# LIVERPOOL'S COMMUNITY SAFETY PARTNERSHIP

## DOMESTIC HOMICIDE REVIEW

## Rachael DHR 12

## OVERVIEW REPORT

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Supported by Paul Cheeseman

April 2020

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## 1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to and supported Rachael a resident of Liverpool.

1.2 Rachael had been in a relationship with Harry for about a year. They had one child together who was less than two months old at the time of Rachael's homicide in spring 2017.

1.3 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer'.[1]

1.4 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'. [1]

1.5 The members of the Domestic Homicide Review Panel extend their most sincere condolences to all of Rachael's family.

[1] Home Office Guidance Domestic Homicide Reviews December 2016

## 2. TIMESCALES

2.1 On 11 April 2017 Citysafe [Liverpool's Community Safety Partnership] sent requests to 22 agencies asking for information about Rachael and Harry. On 2 May 2017 the Liverpool Domestic Homicide Review Standing Group met and determined that it wanted more information on the domestic violence disclosure scheme before making a decision.

2.2 On 5 June 2017 the decision was taken by the chair of Citysafe that the criteria for a domestic homicide review were now met following concerns about the 'right to know' element of the Domestic Violence Disclosure Scheme[2] [Clare's law] not being used.

2.3 Coordinating the diaries of the proposed panel members meant that the first domestic homicide review panel meeting was unable to be held until 4 July 2017. At this meeting a time table was set to deliver the review by 4 December 2017.

2.4 Illness, resulted in the requests for individual management reviews being delayed.[3] The second meeting of the Panel was not held until 8 November 2017. At that meeting the timetable for completing the review was adjusted and later agreed with the chair of Citysafe who notified the Home Office Domestic Homicide Team that the completion date would now be 28 February 2018.

2.5 That was further adjusted to 30 November 2018 for two reasons. The action plan required updating and Rachael's mother [Ann] made contact with Citysafe in September 2018 through Victim Support asking to be involved. Ann was visited at her home in mid-October 2018 by David Hunter and Angela Clarke. An updated version of the report was shared with Ann whose thoughts led to some amendments. Ann did not meet the panel.

2.6 The domestic homicide review was presented to Citysafe on 20 May 2019 and sent to the Home Office 29 July 2019.

[2] Clare's Law, or the Domestic Violence Disclosure Scheme [DVDS], is designed to provide victims with information that may protect themselves from an abusive situation. www.merseyside.police.uk/advice-and-protection/crimes-against-people/domestic-abuse/clares-law-domestic-violence-disclosure-scheme/

[3] An individual management review is a written report detailing what contact each agency had with the subjects of the domestic homicide review. Its content and format are governed by Section 7 of the Home Office Domestic Homicide Review Guidance 2016.

## 3. CONFIDENTIALITY

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

3.2 The pseudonyms used in this report to protect identities were initially selected by the DHR Panel chair in the absence of contact from Rachael's family. The final pseudonyms were agreed at a meeting with Rachael's mother in October 2018. Professionals are referred to by an appropriate designation.

3.3 The Panel was grateful to Merseyside Police for the assistance it provided the review with trying to meet the family. After the review had been accepted by the Citysafe Chair it was sent to agencies to update their action plans prior to submitting it to the Home Office for quality assurance. During this period Rachael's mother made contact with Citysafe asking to be part of the review.

3.4 This table shows the age and ethnicity of the victim and perpetrator at the time of the homicide.

| Name | Who | Age | Ethnicity |
|---|---|---|---|
| Rachael | Victim | 29 | White British |
| Harry | Perpetrator | 31 | White British |

3.5 This table shows the relationship of other people to Rachael and Harry

| Designation | Relationship |
|---|---|
| Ann | Rachael's mother |
| John | Rachael's father |
| James | Former partner of Rachael |
| Anthony | Rachael's brother |
| Francis | Rachael's brother |
| Michael | Former partner of Rachael's mother |

## 4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 4 July 2017. They were sent to Rachael's family who were invited to comment on them.

**The purpose of a DHR is to**:[4]

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

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

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

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

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

f] Highlight good practice.

**Specific Terms**

1. What indicators of domestic abuse did your agency have that could have identified Rachael as a victim of domestic abuse and what was the response?
2. What knowledge did your agency have that indicated Harry might be a perpetrator of domestic abuse and what was the response?
3. What consideration did your agency give to the Domestic Violence Disclosure Scheme? Did it bring the scheme to Rachael's attention under the 'right to ask' criterion or suggest to Merseyside Police that they should consider informing Rachael under the 'right to know' criterion?
4. What services did your agency offer Rachael and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Rachael from seeking help for the domestic abuse?

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

5. What knowledge or concerns did Rachael's family, friends and employers have about her victimisation and did they know what to do with it?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Rachael and Harry?

7. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Rachael and Harry, or on your agency's ability to work effectively with other agencies?

8. What learning has emerged for your agency?

9. Are there any examples of outstanding or innovative practice arising from this case?

10. Does the learning in this review appear in other domestic homicide reviews commissioned by Citysafe Liverpool?

## 5. METHODOLOGY

5.1 The domestic homicide review screening meeting decided the review period should begin on 1 April 2016, when it is believed Rachael and Harry started their relationship, and ended in mid-spring 2017 when Rachael died.

5.2 The review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff to understand what happened.

5.3 A combined chronology was produced which allowed Panel members to see the same event from different agencies perspective.

5.4 The Panel chair had a very useful telephone conversation with Detective Inspector Ben O'ROUKE from Central MASH, Merseyside Police who explained the Domestic Violence Disclosure Scheme and how it was administered in Merseyside.

5.5 The written material was distributed to panel members and used to inform their deliberations. During the course of those deliberations additional queries were identified and supplementary information sought.

5.6 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed.

5.7 The report was not initially seen by the family because the panel was unable to find a way of involve them. After the Citysafe Chair approved the report Ann (Rachael's mother) contacted Angela Clarke asking to be involved in the review. Ann's valued contribution appears in the report and is attributed accordingly.

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

6.1 The Panel chair wrote to Rachael's parents and her two brothers. The police Family Liaison Officer delivered the letters and the Home Office Domestic Homicide Review leaflet for Families, and the Advocacy After Fatal Domestic Abuse[5] leaflet. Additionally the terms of reference for the review were included. Ann contributed to the review in October 2018.

6.2 The Panel Chair wrote to: two of Rachael's friends and her employer, enclosing the Home Office leaflets for Friends and Employers/Colleagues respectively. No response has been received from her friends. The Panel Chair exchanged e-mails and had a telephone conversation with the manager of the care home where Rachael has worked for many years. That conversation helped to build a picture of Rachael's life. The care home staff did not take up the offer by the Panel chair to meet them.

6.3 The Panel Chair also wrote to the perpetrator's family telling them of the review and inviting their contribution. To-date no contact has been made.

6.4 Harry's Offender Supervisor asked him if he wanted to contribute to the review, he declined. He identified several pseudonyms he did not want to be known by.

6.5 The Panel Chair also wrote to two of Harry's former partners who had been victims of his domestic abuse. The Chair did not receive a response from either.

6.5 The index of multiple deprivation[6] shows that the Liverpool Ward where Rachael live was ranked 924 out of 32,844 in England, where 1 was the most deprived and 32,844 the least. 11.2% of all 16-74 year olds residents are economically inactive, disabled or long-term sick. The average for Liverpool is 8.0%.

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

[6] http://www.uklocalarea.com

## 7. CONTRIBUTORS TO THE REVIEW.

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

| Agency | IMR[7] | Chronology | Report |
|---|---|---|---|
| Merseyside Police | Yes | Yes | |
| Liverpool Women's NHS Foundation Trust | Yes | Yes | |
| Liverpool Community NHS Trust | Yes | Yes | |
| General Practitioner for Rachael | Yes | Yes | |
| Merseyside Community Rehabilitation Company including information from the former Merseyside Probation Trust. | No | No | Short Report |
| Halton CCG GP for Harry | No | No | |
| Liverpool Mutual Homes | | | Short Report |
| | | | |

7.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with Rachael or Harry. Merseyside Police's individual management review was quality assured by the organisation's representative on the Review Panel. The Panel Chair did not see a conflict of interest.

[7] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

## 8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

| Review Panel Members | | |
|---|---|---|
| **Name** | **Job Title** | **Organisation** |
| Paul Cheeseman | Support to Panel Chair | Independent |
| Angela Clarke | Team Leader Supporting Victims and Vulnerable People | Safer and Stronger Communities, Liverpool City Council |
| Maria Curran | Risk Assessment Coordinator | Safer and Stronger Communities, Liverpool City Council |
| Martin Earl | Detective Chief Inspector | Merseyside Police |
| David Hunter | Panel Chair and author | Independent |
| Helen Smith | Head of Safeguarding | NHS Liverpool Clinical Commissioning Group |
| Jacki Walsh | Senior Probation Officer | Her Majesty's Prison and Probation Service |
| Caroline Grant | Head of Domestic Abuse Services | Local Solutions[8] |
| | | |

8.2 The Chair of Citysafe was satisfied that the Panel Chair was independent. In turn the Panel Chair believed there was sufficient independence and expertise on the Panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The Panel met four times and the circumstances of Rachael's homicide were considered in detail to ensure all possible learning could be obtained from her death. Outside of the meetings the Chair's queries were answered promptly and in full.

[8] Local Solutions is a charity that, since 1974 has been generating and delivering services to support individuals, families and communities with a primary focus on those experiencing disadvantage, exclusion and vulnerability. www. localsolutions.org.uk

## 9. AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the Chair and author was the same person, a position permitted by the guidance.

9.2 The Chair competed forty one years in public service [HM Forces and a British police service] retiring from full time work in 2007. Since then he has undertaken the following types of reviews:
Child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews.

9.3 He undertook a domestic homicide review in Liverpool in 2016 and a joint child serious case review and domestic homicide review in 2011. He has never worked for any agency providing information to the current review.

9.4 The Chair was supported by Paul Cheeseman, an independent practitioner, with a similar professional background.

## 10. PARALLEL REVIEWS

10.1 HM Coroner for Knowsley opened and adjourned an inquest on Wednesday 26 April 2017 and confirmed to Merseyside police that it will not be reopened given the finding of murder.

10.2 The Coroner has the discretion to resume an inquest (or not) following the conclusion of criminal proceedings (see paragraph 7 of Schedule 1 of the Coroners and Justice Act 2009); there will sometimes be a resumption of an inquest, despite a suspect being convicted of one of the offences listed in paragraph 1(6) of Schedule 1 of the Coroners and Justice Act 2009. When a coroner resumes an inquest following criminal proceedings, the coroner must ensure the outcome of the verdict is not inconsistent with the relevant criminal proceedings or other reason(s) that the Coroner's investigation had been originally suspended (paragraph 8 of Schedule 1 of the Coroners and Justice Act 2009). The Coroner is more likely to resume an inquest following criminal proceedings which has resulted in a conviction where Article 2 issues, in his/her opinion need to be explored.[9]

10.3 Merseyside Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.4 The Review panel did not identify any other reviews in connection with Rachael's death.

[9] https://www.cps.gov.uk/legal-guidance/coroners

10.5 **11. EQUALITY AND DIVERSITY**

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

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

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

[1] A person [P] has a disability if—
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[10]

11.1.3 Neither Rachael nor Harry had any known disabilities. The use of illegal drugs and the misuse of alcohol are statutorily excluded from the definition of disability under the Act, albeit they are taken into account under the Care Act 2014. In this case neither Rachael nor Harry had care and support needs as defined by the Care Act 2014.

11.1.4 The panel found evidence that Rachael and Harry accessed local services and concluded that neither of them faced any barriers for non-domestic services. For example Rachael booked her pregnancy through her local children's centre, attended her ante-natal appointments and engaged with health visiting after the birth of their child. Harry accompanied her to some appointments and was present at the birth. Harry claimed and drew benefits during his long periods of unemployment.

11.1.5 There is no suggestion that either of them lacked capacity[11] and professionals applied the first principle of Section 1 [2] Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

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

## 12. DISSEMINATION

12.1 The following organisations/people will receive a link for the Liverpool City Council webpage where they can see the report after any amendment following the Home Office's quality assurance process.

Rachael's Parents and her two brothers[12]
Citysafe Board constituent agencies
Merseyside Police
NHS Liverpool Clinical Commissioning Group
Liverpool Mutual Homes
The Care Home where Rachael worked
Independent Domestic Violence Advocate Service Liverpool
Her Majesty's Prison and Probation Service
The Office of Merseyside Police and Crime Commissioner

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

## 13. BACKGROUND INFORMATION [THE FACTS]

13.1 Rachael and Harry met through a dating web site in April 2016 and soon formed a relationship.

13.2 At the time of the homicide Rachael, Harry and their seven week old child lived with Rachael's father in social housing in Liverpool. On 19 June 2016 Rachael made an online application for housing to Liverpool Mutual Housing. She did not proceed with it.

13.3 On a day in April 2017 Rachael and Harry attended a family barbecue followed by an evening drinking in a public house, arriving home about 11.0 pm. Rachael's father went to bed leaving his daughter and Harry downstairs. Their child was staying with the paternal grandparents. Rachael's father heard them arguing but was not particularly concerned. He woke naturally in the early hours of the next morning, went downstairs and found Rachael apparently dead. He informed the police. Harry was not present. Merseyside Police attended the home and began a homicide investigation. Ann (Rachael's mother) felt that Harry must have attacked Rachael while she was asleep otherwise she would have fought back.

13.4 A Home Office post mortem established Rachael died as a result of strangulation. Harry was soon arrested and charged with her murder.

13.5 In October 2017 Harry pleaded guilty to murder at the start of his trial and sentenced to life imprisonment with a minimum tariff of 15 years and 219 days.

13.6 The sentencing judge is reported as saying, 'Shortly after midnight…you attacked Rachael, punching her to the chin and to the side of the head and applying pressure to her neck thereby using significant force to strangle her… Having inflicted fatal injuries you left her to die on the sofa to be discovered by her father while you made your getaway.'

13.7 The child lives within the extended family.

# 14. CHRONOLOGY and OVERVIEW

## 14.1 Introduction

14.1.1 The chronology and overview sections of the Home Office domestic homicide review report template have been combined into one section in this report for two reasons: to avoid duplication and to reflect the small number of agencies who had contact with Rachael and Harry.

## 14.2 Background to Rachael and Harry

| **Rachael** |
|---|
| Rachael was born in Liverpool and was twenty nine years of age at the time of her death. She had an older and younger brother. All the siblings were all brought up by their parents in Merseyside. Rachael's parents separated in 2004 when she was about 17 years of age. Initially Rachael lived with her mother and in 2009 with her father.<br><br>Rachael was employed as a care assistant for the elderly at a local care home, a position she held for a number of years. She was very well respected by residents and staff who thought she had the gift of compassion. At the time of her death she was on maternity leave, Rachael had taken her daughter to see staff during this leave.<br><br>Her family said, 'she had a few boyfriends but nothing serious.' Rachael had an on/off relationship with a man called James who her mother described as being old enough to be her father. 'Harry was the first person she was in a relationship with.'<br><br>Rachael's father said he got on very well with her. He and one of Rachael's brothers stated that she was not soft and could stand her ground and look after herself physically. Her mother confirmed this.<br><br>The family wanted Rachael remembering as a caring person whose longstanding maternal instinct was fulfilled by the birth of her daughter. Her mother paid this moving tribute to Rachael in a victim impact statement:<br><br>'There are no words to describe what has happened, how I feel or the impact this has had on me and my family. Rachael was my only daughter, the only sister to two brothers and the only Aunt to her niece and nephew. I have now lost my only daughter who was very special and very hard working. Rachael had waited all her life to be a mum and to be gifted with a child was the best thing that had ever happened to her. I cannot believe that her life with the child was such a short one – that fact alone breaks my heart. My life will never be the same again, surrounded by clouds of distress and grief. My wider family have suffered as has Rachael's father but no one has lost as much as my granddaughter who faces a life without her mum, who would have been the best mum ever'. |

**Harry**

Harry was born in Cheshire. He and his brother were brought up by his mother and stepfather. Harry was educated locally and left school aged 16 years. He lived at home until summer 2007 when a family disagreement resulted in him leaving and becoming estranged from his family.

He renewed contact with his parents in 2016 when he told them of his relationship with Rachael and her pregnancy. His parents took an active interest in their first grandchild, including having the child for one overnight stay.

Harry was unemployed for long periods and worked briefly as a warehouseman for a local car manufacturer, leaving in March 2017. There was a general feeling in Rachael's family that he was workshy.

As will be seen later in the report he was a perpetrator of domestic abuse in previous relationships.

**The Relationship**

Rachael's father recalled that Rachael met Harry via an internet dating site in April 2016. He remembers advising her to be careful when she went to meet Harry for the first time. Rachael later told her father that she liked Harry and would probably see him again.

Some weeks later Harry visited Rachael at home and met her father. Rachael's father and brothers all said that they did not particularly like Harry but found it difficult to explain why. They felt his social skills were very limited. Ann [Rachael's mother] met Harry and had an unspecified unease about him and cautioned Rachael to be careful. His nickname was 'Harry the nark'. This is a local term meaning the person is moody. Ann encouraged him to work and provide for Rachael and the baby. Ann witnessed Harry being obsessive with the baby.

Her father was not pleased that Rachael was dating Harry but felt if she was happy he would go along with it and accept Harry as best he could.

Rachael's father recalled two incidents between his daughter and Harry that made him uneasy. However, he restrained himself from getting involved.

The first was when Rachael telephoned him from Harry's flat. She said that she was having a drink and had the glass raised to her mouth when Harry kicked the glass causing the contents to spill and her mouth to hurt.

The second incident in June 2016 happened during a family celebration. It appeared Harry flicked a burning cigarette butt at Rachael which hit her in the face. Rachael sought advice from her mother about the incident and wondered if she should see Harry again and was uncertain on whether to trust him. Rachael made an excuse to her brother Anthony for Harry's behaviour saying he did not mean it.

Her father recounted nothing happened as a result of the incident but it indicated to him the type of person Harry was. He remembers Rachael and Harry would sometimes fall out and Harry would quickly become aggressive.

In July 2016 Rachael told the family that she was pregnant with Harry's child. Her father was not pleased because he disliked Harry. He described himself extremely close to his daughter and therefore accepted the position. He allowed Harry to move in with him and Rachael around November 2016. He said Rachael and Harry continued to have minor tiffs which would not amount to much.

Ann recalls that Harry was jealous of the baby because the child was the centre of Rachael's attention and thereby naturally monopolising her time.

Her father recalled an incident involving Harry, who was drunk. He collected the baby from Ann during the evening took the child to Anthony's house and stayed the night. This incident was reported to the police and is explored at 15.1.4] Consequently, they argued and Rachael asked Harry to leave the family home. About a week later they were reconciled.

Within a few more weeks Rachael was dead.

## 14.3 Events

14.3.1 This section of the report summarises what information was known to the agencies and professionals involved with Rachael and Harry. Some narrative commentary is made here and the full analysis appears at Section 15.

14.3.2 Between April 2009 and March 2017 Merseyside Police recorded Harry as the perpetrator of domestic abuse on 6 occasions. His victims were his former partners and on some occasions he made counter allegations against them. On two occasions he was charged with assault and given non-custodial sentences.

14.3.3 In the same period Rachael came to the attention of the police following domestic arguments with some male members of her family. She was

cautioned by the police after one such incident. Ann said that for a period around 2011 Rachael found it difficult to deal with the pressures in her life and this coincided with many of the reports to the police.

| Date | Event |
|---|---|
| 19.06.16 | Rachael applied on-line to Liverpool Mutual homes to rent a property |
| 08.07.16 | Rachael visited her general practitioner 6 weeks pregnant |
| 26.07.16 | Rachael booked an appointment for ante-natal care |
| 10.10.16 | Rachael given advice by community midwife about smoking during pregnancy |
| 24.02.17 | Health Visitor completes home birth visit. Rachael and Harry present; therefore the Health Visitor does not ask about domestic abuse. |
| 11.03.17 5.04 pm | Harry telephoned Merseyside Police and stated Rachael had thrown him out that morning and he was concerned about her fitness to care for their baby, as she had been drinking all night. The police attended and noted that Rachael was not drunk and that she and the baby were safe and well. Rachael told the officer that the baby had been cared for at Ann's house overnight while she and Harry went out for a drink. They argued the next morning and Harry ran out the house, collected the baby from Ann and took the child to her brother's [Anthony] home from where Rachael collected the child. A Vulnerable Persons Referral Form [VPFR1 was completed, forwarded to the Multi-Agency Safeguarding Hub [MASH] and risk assessed as 'Bronze', which is standard risk.[13] The matter was referral to Children's Services, Liverpool Women's Hospital and the Health Visiting Service. This was an opportunity for the police to consider a disclosure to Rachael under the 'right to know' element of the Domestic Violence Disclosure Scheme. |
| 20.03.17 | Liverpool Women's Hospital [midwifery] receive notification from Merseyside Police of the 11 March 2017 incident. The hospital notified the Health Visiting Service because midwifery had discharged the baby. |
| 21.03.17 | Merseyside Police notified the Health Visiting Service of the March 2017. |
| 22.02.17 | First visit by a health visitor as per healthy child programme no concerns identified. Domestic abuse not discussed with Rachael as Harry present. The health visitor did not know of the police referral. This is explored later. |

[13] Merseyside Police use MeRIT to assess risk in domestic abuse cases and categorises risk to victims of 'domestic abuse' as 'Gold', 'Silver' or 'Bronze'. Each of these categories has a list of interventions to be considered.

| | |
|---|---|
| 24.03.17 | Second visit by a health visitor as per healthy child programme no concerns identified. Domestic abuse discussed with Rachael, no concerns identified. The health visitor did not know of the police referral. This is explored later. |
| | |

## 14.4 Merseyside Police

14.4.1 The key features in the period predating the scope of the review are:

- Rachael and Harry were recorded as victims and perpetrators.
- Neither offended against the other.

14.4.2 There is one recorded domestic abuse incident between Rachael and Harry within the scope of the review

## 14.5 Merseyside Community Rehabilitation Company

14.5.1 In September 2014 Harry was arrested for assaulting his partner. In February 2015 he pleaded guilty to Common Assault and was sentenced to: 12 month Community Order with requirements of 12 month Supervision and 120 hours Unpaid Work. Harry had one previous conviction for battery and criminal damage in 2009 against a different partner.

14.5.2 The circumstances of the 2014 assault were: Harry and his partner attended an informal gathering at a friend's house. Over the course of the previous 24 hours he had consumed a considerable amount of alcohol and had taken cocaine. Whilst at the friend's house he became involved in an argument with his partner. He smashed her mobile telephone and punched and slapped her face. They had been living together for six months prior to the assault. It appears Harry discovered his partner had contacted her former partner and Harry resorted to violence during the subsequent argument.

14.5.3 Harry was assessed as posing a medium risk of serious harm to the victim. The nature of the risk was identified as physical and emotional harm within the context of domestic abuse. This assessment was based upon his current and previous offending, and the identified risk factors and triggers for his offending behaviour. The risk factors are explored in section 15 of the report.

## 14.6 Rachael's General Practitioner

14.6.1 During the time period covered by the review there were no specific indicators that Rachael was suffering domestic abuse. She attended the surgery on four occasions, and received what could be considered standard universal care for the presentations that she made. There was potential for opportunistic enquiry but that is not yet routine. Rachael informed her doctor that she was pregnant.

### 14.7 Harry's General Practitioner

14.7.1 There is very little held within Harry's current medical GP records. There is a single reported mention of self-harm from 2007, but with no further details provided.

### 14.8 Liverpool Women's NHS Foundation Trust

14.8.1 Rachael booked her pregnancy with Liverpool Women's NHS Foundation Trust through a local Children's Centre. Some months later a Community Midwife spoke to Rachael about drinking alcohol during pregnancy. Rachael reported consuming 5-10 units a week prior to pregnancy and had stopped when her pregnancy was confirmed.

14.8.2 The baby was born in spring 2017 and discharged from midwifery care about a month later.

### 14.9 Liverpool Community Trust NHS Trust

14.9.1 In spring 2017 a Health Visitor undertook a birth visit at the family home. Rachael, Harry and the baby were present. The Health Visitor did not ask Rachael about domestic abuse because Harry was present.

14.9.2 Later in spring 2017 health visiting received a notification from Merseyside Police that they had attended a call to the family home on 11 March 2017 but the police deemed the call to be malicious.

14.9.3 On 24 March 2017 the Health Visitor saw Rachael and the baby at their home; Harry was not present. No domestic abuse concerns were identified. However, the Health Visitor was unaware of the 'malicious' domestic abuse report from three days earlier and therefore did not ask Rachael a direct question. The reasons for this appear in the analysis section of the report.

### 14.10 Liverpool Mutual Homes[14]

14.10.1 On 19 June 2016 Rachael made an on-line application to rent a property. One of the questions on the application form asked if the applicant was suffering from domestic abuse. Rachael ticked the box to indicate she was not. She said she wanted to live independently. There was no indication that she was in a relationship or pregnant. The section on household details indicated that Rachael was the only person to be rehoused.

[14] Liverpool Mutual Homes was created in 2008 after a stock transfer saw it take over Liverpool Council's remaining 15,000 properties, making it the city's largest housing association.

# 15. ANALYSIS USING THE TERMS OF REFERENCE

## 15.1 Term 1

**What indicators of domestic abuse did your agency have that could have identified Rachael as a victim of domestic abuse and what was the response?**

**Indicators prior to the scope of the review**

15.1.1 Rachael was identified as a victim in 2012 when she was assaulted by her mother's partner. He was arrested and charged, but subsequently found not guilty on the direction of the trial Judge. The incident was assessed as 'Bronze' and Rachael was provided with details of support agencies. That response was in line with Merseyside Police policy. Ann told the review chair that Rachael did not want to give evidence and the not guilty verdict was directed by the court.

15.1.2 Merseyside Police recorded Rachael as the perpetrator on three occasions between 2009 and 2012. The person reporting the alleged abuse [James] was a former partner who was more than twice her age. Ann said it appeared James could not accept that the brief relationship was over and his efforts to reinstate his former position brought confrontation with Rachael. James' actions would now be seen as harassment and potential stalking. There were other reports of disputes between Rachael and some male members of her family.

15.1.3 The Panel discussed why it was that between 2009 and 2012 Rachael came to the attention of the police on six occasions. Rachael's mother said her daughter was young and going through a difficult time in her life and on occasions could not cope too well with daily stresses.

**Indicators within the scope of the review**

15.1.4 Merseyside Police recorded one domestic abuse incident between Rachael and Harry. At 1704 hours on 11 March 2017 they received an emergency call from Harry who stated his partner Rachael had thrown him out that morning and he was concerned about her fitness to care for their baby, as she had been drinking all night. An officer attended a short time later and determined that Rachael and the baby were safe and well and that Rachael was not intoxicated. She told the officer that the baby had been cared for at Ann's house overnight while she and Harry went out for a drink. In the morning they argued and Harry ran out the house. He collected the baby from Ann and they went to a maternal uncle's home from where Rachael later collected the child. Harry was not at the house but was later spoken to by the officer. A Vulnerable Persons Referral Form 1 was completed, forwarded to the Multi-Agency Safeguarding Hub who risk assessed Rachael as 'Bronze' [standard]. The incident was deemed to be a malicious call made by Harry.

15.1.5 Rachael cooperated with the questions on the Vulnerable Persons Referral Form 1 and her preferred method of accessing domestic abuse service information was via the Merseyside Police Force Website. Question 30 of the MeRIT risk assessment asks if there have been any unreported incidents of domestic abuse. Rachael said there had not been, adding she had a lot of family support in the locality.

15.1.6 A closer examination of the Vulnerable Persons Referral Form 1 by the Merseyside Police reviewer shows that while the previous convictions of Harry appeared on it, there is no reference to Rachael and her domestic abuse history. The officer who completed the referral form correctly stated the majority of incidents between Harry and his previous partners were verbal arguments with 'Bronze' assessments. However, a basic check on the Niche[15] system would have shown that Harry posed a 'Silver' [medium] risk of causing harm to the victims and that he had two convictions for assaulting partners. These facts do not appear to have been taken fully into account when the Bronze risk level was set for the March 2017 domestic abuse incident between Harry and Rachael.

15.1.7 The officer recorded that the baby was safe and well. The Vulnerable Persons Referral Form 1 would have benefitted from some recognition that a new baby [seven weeks old] was very likely to cause increased tension in any relationship and that Harry was potentially using the baby as a form of exercising control over Rachael by claiming she was drunk and unfit to look after the infant. Harry's approach in portraying his partners to the police as 'bad' and himself as a 'victim' of domestic abuse is a feature of this review and should add to the body of evidence that controlling and coercive behaviour is a pernicious form of domestic abuse. Merseyside Police recognised the call from Harry was malicious but did not associate it with controlling behaviour.

15.1.8 A member of the Multi-Agency Safeguarding Hub, hosted by Merseyside Police referred the incident to Liverpool Women's NHS Foundation Trust [midwifery], Liverpool Community NHS Trust [health visiting] and Liverpool City Children's Services. Children's Services care line logged the contact as a notification and took no further action. See Term of Reference 10 for further commentary.

15.1.9 The Liverpool Women's NHS Foundation Trust routinely ask pregnant women whether they are victims of domestic abuse. Rachael did not identify any victimisation. The service received the 'referral' from the police on 20 March 2017 [nine days after the incident] by which time Rachael had been discharged. They did however flag it on their records system so that it would be available to staff should they provide future services to Rachael. Sharing information in this way is standard procedure. This is an example of professionals adhering to sound routine practice which the DHR Panel recognised happened daily in all agencies.

[15] Merseyside Police record management system for crime, custody and intelligence records

15.1.10 Health Visiting was providing standard Universal Service to Rachael and the family. Prior to receiving the report of a domestic abuse incident from Merseyside Police on 21 March 2017 a Health Visitor had seen Rachael, Harry and the baby once for what is termed, 'the birth visit'. Health Visitors routinely ask mothers whether they are victims of domestic abuse but in this case the attending Health Visitor was unable to do so because of Harry's presence. The DHR panel heard from it Clinical Commissioning Group member that the Liverpool Community NHS Trust's [health visiting] current policy of not asking women about domestic abuse if a male is present is under review. The Trust thinks that unless there are known risk factors, domestic abuse should be discussed where a male is present as not to do so potentially stigmatises all males as perpetrators of abuse. Achieving 'universal enquiry' requires additional training for health visitors.

15.1.11 The Health Visitor saw Rachael on 24 March 2017, three days after the police 'referral', and discussed domestic abuse with her. Rachael said she had no concerns. However, the Health Visitor did not know that the police had attended a domestic incident the 11 March 2017. The DHR panel heard that during the course of work not associated with this DHR, Liverpool Community NHS Trust discovered about 150 referrals from the police that had been received but not passed onto health visitors. The reasons for this are being investigated and may stem from a software problem. It is not known for a fact whether the 11 March 2017 referral from the police was one of the 'missing' referrals. It is within the timeframe so appears very likely.

15.1.12 Liverpool Mutual Homes did not see Rachael but did receive an on-line application for rented accommodation. Rachael indicated she was not suffering from domestic abuse and was to be the sole occupant of the new property.

15.1.13 The panel observed that the use of alcohol was present in the relationship between Rachael and Harry and on the night Rachael died she and Harry had been drinking. Alcohol also featured in several of the domestic incidents involving Rachael and Harry and their former partners. There is no evidence to say Rachael misused alcohol or was a dangerous drinker. Merseyside Community Rehabilitation Company recorded that Harry's misuse of alcohol was a risk factor for offending. The following paragraph illustrates one consequence of alcohol use in Liverpool.

15.1.14 In one public health study[16] the number of 'months of life lost per person' due to alcohol for Liverpool [males and female under 75 years] was significantly higher than the English core cities[17] average. Within the six local authorities[18] comprising the Liverpool City region, Liverpool ranked highest.

[16] http://www.cph.org.uk/wp-content/uploads/2013/03/Liverpool-city-region-alcohol-profile.pdf

[17] Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield

[18] Halton, Knowsley, Liverpool, Sefton, St Helens and Wirral

## 15.2 Term 2

**What knowledge did your agency have that indicated Harry might be a perpetrator of domestic abuse and what was the response?**

15.2.1 Gadd et al [2002] identified 4 groups of men who present as domestic violence and abuse victims:

**Non retaliatory** - won't use/instigate abuse but will use force to restrain a partner who is attacking him

**Retaliatory** - Abuse in response to the partner's prolonged abuse and controlling behaviour

**Equal combatant** - instigates/abuses in proportion to his partner's abuse

**Primary instigator** - who is the instigator of abuse but whose partner will respond to this abuse with force on occasion

Gadd suggests the need to screen the person who states they are a victim as this will identify a primary aggressor and a primary victim. If the primary aggressor is stating they are a victim this needs to be managed in a way that doesn't elevate risk to the primary victim - including undertaking any activity with the victim that may be seen, by the primary aggressor, as collusive or supporting his version of events or his perception of the abuse dynamic. Where this has to happen (e.g. Arrest), then additional support needs to be offered to the primary victim in terms of signposting to support, risk assessment, etc.

15.2.2 Prior to the scope of the review, Cheshire Constabulary, Merseyside Police, and Merseyside Community Rehabilitation Company knew that Harry was a perpetrator of domestic abuse.

15.2.3 Cheshire Constabulary dealt with two incidents in April 2009 involving Harry and his partner. In the first he claimed to be the victim saying his partner had bitten his knuckles. The police took no further action. The second incident between them saw Harry arrested and charged with assault and criminal damage to his partner's car. Harry was sentenced to an 18 month Community Order. In 2014 Merseyside Police charged Harry with assaulting his partner and damaging her mobile telephone. The Community Order he received for the 2014 offence brought him under the supervision of the Merseyside Community Rehabilitation Company.

15.2.4 The Merseyside Community Rehabilitation Company individual management review has the following passage. 'The victim of the offences in 2009 was his partner xxx, and it was assessed that the commission of the common assault on a different partner, in 2014, evidenced of a pattern of offences committed against partners, causing harm to them and damage to their property'.

15.2.5 Harry's risk factors were identified as: offending behaviour, substance misuse [[drugs and alcohol], conflict within relationship, controlling behaviour and poor emotional management. Harry's sentence plan objectives included: to increase his understanding of his triggers and motivations for offending. Merseyside Community Rehabilitation Company identified the following learning point, 'his sentence plan would have benefited from further development'.

15.2.6 The Police recorded that Harry was the victim of domestic abuse on three occasions and the perpetrator on five. In several of the incidents the police noted that Harry was drunk. Jealousy seemed to be a feature of the domestic abuse against his partners. The weight of the evidence suggests that Harry was predominantly a perpetrator. The Panel wondered whether on the three occasions Harry called the police to report his victimisation he was not in effect exercising controlling and coercive behaviour in that he was signalling to the 'real' victim that he was prepared to call the police if he was not getting his own way. This view can be further evidence when Harry called the police in March 2017 and reported Rachael for being drunk while looking after their baby, a claim that was assessed as malicious. The Panel could not make an evidenced based conclusion that Harrys' call to the police was an example of controlling behaviour; they suspected it was.

**Controlling and Coercive Behaviour**

15.2.7 The Government's definition of controlling and coercive behaviour is:

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

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

15.2.8 In one study of domestic abuse survivors 95 out of 100 reported experiencing coercive control.[19] Data from the Crime Survey for England and Wales suggest that women are overwhelmingly the victims of coercive controlling behaviour.[20] One study of crime survey data found that women are far more likely than men to be the victims of coercive controlling

[19] Kelly, L; Sharp, N and Klein, R, Finding the Costs of Freedom How women and children rebuild their lives after domestic violence [London: Child and Woman Abuse Studies Unit, 2014], p.19

[20] Myhill, A, Measuring coercive control: what can we learn from national population surveys?[Violence Against Women 21[3], 2015, pp. 355-375]

behaviour abuse that involves ongoing degradation and frightening threats – two key elements of coercive control.

15.2.9 Within the scope of the review three agencies knew that Harry had called Merseyside Police to report Rachael for being drunk while caring for the baby. Their responses appear in Section 15.1 of the report. The Panel observed that Merseyside Police disbelieved Harry's claim as evidenced by their allocation of a malicious label to the call and citing Rachael as the victim on the Vulnerable Persons Referral Form 1.

15.2.10 In summary Harry was known as a perpetrator of domestic abuse and had convictions for assault and criminal damage on two partners. There is no evidence to say, other than addressing his offending behaviour though the supervision of his case manager in Merseyside Community Rehabilitation Company, that he was ever required or volunteered to address his domestic abuse offending. His actions in damaging his partner's mobile telephone is an example of trying to control and coerce her. A common barrier to victims not reporting abuse is the fear of not being believed. Harry's tendency to call the police and report himself as the victim is likely to signal to the real victim that he is the person who will be believed, thereby reinforcing the real victim's fear of not being believed. This behaviour has been observed by the review chair and Paul Cheeseman in other domestic homicide reviews.

15.2.11 In this case the DHR Panel felt that Harry was a primary instigator. See 15.2.1

## 15.3 Term 3

**What consideration did your agency give to the Domestic Violence Disclosure Scheme? Did it bring the scheme to Rachael's attention under the 'right to ask' criterion or suggest to Merseyside Police that they should consider informing Rachael under the 'right to know' criterion.**

15.3.1 Merseyside Police helpfully included the following description of the Domestic Violence Disclosure Scheme in their individual management review.

- The Domestic Violence Disclosure Scheme [DVDS] [Clare's Law, Right to Know / Right to Ask] was introduced nationally in March 2014. It did not introduce any new legislation, therefore any disclosure must be within the existing legal framework, and in particular have due regard to established case law; The Human Rights Act 1998, the Data Protection Act 1998 and the Rehabilitation of Offenders Act 1974. The scheme provides consistent procedures for disclosing information to enable the partner of a previously violent individual to make informed choices about how and whether to take their relationship with that individual forward.

- There are two entry routes into the scheme, the first being 'The Right To Ask' which is initiated by an individual approaching the Police to ask for

information they may hold about the subject. The second route is 'The Right to Know' where Police or a partner agency are aware of a previously violent individual and the level of concern is such that disclosure of information needs to be considered. Either scenario should trigger the process.

- In the first scenario whoever is the first point of contact within Merseyside Police must complete a [Vulnerable Person Referral Form 1] DVDS 1 which should contain as much detail as possible about the parties concerned and the reasons for the request. It should include the identity of the person who is asking for the information to be disclosed, this may not always be the partner of the subject, i.e. a guardian, parent or other concerned family member or friend.

- A Storm[21] log must be created, tagged [DVDS] and forwarded to the relevant Multi-Agency Safeguarding Hub, who will carry out the necessary Police National Database checks and have a face to face meeting with the person raising the concerns, in order to confirm their identity and integrity, unless that person is from a partner agency. There will be a risk assessment followed by a referral to Multi Agency Risk Assessment Conference.

- In the second scenario, whichever individual, police officer or member of police staff holds the concern should complete a [VPRF 1] DVDS 1 and create a Storm log tagged for the Multi-Agency Safeguarding Hub, who will carry out a risk assessment, complete Police National Database checks and refer to Multi Agency Risk Assessment Conference.[22]

- The Multi Agency Risk Assessment Conference will convene a case conference according to the urgency of the situation, where a decision will be made as to whether information will be disclosed, what that information will be and how disclosure will be managed.

15.3.2 The Domestic Violence Disclosure Scheme was operational in Merseyside from March 2014. Between then and the homicide of Rachael in spring 2017 there was one incident of domestic abuse involving her and Harry known to Merseyside Police. They shared the detail with Midwifery and Health Visiting. Harry had a long history of perpetrating domestic abuse against more than one partner and there was material available for disclosure under Clare's Law.

15.3.3 Midwifery had already discharged Rachael from its service and therefore did not have an opportunity to consider whether Clare's Law was applicable in this case. At the time of the events under review the Domestic Violence

[21] Merseyside Police's Command and Control system

[22] The officer responsible for managing Merseyside Police's DVDS told the DHR chair that each application can take up to eight hours to research.

Disclosure Scheme was not part of midwifery training. It is now going to be included in 2018. This will provide midwives with an additional tool when considering how to respond to suspicions of domestic abuse.

15.3.4 Liverpool Community NHS Trust who provide health visiting services said in its individual management review, 'I do not feel that Liverpool Community Health can give significance assurance that the staff are fully confident or knowledgeable in advising about the Domestic Violence Disclosure Scheme,' and have made a recommendation that the scheme is included in the Trust's statutory training programme.

15.3.5 Merseyside Police had one opportunity to consider applying the 'right to know' leg of Clare's Law when, on 11 March 2017, they dealt with a call from Harry claiming Rachael was drunk while caring for their baby. The call was initially categorised as a 'concern for a child' and as such would not have merited consideration of Clare's Law. The attending officer established from Rachael, that Harry's call was preceded by a verbal argument between them and as such re-categorised the call as domestic abuse. There is nothing in the subsequent paper work or electronic file to say the officer considered Clare's Law or advised Rachael of it.

15.3.6 As identified in paragraphs 15.2.2 and 15.3.2 the police service held material that may have benefitted Rachael. In any event it would have allowed her objective information with which to make any decisions about her relationship.

15.3.7 The officer who saw Rachael on the 11 March 2017 was asked by the Merseyside Police individual management review author whether she considered the 'right to know' leg of the Domestic Violence Disclosure Scheme. The officer's reply was:

> 'The incident was a concern for their child, not a domestic – he reported she was drunk in charge of their child, I believed the call to be malicious. As you say, I attended "the only incident" therefore, I did not consider this to be a high risk or volatile relationship. The victim said she was in no way scared of the suspect and that there had not been any violence in their relationship, albeit it was a new relationship and they had just had a child together. Upon checking his niche record, the majority of incidents have been graded as 'Bronze', Verbal argument only, not with victim. The amount of domestic incidents over the last number of years did not highlight a major concern'.

15.3.8 The Merseyside Police individual management review author spoke with the officer responsible for the Domestic Violence Disclosure Scheme in Merseyside Police and asked whether the incident on the 11 March 2017 was suitable for disclosure under the scheme. The responsible officer provided the review with a comprehensive reply which dealt with the volume of reported cases and the lack of resources to deal with them. The officer felt '…the issue in this case was not around their suitability [which

is evident] but who had responsibility for the initial consideration of their suitability for the scheme'.

15.3.9 'In this case that responsibility sat with the attending officer and the risk assessor at the Multi-Agency Safeguarding Hub. As this was the first reported 'domestic abuse' incident between the two parties, research into their backgrounds should have been undertaken, but was not. The amount of newly reported 'domestic abuse' cases between parties does not account for a huge percentage of the overall reported incidents to the Force. Therefore research should have been conducted as a matter of course'.

15.3.10 The officer responsible for the Domestic Violence Disclosure Scheme in Merseyside Police told the review chair that in his experience of making disclosures to victims it was common for them to say they knew all about their partner's past. Very often all they knew was the perpetrator's sanitised version of history. Revealing the facts balances the perpetrator's biased account.

15.3.11 Merseyside Police made two recommendations to remedy the general lack of knowledge about the Domestic Violence Disclosure Scheme among its staff and the need to conduct research for 'first' time domestic abuse cases.

15.3.12 In summary the Panel thought that Rachael may have benefitted from knowing about Clare's Law and that the circumstances of the incident between Rachael and Harry on 11 March 2017 merited serious consideration by the attending officer and staff in the Multi Agency Safeguarding Hub to activate the process around the 'right to know' leg of the Domestic Violence Disclosure Scheme. Additionally, information about Clare's Law is widely available of the internet, but in this case the onus was on Merseyside Police to consider applying the 'right to know' leg of Clare's Law.

15.3.13 The DHR Panel Chair searched the internet using the words, 'Clare's Law Merseyside'. Merseyside Police consistently came top of the return list and the link revealed the following information on Merseyside Police's web site.

'**Click here if you need to navigate away from this site quickly**

Clare's Law, or the Domestic Violence Disclosure Scheme [DVDS], is designed to provide victims with information that may protect themselves for an abusive situation.
Under Clare's Law, men and woman can request information about their partner or third party such as friends or relatives if they are concerned and disclose information about a partners' previous history or violent acts.'

15.3.14 The broader search term, 'Clare's Law' brought an abundance of relevant 'hits'.

15.3.15 Figures obtained from Merseyside Police show a steady increase in the 'right to ask' applications from 99 in 2014 to a projected 770 in the year ending 31 December 2017. The number of 'right to know' cases is also increasing.

Liverpool is one of the five policing areas in Merseyside Police. In the year ending 31 March 2017 the police in Liverpool considered 174 'right to know' applications.

## 15.4 Term 4

**What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Rachael from seeking help for the domestic abuse?**

15.4.1 All the agencies involved with Rachael had and have policies and procedures in place for identifying and supporting victims of domestic abuse. In this case Liverpool Women's NHS Foundation Trust provided Rachael with midwifery services including the opportunity to say whether she was experiencing domestic abuse. She said she was not.

15.4.2 Midwifery has an important role in identifying victims because of the close contact they have with pregnant women. Savelives[23] note on its web site: 'Pregnancy: Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant'. Another source[24] reports that 40%-60% of women experiencing domestic violence are abused while pregnant.

15.4.3 Rachael had suffered domestic abuse from previous partners. There was nothing reported to say that Harry had abused her at that time. However, he was a perpetrator of domestic abuse with previous partners and Rachael's pregnancy probably increased the risk she faced from him.

15.4.4 Rachael was seen twice by a health visitor. The first was the initial birth visit when the baby was two days old. This was originally planned as a pre-birth visit. The health visitor did not ask Rachael about domestic abuse because Harry was present. The second visit was prompted by the police after they attended at a report of domestic abuse. The record states that domestic abuse was discussed and that Rachael was not experiencing any.[25] Rachael was receiving the Health Visiting's Universal Offer which is defined as, 'A universal service from health visitors and their teams, providing the full Healthy Child Programme to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.'[26] This level of service means that Rachael and the baby were not considered particularly vulnerable. Had domestic abuse been

[23] www.safelives.org.uk

[24] Department of Health, *Responding to Domestic Abuse: A handbook for healthcare professionals* London: Department of Health, 2005*]* p. 15, citing British Medical Association *Domestic violence: a health care issue?* [London: BMA, 1998]

[25] Barriers to disclosure of domestic violence and abuse in health visiting. www.magonlinelibrary.com/doi/10.12968/johv.2016.4.7.354

[26] www.england.nhs.uk/wp-content/uploads/2014/03/hv-serv-spec.pdf

suspected the level of service offered to the family would have increased and a referral made to Children's Services.

15.4.5 The officer who attended the dispute between Rachael and Harry [March 2017] saw beyond the version of events presented by Harry and turned a concern for child call into a domestic abuse incident and completed a risk assessment. That was sound professional judgement. The officer, or a member of staff in the Multi-Agency Safeguarding Hub, should have considered Clare's Law but did not do so for the reason stated earlier.

15.4.6 In many of the Domestic Homicide Reviews undertaken in Liverpool, and elsewhere, the homicide victim had not told anyone in authority what was really happening in their relationship. There are many barriers that prevent victims from identifying their victimisation or leaving the relationship. Professionals on panel who work with victims say common barriers include, they:

- The victim loves the abuser
- Do not want to criminalise them
- Want the child to have a father

15.4.7 Other barriers to leaving a relationship include: [27]

'Survivors may be afraid that:
Their batterers will kill them if they leave
The violence will increase, based on their past experiences
Their partners are not able to survive alone or may commit suicide
The batterers will take the children or harm another family member
The abuser may harm pets
They will lose their children

In most cases, the fear is well founded. Survivors are at increased risk when they are leaving an abusive relationship. Those who have tried to leave may know they are at increased risk of severe violence if they try again. This separation violence may include:

Stalking, harassment or threats
Kidnapping the children or holding her hostage
Teaching them a lesson" for trying to leave
Homicide.'

15.4.8 The barriers to disclosing include: [28]

'A victim may:-

Minimise her experiences and/or not define them as domestic violence [this view could also be culturally based]

[27] http://stopabuse.umich.edu/about/barriers.html
[28]www.nscb.org.uk/sites/default/files/Safeguarding%20Children%20DV%20Guidance%20disclosure.pdf

Be unable to express her concerns clearly [language can be a significant barrier to disclosure for many victims]
Fear that her children will be taken into care.
Fear the abusive partner will find her again through lack of confidentiality.
Fear being killed if she speaks out about the abuse.
Believe her abusive partner's promise that it will not happen again [many victims do not necessarily want to leave the relationship; they just want the violence to stop].
Feel shame and embarrassment and may believe it is her fault.
Feel she will not be believed.
Fear that there will not be follow-up support, either because services are just not available or because she is concerned about experiencing institutional discrimination, or because a previous disclosure resulted in no follow up or offer of support.
Fear the abuser could have her detained by the authorities.
Fear that she will be isolated by her community.
Fear she will be deported.
Fear that the perpetrators immigration status will be exposed and she will be punished with an escalation of violence.
Be scared of the future [where she will go, what she will do for money, whether she will have to hide forever and what will happen to the children].
Be isolated from friends and family or be prevented from leaving the home or reaching out for help.
Had previous poor experience when she disclosed.

Some victims are simply not ready to disclose abuse. It is therefore important that professionals are always alert to the possibility that their client is experiencing domestic violence and to be ready to offer support'.

## 15.5 Term 5

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

15.5.1 After Rachael's death evidence of abuse emerged from the family. They did not like Harry or his flares of temper but believed that Rachael could look after herself and for this reason did not intervene. The panel members heard that the area of Liverpool where Rachael lived was culturally insular, unwelcoming to the police and families who had contact with the police were often viewed with suspicion.

15.5.2 Rachael's employers had no information or suspicion that Rachael was a victim of domestic abuse. They thought she was a happy peaceful person who was really looking forward to being a mother; something she had long wanted.

## 15.6 Term 6

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

15.6.1 Section 11 above examined this Term of Reference by exploring the protected characteristics of Section 4 Equality Act 2011. The Panel concluded that Rachael and Harry were treated without bias by agencies completing assessments and providing services to them.

15.6.2 All agencies contributing to this review reported they had policies and procedures in place applicable to diversity issues.

## 15.7 Term 7

**Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Rachael and Harry, or on your agency's ability to work effectively with other agencies?**

15.7.1 Merseyside Police was the only agency to identify a resourcing issue. Their Individual Management Review said:

'The review has the benefit of the comments made by the officer with responsibility for Domestic Violence Disclosure Scheme in the Central Merseyside Police area, which is geographically large, and the most densely populated area of the force. With considerable experience in the field, he has identified issues around the volume of disclosures and the resources allocated to this field, which he considered impact on effective delivery of the scheme. He has previously highlighted this issue his Command Team, who are in the process of addressing the matter'.

15.7.2 The Panel noted that statement and considered what it could have meant in this case. Merseyside Police accepts it should have initiated the Domestic Violence Disclosure Scheme 'right to know' process on 11 March 2017. Had that been done it is almost certain the decision to disclose information to Rachael via a Multi-Agency Safeguarding Forum would have been completed before her death. However, the process should have been initiated but was not for the reasons stated in paragraph 15.3. – 'The benefit in Rachael receiving a formal disclosure is that she would have been able to add the factual information about Harry's violent past to her own experience of living with him. Taken together they could have influenced her decision making'.

15.7.3 The Review Panel nor any agency identified problems with how they worked together in responding to Rachael's victimisation by Harry.

## 15.8 Term 8

**What learning has emerged for your agency?**

15.8.1 This term is addressed at section 18 of the report.

## 15.9 Term 9

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

15.9.1 The agencies and the panel did not identify any outstanding practice but recognised that many professionals discharged their duties diligently, expeditiously and to a good standard.

## 15.10 Term 10

**Does the learning in this review appear in other domestic homicide reviews commissioned by Citysafe Liverpool?**

15.10.1 The following table shows learning from this review has appeared in others.

| Repeat Learning from this Domestic Homicide Review with Other Liverpool Domestic Homicide Reviews | | |
|---|---|---|
| **This Review** | **Other Review** | **Notes** |
| Do Merseyside Police officers/other staff understand the difference between a 'referral' to children's services and the 'notification' of an incident'. | DHR8 | Liverpool Safeguarding Children Board [LSCB] continue to offer multi-agency training on a regular basis to improve understanding of the terminology of referral/notification. |
| | | |

15.10.2 The panel noted that this was the third domestic homicide review in Liverpool where the perpetrator had met the victim through internet dating. The independent reviewers for this DHR have seen this in a current review in another area.

15.10.3 In that review research was undertaken to establish if personal safety advice appeared on the site used. It did, and while the advice was sound, it was let down by providing details of American agencies and their contact numbers.

15.10.4 This panel wondered whether the emerging association between internet dating and domestic homicides was: coincidental, a trend and whether there was cause and effect and felt it was an area worth pursuing at a national level. At the very least the safety contact details on such sites used by people living in England and Wales should direct them to relevant national services.

## 16. Conclusions

16.1 The Panel noted that there was one reported incident of domestic abuse between Rachael and Harry within the timeframe of the review and that was nearly a year after they began their relationship, but only a few weeks after the birth of their child and before Rachael's homicide. That narrow window had the potential to restrict the review's insight into Rachael's experience of victimisation and Harry's as a perpetrator. Therefore, the Panel took a more detailed look at the events leading up to their relationship.

16.2 Very significantly Harry came to the relationship with Rachael in 2016 with a history of being involved in domestic abuse as a perpetrator and ostensibly as a victim. The Panel was careful not to say that Harry was not a victim of domestic abuse. Some of his claimed victimisation could reasonably be interpreted as him exercising coercive and controlling behaviour. It was Harry who reported the only incident between him and Rachael when he claimed she was drunk while looking after their baby. The police officer who attend uncovered a domestic incident between the couple, and from there judged that Rachael was the victim and that Harry had made a malicious call.

16.3 Harry had convictions for domestic abuse against different female partners thereby demonstrating beyond reasonable doubt that he was a perpetrator of violence. Merseyside Community Rehabilitation Company identified a number of risk factors for Harry including, drug and alcohol misuse, conflict within relationships, controlling behaviour and poor emotional management. Some of these factors were present at the time he took Rachael's life. For example he had been out drinking and Rachael's father heard them arguing.

16.4 Rachael was a victim of domestic abuse from a previous partner and family members. She was also involved in domestic arguments with close family members.

16.5 Rachael had an excellent work ethic and was a very popular member of staff in a local care home. Staff had no knowledge that she was a victim of domestic abuse from Harry. She met Harry through an internet dating site in April 2016 and he moved in with her and her father. Relationships beginning via internet dating featured in previous domestic homicide reviews and warrants national exploration. In June 2016 Rachael completed a housing application and indicated she was not suffering from domestic abuse and was not pregnant. She was the sole applicant indicating she was going to live alone. There was nothing in the application to suggest she was in a relationship. A few weeks later she told her general practitioner she was six weeks pregnant.

16.6 Midwifery provided a safe environment for Rachael to share any concerns she had about domestic abuse but none were forthcoming. It is known from the family that Harry was abusing her prior to the birth of their child. Listening to their descriptions of the abuse, it was clear to the panel

members that his behaviour was coercive and controlling. However, the family believed she could stand her ground.

16.7 The single report incident of domestic abuse between them took place several weeks after the birth of their baby. Merseyside Police shared the information with the appropriate agencies albeit there is an issue around whether they were 'referring' or 'notifying'.

16.8 A glitch in Liverpool Community NHS Trust's systems meant the Health Visitor was unaware of the police notification of the domestic abuse incident before she visited Rachael. This is being remedied by the Trust who have started to increase health visitors' skills to enable them to discuss domestic abuse when males are present.

16.9 With the exception of Merseyside Police, agencies' knowledge of the Domestic Violence Disclosure Scheme is very limited. Merseyside Police is the prime agency responsible for dealing with the 'right to ask' requests and for initiating the 'right to know' process. In this case the two members of staff who had the chance to commence the 'right to know' process did not recognise it needed consideration. That is not a new situation.

16.10 Had the 'right to know' process had been started and a disclosure made to Rachael it cannot safely, or objectively, be concluded what she would have done with the information about Harry's history and whether that would have altered the outcome for her. Ann thought it would at least have allowed her to make an informed choice.

16.11 Rachael's family and work colleagues remain shocked by her death and had no indication that it was even a remote possibility.

## 17. LEARNING IDENTIFIED

### 17.1 Agencies Learning [taken from their individual management reviews]

| Agency | Learning |
|---|---|
| Merseyside Police | 1. The manner in which we approach the Domestic Violence Disclosure Scheme requires reviewing. It is evident that Merseyside Police are not utilising it to its full capacity and staff are unclear as to who is responsible for the initial consideration of a party's suitability. This is despite clear guidance and policy. It would therefore appear to be a training and compliance issue.<br><br>2. There is still ambiguity and a lack of expectation around contacting other agencies to inform them about domestic abuse and child protection. All such contact is recorded on systems as a 'referral'. This gives the expectation that some form of action is required, when in fact there are cases when the 'referral' has been made for information only and there is no expectation of any action. This is a 'notification' and should be recorded as such during any such inter agency contact. |
| General Practitioner | 1. Routine enquiry of domestic abuse and professional curiosity to explore the hidden agenda of the consultation continue to be themes to include in general practitioner training. |
| Liverpool Community NHS Trust | 1. Staff need to be trained in Domestic Violence Disclosure Scheme as part of mandatory training.<br><br>2. Domestic abuse should be part of routine enquiry as not discussing because father is present is not acceptable. |

## 17.2 The Domestic Homicide Review Panel's Learning

**Learning 1**
**Narrative**
Rachael's family knew Harry's behaviour towards Rachael was not appropriate but felt she could look after herself. What they probably did not recognise was it amounted to coercive and controlling domestic abuse. In any event like many other families did not know what to do with their knowledge. Citysafe has run campaigns aimed at supporting families who know about domestic abuse and may be unsure what to do with their knowledge.
**Learning**
Families of victims often know that a member is the victim of domestic abuse but for barriers such as, 'I was sworn to secrecy', 'I didn't know who to tell'
This is not new learning and Citysafe continues to campaign on the subject and therefore the DHR panel does not make a recommendation.

**Learning 2**
**Narrative**
The Domestic Violence Disclosure Scheme is a useful tool with which to protect victims of domestic abuse. This review has shown that some professional are unaware of it or have gaps in their knowledge.
**Learning**
Combatting domestic abuse is difficult and requires the deployment of varied tactics. Ignorance or gaps in professionals' knowledge of the Domestic Violence Disclosure Scheme means they are less equipped to support victims.

DHR Panel Recommendation 1 applies.

**Learning 3**
**Narrative**
There was some coercive and controlling behaviour in this case. The one incident between Rachael and Harry which came to the attention of the police was not identified as an example of such behaviour. Had it been, greater scrutiny may have been given to how best to support Rachael.
**Learning**
Victims can be better supported if coercive and controlling behaviour is recognised

DHR Panel Recommendation 2 applies.

**Learning 4**
**Narrative**
Anecdotally the use of internet dating sites for meeting people is increasing. Factually, this method of meeting people and forming relationships has featured in three Liverpool domestic homicide reviews and one other known to the panel. Two internet sites reviewed had good safety advice but did not mention domestic abuse by name. It is not known whether perpetrators of domestic abuse use such sites specifically to identify future victims or whether meeting someone via this method may highlight a vulnerability.
**Learning**
The use of internet dating sites may pose, as yet, an unrecognised risk of highlighting vulnerabilities of users to domestic abuse.

DHR Panel Recommendation 3 applies.

# 18. RECOMMENDATIONS

## 18.1 Agencies Recommendations

| Agency | Recommendation |
|---|---|
| Merseyside Police | 1. Review policies and procedures relating to the delivery of DVDS Domestic Violence Disclosure Scheme in Liverpool Central area.<br><br>2. Consider reinforcing guidance on DVDS to officers and staff engaged in the process, particularly around conducting the necessary research into parties who report their first incident of domestic abuse. |
| General Practitioners | 1. Promotion of surgery as safe place for victims<br><br>2. Promotion of routine enquiry into domestic abuse<br><br>3. Promotion of support for victims of domestic abuse<br><br>4. Ensure index surgery attends safeguarding domestic abuse training<br><br>5. Domestic abuse awareness training for primary care<br><br>The Home Office quality assurance letter felt the above training requirements would be enhanced if they stipulated that the training should be supported by the Royal College of General Practitioners, the Royal College of Midwives and Institute of Health Visiting. The Home Office quality assurance panel highlighted the need for training that is standards driven with a national accreditation that is competency based.<br>This information has been passed to the appropriate Clinical Commission Group. |
| Liverpool Community NHS Trust | 1. Staff to be trained in DVDS as part of mandatory training programme. |
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## 18.2 The Panel's Recommendations

| Number | Recommendation |
|---|---|
| 1 | That Citysafe establishes its constituent agencies' knowledge and use of the Domestic Violence Disclosure Scheme as a |

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| | method of supporting victims of domestic abuse and considers a programme to raise public awareness of the scheme. |
| 2 | That Citysafe establishes its constituent agencies' knowledge of how to identify coercive and controlling behaviour and what tactics they use to support victims so affected. |
| 3 | That the Home Office considers if research is needed to establish whether there is an increased risk of becoming a victim of domestic homicide where the relationship was formed through the internet. |

**Appendix A Action Plan**

| **Recommendation Merseyside Police** | **Scope local or regional** | **Action to take** | **Lead Agency** | **Key milestones achieved in enacting recommendation** | **Target Date Completion** | **Completion Date and Outcome** |
|---|---|---|---|---|---|---|
| 1.<br>Review policies and procedures relating to the delivery of DVDS Domestic Violence Disclosure Scheme in Liverpool Central area. | Local | Review of DVDS Policy and Procedure | Merseyside Police | Merseyside Police follow the national guidelines in relation to DVDS across the Force area. The DVDS policy was reviewed, and has been brought under the Vulnerable Persons Unit (VPRU) to have a more consistent approach. The VPRU also has dedicated staff whose sole responsibility is to deliver DVDS across the Force as opposed to the previous process of individual geographical areas | **Completed** 2018 | **Completed** 2018 |

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| | | | | in Merseyside dealing with the process differently. This has created a more consistent process. | | |
| 2.<br>Consider reinforcing guidance on DVDS to officers and staff engaged in the process, particularly around conducting the necessary research into parties who report their first incident of domestic abuse. | Local | Ensure staff are informed of the policy and procedure for DVDS | Merseyside Police | Merseyside Police have reviewed the DVDS policy, and the process has been centralised under the Vulnerable Persons Unit (VPRU) to have a more consistent approach. The VPRU also have a dedicated team with specialist experience whose sole responsibility is to deliver DVDS across the Force | **Completed** | March 2019 |
| **Recommendation General Practitioner** | **Scope local or regional** | **Action to take** | **Lead Agency** | **Key milestones achieved in enacting recommendation** | **Target Date Completion** | **Completion Date and Outcome** |
| 3.Encourage professional curiosity into domestic abuse as | Local | Awareness raised during | Health | Appropriate screening for and | **Completed** | Practice safeguarding |

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|---|---|---|---|---|---|---|
| a targeted and routine procedure in general practice. | | training for practice safeguarding leads | | management of domestic abuse disclosure or identification in general practice. | | leads training 26/7/2017 and 28/11/2018 |
| 4.Increase awareness and offer advice about services available to support those at risk of, or victims of domestic abuse. | Local | Practice safeguarding leads made aware of local resources | Health | Leaflets referencing domestic violence available in all GP surgeries.<br>GPs and practices staff aware of local services.<br>Increased knowledge of Harmful Practices. | **Completed** | Practice safeguarding leads training 26/7/2017 and 28/11/2018 |
| 5.<br>Domestic abuse awareness training for primary care | Local | Practices aware of available training via LCCG intranet and bulletin | Health | All GPs and staff have training on domestic abuse | **Completed** | Safeguarding training availability accessed through CCG intranet. |
| **Recommendation Liverpool Community NHS Trust [Now part of Merseycare Trust]** | **Scope local or regional** | **Action to take** | **Lead Agency** | **Key milestones achieved in enacting recommendation** | **Target Date Completion** | **Completion Date and Outcome** |
| 6. | Local | Safeguarding training to be reviewed to | Merseycare | Mersey Care staff fully informed of Clare's Law via | **Completed** April 2018 | April 18 training reviewed |

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|---|---|---|---|---|---|---|
| Staff to be trained in DVDS as part of mandatory training programme. | | ensure inclusion of DVDS | | safeguarding training | | and updated to include information re Clare's Law |
| **Recommendation Domestic Homicide Review Panel** | **Scope local or regional** | **Action to take** | **Lead Agency** | **Key milestones achieved in enacting recommendation** | **Target Date Completion** | **Completion Date and Outcome** |
| 7.<br>That Citysafe establishes its constituent agencies' knowledge and use of the Domestic Violence Disclosure Scheme as a method of supporting victims of domestic abuse through a multi-agency approach and considers a programme to raise public awareness of the scheme. | Local | Consult with the CSP members via questionnaire to gain understanding of knowledge | Safer and Stronger Communities | Increase awareness of DVDS as a method of supporting victims | September 2019 | Questionnaire will be developed in August 2019 |

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|---|---|---|---|---|---|---|
| 8.<br>That Citysafe establishes whether its constituent agencies know how to identify coercive and controlling behaviour and how they support victims so affected. | Local | Consult with the Community Safety Partnership members using a questionnaire to gain understandin g of knowledge of CC | Safer and Stronger Communities | Increase awareness of coercive control if required | July 2019<br>**Completed** | **Completed**<br>Multi-agency spotlight session & Conference delivered to over 180 front line professionals |
| 9.<br>That the Home Office considers if research is needed to establish whether there is an increased risk of becoming a victim of domestic homicide where the relationship was formed through the internet. | National | Consideration for a review of internet dating by the Home Office | Home Office | Understanding of the risks associated with internet dating | January 2020 | For the Home Office to consider |

End Liverpool DHR12 overview report for Home Office quality assurance