SHROPSHIRE COMMUNITY SAFETY PARTNERSHIP

EXECUTIVE SUMMARY

Under Section 9 of the Domestic Violence and Victims Act 2004

of a

Domestic Homicide Overview report DHR 1

Report into the death of a woman aged 47 years

on 23rd-24th December 2014

Case No DHR1

Independent Chair and Author

Ivan Powell

October 2016

Introduction

For the purposes of this report to protect the identity of those involved and having been agreed with the family of the victim the following key will be used throughout:

The victim – Jessica

The perpetrator – Richard

Their daughter – Rebecca

Mother of the victim – Victoria

Sister of the victim – Diana

Ex-wife of the perpetrator - KB

This Domestic Homicide Review DHR) examines the circumstances surrounding the death of Jessica who was 47 years of age at the time of her death. Richard was 45 years old and the partner of Jessica at the time of her death.

Richard appeared before Worcester Crown Court, where after a three-week trial, he was convicted of her murder on 11th March 2016. He was 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 Jessica and Richard were living together with their one child, Rebecca, at an address in Shrewsbury. Rebecca was 22 years of age at the time of her mother's death.

Jessica worked for a local charity as a finance officer, where she was in fact the longest serving of the members of staff.

Richard was unemployed.

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 month's 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'.

West Mercia Police were called to domestic incidents and crimes variously involving Jessica, Richard and Rebecca on 22 occasions between 12th April 2003 and the date of Jessica's death, overnight of the 23rd – 24th December 2014.

On many of the occasions alcohol was an impacting factor on the part of both Jessica and Richard. Rebecca reported that in her view both of her parents were dependant on alcohol.

Richard has one conviction for domestic abuse assault against Jessica. During the review it was established that assaults committed by Richard on Jessica had been reported to the police on seven occasions between 12th April 2003 and 4th December 2012. On the latter five of these occasions he been arrested by West Mercia Police but police did not manage to secure Jessica's engagement with the investigative process.

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.

There were also three occasions on which Richard was arrested by West Mercia Police to prevent a breach of the peace, five occasions when at Jessica's request he was removed by police from the home and two occasions where Jessica had called the police but Richard had left prior to their arrival and no criminal offences were shown to have been committed by him.

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.

The panel were of the view that one of these, his relationship with and subsequent marriage to KB had relevance to this review. On 12th April 2000 and 18th December 2001 KB was the victim 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. They had two children together, a son born in 1996 and a daughter born 1999. The three have no contact with Richard now.

The relevance to this review was the opportunity these convictions presented to agencies to share information to inform later risk assessments later were significant.

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review.

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"

The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of the representatives of agencies who were involved in delivering services to the family of Jessica, including her daughter Rebecca. It included senior members of agencies that were involved. The professional designations of the panel members were:

- Assistant Chief Officer, Warwickshire and West Mercia Community Rehabilitation Company
- Shropshire Women's Aid Manager
- Assistant Chief Officer, National Probation Service, Head of Service for West Mercia
- Detective Chief Inspector West Mercia Police
- Chief Executive West Mercia Women's Aid
- Independent Review Officer, Shropshire Council Children's Services
- Interim Internal Review Unit Manager Shropshire Council Children's Services
- Regional IDVA and Safeguarding Support Services Manager West Mercia Women's Aid

- Named Nurse for Safeguarding Children and Domestic Violence Lead, Shrewsbury and Telford Hospital NHS Trust
- Head of Legal and Democratic Services, representing Shropshire Council Children's Safeguarding Board.
- Business Manager Shropshire Community Safety Partnership

None of the panel members had any direct dealings with Jessica, Richard or Rebecca and the broader family.

The Panel was chaired by an Independent Chair who also produced the Overview Report and this Executive Summary (herein after the Report Author). He had no dealings with any of the family involved prior to this review.

Time Period

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 subsequently 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).

As the review progressed the panel felt it was appropriate to include the assaults committed by Richard against his then wife KB on 12th April 2000 and 18th December 2001 given the significance of the opportunity for the resulting convictions to be shared between agencies.

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 Services

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.

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

Process of the Review

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.

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

This was Shropshire Community Safety Partnership's first experience of a Domestic Homicide Review. It was a complicated case at the outset as originally the perpetrator had been released on police bail whilst their investigation continued. This caused the partnership to be uncertain as to how to proceed. Once Richard was charged there was also a period of further deliberation before the Home Office was notified. It is now however appreciated by the CSP that the process needed to begin straight away. Lessons have now been learned by the CSP and all associated agencies.

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 a delay in affording Richard the opportunity to engage with the review.

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

The Home Office duly granted an extension to the period of the review.

Terms of Reference for the Review

The purpose of a DHR is to:

- 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;

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

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

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

Family Involvement

Home Office Guidance requires the family, friends and colleagues who have details or knowledge of the victim or perpetrator to be given the opportunity to contribute to the review process. In this case the Report Author met on four occasions jointly with Jessica's daughter Rebecca, her mother Victoria and her sister Diana. All made significant contributions to the review process. Their views were faithfully recorded and are included within the Overview Report. They were provided with an early draft of the Overview Report and commented upon it, and have been provided with an anonymised copy of the final report together with the Action Plan and Executive Summary.

The Report Author also met with Jessica's manager. Other work place colleagues did not wish to engage with the review, but the manager was helpfully able to give both her individual and overall workplace views.

Summary of Events

Jessica was 47 years of age at the time of her death. She and Richard first commenced a relationship in 1990. They had a daughter together, Rebecca, but separated when she was 3 years old, this would have been approximately 1995.

They resumed their relationship 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.

West Mercia Police were called to the family's home address on 22 occasions between 12th April 2003 and the date of Jessica's death, overnight of 23rd-24th December 2014 to deal with domestic incidents and crimes.

West Mercia Police made their first referral concerning Rebecca's exposure to domestic abuse between her father and mother on 12th April 2003, however Shropshire Council Children's Services could find no record of it.

Between the 24th March 2004 and 11th July 2007 West Mercia Police made a further seven referrals to Shropshire Council Children's Services outlining Rebecca's exposure to domestic abuse.

This included an incident on 3rd May 2005 where Richard had directly assaulted Rebecca by striking her three times with the metal buckle of his belt. During this incident he had also assaulted Jessica.

He was subsequently charged with both offences and appeared before magistrate's court on 12th October 2005 where he offered a guilty plea in respect of the assault on Rebecca, and was convicted, but offered a not guilty plea in respect of the offence against Jessica and was found not guilty. Richard was sentenced to a six-month community punishment with supervision order.

Between July 2007 and May 2010 there were no reported incidents of domestic abuse.

The panel could find no evidence but the collective professional view was that there was a strong possibility that Jessica may have ceased reporting matters to the police following her receipt of an intervention letter from Shropshire Council Children's Services. In this letter they recorded that they would wish to conduct a risk assessment with her prior to Richard staying at her home. This on the basis that Jessica had informed them their relationship had ended.

On 2nd May 2009 Jessica self-presented at the local emergency department (ED) with a head injury. The account she gave has been examined with family members. They view it as a not credible account and were of the view that the injury was most likely sustained following a further assault by Richard.

In July 2010 Rebecca became 18 years of age at which time she could no longer benefit from any potential intervention and support to her from Shropshire Council Children's Services.

On the 29th November 2011 Richard assaulted Rebecca during which he pulled a clump of hair from her head. He was arrested and charged with the assault on 30th November 2011.

Richard appeared and was convicted before the magistrate's court on 21st December 2011 at which time he was sentenced to 120 hours' community service, with a 12 months' community order and a 6 months' alcohol treatment requirement, which had a supervision element to it.

On the 16th January 2012 Police were called to the family home as Richard had punched Jessica in the face and when Rebecca had tried to intervene Richard had thrown her television set to the floor causing it to smash. Jessica was unwilling to provide a witness statement however Rebecca provide two which outlined the lead up to the assault on Jessica and the damage to the television. Richard was subsequently charged with two offences of assault and criminal damage.

He appeared before the magistrate's court on 2nd April 2012 when he pleaded guilty to and was convicted of both offences. He was sentenced to 24 months' community order with 24 months' supervision and with a requirement to complete the Integrated Domestic Abuse Programme (IDAP).

This sentence was in addition to the requirements of the existing order imposed on 21st December 2011.

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

On the 2nd December 2012 Rebecca returned home to find both of her parents drunk. An argument followed during which she tried to prevent Richard from assaulting Jessica. As a consequence, Rebecca was assaulted repeatedly by Richard during a three-hour period. She sustained bite marks to her hand, a bloody nose and soreness to her throat and neck when her father grabbed her around the throat. Rebecca went to her local police station to report the assault.

Richard was arrested on 4th December 2012. During his time in police custody he was taken to the Royal Shrewsbury Hospital as he complained of chest pain. It was noted on his medical records that he was suspected of assaulting his daughter.

He was later released from hospital following negative investigations regarding a possible cardiac episode.

The police investigation continued and on 18th December 2012 the Crown Prosecution Service (CPS) authorised two charges of assault against Richard. The CPS noted that Jessica had declined to make a statement to the police. On this basis the charge in respect of Jessica was a victimless prosecution authorised in consideration of the evidence given by Rebecca.

Richard was charged with the two offences of assault on 9th January 2013. He appeared before the magistrate's court on 28th January 2013 when he submitted 'not guilty' pleas to both charges.

Richard appeared before the magistrate's court for trial on 12th March 2013. Jessica did not attend court but Rebecca did. She was accompanied by her grandmother Victoria and aunty Diana.

On that date Richard ultimately pleaded guilty to the assault on Rebecca but not guilty to the assault on Jessica. In the event the CPS accepted the guilty plea in respect of the assault on Rebecca and offered no evidence in respect of the assault on Jessica.

Richard was convicted on that basis and was sentenced to 5 months' imprisonment wholly suspended for two years, made the subject of a supervision order, fined £300 costs placed on an alcohol treatment order and was made the subject of a restraining order 'not to behave in a threatening or abusive manner towards Rebecca'.

From the date of Richard's conviction on 21st December 2011 there were opportunities for engagement with Rebecca and possibly Jessica for the former probation West Mercia Probation Service Trust and from 1st June 2014 the Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC).

On the 22nd September 2013 police were called to the address in response to a report of a loud domestic argument. No offences were found to have been committed but Richard was removed from the address at Jessica's request.

On 24th December 2013 Jessica attended her local police station in what was described as 'a highly intoxicated state'. She was accompanied by Victoria and Rebecca. She initially wanted the police to remove Richard from her home, but as the conversation progressed she decided to spend Christmas with her mother as she was concerned that Richard would have nowhere to spend the period. The family were clear that they were told by the police to return to the police station when the matter would be revisited.

When they did return a few days later they were told by the Police that there was nothing they could do. Victoria described this as a significant let down of Jessica.

At this time Richard was still the subject of the 24-month supervision order.

On the 4th September 2014 police again responded to a report of a domestic argument at the home. They discovered that Richard had spent the previous night there, but Jessica stated it had only been the one occasion as she had felt sorry for Richard as his father had recently undergone a major operation. Police officers took this at face value.

Analysis and Recommendations

It was identified throughout the review that Richard continually displayed an unwillingness to accept responsibility for his behaviour. In particular, during his time under probation supervision it is recorded that Richard felt that alcohol was the significant contributing factor

to his violence. This is not the case. 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.

The Police and Probation services and the Shrewsbury and Telford NHS Hospitals Trust (SaTH) all have noted on their records that alcohol was a factor when dealing with Richard. He was also formerly the subject of two alcohol treatment orders when Probation managed. It is less clear how robust agencies were in engaging with him regarding his alcohol consumption in relation to his violence.

The panel specifically discussed the matter of alcohol and its prevalence within domestically violent relationships. All agencies were agreed that under current working practices this was given due cognisance. The panel did not therefore feel there was a need to undertake any alcohol specific workforce communications activity.

Jessica's workplace manager recalled the conversation she had with Jessica on the occasion of Richard appearing before the court charged with the assaults against both her and Rebecca. Notably she reported that they were discussing her decision not to attend court, Jessica's response being 'it won't do any good, even if he is bound over it will make him mad, he will still come back'. This was significant in that Jessica did not appear to have made such a clear disclosure to any agency or indeed her family members.

Jessica's manager articulated that even though suspecting domestic abuse they could not get Jessica to seek support, even when they offered to help her to do so. They often felt bounded by their recognition of the need to respect Jessica's wishes and were frustrated by a lack of reference point to go to for advice. The review revealed that such advice is in fact provided as part of the core IDVA service locally.

In 2003 and 2004 when Richard assaulted Jessica police did not arrest him as a consequence of her specific requests not to do so.

On all subsequent occasions where police had opportunity and indeed obligation to undertake positive action in accordance with procedures they did so. They were unable however unsuccessful in securing Jessica's engagement with the subsequent investigative processes.

Similarly, they were only occasionally successful in securing Jessica's engagement with the risk assessment processes.

There is evidence that on the occasions that Jessica was not successfully engaged officers did endeavour to conduct risk assessments using historical information, however this tended to result in officers taking a single event approach rather than achieving a broader view of the risks she faced.

There were at least two occasions when the Police Service should have shared the information concerning Richard's domestically abusive behaviour with the Probation Service. The review revealed that the entry on Richard's police intelligence record would lead an officer to believe that the expectation of contact with the Probation service was two legged in that;

(i) On the occasion of Richard being arrested, and
(ii) The officer needed further information concerning the terms of his management.

This may well have caused officers not to share information concerning the domestic incidents which occurred on 22nd September and 24th December 2014.

The WWMCRC report author identified a number of shortcomings with regard to probation activity and intervention.

The factors that were taken into account regarding the level of risk posed by Richard were the status of his relationship with Jessica, his place of residence, his alcohol consumption and his relationship with Rebecca.

The relationship being off, his residence other than at the home were the two most significant factors when determining the risk.

The IMR author identified that a woman's safety worker (WSW) should have been allocated to Rebecca whilst Richard was under probation supervision this did not happen, he regarded it as a 'fundamental flaw'.

The deployment of the WSW to Rebecca would have given her the opportunity to reveal ongoing behaviour by Richard which would have constituted breaches of his restraining order. Rebecca revealed to the Report Author that Richard had in fact been repeatedly abusive towards her but as she believed 'they were too minor to tell the police' she did not report any of these matters. The opportunity to engage with a WSW would have undoubtedly led to her revealing her father's ongoing abuse.

The deployment of the WSW may also have presented an opportunity to engage Jessica at times other than crisis point when she felt she had to call for the police.
It cannot be known that she would have engaged, but it has to be considered a realistic possibility.

Shropshire Council Children's Services failed to deliver their responsibilities to intervene and support both Rebecca and in turn Jessica.

Contact was in fact made with Jessica in 2005 by telephone but she explained that she and Richard had separated with no plan to reconcile their relationship, and specifically that Rebecca did not wish to speak to a social worker.

An initial assessment was eventually conducted in 2007 but again this fell short of expected standards.

The IMR author reported that:

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

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

Additionally, 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'.

It was established that Richard was never identified as the birth father of Rebecca, and further that connections with half siblings were not made. It was also identified that Richard was never spoken to, to inform any of the risk assessments, again a failing.

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.

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.

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.

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.

There were a number of agency recommendations made and accepted by the panel these are detailed at pages 84 – 86 in the overview report.

The following overarching recommendations are made:

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.

This will ensure that relevant information is shared across the multi-agency partnership for all domestic incidents whether substantive crimes or not. This would include the sharing of the broader family context and the existence of community and restraining orders.

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 notice' to a family and a process of periodic review.

This is to ensure that all assessments with non-abusing parents are conducted in a therapeutic and supportive manner when considering the parent's ability to protect a child.

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.

Recommendation No 34

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

This is to deal with the apparent lack of escalation procedures across the range of agencies in the light of what where actions were not in accordance with child protection procedures.

The single agency recommendations as proposed by individual IMR authors are contained within the analysis and recommendations section of the overview report pages 42-76 and are separately listed at pages 84-86.

Conclusions

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.

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.

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 Jessica's 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.

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.

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.

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.

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.

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.

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.

During the period of supervision Richard was acknowledged to be complying with programme attendance requirements but it was noticed that his behaviour was not changing.

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.

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

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.

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.

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.

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.

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.

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

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

These three incidents were key opportunities for intervention by the Probation Service however the Police failed to share this information with them. Both Police and Probation have reported that their information sharing arrangements were lacking.

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.

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

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.

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