SAFER KIRKLEES - KIRKLEES COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Victim Lucy

Died February 2017

Review Panel Chair	David Hunter
Report Author	Paul Cheeseman
Date	January 2019

CONTENTS

1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to and supported Lucy, a resident of Kirklees, prior to her death in February 2017.

1.2 Lucy had been in a brief relationship with Roger and lived at address one[1].

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'.[2]

1.4 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'.

1.5 The domestic review panel wish to extend their condolences to Lucy's family on their loss.

[1] This is an address in the Kirklees area of West Yorkshire where Lucy and Roger lived.
[2] Home Office Guidance Domestic Homicide Reviews December 2016.

2. TIMESCALES

2.1 On 10 April 2017 the Kirklees Safer Stronger Communities Partnership Standing Panel determined that the death of Lucy met the criteria for a domestic homicide review [DHR].

2.2 The first meeting of the review panel took place on 12 May 2017.

2.3 The DHR covers the period 3 March 2014 [when Roger entered the country] to 2 April 2017. The end date is after the death of Lucy and caters for child safeguarding.

2.4 The domestic homicide review was presented to Kirklees Safer Stronger Communities Partnership on 25 April 2018 and concluded on 25 May 2018 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014.

3.2 Lucy's children, her mother and sister did not want to be involved in the review. The reasons are in Section 6. Her estranged husband Daniel agreed that the pseudonym 'Lucy' was appropriate for his wife. The panel chair wrote to Lucy's mother and adult children informing them of the name. The offender agreed to be seen and accepted and the pseudonym 'Roger.' The names of any key professionals involved are disguised by use of an appropriate designation

3.3 This table shows the age and ethnicity of the victim, her children, the perpetrator of the homicide and other key individuals.

Name	Relationship	Age[3]	Ethnicity
Lucy	Victim	43	White British
Roger	Perpetrator	41	Black Caribbean
Kamaria	Daughter of victim	26	Mixed white and black Caribbean
Argenta	Daughter of victim	17	Mixed white and black African
Michael	Son of victim	10	Mixed white and black African
Daniel	Husband of victim and father of Michael	<40	Black African male
Former partner of Lucy	Former partner of victim	unknown	Black Caribbean male
Ruth	Estranged wife of Roger	>60	Black Caribbean female
Zara	Friend of Lucy	unknown	White British

[3] At time of homicide

4. TERMS OF REFERENCE

4.1 The panel settled on the following terms of reference. They were shared with Lucy's family in September 2017 who did not respond to the invitation to comment on them.

The purpose of a DHR is to:[4]

a) 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;

b) 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;

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

d) 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;

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

f) Highlight good practice.

Specific Terms

1. What was the agency involvement with Lucy or Roger?

2. Did the agency identify any indicators of domestic abuse in their contact with Lucy? What actions were taken in response to these indicators?

3. What was the agency's awareness of Lucy's social history and did the agency response take account of this as part of their service?

[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

4. Did the agency know or provide a service to Roger? If so what knowledge did the agency have that indicated Roger might be a perpetrator of domestic abuse and what was the response?

5. Is the agency aware of any barriers that might have stopped Lucy from seeking help for the domestic abuse?

6. What knowledge or concerns did the victim's family and friends have about Lucy's victimisation and did they know what to do with it?

7. Were there any concerns about the agency delivering a service to Lucy or Roger, including any racial, cultural, linguistic, faith or other diversity issues?

8. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Lucy and Roger?

9. Does the agency have any concerns about inter-agency information sharing and cooperation in response to Lucy and Rogers's needs? Did the agency share information appropriately with other agencies?

10. Were appropriate policies or procedures followed or were any gaps identified?

11. Within the agency are there arrangements for support to frontline practitioners who might be dealing with domestic abuse? Were these effective in the case of Lucy or Roger?

12. Are there any lessons from the case that can be identified for the agency to improve future practice?

13. Are there any examples of good or innovative practice arising from this case?

14. Is the agency aware of what services are available to perpetrators of domestic violence in Kirklees?

15. If concerns about Lucy or Roger were identified by the agency, was the welfare of the child considered and appropriate referrals made?

Other Matters

The role of the DHR Panel

- To ensure the review is conducted according to best practice; with effective analysis and conclusions of the information related to the case

- The panel has the responsibility for quality assuring and challenging all the Individual Management Reviews [IMR's] submitted and the overview report produced by the Independent Author for the DHR review conducted under the Home Office statutory guidance

- The panel will ensure that the final report recognises any experience of families, friends and colleagues and that this is approached in an open, true and honest manner

- The panel will identify any good practice, common themes and opportunities missed with a focus on lessons learned for agencies

- The panel is responsible for ensuring that the chair of Kirklees Safer Stronger Communities Partnership Board is briefed regularly on the progress of ongoing DHRs and any emerging recommendations

Agreement by Panel Members

- If a panel member is directly involved with this review, or there is any conflict of interest in a particular case, they should remove themselves from panel discussions

- Panel members have agreed to operate according to Kirklees DHR policy and sign confidentiality agreements

- Recognising that the review may identify significant learning for providers of services to the individuals involved in the case, panel members will be suitably positioned within their organisation to bring to the Panel their knowledge and expertise and ability to make decisions

- All panel members will contribute to the Panel process with information relevant to their organisation and specifically related to the individuals identified within the DHR

Membership commitment

- Panel members should ensure they prioritise the need to attend the meetings

- Where the panel member is unable to attend they should liaise with the chair of the panel to agree who will provide appropriate representation at the meeting

- Where possible a representative should be avoided, this helps to ensure consistency in panel members

5. METHOD

5.1 West Yorkshire Police notified Kirklees Safer Stronger Communities Partnership on 4 March 2017 of the homicide and that it potentially met the criteria for a domestic homicide review. The domestic homicide review panel called for reports from agencies on their contacts with Lucy and Roger. Using the agencies' information, the panel determined on 10 April 2017 that a domestic homicide review was required.

5.2 The first meeting of the review panel decided the review period should begin on 3 March 2014 and end on 2 April 2017. The 3 March 2014 was selected because it is the date Roger entered the UK. The end date extends a week beyond Lucy's death to cater for child safeguarding.

5.3 The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made.

5.4 The written material was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.5 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Daniel whose helpful comments were reflected in the final version. The panel also sought independent scrutiny of the report before it was finalised and presented to Kirklees Safer Stronger Communities Partnership. This was because the panel were not able to engage with Lucy's family and felt additional independent scrutiny of their findings was needed. This was undertaken by the Director of the Pennine Domestic Violence Group [PDVG][5] who has expertise in this area and she provided a commentary on the findings.

[5] PDVG is a registered charity that provides support, advice, information and safe accommodation to anyone effected by or experiencing domestic abuse. It has been in operation delivering a range of specialist domestic abuse services in Kirklees since 2002.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES NEIGHBOURS AND WIDER COMMINUITY

6.1 The Family Liaison Officer from West Yorkshire Police delivered letters from the review chair to Lucy's sister, Kamaria and Daniel, informing them of the review and inviting them to contribute after the trial. Also delivered at the same time was the Home Office domestic homicide review leaflet for families and the Advocacy After Fatal Domestic Abuse[6] leaflet. Additionally, the terms of reference for the review were included.

6.2 Daniel responded. The panel chair and a representative from AAFDA saw him at his home in late October 2017. He provided useful background information including evidence from a family member that Roger was aggressive and controlling towards Lucy. He undertook to encourage other family members to help the review.

6.3 In the absence of contact from Lucy's family, the review chair wrote to Lucy's mother to gain further insight into what was happening in Lucy's life. A response was not received. In December 2017 the review chair enlisted the help of West Yorkshire Police in a final attempt to engage with Lucy's family. By 31 December 2017 nothing had been heard from Lucy's family and the review chair felt further attempts to engage with them could be construed as intrusive. Nevertheless, the review chair felt that a personal visit was justified and saw Lucy's mother in January 2018. Whilst courteously received, the chair learned that the family had made a positive decision not to be involved in the review and wanted to consolidate and move forward with their lives. The victim's mother paid the following tribute to Lucy saying, 'she was a wonderful mother, kind and hardworking, whose death was a tragedy for the family'. Further tributes appeared in the local press. Prior to the report being published the family will be written to and offered the opportunity to be briefed on the review's findings.

6.4 The review chair wrote to Roger's estranged wife Ruth who agreed to a meeting. The panel chair and Paul Cheeseman travelled to Manchester and met with Ruth. Her contribution appears later. Like Kamaria, Ruth described Roger as a person who wanted to control the relationship.

6.4 The panel chair met again with Daniel and an AAFDA representative in early April 2018 to receive feedback on the report following which amendments

[6] www.aafda.org.uk A centre of excellence for reviews into domestic homicides and for specialist peer support

were made. Daniel and AAFDA felt that in the absence of family input it was important to see someone who knew Lucy well. They nominated Zara, Lucy's best friend and made a telephone introduction to the chair who saw Zara on 11 April 2018. Her attributed contribution appears in the report.

7. CONTRIBUTORS TO THE REVIEW.

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

Agency	IMR[7]	Chronology	Report
West Yorkshire Police	Yes	Yes	n/a
Kirklees Council Children's Services	Yes	Yes	n/a
South West Yorkshire Partnership NHS Foundation Trust	Yes	Yes	n/a
Calderdale and Huddersfield NHS Foundation Trust	Yes	Yes	n/a
GP Practice Huddersfield	Yes	Yes	n/a
Pennine Acute Hospitals NHS Trust	Yes	Yes	n/a
GP Practice Manchester	No	Yes	Yes

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

7.3 The standard of the individual management reviews was good.

[7] Individual Management Review

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Saf Bhuta	Head of Safeguarding and Quality	Kirklees Council
Paul Cheeseman	Support to panel chair Author	Independent
Ian Clarkson[8]	Interim Service Manager	Kirklees Council
Amanda Evans	Service Director for Adult Social Care Operations	Kirklees Council
Christina Fairhead	Designated Nurse, Safeguarding Children	NHS Greater Huddersfield CCG and North Kirklees CCG
Alexia Gray	Service Manager for Domestic Abuse and Safeguarding Partnerships	Kirklees Council
Rebecca Hirst	Director and independent report scrutiniser for this review	The Pennine Domestic Violence Group
David Hunter	Panel chair and author	Independent

[8] Represented Children's Services at the final panel meeting.

Clare Robinson	Designated Nurse, Safeguarding Adults	NHS Greater Huddersfield CCG and North Kirklees CCG
Seth Robinson	Detective Inspector	West Yorkshire Police
Vicky Thersby	Head of Safeguarding	Calderdale and Huddersfield NHS Foundation Trust
Sally Williams	Head of Service, Integrated Response, Family Support and Child Protection	Kirklees Council

8.2 The chair of Kirklees Safer Stronger Communities Partnership was satisfied that the panel chair was independent. In turn, the panel chair believed there was sufficient independence and expertise of the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met four times and matters were freely and robustly considered. Outside of the meetings the chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

9.2 The chair completed forty-one years in public service [the military and a British police service] retiring, from full time work in 2007. The author completed thirty-five years in public service [British policing and associate roles] retiring from full time work in 2014. Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews.

9.3 The chair undertook domestic homicide reviews in Kirklees in 2013 and 2014 and the author wrote the report for the latter. Otherwise neither the chair nor author has ever worked in Kirklees or for any agency providing information to the review.

10. PARALLEL REVIEWS

10.1 On 14.03.2017 Her Majesty's Coroner for Kirklees opened and adjourned an inquest into Lucy's death pending the outcome of the criminal trial. Subsequently the inquest was closed.

10.2 West Yorkshire Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.3 The chair is not aware that any other agency has conducted a review or investigation into Lucy's death nor intends to do so.

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

11.2 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if—
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[9]

11.3 Lucy suffered some mild bouts of depression. However, there was nothing to suggest this impaired her ability to carry out normal day-to-day functions. Zara was full of praise for Lucy's business acumen. Ruth said that Roger misused alcohol and illegal drugs including cannabis. Illegal drugs and alcohol are statutorily excluded from the definition of disability under the Act.

11.4 Roger's Jamaican heritage did not preclude him from asking for or receiving services. His first language was English, and he never needed an interpreter.

11.5 No agency held information that indicated Lucy or Roger lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them.[10]

11.6 Roger said he was brought up in an environment dominated by his father and almost daily witnessed domestic abuse by his father against his mother. He and his male and female siblings were also victims of domestic abuse perpetrated by their father. Roger felt that after he moved to England the expectations placed on him by Ruth and latterly Lucy, challenged his idea of how he should live his life. The DHR Chair discussed with Roger what those expectations were. Roger felt he was expected to work and contribute to the household in terms of finance and everyday

[9] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.
[10] Mental Capacity Act 2005

domestic tasks. He gave an example of being ‘required’ to decorate which he thought was not his job. Roger’s preference was for meeting with friends, drinking and using illegal drugs.

12. DISSEMMINATION

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

The victim's: mother, adult daughter, sister and Daniel[11]

Police and Crime Commissioner for West Yorkshire

The perpetrator's Offender Managers from Her Majesty's Prison and Probation Service

Kirklees Safer Stronger Communities Partnership

Kirklees Council

West Yorkshire Police

South West Yorkshire Partnership NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

Greater Huddersfield Clinical Commissioning Group

Pennine Acute Hospitals NHS Trust

NHS England Yorkshire and Humber Region

[11] They will be written to in advance of publication telling them the date and place of publication.

13. BACKGROUND INFORMATION [THE FACTS]

13.1 Roger entered the UK in March 2014 after marrying Ruth in Jamaica in 2011. They lived together in Greater Manchester. He perpetrated domestic abuse upon Ruth. The relationship broke down and he left the marital home in 2016, although he returned occasionally. In December 2016 Greater Manchester Police issued him with a Protection from Harassment Notice. This happened after Roger made multiple threatening telephone calls to Ruth demanding money and property from her home.

13.2 Roger met Lucy through a dating web site in September 2016. He moved into her address in the Kirklees area in October/November 2016. Lucy had been the victim of domestic abuse at the hands of a previous partner. While those incidents are outside the timescale of this review the panel felt it was important to include those facts to help with a wider understanding of Lucy's life and relationships. There is no evidence the partner who perpetrated abuse on Lucy had any connection with or knew Roger. The web site contains some safety advice to its users (See Appendix C).

13.3 West Yorkshire Police had no contact or information concerning Lucy and her relationship with Roger. He was also unknown to West Yorkshire Police who had no record of any contact with him. No other agency in Kirklees or anywhere else, as far as the panel can ascertain, held information to indicate there was any domestic abuse in the relationship between them.

13.4 During the timescale of this review West Yorkshire Police and other agencies had some contact with Lucy. One of those contacts related to a violent offender who had contact with her children. The police and Kirklees Council Children's Services took steps to protect Lucy and her children from him.

13.5 Agencies had contact with Lucy in relation to issues connected to two of her children, Michael and Argenta. These events are explored in more detail within Section 15 of this report. The only recorded contact Roger had with services in Kirklees was when he visited a clinic run by Locala Community Partnerships[12].

13.6 At 02.21 hours on a day in early 2017 West Yorkshire Police received a call from Lucy's neighbour. They informed the police that Lucy had been stabbed at address one. Her eldest daughter Kamaria had also received stab wounds. Police Officers immediately went to address one and found Lucy had

[12]Locala Community Partnerships is an independent Community Interest Company providing NHS community services to over 400,000 people in Kirklees and beyond.

significant wounds. Lucy and Kamaria were taken by ambulance to hospital. Michael had witnessed some of the events.

13.7 A few hours later Roger handed himself in at a police station in the Kirklees area and said he was responsible for injuring Lucy and was arrested. He had taken an overdose of tablets and was treated in hospital. He was interviewed and charged with the attempted murder of Lucy and assault occasioning grievous bodily harm on Kamaria.

13.8 Sadly, three days after she was attacked by Roger, Lucy died in hospital. A post mortem examination found she had suffered 23 knife injuries and her death was due to complications from multiple stab wounds.

13.9 Following Lucy's death, Roger was charged with her murder. He appeared before a Crown Court in late 2017. During his trial Roger admitted killing Lucy although he denied murder. He claimed that when he killed her he had drunk about half a bottle of brandy, had been smoking cannabis, sniffing cocaine powder and had some dissolved Ecstasy crystals in the house. He was found guilty of murder and sentence to life imprisonment with a minimum tariff of nineteen years. This means he will not be released on life licence until he has been in prison for at least nineteen years. Lucy's friend Zara felt this was a lenient tariff.

13.10 Lucy's mother spoke to the press following Roger's conviction and said;

'We are a broken family. My own feelings cannot be expressed in words. I do not think I will ever get over losing Lucy and ever come to terms with the way she died'.

'The whole family is in turmoil……it will take a long time if ever to get over the loss of Lucy and I will never be able to forgive Roger for the nightmare that he has put my family through'.

13.11 A family statement issued through West Yorkshire Police said;
'Lucy was such a loving, bubbly and friendly person with a very outgoing personality. She gave everyone she came across a sense of positivity and warmth'.

13.12 Daniel described Lucy as a good mother to all her children and someone who gave a lot to looking after those she loved. Michael misses his mother and cannot understand why she was killed by the perpetrator.

14. CHRONOLOGY

14.1 Background to Lucy and Roger

Lucy
Lucy came from a Yorkshire family and was educated in that county. On leaving school she took up employment in the beauty industry and for many years ran a successful business in that field. She successfully combined parenting, family and business. Zara described Lucy as: a strong woman, kind, generous and very supportive of people who needed help. She was clever, a successful and good business woman and most of all the best mother her children could have had. Zara misses Lucy each day. And described her as a beautiful woman. Daniel provided additional background information. He entered the UK from his home country of Cameroon and met Lucy in March 2005. They formed an intimate relationship and lived together in Bradford. Michael was born in 2006. They sometimes argued, and he acknowledges the circumstances of his caution for assaulting Lucy. Daniel returned to the Cameroon as he had over-stayed his entry visa. He and Lucy married there in September 2007. They returned to the UK and lived together and ended their relationship by agreement in 2008 because it was not working. Daniel saw Michael fortnightly. In 2012 Lucy moved to Huddersfield and Daniel's contact with her, Michael, Kamaria and Argenta was spasmodic. Daniel said that in 2012 Michael began behaving badly in school and had anger issues for which he was referred to CAMHS.[13] Lucy felt it was just a phase he was going through and did not seem to accept Michael needed any support. In the coming years Daniel had limited contact with the school over Michael's behaviour. Between 2013 and 2015 Lucy and Daniel had a strained relationship.

[13] Child and Adolescent Mental Health Service

Around December 2015 Michael told his father that his mother's boyfriend[14] was hitting her. Daniel asked Lucy about this, but she would not talk about it.

Daniel said he noticed a change in Lucy who appeared to be worn down by coping with Michael. She entered a relationship with Roger and Daniel said she was not the same person. She became reserved and struggled more with Michael's behaviour. Daniel felt she never really received the support from services to deal with Daniel and by the time she met Roger her resistance to his controlling behaviour was low. Daniel felt that normally Lucy would easily have dealt with someone displaying Roger's control and coercion. This view was echoed by Zara who now understands the fear Lucy was in.

Michael is now receiving appropriate help and support though the education system.

Zara said that about four years ago, West Yorkshire Police approached Lucy to tell her about the background of someone she was seeing. That resulted in a visit from children's services who provided her with advice on how to keep herself and the children safe. Consequently Lucy ended the relationship.

Roger

The Chair and Author of the review visited Ruth who lives in Greater Manchester and she provided important and relevant information about Roger and his behaviour.

Roger was born and raised in Jamaica. He has no convictions recorded against him in the UK. He told Ruth he had never been married although he had some children in Jamaica.

He met Ruth in Jamaica during 2010 when she was visiting family there. She was older than him. They married in 2011 and Roger joined Ruth in the UK on a spousal visa in 2014.

Ruth had been married before she met Roger and had suffered domestic abuse at the hands of her husband. During the early part of their relationship Ruth describes Roger as being a 'genuine fella'. Ruth says

[14] This boyfriend was not one of the key individuals referred to in this report. There is no information held by any of the agencies which indicate these incidents were reported.

Roger struggled with reading and therefore found it difficult to gain work, although he was employed for a period as a cleaner. Ruth worked as a nurse in a hospital.

Roger's behaviour towards Ruth started to change. Roger became lazy, used cannabis[15] and became verbally abusive towards Ruth accusing her of treating him badly. For example, he said she deliberately turned on the light and radio when she was getting up for work and he was asleep. By that stage Roger was no longer working. Ruth said he also complained that she went to work when he didn't.

Ruth is a Christian and on one occasion Roger telephoned the pastor at the church Ruth worshipped at to complain about her behaviour. The pastor came to their house and Ruth says Roger tape recorded the conversation. When it was her turn to speak Ruth says she shouted because Roger was such a liar. When the pastor left, Ruth says she felt as though she was in the wrong.

Ruth described how Roger made two suicide attempts by taking tablets she was prescribed for diabetes. On one of these occasions Ruth said she telephoned Greater Manchester Police. At that point Roger locked her in the house and said; 'when they come you will be dead'. The police attended although Ruth said she did not wish to make a complaint against him[16].

Ruth said Roger's abusive behaviour continued. On one occasion, she described Roger 'kicking off big style and shouting…I was frightened…it was just like in my first relationship'. Ruth said Roger kept asking her to throw him out of the house. Ruth said she would not do this. Eventually she rang the UK Immigration and Visa Office and offered to pay for Roger to return to Jamaica as he had not been successful in obtaining his full UK passport. Ruth says she consulted a solicitor who told her that if Roger thought he was being mistreated he might be able to obtain leave to remain on the grounds he was the victim of domestic abuse. Ruth said

[15] When Roger was arrested and booked into police station following his attack on Lucy he said he was depressed (self-diagnosed), took cannabis, cocaine and MDMA.

[16] The DHR review panel recognise there are many reasons why victims choose not to report domestic abuse to the police. Reasons victims gave were identified in a survey as: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent). Source: Everyone's business: Improving the police response to domestic abuse; HMIC March 2014

Roger was very clever and that he eventually claimed he was a victim. Ruth says this was an example of how Roger gained control[17].

Ruth says she returned home one day and found Roger had packed his cases. He asked Ruth for £30,000. She did not have this money although she says she was prepared to pay for him to return to Jamaica. Ruth says she had already paid sums of money to help Roger build his house in Jamaica. Ruth contacted Greater Manchester Police about Roger's demands and says she was told not to give him anything. He then left although he continued to make demands. Ruth says she eventually gave Roger £1500 although he claimed he had only received £1100.

Ruth says the last contact she had with Roger was in December 2016 when he spoke to her by telephone. At that time, he threatened to take Ruth to court for half of her house and £30,000. Ruth reported the threat and on 23 December 2016 Greater Manchester Police issued Roger with a harassment warning notice[18].

Ruth never heard from Roger again and says the next she knew of him was when she found out he had killed Lucy.

Ruth was extremely distressed when she spoke about the death of Lucy and recognised that she and her family could have been victims of fatal domestic abuse at his hands. Although Roger did not use physical force against Ruth, she did fear he might use a knife against her. When they argued she said she hid the knives in the house. This fear was based upon the experience of Ruth's previous abusive relationship.

Ruth said she recognised that Roger's behaviour towards her was controlling. She was asked by the Chair and Author whether there was anything she felt could have been done to address Roger's behaviour towards her. Ruth said she thought the pastor would understand and that if she could have managed to talk to someone about Roger's suicidal threats that might have helped.

[17] Although Roger made this claim it was not accepted by UK Immigration and Visa Office and it did not lead to him being granted leave to remain.

[18]The police sometimes issue warning notices to individuals where there are allegations of harassment. These notices (sometimes called Harassment Warning Notices or Early Harassment Notices) are not covered by legislation, and do not constitute any kind of formal legal action. One reason the police do this is to show in possible future legal proceedings that a suspect was aware their behaviour would count as harassment. This is important because the offence of harassment occurs where there has been a "course of conduct" (not just one event); and the perpetrator knows or ought to know that their conduct amounts to harassment. Source: www.parliament.uk

The chair met with Roger and his Offender Supervisor in prison after his conviction. He described growing up in his home and witnessing domestic abuse within the family. He felt that his relationship with Lucy started well and slowly deteriorated. He thought this was because he was at home all day, unable to work because of visa restrictions, and practically confined to the house as he had no transport or money. This caused friction and led to many verbal arguments, some of which were witnessed by the youngest child. He has no one to turn to for support, his few friends were in Manchester. He used drugs and alcohol for pleasure and as a coping mechanism, a pattern he repeated on the day of the homicide. Whilst Roger sought to identify these issues as associated factors, the panel firmly believe they were not the underlying cause of the domestic abuse and the homicide.

Roger's advice to anyone who found themselves in his position was to walk away from the relationship. He said his isolation in Yorkshire and lack of personal resources made that impractical.

Lucy and Roger's Relationship

Lucy met Roger through an internet dating site in September 2016. Zara said that in the beginning they were probably friends, with Roger living at the house in exchange for decorating it. The friendship developed into a relationship and at first Lucy seemed happy.

That soon changed and Zara noted a decline in Lucy's usual cheerful disposition and she became more withdrawn. Zara did not know why and Lucy said everything was fine. Zara and her husband met Roger and felt he was odd in that he always appeared to be watching Lucy. She acted differently when Roger was present in that she was quieter as if afraid of doing or saying the wrong thing.

In December 2016 Michael told his father that his mother had a new boyfriend (Roger) who he did not like. Michael would not elaborate on his dislike. Daniel spoke to Lucy and told her what Michael had said.

Lucy told Daniel that Roger could be strict with the boy but that was because he was naughty. Daniel was concerned that Michael would

regress to poor behaviour. One day Daniel went to the family house and found two holes Michael had punched in the walls. He discussed this with Lucy who was also stressed and was going to take Michael to CAMHS.

Daniel described an incident in January 2017 when Lucy and Michael were 'fighting' as she had taken a mobile telephone or computer from him.

In February 2017 Lucy, Roger and her children moved to address one, a three-storey rented property in Kirklees

Argenta told Daniel that Roger was controlling and aggressive. After his mother's death Michael told his father that he knew this was going to happen and said, 'you didn't listen.' Michael described Roger as 'so angry.'

Information provided to the police as part of the homicide enquiry added some additional detail to the information that Daniel gave.

Around December 2016 Roger's relationship with Lucy changed. They started having petty arguments. Roger would not help around the house or keep it tidy and they argued about money. Roger smoked cannabis daily and drank.

He was also known to take MDMA.[19] Towards the beginning of 2017 Roger started to drink spirits. At a family event in January 2017, having consumed vodka, he started shouting before immediately bursting into tears, causing a scene. The tears are described as not appearing to be real as they stopped almost as quickly as they had started.

Roger became moodier and the number of arguments between the couple increased. The relationship was so strained that Lucy spoke to Argenta about the possibility of Roger moving back to Manchester and only visiting the family every couple of days. Roger reportedly made daily demands upon Lucy that were identical in nature to demands that Ruth said he made upon her. Zara confirmed this in the meeting with the review chair.

[19] *methylenedioxy-methamphetamine* (MDMA) is a synthetic drug that alters mood and perception (awareness of surrounding objects and conditions). It is chemically similar to both stimulants and hallucinogens, producing feelings of increased energy, pleasure, emotional warmth, and distorted sensory and time perception. www.drugabuse.gov/publications/drugfacts/mdma-ecstasymolly

Lucy told Zara several things relevant to the review: Roger stole money from her purse; locked her in the house taking the key [Lucy had to escape by climbing out of a window] and was wary of Roger around her daughters to the point of telling them not to come downstairs in their nightclothes when Roger was about. Lucy did not tell Zara why but it was pretty obvious she did not trust Roger.

It was not until the Monday before the homicide, during a telephone conversation with Lucy that she disclosed to Zara the violent, coercive and controlling nature of the relationship.

Lucy told Zara that over the weekend Roger was sick in the house from drugs/drink and made a mess upstairs by vomiting and urinating. Lucy had worked out that Roger was a 'waster' and very controlling.

Lucy was very upset and told Zara that Roger tried to strangle her during sex and she was frightened of him. He demanded sex all the time. Zara told Lucy to get rid of him. She had tried but he refused to go. However Lucy said she would tell him to leave that week.

Lucy asked Zara to look after her kids if anything happened to her. Zara was worried but felt Lucy would make him leave as she was determined to end the relationship.

The following table contains events which help with the context of the domestic homicide review.

Table One

No	Date	Event
1	07.08.2008	Lucy reported a domestic abuse incident to West Yorkshire Police involving Daniel as the perpetrator.
2	05.04.2009	West Yorkshire Police recorded a second domestic abuse incident between Lucy and Daniel. He was arrested, charged and cautioned for common assault on Lucy.
3	2011	Ruth married Roger in Jamaica
4	January 2013	Lucy formed a relationship with a partner who is a violent offender. West Yorkshire Police visit Lucy and disclose his offending history. Lucy said she could protect herself.

5	March 2014	Roger arrived in the UK with entry clearance as a spouse valid from 6.11.2013 to 6.08.2016 and lived with Ruth in the Greater Manchester area.
6	June 2015	Michael's behaviour in school deteriorated which Children and Adolescent Mental Health Service (CAMHS) assessed as consequential to witnessing domestic abuse.
7	15.06.2016	Roger took an overdose of tablets and attended hospital in North Manchester stating he did this after an argument with Ruth.
8	5.08.2016	Roger applied for further leave to remain as a spouse
9	Sept 2016	Roger left Ruth and moved out of the address.
10	Sept 2016	Roger met Lucy through an internet dating site
11	28.09.2016	Roger's application to remain in the UK is refused (financial support grounds not met) with an in country right of appeal. No appeal submitted
12	5.12.2016	Roger submitted an application for Indefinite Leave to Remain in the UK (Citing Domestic Violence Grounds).
13	23.12.2016	Greater Manchester Police issued a harassment warning notice to Roger following threats he made to Ruth.
14	29.12.2016	Roger's legal representative is advised their client can remain in the UK while the application is being considered but he does not hold leave and will be considered an over-stayer if the application is unsuccessful.
15	24.01.2017	Michael disclosed to his school that Lucy had kicked and punched him. He had a mark above his left eye. A referral was made to Children's Social Care and a strategy discussion held with West Yorkshire Police. Michael was seen by a Paediatrician and the incident was finalised as accidental injury. Daniel was present at the hospital as was Roger and two social workers.
16	Feb 2017	Roger, Lucy and her children moved into address one.
17	Early 2017	Roger attacked Lucy inflicting stab wounds from which she later dies. He also attacked and wounded Kamaria.

15. OVERVIEW

15.1 Introduction

15.1.1 This section of the report summarises what information was known to the agencies and professionals involved with the victim and perpetrators. The structure adopts a chronological approach in which each issue of significance is described, and the input of each agency considered. The events are cross referenced to table one. Detailed analysis of the contacts appears at section 16.

15.2 Events predating the timescale of the DHR

15.2.1 The panel felt it was important to consider Lucy's relationship with Daniel and a former partner to help understand her experiences and the advice she received about domestic abuse. The review panel also felt it was important to understand the impact of domestic abuse on Lucy's children and the family unit.

15.2.2 The first incident with Daniel occurred on 7 August 2008. He returned from work and argued with Lucy who rang the Police. Officers from West Yorkshire Police attended. The argument had ended when they arrived, and Daniel was taken to a relative's address. The incident was correctly recorded as domestic abuse with Daniel as the perpetrator. No offences were identified. Argenta and Michael were recorded and linked to the incident and a child protection referral made to Children's Social Care (CSC). A risk assessment was carried out using the SPEC risk assessment model[20] and this identified that Lucy was at medium risk from Daniel.

15.2.3 The second incident occurred on 5 April 2009. West Yorkshire Police recorded this as an incident of domestic abuse with Lucy as the victim and Daniel as the perpetrator. The incident log records the couple were 'going through a difficult patch'. Daniel, who was sleeping downstairs, went upstairs to pack his bags. He woke Lucy and an argument took place. He pinned Lucy down, put his arms around her throat and applied pressure. Argenta witnessed the incident and called for the police.

15.2.4 Police officers attended and arrested Daniel. Lucy had no visible physical injuries and Daniel admitted an offence of assault contrary to S39 of the

[20] Until May 2011 West Yorkshire Police used the SPEC risk assessment tool. This was then changed to the Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model. Both models use a series of questions to assess and classify risk. Depending upon the answers given risk is then classified as Standard, Medium or High.

Offences Against the Person Act 1861. He received an adult caution for this offence.

15.2.5 West Yorkshire Police conducted a risk assessment and graded the incident as medium risk. They made child protection referrals to CSC. Lucy told the police she did not want Daniel back home and from that point they became estranged. Lucy was offered, although did not wish to access, the domestic violence support service 'Staying Put'. She told the police that Daniel held a spousal visa until July 2010 and she intended to tell UK Visas and Immigration Service she no longer supported him. That agency was also updated by the Domestic Violence Co-ordinator.

15.2.6 Lucy was in a relationship with a man who visited her place of work and threatened Lucy and her then partner with a firearm. This partner was a violent offender and had previously been managed at MAPPA Level 3[21] he was also subject to a violent offender order[22]. Police recovered a BB gun and the man who made the threats was charged with firearms offences. He was convicted of threats to kill and common assault.

15.2.7 Lucy told officers from the West Yorkshire Police Public Protection Unit that she met her partner on New Year's Eve. She said they were friends although they both liked each other. Lucy said she knew about his past offending having conducted a search on Google. She had questioned him, and he disclosed his offending history to her. The police officers gave advice to Lucy about the dangers of having any kind of relationship with him. Lucy told the officers that he had only met her children on one occasion.

15.2.8 Lucy said she was not stupid and was able to protect herself and her children. She said her partner was 'really nice to her'. West Yorkshire Police were concerned this man targeted vulnerable people who he tried to mould into his way. If they did not conform, he then became violent. The police made a referral to Kirklees Children's Social Care (CSC).

15.2.9 An agreement was made between Lucy and CSC that she was not to have contact with this partner and neither were her Children. There were concerns that Lucy was not complying with the agreement. Following a child protection

[21] The Criminal Justice Act 2003 established Multi-Agency Public Protection Arrangements. These are designed to protect the public from serious harm from sexual and violent offenders. Offenders are managed at one of three levels. Level 3 is for offenders posing a high or very high risk of serious harm and it is determined the management issues require senior representation from agencies.
[22] The Criminal Justice and Immigration Act 2008 created Violent Offender Orders (VOO). These allow an order to be made by a court that contains prohibitions, restrictions or conditions considered necessary for the purpose of protecting the public from the risk of serious violent harm caused by the offender.

conference, Lucy's two youngest children were made the subject of a Child Protection Plan[23] under the category of physical harm.

15.2.10 The child protection plans ended when the relationship ended.

15.3 Events within the timescale of the DHR

15.3.1 In October 2014 Michael's school made a referral to South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) as there was cause for concern that he may have Attention Deficit Hyperactivity Disorder (ADHD). He required further intervention from the specialist pathway of ADHD services for Kirklees and was placed on the ADHD waiting list.

15.3.2 In June 2015, Michael was assessed in school by the Child and Adolescent Mental Health Service (CAMHS) provided by SWFYT. This identified he had witnessed domestic violence, which was considered by the CAMHS practitioner to have impacted on his outlook and mood. He displayed very few symptoms of ADHD although he did display some emotional dysregulation. The records do not show whether Michael made a direct disclosure or whether this disclosure came from staff at the school. There is no evidence any further action was undertaken because of the disclosure. The CAMHS practitioner has now left the service and has not been seen.

15.3.3 The assessment advised that, should no further progress be made, then consideration should be given to engagement with Family Therapy Services for the family unit. This would require a further referral. It was unclear in the record who would make this re-referral back into service and whether this would be an action for school or for the parent.

15.3.4 In October 2015 the Special Educational Needs (SEN) Manager from Michael's school wrote to the CAMHS practitioner expressing concerns about his escalating behaviour. The letter also indicated that Lucy wished to appeal the decision of the CAMHS practitioner or seek a second opinion.

15.3.5 There was further dialogue involving the SEN Manager, the CAMHS practitioner and Lucy. She told the CAMHS practitioner in a telephone conversation in October 2015 that Michael's behaviour was deteriorating. The CAMHS practitioner suggested a plan. When this plan was completed Lucy would be offered an appointment with CAMHS with a view to completing Family Therapy and the possibility of a further ADHD assessment for Michael.

[23] A child protection plan is a plan drawn up by the local authority. It sets out how the child can be kept safe, how things can be made better for the family and what support they will need. Source: www.citizensadvice.org.uk

The SWYFT records do not indicate whether Lucy agreed with this plan. There is no evidence the telephone conversation was followed up with a letter and there is no record of a referral for Family Therapy. No further contact was made directly with CAMHS following this conversation and the case was closed.

15.3.6 On 15 June 2016 Roger attend North Manchester Hospital accident and emergency unit saying he had taken an overdose of 20 paracetamol and 4 other unknown tablets. He told the doctor who examined him that he had taken the overdose following an argument with his wife. Roger said he wanted to kill himself and felt tired and down. He was referred to the Rapid Access, Intervention and Discharge team (RAID) service and after a review by a mental health practitioner was discharged the same day.

15.3.7 Roger has no previous convictions within the UK. The only relevant police matter is that on 23 December 2016 he was issued with a Protection from Harassment Notice by Greater Manchester Police. As outlined by Ruth, this happened after he made several telephone calls to her house demanding property and money. This information was correctly recorded on the Police National Database (PND) meaning it was available to other police forces if they conducted a check of Roger on that system.

15.3.8 In January 2017 Michael disclosed to his school that Lucy had kicked and punched him. He had a mark above his left eye. He said this happened when he refused to come off his mobile telephone the night before. Michael said Lucy grabbed the telephone and started kicking and punching him.

15.3.9 CSC contacted West Yorkshire Police Safeguarding Unit and held a strategy discussion[24]. This resulted in Lucy and Michael being spoken to individually by a social worker. This confirmed that the injury to Michael had been caused when Lucy went to take the phone from him and caught his eye.

15.3.10 Enquiries established that Michael had moved to his present school on a managed transfer from a previous school after he was at risk of being excluded due to behavioural issues. There had been an early referral for ADHD although no formal diagnosis had been made. He had settled well into his current school and it was reported his behaviour, albeit challenging, had improved.

[24] This is a discussion between agencies whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm. Among other things the purpose is to share information and agree the arrangements for any criminal investigation.

15.3.11 Michael was examined by a paediatrician. He and Lucy were asked about life at home and neither of them mentioned Roger. They did not say he was part of the wider family, a partner of Lucy or lived at the home or nearby. Michael said he lived with his mum and two sisters. Lucy told the paediatrician she was separated from her husband and he had open access at weekends. The paediatrician tried to obtain the voice of Michael by asking questions, however he denied knowing why he was there. Lucy gave an account of what had happened and said that while trying to restrain Michael, following an altercation, she caught his face with her finger nail.

15.3.12 The paediatrician concluded Michael did not appear to have symptoms in keeping with abuse. The paediatrician identified significant concerns at home with his behaviour which Lucy was receiving help for. The conclusion of the medical examination was that there were no symptoms in keeping with abuse. The investigation into the incident had not been finalised when Lucy was killed by Roger. However, since then, West Yorkshire Police has recorded the matter and concluded and that the injury suffered by Michael was the result of an accident.

Contact with health services

Lucy

15.3.13 Lucy registered herself and her two children with a GP practice in Kirklees in 2013. No other adults were registered at the same address with the practice although Lucy did mention a partner during a consultation. There is no name recorded for the partner.

15.3.14 During the timescale of the review Lucy attended her GP practice on fifteen occasions. Most of the consultations related to moderate depression, stress and anxiety. At most of the consultations Lucy attributed the stress to work related issues.

15.3.15 On some occasions Lucy was prescribed anti-depressants. During a visit to her GP in January 2016 Lucy said she was depressed because of Michael's behaviour.

15.3.16 On 20 January 2017 Lucy visited a specialist clinic in Kirklees run by Locala Community Partnerships. Records show Roger also visited the same clinic on the same day. There is no link in the records to indicate they were a couple or that they attended together. Patients attending this clinic are routinely asked about current and past relationships and intimate partner violence. There is no indication in the records that either of them made any disclosures

relating to domestic abuse, although there is nothing documented to indicate they were asked.

15.3.17 Lucy last visited her GP on 7 February 2017. This was for repeat medication for a long standing medical condition unconnected to this review. During the consultation Lucy said she was struggling to cope with Michael who had learning disabilities and anger issues. She told the GP of a recent episode in which he hurt his head during restraint and social services had been notified. Lucy said she had also recently received notice to leave the property although she had a new property to go to.

15.3.18 Lucy made no references to Roger and there was no further enquiry regarding the family or social circumstances or what may have been contributing to Michael's behaviour. Lucy's medication for depression was increased.

Roger

15.3.19 Roger registered with a GP practice in Manchester in early 2014. The GP records show some routine attendances for matters unrelated to this DHR. There are cross references within the GP records to a fall from a bicycle and the overdose in June 2016.

15.3.20 There is no direct reference within the GP records to Ruth although it is recorded that when Roger took the overdose he reported marital disharmony and said he did it for attention. Mental Health Liaison wrote to the GP and said no follow up was necessary at that time from mental health services. Roger was advised to see his GP or attend Accident and Emergency out of hours if he had any further difficulty.

15.3.21 In February 2016 an immigration law practice wrote to the GP seeking medical information and said they had been instructed by Roger regarding his immigration status. In December 2016 UK Visas and Immigration wrote to the GP requesting medical evidence concerning Roger's attempt to commit suicide which he had declared on his visa application form.

15.3.22 Roger was not registered with a GP Practice in Kirklees and so there are no GP medical records for him in this area. The only contact he appears to have had with health agencies in the Kirklees area is the one outlined at paragraph 15.3.19.

15.4 Events following the homicide of Lucy

15.4.1 On the day of his arrest for the attack on Lucy, Roger was brought from police custody to the casualty department at Calderdale and Huddersfield NHS Foundation Trust. He had allegedly taken an overdose several hours before. He gave inconsistent accounts about the volume and type of tablets he had consumed. He eventually said he had taken 60 tablets with alcohol. Observations and tests were conducted, and he was deemed to be fit to return to custody.

15.4.2 Following Lucy's homicide, Kirklees Children's Social Care (CSC) completed a single assessment for Michael. This recommended he should be supported under a 'Child-In-Need Plan'. He was also offered counselling to promote his emotional wellbeing.

16. ANALYSIS USING THE TERMS OF REFERENCE

16.1 Term 1

What was the agency involvement with Lucy or Roger?

16.1.1 Each agencies' involvement with Lucy and Roger is set out in section 15 of this report.

16.1.2 In December 2016 Roger applied for Indefinite Leave to Remain in the UK claiming to be a victim of domestic abuse from Ruth. His legal representative was told by the immigration authorities that roger could remain in the UK while the application was considered and would be considered an overstayer if the application failed. At the time of the homicide in February 2017 the application was still under consideration and therefore Roger was lawfully in the UK. It was not until after the homicide that the application was refused

16.2 Term 2

Did the agency identify any indicators of domestic abuse in their contact with Lucy? What actions were taken in response to these indicators?

16.2.1 No agencies in Kirklees held any information that would have indicated Lucy had suffered domestic abuse from Roger. Consequently, there were no indicators of abuse and no opportunities to act.

16.2.2 Roger perpetrated domestic abuse upon Ruth, who was his previous partner. That abuse was known to Greater Manchester Police who issued Roger with a protection from harassment notice on 23 December 2016. That information was correctly recorded on the Police National Database[25] (PND). This meant that, had West Yorkshire Police received any information concerning abuse in the relationship between Roger and Lucy and carried out a check on PND, they would have become aware that Roger had perpetrated domestic abuse in a past relationship.

16.2.3 In turn that information may have helped the police and other agencies consider options for protecting Lucy from Roger. For example, steps such as considering making a disclosure to Lucy about Roger's history under the Domestic Violence Disclosure Scheme (also sometimes known as 'Clare's Law')[26]. That did not happen as neither West Yorkshire Police nor any other

[25] The Police National Database is PND is a national police database which draws information from all English, Welsh and Scottish forces. It allows an individual's record to be searched for police contact nationally.

[26] The Domestic Violence Disclosure Scheme was introduced in 2014, giving members of the public a 'right to ask' the police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their family or a friend may pose a risk to

agency received a report of domestic abuse or identified any indicators of abuse perpetrated by Roger upon Lucy that would have given them cause to check PND.

16.2.4 There was evidence that Lucy had suffered domestic abuse at the hands of Daniel. These incidents pre-dated the timescale of the review although the panel felt it was important to include them to understand how the children in the family might have been affected by domestic abuse. On both occasions, West Yorkshire Police recorded the incidents as domestic abuse. On the second occasion police officers arrested Daniel and he was cautioned for common assault.

16.2.5 There are no reports or indicators the former partner of Lucy perpetrated abuse upon Lucy. However, he was a violent offender and therefore presented a risk of harm to Lucy. West Yorkshire Police correctly took steps to warn Lucy about the risks she faced and discouraged her from engaging in a relationship with him. The disclosure made under MAPPA authority was part of a risk management plan.

16.2.6 CSC also took steps to protect Lucy's children through entering into an agreement with her that she would not see this partner. When it appeared that agreement was not working CSC acted through a child protection conference to make the two children subject of child protection plans. The review panel felt the actions of West Yorkshire Police and CSC were appropriate and swift and helped minimise the risk of harm to Lucy and her children.

16.2.7 The panel looked carefully at each of the agencies' contacts with Lucy to consider whether there were opportunities to discuss domestic abuse with her. Except for the incidents outlined above, Lucy did not make a direct disclosure of domestic abuse to any agency nor did she present with injuries that were consistent with abuse.

16.2.8 However, Lucy did present to her GP on several occasions with symptoms that included depression. The GP IMR identified that depression can be caused by domestic abuse and is also cited as a 'risk factor' in other research. The World Health Organisation website cites that women who experience domestic abuse are twice as likely to experience depression. There is no mandatory requirement on GP's in Kirklees to ask routine questions about domestic abuse. The Royal College of General Practitioner guidance (CAADA

that individual. Under certain circumstances the police can disclose information to a victim without an application.

& IRIS, 2012)[27] for GPs identifies that patients presenting with depression and anxiety could be a 'Marker' for domestic abuse. Therefore, it would be good practice to consider the possibility and 'ask the question.' The review panel heard that two GP Practices in Kirklees have agreed to undertake a pilot project asking routine questioning about domestic abuse. The CCG Safeguarding Team are supporting the practices and the evaluation from the project will be shared with all local GP Practices.

16.2.9 A review of the environment within Lucy's GP Practice found that it did not facilitate or encourage patients to disclose they may be experiencing domestic abuse. For example, there was no information (posters/leaflets) within the waiting room which would encourage a patient to feel safe to make a disclosure to a health professional. When interviewed women have said they would like more information about domestic violence and the help available to be accessible from the GP. (Alberti 2010).

16.2.10 During the interview by the IMR author the practice acknowledged that women of child bearing age were asked about domestic abuse as part of routine enquiry by Primary Care staff (including midwives, health visitors and GPs).

16.2.11 One GP stated that in addition to asking about domestic abuse in this cohort they would also routinely ask if a family had the other two recognised components of the 'toxic trio' within the family home (mental ill health and substance misuse). There were no known issues with substance misuse in respect of Lucy and her alcohol consumption when assessed by the GP Practice staff did not indicate any concerns, so the 'trigger' to ask about domestic abuse was not present.

16.2.12 The review panel has not seen evidence that, during the time Lucy was in the relationship with Roger, she was the victim of domestic abuse nor presented with indicators of abuse. Her depressive episodes commenced several years before she met Roger. The review panel does not believe it is therefore possible to say the failure to ask direct questions about domestic abuse are in any way linked to Lucy's homicide at the hands of Roger. However, the review panel does welcome the agency recommendations identified in the GP IMR in relation to improving information in GP surgeries and recognition that depression and anxiety are a potential 'Marker' for domestic abuse.

16.2.13 Daniel believes that the impact on Lucy of Michael's poor behaviour was not fully understood by the professionals she had contact with and its root

[27] Coordinated Action Against Domestic Abuse (CAADA) is a registered charity www.caada.org.uk/commissioning

cause was never established. This left Lucy somewhat isolated and less able to resist Roger's abusiveness. The DHR chair who saw Daniel did not believe he was in any way blaming Lucy for being a victim; rather Daniel was putting context around Lucy's life at that time in an effort to explain her vulnerabilities'.

16.3 Term 3

What was the agency's awareness of Lucy's social history and did the agency response take account of this as part of their service?

16.3.1 As set out in the detailed facts about contact with Lucy (see section 15), there was evidence that some agencies were aware of her social history and took account of it when providing a service. For example, when West Yorkshire Police discovered she was in a relationship with a dangerous offender. Consequently, West Yorkshire Police made a referral to CSC and acted to protect her and her children.

16.3.2 The review panel found that, while Lucy had been recorded as the victim of domestic abuse on two occasions before she was killed, there had also been other incidents and indicators of domestic abuse within the family which were part of its social history. For example, Argenta witnessed the abuse that Daniel perpetrated upon her. In 2015 Michael had become disruptive at school. It was identified he had witnessed domestic violence which had impacted on his outlook and mood.

16.3.3 While individual direct disclosures of domestic abuse had been dealt with appropriately when reported, the review panel felt it would have been helpful if the family unit had been given the opportunity to reflect upon its own social history. This might have been a chance for the family to consider how, either as a unit or individually, domestic abuse was impacting upon their lives and for services to be put in place.

16.3.4 In considering the links between domestic abuse and the impact upon the family, the panel took cognisance of important findings within a report published by CAADA: In Plain sight: Effective support for children exposed to domestic abuse (2014). The report states an estimated 130,000 children in the UK live in households with high-risk domestic abuse and 6% of all children are estimated to be exposed to domestic abuse between adults in their homes at some point in childhood.

16.3.5 Amongst the important findings in the report, the panel felt the second bullet point (behavioural problems) was particularly relevant to Michael whose disruptive behaviour in school, may have been influenced by what he saw and heard at home.

- There is a major overlap between direct harm to children and domestic abuse. Almost two-thirds (62%) of the children exposed to domestic abuse were also being directly harmed (physically, emotionally or neglected) as well as witnessing the abuse of a parent. In almost all (91%) of our cases the direct harm was perpetrated by the same person as the domestic abuse: principally their father or mother's male partner.
- Children are suffering multiple physical and mental health consequences as a result of exposure to domestic abuse. Amongst other impacts, over half (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school, and nearly two thirds (60%) felt responsible for negative events.
- A quarter of both boys and girls exposed to domestic abuse exhibit abusive behaviours themselves. We found that children were more likely to show abusive behaviours after exposure to the domestic abuse had ended. Abusive behaviour was most common amongst 15 to 17-year olds. The children's abusive behaviour was most frequently directed towards their mother, sibling or friend, and rarely towards the main perpetrator of the domestic abuse.
- Worryingly, only half (54%) of the children exposed to domestic abuse, and two thirds (63%) of those living with severe domestic abuse, were known to local authority children's social care prior to intake. This is very concerning, given the evidence that two-thirds were also directly harmed, 91% by the same perpetrator. However, the great majority of these children (at least 80%) were known to at least one public agency at intake: they are in plain sight.
- Children's outcomes significantly improve across all key measures after support from specialist children's services. Our data show that specialist children's services have an immediate positive impact across all indicators of safety, health and wellbeing of children exposed to domestic abuse and direct harm.

16.3.6 The above findings demonstrate the importance that specialist support can have on improving a child's outcomes. The panel felt the opportunity for this to happen might have been when Michael was seen by CAMHS and a plan discussed with Lucy. During those discussions, consideration was given to completing Family Therapy. It does not appear that ever took place and it has not been possible to establish why. The panel feel that is regrettable that did not happen. Had it been undertaken it might have been an opportunity for discussion about how domestic abuse issues were affecting the family although the review panel recognise that falls well short of any connection with Lucy's death.

16.4 Term 4

Did the agency know or provide a service to Roger? If so what knowledge did the agency have that indicated Roger might be a perpetrator of domestic abuse and what was the response?

16.4.1 Roger only visited one service in Kirklees. There was no indication there that he might be a perpetrator of domestic abuse or that Lucy was at risk from him.

16.4.2 Roger was known to Greater Manchester Police who attended a call made by Ruth after Roger took an overdose and was admitted by ambulance to the accident and emergency unit at North Manchester hospital. They also served Roger with a protection from harassment notice. Greater Manchester Police appear to have correctly recognised that Roger had perpetrated domestic abuse and by placing the information on PND this meant it was available to other police forces if Roger came to their attention.

16.4.3 Government defines domestic abuse as;

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

The panel considered the issue of coercive and controlling behaviour. Coercive behaviour is a component of domestic abuse. It is;

'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'

Controlling behaviour is another component and is;

'a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour'

16.4.4 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. The panel discussed Roger's behaviour towards Ruth. They felt there were examples of controlling or coercive behaviour. These included when Roger became abusive towards Ruth for turning on the light and radio and then going to work.

16.4.5 Another example was when Roger contacted Ruth's pastor alleging she mistreated him and then tape recorded the conversation. Ruth says this made her feel as though she was in the wrong. Roger also took two overdoses. The panel recognised that perpetrators will sometimes act in this way; taking an overdose to draw attention and sympathy to them and away from the victim. The panel felt it was noteworthy, and was probably another example of Roger's controlling behaviour, that he took an overdose after attacking Lucy (the third known occasion he had done this).

16.4.6 When he took the second overdose, Roger was taken to the accident and emergency department of North Manchester Hospital. While Roger did not disclose he had perpetrated domestic abuse, when he spoke to the clinicians, he said he had argued with Ruth. The panel felt that could have been a trigger for some direct questions to Roger about their relationship and about the possibility of abuse.

16.4.7 According to Ruth, Roger approached the Visa and Immigration Service and tried to obtain a visa on the grounds he was the victim of domestic abuse. The review panel have seen no evidence Roger ever suffered domestic abuse from Ruth. Rather, there is clear evidence Roger was a perpetrator of domestic abuse. Ruth recognised that, by doing what he did, Roger was trying to gain control. The panel agreed with Ruth's assessment.

16.4.8 The panel felt Roger's attempts to make Ruth hand over substantial sums of money to him, including half of a house he had no financial stake in, was also an example of coercive behaviour. Roger tried to reinforce this demand by frightening Ruth and threatening that he would take her to court. Ruth contacted Greater Manchester Police and the panel felt their use of a harassment warning demonstrated how positive police action against perpetrators can be effective.

16.4.9 The panel recognised that much of Roger's other behavioural traits that would have been indicators of domestic abuse towards Ruth, were unknown to Greater Manchester Police and only emerged following a detailed investigation into the homicide of Lucy.

16.4.10 Roger was financially dependent on Ruth and Lucy. His unwarranted demands for £30,000 from Ruth and constant pestering her and Lucy for money are examples financial abuse. It appears he felt an entitlement to be kept supplied with money without having to work. His focus was on having money to support his lifestyle of drink and drugs.

16.5 Term 5

Is the agency aware of any barriers that might have stopped Lucy from seeking help for the domestic abuse?

16.5.1 The panel did not feel there were any obvious barriers to Lucy seeking help for domestic abuse. Lucy had been in an abusive relationship with Daniel. In 2008 and 2009 she sought and received help from West Yorkshire Police that resulted in his arrest and conviction for common assault. Lucy was offered support from the domestic violence service although she chose not to access this.

16.5.2 Lucy was in a relationship in 2013 with a partner who was a violent offender. West Yorkshire Police were concerned about the risks he presented and visited Lucy. She told the officers she had conducted a Google search and knew about his past and that he had disclosed his offending history. She told the police officers that she was able to protect herself and her children.

16.5.3 Through Lucy's previous exposure to domestic abuse and her contacts with the police, it appears she knew how to report abuse and had been told that services are available to those who are victims. As set out in a footnote on page 26, the panel recognised there are many reasons why victims choose not to report domestic abuse. Sadly, the panel will never know whether Lucy considered taking any of these steps in respect of Roger and if not, why not. However, Zara provided some insight into Lucy's thinking in the days before her death. Lucy told Zara that Roger was sexually violent and she was frightened of him. The level of fear can be demonstrated by Lucy's request to Zara to look after the children should anything happen to her.

16.5.4 The panel also thought it relevant to highlight how Lucy had relied on Google for information about a previous partner. While on that occasion it did return some relevant information, Google is not a reliable source for self-assessing the risks of abuse. The lack of information returned by Google or any other search engine should certainly not be taken as indicative that a person does not have convictions, has not abused previous victims or is someone with whom it is 'safe' to form a relationship with. The panel therefore believe it is vital to promote the Domestic Violence Disclosure Scheme as the primary source that should be used for seeking such information.

16.6 Term 6

What knowledge or concerns did the victim's family and friends have about Lucy's victimisation and did they know what to do with it?

16.6.1 The review panel has not been able to engage with Lucy's family and therefore have no direct information from them which might illuminate the

relationship between her and Roger. However, Daniel, through his discussions with Michael and Argenta, and Zara through her friendship with Lucy, were very helpful in being able to describe some aspects of the relationship.

16.6.2 It appears from the conversations Daniel had, that Roger was acting in a way which the children, although not using the words domestic abuse, recognised was wrong. Argenta described Roger as 'controlling and abusive'. Michael said he was 'so angry'. Information that emerged during the homicide enquiry indicates that Roger was using MDMA, was smoking cannabis and was drinking spirits. He admitted he misused controlled drugs and alcohol when he gave evidence at his own trial.

16.6.3 It appears to the review panel that Roger's behaviour when he lived with Lucy mirrored, in many ways, the behaviour he displayed when he was married to Ruth. He misused drink and drugs, repeatedly made daily demands upon both women, was controlling, abusive and angry. The review panel conclude from this that Roger undoubtedly inflicted domestic abuse upon both Ruth and Lucy.

16.6.4 It is also clear to the review panel that the children in the household were exposed to domestic abuse which will have impacted upon them. How much of Michael's behaviour was a direct result of his exposure to abusive behaviour from Roger or from other partners that Lucy lived with is not clear. Daniel thinks the underlying cause of Michael's poor behaviour is not what he saw or heard in the home. He says that the current assessments Michael is undergoing indicate other reasons.

16.6.5 The review panel are not able to reach any conclusions as to why Lucy or her family did not report the domestic abuse Roger perpetrated. Lucy had previously expressed to the police a view that she could protect herself and her children from any abuse. It is not clear whether Lucy repeated that belief to her family and children when Roger became abusive towards her. If she did, then it is possible that her attitude, directly or indirectly, discouraged those around her from telling agencies what they knew. Zara's conversation with Lucy suggests that she was afraid of Roger to the extent of making provision for the care of her family should anything happen to her.

16.6.6 While the children did not directly report Roger's abusive behaviour to any agencies they did share information with Daniel. When Daniel discussed with Michael's head-teacher the incident where Lucy and Michael 'fought', the head said that they could not take sides. While that is right, Daniel thought that was not a helpful response and was looking for a more rounded view aimed at helping Michael. When Daniel met the review panel chair and a

representative from AAFDA he helpfully reflected on events. He said he had identified the following learning;

a. That professionals dealing with the poor behaviour of a child whose parents are living apart should involve both parents in trying to solve the problem;

b. He would pay more attention to what Michael was saying about what was happening at home. Daniel has feelings of guilt for not having picked up on his Michael's clues.

16.7 Term 7

Were there any concerns about the agency delivering a service to Lucy or Roger, including any racial, cultural, linguistic, faith or other diversity issues?

16.7.1 There were no concerns about the services any agency delivered in this case in relation to race, culture, linguistics, faith or diversity. All the agencies involved in providing services have policies in place that are compliant with the Equality Act 2010 (See section 11 for a more detailed analysis)

16.8 Term 8

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Lucy and Roger?

16.8.1 No agency identified any capacity or resource issues that impacted upon their ability to deliver services to Lucy and/or Roger.

16.9 Term 9

Does the agency have any concerns about inter-agency information sharing and cooperation in response to Lucy and Rogers's needs? Did the agency share information appropriately with other agencies?

16.9.1 Only one agency in the Kirklees area had contact with Roger. This was when he and Lucy attended an NHS clinic on 20.01.2017. The clinic routinely asked patients about current and past relationships and intimate partner violence. There is no indication in the records that either of them made any disclosures relating to domestic abuse although there is nothing documented to indicate they were specifically asked and their response recorded. Consequently, there would have been no need to share information about this visit with other agencies. No other agencies in Kirklees provided a service to Roger and there were no indicators he posed a risk to Lucy. Consequently, there

were no opportunities to share information about him and to assess the risks he might have posed to Lucy.

16.9.2 Information was shared between West Yorkshire Police and CSC in respect of the two domestic abuse incidents involving Lucy and Daniel which pre-date this review. On the second occasion, West Yorkshire Police also shared information with UK Visas and Immigration.

16.9.3 Information was shared by West Yorkshire Police with CSC when it was discovered that Lucy was in a relationship with a violent offender.

16.9.4 When Michael disclosed at school that he had suffered an injury his school shared that information with CSC who in turn held a strategy discussion and shared the information with West Yorkshire Police.

16.9.5 The panel discussed the events in June 2015 when Michael's school raised concerns about his behaviour. This led to him being assessed by CAMHS. This assessment identified that Michael had witnessed domestic abuse, and this was impacting upon his outlook and mood. The panel felt this was a missed opportunity to explore Michael's disclosure. It was not clear from the records whether this information was ever referred to another agency by CAMHS. The CAMHS professional that dealt with Michael has left the service and the panel has not been able to explore why that opportunity was missed.

16.9.6 The panel noted that the Kirklees CAMHS Service was subjected to an independent review commissioned by Kirklees Safeguarding Children Board (KSCB) following a lengthy period of concern about the quality and impact of services for children and young people. The review took place between April and September 2016[28]. The report identified several areas for improvement that have parallels with the way in which CAMHS dealt with Michael. The report made thirteen key recommendations to radically simplify and improve the CAMHS service. Therefore, the DHR panel did not feel it necessary to make separate recommendations regarding CAMHS as part of its work.

16.10 Term 10

Were appropriate policies or procedures followed or were any gaps identified?

[28] A full review of all the impact of emotional well-being and mental health services provided in Kirklees for children and young people on safeguarding children and promoting their welfare, commissioned by Kirklees Safeguarding Children Board from Jane Held Consulting Ltd. October 2016 https://www.kirkleessafeguardingchildren.co.uk/managed/File/Info%20for%20Professionals/20170515%20-%20KCSB%20CAMHS%20Review%20October%202016.pdf

16.10.1 The review found that all agencies involved in the review had safeguarding policies in place. Information sharing arrangements are in place within Kirklees through a multi-agency hub (MASH)[29]. Most agencies have a separate policy in relation to domestic abuse.

16.10.2 The Kirklees GP IMR identified that there are no references to domestic abuse in either of the generic policies used by the GP practice Lucy was registered with. Whilst the practice has stand-alone polices for other safeguarding issues, (e.g. Female Genital Mutilation) they do not have one for domestic abuse. This gap was recognised, and the GP practice intend to develop a policy in response.

16.11 Term 11

Within the agency are there arrangements for support to frontline practitioners who might be dealing with Domestic Abuse? Were these effective in the case of Lucy or Roger?

16.11.1 The review found that in general most agencies within Kirklees provided both training and guidance to equip their staff with the skills to deal with domestic abuse and this was to a good standard. There was evidence that agencies responded to changes in legislation and policy by providing their staff with updated training. For example, previous domestic homicide reviews in West Yorkshire identified that awareness and understanding of coercion and control has been limited amongst police officers and staff. Consequently, since December 2015, West Yorkshire Police have delivered a programme of training in respect of this.

16.11.2 As identified in paragraph 16.9.5 there are concerns that the disclosure made by Michael was not explored or referred to other agencies. SWYPFT recognised there is a question as to whether this was a lack of knowledge on the part of this specific practitioner or whether actions had been taken but not recorded. As the practitioner involved is no longer available this cannot be established. SWYPFT have made a single agency recommendation to deliver specific domestic abuse training sessions to the CAMHS service[30].

16.11.3 The GP Safeguarding Lead raised a concern about the difficulty in attending all the GP Safeguarding Lead meetings that are facilitated by the Designated Nurses for Safeguarding Adults and Children. The GP was concerned that they may not receive all the necessary updates. The GP IMR author discussed this with the CCG safeguarding team members responsible for arranging and

[29] The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all professionals to report safeguarding concerns.

[30] Domestic Abuse is already a feature of Mandatory Safeguarding Children Level 1, 2 and 3 training for SWYPFT staff.

facilitating the meetings and was informed that both the dates and times of the meetings along with the notes are circulated to all safeguarding leads via GP Practice Managers. The author has relayed this information to the practice.

16.12 Term 12

Are there any lessons from the case that can be identified for the agency to improve future practice?

16.12.1 These are identified separately at section 18 of this report.

16.13 Term 13

Are there any examples of good or innovative practice arising from this case?

16.13.1 The panel did not feel there were any examples of good or innovative practice in this case. However, they did feel there were several examples of agencies routinely following procedures that evidenced practitioners knew and understood the value of the need for sound practice in relation to domestic abuse.

16.14 Term 14

Is the agency aware of what services are available to perpetrators of domestic violence in Kirklees?

16.14.1 West Yorkshire Police identified that in Kirklees all domestic abuse cases are discussed at the Daily Risk Assessment Management Meeting (DRAMM) between Social Care and the Police Domestic Violence Hub (Skype Meeting). The main services available for perpetrators of domestic abuse in Kirklees are the Yorkshire Children's Centre (medium to high risk) and the West Yorkshire Choices Perpetrator Programme commissioned by the Office of the Police and Crime Commissioner[31]

16.14.2 The author of the overview report carried out research on the web to identify whether there was adequate information available to sign post users to information about perpetrator services. The author found several references to the Choices Programme and to other agencies within Kirklees providing information and support to perpetrators. Some of that information was not up to date and the panel felt it would be helpful if partner agencies in the

[31] The Choices Perpetrator Programme was commissioned by the West Yorkshire Police and Crime Commissioner but the contract ceased in November 2017. Discussions are currently underway to consider future commissioning of a regional Perpetrator Programme.

statutory and voluntary sectors are asked to ensure they review their individual web sites to ensure the information contained there is up to date.

16.14.3 The GP IMR author looked at the issue of domestic abuse services and information within the GP practice. It found there was no information displayed, and only one GP held key supportive information about domestic abuse and service availability. The author has taken immediate steps to address that gap and made an agency recommendation.

16.14.4 The GP IMR author found the safeguarding lead at the GP practice had attended the 'masterclass' provided on domestic abuse during which the Perpetrator Programme was discussed. However, the author also found some evidence that GP's might be confused about the services to both victims and perpetrators in the area. There were variable levels of understanding and one GP said they found it hard to keep themselves informed of changes to service delivery in the area.

16.14.5 There is no evidence that Roger was ever referred by an agency to the Choices Programme or any other perpetrator programme nor that he recognised that he was a perpetrator of domestic abuse. Based upon the internet research and views of the GPs the DHR panel felt there was scope for refreshing the way in which the Choices Perpetrator Programme is advertised in the Huddersfield area; making it more prominent for professionals and those who may be worried they are perpetrators. This work needs to ensure that sites used as a main resource for professionals (such as GPs) are up to date and that when other organisations present links within their sites they contain up to date information

16.15 Term 15

If concerns about Lucy or Roger were identified by the agency, was the welfare of the child considered and appropriate referrals made?

16.15.1 Evidence was found throughout this review that consideration was given to the welfare of the child and that services were timely and appropriate. This was the case when Daniel abused Lucy in 2008 and 2009. On both occasions, West Yorkshire Police made child protection referrals to CSC.

16.15.2 The welfare of Lucy's children was also a clear cause for concern when she entered a relationship with a partner in 2013. As a violent offender, he presented risks to Lucy and her children. West Yorkshire Police responded by visiting Lucy and disclosing his offending behaviour and making a child protection referral to CSC.

16.15.3 In turn CSC entered into an agreement with Lucy that she would not engage in a relationship with this man. When it was suspected that Lucy was still

seeing him, CSC took steps to make the two youngest children subject of a Child Protection Plan which was revoked when Lucy ended the relationship.

16.15.4 In June 2015, following concerns raised about his behaviour, Michael's school made a referral for a CAMHS assessment for ADHD. He was assessed in school by the CAMHS practitioner and this identified that he had witnessed domestic violence, which was considered by the CAMHS practitioner to have impacted on his outlook and mood. The review panel have outlined at paragraph 16.9.5 that they feel there was a missed opportunity here to follow these concerns up and to consider therapy for the family who found their lives affected by exposure to domestic abuse.

16.15.5 In January 2017 Michael presented at school with an injury above his eye and said his mother was responsible for it. The school correctly made a referral to CSC who in turn held a strategy discussion with West Yorkshire Police. Michael was examined by a Paediatrician and both he and Lucy were spoken to about the incident. The Paediatrician concluded that this incident did not disclose Michael had symptoms in keeping with abuse.

16.15.6 Finally, following the attack on Lucy by Roger, West Yorkshire Police made a child protection referral to CSC in respect of Michael. CSC completed a single assessment on Michael and recommended he should be supported under a Child in Need Plan. Counselling support was offered to him to promote his emotional wellbeing.

16.15.7 Except for the failure to follow up the disclosure made by Michael, the review panel felt that agencies appropriately prioritised the welfare of the children.

17. Conclusions

17.1 Roger was a perpetrator of domestic abuse and Ruth suffered at his hands. Many of Roger's other behavioural traits that would have been indicators of domestic abuse towards Ruth, only emerged following a detailed investigation into the homicide of Lucy. While the relationship between Roger and Ruth was stable at first, Roger's behaviour deteriorated as time went by. He misused cannabis.

17.2 The panel believe his behaviour and some of the tactics he used were coercive and controlling behaviour. For example, the church was a significant part of Ruth's life. Involving her pastor, behaving towards her in a way that caused her to shout and tape recording the events were attempts to humiliate Ruth and separate her from the church. Hence Roger would have more control over her life.

17.3 Roger's two overdose attempts were also examples of controlling behaviour. The panel believes these were simply attempts to draw sympathy and attention to himself. He then applied for a UK visa claiming he was the victim of domestic abuse and used the overdose incident to back up his story. This account was disregarded by the authorities. The panel have seen no evidence Roger was a victim of abuse from Ruth. Far from it, she was hard working, caring and kind and gave him money, including for his house in Jamaica.

17.4 When Roger left Ruth he continued to be abusive towards her demanding money and a share of her house of which he had no legitimate claim. He threatened court action to frighten Ruth. She acted by reporting his behaviour to Greater Manchester Police. They served a harassment notice on him which appeared to be effective and Ruth received no further contact from him.

17.5 By placing information about Roger on PND, Greater Manchester Police took appropriate action to ensure his behaviour as a perpetrator would be recorded and recognised if he came to police attention again. Because that never happened, there was no opportunity to identify Roger presented a risk of harm to Lucy.

17.6 Lucy experienced domestic abuse from Daniel which Argenta witnessed.

17.7 Michael also appears to have been affected by the domestic abuse he had witnessed within the household, albeit there are other emerging reasons for

his poor behaviour. He disclosed this when he was assessed for ADHD by a CAMHS professional. The panel felt it was disappointing that Michael's disclosure was not recorded nor referred on to other agencies. Hence, he was denied the opportunity for his voice as a child to be heard and possibly for the abuse he witnessed to be investigated and measures put in place to protect him, his siblings and his mother. In reaching this finding review panel again highlight the important findings in the CAADA report concerning the positive impact of early intervention.

17.8 It is not possible to say who he had witnessed perpetrating this abuse. While the perpetrator could have been Daniel the possibility exists that it could someone else.

17.9 While there is no evidence he perpetrated abuse upon her, Lucy was clearly at risk from the partner who was a violent offender when she entered a relationship with him. The panel is concerned that Lucy used Google to establish his background. The review panel do not know whether Lucy similarly carried out an internet search on Roger when she met him. The possibility she did so must exist[32]. Had she done so it was simply not possible that she could establish anything about the risks he posed, unless unofficial accounts of his behaviour against Ruth were on social media. The review thought that internet dating sites should contain a reference to 'Clare's Law' on their front pages. Using official channels to identify a person's history is a more reliable method of protecting yourself.

17.10 The review panel believe the comments she made to police officers when they visited Lucy to warn her that her partner was a violent offender are significant. She said she had been in violent relationships before, was not stupid and was able to protect herself and her children. The comments repeated by family members during the homicide investigation are also significant. They said Lucy was a strong lady who lived her life her way, was determined and able to stand up for herself. The panel believe it is entirely possible that, having survived previous violent relationships and finding nothing to indicate Roger had a history of violence, Lucy unwittingly felt she was not at risk from him or if she was she had the means to protect herself without support from agencies. However, whatever the merits of using the internet to check on a person's background, Lucy was entitled to be safe and secure and not be abused by anyone.

[32] Appendix C is safety advice for users extracted from the web site which it is believed Lucy may have used and through which she met Roger.

17.11 The panel believe there is a lesson here about the dangers of using the internet in the belief it can provide a means of protection against the risk of abuse. This leads to a need to reinforce the value of the Domestic Violence Disclosure Scheme [Clare's' Law].

17.12 Other than the one contact Roger had through the clinic he was unknown to agencies in Kirklees. There is no evidence Lucy ever reported any abuse at the hands of Roger or spoke about her relationship to local agencies. While there are some areas for improvement in the way agencies promote domestic abuse services locally, these have no bearing whatsoever on the homicide of Lucy.

17.13 Daniel felt that in the month or so before her death that Lucy was in a 'very dark place' which impaired her judgement. It was not like Lucy to allow herself to be dominated. Daniel believes that Roger must have worn her down, something that was not recognised at the time.

17.14 When Roger killed Lucy, it was behind closed doors. He acted with extreme violence and determination and perpetrated wilful attacks on her and her daughter. Zara feels that Lucy told him the relationship had ended and to leave the house. Evidence that emerged during the investigation indicates he had consumed alcohol and misused drugs. The review panel conclude that no agencies within Kirklees held information that might have indicated that Lucy, Kamaria and family faced such a risk from Roger.

17.15 As the review panel have not, at this stage, been able to engage with Lucy's family they felt it was important to seek additional independent scrutiny of their report. Consequently, they asked the Chief Executive of the Pennine Domestic Violence Group[33] to read all the relevant documents, IMRs, minutes and the final report. The member commented as follows;

'After intense scrutiny of all documents above, I have found a clear in-depth process followed throughout the DHR by Kirklees Safer Stronger Communities Partnership DHR Standing Panel, this has guided me to agree with the conclusions reached, stated within point 17. - 17.1 – 17.4'.

[33] The Pennine Domestic Violence Group (PDVG) is a registered charity that provides support, advice, information and safe accommodation to anyone effected by or experiencing domestic abuse. PDVG has been in operation delivering a range of specialist domestic abuse services in Kirklees since 2002 when two long standing domestic abuse services merged. Huddersfield Women's Aid which had been in operation since 1975 and Kirklees Asian and Black Women's Welfare Association which had also been operating services in Huddersfield for over 10 years.

18. LEARNING

Learning 1
Narrative
There was evidence from some agencies in the Kirklees area that routine enquiry does take place in respect of domestic abuse and progress is underway to extend that. However, the panel felt there might be a tendency to see violent acts as the most dangerous form of domestic abuse.
Learning
Domestic abuse can take many forms including coercive and controlling behaviour. Agencies and practitioners need to understand what these comprise and that there are many forms of abuse other than behaviour that involves the use of physical force. When listening to the accounts of victims and their families, professionals need to look for evidence that coercive and controlling behaviour maybe occurring and ensure safety plans protect the victim from this form of abuse.

Learning 2
Narrative
Lucy's children witnessed domestic abuse within the home. For example, Argenta was present in 2009 when Daniel pinned Lucy down and applied pressure to her throat. An assessment by CAMHS identified that Michael had witnessed domestic abuse. Lucy was given advice not to continue a relationship with a former partner (a violent offender). She also signed an agreement that she would not let her children have contact with him. There were concerns she did not comply with that agreement.
Learning
Professionals need to ensure that appropriate responses are in place to support victims of domestic abuse and children when they live in the same household.

Learning 3
Narrative
Michael had behavioural traits that were indicators he had witnessed domestic abuse. No action seems to have been taken by CAMHS in response to these indicators. Daniel also describes how Lucy's relationship with Roger seemed to have changed Michael's behaviour and that he 'punched a hole in a wall'.
Learning

When children are behaving in an abnormal manner such as punching walls, then professionals need to make better enquiry to identify, record and address why this may be happening[34].

Learning 4
Narrative
Lucy used the internet as a method of assessing the background of a partner. When seen and given advice by the police concerning her relationship with him, Lucy indicated she 'was not stupid and was able to protect herself and her children'.
Learning
The Domestic Violence Disclosure Scheme is a much safer way of checking on a partner's background where doubts exist.

Learning 5
Narrative
Agencies did not engage with Daniel when Michael displayed challenging behaviour at school. This was because Daniel and Lucy lived apart.
Learning
That professionals dealing with the poor behaviour of a child whose parents are living apart should involve both parents in trying to solve the problem (subject to no legal or safeguarding barriers).

[34] The review panel have not made recommendations in relation to the CAMHS service as they have recently been subjected to an extensive independent review with recommendations that mirror the learning in this report.

19. RECOMMENDATIONS

19.1 Agencies Recommendations

19.2 The individual agency recommendations and action plans are set out at Appendix A.

19.3 The Panel's Recommendations

Number	Recommendation
1	That Kirklees Safer Stronger Communities Partnership will seek formal assurance from all partners and local providers of domestic abuse services that coercive controlling behaviour is incorporated into all domestic abuse training programmes provided by the organisation
2	That Kirklees Safer Stronger Communities Partnership incorporates the impact of domestic abuse on children when offering advice and materials to victims and perpetrators
3	That Kirklees Safer Stronger Communities Partnership seek assurance from education and children's social care as to the following. That when a child displays challenging behaviour at school, and the parents are living apart, there is a process for informing or engaging both parents in trying to solve the problem (unless there is a legal or safeguarding obstacle to this happening).
4	That Kirklees Safer Stronger Communities Partnership identifies to the appropriate Government department the need to have 'Clare's Law' prominently displayed on internet dating sites.
5	Given much of the historical context of this case was in Greater Manchester, Kirklees Safer Stronger Communities Partnership are to share the report with Greater Manchester Community Safety Partnership so they can review if there is any learning they could have taken from their previous involvement

Agency Plans

South West Yorkshire Partnership NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	CAMHS practitioner's to be updated regarding their roles and responsibilities when a child makes a disclosure of domestic abuse the importance of understanding the emotional impact of domestic abuse on children even when they are not being directly targeted.	Local (trust wide)	In CAMHS team meetings, manager to emphasise the importance of acting on disclosures of domestic abuse by children and to understand the impact of domestic abuse on children even when they are not being	SWYPFT CAMHS		Completed	November 2018 CAMHS practitioners are aware of their safeguarding responsibility when a child makes a disclosure of domestic abuse even when they are not being directly targeted.

			directly targeted. This will also be cascaded by the safeguarding team through the CAMHS service line and governance meetings.				

Calderdale and Huddersfield NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	All Outpatient staff to undergo awareness training on Domestic Abuse; to identify domestic abuse, how to appropriately refer to specialist services and multi-agency discussions e.g. MARAC.	Local	All Outpatient qualified staff to undergo awareness training on Domestic Abuse; to identify domestic	CHFT – Domestic Abuse health service and PDVG (Health IDVA role)	All reception staff and health care staff to undergo DA awareness training All outpatient sisters (both Calderdale and Huddersfield) to have completed bespoke	January 2018 October 2017	January 2018 All outpatient sisters and Matron (both sites) have

			abuse, how to appropriately refer to specialist services and multi-agency discussions e.g. MARAC.		training on 'Identifying and responding to domestic abuse'. All outpatient therapists to undergo bespoke training on 'Identifying and responding to domestic abuse'.	October 2017	undergone training 18/8/17 All outpatient therapists and managers have undergone training (28/9/17)
2	To utilise poster and leaflet space with DA specialist services available for patients attending from Calderdale area as well as Kirklees.		To utilise poster and leaflet space with DA specialist services available for patients attending from Calderdale area as well as Kirklees.	CHFT – Domestic Abuse health service	Posters to be provided to the department and displayed Virtual noticeboard and Safeguarding newsletter to be available Advertisement of the Health IDVA role	August 2017 Monthly October 2017	August 2017 posters provided. 'Go see' to establish if posters are being displayed appropriately in November 2017 Poster advertising role completed and disseminated to Emergency Department, Maternity services, Medical Assessment

							unit and Outpatients.
3	To specially train the Safeguarding Champions for outpatients to a higher level so that they can risk assess and carry out face to face consultations with a patient who may disclose domestic abuse whilst visiting their department.		To specially train the Safeguarding Champions for outpatients to a higher level so that they can risk assess and carry out face to face consultations with a patient who may disclose domestic abuse whilst visiting their department.	CHFT – Domestic Abuse health service	All Safeguarding Champions (both Calderdale and Huddersfield) to have completed bespoke training on 'Identifying and responding to domestic abuse'. Further training identified re: routine enquiry and DASH risk assessment to be completed	October 2017 January 2018	19 September 2017, safeguarding champions at both Huddersfield and Calderdale Royal underwent training.

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

1	The Practice will display posters containing domestic abuse information in areas accessed by patients to encourage patients to have the confidence to disclose. Leaflets containing specific information of how to access local services should be available to staff in consultation rooms and to patients in communal rooms. This information will support the staff in the Practice to identify where to seek support when a patient does disclose.	Local	Named Nurse Safeguarding Adults (GHCCG) to visit GP practice (specific to DHR) to provide posters and leaflets and contact for further supplies. Learning from DHR shared with all GP Safeguarding Leads including where to access posters, leaflets and key information locally.	CCG CCG	Posters are displayed in the communal areas of the surgery Leaflets and information are also available in communal areas and on request from the GP during consultation. Briefing to be circulated to all GP Practices To be discussed at the next Safeguarding Lead Network meetings	End Dec 2017 End Dec 2017 By April 2018	A member of the safeguarding team visited the Pennine Domestic Violence Group (PDVG) on 23/1/18 to pick up posters and leaflets for the Surgery and delivered them to the Practice the same week. The Learning was circulated to all GP practices through the CCG communication with GP practices on 11th April 2018. Fortified.pdf This included an 'electronic link' within the text which led to the

							three recommendations from the DHR. This included the link to PDVG to access posters and leaflets. The same information was communicated at the Safeguarding Leads meetings (minutes below)
2	The authors of this IMR will contact the Practice and the individual GP who left the Practice on 1/4/17 to share the learning following review and approval from NHS England.	Local	Named Nurse Safeguarding Adults (GHCCG) to contact the individual GP and share the lessons learnt from the review	CCG	The GP will be contacted by telephone initially and offered an on-site visit if requested	End Dec 2017	The GP was contacted by telephone and offered a site visit but this offer was not taken up. However, the GP still works at another practice within Kirklees and the learning from the DHR has therefore been communicated to the individual through other mechanisms.

3	The learning from this case which includes depression being a potential marker for domestic abuse should be shared with all GP Practices in Kirklees.	Local	Learning from DHR shared with all GP Safeguarding leads including depression being a marker for domestic abuse	CCG	Briefing to be circulated to all GP Practices To be discussed at the next Safeguarding Lead Network meetings	End Dec 2017 By April 2018	The learning from the case was discussed at the four GP Safeguarding Leads cluster meetings. An example of one set of the minutes is provided below in one of the clusters which were replicated in the other three across both Kirklees and greater Huddersfield.  2018 03 09 GP SG Leads Meeting - V2.d This information was also circulated out to all GP practices through both NKCCG and GHCCG communications. An example from

							11th April 2018 is given below:  Fortified.pdf The case was also discussed during a PPT training event which over 170 GPs attended. The dialogue sheet used on the day is included below:  Kirklees PPT Event (July 2018) - Session Whilst this is beyond the initial timescale it is included to demonstrate that the message is continued to be communicated whenever the opportunity arises.

DHR Review Panel							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That Kirklees Safer Stronger Communities Partnership will seek formal assurance from all partners and local providers of domestic abuse services that coercive controlling behaviour is incorporated into all domestic abuse training programmes provided by the organisation	Local	DA Service Manager to communicate this to all partners and agencies represented at the Domestic Abuse Strategic Partnership requesting that CCB is incorporated into training and this will be collated and kept centrally. Any agencies not	Adult Safeguarding & Quality		October 2018 Completed	All agencies represented at the Domestic Abuse Strategic Partnership have confirmed that coercive controlling behaviour is incorporated into all training programmes

			currently providing this will be asked to plan for inclusion and feedback when/this will happen by				
2	That Kirklees Safer Stronger Communities Partnership incorporates the impact of domestic abuse on children when offering advice and materials to victims and perpetrators	Local	DA Service Manager to communicate this to all partners and agencies represented at the Domestic Abuse Strategic Partnership requesting that agency updates for how the impact of domestic abuse on children is communicated. This will be collated and	Adult Safeguarding & Quality KCSB Children's Services		October 2018 Completed	All agencies represented at the Domestic Abuse Strategic Partnership have confirmed that the impact on children is incorporated into all training programmes. The needs of the family are considered through referrals into Children's Social Care who undertake Family Group Conferencing and recently introduced Multi-Systemic Therapy. Both of these approaches explore the impact

			kept centrally. Any agencies not currently providing this will be asked to plan for inclusion and feedback when/this will happen by				domestic abuse can have on children in the context of the wider family.
3	That Kirklees Safer Stronger Communities Partnership seek assurance from education and children's social care as to the following. That when a child displays challenging behaviour at school, and the parents are living apart, there is a process for informing or engaging both parents in trying to solve the problem (unless there is a legal or safeguarding obstacle to this happening).	Local	Chair of the Communities Board to seek clarification from Children's Services about their processes to ensure that estranged partners are included in discussions/information about their child (ren) routinely.	Adult Safeguarding & Quality KCSB Children's Services	The Chair has written to the Children's Board and this is currently being explored	October 2018 July 2018	July 2018

			To raise at the DHR Standing Panel Meeting to agree process for future reviews		On agenda for July 2018 Standing Panel		DHR Standing Panel agreed that for future reviews, at the point that Terms of Reference are being set and requests are made for chronologies that it is made clear that agencies should follow their lines of enquiry into both parents (irrespective of whether they were living together at the time or not).
4	That Kirklees Safer Stronger Communities Partnership identifies to the appropriate Government department the need to have 'Clare's Law' prominently displayed on internet dating sites.	Local Regional National	DA Service Manager to contact Home Office for guidance on who best to contact to progress this	Adult Safeguarding and Quality	E-mailed Home Office October 2018	October 2018	Home Office responded 20th Dec 2018 to advise that to take this action forward, there is to be a meeting in the new year with dating websites to discuss this and other public protection issues.

5	Given much of the historical context of this case was in Greater Manchester, Kirklees Safer Stronger Communities Partnership are to share the report with Greater Manchester Community Safety Partnership so they can review if there is any learning they could have taken from their previous involvement	Local Regional	DA Service Manager to share report with and findings with Manchester CSP	Adult Safeguarding and Quality	July 2018	July 2018	Report and findings shared with Manchester CSP via e-mail on 25th July. They will also be consulted as part of plans for publication

Appendix B

Controlling Behaviour is Domestic Abuse[35]

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over, who are, or have been intimate partners or family members regardless of gender or sexuality.

The abuse can encompass but is not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial and or
- Emotional

Coercive and controlling behaviour became an offence in December 2015 and gives powers to the authorities to bring prosecutions for psychological abuse, closing the gap in the law around patterns of such behaviour.

The offence carries a maximum 5-year prison sentence and a fine.

Controlling acts may include, but not be exclusive to, manipulation, intimidation, sexual coercion and psychological abuse. The behaviour is intended to make a person become submissive, or to isolate them from sources of support, such as their friends and family. It might include monitoring their time, or communication with others, including checking someone's mobile phone or online communication.

It could also be exploiting their resources, such as their wages or access to money, depriving them of their independence and trying to regulate or control every day behaviour such as where they can go, who they can see and what to wear.

It may be stopping someone accessing specialist support services, repeatedly putting them down, humiliating or degrading them and making threats to hurt them or their children, or publish private information about them.

Something that may seem like harmless behaviour in isolation, can have devastating effects on a victim when they are subjected to repeated controlling behaviour. We would encourage people to speak to someone about any behaviour that is concerning them, all reports will be treated sensitively and taken seriously.

If you are a victim or know someone who could be a victim you can speak to police, or other agencies that can help. You can contact police via 101, in an emergency always call 999.

[35] https://www.westyorkshire.police.uk/domesticabuse:

Appendix C

Source: http://www.pof.com/safety.aspx

Dating Safety Tips[36]

How to Date Safely

At POF, user safety is a priority. We understand that meeting someone for the first time whether online, through an acquaintance or on an outing is intriguing and exciting. However, your safety is very important and because you are in control of your POF experience, there are certain safety steps that you should follow while dating – both online and offline.

We ask you to read the tips and information below, and strongly urge you to follow these guidelines in the interest of your personal safety and well-being. However, you are always the best judge of your own safety, and these guidelines are not intended to be a substitute for your own judgment.

Online Behaviour

- **Finance: Protect Your Finances & Never Send Money or Financial Information**

Never respond to any request to send money, especially overseas or by wire transfer, and report it to us immediately – even if the person claims to be in an emergency. Wiring money is like sending cash: the sender has no protections against loss and it's nearly impossible to reverse the transaction or trace the money. For more information, click on the video below to the U.S. Federal Trade Commission's advice to avoid online romance scams, also available here: http://onguardonline.gov/articles/0004-online-dating-scams.

- **Protect Your Personal Information**

Never give personal information such as your social security number, credit card number or bank information, or your work or home address to people you don't know or haven't met in person.

Note: POF will never send you an email asking for your username and password information. Any such communications should be reported immediately.

[36] As this is taken from an international web site the telephone contact numbers relate to USA law enforcement agencies and support services.

- **Be Web Wise**

Block and report suspicious users. You can block and report concerns about any suspicious user anonymously from any profile page, email or messaging window. Keep conversations on the platform. Bad actors will try to move the conversation to text, personal email or phone conversations.

- **Report All Suspicious Behaviour**

Additionally, please report anyone who violates our terms of use here. Examples of terms of use violations include:

- Asking you for money or donations.
- Requesting photographs.
- Minors using the platform.
- Members sending harassing or offensive messages or emails.
- Members behaving inappropriately during or after meeting in person.
- Fraudulent registration or profiles.
- Spam or solicitation, such as invitations to call 1-900 numbers or attempts to sell products or service.

Offline Behaviour

First in-person meetings are exciting, but always take precautions and follow these guidelines to help you stay safe.

- **Get to Know the Other Person**

Keep your communications on the platform and really get to know users online/using the app before meeting them in person. Bad actors often push people to communicate off the platform immediately. It's up to you to research and do your due diligence.

- **Always Meet and Stay in Public**

Meet for the first few times in a populated, public place – never in a private or remote location and *never* at your date's home or apartment. If your date pressures you, end the date and leave at once.

- **Tell Your Friends and Family Members of Your Plans**

Inform a friend or family member of your plans and when and where you're going. Make sure you have your cell phone charged and with you at all times.

- **Transport Yourself to and from the Meeting**

You need to be independent and in control of your own transportation, especially in case things don't work out.

- **Stay Sober**

Consumption of alcohol and/or other drugs can impair your judgment and potentially put you in danger. It's important to keep a clear mind and avoid anything that might place you at risk. Be aware that bad actors might try to take advantage of you by altering your beverage(s) with synthetic substances.

Health

POF welcomes everyone and empowers our community of users to create and cultivate relationships. An important aspect of any healthy relationship though – whether formed on POF or otherwise – is ensuring proper sexual health and safety. And as an essential member of the POF community it is your responsibility to make sure you do the following, if you choose to engage in sexual activity.

- **Protect Yourself**

You and your partner should use proper protection. Condoms and other mechanisms can significantly reduce the risk of contracting or passing on an STI, such as HIV. However, you can still get certain STI's, like herpes or HPV from contact with your partner's skin even when using a condom. To be effective, however, protective measures must be used consistently.

- **Be Open and Honest**

It is completely reasonable to have a conversation with your partner regarding sex and sexual contact before actually having it. All issues ranging from the number of partners each of you has had, to the last time each of you was tested for STI's are fair game. Many STI's are curable or treatable. If either you or your partner has an STI that is curable, you both need to start treatment to avoid becoming re-infected. It is important to be completely honest in these conversations.

- **Vaccinate**

The risk of contracting some STI's can be reduced through vaccination. Talk to your doctor or a professional at a sexual health clinic to learn more.

- **Know Your Status**

Know your status. Some STI's don't show symptoms. Regular testing is critical to staying on top of your health and helping prevent the spread of STI's after testing, always ask for a copy of your test results so you are sure of your status.

For Further Help, Support or Advice

In the case that something has happened, immediately call **911**. Emergency situations include a recent threat of violence or sexual violence, recent act of violence or sexual violence or if your health or someone else's is in danger.

If something has happened and you're in need of help, support or advice pertaining to physical or sexual assault, please call the below 24hr hotlines.

The numbers given on the website are for American based services.

The equivalent United Kingdom numbers are:

The national Rape Crisis helpline (run by our member Centre Rape Crisis South London) on 0808 802 9999 between 12 noon - 2.30pm and 7 - 9.30pm every day of the year.

Or visit www.rapecrisis.org.uk/centres.php to find local services.

National Domestic Abuse Helpline

24-hour National Domestic Violence
Freephone Helpline 0808 2000 247

End For Publication Overview Report Huddersfield DHR