implemented The Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification, Assessment and Management Model (DASH) to assess levels of risk posed to victims of domestic abuse. It is designed to inform the decision making process on appropriate levels of intervention for victims of domestic violence. West Mercia Police have been using the DASH model since June 2009.

22.29 It is a multi-agency tool; however, it is used in different ways by the Police and other agencies. For example, for the Police service the tool is used by first response staff who are conducting the initial risk identification. It is then used by specialist staff conducting the risk assessment in full.

22.30 The three levels of risk are:

- Standard - no significant current indicators of risk of harm.
- Medium **-** there are identifiable indicators of risk of harm. The offender has the potential to cause harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.
- High - there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

22.31 The Report Author tasked West Mercia Police to give an overview of the effectiveness of the DASH risk assessments where able to do so.

22.32 Many of the Police risk assessment documents have been destroyed in accordance with their information weeding policy, however West Mercia Police were able to provide analysis of their responses to and more particularly, the risk assessments concerning the domestic incidents on 16th January 2012, 22nd July 2012, 2nd December 2012, 22nd September 2013, 24th December 2013 and 4th September 2014.

22.33 West Mercia Police's operating procedures require the details of the incident to be recorded on West Mercia Police form CO1. Where there is a substantive criminal offence the matter will be recorded formally as a 'crime', if it is beneath this threshold it is formally recorded as a 'domestic incident'. This report requires officers to record details of the victim and perpetrator, or if indeed, there is so called 'equal blame' being attributed. This most often occurs in the case of domestic arguments where no substantive offence can be established and each partner apportions responsibility on the other, and there is a lack of independent information either way.

22.34 West Mercia Police's current and domestic abuse policy in existence at the time of the following events determines that a DASH assessment should be conducted with anyone at risk of domestic abuse. In circumstances where there is more than one person identified as being at risk of domestic abuse then the DASH risk assessment should be conducted with each person.

22.35 In cases of 'equal blame' officers are required to complete a DASH risk assessment with both parties.

22.36 When the DASH risk assessment was first implemented there were two models used by larger and smaller forces. The first model required the front line officer attending the incident to ask all 29 DASH questions and to make a risk assessment, the second, as adopted by West Mercia Police, required the frontline officer to ask 15 of the 29 questions, and then this would be followed up specialist domestic abuse staff who would ask the full 29 questions where risk determined it.

22.37 West Mercia Police policy at that time was for all medium and high-risk cases to be subject of the full 29 questions assessment.

22.38 On the 16th January 2012 officers recorded two crime reports in respect of the criminal damage to Rebecca's television set and the assault by Richard on Jessica.

22.39 Two initial 15 question DASH risk assessments in accordance with force procedure were conducted by the officer with Rebecca and Jessica, the risk level being determined as medium.

22.40 In endeavouring to take account of the wider aspects to inform the risk assessment Police records showed that the officer had checked local systems and intelligence and recognised the domestic violence history and that had informed the assessment of a medium level of risk. It also showed that Jessica had been unwilling to engage in the risk assessment process. This was also followed up with firearms licensing checks and Child Protection Plan checks by the DA risk assessor, now part of routine extended background checks with regard to domestic abuse.

22.41 The reviewing officer was of the view that the level of risk being assessed as medium was conducted in accordance with procedures in place at that time and correct based on the information available.

22.42 In view of the medium level of risk, on 17th January 2012, Jessica was spoken to by a specialist domestic abuse officer who completed the full 29 question risk assessment. This officer deemed that the level of risk should remain at medium, and recorded that she had sent details of support agencies to Jessica and in accordance with Jessica's request had arranged for a member of the local policing team to visit her at home.

22.43 Procedures operating at that time enabled IDVA referrals in respect of both Jessica and Rebecca to also be made.

22.44 This DA risk assessor also took account of the risks posed to Rebecca within this further assessment of the risk. She recorded that Jessica stated her relationship with Rebecca was 'very close' and that therefore her account conveyed risk detail on

behalf of them both. On this basis, the officer did not feel the need to conduct a reassessment of the risk directly with Rebecca.

22.45 The reviewing officer reported that ideally a risk assessment should be conducted with both individuals but it realistic to accept that a conversation with both was not necessary. It is further reported that this was acceptable if the officer felt that Jessica had explained sufficiently what the risk situation was.

22.46 The referral to the local policing team could have been made in a number of ways. It cannot be established whether such a visit was ever made, as no entries exist to confirm either way. In some cases, a risk management plan would be opened in respect of the victim where such visits would be recorded, however in this case no risk management plan was deemed to be needed by the assessing officer.

Recommendation No.5

West Mercia Police in the absence of a Risk Management Plan to record all local policing support visits on the 'CO1' crime or incident record.

22.47 Police records showed that in response to the domestic incident on 22nd July 2012 when an argument had occurred between Richard and Rebecca, the officer conducting the risk assessment with Rebecca had also conducted checks on both the Police national computer and local intelligence systems. The reviewing officer was of the view that the risk assessment of standard was appropriate in the circumstances.

22.48 As a standard risk there would not be routine reassessment by the domestic abuse unit, there is however a policy of a dip sample of 10% of standard risk cases.

22.49 Additionally, the domestic abuse unit (DAU) are charged with considering the need for referral to other agencies. In reaching a decision on whether to refer or not the DAU conduct other lateral checks, for example Police firearms licensing records and the existence of children being resident at the address concerned. In this case, no referral to partner agencies was required.

22.50 In response to the domestic offences committed by Richard on 2nd December 2012 Police records showed that a DASH risk assessment was conducted at the time with Rebecca.

22.51 The officer completing the risk assessment conducted lateral checks and assessed the risk level as being high. It is recorded that because of the high-risk levels repeated attempts to contact Rebecca were made by the DAU assessor, the IDVA and the initial attending officer with a view to conducting the full 29 question DASH risk assessment with her.

22.52 By 25th January 2013 no contact had been successfully made with Rebecca.

22.53 At this time the risk was downgraded to medium on the basis that by this time Richard had been charged with offences of assault against Rebecca and Jessica and was the subject of bail conditions not to contact them and to live elsewhere than at their home address. It was recorded that the DAU would monitor the ongoing risk.

22.54 The Report Author explored this with the reviewing officer. It was confirmed that such ongoing monitoring in reality would have only taken account of newly reported incidents or an approach by other agencies such as probation reporting an escalation in risk through MAPPA or MARAC. Crucially it was confirmed that the proposed method of 'HAU to monitor', in the absence of further reported incidents would not have revealed the fact that Richard had moved back into the home.

22.55 It was also confirmed that the only mechanism by which ongoing proactive monitoring of such a position would be by means of the implementation of a risk management plan. This was not put in place on this occasion.

22.56 It is known that the Police had not managed to secure Jessica's support for the investigation, however during the investigation it was noted that Rebecca had given evidence of an assault by her father Richard on her mother Jessica, and so albeit at a late stage, a crime was recorded on 7th January 2013 for the assault on her.

22.57 The reviewing officer identified that:

'The risk to Jessica does not appear to have been considered in her own right once she was recorded as a victim herself'.

In effect, this was a missed opportunity to re-assess the level of risk posed to Jessica.

22.58 On the 22nd September 2013 Police were called by an anonymous third party to the address where a loud disturbance was reported to be taking place. Jessica asked officers to remove Richard from the home which they did; she did not want any further action to be taken.

22.59 Jessica declined to complete the DASH with officers and declined to sign consent for the information to be shared.

22.60 The reviewing officer has had to provide a professional judgement assessment from paper records from this point onwards. It is her best assumption, given Jessica had declined to complete the DASH, that the officers have completed it based upon the circumstances of their attendance and on historically held Police information.

22.61 The DASH assessment had Rebecca's name recorded but then crossed out and replaced with Jessica's details, the assumption here is that officers completed the assessment from systems held intelligence records and simply incorrectly recorded names from a list of people who were recorded as resident at the address. Realising their error they then correctly completed the DASH in respect of Jessica.

22.62 The officer conducting the DASH noted Richard's previous convictions for assault and criminal damage but also that there were currently no bail conditions in place. The attending officer assessed the risk as medium.

22.63 Later a Detective Sergeant in the DAU downgraded the risk to standard on the basis of the lack of cooperation from Jessica previously and the fact that this was the first reported incident in 2013.

22.64 The incident on 24th December 2013 was recorded as a domestic incident. It is recorded that Jessica and Richard had been drinking and had argued. The record indicated that Jessica had attended the Police station for advice, as she intended to

spend Christmas with her mother and she was worried about what Richard might do to her property whilst she was away. The officer recorded that Jessica stated Richard had been violent in the past, but that he had not been violent on that day, he had however been drinking heavily.

22.65 The officer completed a risk assessment with Jessica. The officer checked local systems but there was no risk detail recorded other than the fact that Richard was drinking daily. The officer assessed the risk as being standard.

22.66 The reviewing officer deems this as appropriate given the circumstances as reported, she does note however that it was unusual for Jessica to attend the Police station given that she would often not engage with Police responding to calls to her home regarding domestic abuse.

22.67 From Victoria's perspective as documented earlier in this report she is clear that Jessica had attended the Police station, as she wanted help in removing Richard from her home. As the conversation continued Jessica stated she felt sorry for Richard in that he would have nowhere to spend Christmas and so she decided to spend Christmas with her mother. It was agreed that after that she would return to the Police station for the Police to help with her request to remove Richard.

22.68 This was a missed opportunity to both engage with Jessica on her return to the Police Station and to conduct a further risk assessment given that it was unusual for her to reach out to the Police Service in this way.

22.69 On 4th September 2014 an anonymous third party called Police to the address and reported swearing, shouting and banging'. During the conversation, the third party informed the Police that they didn't think Richard was supposed to be at the address.

22.70 On this occasion Jessica stated that they had in fact separated in January 2014, but that she had allowed him to stay at the home as she felt sorry for him, (his father had recently undergone an operation for a serious illness).

22.71 The officer assessed the risk as being standard which was agreed by the supervising officer, their rationale being that the last incident had been in December 2013. The previous assault history was noted but within the context that it had occurred at the time when the couple were 'at the height of separation'. The officer's judgement here was clearly based on the account given that Richard had only stayed that evening and the relationship had ended in January 2014.

22.72 It was identified by the Police control room staff that Richard was the subject of Probation Service management.

22.73 In recognition of the fact that both Jessica and Rebecca were victims of Richard's abuse the Report Author is of the view that the risk assessments did not always enable a broader view of the risks being secured. It has been established that on each occasion the risk assessment processes, conducted in accordance with policy, were in respect of the direct victim of the incident or crime under consideration. The Regional IDVA manager on the panel identified that the DASH process is secular and focusses on actuarial risk. West Mercia Police are currently undertaking training with their staff to encourage officers to take a broader view of vulnerability and to encourage staff to exercise their professional judgement.

22.74 On the occasion of the assault by Richard on Rebecca on 29th November 2011 the Police assessed the risk as standard. This risk was reviewed by a specialist DAU officer on the 6th December 2011. He also assessed the risk as standard, the basis being that the bail conditions prevented her father having contact with her or living at their home. No risk management plan was put in place for Rebecca. Richard was sentenced on the 21st December 2011; the impact being that the bail conditions would now no longer apply.

22.75 On 16th January 2012 Richard was again arrested for assaulting Jessica and damaging Rebecca's television set during a domestic dispute. On this basis, it is assumed that Richard after his sentence had moved back into the family home.

22.76 Given the previous Police risk assessment of 29th November 2011 was deemed to be standard on the basis of Richard being bailed to restrict his access to the home it would seem necessary to have in place a process which reviews the level of risk once he returned. Whilst this logic is accepted by West Mercia Police, the practicality of such a process is viewed by them to unlikely to be achievable. On that basis the following recommendation is made.

Recommendation No.6

West Mercia Police need to consider risk assessment levels when impacted by dynamic factors i.e. residence and prohibition of access to victims. Consideration should be given to the ongoing management of cases and utilising a risk management plan where appropriate.

22.77 The effectiveness of the DASH risk assessment process can be impeded where victims are not effectively engaged by the agencies.

22.78 In trying to therefore offering a broader view on the effectiveness of the agencies assessment of risk the following factors were considered:

- The frequency and accumulative nature of the domestic abuse of Richard;
- The fact that his abuse was directed at two victims, Jessica and Rebecca;
- The failure of agencies on occasions to secure Jessica's engagement in meaningful structured risk assessment conversation;
- The prevalence of alcohol as an aggravating factor; and
- The probation assessments that Richard presented a medium and on occasion high risk of harm towards Jessica.

22.79 Within the DASH model there are 15 areas considered to be high risk factors, of which in this case arguably the following four were present:

22.80 **Escalation**: repeat victimisation and escalation must be identified. Domestic abuse victims are more likely to become repeat victims than any other type of crime; as violence is repeated it gets more serious.

22.81 The repeat nature of the domestic abuse perpetrated by Richard is not in question, over a 12- year period he was responsible for 22 incidents which were reported to the Police. This of course does not include those matters which were not reported to the Police.

22.82 **Strangulation** (choking/suffocation/drowning): escalating violence, including the use of weapons and attempts at strangulation must be recorded when identifying and assessing risk. This includes all attempts at blocking someone's airway.

22.83 Richard had previous convictions for two offences in 2001 and 2002 where he choked his ex-partner KB. Choking was also a specific part of the assault on his daughter Rebecca on 2nd December 2012.

22.84 Medium risk is identified as circumstances where there are identifiable factors of risk of serious harm. The offender has potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example failure to take medication, loss of accommodation, relationship breakdown and drug or alcohol misuse.

22.85 Given Richard's propensity for violence towards both Jessica and Rebecca, the fact that in reality he had no permanent residence other than Jessica's home, the fact that within three of his convictions his Modus Operandi included choking the victim; and his use of alcohol it is contended that on occasion, had these broader factors been more consistently taken into consideration, the minimum level of risk would have been medium.

22.86 West Mercia force policy is for Protecting Vulnerable People department supervisors to dip sample 10% of standard risk cases to ensure consistency of application. In HMIC inspection of 2013 'Everybody's business: Improving the Police response to domestic abuse', this was noted to be inconsistently applied across the force and was the subject of an HMIC recommendation.

22.87 On the date of the HMIC inspection, 23rd October 2013 West Mercia Police had 402 active domestic abuse cases; 17% high risk; 79% medium risk; 4% standard risk. This 4% equates to only ten cases only one of which to be dip sampled to comply with force policy requirements.

Recommendation No.7

West Mercia Police to report progress against the HMIC action plan to ensure a 10% dip sample of standard risk cases.

22.88 On the first and subsequent calls to West Mercia Police enquiries by Police officers afforded them the opportunity to understand the significance of Richard's convictions from 2001 and 2002 and latterly following the assault on Rebecca in December 2012 and in particular the high risk elements of the modus operandi, namely choking his victims.

22.89 This could have informed Police risk assessments and also featured as part of information shared with agencies, in particular children's services and probation.

22.90 Analysis of Police referrals showed that when sharing information with Shropshire Children's Services it was never made clear that Richard was the birth father of Rebecca.

Recommendation No.8

West Mercia Police to ensure that when information is being shared with partner agencies the actual relationship between perpetrators and those to be subject of risk review activity is explicitly clear.

22.91 MARAC is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.

The aims of MARAC are:

- to share information to increase the safety, health and well-being of victims – adults and their children
- to determine whether the perpetrator poses a significant risk to any particular individual or to the general community
- to identify outstanding aspects of risk assessment in regard to the victim, children or perpetrator that need referral or progress
- to pull together a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- to reduce repeat victimisation
- to improve agency accountability and
- improve support for staff involved in high risk domestic abuse cases

Cases to be submitted to MARAC should include the following:

- all cases assessed as high risk or complex medium risk
- if capacity allows any other case which does not meet the criteria for high risk but gives cause for significant concern (may include repeat victim cases).

22.92 There is contention earlier that Jessica's case should have been more often identified as at least a medium risk. In support of this, there are two occasions when the risk level is initially assessed as high but then on review reduced to medium, given the complexity of the case overall the case could have been referred to MARAC.

Recommendation No.9

West Mercia Police to remind officers that all high risk must be referred to MARAC, and additionally that there is sufficient flexibility, subject to MARAC capacity to refer other cases.

22.93 The College of Policing Authorised Professional Practice on Domestic Abuse states:

''When a victim indicates that they wish to withdraw their support for the prosecution process, a statement should be taken stating and describing any reasons for the withdrawal. This should be done by a domestic abuse specialist where possible''.

22.94 Previous NPIA guidance on this matter also continued ‘’any withdrawal of support for a prosecution should prompt a revised risk assessment and safety planning (page 51)’’.

22.95 This has been incorporated into the current Domestic Abuse Authorised Professional Practice for Domestic Abuse issued by the College of Policing.

22.96 Jessica only provided witness statements to Police on two occasions, the first following an assault by Richard on her on 18th May 2004 the second on 4th May 2005 following Richard assaulting both her and Rebecca. Both of the statements she later retracted. On the second occasion Rebecca, 13 years of age at the time, had also given a witness account recorded appropriately on a VW1 ‘initial contact log’ in line with achieving best evidence (ABE) guidelines in place at that time. Following this second occasion, withdrawal statements were taken from both Jessica and Rebecca on 6th May 2005.

22.97 These withdrawal statements were not taken by specialist DAU officers; however, the Police IMR author’s professional judgement, given the existence of only a basic electronic record is that this was in line with operating policy at that time, in that the investigation record is scrutinised by a specialist DAU supervising officer.

22.98 Current Police policy would require that in circumstances such where a child has made a witness statement and intends to make a withdrawal then a specialist officer would conduct that interview by way of ABE video-recorded interview. In particular, the appropriate adult would be carefully chosen, and as in this case would not be a victim of, or other witness to the crime under investigation.

22.99 Any decision to undertake such activity would have further scrutiny applied by means of a joint section 47 strategy discussion with partners.

22.100 No records are held to establish whether, on the occasions of these withdrawal actions, Police reviewed the level of risk to Jessica and Rebecca.

22.101 On 12th October 2005 Richard was sentenced to a 6-month community punishment order with supervision.

22.102 There is an interesting paradox concerning the administration of a caution to the victim following her throwing a glass at the perpetrator on 4th November 2005. On all previous occasions where Jessica had not wanted to Police to pursue the matter, the fact that the Richard denied any of the allegations resulted in no action being taken against him.

22.103 On this occasion the Jessica openly told the Police what had occurred and ended up with a criminal outcome. This would seem on the face of it to be a course of convenience to quickly conclude the incident for the Police, rather than dealing with the incident yet another occasion where there was opportunity to intervene properly to assess the true extent of the domestic abuse within the household and the ongoing risk to the victim. (It is acknowledged that where individuals admit the commission of an offence then appropriate sanction should be considered). Since 2005, Police practice has changed considerably and whilst apparent criminal offences are investigated, more exploration of the context is conducted alongside a more thorough review of the risk and history. In current circumstances, Police practice would identify Jessica as a serial victim of domestic abuse and it is highly likely that a more considered approach to her throwing of a glass would be taken.

22.104 This 'outcome' is highly likely to be indicative of the performance expectations being placed upon the Police service nationally at the time, and indeed on individual officers at a local level.

22.105 Whilst subject of probation supervision he was involved in domestic arguments with Jessica on 4th November 2005 and 26th March 2006.

22.106 On the 21st December 2011 Richard was convicted of an assault on Rebecca and sentenced to 120 hours community service, 12-month community order with supervision and a 6-month alcohol treatment requirement.

22.107 On 16th January 2012 whilst subject of probation supervision Richard assaulted Jessica and committed an offence of criminal damage to Rebecca's television set.

22.108 Richard was convicted of these offences on 2nd April 2012 when he was sentenced to 24 months community order, 24 months supervision with a requirement to complete IDAP, and these were in addition to the conditions of the existing order.

22.109 Whilst subject of probation supervision on the 22nd July 2012 Police were called to a domestic argument between Richard and Rebecca and again on 4th December 2012 when Richard had assaulted both Jessica and Rebecca.

22.110 On the 12th March 2013 he was convicted of the assault on Rebecca and sentenced to 5 months imprisonment, wholly suspended for 2 years, an alcohol treatment requirement, and made subject of a restraining order in respect of Rebecca.

22.111 On this date as has been outlined earlier the Crown Prosecution Service offered no evidence in respect of the charge of assault against Jessica. Given the fact that a victim's withdrawal of support during an investigation/prosecution should result in the risk level being reviewed then logically it should apply similarly when a prosecution is withdrawn.

22.112 During the review the CPS did not have the capacity to meet with the Report Author, but helpfully a member of the CPS engaged in the review through telephone conversations and electronically.

22.113 This CPS member explained:

> ''The CPS will write to the victim within 24 hours of the decision to discontinue a case involving domestic abuse, explaining our reasons for the decision. This is one of our commitments under the Victims' Code. At the same time, we will notify the Police. Our policy dictates that we must also consult with the Police before the decision to discontinue, explaining why it is proposed to discontinue and inviting representations from the Police before the final decision is made.

22.114 The communication to the Police confirming the discontinuance, and the prior consultation ahead of discontinuance, would normally be sent to the Police Criminal Justice Unit department which is a single point of contact for all CPS/Police communications.''

Recommendation No.10

West Mercia Police to review current policy and working practice to ensure that in the event of discontinuance of a prosecution and/or the withdrawal of support for an

investigation by a victim, this is consistently drawn to the attention of the harm assessment unit for them to consider the need to review the level of risk.

22.115 Whilst subject of probation supervision Richard was responsible for domestic abuse incidents on 22nd September 2013, 24th December 2013 and 4th September 2014 all with Jessica, and in circumstances where alcohol was an aggravating factor. None was proactively shared by West Mercia Police with the Probation Service.

22.116 The Police IMR author comments:

> 'At the time of the incidents Richard was living at (the address) despite the fact that he had told the Probation Service that he was single and not having any contact with Jessica. When Jessica was asked the question, 'had she separated from Richard?' She informed the officer that they had split up in January 2014 and she did not mention that Richard had returned (living at the address). There is nothing to indicate that a referral was made to probation which is a concern as Richard's presence at the home was a significant risk factor'.

22.117 The incident on the 22nd July 2012 was brought to the attention of the Probation Service as a consequence of an application from the Probation Service to Police under Management of Police Information procedures, as part of their routine enquiry process.

22.118 An understanding as to why West Mercia Police did not proactively share the information regarding these incidents (paragraph 22.115 above) with WWMCRC has been established though close examination of Police records.

22.119 West Mercia Police record calls for service on their Operational Information System (OIS). On receipt of a call for service, an OIS log is opened recording basic details of who the caller is and what the nature of the call is. OIS logs are opened in a number of ways, but in this case would have been opened when Jessica attended the Police station front counter.

22.120 West Mercia Police operate a policy known as 'view previous incidents' (VPI). As part of this process control room operators conduct background checks on the address, people linked to it and people linked to the incident. This is intended to give officers better contextual information with regard to the matter they are attending and serves to give advanced notice of possible officer and public protection considerations.

22.121 Within the VPI process extracts felt to be of relevance by control room operators from systems such as PNC, and in West Mercia Police's case their own intelligence system 'GENIE', will be 'cut and pasted' onto the OIS record. Such 'cut and paste' entries are limited in terms of the numbers of characters that can be pasted across to OIS. By way of example, and relevant to this case an offender being managed by probation will be 'flagged' on the Police GENIE intelligence system as probation 'managed'.

22.122 The VPI process does not seek to replace enquiries and intelligence checks officers should make when dealing with a range of matters, and bringing them to conclusion.

22.123 The following 'cut and paste' extract was recorded on the OIS log in respect of the incident on 24th December 2013'

''Signal Code PM PROBATION MANAGED OFFENDER. THIS OFFENDER IS BEING MANAGED BY SHREWSBURY PROBATION OFFICE. THE CURRENT STATUS IS COMMUNITY. IF ARRESTED TH''

22.124 It should be noted that this is a partial extract from the GENIE intelligence system; the full details could not be retrieved.

22.125 The reviewing officer's professional assessment is that this entry would steer officers only to make contact with the Probation Service in the event that;

(i) Richard had been arrested and

(ii) That the officer required further information.

22.126 It is highly likely that this intelligence entry was placed onto the Police GENIE system sometime close to the point at which Richard commenced his suspended sentence supervision order. It was not apparent from this record that Richard was the subject of the BBR programme.

22.127 It was established that control room staff also appended the same cut and paste information on the OIS log relating to the domestic abuse incident of 4th September 2014.

22.128 On the 27th January 2007 Richard, following a domestic argument, was arrested to prevent a further breach of the peace. On this occasion, he had kicked a hole in the kitchen door. The property was a housing association property, and as a consequence, there may have been an opportunity to purse an investigation of criminal damage against him.

22.129 On the 22nd September 2013, 24th December 2013 and 4th September 2014 there were domestic incidents at the home when Richard was subject of the restraining order in respect of Rebecca. It is not clear whether on any of these occasions' officers made direct enquiry of her. Had they done so they would have established that he was in fact conducting himself in a manner that would have constituted a breach of the restraining order, given Rebecca's account recorded earlier in this review?

22.130 This would have presented opportunities for both Police and probation to undertake positive action with Richard.

Recommendation No.11

West Mercia Police to review the feasibility of managing cases where a restraining or other protection order exist by way of a risk management plan.

Recommendation No.12

West Mercia Police to establish a process whereby protection orders are routinely shared with the Probation Service for managed offenders.

22.131 Given Rebecca's explanation that she felt the actions of Richard were 'too minor to tell the Police' the Report Author explored this aspect with the Crown Prosecution Service, and more particularly whether the CPS lawyer making application could engage with those protected by orders during the court process.

22.132 It was established that there could be many occasions when the victim would not be in court and so would not be a practical option.

Recommendation No 13

West Mercia Police witness care unit need to consider, in conjunction with CPS, the most effective practice to engage with victims who are protected by court orders granted as part of criminal proceedings to ensure the victim understand the terms of the order and what would constitute a breach.

Shropshire Council Children's Services

22.133 The Children Act 1989 introduced significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children.

22.134 The local authority, through its Children and Young People Services, has a statutory duty to carry out a section 47 enquiry in any of the following circumstances:

- Where there is information to indicate that a child has suffered or is likely to suffer significant harm;
- Where a child is subject to an emergency order;
- Where a child is subject to Police protection.

22.135 There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes a single violent episode may constitute significant harm but more often, it is an accumulation of significant events, both acute and longstanding, which interrupt damage or change the child's development.

22.136 Physical abuse, sexual abuse, emotional abuse and neglect are all categories of significant harm.

22.137 Harm is also defined as the 'ill treatment or impairment of health and development'. This definition was clarified in section 120 of the Adoption and Children Act 2002 (implemented on 31st January 2005) so that may include, 'for example, impairment suffered from seeing or hearing the ill treatment of another'.

22.138 When conducting a section 47 enquiry there is a legal duty on the local authority to ascertain the child's wishes and feelings regarding the enquiry. The children who are focus of the concern should be spoken to alone by the lead social worker.

22.139 Normally parental consent should be secured, however there are circumstances under which social workers can interview a child without.

22.140 West Mercia Police records show their first referral to children's services concerning Rebecca's exposure to domestic violence at the hand of Richard was made on 12th April 2003, however children's services records which remain do not have a record of it.

22.141 West Mercia Police made seven further referrals notifying children's services of the fact that Rebecca was being exposed to domestic abuse at the hands of Richard, between 24th March 2004 and 11th July 2007.

22.142 On 24th March, 6th August and 6th December 2004 Police notified children's services of Rebecca's exposure to domestic abuse, during which time she had reached her 13th birthday. On 3rd May 2005 Richard was responsible for committing an assault on Rebecca that was also referred to children's services.

22.143 Given either the accumulative effect of the ongoing exposure to domestic abuse or the single incident of violent assault would fit within the category of serious harm towards Rebecca. On that basis, the children's services should have undertaken a section 47 enquiry.

22.144 The children's services IMR author reported;

> 'In respect of the referrals (in 2004) it would have been beneficial for a discussion have taken place between Police and social services. This would have better informed the judgement regarding the risk to the victim's daughter and any subsequent action required to protect her.'

22.145 Concerning the assault on 3rd May 2005 the IMR author reported;

> ''There is no record of children's services undertaking the initial assessment and no record of whether consideration was given to a strategy discussion regarding the physical assault on the daughter. If it was considered, there is no rationale recorded as to why such a discussion was not convened.

22.146 ''There is also no evidence regarding any management direction or advice being given to the social worker''.

22.147 ''The incident resulting in the assault appears to have been treated in the same way as the notifications of domestic violence incidents. This is a significant failing in our duty to safeguard children. There is no doubt that the Child Protection Procedures would have necessitated a section 47 enquiry in these circumstances''.

22.148 ''The child should have been spoken to both directly and separately by a children's social worker, and it would have been beneficial for discussions to have taken place between Police and social services. This would have better informed any judgements regarding the risk to the victim and her daughter and any subsequent action required to protect her''.

22.149 With continuing regard to the assault committed on 3rd May 2005, within the Police referral it is made clear that Richard is the subject of bail conditions in relation to the case.

22.150 Attempts were made by the social worker to contact Jessica by means of a letter on 9th and 17th May and by visiting the home address on 3rd June 2005, at which time a message was left for Jessica to make contact.

22.151 Contact was made with Jessica in the form of two telephone calls on the 3rd and 6th June 2005. During the first conversation Jessica explained she and Richard had separated and had no plans to reconcile their relationship. In the second conversation, she confirmed this but also crucially, Jessica explained that she and Rebecca had withdrawn their statements, and that Rebecca did not want to speak to the social worker.

22.152 ''These actions on the part of the social worker fall short of what is expected in these circumstances, in particular that Rebecca should have been spoken to alone''.

22.153 Concerning analysis of the Police referral of the incident on 27th January 2007 the children's services IMR author identified that:

'The initial assessment did not address all areas required. The family history, family dynamics, relationships and information regarding the perpetrators previous relationships were not assessed'

22.154 The IMR author also helpfully commented:

'The victim's daughter's history of being parented and experiences at that time were not explored in the initial assessment'.

22.155 The expression 'withdrawn their statements' from a victim's perspective indicates, of course, that they have withdrawn their support for any Police investigation. Professionals need to be cognisant of the fact that this presents a need for all professionals to discuss the victim's decision, and to revisit the risk levels they face.

22.156 A joint discussion between Police and social services would inform better understanding of the imposed bail restrictions, and later would have enabled a professional discussion concerning Jessica's explanation that she and Rebecca had 'withdrawn the charges' against Richard, and what that meant for the ongoing levels of risk they faced.

22.157 The Report Author pursued with the social care IMR author the view that children's services were dealing with each incident in isolation and were not considering the cumulative effect of repeated incidents.

22.158 The IMR author confirmed:

'Each individual referral appears to have been considered in isolation and as a consequence, there is no evidence of the incremental concerns, building a picture of increasing risk within the family'.

22.159 This view is upheld further following referral of the incident of the 26th March 2006, The referral from Police is reviewed by children's services on 21st April 2006 when it is recorded that no further action will be taken, the rationale being 'this is almost a year on from the previous referral and no other information or concerns received from any agency during this time'.

22.160 This record entry would also appear to indicate an expectation on the part of children's services, of referrals from other agencies, rather than a proactive approach to seek information from other agencies to inform decisions, judgements and risk assessments.

22.161 Richard at this time was the subject of the six-month community punishment and supervision order imposed on 12th October 2005, following the assault on Rebecca in May 2005. Proactive enquiries with the Probation Service on the part of children's services would have identified this and provided an opportunity to both review the risk and to consider a relevant intervention.

22.162 Following the Police referral of the incident on 27th January 2007 the children's services IMR author identifies that:

'The initial assessment did not address all areas required. The family history, family dynamics, relationships and information regarding the perpetrators previous relationships were not assessed'

22.162 The IMR author also helpfully commented:

'The victim's daughter's history of being parented and experiences at that time were not explored in the initial assessment' and further 'the perpetrator was not contacted directly and neither he nor the victim provided any reassurance that the victim's daughter was safe while they were in a relationship given the nature and history of their relationship. However, the victim's daughter's case was closed and no work completed with the couple. Details of services were offered to the victim. However, statutory services were never offered to the victim's daughter.'

22.163 The IMR author concluded that 'as a consequence, consideration was not given to the victim's daughter's situation being reviewed under either Child in Need or Child Protection Procedures.

22.164 The IMR author also recorded;

'There is no record of any contact being made between Police and social care, and indeed with health professionals who may have had information to contribute'.

22.165 These are of course similar findings to the review of children's services response to the assault on Rebecca in 2005.

Recommendation No.14

Shropshire Council Children's Services to ensure that social workers and managers do not rely on one source of information (alone), in particular self-reporting, and must ensure that there is regular and ongoing dialogue with all key professionals and agencies involved with a family.

22.166 On the occasion of the first recorded contact from West Mercia Police by children's services on the 24th March 2004 records do not make it clear that Richard is Rebecca's biological father, this remains a flaw throughout the duration of children's services involvement with the family.

22.167 Within children's services records on 6th April 2010 there is also an additional child linked to Richard as the father. Critically the case file information identified Richard as having been identified as a domestic abuse risk within a previous relationship and towards this child. As a consequence, the previous child had no contact with their father.

22.168 On these matters the IMR author reported:

'There was an additional child linked to (Richard) but this was not linked to (Rebecca). This case file recorded further incidents of domestic abuse that were not linked,' and comments further:

'There is no record of whether the perpetrator (Richard) is the birth father of (Rebecca) or whether the connection is through the victim (Jessica) and the perpetrator (Richard). The connection between the siblings was therefore not made and the cases not linked in anyway. This further exacerbated the failure to consider the incremental impact on the child and the true picture. The assessment should have considered all siblings and significant relationships but this was omitted from the second assessment and as there is no record of the first assessment it is unclear if this was even considered'.

22.169 The links between Richard and the half siblings were not made. This was a missed opportunity to better understand the whole picture to identify the risks posed by

Richard, and in particular, the incremental impact on Rebecca and the true extent of Richard's domestic abuse, particularly where children were concerned.

22.170 Following discussions between the Report and IMR authors current day activity was modelled on the current Shropshire Council Children's Services system 'Carefirst'. It was established that in the event of a social worker conducting enquiries on a particular child/family the system provides adequate automatic cross-referencing of records.

22.171 The Report Author holds the view that professionals should have been considering whether Jessica was adequately able to protect herself from Richard let alone their daughter. At the least, Jessica outwardly did not appear to be recognising the risk Richard posed to her and Rebecca. Comment has already been made with regard to the potential significance of her 'withdrawing' her statement.

22.172 Within case file notes specifically Jessica stated 'she is not frightened of (Richard)' to the social worker, yet despite this history indicated her repeated abuse at his hands.

22.173 It is widely acknowledged that domestic abuse is significantly under reported; it is therefore highly likely that Jessica as with many victims would only call the Police under more extreme circumstances. This contention is supported from conversations between the Report Author and Jessica's family, Rebecca in particular, who not only confirmed this was the case but should also be considered in the context given by her, that Police were only called on 1 in 20 or 30 of the actual occurrences of domestic abuse.

22.174 In the Report Author's view, it was likely that Jessica was so disempowered by the abuse, coupled with her use of alcohol to help her cope, that it resulted in some impairment of her ability to recognise the full degree of threat that Richard posed to her and her daughter. While the decisions Jessica made may not have fully recognised her own, and Rebecca's vulnerability, they were clearly decisions she took that worked for her and helped her cope with her situation.

22.175 It is also reported that she provided reassurance to social workers concerning her own and Rebecca's welfare. She also told social workers that Rebecca did not wish to speak to them directly.

22.176 It is accepted that social workers should have in fact spoken to Rebecca directly but they did not.

Recommendation No.15

Shropshire Council Children's Services should ensure that all assessments with non-abusing parents are conducted in a therapeutic and supportive manner when considering the parents ability to protect a child.

22.177 Richard should also have been spoken to by a children's services social worker as part of the assessment of risk process as opportunities arose throughout this case.

22.178 Clearly the social worker in the casework in 2007 recognised the importance of meeting with Richard in order to properly assess the levels of risk involved as three attempts were made to meet with him, however the case was closed without direct contact taking place between the social worker and Richard.

22.179 In closing the case on 4th May 2007 the team manager noted 'Mr (Richard) does not reside in the home, stays on a weekend. Ms (Jessica), whilst acknowledging that

(Richard) can be aggressive, feels that she is not frightened of him. If there were any issues, she would not let him in the home. Contact numbers provided to the victim'.

22.180 The Report Author cannot see a marked difference between the threat posed by someone living permanently at an address or 'only staying on weekends'. Given the apparent aggravating involvement of alcohol within this relationship, it would seem likely that a weekend was of a higher degree of risk than a weekday.

22.181 The case record entry would also appear to be at odds with the content of the letter sent to Jessica on the 30th April 2007 by children's services which stated ''Due to concerns for your own and your daughter's safety, Social Services would wish to complete a risk assessment prior to (Richard) staying at your address''. This would presumably include 'staying at weekends'.

22.182 Following the Police referral to children's services of the details of the incident on 30th June 2007, children's services decided to take no further action (on the basis that the Police referral made it clear that the parties were not in a relationship). This was a missed opportunity to revisit the risk assessment process as indicated in the letter to Jessica on the 30th April 2007. It should have as a minimum prompted a discussion between Police and social services to check the voracity of the claim that Richard was not living at the address and/or resumed the relationship with Jessica.

Recommendation No.16

Shropshire Council Children's services to ensure that in every case the perpetrator is seen and an assessment in respect of the risk posed by the perpetrator to the child should be completed.

22.183 From an overview perspective the IMR author reports that from her review of case files; 'the involvement of senior managers was not deemed relevant during either period of social work involvement. This is appropriate; however, given that the first line manager did not manage the case appropriately, the level of risk was not assessed correctly and was not stepped up to trigger a formal child protection investigation. Had this occurred the case may have been subject to a higher level of scrutiny.'

Recommendation No.17

Shropshire Council Children's Services must ensure that their audit activity ensures that there is sufficient scrutiny of case decisions, case recording and management oversight.

22.184 This section cannot be concluded without the following contextual narrative. Children's services had closed Rebecca's case in 2007. The significance of the collective failings of services reported above to appropriately action child protection activity, and the closure of the case in 2007 is stark from this point on.

22.185 In May and June 2010 West Mercia Police failed to notify children's services of further domestic abuse incidents at the hands of her father.

22.186 By 2010 children's services were in possession of information relating to Rebecca's half siblings which indicated clearly that Richard had posed risk of domestic abuse to his children during a previous relationship.

22.187 Given the open and transparent acknowledgement by services that interventions should have taken place earlier in Rebecca's childhood, these facts presented a last

opportunity for children's services led intervention prior to her 18th birthday, which was in July of 2010.

22.188 Having been failed as a child she was no longer able to benefit from the opportunity of state intervention by children's services to protect her from abuse at the hands of her father.

Shrewsbury and Telford Hospitals NHS Trust (SaTH)

22.189 The IMR author outlined the following in respect of staff at SaTH:

> 'All nursing staff have had Domestic Abuse training since 2010, as well as having annual updates. All medical staff in the emergency department have had Basic Awareness of Child Protection Training together with safeguarding training as part of their induction to the department. In the last two years, the medical staff have also had Domestic Abuse Awareness Training and information on how to complete a Multi-Agency Risk Assessment Conference (MARAC) referral. The Trust does have a domestic abuse guideline and flowchart on how to deal with victims of domestic abuse and their children under 18 years of age'.

22.190 On 2nd May 2009 Jessica attended the emergency department (ED) of the Royal Shrewsbury Hospital. She reported to have tripped over a roll of wallpaper and hit her head on a hoover. The wound required three sutures; she was discharged from ED, and told to make an appointment with her GP for the sutures to be removed.

22.191 This was during the period 2007-2010 where no reports of domestic abuse were made to West Mercia Police and was an important opportunity for staff at the emergency department to have engaged more thoroughly with Jessica on the cause of her head injury, and indeed to directly enquire about the prevalence of domestic abuse at home. Enquiry by the staff may have resulted in disclosure of domestic abuse that was otherwise not being reported by her.

22.192 Richard attended the emergency department on two occasions, the first as a self-referral on 11th May 2012 and the second under Police escort on 4th December 2012. On both occasions, it was clear to emergency department staff that he presented a domestically abusive risk to members of his family. This was recorded in his medical notes on both occasions.

22.193 On neither of these occasions were conversations held with Richard regarding the welfare of anyone at home, nor were there any references to him being a domestic abuse risk to family members in the GP letters of referral detailing his attendance at the ED.

22.194 Additionally, on the 4th December 2012 there is nothing recorded in his medical notes to indicate he was offered the support of the alcohol liaison team given his recorded heavy drinking, nor is anything documented concerning his status as a Police detainee.

22.195 The standard discharge letter sent to Richard's GP informing the practice of his attendance at the emergency department with chest pain, does not refer to his status as a detained person suspected of domestic abuse against his daughter.

22.196 SaTH has emergency departments at Shrewsbury and Telford. The review established that one of six consultants across both of the ED's undertakes effective practice to routinely inform GP's of the domestic abuse risk presented by particular patients in the ED.

Recommendation No.18

SaTH to introduce as a requirement for all cases where a patient presents a domestic abuse risk to family members to be formally communicated to the GP.

22.197 With specific regard to the attendance at the emergency department on the 4th December 2012 there is no record of any information from Police concerning whether he was still 'under arrest' or had in fact either been released on bail or de-arrested'

Recommendation No.19

SaTH and West Mercia Police establish a joint policy on how information should be passed between each other, including what and how it should be documented.

22.198 Recommendation 6 of the NICE guideline PH50 February 2014 'Domestic Violence and Abuse; Multi-agency working' states:

'Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse'

'This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse'.

22.199 Concerning responses to the terms of reference with regard to the use of the MARAC process the IMR author reports:

'As neither victim (referring to both Jessica and Rebecca) were in the ED on either occasion it would have been difficult for the ED staff to make a MARAC referral or discuss the situation at home with them. It is not known what discussions occurred between health and Police at the attendance in ED when Richard attended in Police custody.'

22.200 At the time of this review SaTH had recently commenced their own review of their policy and procedure on responding to incidents of domestic abuse. In conjunction with the domestic abuse lead for SaTH (who was also the IMR author) the Report Author felt that a composite of areas for exploration within that review would be more productive than a list of individual recommendations.

Recommendation No.20

SaTH's domestic abuse policy and procedures to be reviewed.

The review should incorporate the following areas:

1. Guidance to staff on recommendation 6 NICE guideline PH50 February 2014.
2. Establish/follow NICE guidance to staff on dealing with perpetrators
3. The current policy and procedure is wholly compliant with child protection procedures and therefore deals with the matter of children under 18 years of age, but by definition and as shown in this case there is currently no NICE guidance to staff on dealing with sons and daughters (of perpetrators) who have attained the age of 18 years and are victims of their abuse.
4. Empowerment of staff to have open and frank discussions with patients, including support for them to be professionally sceptical, but supportive to patients within those discussions.

5. Staff to enquire with perpetrators of the welfare of those normally resident at the home
6. Given the responses within the IMR on MARAC not being able to be considered in the absence of a victim being present, to consider how the information given by a perpetrator should be appropriately actioned/shared with other agencies.
7. Guidance on the referral process for the IDVA service (to speak to a patient)
8. Health Visitors and School Nurses currently receive a copy of the Safeguarding Information Sheet where children are involved in DV situation. This should be extended to include information being provided to the relevant GP practice.

22.201 The review established that SaTH record 'domestic abuse victim alerts' on their patient record system concerning those victims subject of MARAC.

Recommendation No.21

SaTH should explore how 'alerts' may be applied to high risk perpetrators of domestic abuse as identified by MAPPA and MARAC processes.

(It is acknowledged that there may be some limitations on the patient record system which could only be addressed at a national level).

Shropshire Clinical Commissioning Group (CCG)

22.202 On 11th August 2016 the review author met with a GP practice partner and the practice manager of the surgery where Jessica was registered as a patient.

22.203 There was little in the way of learning opportunity with regard to Jessica's specific case, however what did emerge from the conversation was the fact there would seem to be benefit in the CCG establishing a process whereby GP practices are better informed of the status of their patients when known or suspected to be victims of domestic abuse.

Recommendation No.22

Shropshire Clinical Commissioning Group to work with Shropshire Community Safety Partnership to put in place an information sharing arrangements concerning patients who are identified as victims of domestic abuse.

Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC)

22.204 Richard was first placed under the supervision of the Probation Service in January 2012 at which time he was managed by the former West Mercia Probation Trust. The Probation Service IMR author helpfully outlines the impact of government policy introduced at this time.

22.205 'In May 2013 the Ministry of Justice announced major changes to the delivery of Probation Services publishing; 'Transforming Rehabilitation: A Strategy for Reform'. The former Probation Trusts were split into a public sector National Probation Service (NPS) and 21 private Community Rehabilitation Companies.

22.206 During April 2014 in preparation for the split a major restructure occurred in which all staff were re-assigned to their new organisations and the entire caseload was subject to sifting, appraisal and assignment or transfer to either of the NPS or WWMCRC depending on the risk level of the case.

22.207 On 1st June 2014, West Mercia Probation Trust was replaced by the NPS, which manages high-risk offenders and the new Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC) managing the medium and low-risk offenders.

22.208 The Probation Service IMR author explained that ''all Probation Officers (PO's), in this case had a nationally recognised qualification. Probation Service Officers (PSO's), as part of their core training, undertake a course on working with perpetrators of domestic violence. PSO's involved in the delivery of the Building Better Relationships programme complete an intensive course to qualify as a programme tutor.

22.209 POs and PSOs are trained to understand the completion of the Spousal Assault Risk Assessment (SARA) and Offender Assessment System (OASY) assessment processes''.

22.210 The IMR author explained:

''This case was therefore being managed at a time when the Probation Service was undergoing this significant change. This extremely busy period of organisational change saw large numbers of cases handed from one Offender Manager to another within a short period of time, and normal Probation Service practice relating to the quality of handover of cases was adversely affected, often with no in depth discussion on the issues.

22.211 During this case Richard had involvement with a number of members of probation staff. The split in the delivery of Probation Services meant that POs 1 and 2 and Senior Probation Officer (SPO) 1 transferred to the National Probation Service and PO3, PSOs 1 and 2 and SPOs 2 and 3 moving across to WWMCRC''. (This service split coming into effect on 1st June 2014).

22.212 WWMCRC use the Offender Assessment System (OASY) developed jointly by the prison and Probation Services. OASY is designed to:

- Assess how likely an offender is to be reconvicted
- Identify and classify offending related needs
- Assist with management of risk of harm
- Links assessments, supervision and sentence plans
- Indicate any need for further specialist assessments
- Measure how an offender changes during the period of supervision/sentence

22.213 OASY informs the risk assessment of the offender's risk of reoffending and risk of serious harm.

22.214 WWMCRC also uses the Spousal Assault Risk Assessment (SARA) tool which helps probation staff predict the likelihood of domestic violence.

22.215 The SARA assessment screens for risk factors in individuals suspected of being treated for spousal or family related assault. It helps to determine the degree to which an individual poses a threat to his spouse, children, family members or other people involved.

22.216 As a legacy position from the former West Mercia Probation Trust both the NPS and WWMCRC are signatories to the Shropshire Domestic Abuse 'Sharing of Information Procedures' and MARAC process. WWMCRC therefore undertake domestic violence checks with the Police.

22.217 On 2nd April 2012 Richard received a two-year community order with a requirement for him to complete the Integrated Domestic Abuse Programme (IDAP).

22.218 The IDAP is a nationally accredited community based group work programme designed to reduce reoffending by adult male domestic violence offenders.

22.219 IDAP requires cooperation between the agencies concerned with domestic violence and prioritises women and children's safety. It is delivered within the Multi Agency Public Protection Arrangements (MAPPA). IDAP can be a requirement of a community order or suspended sentence order. It must be accompanied by a supervision requirement.

22.220 The IMR author explained:

> ''It was not possible for (Richard) to commence IDAP prior to being sentenced to the new Suspended Sentence Supervision Order (SSSO) in March 2013. It was explained by the programme tutor that there was a delay due to the programme changing from IDAP to BBR and the need for tutors to be trained in the new programme''.

22.221 In 12th March 2013 Richard was sentenced to a 2 year suspended sentence, supervision order, the Building Better Relationships (BBR) programme and alcohol treatment requirement (ATR).

22.222 The BBR programme is a 28-session programme for men who have been violent in their relationships and the aim is to:

- Reduce reoffending and promote the safety of current and future partners and children
- Work collaboratively with other agencies to assist offenders in managing their risk of intimate partner violence

22.223 The Alcohol Treatment Requirement (ATR) focuses on offenders who are dependent on alcohol or whose alcohol use contributes to their offending. The aim is to reduce or eliminate the offender's dependency on alcohol.

22.224 The Probation Service also works with the victims and partners of men completing the Probation accredited community domestic violence programmes Integrated Domestic Abuse Programme (IDAP) and more recently the Building Better Relationships (BBR) programme. This is conducted through its Woman Safety Worker (WSW) role.

22.225 The WSW role is an integral feature of the delivery of domestic violence interventions within the National Probation Service Domestic Abuse strategy as part of the coordinated community response to domestic violence. The WSW role maintains a focus on the safety of victims whilst intervening with the perpetrator.

22.226 The WSW role includes:

- Safety planning to alleviate immediate and longer term risk;
- Contribution to risk assessment and management and potential contribution to Multi Agency Risk Assessment Conferences (MARAC) and Multi Agency Public Protection Arrangements (MAPPA);
- Signposting resources available in the community and advising on legal and civil sanctions;

- Informing ex/current female partners about the programme and the man's attendance on the programme.

22.227 In November 2011 Richard was sentenced to the 12-month community order (supervision; alcohol treatment requirement, unpaid work). Whilst subject to this order he was convicted of a further section 39 common assault against his partner Jessica, and sentenced in April 2012 to a two-year community order (Supervision and Integrated Domestic Abuse Programme requirements). He was subsequently convicted in March 2013 of a third offence of section 39 common assault against his daughter and was sentenced to 5 months imprisonment wholly suspended for two years, and a 2 year supervision order (Supervision; Building Better Relationships programme and 6 month alcohol treatment requirement).

22.228 On this latter occasion he was also made subject of a restraining order to prevent him from behaving in a 'threatening or abusive manner' towards his daughter Rebecca.

22.229 Regarding this order the IMR author reports:

> ''Whilst there is reference to a Restraining Order in place to prevent Richard from contacting his daughter Rebecca at the start of the suspended sentence supervision order (SSSO) there is limited further detail in regard to how this is being enforced or operated or any liaison with the Police regarding the restraining order''.

22.230 Richard's initial post sentence assessment was completed by PO1 in January 2012 following his conviction for assault on Rebecca committed in November 2011.

22.231 The IMR author records that:

> ''The assessment was completed to a satisfactory standard using information available collected at the pre-sentence report interview and accompanying court papers. There was appropriate referencing to previous domestic abuse history. Although there were no known domestic abuse convictions at that time there was call out information that indicated previous information relating to the same victim.

22.232 The OASY risk assessment from January 2012 provided a good indication of potential risks and a comprehensive risk management plan. The SARA was completed and indicated the level of his risk to be low.

22.233 This would be appropriate on the basis of his first conviction for domestic violence.

22.234 The SARA risk level was raised to medium when Richard committed the further offences of assault on Jessica and criminal damage to Rebecca's television on 16th January 2012. This assessment appropriately linked alcohol consumption to behaviours and identified the need for Richard to address his alcohol misuse and complete an alcohol treatment requirement''.

22.235 The IMR author reports that ''PO 2 completed subsequent assessments from 22nd March 2013, including the post sentence assessment at the start of the last period of supervision. PO 2 noted an escalation of violence towards family members, ongoing concerns about his under reporting of alcohol misuse and his lack of victim awareness''.

22.236 Within the pre-sentence report dated 12th March 2013 there is reference to domestic violence checks being carried out by PO 1'', who noted ''seven incidents of Police being called in relation to (Richard) over the preceding twelve month period for

emotional domestic abuse''. (Emotional domestic abuse being incidents where no substantive criminal offence has been committed).

22.237 ''Whilst the risk assessments and risk management plans at the post sentence stage are comprehensive, with noticeable amendments to reflect new periods of supervision, it is apparent that up dated assessments relied heavily on the previous assessments and plans as opposed to a more detailed discussion about the threats he posed to his family due to continued offending''.

Recommendation No.23

WWMCRC to ensure that assessments provide a clear summary of circumstance at point of actual case review and not to be focussed purely on historical information.

22.238 The IMR author identified the following concerning the frequency of case reviews:

''OASY and SARA reviews took place when there was further conviction and/or every six months whilst (Richard) was under supervision, however the frequency of reviews declined after February 2014 when no subsequent reviews took place. There was a further review in February 2014 following completion of the BBR programme.

22.239 The IMR author provides comment that POs 1 and 2 had made professional judgement entries in line with policy, and continued:

''Following the transfer of (Richard's) case to PO 3 in April 2014 there are no further OASY reviews although there was a professional judgement entry on 9th October 2014 explaining that the case was due to be returned to court for good progress.''

22.240 Analysis has been provided with the section 'actions of the Police', concerning Richard's domestic abuse when subject of probation supervision. It is identified that the Police service did not inform WWMCRC of any but one of these occasions. To provide balance it should also be recorded that WWMCRC only proactively sought information on one occasion from West Mercia Police.

22.241 The importance of proactive enquiry is demonstrated following the explanation given as to why the information was not routinely shared with the Probation Service (paragraphs 22.118 - 22.127 page 57). Had a proactive enquiry been made the information would have been shared and the poorly worded entry on the Police intelligence system may have been understood at an earlier juncture.

22.242 Reviews were conducted in September 2013 after Richard had completed the alcohol treatment requirement, and in February 2014 when he completed the Building Better Relationships programme, from this point on the frequency of reviews declines significantly.

22.243 In the view of the probation IMR author:

''The assessment was based on static risk factors and did not consider dynamic risk factors i.e. changing circumstances or significant events. There was no evidence of the West Mercia Police DASH risk assessment being used to inform the risk assessment processes.

There were no home visits undertaken when they should have been on a number of occasions which presented themselves, there was no liaison between the Offender Manager and the Police domestic violence unit, and no women's safety worker was allocated to the victim.

The case was allocated to PO 2, in the view of the IMR author from his review of the case documents, 'there was very little evidence in addressing relationships and managing the risks he presented to his daughter and partner'. The IMR author believes that this was 'because he was said to be living with his parents but his address was never verified whilst he was under probation supervision. This was a major flaw running throughout the management of this case''.

22.244 The IMR author identifies that ''information received from all staff in this case was broadly consistent in that there was a belief that Richard's risk was reduced because he was not living at the family home, and during the period of the SSSO was no longer in a relationship with his partner Jessica. However there was no corroborating information available to verify if this was the case or not''.

22.245 On the 14th February 2012 when Richard informed the probation officer that he was no longer living at the address, a factor which was considered to reduce the risk he posed, no action was taken to verify this fact. The IMR author concluded this ''should have included a home visit and a discussion with the victim''.

22.246 On the 29th February 2012 when a professional judgement entry is placed on the probation case notes detailing the risk Richard presented to women no protective measures were put in place in the respect of Jessica and Rebecca. The IMR author is of the view that this was because ''the focus was on addressing the perpetrators alcohol misuse''.

22.247 When Richard was convicted of the assault on Jessica and criminal damage to Rebecca's television a women's safety worker should have been allocated. This was not done and is described by the IMR author as a 'fundamental error and remains a flaw throughout the period of contact between the perpetrator and the Probation Service''.

22.248 On the 27th September 2012 the Offender Manager made a professional judgement decision to reduce Richard's supervision to monthly on the basis that he was due to commence the BBR programme.

22.249 The reviewing probation IMR author viewed this as a wrong decision given that Richard was living back at the home and still presented a risk to the victim and their daughter, and there was no indication of the risk level being reduced. The Report Author concurs with this given that opportunities to review the risk had presented themselves on numerous occasions and had not been undertaken.

22.250 On the 12th June 2012 during an appointment Richard indicated he was spending more time at Jessica's home, and the Offender Manager noted that Richard blamed alcohol for the dysfunctional relationship and showed ''very little insight in to his own behaviour and attitudes towards women''.

22.252 The IMR author recorded this as 'a significant event, again no protective measures such as a home visit or discussion with the victim were undertaken. Also there was no review of the level of risk presented'.

22.253 On the 22nd July 2012 when Richard had a domestic argument with his daughter he was still the subject of the community order imposed on 21st November 2012. The IMR author reported that ''on this occasion the Probation Service should have had contact with the daughter and the victim and considered their risk assessment''.

22.254 On the 24th July 2012 the Probation Service were made aware that Richard was now living at home with the victim as their daughter had moved out. Again, a review of risk should have been undertaken to verify the actual address of their daughter and to check the welfare and safety of the victim.

22.255 Similarly on 21st August 2012 when probation were informed the daughter had moved back home, a home visit should have been conducted, with a view to considering protective/preventative action required to ensure the safety of both the daughter and victim.

22.256 On the 1st September 2012 when Richard informed his probation officer that he was no longer drinking heavily and that he felt his alcohol was under control, this again should have triggered a review of the risk status and attracted a home visit and consideration of necessary protective measures. The reviewing probation IMR author reported that again 'there was too much focus on the alcohol misuse rather than a focus on relationships between the perpetrator and his daughter'.

22.257 On the 27th September 2012 the Offender Manager made the decision that as Richard would be commencing the Building Better Relationships (BBR) programme on the 8th October 2012 his supervision should be reduced to monthly meetings.

22.258 The reviewing Probation IMR author viewed this as a wrong decision given that Richard was living back at the home and still presented a risk to the victim and their daughter, and there is no indication of the risk level being reduced. The Report Author again concurs with this given that opportunities to review the risk have presented themselves on numerous occasions and they have not been undertaken.

22.259 On the 6th November 2012 when the Offender Manager noted that Richard was living with Jessica and Rebecca and had a poor attitude with regard to his expectations of them, it should again have caused a review of the risks posed.

22.260 On the 11th December 2012 when Richard informed his probation officer that he had been arrested and was on Police bail for assaulting his daughter this should also have resulted in a review of the risk posed by the perpetrator but the Offender Manager took no action.

22.261 On the 8th January 2013 again when Richard informed his probation officer that he was having contact with the victim the Offender Manager should have contacted the Police and other partner agencies, and also conducted a home visit with the overall aim of again reviewing the risk posed by the perpetrator. This was not done.

22.262 On the 15th January 2013 again when Richard informed his probation officer that he was in contact with the victim the Offender Manager took no appropriate action, and in fact informed the perpetrator that he needed to have his bail conditions varied.

22.263 On the 12th February 2013 Richard informed the Offender Manager that he was no longer in contact with Jessica as they had argued. Again, the Offender Manager failed to make any checks with the victim or her daughter.

22.264 With regard to the sentence planning for the assault conviction on 12th October 2005 the IMR author reported ''given the number of incidents and the domestic violence offence the pre-sentence report authors should have proposed the domestic violence accredited programme''.

22.265 He goes on to explain that ''the pre-sentence report author however felt that the offender's attitude and behaviour in relationships could be addressed during one to one supervision and that his alcohol misuse was the major factor in his offending''.

22.266 PO 2 had written comprehensive pre-sentence reports with robust sentence plans. Richard was assessed as medium risk of harm. The IMR authors view is that 'given the pattern of offending and number of convicted and unconvicted violence perpetrated against partners when he is in a relationship I would have considered him to be high risk, especially when he has been drinking''.

Recommendation No.24

WWMCRC introduce a policy for mandatory home visits to all offenders with domestic violence issues in order to verify residence and to commence contact/engagement with victim.

22.267 No women's safety worker was allocated to the victim as no referral was made by the probation officer, and this was not picked up by the BBR programme tutor.

The IMR author reported:

''The consequence of this was a distinct lack of victim focus in this case, and missed opportunities to properly and fully understand the risks posed to both Rebecca and her mother''.

Recommendation No.25

WWMCRC BBR programmes lead must check before commencing the programme to ensure that a referral has been made to the Women's Safety Worker and that a response has been received. This is to ensure contact has been made with victims.

Recommendation No.26

WWMCRC ensure all Offender Managers are appropriately trained and informed of public protection issues with regard to the victims of domestic violence cases. This will improve victim awareness and understanding with a view to reducing the number of repeat victims. To be completed end of March 2017.

22.268 With regard to the monitoring of Richard's progress on the BBR and ATR the IMR Author reports:

''The BBR tutor provided diligent feedback to the Offender Manager about Richard's progress. In particular, the tutor drew the Offender Manager's attention to matters that needed to be addressed such as Richard's continued contact with Jessica and his visits to the home address.

He continued:

'it is clear from the case file that there was a lack of response from PO 2 nor was there any discussion with the BBR tutor about Richard's progress or lack thereof. There was no evidence of this case being discussed in supervision and hence there was very little management oversight as it was not brought to the attention of SPO's. The only protective factors put in place was weekly reporting and attendance at the BBR and ATR programmes.

22.269 Despite Richard having regular contact with Jessica and Rebecca the Offender Manager took no action with regard to change of risk or protective factors. PSO 1 felt

that PO 2 did not engage well with the programme tutors and did not review or discuss feedback with them on matters of risk, attitude and behaviour that needed addressing post programme.

22.271 Similarly on the 9th April 2014 during a supervision meeting the Offender Manager does not challenge the perpetrator regarding his contact with the victim.

Recommendation No.27

The CRC are to ensure staff understand the need to make quality professional judgements in response to significant events or changes of circumstances. This would improve practice in recording and evidencing defensible decision- making. Quality assurance audit will take place monthly during individual supervision and learning from audits will be discussed during monthly team meetings.

22.272 Richard regularly attended the alcohol treatment requirement appointments, but according to the alcohol worker, PSO 1 and PO 2 he was not very truthful about the extent of his drinking. They also report that he never did take any responsibility for his behaviour and blamed the victims for the violence he perpetrated''.

22.273 On reviewing Richard's case file in respect of the alcohol treatment requirement the service provider reports that 'he had received a previous ATR order that had been delivered by IMPACT, and that ''he had not always been honest with his reported alcohol use''.

22.274 During the conversation between Richard and the Report Author Richard openly stated that it was easy for him to be inaccurate when reporting how much he had been drinking, he explained he simply had to fill in a form self-declaring his drinking levels. He did state however that at some points he had genuinely reduced his drinking.

22.275 Additionally when Richard described his probation appointments the Report Author formed the view that the Offender Manager was less than robust. Richard explained that on attending one appointment the Offender Manager had gone out, ironically on a home visit, presumably to another offender. Richard also described the meetings as being very brief, sometimes only a few minutes long.

22.276 One crucial aspect of this case is that the IMR author is of the view that despite completing the BBR Richard had not in fact changed his behaviours and attitude towards Jessica and Rebecca. The Report Author concurs with this view based upon his conversation with Richard. The overarching conclusion of the IMR author is that it was apparent whilst Richard was attending the required elements of the alcohol treatment order and BBR, he was not engaging. It was noted by the tutors that the learning was not embedded and his response was assessed as being superficial.

22.277 By way of example when Richard was asked for his view of the Police approach when responding to domestic abuse incidents involving him Richard stated 'that they always took the side of the person whose name was on the rent book'. (In this, case the victim Jessica, as she was the sole tenant of the property). This was typical of the type of responses he gave during their meeting. Richard was robustly challenged by the Report Author who pointed out that the Police response was based upon the fact that she was the victim of domestic abuse at his hands and not in any way related to ownership or tenancy of a property.

Recommendation No.28

WWMCRC programmes team to ensure there is improved communication between Programme Tutors and Offender Managers to ensure information is exchanged appropriately and consolidated into offender supervision.

Recommendation No.29

WWMCRC to conduct an audit of management oversight in domestic violence cases, to ensure the offender management checklist is being used appropriately and the manager has a grasp of the issues in the case.

Recommendation No.30

WWMCRC conduct a risk audit following up on the audit conducted in January 2016.

Identified issues of good practice

22.278 It was reported by the National Probation Service that locally the Police service are very timely in their response to Probation Service applications under Management of Police Information protocols. Responses are within 24 hours, which is significantly better than in many other areas of the country.

22.279 The following effective practice was recognised within the review of SaTH procedures and should continue:

- Staff to be advised to continue to take advice from the Domestic Abuse Lead Nurse or the Adults Safeguarding Lead Nurse where necessary.
- All new staff members to continue to attend induction training (includes Domestic Abuse, Child Protection and Adult Safeguarding)
- Ongoing monitoring of training attendance for staff at safeguarding (includes Domestic Abuse, Child Protection and Adult Safeguarding)
- Emergency Department nursing and medical staff to continue to receive annual training and refreshers.
- All staff in ED to receive at least annual safeguarding supervision to discuss cases and lessons learned.
- The Trust to continue to be a proactive partner agency at both Safeguarding Adult and Children's Boards; as well as a partner agency within the MARAC process.

23. Changes since this incident occurred

23.1 Since this incident occurred West Mercia Police have revised their approach to the conduct of the DASH risk assessment. Current procedure requires initial responding officers to ask all 30 DASH questions in full and to submit the full DASH electronically as it forms a constituent part of the incident reporting form CO1. The additional questions asked by Police are:

(i) who has answered the questions (within the DASH)?

(ii) Has a Domestic Violence Protection Notice been considered and not proceeded with? In the event of answering 'yes' to this question the officer is required to record their rationale.

23.2 This revised process benefits from better supervisory oversight and timelier submission of the full DASH to the DAU. It also leads to a fuller picture being

provided to the DAU and removes the need for the reassessment process to be conducted, (the former requirement being completion of Part 2 of the DASH). This earlier submission of the full assessment also removes the previous time delays which existed whilst part 2 assessments were completed.

23.3 Whilst these developments should be viewed as welcome and a positive development they still do not remove the need for a risk management plan to be put in place where the assessment reveals a need for monitoring of circumstances which can change dynamically, in this case, by way of example, bail conditions and place of residence.

23.4 West Mercia Police have also introduced a process of dynamically reviewing all domestic abuse incidents within a multi-agency setting, this process is known as 'Every Victim of Domestic Abuse (EVODA)'.

23.5 In terms of sharing the details of domestic abuse crimes and incidents West Mercia Police share the full details of the modus operandi (the circumstances on how and when things happened). This ensures that matters such as in this case, where an offender displays certain high-risk characteristics, the full details are known to partner agencies.

23.6 West Mercia Police have developed a bespoke training package to encourage officers to take a broader view and to exercise their professional judgement when considering 'vulnerability'. This training is considered to be directly applicable to the area of taking a broader view of risk that has been identified within this review, in particular during the completion of the DASH risk assessment

23.7 West Mercia Police have recently undergone a programme where the IDVA service have visited all patrol teams during briefing to provide an overview of the services that they can provide to domestic abuse victims. This involved a short presentation followed by a question and answer session.

23.8 The feedback has been positive as officers now have a better understanding of the IDVA service and can therefore better articulate the value of the IDVA service and encourage victims to engage.

23.9 Shropshire Council Children's Services now have case information recorded on IT automated which operates in a manner to ensure full risk history and family and relationship profiles are fully understood.

23.10 When parents/carers are reluctant to enable social workers to speak to a child it is now routine practice for professional decision making to consider the need to convene a section 47 (Children's Act 1989) strategy meeting.

23.11 The Women's Safety Worker employed as a support to the victims of perpetrators who are undertaking domestic abuse intervention programmes are now known as the Partner Link worker. This is to reflect the shift to acknowledge there are occasions when the victim may be male.

24. Overarching Recommendations

24.1 Information sharing on Offender Management

24.1.1 There remains a need to explore with Police and National Probation Service/CRC the issue of information sharing concerning managed offenders, sentences, community orders, civil protection orders etc. Currently no obvious IT solution is apparent.

Recommendation No 31

Shropshire Community Safety Partnership to arrange a multi-agency workshop to explore current and desired contribution to the 'Every Victim of Domestic Abuse' (EVODA), daily briefing process.

24.1.2 Within the above discussion should be centred on the following factors:

24.1.3 OASY and offender violence prediction processes are not currently shared with Police to inform their risk assessment processes. Similarly, DASH risk assessments are not currently shared with Probation Services. There would appear to be an opportunity to bring some synergy to these two processes, one being offender focussed the other being victim focussed.

24.1.4 This process should afford the opportunity for information to then be shared with the broader partnership to enable joined up process to exist, for example children's services would in turn be able to identify where families were subject to child protection interventions, and visiting agencies could be the eyes and ears of the broader partnership.

24.1.5 West Mercia Police witness care unit should ensure the existence of court orders are brought to the attention of harm assessment units and risk management plans should be considered in appropriate cases.

24.2. Information sharing on Children's Services interventions

24.2.1 The panel extensively discussed the period between 2007 and 2010 when there were no reported incidents of domestic abuse against a 'professional judgement' background by the panel that Jessica would most likely still have been the victim of ongoing abuse.

24.2.2 A working theory was that the 'threat' (from Jessica's perspective) of children's services interventions (''Due to concerns for your own and your daughter's safety, Social Services would wish to complete a risk assessment prior to (Richard) staying at your address'') may have caused her to avoid calling Police for help.

24.2.3 Building upon this the panel felt that it would be advantageous if children's services interventions were better signposted to the multi-agency partnership to ensure any reduction in reporting reflects a genuine reduction in offending behaviour and risk faced by the victim, rather than a reluctance to engage with the 'system'. It has been established that Police could cause a crime record to re-open at a set interval following any such intervention.

One suggestion has been that the delivery of such a message may be better from a support agency e.g. IDVA service where they are engaged with a victim.

Recommendation No 32

Shropshire Community Safety Partnership to arrange a task and finish group workshop to establish a multi-agency approach to the delivery of 'intervention letter' to a family and a process of periodic review.

24.3 IDVA service returns on 'did not enter service' or 'no contact made'

24.3.1 In exploring whether Rebecca had entered the IDVA service following referral from the Police on 6th December 2011 it was established that the process is for the IDVA service to contact victims who consent to having their details passed to the service. If the victim is not contacted after three attempts, the referring agency will be notified so that they can find alternative contact methods.
Victims who do not consent to having their details passed to the IDVA service will not be contacted by the IDVA. Consent is obtained by the agency who has contact with the victim, in most cases, this is the Police, but a small number are referred by other agencies such as health or children's social care.

24.3.2 The review established that in 2015-16 West Mercia Women's Aid received 1413 referrals for the IDVA service. Of those 26 were still at the referral stage at the end of March 2016.

24.3.3 Of the remainder 73% (1032) of victims were successfully contacted by the IDVA service, of which 89% (915) received support, but 11% (117) declined support.

24.4.4 In 25% (355) of the cases the IDVA was unable to make contact with the victim and in accordance with the policy; this was notified to the referring agency.

Recommendation No 33

Shropshire Community Safety Partnership to coordinate a multi-agency review of where returned referrals are received, to ensure they are appropriately re assessed for levels of risk, and to put in place procedures to provide further response and/or support to the victim.

24.1 Escalation procedures

24.4.1 Given the number of failings across organisations to share relevant information at all in some cases, and in a timely manner in others, it is apparent that escalation processes should have been invoked.

24.4.2 In September 2015 HMIC published 'In Harm's Way. The role of the Police in keeping children safe'. This found that ''most areas had policies and procedures in place for 'escalating concern' (i.e. when staff are concerned that another sector or another agency is not fulfilling its responsibilities, they could report the matter to more senior staff who would then take up the matter with their counterpart in the other organisation or section) We saw very little evidence of this facility being used by staff even though complaints about other agencies or other parts of the Police service were widespread''.

24.4.3 It would seem inappropriate to use this inspection finding of one agency, the Police service, to place wholesale responsibility on them to undertake escalation activity. It should be considered a multi-agency function. It is acknowledged however that the Police are responsible for the significant majority of initial referrals, and therefore they have the more significant opportunity/responsibility for matters to be tracked from another agencies decision-making perspective.

24.4.4 The panel felt that there was a need to reinforce local escalation procedures so that they are widely understood across both statutory and voluntary agencies.

Recommendation No 34

Shropshire Safeguarding Children's Board to re-launch their policy on ''Professional Disagreements and Escalation Procedure''.

25. Conclusions

25.1 In reaching a conclusion the review the panel have been cognisant of the wisdom offered in the following:

''We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lead to the application of hindsight and that looking back to learn lessons often benefits from that very practice. We have however made every effort to avoid such an approach where possible''. [10]

25.2 The following factors have been taken into account, recorded as matters of fact established during the review and reported on within the analysis. The obvious questions which arise from these matters have been addressed earlier in this report.

25.3 The failure of services to effectively engage Jessica in properly informed assessments of the risks she faced posed a significant challenge to those endeavouring to make reasoned risk assessments.

25.4 Specifically it is known that during children's services initial assessments conducted in 2007 Jessica inaccurately reported that she and Richard had separated. Later in her life Jessica denied to her work colleagues, that she had resumed a relationship with Richard even when they told her they suspected otherwise (because of how she was presenting in the workplace). In July 2014 during the Police DASH risk assessment process Jessica stated to the officer that she and Richard had separated in January 2014.

25.5 Jessica's family confirmed that she would deny being the victim of abuse, even when she had obvious facial injuries, and Rebecca specifically described her mothers and fathers relationship as having resumed 'in secret'.

25.6 The Women's Aid panel members pointed out that when agencies were being less than robust in their responses to domestic abuse, from Jessica's perspective they were potentially minimising the risks she faced.

25.7 Failure to effectively engage victims of domestic abuse is not uncommon. It is for this reason that continuing and repeated attempts across the multi-agency system should be made to give opportunities for victims to engage.

25.8 Additionally attempts to triangulate the risks posed to victims through other avenues should also be continually and robustly pursued.

[10] Paragraph 4.6. A Domestic Homicide Review into the deaths of Julia and William Pemberton, a report for West Berkshire Community Safety Partnership, November 2008

25.9 Given the extent of the findings during the post mortem and in particular Jessica's severe rib injuries, it was clear she was exposed to incidents of severe violence during the last twelve months of her life. In considering those serious injuries, it is unlikely that without her engagement the full extent of the severity of the violence being suffered by her would have been fully understood by the agencies, however there were opportunities to have understood the frequency of the violence she faced through other means.

25.10 There is information to indicate the Police service did endeavour to undertake a broader approach to risk assessment, but these endeavours were largely confined to the reviewing of historic information and intelligence on Police systems.

25.11 The Police shared information with children's services on numerous occasions in circumstances where children's services acknowledge they ought to have undertaken more robust action. It is less clear if the Police service undertook escalation procedures in the absence of appropriate interventions by children's services, particularly following the assault on Rebecca when she was 13 years of age.

25.12 The lack of robust intervention by children's services meant that Jessica was not challenged on the accounts she was giving to social workers. The view of the Women's Aid panel members was that in their experience robust conversations with parents concerning the possible consequences for their family (child protection procedures) more often or not resulted in positive engagement by mothers experiencing domestic abuse, a view shared by the children's services panel members.

25.13 Children's services not undertaking a section 47 enquiry during 2005 led to the missed opportunity to speak with Rebecca. Given Rebecca's consistent approach to reporting matters to the Police, coupled with her ongoing engagement in the investigation and risk assessment processes it would seem likely that she would have been open with social workers had she been afforded the opportunity.

25.14 The children's services IMR author confirms them not speaking to Richard during July 2007 as a missed opportunity to secure a more rounded view of the risk posed by him. She makes particular reference to the fact that this should have revealed an insight into his background convictions with his former partner and their children.

25.15 It is not possible to predict what might have happened if children's services had moved to undertake child protection proceedings.

25.16 From the point when the 2 year suspended sentence and supervision order was imposed on Richard on 12th March 2013 this provided a clear opportunity on an ongoing basis for Police and Probation to have established a better understanding of the levels of risk faced by both Rebecca and Jessica, but of course more particularly Jessica.

25.17 The Probation Service IMR author records the failure to allocate a women's safety worker (WSW), to the case to be a 'fundamental flaw'. Had the WSW been deployed this would have provided a significant opportunity through the potential combination of home visits and face to face discussions with Rebecca and possibly Jessica to explore the true extent of Richard's violent behaviour.

25.18 During the period of supervision by the Probation Service those dynamic risk factors which were considered to be of significance with regard to the levels of risk posed by

Richard, were his place of residence, the status of his relationship with Jessica, his level of alcohol consumption and his relationship with Rebecca, their daughter.

25.19 Richard living away from Jessica, not being in a relationship with her were deemed factors which reduced the levels of risk she faced. Higher levels of alcohol consumption by Richard was also considered to a factor which increased the levels of risk.

25.20 His relationship with his daughter was also a factor considered.

25.21 Richard was acknowledged to be complying with programme attendance requirements but it was noticed that his behaviour was not changing.

25.22 This coupled with a misunderstanding of the fact that he was residing with Jessica and had resumed the relationship led to a Probation Service view of stability, when in fact the opposite was true.

25.23 Again given Rebecca's consistent engagement with the Police and criminal justice system had she been allocated a women's safety worker she would have been highly likely to have disclosed the ongoing abuse from her father, which were breaches of his restraining order.

25.24 This would have presented an opportunity for positive intervention by the Police and the Probation Services.

25.25 Police and Probation are of the joint view that Richards actions constituted a breach of his restraining order and therefore if reported would have presented opportunities for positive action. (The potential for hindsight bias is acknowledged but these questions were discussed directly with the family and have duly been addressed).

25.26 There is a possibility, although likelihood cannot be estimated, that visits by the WSW would have afforded the opportunity for conversations with Jessica, this may in turn have enabled engagement with her. Similarly, the compliance with the need for home visits to be undertaken by the Probation Service as a minimum may have revealed that Richard was living there and had resumed the relationship.

25.27 It is however highly likely that engagement with Rebecca would have revealed the true status of Richard's residence and therefore the resumption of the relationship between him and Jessica.

25.28 The allocation of a WSW would have presented a clear opportunity for attempted engagement with Jessica. There is insufficient information to formally conclude that such attempts would have been successful but this cannot be dismissed outright, and therefore should be considered to have been likely.

25.29 The significant proportion of risk assessment activity with regard to Jessica was conducted by West Mercia Police. It is clear that the accumulative impact was not fully understood. The failure to engage Jessica meaningfully in the DASH process was a significant factor for the Police service when trying to establish the true extent of risk.

25.30 It is clear that officers did endeavour to make assessments based on the previous domestic history, but on occasion the number of months between incidents and on a number of occasions, no substantive offences were found to have been committed tended to have caused the officers to assess risk in a more isolated manner.

25.31 A possible cause may have been the national 'performance focus' context on the Police service for many years, and a culture which developed over time for Police activity to be doctrine compliant. This in turn led to culture of 'booklet completion and submission' which to some degree detracted from the DASH being a vehicle for conversation with victims. This is possibly best exemplified by Rebecca's description of the 'tick box' booklet.

25.32 The Report Author is of the view that the broader system should have a methodology which draws all of the information together to form an 'accumulating risk picture' but this currently would appear to be challenging and likely only to be achievable through single pieces of detailed analytical work.

25.33 West Mercia Police do have similar methodology within their Integrated Offender Manager IT systems, but with the advent of the national roll out of a new Police IT system, (ATHENA) West Mercia Police are simply unable to invest in their current IT system (CRIMES).

25.34 Recent HMIC inspections are looking at more holistic policing approaches, most notably in this context victim vulnerability but this is a very recent development. In the case of West Mercia Police (and many other forces) some areas for improvement have been identified.

25.35 It would seem likely that any multiagency sharing of information would have provided a considerably richer picture of the extent of the domestic abuse. This would potentially have led to the case being presented to MARAC.

25.36 In reaching conclusions the judgement has to be based upon what was known by the agencies at the time of Jessica's death.

25.37 The Police were called to Jessica's home address on 22nd September 2013, 4th September 2014 and Jessica attended the Police station on 24th December 2013. The Police responses to these three incidents prior to Jessica's death were appropriate given the circumstances they found; they were domestic incidents with no information to indicate Richard had physically assaulted Jessica.

25.38 The risk assessments conducted on each of these occasions assessed the level of risk to be standard.

25.39 These three incidents were key opportunities for intervention by the Probation Service however the Police failed to share this information with them.

25.40 The WWMCRC IMR author has been very robust and honest in his assessment of the facts that a woman safety worker should have been allocated and that some of the levels of risk should have been more robustly assessed.

25.41 Both Police and Probation have reported that their information sharing arrangements were lacking.

25.42 All of the above revealed a sense of momentum where opportunities to engage with Jessica, to secure a better understanding of the relationship with Richard and living arrangements were repeatedly missed.

25.43 This accumulation of missed opportunities in particular conspired to leave the multiagency partnerships to have an ill-informed understanding of the level of risk.

25.44 The challenge for the panel is to reach a conclusion. The panel are of the view that no single agency failure within this sad case contributed more than any other, however they are of the view that if the multi-agency partnership had functioned as it should, that risk assessments and relevant information had been shared, compared and indeed challenged then a much richer understanding of the level of risk faced by Jessica would have been highly likely to have been reached.

25.45 On this basis the panel feel that Jessica's death could have been preventable although it was not in itself predictable.

26. List of Recommendations

Recommendation No.11 Page 58

West Mercia Police to review the feasibility of managing cases where a restraining or other protection order exist by way of a risk management plan.

Recommendation No.12 Page 58

West Mercia Police to establish a process whereby protection orders are routinely shared with the Probation Service for managed offenders.

Recommendation No 13 Page 58

West Mercia Police witness care unit need to consider, in conjunction with CPS, the most effective practice to engage with victims who are protected by court orders granted as part of criminal proceedings to ensure the victim understand the terms of the order and what would constitute a breach.

Recommendation No.14 Page 61

Shropshire Council Children's Services to ensure that social workers and managers do not rely on one source of information (alone), in particular self-reporting, and must ensure that there is regular and ongoing dialogue with all key professionals and agencies involved with a family.

Recommendation No.15 Page 63

Shropshire Council Children's Services should ensure that all assessments with non-abusing parents are conducted in a therapeutic and supportive manner when considering the parents ability to protect a child.

Recommendation No.16 Page 64

Shropshire Council Children's services to ensure that in every case the perpetrator is seen and an assessment in respect of the risk posed by the perpetrator to the child should be completed.

Recommendation No.17 Page 64

Shropshire Council Children's Services must ensure that their audit activity ensures that there is sufficient scrutiny of case decisions, case recording and management oversight.

Recommendation No.18 Page 65

SaTH to introduce as a requirement for all cases where a patient presents a domestic abuse risk to family members to be formally communicated to the GP.

Recommendation No.19 Page 65

SaTH and West Mercia Police establish a joint policy on how information should be passed between each other, including what and how it should be documented.

Recommendation No.20

SaTH's domestic abuse policy and procedures to be reviewed. Page 66

Recommendation No.21 Page 66

SaTH should explore how 'alerts' may be applied to high risk perpetrators of domestic abuse. (It is acknowledged that there may be some limitations on the patient record system which could only be addressed at a national level)

Recommendation No.22 Page 66

Shropshire Clinical Commissioning Group to work with Shropshire Community Safety Partnership to put in place an information sharing arrangements concerning patients who are identified as victims of domestic abuse.

Recommendation No.23 Page 70

WWMCRC to ensure that assessments provide a clear summary of circumstance at point of actual case review and not to be focussed purely on historical information.

Recommendation No.24 Page 73

WWMCRC introduce a policy for mandatory home visits to all offenders with domestic violence issues in order to verify residence and to commence contact/engagement with victim.

Recommendation No.25 Page 73

WWMCRC BBR programmes lead must check before commencing the programme to ensure that a referral has been made to the Women's Safety Worker and that a response has been received. This is to ensure contact has been made with victims.

Recommendation No.26 Page 73

WWMCRC ensure all Offender Managers are appropriately trained and informed of public protection issues with regard to the victims of domestic violence cases. This will improve victim awareness and understanding with a view to reducing the number of repeat victims. To be completed end of March 2017.

Recommendation No.27 Page 74

The CRC are to ensure staff understand the need to make quality professional judgements in response to significant events or changes of circumstances. This would improve practice in recording and evidencing defensible decision- making. Quality assurance audit will take place monthly during individual supervision and learning from audits will be discussed during monthly team meetings.

Recommendation No.28 Page 74

WWMCRC programmes team to ensure there is improved communication between Programme Tutors and Offender Managers to ensure information is exchanged appropriately and consolidated into offender supervision.

Recommendation No.29 Page 75

WWMCRC to conduct an audit of management oversight in domestic violence cases, to ensure the offender management checklist is being used appropriately and the manager has a grasp of the issues in the case.

Recommendation No.30 Page 75

WWMCRC conduct a risk audit following up on the audit conducted in January 2016.

Recommendation No 31 Page 76

Shropshire Community Safety Partnership to arrange a multi-agency workshop to explore current and desired contribution to the 'Every Victim of Domestic Abuse' (EVODA), daily briefing process.

Recommendation No 32 Page 77

Shropshire Community Safety Partnership to arrange a task and finish group workshop to establish a multi-agency approach to the delivery of 'intervention notice' to a family and a process of periodic review.

Recommendation No 33 Page 78

Shropshire Community Safety Partnership to coordinate a multi-agency a review of where returned referrals are received, to ensure they are appropriately re assessed for levels of risk, and to put in place procedures to provide further response and/or support to the victim.

Recommendation No 34 Page 78

Shropshire Safeguarding Children's Board to re-launch their policy on ''Professional Disagreements and Escalation Procedure''.

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ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Shropshire Community Safety Partnership to review current local arrangements for raising awareness of the range and availability of domestic abuse support services.	Local	Review of the Shropshire Domestic Abuse Strategy	Shropshire CSP	This will be undertaken as part of the review and development of the 2017 – 2020 Domestic Abuse Strategy.	June 2017	
SCSP to ensure that the effective quality assurance process is introduced for the patient alert process for the Royal Shrewsbury Hospital.	Local	Review of the Shropshire Domestic Abuse Strategy	Shropshire CSP		March 2017	
SCSP to undertake an audit of multi-agency domestic abuse training.	Local	Review of the Shropshire Domestic Abuse Strategy	Shropshire CSP	This will be undertaken as part of the review and development of the 2017 – 2020 Domestic Abuse Strategy.	June 2017	

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
West Mercia Police to introduce version control for policy development and to secure outdated policies within the organisational corporate memory to assist in informing any future review processes.	Regional	Research & adoption of robust version control	West Mercia Police SSI	• SSI & ICT explore technical options • Research best practice with CoP • WMP to back record convert to earliest point in time • Adopt process to capture policy intro/version/review / revision/archive dates.	April 2017	
West Mercia Police in the absence of a Risk Management Plan to record all local policing support visits of the 'CO1' crime or incident record.	Regional	Review current RMP process	West Mercia Police DA Portfolio Lead	• Review current RMP / SNT working practices • Issue guidance to staff if required • Incorporate into SSI audit schedule for DA	March 2017	

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
West Mercia Police need to consider risk assessment levels when impacted by dynamic factors i.e. residence and prohibition of access to victims. Consideration should be given to the ongoing management of cases and utilising a risk management plan where appropriate.	Regional	Linked to above Review current RMP process	West Mercia Police DA Portfolio Lead	• Review current RMP working practices • Re-circulate DA risk assessment guidance to staff • Explore the impact of EVODA process – DA triage within the HAU/MASH	March 2017	Completed – considered. There is National work piloting an alternative to DASH & the Marac process is due for review. The RMP process will remain until outcome of pilot & regional work is known. EVODA process effective.
West Mercia Police to report progress against the HMIC action plan to ensure a 10% dip sample of standard risk cases.	Regional	Review HMIC activity & report progress to CSP	West Mercia Police DA Portfolio Lead	• Review HMIC 2013 action plan and contrast with recent HMIC DA findings • Explore the impact of EVODA process – DA triage within the HAU/MASH • Incorporate into SSI audit schedule for DA	February 2017	Completed – March 17 DA portfolio owner delivered inputs to operational staff & incorporated into audit process. Business as usual

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
West Mercia Police to ensure that when information is being shared with partner agencies the actual relationship between perpetrators and those to be subject of risk review activity is explicitly clear.	Regional	Review HAU/MASH quality assurance process	West Mercia Police Central PVP	• QA data fields DA referrals passed to Partner Agencies • Checked during EVODA process • Incorporate into SSI audit schedule for DA	March 2017	Completed – March 17 DA portfolio owner delivered inputs to operational staff & incorporated into audit process. Business as usual.
West Mercia Police to remind officers that all high risk must be referred to MARAC, and additionally that there is sufficient flexibility, subject to MARAC capacity to refer other cases.	Regional	MARAC coordinators to re-circulate guidance to staff	West Mercia Police Central PVP	• Guidance circulated and re-circulated periodically • Additional cases to high referred to MARAC • Incorporate into SSI audit schedule for DA	December 2016	Completed – March 17 DA portfolio owner delivered inputs to operational staff & incorporated into audit process. Business as usual – MARAC needs to reflect all agencies as it is not Police owned.

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
West Mercia Police to review current policy and working practice to ensure that in the event of discontinuance of a prosecution and/or the withdrawal of support for an investigation by a victim, this is consistently drawn to the attention of the harm assessment unit for them to consider the need to review the level of risk.	Regional National Issue	Research National Best Practice CJU/ HAU to explore working practices to deliver	West Mercia Police Central PVP, DA Portfolio Lead, CJU	• Review current working practices & interaction with CJU/HAU/DARO • Establish number of cases • Introduce clear process to re-assess risk pre/post charge • Liaise with CoP	January 2017	Feb 2017 – update CJU Actions completed When a victim becomes disengaged or withdraws support from a prosecution, the Witness Care officer will routinely refer to the local Harm Assessment Unit (HAU) to enable them to review the level of risk to that victim.
West Mercia Police to review the feasibility of managing cases where a restraining or other protection order exist by way of a risk management plan.	Regional National Issue	Research National Best Practice Explore with Courts Service	West Mercia Police Court Service Central PVP, DA Portfolio Lead	• Exploration with Courts as currently no consistent approach to inform Police on issue • Liaise with NCDV • Liaise with CoP / HMIC • Introduction of process if feasible.	April 2017	March 2017 – action considered Liaison completed - This is not feasible at this time

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
West Mercia Police to establish a process whereby protection orders are routinely shared with the Probation Service for managed offenders.	Local National Issue Police not always informed	Review HAU/MASH quality assurance & referral process	West Mercia Police Probation & Court Service Central PVP, DA Portfolio Lead	• Ensure Probation is considered during DASH QA by HAU/ EVODA process • Guidance to staff regarding informing Probation • Incorporate into SSI audit schedule for DA	December 2017	Completed – Jan 2017 DA portfolio lead delivered inputs to each MASH / HAU supervisor – EVODA process maturing
West Mercia Police witness care unit need to consider, in conjunction with CPS, the most effective practice to engage with victims who are protected by court orders granted as part of criminal proceedings to ensure the victim understand the terms of the order and what would constitute a breach.	Local National Issue	Research National Best Practice CJU/ HAU/SNT to explore working practices to deliver	West Mercia Police CPS, Court Service Central PVP, DA Portfolio Lead, CJU	• Review current working practices of CJU/HAU/DARO/SNT • Establish volume • Explore up skilling CJU staff to deliver court results & Court Order Info • Clear process/working practice adopted	April 2017	Completed – March 17 CJ update - Victims are advised within 2 days of a court order being granted via their preferred means of contact by a Victim and Witness Care Officer who will also explain what will happen if there were to be a breach.

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Shropshire Council Children's Services to ensure that social workers and managers do not rely on one source of information (alone), in particular self-reporting, and must ensure that there is regular and ongoing dialogue with all key professionals and agencies involved with a family.	Local	Social Workers to be reminded that when undertaking assessments that consideration should be given to all available information from the child, family and involved professionals. Information provided by parents should be either confirmed by other sources or considered in the context of full information available. The outcome of the assessment should be shared with the family and partners This will form part of proposed	Shropshire Council	Social Workers to be reminded that when undertaking assessments that consideration should be given to all available information from the child, family and involved professionals. Information provided by parents should be either confirmed by other sources or considered in the context of full information available. The outcome of the assessment should be shared with the family and partners This will form part of proposed breakfast briefings for all staff	Breakfast briefings to take place in December 2016 and January 2017.	Team Managers and Independent Chairs scrutinise assessments of children known to the service and ensure they are based on collaboration with partner agencies. They must also ensure the triangulation of information reported. Assessments can only be signed off by a team manager. Compulsory briefings on this recommendation have taken place with all social workers within the Children's Social Work Dept. Shropshire Council Children's Service is providing compulsory risk assessment training to their social work teams. This

		breakfast briefings for all staff				training is being tailored to the needs Shropshire Council and is being provided by Martin Calder- who is deemed an expert within this field of work
Shropshire Council Children's Services should ensure that all assessments with non-abusing parents are conducted in a therapeutic and supportive manner when considering the parents ability to protect a child.	Local	Assessments will be undertaken in a supportive manner with the non-abusing parent. Assessments will give due consideration to the needs of the non-abusing partner and available support services will be identified and offered to the non-abusing parent.	Shropshire Council	Non abusing parents indicate via the assessment process that they feel listened to and supported and the needs of the children and them are considered in the assessment process	Assessments will fully consider the role of the non-abusing parent and how they can be supported in their ongoing care of the children This will be a feature of breakfast briefings during December 2016 and January 2017	Compulsory briefings on this recommendation have taken place with all social workers within the Childrens social work Dept. Good practice messages are delivered in this training Social Workers are aware of the supportive services to Women who are the victim of domestic abuse Head of Children's Social Care and Safeguarding attends and represents Children Services on the County Domestic Abuse Forum and contributes to the decision making around the delivery of services to non-abusing

					and key messages Children's Services represented on County Domestic Abuse Forum and contribute to the decision making around delivery of services to non-abusing parents and the impact of this work.	parents and the impact of this work

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Shropshire Council Children's services to ensure that in every case the perpetrator is seen and an assessment in respect of the risk posed by the perpetrator to the child should be completed.	Local	Assessments completed will attempt to involve the perpetrator where possible and where it is appropriate to do so. Where a decision is made not to involve a perpetrator, a management decision will be recorded setting out the rationale for this decision. This area of work will form a key part of the proposed breakfast briefings.	Shropshire Council	There is evidence via assessments and plans completed where domestic abuse is a feature that attempts have been made to involve the perpetrator in this work, where it is appropriate to do so. Where there is a decision not to involve a perpetrator there is a clear management decision setting out the rationale for this decision. Team Managers are aware of these expectations Breakfast briefings planned and subsequent audit activity cycle takes place to consider the	Briefings planned December 2016 and January 2017 Audit activity planned for 2017 will consider domestic abuse and the role of the perpetrator in assessment and planning	Social work staff are expected to engage with perpetrators of domestic violence and assess the risk posed by the perpetrator to the child. Social work staff have attended training on 'Engaging with Perpetrators of Domestic Violence' by Kate Iwi and Chris Newman. They are able to access their website and the recommended assessment tools to enhance their ability to meaningfully engage with perpetrators of domestic violence. Risk assessment tools used in situations where domestic violence is a feature promote the inclusion and engagement of the perpetrator of the abuse

				role of perpetrators in assessment and planning s where domestic abuse is a feature of the concerns.		
Shropshire Council Children's Services must ensure that their audit activity ensures that there is sufficient scrutiny of case decisions, case recording and management oversight.	Local	Audit activity is already in place linked to the child's journey including decision making, case recording and management oversight Children's Services have also recently contributed to SSCB multi-agency audit focussed on domestic abuse	Shropshire Council	Audit activity planned each month with Children's Services Themed audit activity planned around management oversight and decision making Key messages for audit activity is analysed and widely shared within Children's services to improve practice outcomes	Each month Themed audit activity will take place at several stages during the calendar year	Shropshire Council Children's Services undertake 'Child Journey Audits' on a monthly basis. These are carried out by the Director of Children Services, Head of Children's Social Care and Safeguarding, Senior Managers through to the Independent Review Unit and Team Managers. The audits comment on each of the above. Should concerns arise in respect of any of these issues, they are highlighted to the relevant senior manager for action.

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
SaTH to introduce as a requirement for all cases where a patient presents a domestic abuse risk to family members to be formally communicated to the GP.	Local	ED Consultants to write discharge summaries to GP for all victims / perpetrators where abuse was a factor of the admission	SaTH	ED Consultants have been informed of the need to do this and this work has started	November 2016	This is now embedded practice. November 2016
SaTH and West Mercia Police establish a joint policy on how information should be passed between each other, including what and how it should be documented.	Local	Shropshire and Telford & Wrekin MARAC co-ordinators to inform SaTH of victims that no longer need alerts.	SaTH / West Mercia Police	ED staff know to ask the Police about patients who come in 'in custody' about their arrest status.	April 2017	Ongoing January 2017
SaTH's domestic abuse policy and procedures to be reviewed.	Local	Staff Domestic Abuse policy and policy for patients to be combined into one policy.	SaTH		December 2016	Policy complete awaiting approval March 2017
SaTH should explore how 'alerts' may be applied to high risk perpetrators of domestic abuse as identified by MAPPA and MARAC processes.	Local	SaTH can add a 'Violent & Aggressive' alert to perpetrators from the MARAC agenda each month.	SaTH	SaTH are alerting perpetrators from the MARAC agenda. MARAC co-ordinators are now sending de alert statuses through monthly.	November 2016	MARAC alerts now taken from MARAC agenda victims / perpetrators. November 2016

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Shropshire Clinical Commissioning Group to work with Shropshire Community Safety Partnership to put in place an information sharing arrangements concerning patients who are identified as victims of domestic abuse.	Local	Sign up Shropshire CCG to MARAC so that information is shared with GP's	CCG / Shropshire Council		December 2016	Completed December 2016
WWMCRC to ensure that assessments provide a clear summary of circumstance at point of actual case review and not to be focussed purely on historical information.	Regional		WWMCRC	WWM CRC has implemented a quality development plan to assure the NOMS contract management team that the CRC is regularly undertaking quality assurance on a monthly basis. The quality development plan captures team, Local Delivery Unit (LDU) and area wide quality development actions and objectives. The quality development plan incorporates a	March 2017	Monthly audits taking place.

				response to findings of internal audits, NOMS operational assurance reviews, HMIP and serious further offence audits and inspections. This objective is part of internal audit programme and NOMS operational assurance reviews. Audit findings are circulated monthly with ratings for each team and LDU, which are then reviewed at LDU manager meetings. Practice and quality issues are addressed with individuals by senior probation officers in supervision and team issues/themes and recorded on the quality development template.		

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
WWMCRC introduce a policy for mandatory home visits to all offenders with domestic violence issues in order to verify residence and to commence contact/engagement with victim.	Regional		WWMCRC	WWMCRC Home Visit Policy states the following: Home Visits should be made to all cases in which there is a current domestic abuse risk or a current safeguarding concern: • Within a month of completion of the RAPP • At least once every three months After significant events, which suggest a visit, might be helpful, such as a move of address or commencement of new relationship.	February 2016	Policy in place and ongoing monitoring as per quality assurance plan.

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
WWMCRC BBR programmes lead must check before commencing the programme to ensure that a referral has been made to the Women's Safety Worker and that a response has been received. This is to ensure contact has been made with victims.	Regional		WWMCRC	Process and systems in place to ensure female victims of domestic abuse are contacted prior to the perpetrator commencing the BBR programme. Women's safety worker has been renamed Partner Link Worker and are employed by WWMCRC.	On-going monitoring audit as part of WWMCRC Quality development plan.	Completed December 2016
WWMCRC ensure all Offender Managers are appropriately trained and informed of public protection issues with regard to the victims of domestic violence cases. This will improve victim awareness and understanding with a view to reducing the number of repeat victims. To be completed end of March 2017.	Regional		WWMCRC	Arrangements in place to ensure all new staff employed by WWMCRC are given domestic abuse training as an integral part of their induction.	March 2017	Completed December 2016

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
The CRC are to ensure staff understand the need to make quality professional judgements in response to significant events or changes of circumstances. This would improve practice in recording and evidencing defensible decision- making. Quality assurance audit will take place monthly during individual supervision and learning from audits will be discussed during monthly team meetings.	Regional		WWMCRC	We have undertaken an audit of our recording practice with regards to recorded professional judgements entries and offender assessment (OASys) reviews in response to significant events and/change of circumstances. (The offender manager decides whether the seriousness of the change requires an OASys or professional judgement needs to be completed. More information can be input into OASys than a professional judgement). Most cases had safeguarding and public protection issues recorded however the audit	Regional	

				highlighted some common themes: When domestic abuse perpetrator starts a new relationship or returns to the victim of the index offence the offender manager needs to be reviewing the case using either completing a full offender assessment document or a professional judgement to evidence what actions is being taken to manage the risks. If a domestic abuse or Children's services check is returned that has different information than that in a previously completed OASys, offender managers need to be completing a review (either OASys or professional judgement) to evidence that it has been risk		

				assessed and are managing the risk based on the new information.		
WWMCRC programmes team to ensure there is improved communication between Programme Tutors and Offender Managers to ensure information is exchanged appropriately and consolidated into offender supervision.	Regional		WWMCRC	Audit of cases suggests co-location; cross grade working and joint team meetings has improved communication and management.	On-going	
WWMCRC to conduct an audit of management oversight in domestic violence cases, to ensure the offender management checklist is being used appropriately and the manager has a grasp of the issues in the case.	Regional		WWMCRC	During January 2017, we will be undertaking an audit of our sentence plans including management oversight in domestic abuse cases. The audit will be a peer audit with the aim to support the offender manager's awareness and understanding of sentence planning quality standards.	March 2017	Audit to be completed January 2017.

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
WWMCRC conduct a risk audit following up on the audit conducted in January 2016.	Regional		WWMCRC	A recent sample of cases found the assessment of the risk of harm posed to others, and subsequent planning was not carried out well enough in over half of the cases inspected. Assessments were not up to date and had missing or incorrect information. Significant information was not always recognised as such and there was a lack of awareness of domestic abuse issues. This problem was exacerbated where screenings or assessments from court did not include all relevant information.	March 2017	The audits undertaken so far with regards to enforcement, cases seen at 5 days, 6 weeks and 3 monthly periods; and recording practice has highlighted the improvement the CRC needs to make in sentence planning, risk assessment and management of domestic abuse cases.

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Shropshire Community Safety Partnership to arrange a multi-agency workshop to explore current and desired contribution to the 'Every Victim of Domestic Abuse' (EVODA), daily briefing process.	Local		Shropshire CSP		June 2017	
Shropshire Community Safety Partnership to arrange a task and finish group workshop to establish a multi-agency approach to the delivery of 'intervention notice' to a family and a process of periodic review.	Local		Shropshire CSP		June 2017	
Shropshire Community Safety Partnership to coordinate a multi-agency review of where returned referrals are received, to ensure they are appropriately re-assessed for levels of risk, and to put in place procedures to provide further response and/or support to the victim.	Local		Shropshire CSP		June 2017	

ACTION PLAN TEMPLATE Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Shropshire Safeguarding Children's Board to re-launch their policy on ''Professional Disagreements and Escalation Procedure''.	Local		SSCB		March 2017	

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