Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Clarissa
in July 2018

Report Author: Christine Graham
August 2020

Preface

Bassetlaw, Newark and Sherwood's Community Safety Partnership wishes at the outset to express their deepest sympathy to Clarissa's family and friends, particularly to her surviving child. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from families and friends throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Bassetlaw, Newark and Sherwood Community Safety Partnership on receiving notification of the death of Clarissa in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Overview Report has been compiled as follows:

The report begins with a **tribute to Clarissa** from her father.

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Clarissa's death. This section will provide **analysis of the information** known to family, friends, statutory and voluntary organisations and others who held relevant information.

Section 3 will **analyse** the issues considered by the review.

Section 4 sets out the **lessons learned** from the review.

Section 5 will consolidate **the recommendations that arise**

Section 6 will provide the **conclusion** debated by the Panel

Appendix One provides the **terms of reference** against which the panel operated

Where the review considers there has been a missed opportunity, this is highlighted in a text box. Examples of good practice are highlighted by the use of italics.

Contents

A tribute to Clarissa from her father

My remit here is supposed to be writing a pen picture of who my daughter was as a person, of her love of singing, the Peak District, her spirituality, of who she was as a small child and so forth. My concern with that is whilst all that will live in my heart forever there is a side to Clarissa that I think is more important to write about.

In order to better understand about the person Clarissa was and of the person who is lost to us as a family I think an appreciation of what she went through prior to her death is needed. I want to attempt to make the readers of this tribute understand how proud Clarissa made us feel and of the huge amount of respect we feel for her. She had attempted to leave the perpetrator on a number of occasions and we don't doubt she kept elements of the abuse she suffered at his hands secret from us as she was afraid of what might have happened to us had we further challenged him and tried to protect her and their child.

When Clarissa hugged me the day before the murder it was a hug I will never forget, that now feels as if she was saying a final goodbye. It was the hug that a young child gives their parent, strong and close, that says "I love you." Of course the harsh reality was she was expressing her feelings of love and gratitude for my support as she believed the perpetrator was about to move out.

On the day of her death Clarissa was happy, embracing the fact that the perpetrator had finally on that very day, taken his name from the tenancy and was about to leave her and their young child free to start a new life. E had provided Clarissa with direction and hope in her life and it was in that defence of E's future that Clarissa's life was so cruelly and deliberately taken.

No one really knows what happened that evening but police evidence for the murder trial shows that the struggle probably started in the living room with one of Clarissa's shoes being found there and the other still on her foot in the far corner of the kitchen where she had been forced into a place of no escape.

The perpetrator then spent between two and five minutes murdering Clarissa by strangulation with his own hands.

There is no doubt this was a totally deliberate act; as the criminal trial demonstrated it couldn't be anything but deliberate and the jury unanimously reached a verdict very quickly.
To have had that ruthless deliberation to kill Clarissa the perpetrator demonstrated just how evil he was.

The murder took place in a small house with both the rooms close together separated only by a very small hallway. The perpetrator had so little regard for his own toddler as the murder happened with their child so close she was able to watch him. In his defence the perpetrator had concocted a story of Clarissa threatening to cut her arms inside the kitchen and call her father claiming he had done this to her. Shockingly the DHR shows that in September 2017 Clarissa had called the police because the perpetrator had threatened to self-harm by cutting his arms.

I know that the perpetrator was lying, he was known for lying, lying came easy to him and he would go to great lengths to maintain his lies, even falsely claiming to be schizophrenic for years in order to self-excuse his abusive behaviour. It came as no surprise to hear that he concocted a ridiculous story of self-defence with members of his family before they called the police.

You will read within the DHR that in 2003 the perpetrator thought of hurting his young children all the while maintaining a charade in court of being a devoted father. For this reason I strongly believe that their child had been in danger of losing their life whilst the perpetrator alerted his family to come to his aid. They stated in court that had to drive for around 20 minutes to get to their father; for 20 minutes their

child remained in peril. Once at the house they spent around another 20 minutes before alerting the police with no aid or consideration for Clarissa who was laying either dead or dying only feet away from where they colluded.

In the criminal trial the perpetrator's family members stated under oath that their father and Clarissa's house move had been October 2017 rather than August 2017. This aided the perpetrator's defence by concealing the police call out in September 2017 which because it had been classified by the attending officers as a domestic incident rather than domestic abuse had not been recorded on the NICHE data system.

The perpetrator is a violent, controlling and abusive man who has the support of his family, which might appear surprising, as most would disown such perpetrators. For the majority of us raised conventionally, violence and abuse are abhorrent but there are some people like the perpetrator that think this is acceptable behaviour.

By September 2017 Clarissa had been worn down by the perpetrator assisted by his adult children. Yet Clarissa bravely pulled herself up from rock bottom, gained confidence, was planning a future without the perpetrator and fought back so strongly that in just ten months she had become steadfast in evicting him.

The birth of her child changed everything for Clarissa; the child become her motivation and her life. Clarissa valiantly placed her child's needs to the fore knowing that it meant keeping the perpetrator involved in the child's future life. Clarissa had not known the danger the perpetrator was to their child; though you might feel this was information that should have been available to her prior to having his child or at the point of being pregnant: this was never divulged.

We have been led to understand that a DHR is about learning and what could be done differently in order to reduce such crimes in the future. We have voiced how we are concerned with police call-out reporting and of information relevant to mothers-to-be of danger concerns of the partners being withheld. However, we believe that it is not just professionals that should be learning from DHRs.

No baby is born bad they learn through those raising them how to behave ethically or unethically and what to value in life. We believe that it is the responsibility of those that choose to have children to raise them properly. The perpetrator reported that his father was an abusive man and his mother was neglectful. It seems Social Services somehow failed to notice his unmet needs during his childhood. In his teens he struggled with anger management and he turned to theft, criminal damage and then arson. As a grown man he took to carrying offensive weapons and moved on to assault and finally murder. Had the perpetrator been raised differently he might have become a good man, I might still have a daughter and her child might still have her mother and access to her father. Her child probably would never have suffered trauma in her life, they wouldn't have been separated from their parents and home so wouldn't have suffered from the separation anxiety they experience and ~~she~~ wouldn't have so many nightmares.

As Clarissa passed into unconsciousness prior to death she must have felt the horror of the uncertainty of what might happen to her child and that should her child survive, what would happen to them from there, who would raise them and how they would be raised. By our loving her child unconditionally and of following Clarissa's example of placing the child's health, welfare and future before our own we are doing our very best to honour Clarissa's memory and to give her child the love and care that she would have given ~~her~~ and that she would have wanted them to receive.

Section One – Introduction

1.1 Summary of circumstances leading to the review

1.1.1 At 7.40 pm on a Monday towards the end of July 2018 South Yorkshire Police received a call reporting the death of Clarissa resulting from 'self-defence' by the perpetrator. The caller had gone with his own girlfriend, the perpetrator's child and other family members to the home having received a call from the perpetrator following the homicide. The caller said that he believed that there had been an altercation and that the perpetrator had said that he had lashed out at Clarissa and that, after that, he was unsure what had happened.

1.1.2 At 7.42 pm South Yorkshire Police passed the incident to Nottinghamshire Police (the homicide occurring in the Nottinghamshire Police area, which borders South Yorkshire). At 7.53 pm officers arrived at the home and activated their body worn video cameras. Present at the house were the perpetrator, his adult daughter and her partner and his adult son. The couple's young child was also present in the garden when officers arrived.

1.1.3 Clarissa was found dead in the kitchen of the house, she was lying on her back, face up in front of the fridge.

1.1.4 A subsequent post-mortem found that Clarissa had died as a result of manual strangulation.

1.1.5 The perpetrator was arrested at the scene and a murder investigation commenced. He was subsequently charged with Clarissa's murder.

1.1.6 He pleaded not guilty to both murder and manslaughter but was found guilty of her murder. He was sentenced to life.

1.1.7 The couple had been in a relationship for around four years prior to the homicide. In September 2017, Clarissa wrote to a close friend about the relationship in which she describes how the relationship started[1]. She said, 'I was working somewhere, met this guy, had a strong attraction…..started meeting up, I was not looking for a serious relationship…..next thing he broke up with his wife and told me he loved me. My reaction – oh damn….I was not looking for a serious relationship ……trouble is I liked the guy but I was not ready for commitment….He was all or nothing …. Next moment he's telling me who I can and can't see; what I can and can't do….he wanted things about me to change bit by bit…. He loses his job and I say he can move in with me because I feel sorry for him … wasn't meant to be permanent…. Then I'm pregnant ….. then my mum died and he said horrible things and wasn't there when I needed someone…. I felt like killing myself but no one was there.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

[1] Excerpts from the letter are quoted

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the victim had been in an intimate personal relationship with the perpetrator. He has been found guilty of murdering Clarissa. Therefore, the criteria has been met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

1.3.1 Bassetlaw, Newark and Sherwood's Community Safety Partnership was notified of the death by Nottinghamshire Police on 6th August 2018.

1.3.2 An initial meeting was held on 10th September 2018 when it was decided that a Domestic Homicide Review would be undertaken, and an initial trawl of agencies was done.

1.3.3 The Home Office were advised on 4th October 2018.

1.3.4 The Independent Chair and Report Author were appointed on 17th October 2018.

1.3.5 The Independent Chair made contact with the family in February 2019.

1.3.6 The first panel meeting was held on 18th December 2018. The following agencies were represented at this meeting:

- Bassetlaw Clinical Commissioning Group

- Bassetlaw District Council
- Bassetlaw, Newark and Sherwood Community Safety Partnership
- East Midlands Special Operations Unit (Police IMR author)
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police
- Nottinghamshire Women's Aid
- Sherwood Forest Hospitals NHS Foundation Trust

1.3.7 At the first meeting, the panel considered its composition and it was agreed that further information was needed from those areas where the couple had lived.

1.3.8 It was agreed that Individual Management Reviews would be requested from:

- Nottinghamshire Police (to include liaison with other involved police force areas)
- GPs for both Clarissa and the perpetrator
- Calderdale and Huddersfield NHS Foundation Trust (CHNT) (maternity services)
- Nottinghamshire Healthcare Foundation Trust (NHCT) (health visiting services)
- Department for Work and Pensions

Summary reports were requested from:

- Locala Community Partnerships CIC (health visiting services)

1.3.9 The panel met on three occasions in total and the review was completed in August 2020.

1.4 Confidentiality

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

1.4.2 Ordinarily, in line with Home Office guidance, a pseudonym would be selected for Clarissa but, in this case, her father specifically wanted her name to be used within the report. His wishes have been respected and followed.

1.4.3 Clarissa's partner who was found guilty of her murder will be referred to as the perpetrator.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Bassetlaw District Council
- Calderdale and Huddersfield NHS Foundation Trust (CHNT)
- Department of Work and Pensions
- Locala Community Partnerships CIC (health visiting services)
- Newark and Sherwood District Council
- Nottinghamshire and Nottingham Clinical Commissioning Group
- Nottinghamshire Healthcare NHS Trust

- Nottinghamshire Police
- Nottinghamshire Safeguarding Board
- Nottinghamshire Women's Aid

1.6 Methodology

1.6.1 Bassetlaw, Newark and Sherwood's Community Safety Partnership was notified of the death by Nottinghamshire Police on 6th August 2018.

1.6.2 The Home Office was notified on 4th October 2018 that the Community Safety Partnership intended to undertake a review.

1.6.3 An initial meeting was held on 10th September 2018 when it was decided that a Domestic Homicide Review would be undertaken, and an initial trawl of agencies was done.

1.6.4 This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.6.5 Gary Goose and Christine Graham were appointed in October 2018 to undertaken, the review. As the criminal process was still ongoing, following a conversation with the Senior Investigating Officer, it was agreed that the review would proceed in limited scope until this was complete to avoid any issues of disclosure.

1.6.6 The first panel meeting was held on 18th December 2018. At the first meeting the panel considered its composition and it was noted that there were times when the couple lived outside the area and it was agreed that contact would be made with Kirklees Community Safety Partnership in order that they could contribute to the review. The Department for Work and Pensions and Nottinghamshire Healthcare Trust were invited to join the panel. Children's Services were not present, and the Report Author spoke with the director and it was agreed that they would be part of the panel moving forwards.

1.6.7 As the criminal process was not complete, the panel was asked to gather all of the information that they held on the couple. It was decided that the scope of the review would be from 1st January 2014 with any relevant information prior to that date being included. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.6.8 At the end of February 2019 the Chair wrote to Clarissa's family explaining about the review and provided them with details about the support available through AAFDA[2].

[2] Advocacy After Fatal Domestic Abuse

1.6.8 Once the trial had completed, the panel met again on 9th April 2019 and the Individual Management Reviews (IMRs) were commissioned from:

- Nottinghamshire Police (to include liaison with other involved police force areas)
- GPs for both Clarissa and the perpetrator
- Calderdale and Huddersfield NHS Foundation Trust (CHFT) (maternity services)
- Nottinghamshire Healthcare Foundation Trust (NHCT) (health visiting services)
- Department for Work and Pensions

1.6.9 Summary reports were requested from:

- Locala Community Partnerships CIC (health visiting services)

1.6.10 In May 2019 the Chair and Report Author met with Clarissa's father and stepmother who were supported by an AAFDA advocate. Clarissa's father and stepmother met the panel in September 2019. Clarissa's family were provided with a copy of the report to consider in their own time.

1.6.10 The panel met again in September 2019 to consider the IMRs and summary reports. At this meeting it became clear that the review did not have all of the information about the involvement of Clarissa and her child with health services outside of Nottinghamshire. With the help of the Bassetlaw Clinical Commissioning Group, a meeting was convened at which the health bodies from both areas were represented. This allowed clarity to be obtained and further IMRs and summary reports to be commissioned.

1.6.11 The review was not completed within six months as the review did not commence, in full, until after the criminal process and it took time to gather information from the different areas where the couple had lived. The review was then further delayed by the Covid 19 lockdown. This review was so complex that it was felt that to try and proceed without detailed discussion within the panel would be detrimental to the quality of the review.

1.7 Contributors to the review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Bassetlaw District Council (Revenue and Benefits)
- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- Department for Work and Pensions

- Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
- GP for both Clarissa and the perpetrator
- Locala
- NHS Bassetlaw Clinical Commissioning Group
- Nottinghamshire Healthcare Foundation Trust (NHCT)
- Nottinghamshire Police – included contributions from West Yorkshire Police and Lincolnshire Police
- Nottinghamshire Women's Aid
- Sherwood Forest Hospital Trust
- Yorkshire Ambulance Service

1.7.5 The panel considered whether the perpetrator should be invited to contribute to the review. At the time of the Review the victim's family were engaged with the family court a process where the views of the perpetrator were considered. It was felt unwise to involve the perpetrator in this review whilst the sensitive nature of the family court process was underway.

1.8 Engagement with family and friends

1.8..1 The Chair made contact with Clarissa's father and stepmother to introduce the review to them and make them aware of the support that could be offered by AAFDA. The Chair and Report Author subsequently met with them and their AAFDA advocate.

1.8.2 Clarissa's father and stepmother met with the panel when they talked about Clarissa and left the panel with a list of questions that they had. A significant number of these questions were outside the scope of this review, so agencies engaged directly to answer these questions.

1.8.3 The review is very grateful to Clarissa's father for the insights that he has provided to the review, including texts sent between him and Clarissa over a couple of years. Clarissa's father and stepmother were given a copy of the draft report to consider at their own pace.

1.8.4 The Chair wrote to Clarissa's brother, but he did not wish to engage with the review and the panel respects this decision.

1.8.5 Contact was made with a close friend who gave evidence at the trial. Although she chose not to engage the review has been able to have sight of her statement as this was read within the public court hearing.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Ros Theakstone	Director of Corporate Resources	Bassetlaw District Council
Gerald Connor	Community Safety Manager	Bassetlaw District Council

Nicolette Richards	Domestic Violence Co-ordinator	Bassetlaw Newark and Sherwood Community Safety Partnership
Adrian Morgan	IMR author	East Midlands Serious Offences Unit
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Mandy Green	Head of Services	Nottinghamshire Women's Aid
Hannah Hogg	Corporate Safeguarding Lead	Nottinghamshire Healthcare NHS Foundation Trust
Jonathan Webb	Deputy Head of Service	DLNR CRC
Bob Ross	NSCB Development Manager	Nottinghamshire County Council
Gail Stansbury	Jobcentre Manager	Department for Work and Pensions
Elaine Simmonds	Revenue and Benefits	Bassetlaw District Council
Joe Foley	Children's Social Care	Nottinghamshire County Council
Andrew Beardsall	Head of Quality and Patient Care	NHS Bassetlaw CCG
Cathy Burke	Deputy Chief Nurse	NHS Bassetlaw CCG

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs the local Safer off the Streets Partnership.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a number of domestic homicide reviews across the county in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel

investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.10.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended training on the statutory guidance update in 2016
- Attended the AAFDA Annual Conference (March 2017)
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford (September 2018)
- Attended AAFDA Annual Conference (March 2019)

Christine has:

- Attended AAFDA Information and Networking Event (November 2019)
- Attended webinar with Dr Jane-Monckton-Smith on Homicide Timeline (June 2020)
- Attended webinar run by Review Consulting Ltd on 'Engaging Families in Reviews' (June 2020)

1.11 Parallel Reviews

1.11.1 The Coroner closed the inquest following the completion of the criminal process.

1.11.2 There were no other reviews undertaken.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[4] According to a statement by Refuge, women are more likely than men to be killed by partners/ex-partners, with women making up 73% of all domestic homicides, with four in five of these being killed by a current or former partner[5]. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[6]

1.12.3 The majority of perpetrators of domestic homicides are men – in 2017/18, 87.5% of domestic homicide victims were killed by men[7]. Furthermore, in 2017/18, 93% of defendants in domestic abuse cases were men[8] and in 2017, 468 defendants were prosecuted for coercive and controlling behaviour, of which 454 were men and only nine were women[9].

4 (Women's Aid Domestic abuse is a gendered crime, n.d.)

5 ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018'. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#the-long-term-trends-in-domestic-abuse November 2018.

6 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

7 Ibid

8 CPS (2018), 'Violence against women and girls report, 2017-18). September 2018 https://www.cps.gov.uk/sites/default/files/documents/publications/cps-vawg-report-2018.pdf

9 Ministry of Justice (2018), 'Statistics on women and the criminal justice system 2017'. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759770/women-criminal-justice-system-2017..pdf November 2018.

Section Two – The Facts

2.1 Introduction

2.1.1 Clarissa was a white British woman who was 26 years old at the time of her death. She had one older brother. Clarissa had struggled with depression after her mother's death in 2017. She had been in a relationship with the perpetrator for four years having met him through work. They had a young child together.

2.1.2 The perpetrator was 48 years old and had adult children from his previous marriage. He had suffered bouts of depression for which he was prescribed medication to control the symptoms. He had previous convictions for burglary, criminal damage and possession of an offensive weapon and, at the time of Clarissa's death, he was under investigation for an assault on his former wife's current partner.

2.2 Detailed chronology

2.2.1 This chronology includes information provided by Clarissa's family, particularly in form of texts between Clarissa and her father, as well as information known to agencies.

2.2.2 **Incident outside the scope of the review included for background information**

2.2.3 In 2013 there was an incident where Clarissa made friends with a man who had some issues through a workshop she attended. Although she saw this only as a friendship, he saw it as much more and despite her efforts to end the friendship he pursued her. After an incident at her home he was arrested and charged with harassment offences. This incident has been included as it tends to corroborate the view from friends and family of Clarissa being the type of person who would seek to help those in need.

2.2.4 **Detailed chronology from 1st January 2014**

2.2.5 **2014**

2.2.6 At the beginning of the scoping period Clarissa was living in Sandall Parva.

2.2.7 From 23rd April 2014 the perpetrator lived in Cursthorpe.

2.2.8 On 24th July the perpetrator moved to Danum.

2.2.9 **2015**

2.2.10 On 16th April 2015 the perpetrator was employed as a security guard at B&M store in Danum. The security manager had attended the store to interview the perpetrator regarding an internal investigation. During the interview, the perpetrator produced a lock knife which he pointed towards the manager and made threats to stab him. He was detained by members of staff during which he punched the Security Manager in the face. South Yorkshire Police attended and arrested him for affray. When he appeared in court, he was found guilty of possessing an offensive weapon. He was sentenced to a community order with a requirement to carry out 50 hours unpaid work.

2.2.11 On 18th June Clarissa moved to Burring Village and the perpetrator moved to the same address on 2nd October.

2.2.12 On 2nd November Clarissa and the perpetrator moved to Holmwood.

2.2.13 At some point in 2015 the perpetrator was admitted to hospital following a possible seizure.

2.2.14 **2016**

2.2.15 On 18th January the perpetrator attended a new patient screening at a surgery in Holmwood. At this appointment he reported that he had taken anti-depressants for years but was unsure of the dose. He also said that he had run out of medication before Christmas. He reported that he had a first seizure episode recently and, on 4th February, the GP referred him to neurology.

2.2.16 Clarissa's mother was diagnosed with cancer in January 2016. This was obviously very significant for Clarissa who was very close to her mother.

2.2.17 On 21st April Clarissa attended a new patient screening at the same surgery as the perpetrator in Holmwood.

2.2.18 The perpetrator was seen by the Neurology Consultant on 27th May and 1st July in relation to the suspected seizure he had experienced. He had normal ECG, EEG and MRI scans. He was advised about alcohol, staying up late and avoiding stress factors. The consultant felt that if he avoided these factors, he would be fine and would be discharged if he did not have another attack after 12 months.

2.2.19 On 1st August 2016 Clarissa was registered with Locala Supporting Families Unit, in Kirklees on receipt of an antenatal notification from her GP.

2.2.20 On 15th August the perpetrator was sentenced at Sheffield Crown Court for the offence of possession of an offensive weapon. (This relates to the incident of 16th April 2015). He received a 12-month community order with 50 hours of unpaid work.

2.2.21 In September Clarissa's mother moved to be near to Clarissa for her final days.

2.2.22 At some point, approximately 3 weeks before the baby was born, Clarissa learned that the perpetrator had been stalking a girl from work (this is taken from Clarissa's letter which is in full later in the report).

2.2.23 Clarissa was seen by Locala on 26th October for an antenatal appointment. The perpetrator was present and no concerns were expressed.

2.2.24 On 2nd November Clarissa and the perpetrator's child was born at Calderdale and Huddersfield NHS Foundation Trust. The baby was early, and Clarissa believed that this was due to stress exacerbated by the revelation that the perpetrator was stalking a work colleague[10].

[10] The review notes that Clarissa did not indicate to health colleagues that she thought this was the reason for the early birth

2.2.25 Clarissa and her child were seen by Locala on 10th November. The perpetrator was also present.

2.2.26 On 22nd November the health visitor at Locala was advised by the midwife that Clarissa had disclosed that the couple had been arguing and she had reported coercive control by the perpetrator. She had expressed a fear that he would take the child to Danum to see his adult children which she was not happy with. She had said that she was not frightened of him and denied that there had been any other incidents of domestic abuse.

2.2.27 On 30th December Clarissa attended her 8-week check. She was accompanied to the appointment by her mother. and was offered immunisations for her daughter which she declined on that day as she did not feel that she had enough information to make an informed decision. She said that she would like to do more research at home.

2.2.28 **2017**

2.2.29 Clarissa had contact with the health visitor (from Locala) on four occasions between 23rd January and 8th March (two were face to face and two were over the phone). Clarissa's relationship with the perpetrator was discussed on 23rd January. It was documented that her mother had recently died and that the perpetrator was being supportive and understanding.

2.2.30 On 31st January Clarissa had a follow up appointment with the health visitor and no further information about her relationship was recorded.

2.2.31 On 8th March Clarissa had a text conversation with her father:

Clarissa - *Would you be able to come over some day and like help me sort an escape plan out? I'm sure I'll manage without him as long as I have a good plan, just need to get an idea of what I'm going to do if things don't work out.*

Father - *Yes, of course. You know we can accommodate you and the baby if that's what you want.*

Clarissa - *thanks dad can you come over Monday morning. Still think I'll be better off without him, how he's being atm.*

Following a discussion about when her father would go over.

Clarissa - *Hi dad, it's okay. I misunderstood something he said, I thought he was telling me to move out, but it turned out he was looking at the house for both of us. If you can help me sort out a back-up plan just in case but I don't think there's any rush at the moment, so please don't risk coming over. It was one of our misunderstandings again (this text will be deleted) I'll phone you later.*

2.2.32 On 13th March Clarissa's father had gone to visit her to tell her that her grandfather had died. Whilst he was there, the perpetrator came home but did not make his presence known but according to Clarissa's father he sneaked upstairs and eavesdropped their conversation. When Clarissa's father became aware that he was there he behaved in a way that was bizarre

and aggressive. When Clarissa's father challenged the perpetrator about his behaviour, and he became sullen and remote until after he had left. Clarissa's father stayed until he was happy that the perpetrator had sufficiently calmed.

2.2.33 At 4.30 am the next day, 14th March, Clarissa contacted her father and told him that she was locked in the bedroom. She said that she had the house keys in her pocket and so, when the perpetrator had gone to work, her father went to the house at 7am and got Clarissa and her daughter out. At this point, Clarissa and her daughter moved in with her father and his partner.

2.2.34 Clarissa moved back to the home that she shared with the perpetrator on 27th March.

2.2.35 On 28th April 2017 Clarissa's father contacted Lincolnshire Police to report that Clarissa had been in touch with him to tell him that she had been assaulted by the perpetrator. The call was transferred to West Yorkshire Police and when they attended, they found Clarissa had left the address with her child. The perpetrator was present and advised officers that she had gone to her father's home.

2.2.36 The officers managed to make contact with Clarissa before she left the area and she met them at a local police station. She told officers that she had asked the perpetrator for money to get her hair done. He had become angry about this and they had begun to argue. She had got in the car, intending to leave, and he had got into the passenger seat and grabbed her coat by the neck and squeezed the collar causing her pain but no visible injury. She had managed to get out of the car and had contacted her father.

2.2.37 She was reluctant to make a statement but did say that she was subject to controlling and coercive behaviour by the perpetrator. She said that he did not like her meeting her friends, controlled the money, became anxious if she spoke to strangers and threatened to kill himself if she left him. She said he had tried to strangle her a few times albeit that she had not passed out.

2.2.38 Clarissa said that the perpetrator suffered with mental health issues (paranoia, schizophrenia and depression) but that he did not always take his medication. She said she had previously tried to end the relationship, but found this difficult without him persuading her to come back. She said that he had become more difficult to live with since the birth of their child. She said that she did not work due to childcare and so she had no money of her own. She was made to feel guilty if she spent money on herself. A DASH[11] risk assessment was completed and was recorded as MEDIUM.

2.2.39 Two days later the Investigating Officer contacted Clarissa again and she said that she had relocated to live with her father in Lincolnshire and did not intend to return to the perpetrator. She said that she did not wish to support a prosecution as she thought it would make matters worse and she wanted the perpetrator to have a relationship with his child despite their own differences.

2.2.40 At 5.54 pm the perpetrator called the NHS 111 service[12]. He said that he suffered from depression and was not feeling well. He said that he was not thinking straight and thought

[11] Domestic Abuse and Stalking Risk Assessment
[12] Information provided by Yorkshire Ambulance Service

that he needed to be in hospital. He said that he was thinking of ending his life, he stated that he had a plan but not an immediate plan to end his life. He said his partner had left with their child two days earlier and he thought that he was having a breakdown. He said that he was not able to attend A&E. He was called back by a clinician for further assessment who arranged for a taxi for him to attend Huddersfield Royal Infirmary.

2.2.41 On 1st May the perpetrator presented at A&E (South West Yorkshire Partnership NHS Foundation Trust Services) expressing low mood. He said he had previously suffered with depression and self-disclosed that he thought that he was having a breakdown. He was seen by the Mental Health Liaison Team when he said that he was in low mood and thought that he was having a breakdown. It was recorded that when he was seen in A&E, he said that he and Clarissa had argued after she challenged him about his mental health. He said that she had been asking him for 6 months or so to get help for his low mood and said he had been becoming more withdrawn, going for long periods without a wash or shave and not eating or sleeping well. She had also challenged him about his medication and had taken to reminding him to take it as he said he had would have otherwise stopped as he did not feel that it was helping. He said he felt safe at home and was hoping to speak to Clarissa about an agreement about seeing their child and repairing the relationship. The risk assessment undertaken identified previous attempts at own life, depression, recently separated, problems managing his own medication and non-compliance with care plan.

2.2.42 The perpetrator then saw his GP on 2nd May when he was described as having poor eye contact, teary at times and slightly unkempt. He said that he had suffered with depression in the past and felt that it had worsened in recent times. He felt that he had been in denial about the condition and felt ashamed. He said his partner had left with their child because of his depression. He mentioned fleeting suicidal thoughts. He was advised to have another appointment with his GP to review his medication.

2.2.43 On 3rd May Kirklees Children's Social Care received a domestic abuse notification from the police regarding the incident on 28th April. Clarissa was spoken to on the phone and she said that she did not wish to continue the relationship, that the perpetrator had mental health issues and she was moving to stay with her family in Gainsborough. She advised that she may return to Church Lees. As Clarissa was out of the area with family members, advised was given about how domestic abuse impacts on children and she was given the phone numbers for local contact numbers who could assist her with the concerns she raised about the perpetrator's abusive behaviour. It was noted that there was no role for CSC but that, should a further incident occur, consideration should be given to further assessment.

2.2.44 On 4th May the perpetrator was accepted for Core Team Mental Health Outpatients appointment to review his medication (South West Yorkshire Partnership NHS Foundation Trust Services). The plan was that he would be transferred to the Community Mental Health team to have his medication reviewed by a consultant in outpatients.

2.2.45 On 9th May a domestic abuse notification from the police dated 28th April was reviewed by the duty health visitor from Locala. It was noted that Children's Social Care were aware of the incident but were not involved as the family had fled from the area with no forwarding address.

2.2.46 The perpetrator saw his GP on 10th May for his review and said he was feeling much better. He said he had been in contact with his adult children which had helped and was looking to return to work the next week. He did not have any suicidal ideation.

2.2.47 On 11th May Clarissa contacted the health visitor (Locala) and advised that she and their child had moved back to the home.

2.2.48 On 12th May the Domestic Violence Unit contacted Clarissa and she agreed for the relevant support services to be contacted. Social Care and child health referrals were made with a request for that their counterparts in Lincolnshire were notified.

2.2.49 Clarissa advised the health visitor (Locala) on 26th May that she and the perpetrator had resumed their relationship. She reported at this meeting that the perpetrator had a history of depression and schizophrenia and was engaging in support for this. She attributed the domestic abuse to his medication having been reduced and reported that things had been stable since his GP had increased his medication again.

2.2.50 On 6th June Clarissa and the perpetrator took their child to the GP to discuss immunisations which they were now happy to have.

2.2.51 On 13th June the South West Yorkshire Partnership NHS Foundation Trust Services wrote to the perpetrator's GP as he had failed to attend the out-patients appointment with the mental health team.

2.2.52 On 14th June their child was given her immunisations.

2.2.53 On 21st June 2017 the health visitor (Locala) shared the disclosure that Clarissa had made on 26th May at the GP links meeting. The information was shared to alert the GP to domestic abuse within the household so that this information could potentially inform assessments of wellbeing should Clarissa or her child attend for an appointment at the GP surgery. The information should also prompt further discussion around domestic abuse if Clarissa was seen on her own.

2.2.54 Clarissa saw her GP on 22nd June when she said that she was struggling day to day. She was finding being a stay at home mum difficult and did not feel that she could talk to anyone about how she felt. She was described as bright, smiley and chatty during the consultation. She was signposted to Kirkwood Hospice for bereavement support and she was happy with the plan.

2.2.55 The perpetrator saw his GP on 26th June when he said he was feeling well and normal. He said he now had no work or home issues and no suicidal thoughts.

2.2.56 Clarissa saw her GP again on 27th June when she was able to chat and explain matters, although she displayed some inappropriate giggles at times. The perpetrator accompanied her to the appointment and held their child throughout. Clarissa said that she wondered if she was suffering with Asperger's syndrome or autism. She said that she could feel weepy and low at times when she feels alienated from people and when thinking about her mum. It was agreed to refer her to the Adult Autism/Asperger's service.

2.2.57 On 12th July the GP was advised by South West Yorkshire Partnership NHS Foundation Trust that Clarissa had been placed on the waiting list for a Autism/Asperger's assessment. She was never seen by the service.

2.2.58 On 25th July Clarissa sent a text to her father saying that she might need her father to pick her up as the perpetrator 'pissed off at me and car in mechanics'. He was not able to go as he did not have a car at home and his partner was out. He sent a text to Clarissa later that evening asking if she needed rescuing. She said that it was OK as he was 'just being mardy'.

2.2.59 On 14th August Clarissa told the health visitor (Locala) that the family was moving to Doncaster to be nearer their extended family and the things between her and the perpetrator were good, and his mental health was stable.

2.2.60 On 17th August the South West Yorkshire Partnership NHS Foundation Trust Services wrote to the perpetrator's GP as he had failed to attend the outpatient's appointment with the mental health team.

2.2.61 On 25th August Clarissa and the perpetrator moved to Harwarded.

2.2.62 On 11th September Clarissa told her father in a text that she was feeling isolated even though she was just down the road from him. She said that as the perpetrator had the car, she was finding herself depressed again being in the house on her own. She then said to her father that she had the tenancy in her name then she could kick him out. She said that she realised that she would have to claim housing benefit, but she hoped that they would not kick out the main tenant with a baby.

2.2.63 On 22nd September 2017 at 8.47pm Clarissa contacted South Yorkshire Police to say that the perpetrator had become aggressive towards her. He had said that he wanted to die and that he would cut his arms if she called the police. Clarissa confirmed that their child was present and was safe and well. She said that he had not been violent on this occasion although he had been in the past. Having established that she was safe, South Yorkshire Police transferred the call to Nottinghamshire Police at 8.59 pm.

2.2.64 Nottinghamshire Police Control Room contacted Clarissa pending the arrival of officers. It was established that the perpetrator was present but in another room. Officers arrived at 9.10 pm and spoke to both occupants. Clarissa said that she had told the perpetrator that she did not think that the relationship was working and had asked him to leave. He had become upset and had said that she was making a rash decision as she was stressed as they had recently moved.

2.2.65 The perpetrator was advised to go to his parents' home for the evening which he did. In line with practice at the time, a DASH risk assessment was not completed.

The review is aware that Clarissa told her family that the police had said that she was wasting their time for calling them. Although this cannot be verified with the police, comment is made later in the report about the police response to this incident[13].

[13] This is included as it is deemed to be relevant to why Clarissa may not have called the police again as discussed later in the report

2.2.66 Early the next morning Clarissa texted her father to say that the perpetrator had been outside the property and asked if she should phone the police. She said that he had been knocking on the door at 3 am. When asked by her father if he was rational at the minute, Clarissa said that she was not 100% sure as he was not reliably taking his medication. She said he was better than he had been as he knew what the outcome would be but that he was being stubborn. Her father advised her to call the police if there was any sign of trouble. At 10 am she said, on text, that at least they were now talking. The next morning her father texted to check that she was OK, and she said that they were getting on OK and that 'hopefully he deleted them recordings as well'. These were sex videos that he had taken and was threatening to put them on the internet.

2.2.67 On 29th September Clarissa visited a solicitor in Danum who assured that, in the event of separation, the perpetrator would not get custody of their child due to his mental health, record of violent and aggressive behaviour. From this point Clarissa grew in confidence, maintaining stronger stances and separated from the perpetrator under the same roof and again in 2018 when she wanted to evict him rather than leave.

2.2.68 In September Clarissa wrote to a close friend about the relationship. This is found in a later section in the report.

2.2.69 By 4th October Clarissa and the perpetrator were living separately under the same roof. The perpetrator had told Clarissa that he did not want to live locally if she was starting a new life with someone other than him.

2.2.70 On 3rd November Clarissa told her father that the perpetrator had secretly recorded her shouting and swearing at him. Her father advised her that he believed that this was so he could gather evidence for a custody case. He advised her that she and the perpetrator needed to sort themselves out before neighbours called someone about the shouting and children's services became involved. Clarissa said that she had tried to talk to him, but it was useless, and her father reminded her that she was only responsible for her own actions.

2.2.71 On 15th November Clarissa, the perpetrator and their daughter registered with a GP in Nottinghamshire.

2.2.72 On 24th November NHCFT requested the previous child health records from Locala.

2.2.73 In November Clarissa, according to her family, realised that she was the most important person in her baby's life.

2.2.74 At the beginning of December Clarissa was planning a memorial plot for her mother's ashes and she planned to go and talk to her father about it but she wrote in a text 'I would go round to yours but he'd make a thing about asking whether I'm slagging him off and makes it about him as usual. I've been talking to [name removed] and she thinks it's time to go. It's talking to you when he's not here though'. She then says that she has deleted all of her texts but that she has to talk to people, or she would go insane. Her father then told Clarissa that the perpetrator was welcome to come with her to his home. Clarissa then said, 'I still don't trust him ….even though he deleted them he has sent them off somewhere else so he still has them' She said that the perpetrator had taken photos of washing up that needed to be done. She said that their child was her priority and felt that the house should not be a priority. Clarissa said that the perpetrator was being so overbearing that was 'doing her

head in'. She then went on to say that the perpetrator made up stories to 'suppress her from talking to others'. She said, 'slightest bit of freedom I get and making friends with anyone it seems, even with his own daughter..'

2.2.75 The perpetrator was written to by his GP on 7th December to invite him for a health check. There is no evidence to suggest that he responded to this invitation.

2.2.76 On 9th December Clarissa moved in with her father and stepmother but then moved back to the perpetrator on 11th December.

2.2.77 On 11th December Clarissa had an appointment with her GP but, despite two text reminders, she did not attend.

2.2.78 On 14th December 2017 Clarissa was discharged by Locala Community Partnerships CIC in Church Lees as the family had moved out of the area.

2.2.79 The health visitor tried to do a verbal handover to the health visitor in Nottinghamshire on 18th December but there was no-one available.

2.2.80 The verbal handover to the health visitor in Nottinghamshire (NCHT) occurred on 27th December. During this handover the health visitor was made aware of the previous domestic abuse incident, which was described, by Clarissa, as being as a result of his deteriorating mental health. It was reported that this was resolved with a change in medication.

2.2.81 **2018**

2.2.82 On 9th January Clarissa saw her GP for a routine appointment, accompanied by the perpetrator. The perpetrator also had an appointment to see the GP on this day for his medication review and he reported that he was stable and well with no other problems. The perpetrator and the victim were seen by the same GP and had adjacent appointments therefore the review has summised that they were seen together.

2.2.83 On 9th January Clarissa asked her father if she could put her name down for a council house whilst she was living with the perpetrator. Her father advised that the housing association would consider that the person with the child would have priority for the house and that the other partner would have 30 days to leave the property. She then questioned whether she could just tell them that she wanted the perpetrator to leave. She said they were getting on OK but that it was a consideration.

2.2.84 On 17th January the health visitor attended for a home visit. Clarissa said that she could not see her as she was going out and had been expecting her the previous day.

2.2.85 On 31st January 2018 the health visitor (NCHT) carried out a home visit. Both Clarissa and the perpetrator were present and were described as caring and receptive to support and advice. There are no recorded concerns about domestic abuse or safeguarding. The parents were described as engaged throughout the contact and displayed positive attachment to their child. A referral was made to Nottinghamshire Children and Families Partnership Sure Start but the records do not show why this was or if the family engaged with the service.

2.2.86 On 9th February the perpetrator received a second invitation for a health check. There is no evidence that he responded to this invitation.

2.2.87 On 13th February an appointment had been made for the child to be seen by the GP, but the appointment was not attended.

2.2.88 On 13th February Clarissa exchanged texts with her father. At this time, she said that the perpetrator was not taking his medication and had another paranoia episode. She said that the perpetrator had accused her of seeing someone else. She went on to say that he had his medication and he was an adult and it was no longer her responsibility to make sure that he took the medication. She said that he was making her ill and getting her into debt. She went on to say that she might just get a council place in Lincoln and allow him to keep that house. She said, 'I just want rid and now in debt'. She said that she could not sleep and when she did get to sleep, she woke up during the night. She said, 'I'm just absolutely miserable with him, I really feel done now because I stick with him through everything then he when he finally gets this job, he's planning on packing it in'. She goes on to say that she is no better off as she just stays in the house all day while he had her car and she is in fact worse off with all his debts.

2.2.89 On 5th March Clarissa asked her father and stepmother to go round, as she wanted to talk about moving out.

2.2.90 On 6th March Clarissa saw her GP and reported that she had not been feeling well for about a year. She attended the next day for routine bloods to be taken.

2.2.91 Clarissa was seen on 14th March for a follow up appointment. It was agreed that tests would be repeated, and she would be seen again in two weeks.

2.2.92 On 23rd March Clarissa was seen by the GP with stomach upset.

2.2.93 Clarissa saw her GP on 27th March with a medical matter and returned to the surgery the next day for blood tests.

2.2.94 On 11th April Clarissa saw the GP again as a follow up to the appointment at the beginning of March. She was given dietary advice and her blood tests would be repeated and she would be seen again in four weeks.

2.2.95 Clarissa had two appointments – on 16th and 24th April – that she did not attend despite two text message reminders on both occasions.

2.2.96 On 17th April the perpetrator received a third invitation for a health check. There is no evidence that he responded to this invitation.

2.2.97 On 19th April Clarissa asked to stay at her father's for a while as she and the perpetrator were having major problems. She referred to not feeling well and said that one day she felt great and the next completely run down. She said that it was always when she was stressed or after an argument. The perpetrator had told her that he was funny with her yesterday 'because of something that I cannot help and completely infringes on my values'. She said that he was telling her to leave claiming that he would get custody because she was not spending time with their child. She said that this was because she was ill, and he was at

home from work. On 22nd April she said that she would go to her father's some time during the next week as she had to pack up some things. She then said that she would go on the Wednesday and that it would probably only be for a week. She said that she just wanted some time to think.

2.2.98 Clarissa moved in with her father and stepmother on 25th April. She left her child with the perpetrator and his adult daughter. Clarissa returned to her home the next day to collect her child before going back to stay with her father and stepmother.

2.2.99 On 21st May Clarissa asked her father if she could move in as 'he's being a prick'. When her father asked her to make it the next day, she said this was fine. The next day she said she was not now going to come but that she 'might do some other time though if OK, don't know yet'.

2.2.100 On 1st June Clarissa saw her GP as a follow up to the appointment on 11th April. Her family said that she was diagnosed with Chronic Fatigue Syndrome.

2.2.101 On 2nd June Clarissa said in a text to her father that she and the perpetrator were good and back together.

2.2.102 On 5th July 2018 the perpetrator attended the address of his ex-wife and assaulted her partner. The police attended and found the man with facial injuries. The perpetrator was arrested at his home address when he denied the offence and was released under investigation pending further investigations and statements from witnesses. The incident was still under investigation at the time of the perpetrator's arrest for the murder of Clarissa and did not result in a prosecution.

2.2.103 In July Clarissa had decided that the way forward was without the perpetrator.

2.2.104 On 18th July Clarissa asked if she could move in with her father. In the same text she asked if it was possible to apply for an eviction notice whilst she was still living there. He reminded her that the solicitor had said that the one who had their daughter would get the house and that the perpetrator would not gain custody of the child due to his mental health issues. She also said that the perpetrator had lost his job and was in trouble with the police again. Her father said that it would be harder to get the house if she was not living there but that she should move out if she felt that he would harm her.

2.2.105 On 19th July Clarissa made a claim for Universal Credit, naming her household as being herself and her child. The same day her father asked her, on text, if the perpetrator knew that she was planning to leave him, and she said that he knew but that there might be an issue with him moving out. At this point it was clear that Clarissa was concerned about money. She made reference to an appointment about Universal Credit and said that she would apply for a loan then to help with the cost of getting her car back on the road. She said that she needed to use all the money she had for food and travel as she would not get Universal Credit for 8 weeks.

2.2.106 On 20th July she said that she was hoping to visit the Citizens Advice Bureau on the Monday. She indicated that, although the perpetrator was looking at other accommodation, this was to cover herself so that he could not stay in the house forever. The review does not know if this happened.

2.2.107 Clarissa attended an initial evidence appointment to continue her claim for Universal Credit on 23rd July. She advised that her housing benefit would be changing as the perpetrator would be moving out and would be removed from the tenancy agreement. She also began to fill out a form for Council Tax benefit. She also said that she would like her father to go with her to Citizens Advice Bureau about the debts that the perpetrator was refusing to pay. She said that she was 'lying low' at present and would sort this out when he had gone.

2.2.108 On 30th July Clarissa attended her first appointment with her work coach at DWP and said that she was interested in being self-employed as a tarot card reader. She was told about New Enterprise Allowance and Minimum Income Floor and how it worked. She said that she would be trading from 18th August and an appointment was booked for 16th August so that she could bring her pricing plan and basic business plan.

2.2.109 Later on 30th July Clarissa and the perpetrator had been out together. They had been to a local coffee shop where they discussed the arrangements for their separation. Clarissa was murdered by her partner shortly after they all returned home.

2.3 Information known to family and friends

2.3.1 This Review has been told that as a child, Clarissa was fearless and would try anything. She was described as being very 'individual'. For example, she wore 'goth gear'. Clarissa's father described her as a 'free spirit who lacked direction'. She had gained a Grade 8 in music and singing and went to Danum to study performing arts. Unfortunately, she then had to have an operation on her back which meant she had to leave this course. She later went back to studying performing arts in Lincoln and this was when she met the perpetrator.

2.3.2 She met the perpetrator when she was working, part time, in the same store where he was a security guard. She said that he was a fun personality and did bizarre things. He was still married at this time and she did not want, initially, her family to meet him.

2.3.3 Clarissa's father met the perpetrator in September 2014 when Clarissa had asked him to have a look at his car. He was not happy when he later found out that it was the perpetrator's ex-wife's car that he had taken without her consent. Her father also acknowledges that he was not happy when he found out how old the perpetrator was.

2.3.4 Clarissa moved into a house that her father had prepared for her. Clarissa allowed the perpetrator to move in with her because he was suicidal and in rent arrears. At the time she meant this to be a temporary arrangement and she did not want him there in the long term. At this point she thought that she was rescuing a 'lame duck' who had lost his wife and had been evicted. This was very much in character for Clarissa who liked to help people. She saw the relationship as nothing more than a bit of fun and a flirtation. She had neither expected nor wanted him to leave his wife.

2.3.5 Clarissa's father recalls that they had not been together long when Clarissa telephoned him to go over because the perpetrator was 'kicking off'. When he arrived, things had calmed down, but he said that the relationship could not be working if Clarissa felt the need to call him. The perpetrator told him that he had paranoid schizophrenia and had not been taking

his medication. He told Clarissa that she needed to think about what she was getting herself into.

2.3.6 Clarissa's father described how she had spent most of her life without true direction or order, but the birth of her baby changed everything and brought out the best in Clarissa. At the time of her death, Clarissa was planning to leave the relationship. She had set up her own business and had applied to Sheffield University.

2.3.7 The review is grateful to family and friends in helping us to build a picture of the relationship. Information provided by them is also included in the next section.

2.4 Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement. This information is drawn from the Individual Management Reviews (IMR) and summary reports provided to the review.

2.4.1 **Nottinghamshire Police (this section covers all contact with police, regardless of force)**

2.4.1.1 **16th April 2015**

2.4.1.2 The perpetrator was, at this time, employed as a security guard at B&M store in Danum. The security manager had attended the store to interview the perpetrator regarding an internal investigation. During the interview, the perpetrator produced a lock knife which he pointed towards the manager and made threats to stab him. He was detained by members of staff during which he punched the Security Manager in the face. South Yorkshire Police attended and arrested him for affray. When he appeared in court, he was found guilty of possessing an offensive weapon. He was sentenced to a community order with a requirement to carry out 50 hours unpaid work.

2.4.1.3 **28th April 2017**

2.4.1.4 At 4.30 pm Clarissa's father contacted Lincolnshire Police via the 999 system to report that he had been contacted by Clarissa to say that she had been assaulted at her home address about 45 minutes earlier.

2.4.1.5 The incident was transferred to West Yorkshire Police who attended the address. On arriving, officers found Clarissa had left the address with her child. The perpetrator was still present, and he told police that they had an argument and Clarissa had left to go to her father's home. The officers did not consider it necessary to arrest him at this point and were keen to locate Clarissa before she left the area. They explained to him that they may need him to make a statement. He provided his contact details and confirmed that he would be willing to co-operate.

2.4.1.6 Officers were able to contact Clarissa before she left the area and they met her at a local police station. She told officers that she had asked the perpetrator for money to get her hair done. He became angry about this and they began to argue. She had got into her car, planning to leave, the perpetrator followed her and got into the passenger seat where he

grabbed her coat by the neck and squeezed the collar causing her pain but no visible injury. She managed to get out the car and contacted her father.

2.4.1.7 Clarissa was reluctant to make a statement but was happy to complete a DASH risk assessment. She said that she was subject to controlling and coercive behaviour by the perpetrator. She said that he did not like her meeting friends, controlled the money, became anxious if she spoke to strangers and had threatened to kill himself if she left him. She said that he had tried to strangle her a few times albeit that she had not passed out. Clarissa said that the perpetrator suffered from mental health issues (paranoia, schizophrenia and depression) but did not always take his prescribed medication. She said that she had previously tried to end the relationship, but found this difficult without him persuading her to come back. She said that, since the birth of their child, he had become more difficult to live with. She said that she was not working due to childcare and had no money of her own. She was made to feel guilty if she spent money on herself. The DASH risk assessment was recorded as MEDIUM.

2.4.1.8 On 30th April a specialist officer from the Domestic Violence Unit made contact with Clarissa. She confirmed that she had moved to Lincolnshire to live with her father. The officer sent a referral to colleagues in Children's Social Care and children's health asking them to notify their colleagues in Lincolnshire that she had moved to their area.

2.4.1.9 Clarissa's father was also spoken to by the officer. He was keen to encourage her not to return to the perpetrator.

2.4.1.10 The investigating officer contacted Clarissa again two days later and she said that she had relocated to live with her father in Lincolnshire and did not intend to return to her partner. She said that she did not wish to pursue a prosecution as she thought that this would make matters worse and she wanted the perpetrator to have a relationship with their child despite their own differences. As a result, he was not arrested or formally interviewed about the allegation of assault.

2.4.1.11 The Domestic Violence Unit made contact with Clarissa on 12th May and she agreed for the relevant support services to be contacted. Social Care and child health referrals were made with a request that their counterparts in Lincolnshire were notified.

2.4.1.12 A prosecution was not considered appropriate due to Clarissa's reluctance to provide a statement, the lack of visible injuries and no independent witnesses. A Domestic Violence Prevention Order was considered unnecessary as the victim and the perpetrator were living at different addresses.

The review considers the actions of West Yorkshire Police were proportionate in the circumstances and notes that they arranged for agencies in Lincolnshire to be made aware that Clarissa and her child had moved into the area.

2.4.1.13 **22nd September 2017**

2.4.1.14 At 8.47 pm Clarissa contacted South Yorkshire Police, using the non-emergency number stating that the perpetrator had become aggressive towards her. He had stated that he wanted to die and would cut his arms if she called the police. Clarissa confirmed that their child was present but was safe and well. She said that whilst he had not been violent on this

occasion he had been in the past. These initial details were obtained by South Yorkshire Police who confirmed that she was safe and well before transferring the incident to Nottinghamshire Police at 8.59 pm.

2.4.1.15 On receipt of the incident, Nottinghamshire Police Control Room Operator made contact with Clarissa pending the arrival of officers. She was described as calm and collected during the call and re-iterated the information she had given earlier. The operator ensured that she was safe and established that whilst the perpetrator was present, he was in another room. During this call, Clarissa said that there had been a few previous incidents of domestic abuse between the couple and that the police had attended as a result of the last incident, although the details of this incident were not explored. Clarissa said that the perpetrator had threatened to cut his arm if she called the police and that he would claim that she was responsible so their child would be taken away from her.

The review notes that the IMR author had listened to the call and noted that that the operator showed concern for Clarissa's safety and offered her reassurance that officers were en-route. The review agrees with the IMR author that this is an example of good practice.

2.4.1.16 Officers arrived at the address at 9.10 pm where they spoke with both occupants. Clarissa told officers that she had told the perpetrator that the relationship was not working and had asked him to leave. He had become upset as they had only recently moved to the address and he felt that Clarissa was making rash decisions due to the stress of moving house. She told the police that she had called the police previously, at a previous address, due to issues but details were not recorded.

2.4.1.17 The officers recorded that there was no mention of the perpetrator self-harming and that he appeared calm and rational. Clarissa said that she had not been assaulted but felt that they would continue to argue if he remained at the address. He was encouraged to go to his parents' house for the night to allow emotions to calm down.

2.4.1.18 As the incident was recorded as a domestic incident (rather than domestic abuse) a DASH form and NICHE[14] occurrence was not required.

The Control Room carried out intelligence checks, with neither party being recorded, and a PNC[15] check which identified the perpetrator from the details provided by Clarissa. Checks were made for the perpetrator via the NHS into the RIO database which holds records of those in Nottinghamshire who have been referred by a GP for secondary mental health care and again this was negative.

A PND[16] check was not carried out which would have identified the previous domestic abuse incident dealt with by West Yorkshire Police on 28th April 2017. It is noted that it is not a requirement to undertake a PND check and this will depend on capacity in the control room. However, Clarissa had told them that she had been a previous victim of domestic abuse and the PNC check gave the information that he was at risk of self-harm. This information should have prompted a PND check.

[14] A computerised system to manage intelligence, crime recording, reports of domestic abuse and case file preparation. It also allows for tasks to be created for individual members of staff or directed to different departments within the force
[15] Police National Computer
[16] Police National Database

Had this information been available, it would have helped to establish a true picture of the relationship. She had previously been assessed at MEDIUM risk and this would suggest that a further assessment of MEDIUM would have been appropriate here, had a DASH risk assessment been undertaken. This would have generated the involvement of the Domestic Abuse Unit and a referral to Children's Services. It may have also been appropriate to refer the perpetrator to mental health services.

It is also noted that as this was recorded as a *domestic incident* no NICHE record was produced to record details of the incident and parties involved. The resulting entry on the Command and Control presents a different picture to that portrayed by Clarissa during her telephone contact with the Control Room staff. Although the review accepts that this is not a policy or procedural issue for Nottinghamshire Police it does highlight the fact that professional curiosity is needed at all times by attending officers.

The review is aware that from 25th July 2018 the Domestic Abuse Policy was amended. The DASH form is no longer used for cases of domestic abuse. It has been replaced by a Domestic Abuse Public Protection Notice (DA PPN). This must be completed for *all* incidents of domestic abuse and attached to a NICHE occurrence report.

Clarissa's father has asked a number of questions about this change:

- **Could this change create missed opportunities if officers recorded incidents as 'domestic incident'? If this were the case incidents such as this still would not generate a DA PNN.**
- **Is it possible that overworked officers would simply record more domestic abuse cases as domestic incident to avoid increased bureaucracy?**
- **Could the good intent of the DA PPN lead to a statistical fall in cases of domestic abuse over the reality of higher actual figures?**

Having considered this, the review does not feel that this is likely as the change in policy should lead to a better understanding of levels of all the various aspects of domestic abuse and thus a create a better opportunity to intervene at an earlier level to prevent escalation.

2.4.1.19 **5th July 2018**

2.4.1.20 At 9.45 pm the perpetrator attended the home of his ex-wife and assaulted her current partner by punching him in the face.

2.4.1.21 The police attended and found the partner with facial injuries. The perpetrator had left but was arrested at his home address later that evening. He denied the offence and was released under investigation pending further enquiries and statements from witnesses. The incident was still under investigation at the time of the perpetrator's arrest for the murder of Clarissa and did not result in a prosecution.

2.4.2 **GP records**

2.4.2.1 Both Clarissa and the perpetrator registered at a new GP in November 2017 where they remained patients until the time of the incident that led to Clarissa's murder. The IMR was completed by this GP and provides detail of the interactions for this time period. This GP has also accessed the electronic records for both Clarissa and the perpetrator prior to this date and has drawn out the pertinent points. These have then been shared with Greater

Huddersfield CCG and North Kirklees CCG for comment. The pertinent interactions have been analysed here.

2.4.2.2 **The perpetrator's records prior to November 2017**

2.4.2.3 There is evidence in the records of the perpetrator having a history of not attending (DNA) appointments. He was referred to a psychiatrist in 2002 after an overdose and then over the following years he is seen a number of times with thoughts of harming his children, hearing voices and auditory hallucinations along with feeling 'paranoid'. There are repeated reminders to the perpetrator about the importance of taking his medication.

2.4.2.4 The perpetrator presented at A&E on 1st May 2017 when he said he felt like he was having a breakdown. He was then seen by his GP the next day who noted that he was teary at times and had poor eye contact. He said that he had suffered with depression for many years but that he felt that it had worsened in recent times. He said that he thought that he had been in denial about his condition. His medication was increased, and he was advised to see the GP again for his medication to be reviewed.

2.4.2.5 The perpetrator returned to the GP on 10th May when he said that he was coping well with this increased dose. He reported that he had no suicide ideation and was planning to return to work the following week.

2.4.2.6 There are repeated reminders to the perpetrator about the importance of taking his medication.

2.4.2.7 **Clarissa's records prior to November 2017**

2.4.2.8 There is nothing in Clarissa's record other than routine visits to the GP until 22nd June 2017 when she told the GP that she was struggling from day to day. She said that she was a stay at home mum with a small baby and was finding this difficult. She said that she did not feel that she could talk to anyone about how she felt. She was signposted to a local hospice for bereavement support following the death of her mother. Clarissa was happy with this plan.

2.4.2.9 She then returned to the GP on 27th June with the perpetrator when she said that she was concerned that she might be suffering from autism or Asperger's syndrome. The GP agreed to this referral however, due to her murder, this was not pursued.

The review acknowledges that these records were analysed without reference to paper records or the GP practice involved. A more detailed analysis has been undertaken into the interactions from November 2017.

2.4.2.10 **Registration at GP in November 2017**

2.4.2.11 In November 2017 Clarissa, the perpetrator and their child registered with a local GP. They completed a New Patient Registration Form.

The review notes that it is a contractual requirement[17] that once registered all new patients should be offered a healthcheck and that there is no evidence that this was offered to the family.

[17] GMS Primary Medical Care Policy Guidance (PGM) NHSE April 2019

The review suggests that the GP practice considers introducing a process whereby, in line with RCGP SG guidance, one administrative person is responsible for overseeing the coding and summarising of all new notes that come into the practice. This staff member should work closely with the Practice Safeguarding Lead.

The review notes that prior to appointments, the GP practice sends text reminders to patients. This is, the review feels, an example of good practice.

2.4.2.12 On 27th December 2017 the health visitor received a telephone handover from the health visitor where Clarissa and her child had been registered. In this telephone call she was advised about the previous incident of domestic abuse and the perpetrator's history of mental illness. The health visitor noted this in the records but did not liaise with the GP.

Recommendation Two

It is recommended that professionals, other than the GP, who are entering information into the GP records should accompany this with an additional communication to the GP to highlight the information such as a telephone call, email, letter or electronic task.

It is also noted that there was significant history on SystmOne records prior to the family registering with this GP. There is no evidence that this information was reviewed particularly in light of the perpetrator's history of mental illness and the domestic abuse. This is a learning opportunity for the GP practice.

The review considers that the GP practice should explore putting in place a process to ensure that new patient records are reviewed by a clinician and care is managed accordingly.

2.4.2.13 It is noted that for many of her appointments Clarissa was accompanied by the perpetrator, however, there are times when there may have been the opportunity to make a routine enquiry of Clarissa about domestic abuse. For example, her contraception review on 9th January 2018[18], 6th March 2018, 14th March 2018 and 23rd March 2018.

Recommendation Four

It is recommended that the GP practice considers how routine enquiry and the consideration of domestic abuse could be embedded into the practice

2.4.2.14 On 1st June 2018 Clarissa visited the GP with medical symptoms that she had been experiencing for about 12 months. She had visited the GP previously but, it is noted that the GP did not consider that there may be increased anxiety about her health and what might be causing this.

[18] The perpetrator and the victim were seen by the same GP and had adjacent appointments therefore the review has summised that they were seen together.

In the view of the review, this was an opportunity to explore more widely how things were at home for Clarissa. It was also an opportunity, which was not taken, to refer Clarissa to the health visiting service in order that a health visitor could visit and see how Clarissa was coping. There was also no consideration recorded of referring this family to the Think Family meeting or the Early Help Service. In the view of the review this demonstrates a lack of professional curiosity during the consultation. This is a learning opportunity for the GP practice.

2.4.2.15 **Interaction with the couple's child from November 2017**

2.4.2.16 In the child's GP record there is a note that on 13th February 2018 the child **did not attend** for an appointment with the GP.

The review notes that this should have been recorded as Was Not Brought (WNB) rather than Did Not Attend (DNA). It also notes that SystmOne automatically populates DNA but that there is a specific read code for WNB and that this should have been used as well.

Had this been correctly coded, a phone call offering a further appointment would have been made. Referral to the health visitor would have been triggered if another appointment WNB. The review is satisfied that this was an oversight in this case and does not represent a systemic failing by the GP practice.

2.4.2.17 **Interaction with the perpetrator from November 2017**

2.4.2.18 There is nothing of note during this time other than routine appointments.

2.4.3 **Calderdale and Huddersfield NHS Foundation Trust (CHFT)**

2.4.3.1 Clarissa was seen by maternity services whilst she was pregnant with her child.

2.4.3.2 It is the policy of CHFT and the West Yorkshire Safeguarding Children procedures that a woman must be seen alone before asking about domestic abuse.

2.4.3.3 Clarissa was accompanied by the perpetrator at all of her appointments except one. CHFT Domestic Abuse policy also states that staff should be more concerned if they are unable to carry out a routine enquiry around domestic abuse on consecutive occasions and they should consider escalating this to their clinical manager to explore alternative ways for them to be able to make this routine enquiry. It is considered best practice to ask about domestic abuse on more than one occasion during a pregnancy.

There is no evidence to suggest that this was escalated and other opportunities to make the enquiry were explored. This is considered, by the review, to be a learning opportunity for CHFT.

2.4.3.4 On the occasion that she was asked about domestic abuse Clarissa denied any form of domestic abuse in the relationship.

2.4.3.5 Had Clarissa disclosed domestic abuse in the relationship the staff should have completed a DASH risk assessment.

2.4.3.6 It was noted that Clarissa did disclose during her antenatal period that she was stressed due to her mother being ill. She was offered additional support and made aware of who she could contact if she required further help with her mental health.

The review notes this example of good practice.

2.4.4 **Locala Community Partnerships CIC**

2.4.4.1 Locala is a not-for-profit social enterprise that provides a variety of NHS community healthcare services in Kirklees, Calderdale and Bradford. Clarissa was registered with Locala Supporting Families Unit from 1st August 2016 following receipt of an antenatal notification, until 14th December 2017 when the family moved from the area.

2.4.4.2 During this time the allocated health visitor made six home visits and offered support on three occasions via telephone contact. Clarissa also took her child to the health visitor clinic on one occasion.

2.4.4.3 When Clarissa was seen at the antenatal contact on 26th October 2016 and the birth visit on 10th November 2016, she reported that she felt well supported by her partner. However, on both occasions the perpetrator was present and therefore she could not be specifically asked about domestic abuse. Whilst we know that this was the reason it was not specifically documented as such on her record.

2.4.4.4 The first time that it was recorded that there were concerns about Clarissa's relationship with the perpetrator, was on 22nd November 2016 when the midwife contacted the health visitor to inform her that Clarissa had disclosed that the couple had been arguing and reported coercive controlling behaviour by the perpetrator. Clarissa expressed a fear that he would take their child to Danum against her wishes. Clarissa said that she was not frightened of him and denied that there had been any other incidents of domestic abuse.

2.4.4.5 Between 23rd January 2017 and 8th March 2017 the health visitor undertook two face to face contacts and two telephone contacts with Clarissa. There was no specific enquiry made about domestic abuse during those contacts. However, there is evidence that Clarissa's relationship with the perpetrator was considered in the face to face contact on 23rd January when it was documented that Clarissa's mother had recently died and that the perpetrator was being supportive and understanding. There was no information about their relationship recorded at the subsequent support visit on 31st January.

As Clarissa was seen alone the review considers this to be a missed opportunity, by the health visitor, to further explore the information shared by the midwife on 22nd November 2016 and make specific enquiries regarding domestic abuse.

The review notes that since that time a prompt has been added to electronic records to remind health visitors to make a specific enquiry or to document the rationale for not doing so.

2.4.4.6 On 2nd May 2017 a domestic abuse notification from the police dated 28th April was scanned to the child's records. The Duty Health Visitor recorded on 9th May that Children's Social Care were aware of this incident however were not involved as the family had fled from the area with no forwarding address. There is nothing on the record to indicate whether Clarissa and the perpetrator were still in a relationship and whether there were any contingency plans in place should the relationship resume.

2.4.4.7 On 11th May Clarissa contacted the health visitor to advise that she and her child had moved back. At a subsequent home visit by the health visitor on 26th May 2017 Clarissa reported that she and the perpetrator had resumed their relationship.

It would have been appropriate for the health visitor to contact Children's Social Care to share this information in order to facilitate the opportunity for a further risk assessment, but there is no record of this having been done. Although this is, in the view of the review, a missed opportunity the review is satisfied that this was addressed with the individual concerned and, more importantly, since 2018 it has been a mandatory requirement for all health visitors to attend face to face Domestic Abuse Quality Mark training with a view to ensuring appropriate management of such cases.

2.4.4.8 At this meeting on 26th May Clarissa reported that the perpetrator had a history of depression and schizophrenia and was engaging with support for this. She attributed the domestic abuse to his medication having been reduced and reported that things had been stable since his GP had increased his medication again.

When Clarissa disclosed this information there is no evidence that a DASH risk assessment was undertaken, and she was not signposted to local domestic abuse agencies. The review considers that this was a missed opportunity. As stated above, since 2018 it has been a mandatory requirement for all health visitors to attend face to face Domestic Abuse Quality Mark training with a view to ensuring appropriate management of such cases. The review is satisfied that health visitors now understand the importance of undertaking a DASH risk assessment.

2.4.4.9 On 21st June 2017 this information about Clarissa's disclosure was shared at the GP links meeting. The information was shared to alert the GP to domestic abuse within the household so that this information could potentially inform assessments of wellbeing should Clarissa or her child attend for an appointment at the GP surgery. The information should also prompt further discussion around domestic abuse if Clarissa was seen on her own.

2.4.4.10 On 14th August, Clarissa informed the health visitor the family were planning to move to Danum in less than two weeks, however there is no specific date for the move and no forwarding address documented in the records. The health visitor advised Clarissa to register with a local GP following her move out of Church Lees, and has documented the plan was to hand over to the new health visiting team.

2.4.4.11 A verbal handover to the health visitor in Doncaster was undertaken on 27th December 2017 when the information about the domestic abuse incident was shared.

The review notes that there was a delay in this handover taking place. It is understood that this was as the health visitor did not follow up to check if the family had moved out of the area as would have been appropriate, and therefore it was only when Locala received a notification of the new address in of the new address on 14th December that this led to the health visitor handover of

information. The review is satisfied that this has been addressed through reflective supervision and this learning has been shared with the health visiting teams and wider services in Locala.

2.4.5 **Nottinghamshire Healthcare Foundation Trust (NHCT)**

2.4.5.1 Clarissa's child was known to the Children and Young People's 0-19 service from November 2017, following transfer from Church Lees West Yorkshire following their move to the Nottinghamshire area.

2.4.5.2 The Children and Young People's 0-19 service brings together health visitors and school nurses into 20 locally based 'Healthy Family Teams' across the county. They provide integrated health services for children, young people and their families from 0-19 years when they need it. The teams are multi-disciplinary and work with families and children and families in different ways depending on the type of support that they need.

2.4.5.3 On 18th December 2017 Kirklees Supporting Families Service attempted to complete a verbal handover to NHCT Healthy Families Team but no-one was available.

2.4.5.4 A verbal handover was completed on 27th December 2017. This included information about a past domestic abuse incident between Clarissa and the perpetrator which was described as being as a result of his deteriorating mental health. It was reported that it had been resolved with a change in medication. There is no reference to any social care involvement.

2.4.5.5 On 31st January 2018 the health visitor carried out a home visit. Both Clarissa and the perpetrator were present. There were no recorded concerns about domestic abuse or safeguarding. However, the records show that the daughter had been provided with universal services health visiting but following this visit a referral was made to Nottinghamshire Children and Families Partnership Sure Start but the records do not show why this was.

2.4.5.6 There is no other information about engagement with Sure Start so it is not clear if the family engaged with the service. Had the family engaged with this service there would have been more opportunity for routine enquiries to be made about ongoing domestic abuse. However, the limited engagement that the universal service would have had did not make this possible.

2.4.6 **Department for Work and Pensions**

2.4.6.1 On 19th July 2018 Clarissa made a claim for Universal Credit online. She declared that living in her household was herself and her daughter.

2.4.6.2 Clarissa attended an initial evidence appointment on 23rd July. This was to continue her claim for Universal Credit. She advised that her housing benefit would be changing as the perpetrator would be moving out and would be removed from the tenancy agreement.

2.4.6.3 On 30th July Clarissa attended an appointment with her work coach. She said that she was interested in being self-employed as a tarot card reader. The work coach explained to her about New Enterprise Allowance and the Minimum Income Floor and how it worked. She said that she would be trading from 18th August 2018 and an appointment was booked for 16th August so that she could bring her pricing plan and basic business plan.

The review notes that the work coach had only had one meeting with Clarissa and therefore a rapport had not been built. Clarissa did not express any issues, but she was described as being enthusiastic about her self-employment venture.

Section Three – Analysis

3.1 Evidence of domestic abuse

3.1.1 In this section of the report the review will explore the evidence that we have that there was a trail of domestic abuse in the relationship between Clarissa and the perpetrator. This section will draw on information provided by friends and family and information that Clarissa shared with agencies. Unusually in this case we have Clarissa's own words written to a friend in September 2017 where she talks about the relationship. This letter gives us an unnerving insight to the relationship:

'I was working somewhere, met this guy, had a strong attraction. Started meeting up, I was not looking for a serious relationship. Next thing he broke up with his wife and told me he loved me… My reaction…. Oh Damn… I was not looking for a serious relationship, I wanted to do whatever the hell I wanted on my terms, no-one to boss me about for once (after a previous relationship). Trouble is I actually liked the guy but was not ready for commitment. He was all or nothing, that I had to be his girlfriend or nothing at all (which is not what I signed up for!) Next moment he's telling me who I can and can't see; what I can and can't do (what, run, right?). Now in the exact kind of relationship I was trying to avoid, only, I had become romantically attached! Yep, Oh lord no! lol. He wanted things about me to change bit by bit, despite saying that in a relationship he thinks it's really wrong to try and change people…. (this was before we were boyfriend/girlfriend).

In arguments I now feel that he is ripping me apart and is taking away all the good he ever said, I start to feel like he doesn't really love me, the way I am, despite what he says, I think about breaking up with him.

He then has massive depression and schizophrenia episodes that seem to come out of nowhere. I feel the need to look after him. He continuously was bringing knives out with him and particularly to work – I continuously warned him – he wouldn't listen. He gets arrested and sent to jail. He loses his job. Not paying his rent and bills he gets kicked out of his flat. I say he can move in with me (feeling sorry for him, it wasn't supposed to be permanent'). Had to move because the chimney was going to come down. Moved to Holmwood. Massive court case appeared as a result of him not listening with his work.

My mum had pancreatic cancer and only had 4-6 months to live. I'm pregnant …… He is looking at 5 years in prison. I spent all my time and effort on his court case, he did nothing. It's a miracle, we did it, he is clear.

He gets a job. Three weeks before the baby was born my illusions of him were shattered, any that I wanted to believe, I don't know what happened, but he was stalking some girl from work…

Baby arrived then immediately, due to stress early. We didn't get on throughout the whole process of being in hospital….. he was jealous of me spending time with my mum and the baby.

He got in between me and mum in her final days. My mum died. He said many horrible things that wasn't there when I needed somebody, I felt like killing myself, but no one was

there. He said sorry. I don't forgive him. He doesn't get me or understand me. I don't feel I am in love with him.'

3.1.2 Clarissa's family members described to police, after her death, that Clarissa and the perpetrator had an unhappy and turbulent relationship, saying that they argued a lot which led to Clarissa moving to her father's home on several occasions. In November 2017 Clarissa sought advice from a solicitor regarding her domestic circumstances, the inference being that she wanted the relationship to end.

3.1.3 **Physical abuse**

3.1.3.1 On 28th April 2017 Clarissa's father called the police as the perpetrator had got into the passenger seat of the car as Clarissa was trying to leave and had grabbed her coat by the neck and squeezed the collar. When she spoke to the police on this occasion, she said that he had tried to strangle her on a number of occasions, albeit that she had not passed out.

3.1.3.2 On 22nd September 2017 Clarissa called the police again. She said that the perpetrator had become aggressive towards her and said that he had said that he would cut his arms if she called the police. Although she said that he had not physically assaulted her that day, she referred to the incident when he had. It is clear that she was fearful that he would become violent.

3.1.3.3 In July 2018 the perpetrator was arrested for assaulting his ex-wife's partner. This must have caused Clarissa to be even more fearful about what he was capable of.

3.1.4 **Emotional abuse**

3.1.4.1 Clarissa has been described as a young woman who wanted to help people. She would see those who are struggling or vulnerable and seek to help them. We see from the incident that occurred with a man she met at college.

3.1.4.2 Clarissa's family also say that when she allowed the perpetrator to move in with her, she thought that she was rescuing a lame duck who had lost his wife and had been evicted. She liked to help people and would have been susceptible to a sob story.

3.1.4.3 Shortly after the relationship began Clarissa phoned her father and asked him to go over as the perpetrator was 'kicking off'. When he arrived, things had calmed down, but he told the couple that the relationship could not be working if Clarissa felt the need to ask him to go over. The perpetrator said that he had paranoid schizophrenia and that he had not been taking his medication. This was said in order to 'excuse' his behaviour. His mental health will be discussed later in the report.

3.1.4.4 We know that Clarissa was fearful about what the perpetrator was capable of. There were a number of incidents that led her to believe that he could, and would, be violent. For example, in April 2015 he was charged following an incident at work when he threatened his manager with a lock knife and punched him in the face. She also knew that he had been stalking a girl from his work. On 13th March 2017 she has asked her father to come over but later told him it was a misunderstanding. She says in the text conversation, 'please don't risk coming over'.

3.1.4.5 In March 2017 Clarissa's father had gone to visit her as her grandfather had died. Whilst he was there, the perpetrator came home but did not make his presence known and sneaked upstairs and eavesdropped the conversation.

3.1.5 **Coercion and control**

3.1.5.1 When Clarissa first met the perpetrator, she was looking for nothing more than a bit of fun and a flirtation. She says, in the letter, 'next thing he broke up with his wife and told me he loved me…'. She had never wanted him to leave his wife.

3.1.5.2 In September 2014 Clarissa moved into a house that her father had prepared for her. At the time the perpetrator was described as suicidal and in rent arrears, therefore Clarissa allowed him to move in. She was very clear that this was a temporary arrangement and that she did not want to live with him in the long term. Clarissa also told her friend, in the letter, that 'he was all or nothing..'

3.1.5.3 Clarissa's father has told the review how the perpetrator would try to prevent Clarissa from seeing her friends. The review has been told, by Clarissa's family, that he faked an epileptic fit as he did not want to move nearer to her family and wanted to be further away from his. As a result of this he lost his driving licence and Clarissa had to drive the perpetrator around hence exerting even more control on her and what she could do.

3.1.5.4 The perpetrator became more controlling of Clarissa once she was pregnant. He was jealous of the attention that people were paying to her. We know that pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. It has been estimated by the CEMACH that around 30 per cent of domestic abuse begins during pregnancy[19]. He tried to prevent Clarissa from breastfeeding.

3.1.5.5 The perpetrator was jealous of the time that Clarissa spent with her mum in the hospice towards the end of her life. On one occasion, in March 2017, he had locked Clarissa and their child into a bedroom and took the handle off. Clarissa's father came to let them out after the perpetrator had left for work.

3.1.5.6 After the incident in April 2017 when Clarissa was assaulted by the perpetrator, he badgered her to go back to the police and change her statement.

3.1.5.7 In March 2018 Clarissa believed that the perpetrator was planning to leave her as he was looking at properties to rent. She contacted her father to ask him to help her to make a plan to get out. It was agreed that her father would go over and visit her but a short time later she texted to say' it's OK dad. I misunderstood something he said, I thought he was telling me to move out, but it turned out he was looking at the house for both of us.' She then went on to say, 'it was one of our misunderstandings again'.

3.1.5.8 Although she was not able to follow through with the report, when Clarissa spoke to police in April 2017 after he had physically assaulted her she said that he was controlling towards her, did not like her meeting her friends, controlled the money and was anxious if she spoke to strangers. She also said that he threatened to kill himself if she left him.

[19] Confidential enquiry into maternal and child health for England and Wales (2001) *Why mothers die 1997-1999.* London: RCOG Press

3.1.5.9 On 22nd September 2017 when Clarissa called the police as the perpetrator was being aggressive, the police suggested that he went to stay with his parents for the night. This he agreed to and left. However, early the next morning Clarissa sent a text to her father to say that the perpetrator had been knocking on the door at 3am. He obviously wanted her to know that he would do whatever he wished.

3.1.5.10 The perpetrator continued to seek to exert control over Clarissa after her death in the way that he behaved over the custody of their child.

3.1.6 **Isolation**

3.1.6.1 The perpetrator would try to prevent Clarissa from seeing friends of having any freedom. In November 2017 she told her father that he made up stories to 'suppress her from talking to others'. She went on to say, 'slightest bit of freedom I get and making friends with anyone it seems, even with his own daughter'.

3.1.6.2 By February 2018 the perpetrator was accusing her of seeing someone else.

3.1.7 **Economic abuse**

3.1.7.1 The perpetrator would withhold money from Clarissa meaning that she struggled to buy things for the baby such as wipes. When her father visited her and the baby in January there was no heating on in the house.

3.1.7.2 Clarissa had money that her father had given her that she kept inside her phone. It was her 'escape money'.

3.1.7.3 On one occasion, Clarissa had decided to leave but she did not have enough money for fuel. She called the perpetrator's daughter who agreed to give her money and when they met, the perpetrator was there.

3.1.7.4 In April 2017, the day when the police were called as the perpetrator had physically assaulted Clarissa, she had asked the perpetrator for money to get her hair done. He had become angry about this and they had begun to argue.

3.1.7.5 In July 2018 Clarissa spoke to her father about the debts that the perpetrator had accrued. She was concerned about this and asked her father to go with her to Citizens Advice Bureau so that she could discuss this.

3.1.7.6 At time of death, Clarissa was planning to leave. They had rent arrears of £1750. He had been to look at another flat and it is believed that he was planning to move out and leave her to deal with the rent arrears.

3.1.7.7 There is evidence that the perpetrator used Clarissa's car as a means of abusing her. On more than one occasion, over at least twelve months, Clarissa told her father that she felt isolated because the perpetrator had the car. There is evidence that he took control of the car, and had no regard for Clarissa's need to go out with a small baby. Not having access to her car prevented her from doing this.

3.1.7.8 At the time that Clarissa was preparing to leave, she talked to her father about taking out a loan to get the car back on the road as the perpetrator had not paid the necessary bills for the car.

3.1.8 **Online Abuse**

3.1.8.1 Clarissa told her father that the perpetrator had 'sex videos' of her that he was threatening to put onto the internet. She said that the 'hoped that he had deleted' the recordings but she was not certain. She said that although he had deleted them, he had 'set them off somewhere else so he still has them'. This was another way of exerting fear and control over Clarissa.

3.1.8.2 In November 2018 Clarissa told her father that the perpetrator had secretly recorded her shouting and swearing at him. He had taken photos of washing up that needed to be done. It was believed that he planned to use this in a future custody battle.

3.1.9 **Gaslighting**

3.1.9.1 The perpetrator made Clarissa question her ability to be a good mother. He said that because the baby giggled more for him then she was a bad mother.

3.1.9.2 Clarissa's stepmother spoke of how Clarissa was continually seeking reassurance about her ability, way beyond the anxiety you would expect a new mother to experience. By April 2018 the perpetrator was telling her to leave the family home, claiming that he would get custody as she was not spending time with her child. Clarissa had not been well with flu hence why she had not spent so much time with her child.

3.1.9.3 In June 2017 Clarissa went to see her GP, accompanied by the perpetrator, and asked to be referred as she wondered if she was suffering from autism or Asperger's Syndrome. She suggested that her partner was concerned about her. This discussion has no precursor in her medical records and although we cannot be certain, the review raises the question about whether the perpetrator was putting this thought in her head as a way of blaming her for his behaviour.

3.1.10 **Portraying himself as the victim**

3.1.10.1 In his defence, the perpetrator said that whilst they were out on the evening of Clarissa's murder, she had been belittling and demeaning of him. However, the judge noted that he had not mentioned this in his first police interview and would not accept that this was the case.

3.2 Why did Clarissa not feel able to leave the relationship earlier?

3.2.1 We know very clearly that Clarissa was planning to leave the relationship. The judge, in his sentencing remarks, made reference to the fact that although they were still living in the same house, they were effectively estranged. There is no doubt that during this time of separation in the house, the perpetrator was still able to control Clarissa. Only by moving

away from him could she break free. The court was told how they had been out together on the afternoon of the day that she was murdered, and it is thought that this was to discuss the arrangements for the separation.

3.2.2 Clarissa had been that day to sort out her benefits. She was planning to start her own business. She had applied to university. She was planning to make a fresh start. The perpetrator knew that she had tried a number of times to leave but his control had been enough to bring her back. We know from research that Clarissa was most at risk when she had told the perpetrator that she was going to leave. This time he knew that something was different. He knew that she was going.

3.2.3 **Clarissa tried a number of times to leave**

3.2.4 As we clearly read in the chronology, there were a number of times when Clarissa went to stay with her father, but she was unable to leave permanently. Research tells us that, on average, a woman will attempt to leave seven times before finally leaving for good.[20] Why might this have been? Why might she have needed a number of attempts before being finally able to break away?

3.2.5 We have seen how the perpetrator was able to undermine Clarissa and her role as a mother. She began to doubt her ability to be a good mother. We know that living with abusive partner can erode a person's self-esteem to the point that they know longer have confidence in themselves, including their ability to survive alone[21]. It took time for Clarissa to build up the confidence to leave the relationship.

3.2.6 **Wasting police time**

3.2.7 Clarissa called the police on 22nd September 2017 as the perpetrator was being aggressive. When the police came, they talked to the couple and persuaded the perpetrator to go and stay the night at his parents' home which he did. Clarissa told her family that the police officers had told her that she was wasting their time. Whilst we cannot be sure exactly what was said, we have already seen that more professional curiosity could have been shown by the officers. Whatever was said, Clarissa was left with the impression that she was wasting police time. This would, undoubtedly have caused her to question when, and if, she should call the police again.

3.2.8 The review fully understands that there are many police officers who, every day, are doing their very best to keep abused women safe but what can be done to ensure that women like Clarissa don't think that they are wasting police time? Sandra Horley, Chief Executive of Refuge, says that what is needed is, 'Going the extra mile for an abused woman, listening to her and respecting her, understanding the reality of her experiences ….. This is what increases a woman's confidence in the police. This is what keeps her safe'[22].

[20] http://www.standffov.org/statistics/
[21] Policing Domestic Violence, Laura Richards, Simon Letchford and Sharon Stratton, 2013, Oxford University Press
[22] Power and Control, Sandra Horley, 2017, Vermillion

3.2.9 **Clarissa believed that the perpetrator should be a father to their child**

3.2.10 We know that Clarissa was devoted to their child and that she believed that the perpetrator should be involved in the child's life even if they were not together. She spoke to her stepmother about how they might share custody when they separated.

3.2.11 Unfortunately, their child would have been affected by witnessing the domestic abuse within the home. Research has shown that abusers often display an increased interest in their children at the time of separation as a means of maintaining contact with and therefore control over their partners[23].

3.2.12 The regard that the perpetrator had for the child is clear in that the child was in the house when the murder took place. As the judge said we cannot be sure how much she saw of what was going on, but she was very close by.

3.2.13 **Clarissa believed that she would lose custody of her child**

3.2.14 We know from the texts that Clarissa sent to her father that she was fearful of losing custody of her child. For so many women, the fear of having their child taken away keeps them in an abusive relationship. Clarissa had believed the lies that the perpetrator had told her. We know that Clarissa saw two solicitors on separate occasions in 2017. The solicitor had told her that she would not lose custody of the baby if she proceeded. This is a fear that many women express – that they are afraid that if they seek, they might end up losing their children.

3.2.15 **Danger and fear**

3.2.16 One of the most important reasons that women feel unable to leave is because it is very dangerous to do so. The fear that women face when leaving is real – the likelihood of the violence increasing after separation is huge. 55% of women killed by their ex-partner in 2017 were killed in the first month of leaving and 87% within the first year[24].

3.2.17 What we know is that there is unlikely to be just one reason why a woman is unable to leave an abusive relationship. There may be many factors that impact upon her ability to leave. From the information in the review we believe that this was the case for Clarissa. There was not one reason why she was not able to leave but a number of different reasons.

3.3 The perpetrator's mental health

3.3.1 The perpetrator told Clarissa, and her family, that he had a diagnosis of mental illness that explained his abusive behaviour towards her. Over their time together, Clarissa, on a number of occasions, excused his behaviour because he was not taking his medication.

3.3.2 The perpetrator explained to Clarissa that he had paranoid schizophrenia. The review specifically asked for his medical records to be checked thoroughly and, at no time, did the perpetrator have such a diagnosis.

[23] Policing Domestic Violence, Laura Richards, Simon Letchford and Sharon Stratton, 2013, Oxford University Press
[24] The Femicide Census, 2017 findings, Published in 2018

3.3.3 That said, at different times he reported that he had, in 2002 been referred to a psychiatrist following an overdose. In 2003 he said he had thoughts of harming his young children and hearing voices.

3.3.4 In 2007 he reported auditory hallucinations and that he felt 'paranoid'.

3.3.5 The perpetrator had been prescribed anti-depressant medication for a number of years. It is important to note that, over the years, the perpetrator was non-concordant with this medication and on more than one occasion he was advised about the importance of taking his medication regularly. In 2008 the psychiatrist suggested that he got a dosette box to ensure he took his medication regularly.

3.3.6 It is important to note that the judge, in his sentencing remarks, acknowledged that he had a history of clinical depression but said that he did not think that this qualified as what is described as a mental disorder or mental disability.

3.3.7 It is important to note that, according to Laura Richards et al, 'Abuse is a learned behaviour, not a mental illness. Abuse is an effective means to achieve power and control over their partners. It is also reinforced if it works and they get what they want. Abusers are accountable for their actions.'[25]

3.4 Image-Based Sexual Abuse[26]

3.4.1 In exploring the part that this played in this case, it is important that we remember that image-based sexual abuse is motivated by control, as well as misogyny, men's entitlement. It is a gendered harm with many victim and survivors experiencing devastating harms because of the social and political context of the sexual double standard and online abuse of women[27].

3.4.2 We can see very clearly in this case that the perpetrator used the threat of posting the intimate photos on-line as a means to controlling Clarissa.

3.4.3 We can be certain that he took these photos as an 'insurance policy' as a means of keeping or regaining control at some point in the future.

3.4.4 More importantly, for this review than the question of why Clarissa, and other young women like her, would 'consent' to this being done. The review is not making a judgement about how two consensual adults conduct their relationship, this is a private matter for them. However, the evidence of control in their relationship leads us to believe that she did not consent willingly to these videos being taken.

[25] Policing Domestic Violence, Laura Richards, Simon Letchford and Sharon Stratton, 2013, Oxford University Press

[26] For the purposes of this report, the term is used to describe:

- Taking or creating nude or sexual images or photos without consent, including 'fake' nude or pornographic images and/or
- Sharing nude or sexual images or videos without consent and/or
- Threatening to take, share or create nude or sexual images or videos without consent

[27] Shattering Lives and Myths: A Report on Image-Based Sexual Abuse, McGlynn (Durham University), Rackley (University of Kent) and Johnson (Durham University), 2019

3.4.5 In research[28] undertaken victims/survivors spoke of being pressured into taking and sending images, or having images taken. For some this took the form of 'grooming' whilst for others it was to avoid the consequences of implicit or explicit threats, including physical violence or in order to maintain a relationship.

3.4.6 We cannot underestimate the impact of this abuse on women. For women who experience this, it is enduring nature that can be most impactive. Once something is 'out there' it is constantly available to be shared online, with every view being further abuse. Victims spoke about the endlessness and permanency. Victims also spoke about the isolation that they felt in that their world narrowed when they felt unable to access the internet or social media despite the negative impact that this had on their personal and professional lives.

Recommendation Five – National

It is recommended that the Government revisits the current laws in relation to image-based abuse with a view to introducing a comprehensive law covering all forms of non-consensual taking and/or sharing of private sexual images, including threats and fake images.

Recommendation Six– National

It is recommended that the national definition of domestic abuse covers image-based abuse.

[28] Shattering Lives and Myths: A Report on Image-Based Sexual Abuse, McGlynn (Durham University), Rackley (University of Kent) and Johnson (Durham University), 2019

Section Four – Lessons Identified

4.1 **GP practice**

4.1.1 That it is a contractual requirement that all new patients should be offered a healthcheck.

4.1.2 That when the verbal handover was done by the health visitor, a GP was not made aware of this information.

4.1.3 That when the information received on SystmOne when the family transferred into the practice was not reviewed in light of the perpetrator's mental health and domestic abuse.

4.1.4 The review could not be certain that all opportunities to make a routine enquiry about domestic abuse were taken.

4.1.5 Was Not Brought (WNB) were not used appropriately when Clarissa's child missed appointments.

Section Five – Recommendations

5.1 **GP Practice**

5.1.1 It is recommended that the GP practice considers how routine enquiry and the consideration of domestic abuse could be embedded into the practice

5.2 **All health professionals with access to a GP record**

5.2.1 It is recommended that professionals, other than the GP, who are entering information into the GP records should accompany this with an additional communication to the GP to highlight the information such as telephone call, email, letter or electronic task.

5.3 **Her Majesty's Government**

5.3.1 It is recommended that the Government revisits the current laws in relation to image-based abuse with a view to introducing a comprehensive law covering all forms of non-consensual taking and/or sharing of private sexual images, including threats and fake images.

5.3.2 It is recommended that the national definition of domestic abuse covers image-based abuse.

Section Six – Conclusions

6.1 The judge described this as a callous, deliberate and merciless killing. He said that this was all his responsibility and no-one else's. The judge could not be sure that Clarissa's young child directly witnessed what happened, but she was undoubtedly in the house and very close by. The perpetrator did not seek medical assistance but, rather, called his adult children to come to the house, before they called the police.

6.2 We believe that finally Clarissa was finding the strength to break away and rebuild her life with her child.

6.3 All agencies are determined to learn from this awful event. As a result, this Review makes a number of recommendations which we feel will help make victims safer in the future.

6.4 The review extends its sympathies to Clarissa's family.

Appendix One – Terms of Reference

Terms of Reference for the Domestic Homicide Review into the death of Clarissa

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Bassetlaw, Newark and Sherwood Community Safety Partnership in response to the death of Clarissa which occurred on 30th July 2018.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident in[29] July 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Clarissa.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

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

2.4 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

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

[29] Actual date was included in the Terms of Reference but removed here to assist anonymity

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Seek to establish whether the events of the event could have been reasonably predicted or prevented[30].

4.2 Draw up a chronology of the involvement of all agencies involved in the life Clarissa to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.3 Produce IMRs for a time period commencing 1st January 2014.

4.4 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.5 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.6 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.7 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

[30] The review is aware that it is no longer required to include this but these are the Terms of Reference that were adopted by the panel

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Bassetlaw, Newark and Sherwood Community Safety Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

Gary Goose and Christine Graham
Independent Chair and Overview Author