Domestic Homicide Review

Claire
Died April 2018

Author: Mark Wilkie
Chair: Ged McManus
Date: 8 February 2019

	INDEX	Page

1 INTRODUCTION

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Claire (pseudonym used for victim's name), a resident of Warrington prior to the point of her death in April 2018.

1.2 Claire's mother gave a victim impact statement to the court. This is an extract from it.

"*I have not been able to attend court, until today because I am finding it all very difficult. And I could not bear to listen to all the details of the night my daughter died.*

She will always be the beautiful, kind, sensitive and compassionate person she was, and no one, can ever take that away from me.

I am dragging myself through each day the best I can, because I still have a family to be mindful of. My friends are understanding that I cannot spend much time with them as my head is all over the place.

One day, I hope to find some peace and acceptance of what has happened, and will get on with the rest of my life without Claire in it.

I hope that no other woman has to suffer at the hands of this man, please make it so that it is made impossible for this man to ever hurt another woman again. I fear that he may reoffend. On April the 10th of this year my life changed forever. My daughter's life was tragically cut short by the wilful actions of a cruel man. Who took it upon himself to hurt my daughter so badly, to leave her naked and alone on the floor to die, like she was something he had discarded.

She was found by the police and paramedics, and I am so grateful to them that she did not, despite his best efforts, die alone and on her own.

I felt numb and sick and disgusted when the police informed me in the middle of the night that my daughter had died. This feeling of numbness has stayed with me.

I am still trying to make sense of what they told me. I lay awake every night, waiting for knocking and banging at my door. My beautifully caring daughter has gone, and I don't know where she has gone to, or if she will ever return.

I know she has died, I have her remains at home, I light a candle for her, and

look at her photographs, but I sit at home waiting for her to call round, as was usual at the weekends.

I have not slept very well since April; I now have to take sleeping pills in order to get a decent night sleep a couple times a week.

It breaks my heart to think she was hurt so badly, she was battered and bleeding, and my beautiful daughter was still fighting to live.

I lie in bed every night, appalled, that this man took away my daughters right to have a life.

She will no longer talk to me, sing or dance, she will never grow old. Nor will she watch me grow old, the way it was supposed to be.

She will no longer visit me; go shopping with me, or out and about.

Not only has my daughter's life been taken, my life has been turned upside down, and altered in ways that I could never even imagine.

There is nothing but emptiness and numbness most days, I am acting brave, but mostly feel bereft. No kind words, apologies or comfort can fix this for me.

The only thing that is helping me get through this is my kind, caring and trusting daughter can never be hurt again at the hands of a man.

I would like you to give him the maximum sentence that you can so that he will not ever be capable of hurting women.

And leave my daughter in peace and in doing so leave myself and my remaining family in peace also."

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

1.4 Claire and John had known each since 2016, it is unknown when this became an intimate relationship. Claire lived in a flat in Warrington and John either stayed there with her or at the Room at The Inn, formerly the YMCA. John was released from prison on 3 April 2018, after serving a custodial sentence for assaulting Claire. There was a restraining order in place that prevented

John from having contact with Claire or entering the street where she lived. However, on the evening of 10 April 2018, John beat Claire to death in her flat. He was arrested later that evening. He was charged with Claire's murder which he was found guilty of at Liverpool Crown Court. He was sentenced to life imprisonment with a minimum term of 19 years.

1.5 The review will consider agencies contact/involvement with Claire and John from 27 February 2016, to Claire's death in April 2018. This period was chosen as it encompasses the death of Claire's previous partner and the forming of a new relationship with John. As it was known that their relationship had not pre-dated February 2016, this was thought to be a proportionate and sufficient period.

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

1.7 **Note:**
It is not the purpose of this DHR to enquire into how Claire died. That is a matter that has already been examined during John's trial.

2 TIMESCALE

2.1 This review began on 11 July 2018 and the panel met on six occasions. The review was concluded on 8 February 2019.

3 CONFIDENTIALITY

3.1 A pseudonym, Claire was agreed with the victim's family and used in the report to protect the victim's identity. The panel agreed to use a pseudonym John for the perpetrator.
Claire 40 years old, white British. Victim
John 55 years old, white British. Perpetrator

4 TERMS OF REFERENCE

4.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide

regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

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

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

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

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

4.2 Timeframe under Review

The DHR covers the period 27 February 2016 to April 2018.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Claire 40 years old
Perpetrator John 55 years old

Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour[1] did your agency have that could have identified Claire as a victim of domestic abuse and what was your response?

2. How did your agency assess the level of risk faced by the victim from the perpetrator and which risk assessment model did you use?

3. What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

4. What care and support needs did your agency identify for the victim and perpetrator and what action was taken?

5. What information did your agency have to suggest that the victim or perpetrator may have been experiencing or at risk of abuse or neglect? Were any opportunities missed to make a safeguarding adult alert/referral?

6. How did your agency ascertain the wishes and feelings of the victim about her victimisation and were her views taken into account when providing services or support?

7. What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?

8. Was there sufficient focus on reducing the impact of the perpetrator's abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

[1] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

9. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

10. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies that needed it?

11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator?

12. How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

13. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

14. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

15. What knowledge did family, friends and employers have that the victim was in an abusive relationship and did they know what to do with that knowledge?

16. Were there any examples of notable good practice?

5 METHODOLOGY

5.1 Following Claire's death, the chair of the Warrington Community Safety Partnership informed members on 19 April 2018, that the circumstances met the criteria for a Domestic Homicide Review. The Home Office was informed on 10 May 2018.

6 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES AND WIDER COMMUNITY

6.1.1 The Independent Chair and Author met with Claire's mother, half-brother and half-sister. They were supported by a member of staff from Victim Support. They gave a history of Claire's life and asked a number of questions. The family have been deeply affected by Claire's death and the DHR panel would

like to extend their condolences.

6.1.2 Claire's family were provided with a draft of the report and were able to review it over several weeks. They provided useful feedback as a result of which a number of amendments and clarifications were made, enhancing the report. The panel are grateful for their involvement.

6.2 The Family

6.2.1 Claire was born in 1977. Her mother and father separated when Claire was very young. Claire lived with her mother. There was little to no contact with her father who moved out of the area.

6.2.2 Claire had a half-brother who was 2 years younger and a half-sister who was 7 years younger. They only lived together for a short time as Claire's half-sister went to live with her father when her parents split up.

6.2.3 From 1983, Claire, her half-brother and mother lived in Warrington with Claire attending local schools. Claire was a very bright and well-liked student, who had a natural ability for art and painting. She gained many high-grade GCSE's and 2 A-levels. Claire left sixth form before completing all of her A-Levels.

6.2.4 During childhood, Claire was a healthy and happy child. She only suffered from the usual childhood illnesses. In 1993, when Claire was around 15 years old, she was present in Warrington town centre when the IRA exploded a bomb. Claire was not physically injured but witnessed the immediate aftermath. This impacted heavily on Claire's mental health.

6.2.5 It is believed that this triggered Claire's eating disorders, starting with anorexia and developing into bulimia. Claire refused to seek help or speak to anyone about her issues.

6.2.6 In 1995 Claire was subject to an indecent assault for which a DNA match was later linked to an offender in 2001. This male was arrested and later pleaded guilty. He was sentenced to 3 years imprisonment.

6.2.7 In 1996 Claire's depression was first noted in her GP records. There is reference to her feeling stressed and she was taking her exams at the time. Depressive disorder, binge eating and possible assault were also noted.

6.2.8 Around this time Claire formed a relationship with a man who lived in Oldham. Claire moved in with him and they were together for around 13

years. Claire briefly worked as a florist and also worked in a sandwich shop but struggled to keep the jobs because of her health issues.

6.2.9 On 23 December 2004, Police were called to an address in Oldham where Claire and her partner lived after neighbours heard screaming and banging. No offences were disclosed and the couple were signposted to relevant agencies.

6.2.10 Claire's mental health got worse, suffering from OCD, depression and she became obsessed with keeping fit. It is believed Claire's drinking became problematic during this period as she would phone her mother and sounded drunk on the phone a lot of the time.

6.2.11 Claire had been admitted to hospital in Oldham after being arrested for drunk and disorderly and her mother spoke to a doctor on the telephone and asked the doctor to speak to Claire about her eating disorders.

6.2.12 Claire would visit Warrington to see her mother and vice-versa. Claire and her partner parted around November 2011 and she moved back to Warrington, initially moving in with her mother before moving into a bedsit in 2012. Claire formed a relationship with a man who lived in a bedsit on the floor below hers. It is believed that Claire suffered domestic abuse from this man.

6.2.13 In 2013, Claire moved into her own flat at a different location where she lived until her death. Claire's family believed that having space away from her partner really benefitted Claire. They remained friends and she helped care for him during the last year of his life whilst he was terminally ill. He died in February 2016.

6.2.14 In January 2014, Claire sent her half-brother a photo of herself with bruising to her face but said she couldn't remember how it had happened. This was not reported to any agency and Claire always denied that her partner had caused any injuries to her.

6.2.15 Claire's mother was concerned for Claire's mental and physical health and took Claire to a GP appointment. She felt that Claire's mental health was deteriorating and she showed a lack of willingness to accept anything was wrong. Claire's mother recalls that during the appointment there was a discussion about domestic abuse.

6.2.16 Her family felt that Claire's mental health improved over the last couple of years and she was trying to get her alcohol problem under control. Her

family thought that Claire had been attending alcoholics anonymous meetings and that she was no longer drinking. She had completed a course in care-work and had been searching for jobs and regaining confidence in herself. She wanted to try and help other people who struggled and had an ambition to be an art therapist.

6.2.17 During the 12 months before Claire died, she would visit her mother's house more often and this would generally be every weekend. She would make her food; they would watch TV together, catch up and would also go into town shopping. Claire didn't open up to her mother about relationships but she would tell her about other things in her life, such as trying to get work or going to college. Claire never spoke about John to her mother or the rest of the family other than she was friends with him. Claire's mother had seen a man who she thought was John in Warrington town centre. At this time in her view he was drunk and causing a nuisance. Consequently, she told Claire that she should have nothing to do with him as he was trouble. There was no other contact with him by Claire's mother or the rest of the family.

6.3 **Claire's family asked a number of questions which they hoped that the review would be able to answer:**

1. Why was the offender repeatedly bailed by magistrates before the final prison sentence? *John was bailed on 2 occasions with regards to the assault on Claire. (Para 15.5.2 & 15.5.3)*

2. Did the offender have a history of Domestic Violence? Did Claire know about it?
John did not have a record of domestic abuse.

3. When the offender was in prison did Claire give him permission to write to her or call? If she did not, why was he allowed to contact her?
It is policy that the prison always ask permission for contact to be made from an inmate however records are not kept and therefore it is not possible to confirm that Claire gave permission.

4. Did Claire visit the offender in prison?
Claire did not visit John in prison.

5. Claire's mother says she was never spoken to about Claire's issues by an Independent Domestic Violence Advocate (IDVA), where did that information come from?
This is correct; the information came from the MARAC minutes. The minutes of the MARAC meeting were not recorded accurately. (Para

16.9.3, 16.9.4)

6. Will the DHR look at the results of the Independent Office for Police Conduct (IOPC) report*?*
Both the DHR and IOPC reviews are independent.

7. Was Claire a victim of DV when living in Oldham? Was she offered any help if she was? Was anyone prosecuted for any injuries?
This is outside of the review time frame however there is no evidence to suggest that Claire was subject to DV whilst in Oldham. (Para 6.29)

8. Claire was given sick notes from her GP. Would they have been aware from a MARAC that she was a vulnerable person and was help offered?
The GP was not aware of the information from the MARAC (Para16.9.9)

9. How many times did Claire visit hospital?
Claire only visited the hospital on one occasion during the period under review. This led to the MARAC. (Para 16.18)

10. Her family believe that Claire and offender met at the YMCA in Warrington. Would staff have known about their relative backgrounds?
Claire and John initially met in Warrington town centre. (Para 15.5.1)

7 CONTRIBUTORS TO THE REVIEW / AGENCIES SUBMITTING

INDEPENDENT MANAGEMENT REVIEWS (IMRs)

7.1

Agency	Contribution
Cheshire Constabulary	IMR
Warrington Care Commissioning Group (CCG)	IMR
Torus	IMR
Refuge	IMR
Change Grow Live known in Warrington as Pathways	IMR
Adult Social Care	IMR
HMP Altcourse	IMR
National Probation Service	Chronology
Cheshire and Greater Manchester Community Rehabilitation Company	IMR
RATI (Room at The Inn) Project	Short report
Homeless Team	Short report
Warrington & Halton Hospital NHS Trust	IMR
North West Boroughs Healthcare NHS Foundation Trust	IMR

7.2 A number of service providers in the Warrington area are mentioned in this report. The official title of that provider is not necessarily the one used by local people or staff in that provider or by other agencies. The local terminology is used in the report. Below is a list of those providers, the name they are commonly known by and their official title.

RATI	Room at the Inn (RATI) is the name of a night shelter which provides emergency bed and breakfast drop-in accommodation. It is open between 9pm and 8am daily and the building consists of 10 unisex pods in the main room (each pod is separated by a curtain), two lounge areas, kitchen, bathroom, offices and a small outside area. The facility was originally set up by the YMCA in December 2010 and is now managed by the Y project, a Charitable Incorporated Organisation (Charity No. 1176629), registered on 11 January 2018. The Y project also includes a co- located day time support facility which was previously operated from a separate building by the YMCA. The day service is open in the morning and then again in the afternoon and provides activities, information and support for up to 50 people.
Pathways	Pathways to Recovery is the local term for Change

	Grow Live (CGL) which deliver alcohol and drug services for adults.
Refuge	Refuge provides Independent Domestic Violence Advocates (IDVAs) to support anyone in Warrington who is experiencing domestic violence.
Warrington Hospital	Warrington Hospital is part of Warrington and Halton Hospitals NHS Foundation Trust.
New Leaf	New Leaf is a local project funded by the European Social Fund and the National Lottery aimed at getting people nearer to or back into work. Each client gets 1-2-1 support from an allocated mentor who assists in finding training opportunities. Budgeting and building confidence.
Torus	Torus is a housing group in the North West of England that provides housing and services for the Warrington area.
Golden Gates Housing Trust (GGHT)	Golden Gates were established in 2010 when they took over Warrington Borough Council's social housing stock. They now work in partnership with Torus.
Housing Plus	Housing Plus is a Warrington Borough Council service delivering homelessness and housing services, including services for rough sleepers.
North West Boroughs Healthcare NHS Foundation Trust	Provide mental health services to the local community.

7.3 As well as the IMRs, each agency provided a chronology of interaction with Claire and John, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate.

7.4 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and the perpetrator over the period of time set out in in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to Claire and John and any other action taken.

7.5 It should also provide an analysis of events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved the review should consider not only what happened but why.

7.6 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.7 The IMRs in this case were focussed on the issues facing Claire. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made they were responded to promptly and in a spirit of openness and co-operation.

8 THE REVIEW PANEL MEMBERS

Ged McManus	Independent Chair
Mark Wilkie	Support to Chair and Author
Julie Ryder	Warrington CCG
Susan Wallace	Detective Constable Cheshire Constabulary
Paula Underwood	Manager Torus
Rosie Lyden	Board Manager Safeguarding Adult and Children Board
Steve Cullen	Manager, Citizens Advice Bureau, Warrington
Jackie Hodgkinson	Named Professional Adult Safeguarding North West Boroughs Healthcare NHS Foundation Trust
Wendy Turner	Warrington & Halton Hospital NHS Trust
Theresa Whitfield	Warrington Borough Council, Community Safety Partnership
Margret Macklin	Head of Service, Quality Assurance and Adult Safeguarding Warrington Borough Council
Mari Edwards	Senior Operations Manager, Refuge
Cathy Fitzgerald	Head of Service Substance Misuse and Commissioning Development Public Health Warrington Borough Council,
Cheryl Holdbrook	Room at The Inn RATI
Jenny Archer-Power	Cheshire and Greater Manchester Community Rehabilitation Company (CGMC CRC)
Wendy Teague	Administrator WBC
Ann Woods	Housing
Alan Warburton	HMP Altcourse
Sally Starkey	Women's Aid
Jessica Smith	Pathways to Recovery
John Davidson	National Probation Service
Maria Guidera	Domestic Abuse Co-ordinator WBC

9 AUTHOR OF THE OVERVIEW REPORT

9.1 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has previously Chaired and authored DHR reports and Safeguarding Adult Reviews. He is currently Independent Chair of a Safeguarding Adult Board in the north of England. He was assisted by Mark Wilkie the report writer who is another independent practitioner. Neither of them has previously worked for any agency involved in this review.

10 PARALLEL REVIEWS

10.1 An Inquest was opened by the coroner on 3 May 2018. It has not been closed at this time due to the IOPC investigation.

10.2 The IOPC is currently investigating Cheshire Constabulary's actions in relation to the murder of Claire.

10.3 The management of John by CGM CRC was the subject of a Serious Further Offence Review (SFO), which was submitted to Her Majesty's Prisons and Probation Service, HMPPS in July 2018.

10.4 Warrington Safeguarding Adults Board considered whether the circumstances met the criteria for a Safeguarding Adult Review and concluded that this would be dependent on whether Claire had care and support needs which had prevented her from being able to protect herself from abuse and that this was not established. Given the lack of evidence at the time of Claire's death in relation to whether she had care and support needs and with reference to the statutory guidance for SARs (which emphasises the requirement to consider how safeguarding learning processes can dovetail with other relevant investigations in order to reduce duplication of work for the organisations involved and to maximise learning), it was agreed that the Safeguarding Adults Board would contribute to the terms of reference of the DHR and to the process, in order that this particular area could receive the necessary focus.

10.5 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process.

11 EQUALITY AND DIVERSITY

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

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

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
  (a) P has a physical or mental impairment, and
  (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 All subjects of the review are white British. At the time of the review they were living in an area which is predominantly of the same demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.3 Domestic homicide and domestic abuse in particular, is predominantly a gender crime with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. In England and Wales 46% of all females killed in 2013/14 were killed by a partner or ex-partner, compared to just 7% of male victims (Payton J et al 2017)

11.4 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 [care and support] assessment is completed.

11.6 When determining eligibility under the Care Act, local authorities must consider the following three conditions.

11.7 *Condition 1*

11.8 The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.

11.9 This includes if the adult has a condition as a result of physical, mental,

sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

11.10 *Condition 2*

11.11 As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section 'Eligibility outcomes for adults with care and support needs'.

11.12 *Condition 3*

11.13 As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

12 DISSEMINATION

The Home Office
Warrington Community Safety Partnership
Cheshire Constabulary
Warrington Clinical Commissioning Group
Torus
HMP Altcourse
National Probation Service
Warrington & Halton Hospital NHS Trust
Cheshire and Greater Manchester Community Rehabilitation Company
Family members
Cheshire Police and Crime Commissioner

13 BACKGROUND INFORMATION (THE FACTS)

13.1 Claire lived on her own in a social housing flat in Warrington. She met the perpetrator John in 2016. John had been in Warrington for about 2 years at this time having moved there from another area, he was arrested several times for offences relating to drunkenness and public order. He was officially homeless but being assisted by the Room at The Inn (RATI). He would stay with Claire when he was not at the local Room at The Inn accommodation.

13.2 On 30 September 2017, John was arrested for assaulting Claire and possession of an offensive weapon (knife). He was bailed to allow for further evidence to be gathered. The bail conditions were (i) John not to have any contact by whatever means with Claire and (ii) for John not to enter the street where Claire lived. Claire was informed of his release and bail conditions. This charge and the bail conditions imposed set off a catalogue of incidents

where by John was further arrested for repeated breach of the bail conditions, resulting in a 9-week custodial sentence.

13.3 On 19 February 2018, John was sentenced to five months imprisonment for assaulting Claire on 30 September 2017. He was issued with a restraining order not to contact Claire or enter the street where she lived. This was in force for a year.

13.4 On 3 April 2018, John was released from prison, he failed to attend his post release meeting with his CRC manager and on 6 April 2018, papers were issued for his recall to prison. Cheshire Constabulary was informed on this date.

13.5 On the evening of 10 April 2018, an off duty Special Sergeant saw John in the street shouting and gesturing with blood on him. He reported this and police attended at Claire's home address. The door was open and they found Claire on the floor in the living room. She had been subject to a violent assault and had extensive facial injuries. Claire was taken to Warrington Hospital where she was pronounced dead.

13.6 John was arrested later that evening on suspicion of the murder of Claire. He was interviewed and subsequently charged with her murder.

13.7 A post mortem was carried out on Claire. The cause of death is recorded as multiple blunt force trauma.

13.8 In October 2018 at Liverpool Crown Court, John was found guilty of the murder of Claire. He was subsequently sentenced to life imprisonment with a minimum term of 19 years.

13.9 The trial Judge described John as a, "Devious and manipulative man" adding, "You subjected Claire to a sustained and repeated attack, from which she must have suffered terribly. You have shown no remorse for what you have done, and your actions have been motivated by self-interest throughout."

14 **CHRONOLOGY**

14.1 THE FACTS BY AGENCY

14.1.1 The agencies who submitted IMRs are dealt with in a narrative which identifies the important points relative to the terms of reference without comment. The main analysis of events appears in Section 16.

14.1.2 To add context to the background story contacts with Agencies prior to the timescales under review are mentioned.

14.2 **Prior to the review timeframe**

14.2.1 2012 - 2016 Claire was in a relationship with a male who died February 2016. This relationship came to the attention of Cheshire Constabulary on a number of occasions in relation to intoxication and reports of verbal arguments and damage to property. Bruises and injuries were noted on Claire by the police, but these were never attributed to her partner and she did not make any formal allegation against him. However, he was arrested on one occasion for assault, which was 'no further actioned' (NFA) by the Crown Prosecution Service (CPS) due to no complaint being made by Claire, her history of self-harm and inability to recall the incident due to intoxication.

14.2.2 Between 2012 and 2015 Claire accessed services offered by Talking Matters Warrington in relation to her mental health issues. These were telephone discussions. Engagement was intermittent and generally Claire would fail to keep appointments or be uncontactable.

14.2.3 Claire also came to the attention of Cheshire Constabulary due to her own actions. These incidents related to alcohol misuse and possible mental health issues.

14.2.4 January 2014, John joined a GP surgery in Warrington. He had a historical diagnosis of "acute schizophrenic episode" and known episodes of drug induced psychosis thereafter. He had been detained under the Mental Health Act in the past and had a history of alcohol dependency, drug misuse, smoking and homelessness.

14.2.5 On 7 July 2015, Claire attended her GP and was diagnosed as suffering from endogenous depression[2]. There is no record at this attendance of any questions being asked about domestic abuse.

14.2.6 On 1 October 2015, John presented to Housing Plus with a social worker to make a statutory homelessness application following discharge from Hollins Park hospital. Prior to Hollins Park hospital John was homeless in Liverpool after leaving accommodation with the Salvation Army in Liverpool in May 2015. Following an investigation on 2 October 2015 a statutory decision was made that John was eligible for assistance, homeless, had a priority need for housing, was not homeless intentionally, although had no local connection to

[2] Endogenous depression is a type of major depressive disorder (MDD). It is a mood disorder characterised by persistent and intense feelings of sadness for extended periods of time.

Warrington. It was established that John's local connection was with Liverpool. Housing Plus contacted Liverpool City Council who accepted a full housing duty to provide accommodation for John and a formal referral was made by Housing Plus. This was explained to John and he was advised that he needed to return to Liverpool and was offered transport. John refused to return to Liverpool.

14.2.7 After refusing to return to Liverpool he was helped with accommodation at the Room at The Inn (RATI) where on and off he spent the next four years.

14.2.8 December 2015, John was admitted to Hollins Park under section 2 of the Mental Health Act[3] (MHA) with an episode related to poly-substance abuse. Emotionally unstable personality disorder was also written in his discharge letter. He was discharged to the RATI and referred to social services for support with social isolation and housing following an assessment that determined he had eligible care and support needs.

14.3 **Within the review timeframe**

14.3.1 On 27 February 2016, Claire's partner died after being admitted to hospital.

14.3.2 On 8 March 2016, John's Social Worker liaised with RATI and Liverpool Homeless and Assessment Team to ascertain supporting information for John's housing application. RATI staff completed the application with John.

14.3.3 On 27 July 2016, Claire attended her GP practice and was examined in relation to a knee problem.

14.3.4 On 1 September 2016, John appeared at North Cheshire Magistrates Court (NCMC) for a Section 5 public order offence committed on 27July 2016. He was sentenced to a financial penalty.

14.3.5 On 7 September 2016, John appeared at NCMC for a Section 5 Public Order Offence and failing to surrender on 6 September 2016. He was sentenced to a 12-month conditional discharge.

14.3.6 On 9 November 2016, John's Social Worker discussed transferring his case to another worker within a supervision meeting (worker was leaving the authority). To assist with the case, contact was made with North West Boroughs Healthcare NHS Foundation Trust (NWBH) Home Treatment Team who advised they had had minimal engagement with John and were likely to

[3] Section 2 MHA provides a power to detain a person in hospital for assessment for up to 28 days.

close the case.

14.3.7 On 5 December 2016, John's new social worker had contact from Warrington Hospital, Cash Office regarding clothing that they held from when John was last discharged. The Social Worker also spoke with RATI for an update on John's current situation with regards to; the use of the night shelter, housing application, current mental health and suspected drug use. A meeting with John was planned for 9 December 2016; however, John refused to engage with the Social Worker. The Social worker was told by RATI that John didn't want to work with social services, and the RATI worker raised concerns about the lack of input from Adult Social Care.

14.3.8 On 15 December 2016, Claire visited her GP suffering from depressed mood. She was given a not fit for work certificate. Valid 15 Dec 2016 to 26 Jan 2017.

14.3.9 Between 4 and 31 January 2017, John's Social worker liaised with the RATI about John's housing needs. No vacancies in other housing provision were identified as John was perceived as being unsuitable because of the risks he may have presented to other vulnerable tenants due to his forensic history.

14.3.10 On 26 January 2017, John appeared before NCMC for breach of a 12-month Conditional Discharge (CD) (imposed 7 September 2016) and drunk and disorderly (30 December 2016). He was sentenced to a financial penalty and the CD was revoked.

14.3.11 On 10 February 2017, a Health Care Assistant completed a Care Programme Approach review for John. This was in reference to smoking. John declined, a smoking cessation programme, a referral to a smoking cessation service and smoking cessation drug therapy.

14.3.12 On 16 February 2017, John appeared at NCMC for a Section 4 Public Order offence (22 January 2017), he was sentenced to a financial Penalty.

14.3.13 On 16 February 2017, Warrington Borough Council (WBC) Housing Plus were informed that John's application for housing could not be proceeded with until his previous rent arrears had been cleared in full. He also needed to provide his documents, ID, proof of income, and a recent bank statement.

14.3.14 On 17 February 2017, Torus attempted to contact Claire about rent arrears. Claire got in touch seven days later saying she had paid £40 yesterday. The reason for the problem was that she had her benefit entitlements changed from Employment and Support Allowance (ESA) to Jobseeker's Allowance

(JSA). The decision was being appealed as she was still suffering with depression.

14.3.15 On 7 March 2017, Claire attended the GP Practice for a routine medical test.

14.3.16 On 5 April 2017, John appeared at Chester Magistrates Court for an offence of drunk and disorderly and was sentenced without a probation report, to a financial penalty.

14.3.17 On 17 April 2017, John appeared before NCMC for Possession of a Bladed Article (Knife) and Racially Aggravated Offence (both dated 14 April 2017), sentenced to 18 weeks imprisonment (9 weeks for each offence), he was sentenced without probation reports.

14.3.18 Between 4 and 22 May 2017, Torus attempted contact with Claire to discuss her rent arrears. They eventually had a face to face meeting. Claire said that she was struggling to budget on her job seekers allowance.

14.3.19 On 21 July 2017, Claire reported to Torus that she had lost the keys to her property. A joiner was sent to her property to assist.

14.3.20 On 1 August 2017, John appeared at NCMC for an offence of drunk and disorderly (13 July 2017). He was sentenced to a 12 month conditional discharge.

14.3.21 On 5 September 2017, Claire visited the Torus office to advise that she had a meeting with Universal Credit (UC) the next day and would update with the result. Several unsuccessful attempts were made by Torus staff to contact Claire to ascertain the result of the meeting.

14.3.22 On 16 September 2017, John's social worker liaised with the Mental Health Team seeking information to assist with John's housing application. The pertinent information was that John had a diagnosis of mental and behavioural problems due to poly substance misuse from December 2015.

14.3.23 On 18 September 2017, John's case was placed on a team case load due to the departure of his allocated social worker. It was subsequently closed

14.3.24 On 30 September 2017, Claire contacted Cheshire Constabulary to report that her friend John had banged her head on the front door and threatened her with a kitchen knife. He was calling her names because she had asked him to leave her home address. She had fled the premises to make the call during which time John had also left the premises and had posted the knife through

the letter box. Police officers attended at the address and obtained a formal complaint from Claire which resulted in John being arrested later the same evening. Claire stated that she and John were friends and because he was homeless she allowed him to stay overnight at her home.
John was interviewed and denied the allegation made. He claimed that he and Claire were intimate partners. The facts were presented to the CPS for a charging decision who requested further information prior to charge and as such John was bailed with conditions until 21 October 2017. The bail conditions were (i) John not to have any contact by whatever means with Claire and (ii) for John not to enter the street where Claire lived. Claire was informed of his release and bail conditions.

14.3.25 As part of this incident, a Vulnerable Person Assessment (VPA) was submitted by the attending officer who had been told by Claire that she was a friend to John, and that she felt she needed someone in her life to help her with her mental health. The officer was also aware that John had stated that they were in a sexual relationship. The VPA was graded as standard. This grading was reviewed by an officer at the Police station and the risk changed to medium. Operation Enhance[4] were notified and a referral made to the Independent Domestic Violence Advocate (IDVA). The IDVA and the Police Officer, as part of Operation Enhance visited Claire's home address but were not able to contact her. This was followed up with a phone call but she didn't answer or call back.

14.3.26 A crime report in relation to the incident was submitted in accordance with the National Crime Recording Standards (NCRS). However, a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment was not completed.

14.3.27 On 2 October 2017, John was arrested in Warrington town centre for being drunk and disorderly. He was charged and bailed to court on 19 October 2017.

14.3.28 On 4 October 2017, John was arrested for theft and being drunk and disorderly. He was charged and kept in custody to appear at court the following day.

14.3.29 On 5 October 2017, John appeared at NCMC for offences of theft from shop (4 October 2017) and breach of a 12-month Conditional Discharge imposed 1 August 2017. He was sentenced to a Financial Penalty and no action was taken for breach of the Conditional Discharge.

[4] Operation Enhance is a joint initiative between IDVA and the Police whereby victims of domestic abuse are jointly visited by IDVA and the Police live time.

14.3.30 Between 5 and 9 October 2017, Torus again attempt to contact Claire about rent arrears. The problem was around moving on to Universal Credit (UC). When contact was made the problem was worked through with Claire and she paid £14 to make up the shortfall after the UC contribution.

14.3.31 On 10 October 2017, Claire visited her GP complaining of knee pain. She was prescribed pain killers.

14.3.32 On 19 October 2017, John appeared at NCMC for offences of drunk and disorderly (2 October 2017) and breach of a Conditional Discharge imposed 1 August 2017. The Conditional Discharge was revoked and a Financial Penalty was imposed for both offences.

14.3.33 On 24 October 2017, Claire joined the Torus New Leaf Mentor programme (a programme designed to help get people back into work). Claire attended the initial meeting and booked a review meeting for 1 November 2017, she was also referred to a confidence course due to start on 27 October 2017, which she failed to attend.

14.3.34 On 30 October 2017, Claire visited her GP complaining of a sore right index finger. She was prescribed pain killers and referred to orthopaedic service.

14.3.35 On 1 November 2017, Claire failed to attend her review meeting with her New Leaf Mentor.

14.3.36 At 18.29hrs on 2 November 2017, a third party contacted Cheshire Constabulary via the 999-emergency system. It was reported that a very drunk male (John) was banging on Claire's door threatening to kill her and her mother. Officers attended at the address and spoke to Claire who had a 2cm cut over her left eye and she intimated that John had caused the injury. However, she refused to make a formal complaint or name John as the offender. John was located at the back of the premises and subsequently arrested for breaching his bail conditions (those set after the incident on 30 September 2017) and suspicion of assault on Claire.

14.3.37 Due to Claire not making a formal complaint the CPS took no further action regarding the assault, but John was charged with the breach of bail offence for which he attended at court the following morning. A Domestic Violence Protection Notice (DVPN) was considered but not progressed given the bail conditions already in place. A VPA (medium) and DASH risk assessment were completed with referrals to the IDVA service and Pathways (a local commissioned drug and alcohol service).

14.3.38 On 2 November 2017, Torus New Leaf Money Advisor tried to contact Claire. Text message sent.

14.3.39 On 6 November 2017, Claire self-presented at Warrington District General Hospital Accident and Emergency department complaining of rib pain. Claire disclosed to staff that she had been assaulted by John four nights ago (2 November 2017) and since then he had been calling at her house in breach of his bail conditions.

14.3.40 The Adult Safeguarding Team interviewed Claire and a DASH risk assessment was completed and there was liaison with the IDVA on the night who spoke to Claire. The DASH risk assessment was graded high and a referral for a Multi-Agency Risk Assessment Conference (MARAC) consideration was requested. This was submitted to Cheshire Constabulary. A VPA was created by Cheshire Constabulary and after intelligence checks the case was listed for MARAC on 6 December 2017. The VPA was also shared with the Probation Service.

14.3.41 On 8 November 2017, Claire visited the IDVA office and had an extensive discussion around safety, housing options and her overall situation. She was given advice around criminal and other civil options to deal with domestic abuse. Claire made it clear that she did not want her family to be contacted. Up until the MARAC meeting the IDVA service made eight attempts to contact Claire all of which were unsuccessful.

14.3.42 On 20 November 2017, Cheshire and Greater Manchester Community Rehabilitation Company notified Cheshire Constabulary that John had disclosed to them that he was staying at the home address of Claire. He stated that Claire didn't want the bail conditions and he didn't care about the consequences of breaching them. In response Police officers attended at the home address of Claire. She stated to officers that she didn't want the bail conditions in place, that she and John had been friends for 2 years and in a relationship for 8 months or so. However, Claire also stated that she was scared of John when he was angry and in drink. A VPA graded high was submitted, DASH risk assessment graded medium completed and a referral to the IDVA service was made.

14.3.43 On 27 November 2017, after confirming that John had not complied with his reporting restrictions he was arrested in the street for breach of bail (fail to sign on 23 November 2017). He was charged and remanded into custody

until court the following day. He was subsequently remanded on bail by the court until 19 December 2017.

14.3.44 On 6 December 2017, the MARAC meeting resulted in the sharing of information about Claire and John between multiple agencies in attendance. As a result of the meeting, the IDVA service was recorded as the lead agency for contact with Claire, and actions for certain agencies were identified and a request for feedback to the MARAC coordinator was made.

14.3.45 At 21.18hrs on 10 December 2017, Claire contacted Cheshire Constabulary to report that she had just walked from her home address and had been called names and been shouted at by John. Claire also alleged that he had been beating her. Officers attended at Claire's home address and found her alone but very much under the influence of alcohol. She had no apparent injuries. Due to her intoxication she was advised that an officer would see her the next day.

14.3.46 On 11 December 2017, Officers attended at the home address of Claire. They were allowed access into the premises where they found John on the sofa. He was arrested for a previous section 5 public order offence and for breaching his bail conditions. Claire did not make a statement in respect of her alleging that she had been beaten on 10 December 2017. A VPA was not submitted in connection with this incident however the National Crime Recording Standards (NCRS) were complied with and a crime was submitted for the allegation of assault.

14.3.47 John was charged with the breach of bail and a public order offence and attended at court the following day. He was given conditional bail until 19th December 2017 and then 19th February 2018 for trial at Cheshire Magistrates.

14.3.48 On 14 December 2017, Claire attended at Warrington Police Station help desk to enquire as to when she was to attend court in respect of the assault allegation she made against John. Whilst at the police station she stated that there had been various domestic violence incidents between them, one dating back to November 2017, which at the time she had not wanted to make a complaint about. Claire stated that she now wished to make a complaint. Additionally, Claire disclosed that John had been contacting her and had been round to her home address a couple of nights ago. No Police Officer was available at that time to take a statement, but Claire was informed that an officer would attend at her home address that evening to speak with her.

14.3.49 On 16 December 2017, Claire was seen by a Police Officer at her home

address. No statement was taken because Claire was intoxicated. John was not present at the address and Claire stated she still wished to make a statement.

14.3.50 On 19 December 2017, officers attended at Claire's home address and established that John was not there. Claire again confirmed that she wished to make a statement and asked that officers attended later that day which they did and took a statement of complaint about John breaching his bail. She did not however make a complaint regarding any assault.

14.3.51 John was arrested later the same day for breaches of his bail regarding Claire and failing to report to the police station on 19th December 2017. John was placed before the court the following day and given conditional bail.

14.3.52 On 29 December 2017, Claire sent a text message to the IDVA service from an unknown number wishing them merry Christmas and New Year. The IDVA service text back and rang but there was no answer.

14.3.53 On 1 January 2018, John breached his bail conditions by not reporting at the police station. On 2 January 2018, John was located at the home address of Claire where they were in bed together. John was arrested and charged for breaching his bail. He was placed before the court the following morning when he was remanded into custody.

14.3.54 On 3 January 2018, John appeared at Warrington Combined Courts. He was visited by a Mental Health Nurse in the cells who offered to complete an NHS Court Report if appropriate. John refused to speak to the Mental Health Nurse. John was remanded into custody.

14.3.55 On 9 January 2018, Claire failed to attend a meeting with her New Leaf Mentor. Claire sent a text message saying that she was unwell.

14.3.56 On 2 February 2018, Claire attended her GP with flu like symptoms she also alleged an attack by a friend. This wasn't explored further. Not fit for work certificate issued valid to 15 February 2018.

14.3.57 On 19 February 2018, John appeared at NCMC for offences of Possession of a Bladed article (knife) and Battery (both dated 30 September 2017), he was sentenced without probation reports to 6 months imprisonment for the knife possession and 5 months imprisonment concurrent for the offence of assault on Claire. A 12 month Restraining Order was imposed preventing contact with Claire and not to enter her address.

14.3.58 On 28 February 2018, Claire attended her GP Practice with persistent anxiety problems. Prescribed with Sertraline[5] and given a further not fit for work certificate to run until 11 March 2018.

14.3.59 On 6 March 2018, Claire attended Warrington Orthopaedic Care Service for treatment on her right knee.

14.3.60 On 12 March 2018, Claire attended at her GP Practice for a further unfit for work certificate. This was issued valid until 25 March 2018.

14.3.61 On 20 March 2018, Claire attended a Talking Matters Warrington drop in clinic at the Warrington job centre. She booked a telephone appointment for 23 March 2018, which she completed and talked about her partner dying 2 years ago. No mention was made of John. A further workshop was booked for 28 March 2018, but Claire did not attend.

14.3.62 On 3 April 2018, John was released from custody with licence conditions. This licence was due to expire on 2nd July 2018. Cheshire Police were informed of John's release and license conditions.

14.3.63 On 6 April 2018, Cheshire Constabulary was notified by the National Offender Management Unit (NOMs) that John had been recalled to prison. It was a standard recall, the target time for arrest being 96hrs from receipt of the notification. It was also identified in the document that the risk of reoffending from John was highly likely, especially if he had gained access to alcohol. Cheshire Constabulary conducted a Threat, Harm, Risk, Investigation, Vulnerability, and Engagement (THRIVE) assessment; the outcome was that the incident was graded high.

14.3.64 Cheshire Constabulary then followed their command and control policies and procedures by updating the incident. However, no resources were available for deployment.

14.3.65 On 8 April 2018, the Force Incident Supervisor (FIS) requested that the local sergeant be made aware of the incident and for an officer to be deployed. If this was not possible then the incident was to be risk assessed and closed. This would have been closed on the Force control system but handed over to local policing. The incident log shows that the incident was allocated by the local Sergeant to a uniformed night shift officer however he was unable to deal

[5] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD)

with it, so it was handed on to the morning staff. There is no documented evidence to suggest that any risk assessment was undertaken by the local supervisory officer.

14.3.66 On 9th April 2018, the incident was forwarded to the Local Policing Unit (LPU) to manage on their workloads.

14.3.67 At 22.21hrs on Tuesday 10th April 2018, Cheshire Constabulary was contacted by a member of staff from a shop in Warrington who expressed concerns about a male customer (John) who had blood on his hands and face. This male referred to his female partner who he believed to be dead on the floor. John was also seen in the street by an off duty Special Sergeant who reported what he had seen.

14.3.68 Around 22.40 10 April 2018, Police officers and paramedics arrive at Claire's address and found the door open. On entry they found Claire on the floor in the living room. She had been severely beaten with her face covered in blood. Claire was taken to Warrington District General Hospital but despite attempts to resuscitate her she died.

14.3.69 John was arrested on the street and taken to a police custody suite.

14.3.70 On 9 October 2018, at Liverpool Crown Court John pleaded not guilty to the charge of murder. During his trial he elected to give evidence. During this evidence John quickly became aggressive with the prosecuting female barrister when she repeated her question telling her to, "stop being a typical woman".

14.3.71 At the conclusion of the trial John was found guilty and sentenced to life imprisonment with a minimum term of 19 years.

15 OVERVIEW

15.1 This overview has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs and supplementary reports from some agencies. Information from police statements has also been used. Findings from previous reviews and research into various aspects of domestic abuse have been considered.

15.2 In preparing the overview report the following documents were referred to:

- The Home Office multi-agency Statutory Guidance for the conduct of Domestic Homicide reviews 2013

- The Home Office multi-agency Statutory Guidance for the conduct of Domestic Homicide reviews 2016

- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers

- Call an End to Violence Against Women and Girls – HM Government (November 2010)

- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013

- Key findings from analysis of Domestic Homicide Reviews. Home Office December 2016

- Evan Stark (2007) Coercive Control. How Men Entrap Women in Personal Life. Oxford University Press

- Agency IMRs and Chronologies

15.3 **Claire**

15.3.1 In 1995, Claire was subject to an indecent assault in Warrington town centre. A DNA match was later linked to an offender in 2001. This male was arrested and later pleaded guilty. He was sentenced to 3 years imprisonment for the offence against Claire.

15.3.2 In July 2012, Claire presented at Warrington Hospital with a serious non-accidental injury. She had a stab wound to her buttock. Professionals suspected that Claire may be vulnerable to abuse from her partner.

15.3.3 Between 2012 and 2016, Claire was in a relationship with a male who died on 27th February 2016 (date of the start of the terms of reference). This previous relationship came to the attention of Cheshire Constabulary a number of times in relation to intoxication and reports of verbal arguments and damage to property. Claire also called police about her relationship believing it to be psychologically abusive (pre coercive control legislation).

15.3.4 It is believed that the death of her partner was a key event for Claire. They did

not live together initially but lived in separate flats in the same block. It is thought that they shared one of these flats for a short time before Claire moved to different accommodation.

15.3.5 Warrington Borough Council Adult Social Care had no contact with Claire during the period under review. Previously between 2012 and 2015 Claire had been referred to New Directions and Mental Health Outreach Services. Both of these engage with adults with 'low level' mental health needs.

15.3.6 Claire attended her GP practice on numerous occasions. This was generally for low level mental health issues and a variety of physical medical problems. The medical care provided by the GP practice was in line with expected practice, however relationships and domestic abuse were rarely discussed.

15.3.7 Claire would regularly visit the RATI where she was offered advice and support with regards to the relationship with John, budgeting, her alcohol and mental health issues but Claire would always say that she didn't need any help.

15.3.8 Claire had problems with budgeting. Torus and previously Golden Gates Housing trust had regular contact with her to assist when possible. Claire was in receipt of benefits which changed from time to time. When the amount of benefit dropped this caused her problems as did the transition to Universal Credit. During the time under review Torus had difficulty contacting Claire and getting her to attend appointments.

15.4 **John**

15.4.1 John was born and lived in Liverpool for the majority of his life. He worked as a plasterer until his alcohol and substance abuse made it untenable.

15.4.2 John's father, who was a successful business man died about 5 years ago, he had many properties which were then sold after his death and divided between John and his siblings. John's money was placed in a trust fund that he could access.

15.4.3 John moved to Warrington in December 2014, to the Salvation Army hostel following a transfer from a Salvation Army hostel in Liverpool. However, he left the hostel in Warrington and returned to the Salvation Army hostel in Liverpool between February 2015 and May 2015. Sometime after May 2015 he returned to Warrington. In July 2015, John was admitted to Hollins Park and presented as homeless in October 2015. A homeless investigation identified that he had no local connection to Warrington and Liverpool City

Council accepted a full housing duty and offered to provide accommodation. Housing Options offered to provide transport, although John refused to return to Liverpool.

15.4.4 In December 2015, John was again admitted to Hollins Park Hospital under section 2 of the Mental Health Act (MHA) with an episode related to poly-substance abuse. Emotionally unstable personality disorder was also written in his discharge letter. He was discharged to the RATI and having been identified as having eligible needs, referred to Adult Social Care for support with his accommodation and social isolation.

15.4.5 After refusing to return to Liverpool, who offered to provide accommodation, John was homeless whilst in Warrington but spent most of his time at the RATI. He received support from both the day and evening services. Staff were able to talk to John and he would engage to a degree that he would not with other agencies. To help John manage his money they gave him £10 a day spending money from his own fund.

15.4.6 During the period under review John had two different Social Workers who had been unable to establish a relationship with him. At times he had had been challenging to Social Worker 1 and he had refused to engage with her on some occasions prior to the review period, although she had obtained some personal history from him. He was assessed as having care and support needs, having been at risk of self-neglect and social isolation. The main aim was to try and support him to address his accommodation needs through coordinating enquiries on his behalf and offering advice and support to RATI as this was the agency he would engage with. Partly as a result of John declining involvement with social services, he was only seen once during this time frame.

15.4.7 John came to the attention of Cheshire Constabulary 14 times between 15 July 2016 and 13 July 2017. These incidents did not involve Claire. He was arrested on 8 occasions.

15.4.8 John was released from HMP Altcourse on 3 April 2018. Part of the release process involved CGMCRC completing a release plan which included residing at the RATI and meeting with his CGMCRC case manager on release.

15.5 **John and Claire**

15.5.1 John and Claire met during 2016, in Warrington town centre. Both had alcohol and mental health issues and were lonely.

15.5.2 On 30 September 2017, John was arrested for assaulting Claire and possession of an offensive weapon (knife). He was bailed to allow for further evidence to be gathered. The bail conditions were (i) John not to have any contact by whatever means with Claire and (ii) for John not to enter the street where Claire lived. Claire was informed of his release and bail conditions.

15.5.3 This charge and bail conditions set off a catalogue of incidents where by John was further arrested for repeated breach of the bail conditions. Only one of these being directly in relation to Claire. Other breaches did not involve contact with Claire, for example failing to attend and sign at the police station. This culminated on 2 January 2018, when John was arrested for breach of bail and was placed before the court where he was remanded to custody.

15.5.4 On 6 November 2017, Claire self-presented at Warrington Hospital A&E Department complaining of pain to her ribs. The hospital Adult Safeguarding team got involved when Claire disclosed she had been assaulted by her partner (the police were aware of this incident). Claire disclosed more information to health professionals than she had to police. As a result of this a request for a MARAC was made to Cheshire Constabulary.

15.5.5 The MARAC took place on 6 December 2017, the MARAC shared information between agencies and set 5 actions.

15.5.6 On 19 February 2018, John appeared at NCMC for offences of Possession of a bladed article (knife) and assault (both dated 30 September 2017 and in relation to Claire). He was sentenced without reports to 6 months imprisonment for the knife possession and 5 months imprisonment concurrent for an offence of assault. A Magistrates Court Restraining Order against John was granted on this date, the purpose of which was to protect Claire from further conduct which amounted to harassment or would cause fear of violence. This restraining order specified that John was (i) not to contact directly or indirectly Claire and (ii) not to enter the street where Claire lived. The order was in place until 18th February 2019.

15.5.7 Details of the restraining order were sent to HMP Altcourse. On receipt a paper copy of the conditions was put in an envelope to be delivered to the Public Protection department. This was never received so the relevant staff were not aware of the restraining order. This enabled John to have contact with Claire. He phoned her on 160 occasions during the 39 days between conviction and release. Claire also attempted to phone him.

15.5.8 On 3 April 2018, John was released from prison. He gave his release address as the RATI project. He failed to attend his meeting with probation on his

release.

15.5.9 On 6 April 2018, Probation issue a recall order for John. This information was forwarded to Cheshire Police.

16 ANALYSIS

16.1 Each term appears in bold and is examined separately. Commentary is made using material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

16.1.1 **What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Claire as a victim of domestic abuse and what was your response?**

16.1.2 Cheshire Constabulary did identify indicators of domestic abuse between Claire and John. Officers attended every incident reported and were proactive in their response by arresting John for assault and breaches of his bail even when there was no formal complaint of assault made. Any incident of a criminal nature was progressed via the criminal justice system with appropriate outcomes.

16.1.3 There was no documented information of control and coercion, however Claire mentioned requiring somebody to help with her mental health and that John would bring alcohol to her. The panel heard that John also gave Claire money and wrote letters to her from prison promising to spend money on her on his release from prison. It is possible that whilst the couple were dependent on each other, that John's behaviour was coercive and controlling.

16.1.4 Referrals were made to the IDVA service and considerations of a DVPN were noted. The DVPN was not progressed as John was already on bail with conditions not to contact Claire. This was an appropriate decision.

16.1.5 GP notes indicate that abuse was identified outside the time frame of this review. There was no response provided in terms of support, onward referrals and advice. Claire saw several GPs and there appears to have been a lack of consistency of approach to asking about domestic abuse. On one occasion Claire reported that the domestic abused hadn't occurred for 3 years. This may have given an opportunity to explore what Claire understood by domestic

abuse as she may not have realised that other forms of control by a partner, ex-partner or family member was domestic abuse.

16.1.6 John was sentenced to an 18-week custodial sentence on 17 April 2017 and he was allocated an appropriate CGMCRC case manager. There were no indications of domestic abuse or risks to Claire at this time.

16.1.7 John was sentenced to a further custodial sentence on 19 February 2018, for an assault on Claire. At the point of sentence, the case was allocated to a different case manager. At this stage the incidence of domestic abuse on the part of John and the fact that Claire was a victim of this was clear.

16.1.8 On 6 November 2017, Claire self-presented at the Warrington Hospital A&E department complaining of rib pain. She made disclosures about domestic abuse. The Adult Safeguarding Matron completed a DASH risk assessment and made a request for a MARAC as professional judgement concluded that Claire was at risk.

16.2 **How did your agency assess the level of risk faced by the victim from the perpetrator and which risk assessment model did you use?**

16.2.1 Cheshire Constabulary use the DASH Risk assessment which is used by police and partner agencies when identifying, assessing and managing incidents of a domestic nature. The initial assessments were made by the officers on the facts that were presented at the time. However, the secondary assessments were made in the full knowledge of all previous domestic incidents and referrals to other agencies were made. The secondary assessment on one occasion increased the risk grading and referred to the IDVA. This provides good evidence that the system of secondary assessment put in place by Cheshire Constabulary was effective in this case.

16.2.2 During the time John was managed by CGMCRC his risk was formally assessed on two occasions on 30 June 2017, and on 6 April 2018. These assessments were completed using the Offender Assessment System, OASys. On the 30 June 2017, he was assessed as posing a medium risk of serious harm, (RoSH) to the public and a known adult (the security guard in relation to a shoplifting offence). The second risk assessment was on his recall on 6 April 2018, which was again medium risk. The panel discussed whether all domestic abuse offenders should be treated as high risk on their release from prison and concluded that the volume of offenders made this impracticable.

16.2.3 On 6 November 2017, when Claire self-presented at the Warrington District

General Hospital A&E department complaining of rib pain, she also made disclosures about domestic abuse. A DASH risk assessment was completed and a request for a MARAC was made. This provides good evidence that Domestic Abuse training has been embedded in to practice within WDGH.

16.3 **What services did your agency provide for Claire and John and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?**

16.3.1 Cheshire Constabulary attended numerous incidents involving John or John and Claire. Criminal investigations were instigated and progressed with outcomes usually via the criminal justice route. When circumstances allowed, requests were made to remand John into custody. When he was bailed for further evidence he was subject to conditions not to contact Claire. She was signposted to appropriate agencies for the level of risk identified.

16.3.2 A MARAC referral was made to ensure that all agencies were aware of the domestic incidents for which the IDVA became the lead agency.

16.3.3 Following John's recall to prison on 6 April 2018, Cheshire Constabulary was not able to affect John's arrest before he murdered Claire (this is currently subject to a separate IOPC investigation).

16.3.4 During the time John was managed in the community by CGMCRC historically he attended his appointments regularly and there is some evidence of the completion of appropriate work and the provision of suitable interventions. John's needs were assessed and a plan was put together to address and support these, regarding his finances and work around this was completed.

16.3.5 CGMCRC identified that alcohol was a key risk factor for John and the need to access targeted support was identified at an early stage. He was referred to Pathways, an alcohol agency but this met with resistance from him. John did not attend any appointments with Pathways.

16.3.6 When John was released from HMP Altcourse on 3 April 2018, he breached his licence conditions in that he failed to attend his post release meeting with his CGMCRC Case Worker. A decision was taken to recall him to prison and the relevant paperwork was submitted being received by Cheshire Constabulary on 6 April 2018. There was a delay in the recall of 24 hours caused by a member of staff being on leave and not appropriately leaving it for someone to attend to in their absence. However, in the experience of the Independent Chair and author of the review reflecting on other cases, the recall was processed in a timely manner.

16.4 **What care and support needs did your agency identify for Claire and John and what action was taken?**

16.4.1 Cheshire Constabulary had many dealings with Claire and John. They identified that Claire was a victim of domestic abuse and a referral was made to the IDVA service. It was noted that Claire was often intoxicated on police attendance and a referral was made to Pathways. Referrals were not made in respect of John who was also a frequent user of alcohol.

16.4.2 The Torus New Leaf Officer completed an assessment with Claire as part of accessing the New Leaf Programme which identified that Claire received support from her mother but did not have any friends or social groups. Claire lacked self-confidence and had bouts of depression, she was however happy with where she lived. Claire smoked and would binge drink. Arrangements were made for Claire to attend a self-confidence course. She completed an assessment but did not engage any further despite numerous attempts to contact her. This assessment contains general safe guarding questions but nothing about domestic abuse.

16.4.3 John had an allocated social worker until September 2017. In December 2015 (prior to the review dates) he was in the Hollins Park Mental Health Unit and was assessed as an inpatient. This confirmed he had Care Act eligible needs, the main risks being risk of self-neglect when under the influence of drugs and alcohol, risk of social isolation and homelessness. Although he had two social workers during the period and there were efforts to work with him directly or at through RATI, he remained homeless and resistant to engaging with support to address his needs. Although the case was discussed in supervision, there does not appear to have been a review of the situation and the rationale and basis for continued involvement until September 2017, when the case was due to be transferred as the social worker was moving teams. At this point the case was reviewed and closed as a result of lack of engagement and a view that John had the mental capacity to make his own decisions and was not choosing to accept support for his identified needs

16.4.4 The panel heard that under existing arrangements that John should have been referred to a “hard to house” panel, this referral did not take place.

16.4.5 John’s GP Practice was aware of the patient’s mental health needs but was limited in terms of offering support for both mental and physical health as John didn’t attend appointments.

16.4.6 Claire’s GP Practice did not identify any care and support needs in terms of

physical assistance for her, however Claire was supported in assessments and referrals for both her mental and primary care physical health needs. The Practice also provided timely appointments and carried out assessments around Mental health well-being as well as her physical health.

16.4.7 Accommodation for John was often provided by RATI for the period under review. John had been known to the service for 3 or 4 years so was well known to staff. He received support with his finances and was always advised to seek help to address his drug, alcohol and mental health issues. Staff also acted as intermediaries for Adult Social Care. The staff also knew Claire who attended support groups at the centre and would offer similar advice about alcohol and mental health issues.

16.4.8 No agency referred Claire to Adult Social Care during the period of the review and there was therefore no opportunity for Adult Social Care to conduct a care and support assessment (Care Act 2014) for Claire to establish or confirm whether she had eligible care and support needs. The panel considered that with the information available now she would have been appropriate for a care and support assessment.

16.4.9 John was known to Adult Social Care throughout the time period of the review. The purpose of their involvement was to support him to identify accommodation and to access support with his social isolation. There is no evidence of a review of his needs during the period of the review despite John's lack of engagement with his social workers and the ongoing self-neglect and alcohol misuse which impacted on the availability of suitable housing provision.

16.4.10 In November 2016, John's case was transferred from social worker 1 to social worker 2 as social worker 1 was leaving the authority. John preferred to engage with RATI and would refuse to engage with his social workers. The panel heard that John had been aggressive to his first social worker and there was a view expressed that she may have been frightened of him. It is possible that this may go some way to explain the low level of direct contact through the review period.

16.5 **What information did your agency have to suggest that Claire or John may have been experiencing or at risk of abuse or neglect? Were any opportunities missed to make a safeguarding adult alert/referral?**

16.5.1 Cheshire Constabulary did not have any information to suggest that either Claire or John were at risk of abuse or neglect which necessitated a safeguarding referral, other than the identified domestic abuse and referral to

the IDVA service, Pathways and the intervention of MARAC.

16.5.2 Claire's GP practice could have considered making a safeguarding adult referral for Claire. This would have been likely to be Care Act (Care and support) assessment under section 9 of the Care Act 2014 to determine if Claire had care and support needs. The practice could also have considered a referral to the IDVA service managed by Refuge.

16.6 **How did your agency ascertain Claire's wishes and feelings about her victimisation and were her views taken into account when providing services or support?**

16.6.1 Cheshire Constabulary dealt with several incidents involving Claire as a victim of abuse by John. Positive action was always taken with John being arrested even when there was no complaint from Claire. It was necessary to override her views on these occasions in an effort to protect her. She also stated that she didn't want the bail conditions that had been imposed on John. These however remained in place and John would be further arrested for breaching them. Claire retrospectively made a complaint about being assaulted by John. As such he was arrested for assaulting Claire and breach of bail. Claire did not make a statement about the assault, however John was charged with the breach of bail and put before the Court.

16.7 **What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?**

16.7.1 When John was arrested by Cheshire Constabulary for assaulting Claire he was interviewed regarding the offence and his behaviour. He denied the allegations and as such did not accept the alleged behaviour. He was charged with an offence of assault and put before the Court. There is no record of any additional referral made to address his abusive behaviour.

16.7.2 There were perpetrator programmes available in Warrington at the relevant time, however as John did not acknowledge his abusive behaviour he was correctly not put forward for these services.

16.7.3 Whilst in HMP Altcourse John was not assessed through a sentence planning process due to being sentenced to less than twelve months.

16.7.4 Given John's refusal to acknowledge his offending behaviour it was not possible for agencies to establish the reasons for his behaviour.

16.8 **Was there sufficient focus on reducing the impact of the perpetrator's abusive behaviour towards the victim by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?**

16.8.1 Cheshire Constabulary was positive in it's dealings with John and made several arrests for assaults, breaches of bail and public order offences. After the original offence on 30 September 2017, John was refused bail and placed before the court the following day on every occasion he was arrested. John was not compliant with the bail conditions by repeatedly attending Claire's home address. The magistrates bailed him until his court appearance on 2 January 2018 where he was remanded into custody.

16.8.2 CGMCRC assessed John as presenting a medium Risk of Serious Harm (RoSH). As a result, a risk management plan (RMP) setting out the actions they intended to take in order to manage the risks presented by John was completed. These were not reviewed when John was charged with assaulting Claire. The RMP should have included actions to manage the risks associated with the assault. These could have included making regular contact with the police to obtain detail around domestic abuse call outs, work to address violent offending, and details of action which would be taken in the event of an escalation in this type of behaviour/ offending.

16.8.3 John was also managed in line with a sentence plan (SP). The plan created addressed the key issues linked to John's offending and areas where he needed support, i.e. alcohol misuse and accommodation. As with the RMP however, this should have been reviewed after John had been charged with assaulting Claire and when risks in relation to domestic abuse became evident.

16.9 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?**

16.9.1 The referral for MARAC came from the Warrington Hospital and was based on the professional judgement of the Adult Safeguarding Team. Claire had attended the Accident and Emergency Department complaining of rib pain. It was established that this was as a result of domestic abuse after the incident on 2 November 2017. A DASH risk assessment was completed and a MARAC requested.

16.9.2 On 6 December 2017, the MARAC was held to discuss Claire and John. The meeting shared information about the incidents of 30 September 2017, and 2 November 2017, and Claire's attendance at Warrington Hospital on 6

November 2017. The IDVA service run by Refuge was to be the lead professional for contact with Claire.

16.9.3 The minutes of the meeting do not accurately capture the context of the discussions or actions. It is also apparent that not all agencies were present and some representatives that were present were deputising for a regular member.

16.9.4 The minutes suggest that the IDVA had spoken to Claire's mother who reportedly knew nothing about the incidents. This was not the case no contact was made between a member of IDVA and Claire's mother and this discussion was incorrectly recorded in the minutes.

16.9.5 Five actions were set at the meeting, these were:

1. The IDVA service and Pathways to have discussions with Claire around alcohol and encourage engagement if required. Result: Pathways report that as Claire was not in service at the time of the discussion, Pathways did not have consent to contact Claire or complete assertive outreach to encourage service engagement and required a referral from another agency or a direct self-referral from Claire to initiate contact. No referral was received. The IDVA service was unable to contact Claire following the MARAC meeting.

2. CGMCRC to signpost John to Pathways. Result: this action was not completed, it is to be noted that there was only a short period of time between the MARAC and John being remanded in custody.

3. The Police to confirm Claire's address. This was done in the meeting.

4. Golden Gates Housing Trust (GGHT) now Torus to visit Claire to establish contact details. Attempts were made to contact Claire but failed.

5. GP Practice to "flag accordingly". This is written off as completed 18 December 2017.

16.9.6 There was no follow up to ensure that the actions had been completed. Pathways stated that they couldn't act until they had received a referral for Claire; in fact, Cheshire Constabulary sent a referral to them on 3 November 2017. In any event the MARAC was asking for action and the issue of referral should have been resolved between agencies. It was unacceptable to simply say that nothing could be done. The IDVA service contacted Pathways

on 5 December to see if they had had contact with Claire to see if Pathways could assist the IDVA service in contacting Claire.

16.9.7 The panel heard that information sharing from the MARAC to some agencies was problematic. Whilst there are designated points of contact within agencies information is not effectively processed once it reaches the individual agency.

16.9.8 The representative for Housing plus did not attend the MARAC nor did a deputy. On the information sent out to all agencies prior to the MARAC it was evident that John was homeless and staying at the RATI. This should have triggered a request for information from RATI or an invite for a member of their staff to attend the MARAC. This was the responsibility of Housing plus.

16.9.9 There was no process to request information from GPs or send information to GPs regarding the outcome of MARAC meetings. The panel heard this was due to a staffing issue and the problem is now being resolved.

16.9.10 The actions set at MARAC were either not completed or ineffective.

16.9.11 The panel heard that a series of workshops had been held to review MARAC processes prior to October 2017, and a final draft of a revised MARAC protocol had been sent to relevant agencies on 27 October 2017. The panel reflected that elements of that revised protocol had not been embedded at the time of the MARAC meeting which considered Claire and John's case.

16.10 **How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?**

16.10.1 Information relating to Claire and John was shared with other agencies via the VPA referral process and the MARAC. This allowed agencies to share information they held. It was known that both subjects were known to Pathways, Claire to New Directions and John was open to the Adult Social Care complex team but no work had been completed with him since January 2017.

16.10.2 A DASH form was not submitted on 30 September 2017 by Cheshire Constabulary however, a VPA was submitted which prompted an IDVA to try and contact Claire on several occasions. The failure to submit a DASH did not have a negative impact on this occasion.

16.10.3 There was one occasion whereby a VPA[6] was not submitted (10 December 2017) which should have been, particularly given the fact that the incident only took place 4 days after the MARAC meeting and should have been shared with the IDVA who were the lead agency.

16.10.4 CGMCRC practice is that prior to a prisoner's release there will be liaison between those managing the prisoner in custody and the staff who are appointed to manage him on release. This is known as Through the Gate (TTG). This includes contact and information sharing between the case manager and HMP to formulate release plans. This was not done. Had the guidance been followed improved planning around John's accommodation and other immediate needs could have been completed. There was therefore a lack of timely and relevant information sharing and cooperation.

16.10.5 CGMCRC's agreed procedures for the inter-agency sharing of information were not always used to good effect after John was charged with the assault of Claire in September 2017. Although information regarding John's offending behaviour was shared by Cheshire Constabulary, staff did not act on this. An example of this would have been the completion of a home visit.

16.10.6 RATI staff who knew John and Claire better than any other agency appeared to have not had relevant information passed to them. This was particularly pertinent when John was released from prison on 3 April 2018, as they were not told that he had given them as his release address.

16.10.7 The panel heard that John did not stay at RATI after his release from prison. Staff were told by other residents that he had been released and that they had seen him in the town centre. If RATI had been informed that John was supposed to be staying with them his non - compliance with his licence conditions would have been apparent sooner.

16.11 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator?**

16.11.1 Refer to paragraph 11.

16.11.2 All persons involved are of a white British heritage.

16.11.3 No diversity issues have been identified that have impacted on the circumstances leading to the murder of Claire.

[6] The VPA form is submitted by the officer dealing with an incident and allows Cheshire Constabulary to appropriately assess a person's vulnerability and make referrals to other agencies.

16.12 **How effective was your agency's supervision and management of practitioners involved with the response to the needs of Claire and John and did managers have effective oversight and control of the case?**

16.12.1 John was remanded into custody at HMP Altcourse on 3 January 2018. At this time there was no restraining order in place in relation to John contacting Claire. John was found guilty of assaulting Claire on 19 February 2018 and sentenced to a total of 6 months imprisonment; he was also issued with a magistrate's restraining order forbidding him contact with Claire. An email was sent to HMP Altcourse containing the details of the restraining order. This should then have been added to John's Prison-NOMIS record. John should then have been managed under Harassment Public Protection Measures (HPPM). All such prisoners should be identified on reception and their communications restricted and monitored. As such he should have been served with HPPM form outlining the terms of the restraining order and who he could not contact. This did not happen. [see also para 15.5.7 and panel recommendation 6]

16.12.2 Cheshire Constabulary dealt with John and Claire/John on a number of occasions. There were no issues identified with the supervision of any case, other than when John was recalled to prison. A process driven approach was evident. From the evidence in this review it can be seen that John regularly misused alcohol, frequented Warrington town centre and was easy to locate as he always gravitated to Claire's house or RATI. The prison recall document does give a brief synopsis of the offence for which John was imprisoned and the address where the offence was committed.

16.12.3 The recall was held within the police control centre for 2 days with the control centre being unable to identify a resource in order to allocate the task of finding John.

Time & Date	**Action**
16.43 6/4	Recall received by police, unable to identify a resource to deal
12.23 8/4	Passed to local sergeant
22.27 8/4	Allocated to patrol officer
05.26 9/4	Officer reports has been unable to deal with the recall

16.12.4 Other than administrative tasks there is no evidence that any practical steps were taken to locate and arrest John before he murdered Claire late in the evening of 10/4/18.

16.12.5 The police response to dealing with John's recall to prison was inadequate given that his risks were known, Claire was known to be his victim and he had previously been found at her house on several occasions. It is likely that John would have been easy to find had anyone looked for him.

16.12.6 There is evidence of good management oversight by CGMCRC supervision. John had two case managers during the period under review. At the point of transfer there was appropriate management oversight.

16.12.7 The Recall and Review report Annex A that was submitted to NOMs by CGMCRC could have given more focus to the fact that John's sentence was for a domestic assault. Section 7 could have given Claire's address as a possible address for John. Section 8 could have mentioned Claire being a vulnerable adult to assist the Police with an arrest plan. Section 20 focusses on the risk of reoffending but the emphasis is on drunkenness related offences and domestic abuse with regards to Claire.

16.12.8 Warrington Borough Council Adult Social Care had an open case on John during the period under review. He had two social workers during this period. It is accepted that John was difficult to engage with however there was only one face to face meeting during this time. More effective supervision might have prompted a review of the objectives and rationale for involvement and prevented the apparent drift in this case.

16.13 **Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to Claire and John or to work with other agencies?**

16.13.1 The main resourcing issue identified in this review is that of Cheshire Constabulary's inability to resource the arrest of John when he was recalled to prison. The Command and Control system records on a number of occasions, "No resource available". The incident is then deferred. Process dictated that this system of resource allocation continued for a set period of time. After this time there was a different process. Within Cheshire Constabulary there would have been a resource available, but this would have stepped outside of normal practice so was not adopted. For example, Police officers and Community Support officers from the local policing team could have been briefed and tasked to locate John.

16.13.2 There were no resourcing issues identified that affected Cheshire Constabulary's ability to work with other agencies.

16.13.3 The panel heard that a previous post focussing on outreach to homeless

people had been dis-established several years ago due to a lack of funding. Had this post been in place then John would have been within the client group.

16.13.4 No other agency reported issues in relation to capacity or resources that affected their ability to provide services to Claire or John.

16.14 **Do the lessons arising from this review appear in other reviews held by Warrington Community Safety Partnership?**

16.14.1 There is one previous review held by the Warrington CSP. There were 4 main recommendations which do not have a direct relevance to this review.

16.15 **What knowledge did family, friends and employers have that the victim was in an abusive relationship and did they know what to do with that knowledge?**

16.15.1 In a previous relationship Claire's mother attended the GP Practice with Claire when she had a facial injury and was concerned that this was as a result of domestic abuse. Claire denied any domestic abuse had taken place.

16.15.2 With the full benefit of hindsight Claire's family can now see that Claire may have been the victim of domestic abuse for a number of years before her death.

16.16 **Were there any examples of notable good practice?**

16.16.1 The notable example of good practice in this review is the referral of Claire for a MARAC. This was made by the Adult Safeguarding Team at Warrington Hospital who got involved with Claire when she had attended at the A&E Department. She disclosed domestic abuse to them. A DASH risk assessment was completed and a request for a MARAC. This enabled other Agencies to share information about John and Claire.

17 CONCLUSIONS

17.1 Claire and John met in 2016, in Warrington town centre. John had moved from another area and was homeless. The focal point for their early relationship was the art classes run at the Nora Street community Centre. Both had alcohol and mental health issues. As time went by John spent time at Claire's flat. This relationship was mostly unknown to Agencies; however, John was frequently involved with the Police for drunkenness and public order offences. He was arrested on several occasions. Claire's family were not

aware of this relationship until after her death. Staff at the RATI were aware of the relationship between the couple but not the domestic abuse. They did attempt to give the couple advice and assistance whilst recognising that Claire and John had the capacity to make their own decisions. Claire was offered support services, for example housing, but then did not keep to appointments. John engaged with staff at the RATI but would not engage with Adult Social care.

17.2 There were occasions when Claire presented to her GP with injuries. There was inconsistency of approach with regards to asking about domestic abuse and if it was disclosed opportunities to further explore were missed. There is evidence to support the fact that Claire suffered domestic abuse in all three of her adult relationships. This was over a period of 20 years and does not appear to have been part of a holistic approach to Claire's care. Consideration could be given to commissioning the IRIS[7] model locally to raise awareness of the issues surrounding domestic abuse and how to refer women to IDVAs.

17.3 Claire was referred to MARAC following a referral from Warrington Hospital. The staff involved in this referral correctly identified that Claire was a high-risk victim and acted in accordance with established protocols. This is good evidence that domestic abuse training is embedded in practice in the Warrington and Halton Hospitals NHS Foundation Trust.

17.4 The MARAC meeting that heard Claire and John's case identified Refuge (IDVA) as the nominated lead professional for communication with Claire. The MARAC's purpose is to share information amongst agencies and then formulate an action plan to keep the victim safe. In this case key information was not available to the meeting because there was no input from RATI. Five actions were identified but not all of these were completed and there was no follow up to ensure that the actions were finalised.

17.5 Safelives[8] have produced videos to help with understanding the MARAC process. It explains that the MARAC co-ordinator is the unsung hero and essential to the efficient running of the process. https://youtu.be/Dp9H5SBOKIg

17.6 There were different perceptions as to whether or not a VPA was a referral; Police thought that it was, Pathways thought that it was not. This confusion meant that Claire was not contacted by Pathways.

[7] Identification & Referral to Improve Safety
[8] SafeLives is a UK-wide charity dedicated to ending domestic abuse

17.7 The actions generated by the MARAC meeting were not wholly realistic, for example the panel heard that the action accepted at the meeting by the Pathways representative for Pathways to contact Claire was against their policy and should not have been accepted. This is said to be due to an inexperienced member of staff attending the meeting. Overall the MARAC process was ineffective in this case.

17.8 A series of workshops had been held to review MARAC processes prior to October 2017, and a final draft of a revised MARAC protocol had been sent to relevant agencies on 27 October 2017. The panel reflected that elements of that revised protocol had not been embedded at the time of the MARAC meeting which considered Claire and John's case.

17.9 John entered HMP Altcourse on 5 January 2018 as a remand prisoner with no restraining order in place. He was remanded for assaulting Claire. He attempted to phone Claire on 54 occasions before he was convicted on 19 February 2018. Prior to being remanded into custody Claire was afforded the protection of bail conditions, however once remanded the conditions no longer applied. The guidelines set out in the National Offender Management Service Public Protection Manual 2016 Chapter 6 refers to tackling witness intimidation by remand prisoners. This should be read in conjunction with PSI 46/2011, Prisoner communication services. PSI 46/2011, Tackling witness intimidation by remand prisoner, and PSI 4/2016, The interception of communications in prisons and security measures. Essentially this sets out a process that can protect witnesses from intimidation. If bail has been refused and one of the reasons was because there were substantial grounds to believe that the perpetrator would interfere with witnesses and that interference constitutes intimidation, then the Police can submit this to CPS on the MG6 which would be forwarded to the prison via the PER. The prison governor can then take appropriate steps to mitigate the risk whilst the defendant is on remand. The numbers of such requests per year would suggest that this is not being utilised in domestic abuse cases. The panel discussed this and were of the opinion that the continual communication to Claire from John was a form of coercion and control which could be construed as an act of intimidation.

17.10 HMP Altcourse received John as a convicted prisoner on 19 February 2018, as a result of his conviction at NCMC for assaulting Claire and being in possession of a knife. Accompanying him was a 12-month restraining order issued by the Magistrates preventing John from having any contact with Claire. HMP Altcourse did not appear to follow the guidelines set out in the National Offender Management Service Public Protection Manual 2016. He should have been managed under Harassment Public Protection Measures

which would have ensured his communications were managed and monitored. After his conviction he attempted to phone Claire on 160 occasions. Most of the calls did not connect. He also wrote several letters to her. The system failed Claire.

17.11 Cheshire Constabulary failed to arrest John after he was recalled to prison. Their internal processes did not identify the resources that may have been able to arrest John in a timely manner but instead followed their rigid command and control processes.

17.12 RATI knew Claire and John better than any other agency and could have assisted other agencies with engagement, particularly with John. It is also apparent that they did not have access to relevant information that could have kept Claire safe. For example, they were not aware of the MARAC. This was also the case when John was released from prison, they were told by other users of their service that John had been seen in the town centre.

17.13 When John was released from HMP Altcourse he gave his CGMCRC case manger the RATI as his release address. RATI do not and would not have held a bed for John. It operates on a need's basis and not like a bookable bed and breakfast. This should have been identified and mitigated by CGMCRC.

18 Learning

18.1 **Narrative**

With the full benefit of hindsight Claire's family can now see that Claire may have been the victim of domestic abuse for a number of years before her death.

Learning

There is a continuing need to raise awareness of domestic abuse and healthy relationships within the community.

Recommendation 1

18.2 **Narrative**

A MARAC was held to discuss the relationship between Claire and John after it had been identified that Claire was suffering domestic abuse. This was ineffective and did not contribute to keeping Claire safe.

Learning

Agencies must take a greater degree of responsibility to complete actions than there was in this case. This would have been achieved by better coordination and governance. Agencies need to mainstream work on MARAC cases and ensure that if key members of staff are unavailable then MARAC related work is appropriately allocated to other staff.

Recommendation 2

18.3 **Narrative**

There was confusion during the MARAC meeting and after about whether or not a VPA was a referral and hence could the victim be contacted. The Police believed that it was but the Pathways service were not of the same view.

Learning

Staff need to be aware of their agency's respective information sharing protocols and if unsure seek clarification at the earliest opportunity.

Recommendation 3

18.4 **Narrative**

There are 2 examples in this case where new guidance has been issued to agency/agencies at crucial times. The MARAC guidance workshops and the NOMS Public Protection manual 2016, (Issued November 2017). Neither of these appears to have been effective in this case.

Learning

Agencies should have in place a methodology to check and ensure that any new policy is embedded within the respective agencies practice.

Recommendation 4 and 5

18.5 **Narrative**

There were several occasions where information was either not shared or sought which could have assisted in making Claire safer. RATI were not informed about John's release, nor were their staff asked to contribute to the MARAC

Learning

Third sector organisations make a valuable contribution to keeping potentially vulnerable people safe. Policies and working practices need to be established which recognise and encourage third sector contributions.

Recommendation 6

18.6 **Narrative**

It has been noted in the review that there have been occasions when Claire attended appointments with her GP practice. She was invariably seen by different doctors and there were differing approaches to discussions about domestic abuse and any subsequent referrals.

Learning

It is important that health professionals have a consistent approach in supporting victims of Domestic Abuse. The panel heard that Warrington Borough Council Families and Wellbeing Directorate have provided domestic abuse training to health care professionals. This is a positive as the referral to MARAC by hospital staff indicates. Since then training has been provided for 140 GPs and practice nurses. The panel reflected that it is important that all agencies are fully engaged with domestic abuse training.

Recommendation 7

18.7 **Narrative**

Services were unable to keep Claire or John engaged and the panel heard that John was aggressive and intimidating towards a social worker. There was little visibility of the couple or their relationship across the partnership until 6 December 2017.

Learning

Professionals need to be able to share information on difficult cases where clients are challenging to engage. A partnership approach to these clients has an enhanced chance of success as opposed to a single agency approach. The panel felt that this would be the most effective way of engaging challenging clients to offer them support and thereby reduce risk.

Recommendation 8

19 RECOMMENDATIONS

19.1 Warrington Community Safety Partnership to raise the profile of domestic abuse services within the Borough with emphasis on raising awareness of where to get advice and access to help and support.

19.2 Warrington Community Safety Partnership should put in place processes by which it can gain assurance that.

1. MARAC actions are meaningful and contribute to the safety of the victim.
2. Agencies are held to account for the delivery of agreed actions.
3. Effective MARAC co-ordination arrangements are in place.

19.3 Warrington Community Safety Partnership should seek assurance from it's constituent agencies and the commissioners of Pathways that the purpose and status of a VPA is consistently understood across the partnership.

19.4 Warrington Community Safety Partnership should seek assurance from its constituent partners and third sector agencies that they commission that an appropriate mechanism is in place to ensure that domestic abuse and safeguarding policies are embedded in practice.

19.5 Warrington Community Safety Partnership should seek written assurance from HMP Altcourse that the failure in internal communications which led to John's restraining order not being recorded and his subsequent ability to communicate with Claire in breach of the restraining order has been effectively resolved.

19.6 Warrington Community Safety Partnership should seek assurance from its constituent partners that there are no inappropriate barriers to sharing information with the third sector partners.

19.7 Warrington Community Safety Partnership should seek assurances from all agencies and commissioned third sector agencies that they are fully engaged in local domestic abuse training.

19.8 Warrington Community Safety Partnership and Warrington Safeguarding Adult Board should consider the feasibility of developing a coordinated case management/information sharing approach to the care of high intensity service users, who for whatever reason engage in risky behaviours that are not captured by other safeguarding processes. The two boards are best placed to collaborate and facilitate discussion around this with a view to agreeing and implementing a multi-agency protocol.

Single agency recommendations

19.9 **Torus New Leaf**

When clients are being assessed for the 1-2-1 mentor scheme this assessment should include asking questions about domestic abuse as well as

safeguarding issues.

19.10 **Warrington CCG**
Ensure that staff at GP practices understand the indicators of possible domestic abuse and how to ask about domestic abuse in a sensitive way and manage any disclosures made. Consideration should be given to commissioning the IRIS[9] model locally to raise awareness of the issues surrounding domestic abuse and how to refer women to IDVAs.

19.11 **Warrington and Halton Hospitals NHS Foundation Trust**
Staff should receive targeted domestic abuse training with a focus on recognising controlling and coercive behaviour.

19.12 Targeted DASH completion and assessment training should be provided with a focus on enabling staff in recognising domestic abuse situations; they should be equipped with the knowledge of how to escalate situations in which there is danger even when the victim does not know/realise danger is present, or does not consent to receiving support in high risk situations.

19.13 Staff should be made aware of their statutory and professional obligations and reminded of their professional responsibilities with regard to documentation and record keeping.

19.14 **Pathways to recovery (Change, Grow, Live)**
Pathways to identify two additional staff members as MARAC deputies who will receive the local induction to MARAC, including shadowing a MARAC session, and training from the lead Pathways MARAC representative on record keeping.

19.15 **Warrington Borough Council Adult Social Care**
WBC Adult Social Care to undertake an audit of cases to confirm the effectiveness of recent strength-based approach training including the use of and clarity around service user outcomes.

19.16 WBC Adult Social Care to ensure the integration of the Skills for Care Knowledge and Skills Statement for Practise Supervisors within its supervision policies and procedures.

19.17 WBC Adult Social Care to ensure that supervisors review each case when there is a transfer between case managers to maintain direction and focus.

19.18 WBC Adult Social Care to raise awareness of the use of multi-agency

[9] Identification & Referral to Improve Safety

frameworks to escalate and share risks in relation to capacitated adults, including the lessons identified in the recent Safeguarding Adults Board audit.

19.19 **Cheshire and Greater Manchester Community Rehabilitation Company (CGM CRC)**
CGM CRC to improve the knowledge, understanding and effective use of Through the Gate (TTG) guidance and procedures for relevant staff.

19.20 CGM CRC to deliver SARA3 training across the organisation and across all operational grades of staff.

19.21 CGM CRC to develop and embed Quality Assurance and continuous improvement in relation to EMO arrangement.

19.22 **Cheshire Constabulary**
To review policies and procedures in relation to dealing with prisoner recall orders.

19.23 Cheshire Constabulary to raise awareness amongst officers of the importance of submitting a VPA in cases of breaches of bail when the bail conditions have been imposed as a result of a domestic incident.

19.24 Cheshire Constabulary to consider making use of the current legislation around the harassment and intimidation of witnesses when a remand is sought for the perpetrator of domestic abuse. (Para 17.9)

APPENDIX A

Warrington Community Safety Partnership

No	Recommendation	Lead Agency / Officer	Date of Completion & Outcome
1	Warrington Community Safety Partnership to raise the profile of domestic abuse services within the Borough with emphasis on raising awareness of where to get advice and access to help and support.	WCSP PW / AA (MB)	CSP Reviewed Action - Closed 29 August 2019
2	Warrington Community Safety Partnership should put in place processes by which it can gain assurance that. 1. MARAC actions are meaningful and contribute to the safety of the victim. 2. Agencies are held to account for the delivery of agreed actions. 3. Effective MARAC co-ordination arrangements are in place.	WCSP PW/AA (MB)	CSP Reviewed Action - Closed 29 August 2019
3	Warrington Community Safety Partnership should seek assurance from its constituent agencies and the commissioners of Pathways that the purpose and status of a VPA is consistently understood across the partnership	WCSP CF	CSP Reviewed Action - Closed 14 November 2019
4	Warrington Community Safety Partnership should seek assurance from its constituent partners that an appropriate mechanism is in place to ensure that domestic abuse and safeguarding policies are embedded in practice.	WCSP PW/AA (MB)	CSP Reviewed Action - Closed 29 August 2019

No	Recommendation	Lead Agency / Officer	Date of Completion & Outcome
5	Warrington Community Safety Partnership should seek assurance from its constituent partners that there are no inappropriate barriers to sharing information with third sector partners.	WCSP	CSP Reviewed Action - Closed 14 November 2019
6	The Home Office should seek assurance from HMPPS that in all prisons in England and Wales the guidance given in the NOMS Protecting Public Manual 2016; is complied with in relation to the restriction of communications by prisoners who have a Court restraining order in place when they enter custody.	Home Office	CSP Reviewed Action - Closed 14 November 2019
7	Warrington Community Safety Partnership should seek assurances from all agencies and commissioned third sector agencies that they are fully engaged in local domestic abuse training.	WCSP PW/AA (MB)	CSP Reviewed Action - Closed 29 August 2019
8	Warrington Community Safety Partnership and Warrington Safeguarding Adult Board should consider the feasibility of developing a coordinated case management/information sharing approach to the care of high intensity service users, who for whatever reason engage in risky behaviours that are not captured by other safeguarding processes. The two boards are best placed to collaborate and facilitate discussion around this with a view to agreeing and implementing a multi-agency protocol.	WCSP MM to lead on group to explore	CSP Reviewed Action - Closed 14 November 2019

No	Recommendation	Lead Agency / Officer	Date of Completion & Outcome
9	When clients are being assessed for the 1-2-1 mentor scheme this assessment should include asking questions about domestic abuse as well as safeguarding issues.	Torus	CSP Reviewed Action - Closed 29 August 2019
10	Ensure that staff at GP practices understand the indicators of possible domestic abuse and how to ask about domestic abuse in a sensitive way and manage any disclosures made. Consideration should be given to commissioning the IRIS model locally to raise awareness of the issues surrounding domestic abuse and how to refer women to IDVAs	Warrington CCG	CSP Reviewed Action - Closed 14 November 2019
11	Staff should receive targeted domestic abuse training with a focus on recognising controlling and coercive behaviour.	WHHFT	CSP Reviewed Action - Closed 29 August 2019
12	Targeted DASH completion and assessment training should be provided with a focus on enabling staff in recognising domestic abuse situations; they should be equipped with the knowledge of how to escalate situations in which there is danger even when the victim does not know/realise danger is present, or does not consent to receiving support in high risk situations.	WHHFT	CSP Reviewed Action - Closed 29 August 2019
13	Documentation of conversations between professionals and of plans regarding the DASH process is important. In this instance all details of conversations between professionals were not always recorded	WHHFT	CSP Reviewed Action - Closed 29 August 2019

No	Recommendation	Lead Agency / Officer	Date of Completion & Outcome
14	Pathways to identify two additional staff members as MARAC deputies who will receive the local induction to MARAC, including shadowing a MARAC session, and training from the lead Pathways MARAC representative on record keeping.	Pathways CF	CSP Reviewed Action - Closed 29 August 2019
15	WBC Adult Social Care to undertake an audit of cases to confirm the effectiveness of recent strength-based approach training including the use of and clarity around service user outcomes.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
16	WBC Adult Social Care to ensure the integration of the Skills for Care Knowledge and Skills Statement for Practise Supervisors within its supervision policies and procedures.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
17	WBC Adult Social Care to ensure that supervisors review each case when there is a transfer between case managers to maintain direction and focus.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
18	WBC Adult Social Care to raise awareness of the use of multi-agency frameworks to escalate and share risks in relation to capacitated adults, including the lessons identified in the recent Safeguarding Adults Board audit.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
19	CGM CRC to improve the knowledge, understanding and effective use of Through the Gate (TTG) guidance and procedures for relevant staff.	CRC	CSP Reviewed Action - Closed 29 August 2019

No	Recommendation	Lead Agency / Officer	Date of Completion & Outcome
20	CGM CRC to deliver SARA3 training across the organisation and across all operational grades of staff.	CRC	CSP Reviewed Action - Closed 29 August 2019
21	CGM CRC to develop and embed Quality Assurance and continuous improvement in relation to EMO arrangement .	CRC	CSP Reviewed Action - Closed 29 August 2019
22	To review policies and procedures in relation to dealing with prisoner recall orders.	CC	CSP Reviewed Action - Closed 29 August 2019
23	Cheshire Constabulary to raise awareness amongst officers of the importance of submitting a VPA in cases of breaches of bail when the bail conditions have been imposed as a result of a domestic incident.	CC	CSP Reviewed Action - Closed 29 August 2019
24	Cheshire Constabulary to consider making use of the current legislation around the harassment and intimidation of witnesses when a remand is sought for the perpetrator of domestic abuse. (Para 17.9)	CC	CSP Reviewed Action - Closed 29 August 2019