STOKE-ON-TRENT COMMUNITY SAFETY PATNERSHIP

DOMESTIC HOMICIDE REVIEW

SARAH

Died May 2019

26 years of age

OVERVIEW REPORT

Independent Author: **Chris Brabbs**

Date: **July 2022**

CONTENTS

1. CIRCUMSTANCES LEADING TO THE DOMESTIC HOMICIDE REVIEW

1.1 This Domestic Homicide Review (DHR) was commissioned following the murder of Sarah by her former partner Lloyd in May 2019.

1.2 Following a call to Staffordshire Police from the perpetrator, who reported that he had killed Sarah following a dispute, police officers and paramedics found Sarah's body in the kitchen and that she had sustained multiple wounds to her face and neck. Sarah was pronounced dead at the scene. Sarah's primary school age child was also found in the house but unharmed.

1.3 A full police investigation was carried out into the circumstances of Sarah's murder was carried out which concluded that no other perpetrator was involved other than Lloyd. He was charged with Sarah's murder, and remanded in custody by the North Staffordshire Magistrates Court. Later that day, he was found dead in his cell at HMP Dovegate having taken his own life. The criminal prosecution process was officially ended following his death.

Background Information

1.4 Sarah and Lloyd had been in a relationship since January 2018. Prior to that, Lloyd had had been in a long term relationship with Rayann for 17 years and they had 2 children. After Lloyd went to live with Sarah, he continued to visit Rayann daily and he returned to live with her in May 2018.

1.5 Soon after his return, Rayann reported that she had been raped by Lloyd and he had pushed her down the stairs when she had challenged him about this. She also alleged that she had suffered domestic abuse throughout their relationship, citing some serious physical assaults. The outcome of the police investigation was that no further action would be taken regarding the latest allegations because of evidential difficulties. A few days later, Rayann visited a police station to retract her allegations of assault and rape. Multi-agency involvement with Rayann continued in order to provide support and ensure safeguards were in place for her and the children.

1.6 Following the assault, Lloyd returned to live with Sarah and they resumed their relationship. Children's Services became involved to assess any potential risks to Sarah and her child, but ended its involvement in October 2018 when it had not proved possible to engage Sarah with the assessment.

1.7 Two weeks before Sarah's murder, she had ended the relationship and asked Lloyd to find somewhere else to live but had been having difficulty in getting him to leave.

2. THE DECISION TO COMMISSION THE DHR AND TIMESCALES

2.1 Section 9 of the Domestic Violence, Crime and Victims Act (2004) requires the relevant Community Safety Partnership (CSP) to conduct a DHR to review the circumstances of a death which meets the following criterion:-

- the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related, or with whom he was, or had been, in an intimate personal relationship, or a member of the same household as himself.

Timescales

2.2 The DHR commenced in July 2019 when a DHR Panel meeting was held to scope the review and agree the terms of reference.

2.3 The Panel held face to face on two further occasions in October 2019 and January 2020 with the remaining panel processes to discuss the findings and agree the recommendations being carried out through email and video conferencing in order to maintain social distancing in response to the COVID-19 pandemic.

2.4 The final draft Overview Report, which had been endorsed by the Review Panel during April 2021, was presented to, and accepted by, the Community Safety Partnership at a meeting held on 11th May 2021. The report was submitted to the Home office in November 2021 after the report had been shared with Sarah's parents. The report was updated in response to feedback received from the Home Office Quality Assurance Panel in June 2022.

2.5 The length of time taken to complete this DHR was in part due to agencies needing to respond to the impact of Covid-19 and prioritise the maintenance of essential services. It was also due to a considerable amount of additional information needing to be sought from some agencies to address gaps in their Individual Management Reviews (IMRs), so that the DHR could gain the necessary understanding of key events, and importantly, the reasons for actions taken or decisions made.

3. SUBJECTS OF THE REVIEW

3.1 This focus of this DHR was on the following people:-

Name	**Sarah**	**Lloyd**	**Rayann**
Relationship	Victim	Perpetrator	Previous partner of Lloyd
Age at time of the fatal incident	26 years old	44 years old	51 years old
Ethnicity	White British	Black Caribbean	Black Caribbean

3.2 At the panel meeting to scope the review, it was agreed that Rayann and her youngest child should be included as subjects of the review because agency actions in response to her allegations of domestic abuse were viewed as relevant to the consideration of events and agency actions in relation to Sarah.

4. TERMS OF REFERENCE

4.1 The time period covered by the DHR was from January 2018 when Sarah and Lloyd commenced their relationship, to May 2019 when the victim Sarah was murdered and Lloyd subsequently committed suicide.

4.2 In addition to the standard questions to be considered as set out in the Home Office Statutory Guidance, the scoping of the DHR identified the following key issues for the review to consider:-

- the risk management of perpetrators of domestic abuse;
- the local provision of services for perpetrators of domestic abuse;
- how the victim and the ex-partner of the alleged perpetrator, and their children, were safeguarded against harm from him, including consideration of whether an effective multi-agency approach was taken to achieve this;
- the quality of information sharing across agencies;
- the awareness by agencies of perpetrators of domestic abuse making counter-allegations against their victims, and how this is dealt with;
- the use of Domestic Abuse Prevention Orders by perpetrators of domestic abuse against their victims;
- the awareness of domestic abuse by health professionals, and whether appropriate sensitive questions about domestic abuse are routinely asked;
- the decision to bail the perpetrator to the victim's address following the alleged assault on his ex-partner, including whether this was an appropriate decision, and the multi-agency decision making process involved.

5. METHODOLOGY

5.1 The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office. [1] This explains that the purpose of the review 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;

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[1] first issued in 2011 and last updated December 2016

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

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

Confidentiality

5.2 The findings of a domestic homicide review are confidential as far as identifying the subjects, their families or professionals. Information is available only to officers/professionals and their line managers who participated in the DHR. Pseudonyms are used in the report to protect the identity of the individuals involved. Professionals are referred to by their roles such as GP, housing officer or police officer for example.

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

6.1 The review benefited from the invaluable contribution of a number of people as set out below, and their perspectives will be referred to at relevant points in the report.

Family Involvement

6.2 Sarah's parents were informed of the DHR through verbal contact by the Police Family Liaison Officer and followed up with a formal letter sent by the Commissioning Officer for the Stoke-on-Trent Community Safety Partnership.

6.3 Throughout the review, both parents continued to be supported by a Domestic Abuse Homicide Case Worker from Victim Support who had previously provided support following Sarah's death. Both parents expressed their appreciation of this support.

6.4 The Homicide Case Worker and the Independent Chair maintained regular contact during the review. This enabled the former to keep the family informed of progress, and the DHR Chair to be aware of the parent's current circumstances and how they were coping with their loss, when preparing for his own contact with them at different stages of the review.

6.5 The Independent Chair held meetings with the parents at their homes early on in the review to explain its purpose and identify any issues that they considered were important to explore through the review. These discussions provided invaluable in gaining their perspectives about Sarah, her personality, and how she experienced the relationship with the alleged perpetrator. The Review Panel and Chair wish to place on record their appreciation of their openness and willingness to contribute in such sad and upsetting circumstances.

6.6 A copy of the report was hand delivered to both parents following the meeting of the Community Safety Partnership in May 2021 with agreement that they should have 2 to 3 weeks to read the report in private in advance of meetings with the DHR Chair / Report Author. These meetings were to go through the review findings and allow the parents the opportunity to share their response,

raise any content which they thought was inaccurate, and where they wished to request amendments.

6.7 Within these meetings, which were necessarily carried out by telephone in order to maintain social distancing, the parents accepted the findings and recommendations. The sole issue they raised was whether more could have been done to inform Sarah through the Domestic Abuse Disclosure Scheme about the allegations of previous domestic abuse involving Lloyd. Sarah's father shared his view that the parents should also have been informed of this history so that they could have talked to Sarah about the implications for her safety.

6.8 The parents did not express any preference for pseudonyms to be used within the report to maintain confidentiality, but agreed to those suggested by the report author. Rayann was also consulted about her own pseudonym but similarly did not express a preference and was content for this to be chosen by the author.

Involvement of Sarah's friends

6.9 At an early stage in the review, the Independent Chair met with Mrs A, and her daughter Ms B. The latter, who was Sarah's closest and most long standing friend, provided a statement to the police after Sarah's death. Sarah lived with Mrs A and Ms B for 2 years between the ages of 14 and 16 – the circumstances leading to this being described in the next section of the report. Within the discussion with the author, they shared valuable insights about Sarah's childhood experiences, her personality, her relationship with Lloyd, and her relationships with previous boyfriends / partners.

Involvement of work colleagues

6.10 The review panel had the benefit of having access to the police statements taken from 3 of Sarah's work colleagues. In the light of this, the decision was made that it would not be proportionate to approach them to contribute to the review. This was for 2 reasons. First, the statements were very detailed and it was therefore unlikely that further discussions with them would reveal any additional insights. In addition, the panel was mindful of the distress each had expressed in their statements about the impact of Sarah's death, and the panel wished to avoid causing them further upset.

Involvement of Rayann - Lloyd's former partner

6.11 The author met with Rayann early in the review along with the IDVA who had previously provided her with support. This discussion provided helpful insights to supplement what was contained in the agency records regarding the abuse she had experienced during her relationship with Lloyd, and the coercion she alleged she had experienced following its ending.

7. CONTRIBUTORS TO THE REVIEW

7.1 Chronologies and Individual Management Reviews were submitted by:

Glow (domestic abuse services) (formerly Arch North Staffordshire Ltd)

New Era (domestic abuse services)

Staffordshire Police

Stoke-on-Trent City Council – Children's Social Care

Stoke-on-Trent Clinical Commissioning Group

University Hospitals North Midlands

West Midlands Ambulance Service

7.2 Summary Reports of their involvement were provided by:

Crown Prosecution Service

North Staffordshire Combined Healthcare NHS Trust

Savana (sexual abuse counselling and support services)

Staffordshire County Council – Children's Social Care

Staffordshire Victim Gateway

Stoke-on-Trent City Council – Housing Services

Other sources of Information

- Glow (formerly Arch) and New Era records and meetings with the IDVA who supported Rayann, and the IDVA's manager;
- Witness statements taken by the police following Sarah's death;
- GP and hospital records relating to Sarah, Lloyd and Rayann [2].

The Domestic Homicide Review Panel Members

7.3 The membership of the Review Panel comprised:-

Chris Brabbs	Independent Chair & Report Author	
Cheryl Hannan:	Senior Investigating Officer	Staffordshire Police
Scott Bradbury	Family Liaison Officer	Staffordshire Police
Mark Harrison	Major Crime	Staffordshire Police Policy and Review Team
Sam MacDonald	Strategic Manager	Stoke-on-Trent Children's Services
Anthony Morrisey	Strategic Manager, Safeguarding and Quality Assurance Services	Stoke-on-Trent Children's
Jo Moss	Project Co-ordinator	Victim Gateway
Paula Brogan	IDVA Manager	New Era, Victim Support
Lucy Willis	Head of Domestic Abuse Services	Glow
Kim Gunn	Designated Nurse Safeguarding Adults	Stoke-on-Trent Clinical Commissioning Group
Rachael Fitton	Senior Nurse Adult Safeguarding	Stoke-on-Trent Clinical Commissioning Group
Janice Johnson	Safeguarding Adults Manager	University Hospital of North Midlands
Nicola Albutt	To be confirmed	West Midlands Ambulance Service
Nathan Dawkins	Commissioning Officer	Stoke on Trent City Community Safety Partnership Council
Paula Carr	Safeguarding Lead Children	Stoke-on-Trent Clinical Commissioning Group (specialist advisor)
Stephanie Nightingale	Staffordshire and Stoke-on-Trent Safeguarding Children Board (specialist advisor)	
Angela Gardner	Democratic Services (minute taker)	Stoke-on-Trent City Council

[2] Rayann gave written consent for her medical and social care records to be shared with the Review.

Independent Chair and Overview Report Author

7.4 The independent chair of the DHR panel, and report author, was Chris Brabbs, who has been on the approved list of independent chairs maintained by the Stoke-on-Trent Community Safety Partnership since 2019. Mr Brabbs, is a qualified social worker whose career saw him holding the post of Director of Social Services in 3 local authorities. He has been an independent safeguarding and social care consultant, since 1999, and from 2006 has specialised in carrying out the role of independent chair and overview report author of DHRs, safeguarding adult reviews, and child serious case reviews (now child practice reviews). He had no connection with any of the agencies involved in this case.

Specialist Advice

7.5 Specialist advice was provided by a representative of the New Era specialist domestic abuse service, and the Commissioning Officer for the Community Safety Partnership.

8. PARALLEL PROCESSES

8.1 A Coroner's inquest was held in August 2021 having been opened and adjourned in June 2019. The conclusion reached was that Sarah had been unlawfully killed and the cause of death was multiple stab wounds. In advance of the final hearing, a video conference call took place between the DHR Chair and the Coroner at the latter's request, so that the Coroner was aware of any findings from the DHR which would be relevant to the conduct of the inquest.

9. EQUALITY AND DIVERSITY

9.1 The review did not identify any issues specifically related to equality and diversity [3] in terms of any barriers being experienced by Sarah, Rayann and Lloyd in accessing services. This finding was reached after thorough exploration of the issue of whether there were potentially any issues stemming from Rayann and Lloyd's ethnicity. Equally, there is no indication that Sarah's ethnicity was a factor in her murder.

10. DISSEMINATION

10.1 All organisations and people who participated in the review will receive a copy of the published overview report. The report will be shared with the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board and the Stoke-on-Trent Safeguarding Children Partnership so that the learning can be shared with relevant organisations. The Staffordshire Police, Fire and Crime Commissioner (PFCC) will also receive the report.

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[3] The statutory guidance lists the following categories in respect of equality and diversity - age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

11. BACKGROUND HISTORY AND PREVIOUS AGENCY INVOLVEMENT

Introduction

11.1 The following paragraphs provide a brief summary of the background history of Sarah and Rayann and previous agency involvement. Further details are included later in the report when relevant to events within the period covered by this review.

SARAH

11.2 Sarah was born in 1992 - the youngest of 3 children. Sarah's childhood was punctuated with the disruption of the family moving house quite regularly, and then her parents' separation in 2003 when she was 11 years old. She and her younger brother initially lived with their mother but then moved to live with her father.

11.3 In 2006, when Sarah was 14 years old, Sarah went to live with the Ms A, the mother of her closest school friend. The circumstances which led this arrangement could not be verified as there is no record of social services involvement to regulate what in effect was a private fostering arrangement. This arrangement ended when Sarah became 16 years old who then faced the challenges of living independently. The GP notes around this time refer to Sarah feeling unsupported.

11.4 Prior to her relationship with Lloyd, Sarah had a number of relationships which lasted between a few months to 2 years – with a pattern of Sarah immediately starting to live with a new partner after the ending of the previous relationship. In 2010 Sarah gave birth to her only child, and went to live with her mother until she was allocated her own tenancy. Sarah's relationship with the putative father had ended during the pregnancy.

Previous Agency involvement

11.5 The police were involved on two occasions in 2011 and 2014 to deal with arguments between Sarah and her then boyfriend [4] – the second when Sarah reported that she had been assaulted.

11.6 Mental health services were involved briefly in 2014 and 2015 when Sarah was experiencing low mood stemming from trying to balance the pressures of looking after her child alongside work. In 2016, Stoke-on-Trent City Council Children's Services provided support under the child in need processes when Sarah felt unable to care for her child because of these pressures and some difficulties in coping with the child's challenging behaviour.

11.7 This resulted in Sarah's child spending a short period with the grandfather and family, before moving to live with the grandmother and step grandfather in Staffordshire for approximately 2 years. This was at Sarah's request because she believed this would be in the child's best interests. From July 2017, Staffordshire County Council Children's Services provided support to the family in meeting her child's needs, who although happy to live with the grandmother, was struggling with being separated from Sarah.

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[4] The boyfriend in 2011 and 2014 were not the same person

11.8 Sarah’s child returned to live with her around January 2018 when she obtained new accommodation and Staffordshire County Council Children’s Services ended its involvement in June 2018 because of difficulties in engaging with the family.

RAYANN AND LLOYD

11.9 Rayann has 4 adult children living in Jamaica from a previous relationship. She became good friends with Lloyd in 1992 and they later became a couple in 2000. Their first child was born in 2001. After Lloyd came to the UK in March 2002, and was living with his mother and sisters in Birmingham, Rayann and their child joined him in August when Lloyd's extended family moved to other accommodation.

Involvement of Birmingham Children's Services 2005 - 2007

11.10 Birmingham social services became involved in December 2005 when Rayann was pregnant with their second child having disclosed that she was in a violent relationship with Lloyd.

11.11 During subsequent Section 47 enquiries [5] Rayann made allegations of previous incidents of serious physical abuse which she had not previously reported partly because of coercion from Lloyd and his family, and because of her insecure immigration status. She also alleged that Lloyd had been involved in violence as a gang member in Jamaica.

11.12 During the subsequent Section 47 enquiries, Lloyd made counter allegations that Rayann had been equally violent within the relationship. The names of their child and unborn baby were placed on the child protection register but removed 2 months later when it was concluded that the domestic violence was historic and there was no evidence of recent incidents. The case was closed by children's services shortly afterwards.

11.13 The case was re-opened six months later in October 2006 when Rayann and the children were placed in accommodation by the asylum seekers team after she reported that Lloyd had threatened her. The outcome of a further core assessment was that the children appeared well cared for and it was safe for Lloyd to have contact. The conclusion of enquiries carried out by Interpol was that the allegations about Lloyd's violent history in Jamaica were malicious, and the police in the UK were also not pursuing any investigations.

Rayann's move to Stoke-on-Trent in 2006

11.14 Later in 2006, Rayann and the children were re-housed in Stoke-on-Trent, with Birmingham social services ending its involvement in April 2007 when it was judged that Rayann was settled and appropriate support was in place. During 2007 Rayann and Lloyd resumed their relationship with Lloyd staying at weekends until he moved in on a permanent basis in 2012.

11.15 From Rayann's perspective the following 4 years were the best years of their relationship. However, the relationship deteriorated because of arguments about Lloyd's alleged gambling which led to mounting debts. The arguments reached crisis point in November 2017 when Rayann discovered that they had accrued very high rent arrears.

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5 Children Act 1989

12. CHRONOLOGY

Introduction

12.1 Although Sarah is the main subject of this DHR because of her murder, the narrative of key events necessarily covers the response to Rayann's allegations of domestic abuse during the review period, because of the implications in terms of the possible risks to Sarah and her child that agencies needed to consider.

Timeline

12.2 In January 2018 Lloyd moved out of Rayann's home and moved in with Sarah. It remains unclear as to the circumstances which led to this development as Rayann provided 2 different explanations. She told agencies at the time that this was because of the breakdown of their relationship, but her explanation to the DHR Author was that she had asked Lloyd to leave because the amount of housing benefit was being affected by his income being taken into account. However, Lloyd continued to visit her each day to help with the children and household tasks.

12.3 In March 2018, after discovering that Sarah and Lloyd were in a relationship, Rayann visited Sarah who confirmed that he had been living with her since January 2018, and that Lloyd had told her that he and Rayann had been separated for over a year. When confronted by Rayann later, Lloyd moved all his belongings out but continued to come round to help her as before, and according to Rayann they continued to have a sexual relationship. Around this time, paramedics attended on one occasion after Rayann's elder child reported that her mother was attempting to overdose. Rayann explained that this was due to her being upset about the situation.

12.4 During April, Rayann made further visits to Sarah after discovering that Lloyd had told Sarah that he was no longer seeing Rayann. Rayann also sent Sarah a letter warning her about Lloyd because of the domestic abuse that she had experienced previously.

12.5 In late April, the police visited Sarah's address in response to calls from Lloyd reporting that Rayann was causing a disturbance outside Sarah's house, and later that he had been assaulted when returning the children. Lloyd also alleged that 2 days previously Rayann had come to the house with a knife threatening to hurt Sarah but they had not reported this at the time. [6] Rayann's younger child had also rung to report that the parents were arguing. Rayann was taken home and agreed to stay away from Lloyd who was given contact numbers for the National Centre for Domestic Violence (NCDV) so he could seek advice about getting a non-molestation order. He was also referred to Victims Gateway.

12.6 In early May, Lloyd moved back to live with Rayann after Sarah had given him an ultimatum to choose between her and Rayann.

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[6] Further details of the alleged incident involving a knife were given by Sarah when she provided a statement of evidence in June when police officers attended in relation to a subsequent reported incident.

Response to Rayann's allegations of domestic abuse and sexual assault

12.7 In early June, Rayann was taken to A&E by paramedics who responded to a 999 call and found her unable to move at the bottom of the stairs at her home. During their attendance, Rayann alleged that Lloyd had pushed her down the stairs, he had raped her the day before, and that she had experienced domestic abuse throughout their 17 year relationship. Rayann also disclosed this information to hospital staff which led to a nurse completing a written referral to ARCH, who were at that time the commissioned domestic abuse support service in the city, for support to be provided by an Independent Domestic Abuse Advisor (IDVA).

12.8 Rayann repeated the rape allegation when interviewed by the investigating police officer at hospital later that day, and that this was the cause of the argument that resulted in his pushing her down the stairs. Lloyd was arrested for both offences that same day, and pending further enquiries was given police bail with conditions that he resided overnight at Sarah's address and did not have any direct or indirect contact with Rayann.

12.9 The Police IMR included the information that a Domestic Investigation Assessment Log (DIAL) [7] was submitted by the attending officer with an automatic score of 10 because Rayann did not engage with the DIAL process and would not answer the standard set of questions. In addition, a referral was made to the Multi Agency Safeguarding Hub (MASH) in respect of Rayann's children. This included information that Rayann may have suffered life changing injuries, and her allegations of physical, mental and sexual abuse during the 17 year relationship.

12.10 However the initial fears about the possible extent of Rayann's injuries did not prove to be the case with MRI and CT scans revealing no traumatic injury only a slight disc protrusion. By teatime, Rayann had recovered sensation to her limbs and was able to move leading to her being discharged home accompanied by the police later that evening.

12.11 The following morning, the Police OiC visited Rayann at home to offer her the opportunity to attend an "Achieving Best Evidence (ABE)" video interview. [8] However, Rayann declined this offer and instead provided a statement of evidence saying she was not willing to disclose any further information about her allegations, nor agree to a medical examination, nor support the police investigation any further. Rayann was clear that she was taking this stance of her own free will, she did not want there to be any impact on her children and she did not want to stop Lloyd seeing them.

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7 The DIAL used by Staffordshire Police was similar to the Domestic Abuse, Stalking and Harassment and 'Honour'-based violence Risk Indicator Checklist (DASH RIC) developed by Safe Lives which is used by most police forces in the UK. Staffordshire Police have recently adopted the use of the DASH RIC.

8 "Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and using special measures" Ministry of Justice (2011) http://www.justice.gov.uk/downloads/legislation/bills-acts/circulars/achieving-best-evidence-circular-2011-03.pdf

12.12 That same day, when interviewed with his solicitor, Lloyd would not provide an account in relation to either of the alleged offences giving “no comment” answers to all questions put to him. Similarly, when Rayann was seen that day, she would not provide an account, nor consent to a medical examination, and was not willing to make a formal complaint or support the police investigation.

12.13 Later that day, given the evidential difficulties in progressing an investigation, because there were no witnesses, and no injuries had been found, a decision was made by the police to take no further action, with Lloyd being released and his bail cancelled.

12.14 However, Lloyd was served with a Domestic Violence Protection Notice (DVPN) as a protective measure. Two days later, a Domestic Violence Protection Order (DVPO) [9] was made at North Staffordshire Magistrates Court which Lloyd did not try to contest. Rayann was said not to be in agreement with the police taking this step. An update was immediately sent to the MASH confirming these outcomes and that her case was to be considered at a Multi Agency Risk Assessment Conference (MARAC). [10]

12.15 When served with the DVPN, Lloyd showed the Police OiC some text messages which Rayann had sent him while he was in police custody on the first day. These revealed that Rayann had told Lloyd that she had not yet provided a statement, but she would do so unless he contacted her. Lloyd had

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9 The provisions covering the use of DVPNs and DVPOs are set out in Sections 24-33 of the Crime and Security Act (CSA 2010) and were implemented in March 2014.

A DVPN is an emergency non-molestation and eviction notice issued by the police to a perpetrator is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served, an application made by police to a magistrates’ court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days.

For more information see - https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

10 A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety through the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.

For more information see https://safelives.org.uk/practice-support/resources-marac-meetings

not been able to access these at the time because the police had removed his phone, but he had found them after he had been bailed and his phone returned. Lloyd also described threats that Rayann had allegedly made to Sarah, and showed the letters that she had been sent by Rayann.

12.16 Later that day, Rayann later contacted the Police OiC to say she had changed her mind and she did now wish to make a formal complaint. Arrangements were made for an ABE video interview the following day.

12.17 That evening, police officers visited Sarah after she reported that Rayann was banging on her door, that this had happened many times before and that Rayann had made threats towards Sarah because Rayann wanted Lloyd back. Rayann was given strong advice to stop doing this, and Lloyd was given the contact details for the National Centre for Domestic Violence (NCDV) and also ARCH Domestic Abuse services. Lloyd later rang Staffordshire Victims Gateway requesting support with applying for an injunction.

12.18 The following morning during the ABE video interview, Rayann stated that Lloyd had been violent from "day one", was a "control" person, who would use weapons. She alleged he had stabbed her, cut her, burnt her with a spoon, and "a long time ago" had smashed her face with a hammer. She said Lloyd was dangerous but she loved him. Rayann also said she was afraid of what Lloyd could do and that he would kill her children in Jamaica.

12.19 A medical examination was not carried out due to the fact that by this time, Rayann was outside of the "forensic window", [11] but she did give permission for the police to access her health and social services records.

First involvement of Children's Services

12.20 The following day, a Friday, a social worker from Stoke-on-Trent Children's Services visited Rayann to follow up the referral from the police received via the Multi-Agency Safeguarding Hub (MASH) about Rayann's allegations of the assault and rape.

12.21 During that visit, Rayann repeated her allegations, citing examples of previous abuse which had led to her being placed in refuges in Birmingham and Coventry. She also shared information that Lloyd was living with a new partner who had a young child. Appropriate advice was given on how to keep herself safe and report any contact attempted by Lloyd.

Children's Services contact with Sarah

12.22 On the Monday following the Friday social worker visit to Rayann, an internal referral was made to the Safeguarding Referral Team (SRT) for an urgent assessment in respect of Sarah's child. This visit was carried out immediately, with Sarah described as being "shaken" when informed of the allegations. The social worker was unable to speak to Lloyd because he was at work. When Sarah refused to take her child to his grandparent's address, she was advised

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11 National guidance explains that forensic evidence becomes weaker or disappears as time passes, particularly after 36 hours. However, depending on the jurisdiction, evidence may be collected up to 7 days after rape.

not to allow Lloyd to stay while the allegations were being investigated. At this point Sarah explained that Lloyd had been bailed by the police to her address.

12.23 Children's Services contacted the police to explain that he needed to move elsewhere temporarily in order to safeguard Sarah's child, but also to avoid putting Lloyd in a position where he would be in breach of his bail conditions. Lloyd had also contacted the police to raise the potential breach of bail issue. Further checking by the police established that Lloyd was no longer on bail following the NFA decision. However several attempts to make contact with Lloyd and Children's Services to share this information proved unsuccessful. During the evening, Sarah telephoned the Emergency Duty Team (EDT) for an update who agreed that Lloyd could remain at the address overnight after receiving assurances from Sarah that she could keep her child safe, and that she should ring the social work team in the morning.

First IDVA visit to Rayann

12.24 Meanwhile, during the IDVA's first visit to Rayann the same day, Rayann described her relationship as always having been violent, and pointed to the area around her eye when describing an alleged assault when Lloyd was said to have hit her with a hammer. Rayann also said Lloyd had stabbed her in the past and scalded her with a hot spoon. Rayann said she had reported incidents but had always retracted her allegations because Lloyd had threatened to harm her daughters in Jamaica.

12.25 The IDVA recorded that Rayann was extremely distressed and visibly shaking when talking about the alleged assaults and when voicing her confusion as to why Lloyd had sexually assaulted her because it was the first time he had done this. Following the meeting, the IDVA exchanged emails with the police officer regarding the DVPO, and the MARAC co-ordinator to check a referral to MARAC had been made.

12.26 Late that evening, Lloyd rang the police to report that Rayann had approached him when he left work and he was worried about the implications of this in relation to the DVPO. Appropriate advice was given, and the police officer in charge of the investigation (Police OiC) updated.

Rayann's retraction of her allegations

12.27 Two days later, Rayann went to the police station of her own accord and made a written statement to the Police OiC withdrawing her allegations in respect of both the physical and sexual assaults, now saying that she had accidentally fallen down the stairs and that the sex was consensual. Rayann stated that she had made the allegations up because she and Lloyd had been having problems in their relationship for several months and she had been feeling angry.

12.28 It was noted at the time, that Rayann appeared "emotionally upset" and a decision was made that an investigating officer would speak to Rayann to ensure that she was making this disclosure of her own free will, and had not been coerced in any way. The updated crime report later noted that Rayann had been told that her original allegations would not be investigated any further.

12.29 However, during the social worker's next visit, a distressed Rayann maintained that the allegations were true but she had retracted because of the reaction and pressure from her younger child who was worried that Lloyd would be sent to prison. When seen alone by the social worker, the younger child was worried and confused having found the documents relating to the charges against Lloyd, because he had denied the allegations and Rayann would not talk abut them. Children's Services drew up a contingency plan to invoke child protection enquiries if Rayann and Lloyd were to reconcile, and for the social worker to complete work with Rayann to explain their concerns.

12.30 Rayann subsequently provided the same explanation to the IDVA. Rayann also explained the visits to Sarah and the letter sent, to warn Sarah about Lloyd. Sarah's response was said to have been that if this was true, why had Rayann stayed with him. During this IDVA visit, a DASH Risk Identification

checklist (RIC) [12] was completed, which produced a score of 16. An individualised Safety & Support Plan was drawn up and referrals made to Savana [13], ARCH Sunrise service, and for a Fire Service check (FARRS). The IDVA explained how Rayann's case would be discussed at MARAC the following week.

12.31 Over the next 2 weeks, Lloyd twice informed the police that Rayann had kept turning up at his place of work despite the DVPO being in force. A statement of evidence was taken and Rayann was informed that his allegations of harassment were being investigated and a voluntary interview (VISP) would be arranged. A DIAL was completed with a score of 11 and a referral made to the MASH.

Children's Services further attempts to engage with Sarah

12.32 Two weeks after the initial visit to Sarah, the social worker telephoned her to try and progress the assessment, but Sarah said that there was no need for their involvement because the allegations against Lloyd had been dropped, and she ended the call abruptly. Sarah repeated this response when the social worker rang again the following day. When the social worker shared her concern that Sarah might not be in possession of all the facts and would like to go through the information with her, Sarah's response was that Lloyd had told her everything. Sarah asked to speak to a manager because she was unhappy with the time lapse since the last contact, and her view was that the intervention had been handled badly. Sarah subsequently lodged a formal complaint.

First consideration of the case at MARAC

12.33 At the end of June, the case was considered at MARAC when full information was shared by the IDVA, children's services and the police. It was noted that separate assessments were continuing in respect of Rayann and Sarah's children, and that Children's Services had requested background information from Birmingham.

12.34 After listing all the possible risks in respect of Rayann, Sarah and their respective children, the outcome was the standard request for agencies to update their records to assist monitoring and investigation of any further incidents. Consideration should also be given to issuing a DVPN if there were to be further incidents after the expiry of the DVPO in early July. It was also recorded that the MARAC Team would check if Rayann and Lloyd had ever been discussed at Birmingham MARACs. After the meeting, the social worker requested a call back from Sarah because there was more information to share with her, and also to discuss her complaint.

Response to Rayann's explanations about the reasons for her retraction

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12 "DASH" is the shorthand for "Domestic Abuse, Stalking and Harassment and 'Honour'-based Violence Risk Indicator Checklist (DASH RIC)

13 Savana is a charity providing free counselling and support services for anyone from the age of 4 who have been affected by sexual violence and abuse. For more information see https://www.savana.org.uk/

12.35 The day after the meeting, during the voluntary interview with the police regarding her alleged harassment of Lloyd, Rayann explained that she had retracted her allegations because Lloyd had made threats that he would harm her adult children in Jamaica.

12.36 In early July, Rayann repeated this explanation to the IDVA and that her retraction stemmed from a meeting with Lloyd 2 days previously after he had made contact via their younger child. Rayann had not been able to make the retraction the following day, and so when she met Lloyd again it was then that he allegedly made the threat to harm her children in Jamaica. Rayann had then made her retraction later that day. Rayann was advised by the IDVA to avoid all contact with Lloyd after she explained about the harassment investigation.

12.37 During the IDVA's visit, a police officer rang Rayann to say that she would be collected the following day for a video interview about why she had retracted her statement. However, when the IDVA texted the officer to find out more about this, she received a reply saying that this would no longer be going ahead as the OiC had said this had already been done and there was no evidence to support Rayann's claims of her retraction being due to intimidation. The IDVA sent a text reply to the police officer voicing her concerns about the effect this would have on Rayann.

Response to further reports of Rayann contacting Lloyd and Sarah

12.38 In mid July, police officers attended Sarah's address after Lloyd reported that Rayann was shouting outside and trying to gain access. Rayann explained that she was trying to obtain lunch money for her children. Advice was given to both parties and a DIAL completed with a score of 8. The officers recorded that Lloyd had been referred to the National Centre for Domestic Violence (NCDV) for consideration of a non-molestation order.

12.39 The next morning, Sarah rang 999 to complain that she was being harassed by Rayann who had shouted at her in public which had upset Sarah's child. Officers were unable to attend immediately and maintained contact with Sarah over the next few days until they were in a position to attend when Sarah complained that the harassment of her and Lloyd was getting worse.

12.40 At the start of August, Lloyd rang 999 around midnight to report being assaulted by Rayann and that he had sustained a small cut below one of his eyes. The police were unable to attend due to other urgent calls and an ambulance was despatched. Lloyd informed the paramedics that he had been hit over the head by Rayann using a vape and her hands. Lloyd was seen by police officers a week later and a DIAL completed with a score of 11. A referral was made to Children's Services in respect of the 2 children. Rayann was arrested the following day and bailed after denying the alleged offence.

12.41 Rayann's account given to the IDVA a few days later was that she had gone to see Lloyd after work to gain details about his income for her universal credit application. When Lloyd refused to give these, they continued walking and the conversation became heated. Lloyd was holding her by her collar, hitting her and bit one of her fingers on her right hand which had drawn blood. The IDVA was shown the wound between her middle and fourth finger. Rayann was adamant that she would not use violence against Lloyd and had never been a violent person. She referred to her arthritic hands and the difficulty she has in holding things or making a fist. Rayann gave consent for the IDVA to liaise with the police about this incident.

12.42 In the third week of August, Children's Services received the records from Birmingham Children's Services. Further details of what these revealed and the extent to which they were drawn on will be covered in the DHR analysis later in the report.

Further referral to MARAC by the IDVA

12.43 During the IDVA's visit in early September, Rayann referred her to her elder child being verbally abusive towards her, and also described two serious incidents where the child had made physical threats towards her. Rayann shared her view that Lloyd was trying to control her through the children because the change in the elder child's behaviour coincided with his resuming contact with Lloyd. The IDVA responded to these disclosures by submitting a referral and risk assessment form to the MARAC which had shown a risk score of 15.

12.44 Although the referral was principally in respect of the risks posed by the elder child, the referral also included Rayann's claim that during the incident in August which led to her arrest, Lloyd had told her he should have killed her a long time ago, and it was "a big mistake" on his part. Following the visit, the IDVA provided a verbal and email update to Children's Services confirming the MARAC referral, and requesting that they make urgent contact with Rayann that day. The IDVA's records made the observation that throughout the visit, Rayann was distressed and crying.

Children's Services assessment of risk in respect of Sarah and her child

12.45 Four days later, the social worker and team leader involved with Sarah and her child reviewed the situation, noting that there had been no evidence of domestic violence within Lloyd's relationship with Sarah, and although she was refusing to engage, the threshold for a strategy meeting was not met at that time. It was agreed that they would wait to see if Sarah attended the meeting offered to discuss her complaint, and that if lateral checks with the school did not reveal any concerns, the case would be closed and a letter sent to Sarah responding to her complaint. If concerns were to escalate, a strategy meeting would be held.

12.46 In mid September, Rayann spent a week in hospital having been admitted with breathing difficulties and related issues. On examination soft tissue swelling was found to her right middle finger which Rayann stated was due to a domestic issue involving someone biting her finger. The social worker and youth justice team involved with the family were informed of the circumstances who agreed to follow issues up after her discharge.

12.47 At the end of September Rayann was informed that the IDVA support was being transferred to New Era as part of the implementation of the newly commissioned pan-Staffs County Domestic Abuse Service. However this did not result in a change of IDVA as the IDVA was transferred across to the new provider under TUPE arrangements. [14] Rayann also attended the initial

[14] TUPE stands for the Transfer of Undertakings (Protection of Employment) Regulations and its purpose is to protect employees if the business in which they are employed changes hands. Its effect is to move employees and any liabilities associated with them from the old employer to the new employer.

appointment with Savana and was placed on the waiting list for a counsellor. [15]

Second MARAC Meeting

12.48 In early October, Rayann's case was discussed for a second time at MARAC a month after the IDVA's referral. The meeting heard the IDVA's concerns about the risk to Rayann from her elder child, the reasons for Rayann retracting her allegations, and that Rayann had not felt supported by the police. The meeting also heard about Rayann's hospital admission and the alleged cause of her infected finger.

12.49 Children's Services confirmed that Rayann's children were now subject to a Child in Need (CiN) Plan and the records had been received from Birmingham. The plan in respect of Sarah and her child was also shared. It was noted that the Youth Offending Service would be making further efforts to engage with Rayann's elder child which had so far proved difficult.

12.50 The outcome of the meeting was the Chair's recommendation that Children's Services should convene a professionals' meeting to consider the ongoing complex safeguarding issues. It was also agreed that all agencies needed to consider whether disclosure should be made under the "right to know" test of the Domestic Violence Disclosure Scheme (Clare's Law) if Lloyd were to enter into a new relationship.

End of Children's Services involvement with Sarah and her child

12.51 Five days after the MARAC, Sarah was informed that children's services were closing the case after checks with school did not identify any concerns. A week later, a Children in Need (CiN) took place in respect of Rayann's children. This was the first of a series of meetings over the next few months.

Lloyd's application for a non molestation order

12.52 In early October, the IDVA arranged for a free consultation and a legal aid assessment for Rayann, and supported her at the court hearing, following Lloyd's successful ex-parte application [16] for a non molestation order. At the subsequent hearing, Lloyd represented himself, and was successful in getting the order confirmed.

12.53 During the remainder of October, the IDVA maintained close liaison with Rayann to check on progress the solicitor was making in preparing an application and statement for a counter application for a non molestation order that had been advised. At the solicitor's request, the IDVA took photos of some of Rayann's old injuries that had been requested by the solicitor. Rayann also disclosed more detail about the historical abuse to the social

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15 *Savana tried to make telephone contact with Rayann every 4 weeks in September, October and November to let her know she was still on the waiting list).*

16 The term "ex-parte" refers to legal proceedings that are conducted without notice to, and without the presence of, other parties affected by the proceeding.

worker showing her the scars on her hand, face and abdomen that she alleged were due to injuries inflicted by Lloyd.

12.54 Lloyd did not attend the next court hearing in December and his non molestation order was discharged. Rayann was unable to make her application for a counter order because the solicitor had not submitted the application and had not informed Rayann that she would not be attending because legal aid funding was not available for the hearing.

End of IDVA involvement with Rayann

12.55 In February the IDVA ended her involvement with Rayann's agreement after a full review and risk assessment [17] which revealed there had been no contact from Lloyd, Rayann felt safe, and continuing to receive support from Children's Services. Rayann was also about to start the ARCH "Spot the Signs" programme, and the Savana counselling. Savana subsequently closed the case after unsuccessful attempts to find out why Rayann had not attended.

Developments in Sarah's situation from January 2019

12.56 In January 2019 Sarah changed jobs and began working at an insurance company.

12.57 In April 2019, Lloyd was dismissed from his job for fighting.

[17] The DASH Risk assessment produced a score of 11.

Events during the week preceding Sarah's death

Author's Comment

The following summary is based on statements taken by the police, and the author's discussions with Sarah's family, friends and work colleagues.

12.58 On the Saturday evening, a week before Sarah's murder, Sarah video-called her father and was upset because Lloyd had accused her of having an affair as she had been on a night out with a female friend. Sarah told her father that Lloyd was leaving her and she had told him to go if that was what he wanted as she was no longer going to bow down to men as she had in previous relationships.

12.59 The following day Sarah texted the female friend to say that Lloyd was not speaking to her and that he had allegedly called her a "loose cannon and the worse mistake that he had made". Sarah said that she and Lloyd had split up, he was packing his belongings up and would be leaving.

12.60 On the Monday, Sarah was crying when she video messaged her father saying that although she had ended the relationship, Lloyd would not leave. Sarah had packed his clothes and had now given him until Friday to leave and if he did not go, she would put them in the bin. The following morning, Sarah's mother found her packing Lloyd's belongings up. Sarah said that she had had enough of being accused of seeing other people and not being trusted. Sarah also repeated that Lloyd had told her that the relationship had been a mistake.

12.61 During the afternoon, Sarah's step-mother spoke to Lloyd when she was trying to find out who was looking after Sarah's child as Sarah would have gone to work. [18] Lloyd was said to have been very angry and hard to understand because of his accent but she established that Sarah's child was with the grandmother. Lloyd then spoke to Sarah's father asking him to talk to Sarah to sort out their relationship but was told it was for Lloyd and Sarah to sort out as they were both grown adults. Later in the day, Sarah's step-mother received a video message from Lloyd who was again said to be very angry, asking why she had wanted to know who had Sarah's child. Later that evening, Sarah was told about these conversations by her father.

12.62 On the Wednesday, when Sarah's mother picked Sarah up from work she appeared to be her normal self and had had a good day at work. There was no mention of Lloyd and Sarah's step-mother assumed he had left.

12.63 On the Thursday, Sarah told her friend that she was allowing Lloyd to sleep on the sofa and had given him a week or two to find a place to live. Late that evening, Sarah and a work colleague were playing a computer game over the internet which kept being interrupted by an angry sounding Lloyd in the background. When this happened, Sarah muted the volume. When she resumed the game, she was said to have sounded quite calm and untroubled explaining that Lloyd was accusing her of having a relationship. During that week, Sarah had also told another work colleague that she could not wait to get Lloyd out of the house, and she was getting annoyed with him being there.

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18 Sarah's step-mother had rung Sarah's child's mobile phone not knowing that he had recently had a new phone and his old one had been given to Lloyd

12.64 On the Friday, the day Sarah was killed, during a drink after work with a colleague, Sarah said that Lloyd was controlling and he did not like it when she was out with other people. She said that Lloyd had left the home that morning after she had told him to leave. She was expecting him to return to the house to get his clothing before she went to her father's for the weekend. Sarah said that Lloyd's mother had called her begging her to stay with Lloyd, saying that he would change his behaviour. The colleague formed the impression was that Sarah was not afraid of Lloyd, and she seemed calm about everything that was happening.

12.65 At 20.20 hours Sarah called her father to ask if she and her child could go and stay at the weekend, rather than waiting until the Bank Holiday Monday as originally planned, because she did not feel safe on her own as Lloyd had been "hassling" her. Sarah said that Lloyd had taken his belongings and that she had got his keys back so she wanted to lock the house up and then she would not be there if he came back. Sarah's father offered to pick her up but she said that was not necessary as she had already booked a taxi to first call at home, and then go to her father's house. Sarah's father noted that Sarah sounded timid rather than her usual bubbly self.

12.66 At 22.04, paramedics and the police responded to a 999 call. Sarah was found with multiple wounds to neck and face, and efforts to save her were unsuccessful. Her child was in the house at the time.

12.67 In the meantime, Sarah's mother had missed calls form Sarah's mobile because she was at work. When she rang back Lloyd answered and said that Sarah had been seeing a man from work since February, he had just killed her and he had informed the police.

12.68 Following his arrest, Lloyd refused to provide any information and gave "no comment" replies to all questions put to him.

13. THE VICTIMS' EXPERIENCES

Introduction

13.1 Before moving onto the review findings in respect of agency involvement, it is first important to provide a brief overview of information provided by Sarah's family and friends about her life including her relationship with Lloyd. This is to ensure that the DHR keeps Sarah at the centre of this review and provides the necessary focus on how she experienced her situation.

13.2 This will be followed by a summary of how Rayann experienced her relationship with Lloyd, and the impact of the alleged abuse. This is drawn from case records of what she told professionals at the time, her statement to the police after Sarah's death, and the meeting with the DHR Chair.

SARAH

13.3 The information gathered during the review indicate that Sarah was a victim of adverse childhood experiences (ACE) and the disruptions Sarah experienced were previously summarised in the background information provided at the start of the report. Assessments carried out by social workers during the support provided in 2016 identified how the changes in Sarah's care givers had resulted in her having little in the way of emotional support from any particular source.

13.4 Over time, Sarah and her parents rebuilt their relationships as evidenced by the support from her mother in looking after Sarah's child, and the regular contact during the period covered by the DHR with both parents and their new partners.

13.5 When Sarah was able to resume care, the accounts from both family and friends was that she "adored" her child, with whom she spent large amounts of time whenever she was not working including singing, dancing, reading, and watching wildlife programmes. Sarah was also very house-proud, her house was always immaculate, and she also developed dress making skills.

13.6 After passing her GCSE exams, Sarah was always in employment and said to have a strong work ethic, often working long hours. She was well regarded during her employment with the pharmaceutical distribution company and then the insurance company, and popular with work colleagues.

13.7 From the various contributions provided by family and friends, a picture emerges of Sarah being a person who was confident person, who could be quite "feisty", and able to stick up for herself. A common perception was that Sarah always strove to be independent and deal with situations by herself. This may have been a contributory factor in the pattern of some of her contacts with professionals which saw Sarah asking for support but then not engaging when this was put in place.

Previous Relationships

13.8 As outlined earlier, Sarah had a series of relationships prior to becoming involved with Lloyd. According to the information provided to the DHR by the family and friends, Sarah experienced controlling behaviour and some physical domestic abuse during several of these relationships, most of which she did not report. Although at times some of Sarah's family had suspicions that Sarah was a victim of domestic abuse, there was rarely any certainty because Sarah was a very private person who did not talk about what was going on in her relationships. In addition, family members had little direct contact with Sarah's partners, particularly if they disapproved of her choice.

Relationship with Lloyd / Sarah's experiences of the relationship with Lloyd

13.9 It appears that Lloyd moved in with Sarah very soon after she took up her new tenancy in January 2018. Her previous partner had moved with her to this address having helped Sarah obtain this, and had supported her in taking back care of her child. However that relationship with her former partner ended within a month of their moving in. It is not known whey the relationship ended, but there is some speculation that this was because she had become involved with Lloyd whom she had met at work.

13.10 After the short period of separation in May 2018, the relationship had developed to the point where around Christmas 2018 both Sarah and Lloyd were separately sharing with her family their wish to get married and Sarah saying that she would like to have another child. However, the relationship changed after Sarah moved to her new job. Sarah told her family and friends that Lloyd was jealous because of her meeting new friends who would find her attractive, and because she was earning good money.

13.11 This reached a stage where they were regularly having “tiffs” when he was regularly accusing her of having an affair. The tensions in the relationship were exacerbated by Lloyd losing his job after which Sarah would describe how he was miserable, distant, and “off with her all the time” but she could not put her finger on what was causing this. In talking to friends about his jealousy, she described Lloyd as a “control freak” in the way he treated her.

13.12 The family never had suspicions that Sarah experienced any physical abuse from Lloyd. There were initially some concerns about the large age difference, but this dissipated as the relationship developed. A common observation was that Lloyd was always quiet, very polite, and extremely shy. He would tend to stay out of the way when Sarah’s family or friends visited to the point where they had to encourage him to join in so that they could get to know each other. Until the final week, Sarah’s father and step-mother had never heard Lloyd shout which was why they were shocked by the extent of his anger during the two phone calls in the last week.

13.13 From what Sarah told her family and friends, the plan for Lloyd to move out became a drawn out process in part because she felt sorry for Lloyd because he had nowhere else to go having lost his job. Another factor appears to have been that Sarah was dependent on Lloyd at times to look after her child when she was working long hours.

13.14 Perhaps one of the most significant observations that emerged from the police interviews was the change in her mood and demeanour just prior to her murder with her moving from appearing to be untroubled about the situation to being quite anxious when Lloyd refused to leave and started to “hassle” her.

RAYANN’S EXPERIENCES OF HER RELATIONSHIP WITH LLOYD

13.15 During the meeting with the DHR Chair, supported by the IDVA, Rayann was very open about the history of her relationship with Lloyd, and her feelings about how she experienced different aspects of this. The DHR Chair wishes to place on record his appreciation that this was not easy for her and recalling some events caused her some upset. It is important to note that Rayann’s descriptions of how she experienced events and the dilemmas she faced at different points, largely mirrored those recorded by the IDVA and social worker.

13.16 In recounting the background to some of the specific allegations of previous abuse, a significant issue which Rayann had previously shared with the IDVA, was how she had become isolated over the years because of Lloyd’s controlling behaviour - dictating who she could see and what she could do. As a result she had no support network other than professionals.

13.17 It also appears that Rayann was a victim of economic abuse both during the relationship, and after. In the final year of their living together, Lloyd’s secrecy about the management of their finances, and the large debts caused by his alleged gambling, had a significant adverse impact on Rayann’s life because it not only placed the tenancy at risk but also caused her huge emotional distress. It appears that the economic abuse, and Lloyd’s controlling behaviour, continued after he left given his alleged unwillingness to provide Rayann with the financial information she needed to claim for benefits to support herself and the children.

13.18 The records of different professionals’ contact with Rayann provide insights about the adverse impact on Rayann - first because of the discovery of Lloyd’s

new relationship, and then the alleged physical and sexual assaults in June. As recorded by the IDVA at the time, Rayann struggled to make sense of the reasons for the alleged sexual assault in June which she was unable to shut out of her head, leaving her feeling very low and unable to sleep. The anger and hurt caused by both developments is evidenced by the number of times she visited Lloyd and / or Sarah.

13.19 Rayann was quite open with the DHR Chair, and in statement to the police after Sarah's death, in admitting that a large part of the motivation for her actions was the hope that she could get Lloyd to return, and that still loved Lloyd despite everything that had happened. Offsetting the arguments and the abuse over the years was Rayann's description of what she termed "another side of Lloyd" that he was a good father, and a supportive partner who helped in the home, with the shopping, and driving her and the children to school or work. Rayann described to the DHR Chair how she had felt "joyous" when Lloyd returned to live with her in May 2018.

13.20 However, that feeling was shattered by the alleged sexual assault in June. During her contacts with the IDVA, Rayann described how this had developed into an anger whereby she needed to get her life back so that she could break the chain that held them together otherwise he would come back and shame her again. Rayann said she could face the cuts, kicks and being pushed down the stairs but not the sexual abuse. The IDVA recorded at the time that this change in mindset appeared to coincide with Rayann feeling empowered, recognising that she was beginning to take back control, was feeling less isolated and beginning to build a support network.

13.21 A key issue to be noted at this point when this report moves onto the analysis of Rayann's contacts with the police, is her description to the IDVA and social worker of the internal struggle she experienced as to what to do for the best following the alleged assaults. She felt torn between doing what she thought was right in terms of reporting the abuse, and avoiding doing anything which would upset the children. Adding to this dilemma was her real fear that Lloyd would follow through on his threats to harm her adult children in Jamaica based not just the abuse she alleges she experienced but also her knowledge of his involvement in violence before coming to the UK.

14. INTRODUCTION TO THE DHR FINDINGS

INTRODUCTION

14.1 The following sections listed below, provide an analysis of agency actions in response to key developments in the case, having regard to the key lines of enquiry set out in the DHR terms of reference, and include the learning identified as a result of the DHR findings:-

(i) Health agencies awareness of and response to possible domestic abuse;

(ii) Staffordshire police response to Rayann's allegations of domestic abuse;

(iii) Response to Rayann's retracting her allegations;

(iv) Risk assessment and management in respect of Rayann and her children;

(v) Agency action to safeguard Sarah and her child;

(vi) Response to Lloyd's reports of being a victim;

(vii) Overview of multi-agency working and risk assessment.

15. HEALTH AGENCIES RESPONSE TO POSSIBLE DOMESTIC ABUSE

Introduction

15.1 The analysis considers the line of enquiry in the DHR terms reference regarding health professionals' awareness of domestic abuse, and whether appropriate sensitive questions about this are asked routinely. The exploration of this takes as a benchmark the Department of Health guidance issued in 2017 to help health professionals recognise and respond to domestic abuse. [19]

WEST MIDLANDS AMBULANCE SERVICE (WMAS)

15.2 WMAS demonstrated good practice during their attendance in June 2018 in documenting fully Rayann's presentation, the results of assessments carried out, and the details of Rayann's disclosures – both the current incident but also her report of previous abuse. The paramedics immediately informed the police, recording that the latter would be dealing with the safeguarding issues, and they also passed on full information to staff in the hospital A&E unit.

UNIVERSITY HOSPITAL NORTH MIDLANDS (UHNM)

15.3 It was good practice that a nurse provided Rayann with the domestic abuse safety pack and made the referral to ARCH using the standard ARCH referral form. This was picked up two days later by the senior domestic abuse practitioner whose role included liaison with the hospital. [20] The referral provided a summary of the allegations made by Rayann and that she had been discharged from A&E and had left with the police.

15.4 It is a concern however, that there was no copy of this referral stored in the patient notes, which is a requirement in UHNM's policy covering domestic abuse, nor any reference in the hospital records to this referral having been made. These only refer to the police being involved and the comment that Rayann did not want to report the domestic violence at this time. There was no reference to the disclosures of previous abuse, nor the information in the ARCH referral that Rayann's children were safe.

15.5 The DHR heard from UHNM that a reference to the referral having being made should have been entered in the patient notes, but that at that time there was no guidance which also required a copy of the actual referral to be saved there. This has since been addressed, and is now a requirement, as a result of the updating of UHNM's policy in 2019 covering the revised arrangements for making referrals to New Era.

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19 "Responding to domestic abuse - a resource for health professionals" – Department of Health 201

20 The arrangement for referrals made by UHNM was that these would be left in a confidential tray to be collected by the Senior Domestic Violence Advisor from New Era (previously ARCH) whose role included liaison with the hospital and visiting there several times each week.

15.6 Given that Rayann was admitted following an assault, UHNM's Individual Management Report for the DHR (IMR) made the observation that in line with the DoH guidance, completion of a body map would have been expected to evidence any bruising, wounds or signs of healed injuries. However, the proforma body map within the records had not been completed. In addition, and again as set out in the national guidance, it would also have been expected that there would be documentation covering the patient's emotional and behavioural state. However, there was no reference to this within the notes.

15.7 Further checks of the hospital records during the DHR established that CT scans carried out in April and June 2018 [21] had identified a 'metallic fixation of the right inferior orbit' (metal plate around the eye socket) which was an old injury from before Rayann's move to Staffordshire. The DHR noted that it was possible this treatment could have been related to the alleged hammer attack around 2003 referred to earlier in the report. UHNM confirmed that there was no indication that there was any exploration with Rayann about the circumstances leading to that surgical procedure, and explained that further information would usually only be sought if it was relevant to the injury that was being dealt with at the time.

Hospital Discharge Letter

15.8 It is also a concern that the A&E discharge letter only refers to Rayann being pushed from the top to the bottom of the stairs, and there was no reference to the allegations of domestic abuse and the involvement of the Police. The UHNM representative surmised that this was possibly because the doctor completing the letter was not aware of everything Rayann had disclosed because of the limited information in the A&E notes. However, these had referred to domestic abuse and police involvement.

15.9 In contrast to this admission, it was good practice that information was recorded about the historic allegations of abuse during Rayann's September admission after Rayann disclosed that the origin of her infected finger was Lloyd having bitten it during a domestic related incident. Rayann's disclosures of past abuse included her reporting that this had resulted in her suffering a fractured right cheek bone and a fractured left scapula. [22]

15.10 However, it does not appear that this prompted any further enquiries, for example looking for any references to these in her hospital records, or to consideration of completing a body map with Rayann's consent to examine the areas where the injuries were alleged to have been sustained. The DHR were informed by UHNM that in part this was because Rayann confirmed that she was no longer in a relationship with Lloyd, but also because UHNM standard practice is not to ask patients if staff can examine areas of the body where injuries from domestic abuse are alleged to have been sustained in the

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21 These scans were carried out when Rayann attended the hospital with an injury to her arm. sustained from a fall whilst shopping The record stated the injury was suggestive of a non-displaced fracture of the humerus.

22 This information was included in the assessment section completed by the doctor under the heading past medical history.

past. Nor would staff go through the patient notes to look for any information about past injuries.

15.11 It was positive however that checks were carried out which revealed that Rayann was no longer in contact with Lloyd, and she had IDVA support. It was also good practice that information was shared with the social worker and Youth Justice Team to ensure they were aware of the admission, who confirmed the issues would be followed up and ensure appropriate arrangements were in place for the children.

15.12 UHNM confirmed that this information was not shared with the police – partly because the alleged incident occurred 2 weeks prior to admission to UHNM, but also because UHNM would not have reported it to the police unless Rayann had asked them to and gave her consent. The hospital records did not contain any information as to whether Rayann was asked whether she wanted the police to be informed. The implications of information not being shared with the police in this case will be picked up later in the report which considers the police response to that incident when Lloyd reported the alleged assault by Rayann.

Conclusions and Learning

15.13 As a result of issues raised during this DHR, UHNM IMR has already identified five recommendations for its own agency:-

1. Where there is a disclosure of domestic abuse a full account should be entered into the medical notes, followed by what actions have been taken;
2. Notes should evidence that where domestic abuse is a potential factor consideration has been given to any children in the household or other vulnerable adults;
3. A persons demeanour, emotional state and behaviour should be recorded in the medical/nursing notes where deemed necessary and appropriate;
4. Staff require reminding of the importance of completion of body maps;
5. Discharge letters to GP should give a full account of any disclosures made regarding domestic abuse and any actions taken.

15.14 There are 2 further issues from the DHR findings which merit further consideration by UHNM and the Community Safety Partnership. The first is whether staff are encouraged to be proactive in checking if patients wish information to be shared with the police, or other relevant agencies, rather than leaving the onus with the patient to request this. The second is whether there are any situations where concerns about possible domestic abuse should lead to staff to look back through a patient's records to identify any previous history.

PRIMARY CARE

15.15 Rayann was well known to the GP practice and had frequent contact in 2018 regarding the management of some long standing health issues. According to the electronic summary in the GP records, Rayann never shared any information regarding any abuse, either recent or historic, or referred to any problems in her relationship with Lloyd.

15.16 The DHR was also informed that the GPs had never noted any evidence of old injuries. The CCG representative on the DHR Panel made two observations in relation this. First, Rayann has both rheumatoid arthritis, and other health conditions, which would make her present with joint deformities and potential skin reactions. These could potentially have masked any previous injuries. Second “top to toe” skin integrity assessments, or body maps are not routinely completed in primary care.

15.17 The CCG IMR included its assumption that the GP was aware of the historic allegations of domestic abuse because the GP records included those transferred from Birmingham. Examination of the GP records by the CCG established that these included just one letter sent by the Asylum Seeking Service Nurse from Stoke on Trent in February 2007 regarding a surgical procedure that Rayann could not have done in Birmingham as she had been relocated to Stoke due to domestic abuse.

15.18 Given the above findings, it would have been important for the GP practice to be informed through the hospital discharge letter of the full circumstances of Rayann’s admission, and her allegations. This would have enabled the GP to be alert to any indicators of possible abuse, either during direct contacts, or through information received from other agencies, and then follow national guidance in exploring these further with Rayann. While the possibility of domestic abuse might have been inferred from the description in the letter that she was pushed down the stairs, this was not spelled out explicitly.

15.19 Nevertheless, given that description, it could have been expected that the GP would have shown more professional curiosity, and explored the circumstances of the fall in the next contact with Rayann. While agreeing with that finding, the CCG representative made the observation that a contributory factor to this not being explored was that Rayann had a history of “falls and fits” because of her long term arthritic condition.

15.20 It is also a concern that the GP summary record in August 2018 regarding the prescribing of anti-biotics for Rayann’s infected finger, did not record that the UHNM discharge letter had confirmed this was following a human bite. This was significant information given the history of alleged abuse. Again, there is no evidence that the potential significance of this was picked up, or attempts made to explore the circumstances with Rayann. The CCG representative agreed that this should have been explored further.

Conclusions and learning for Primary Care

15.21 The CCG IMR did not initially identify any learning or recommendations from its examination of the records both in respect of the different GP practices involved with Sarah, Rayann and Lloyd. In respect of Sarah, the CCG IMR explained that this was because the GP Practice response to any clinical matters was timely and appropriate, and the GP practice had not picked up, or been informed, of any issues around possible domestic abuse.

15.22 However, as the DHR progressed, the CCG picked up the issue of the lack of curiosity shown by the GP practice involved with Rayann, and made a single agency recommendation that the practice should hold a reflective practice session around this facilitated by the Named GP for Adult Safeguarding.

15.23 One additional area of learning that this DHR has identified is the importance of CCG IMR authors holding discussions with the GP in preparing their IMR to

supplement their examination of both the electronic and paper records. That did not happen in this case.

15.24 One consequence of this omission, as covered earlier, was the CCG only being able to make an assumption, and not being able to confirm, that the GP practice was aware of the historic allegations of abuse. In addition, the lack of discussion with the GP was a missed opportunity to check the wider issue of the extent of the Practice's awareness of domestic abuse issues, both specifically in respect of this case, and generally.

16. RESPONSE OF STAFFORDSHIRE POLICE TO RAYANN'S ALLEGATIONS

Initial response and subsequent NFA decision

16.1 It is evident that the police responded swiftly to Rayann's allegations in trying to obtain an account from her, and detaining Lloyd for both offences. In addition, attempts were made to complete a DIAL with Rayann, and an immediate referral was made to the MASH.

16.2 However, the police's ability to progress the investigation was hampered by Rayann's unwillingness to provide further details and Lloyd's refusal to provide an account. In the absence of any independent witnesses or other evidence, the outcome was a decision being reached very quickly within 2 days of the enquiries being initiated, that no further action would be taken in respect of both the alleged physical and sexual assaults.

16.3 In part the speed of this decision was driven by the requirements of the Policing and Crime Act 2017 which sets out that investigations should be completed wherever possible during the first period of detention after a suspect is arrested. However, making the NFA decision at that point does appear somewhat premature given the possibility that more information might emerge from the video interview arranged for the following day after Rayann had changed her mind and that she now wished to make a formal complaint.

16.4 That proved to be the case with Rayann not only providing a description of the assault and rape, but also making serious allegations about historical domestic abuse. The DHR heard from the police that these allegations of past abuse should have been investigated, and the original NFA decision reviewed, but that did not happen. The police representative informed the DHR Panel that it had not been possible to establish the reasons for this, but did confirm that the police OiC was aware of allegations having been involved in the interview, and had recorded these in the interview controller's notes.

Issue of the DVPN and application for a DVPO

16.5 It was good practice that a DVPN was served on Lloyd when his bail was cancelled and a successful application made for a DVPO. This action reflected Staffordshire Police's proactive use of these orders which was highlighted by the statistics in the 2017 report of Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) [23] that Staffordshire police was in the

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[23] "A progress report on the police response to domestic abuse" – HMICFRS November 2017

https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/progress-report-on-the-police-response-to-domestic-abuse.pdf

top 3 of forces using these orders. Staffordshire's high use was in marked contrast to the concerns expressed in the report about the low rates of the use of these orders in some police areas since their introduction in 2014.

16.6 The DHR heard from the police that the use of DVPOs brings the advantage of there being a lower threshold for demonstrating a breach of the order compared to that required to prove a breach of police bail conditions, and enables a person to be brought back to court immediately who have powers to impose sanctions for the breach.

16.7 Although the police were unable to supply a copy of the DVPN, for reasons that were not made clear, they were able to provide a detailed summary of its contents which provides helpful insights as to how the police viewed the allegations made by Rayann. The DVPN stated that the senior officer issuing the notice:- [24]
"was satisfied on the balance of probabilities that violence or threats of violence had been used against Rayann, and believed a DVPN was necessary to protect her from further violence and provide a breathing space for Rayann to consider her options and for police and partners to engage with Rayann to support her in moving forward".

16.8 If the basis of the police's justification for taking this action as set out in the DVPN is taken at face value, this seems to be somewhat at odds with the decision being reached so quickly to take no further action.

16.9 When faced with the problem of lack of support from Rayann for the investigation, and Lloyd's "no comment" responses, it does not appear that consideration was given to pursuing other possible lines of enquiry to support an evidence led investigation as set out in guidance on domestic abuse issued by the College of Policing and the Crown Prosecution Service (CPS). These will be explained further later in this section.

16.10 In addition, no approach was made to the CPS to seek advice regarding the evidential difficulties and to explore if there were possible ways of progressing the investigation. Early consultations are recommended in CPS guidance [25] where the early involvement of a prosecutor would assist in the gathering of relevant evidence.

16.11 Although Rayann gave consent for the police to access information held by health and social care agencies when she attended for the video interview and

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[24] Not below the rank of superintendent

[25] **Domestic Abuse Guidelines for Prosecutors – CPS - last updated: 28th April 2020**

https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors

disclosed the allegations of previous abuse, it does not appear that such enquiries were pursued which might have established if there was any corroboration of her allegations of past abuse, and alleged injuries she had sustained. The DHR has since established that there was relevant information within both the GP and hospital records.

16.12 It also appears that the police did not supplement their checks of national information systems by making enquiries with West Midlands Police to ascertain if they had had involvement. This may have revealed the information contained in the Birmingham Social Services records that in 2006, West Midlands Police had shared information that in 2003 Rayann had disclosed the alleged hammer attack which she had not previously reported, and in March 2006 Lloyd was arrested and charged after Rayann reported an assault and she sustained an injury to her cheek.

16.13 The significance of this information is that it shows the consistency of Rayann's allegations regarding these two incidents which she shared with various professionals during 2018 including the police.

16.14 In making the above observations, it is important to include the background context that Staffordshire police respond to approximately 25,000 domestic incidents a year and that this high volume of cases means that with the resources available within the current financial situation, it is not possible to follow up every case with the degree of partnership working set out in national guidance.

16.15 It was good practice however, that an International Criminal Conviction Exchange Request was made to Jamaica on the day Lloyd was arrested which was returned "No Trace". However, it remains possible that this result was because of the different names that Lloyd had been known by in the past which did not match those in official records such as the police national computer (PNC). Following Sarah's murder, a further check was requested which again revealed that there was no record of Lloyd having had any convictions.

16.16 Notwithstanding the lack of convictions, the DHR did establish from Lloyd's GP records that he had been caught up in violence in Jamaica because he underwent abdominal surgery in 1995 following a gunshot wound. There is no confirmed date for when this wound was sustained but there is a reference to this being said to have occurred 13 years earlier which would have been when Lloyd was a child. [26]

16.17 It is also important to note that Lloyd's capacity for violence had previously been demonstrated in 2016 when he was convicted of assaulting the female parent of one of a group of boys who had been bullying Lloyd's elder child.

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[26] This had previously been explored by children's services and the police in Birmingham in 2006 when Rayann alleged that Lloyd had been shot in the back during an incident related to Rayann's brother being murdered allegedly by Lloyd's brother-in-law.

Conclusions and Learning

16.18 The above findings lead to some important learning in respect of actions that should be considered when exploring the possibility of progressing an evidence–led prosecution, and how partnership working may be able to support this.

Evidence-led prosecutions

16.19 In situations where a victim does not support further police action, the guidance issued by the College of Policing [27] stresses the importance of officers investigating domestic abuse proactively from the outset with a view to building an evidence-led case that does not rely on that support. It makes the point that while detection is more likely to result if a victim supports police action and prosecution, there may be many reasons why a victim may not do so and it is important to extend the investigation beyond the victim.

16.20 While recognising that it may be challenging to build an evidence-led case which still has to meet the "Full Code Test" set out in the Code for Crown Prosecutors, [28] the guidance affirms that this can be achieved, citing examples of successful prosecutions which have made use of hearsay, circumstantial and / or bad character evidence.

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27 "Major investigation and public protection - Investigative development" – College of Policing

28 "Code for Crown Prosecutors 2018" – CPS – (updated October 2018)

16.21 There is also signposting to more detailed guidance and checklists for police officers and prosecutors to draw on such as the checklist on evidence gathering jointly issued by the CPS and the National Police Chiefs Council (NPCC), [29] and the CPS Aide-memoire on charging in domestic violence cases. [30] This clarifies the information required from the police to enable a decision to be made on whether a case can be built.

16.22 The extensive checklist of possible lines of enquiry includes the following which would appear to be relevant to Rayann's case:-

- gaining as much information as possible about the history of the relationship and any previous incidents of abuse;
- whether there is evidence to support a potential offence of controlling or coercive behaviour. [31]
- incidents that may have been witnessed by the children, or incidents of sexual abuse not previously disclosed;
- evidence held by other agencies such as housing services, children's social care departments, education, probation and medical professionals – the latter might hold body maps or photographic evidence of older healed injuries;

16.23 The DHR heard from a representative of CPS West Midlands region that CPS national policy is always to consider from the outset whether a case for an evidence led prosecution can be mounted, and locally this has met with considerable success, with national statistics showing that the West Midlands is the area with the highest figures for achieving these. These results reinforce the recommendation for the police to initiate early consultation with the CPS.

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29 The Joint NPCC / CPS Evidence Gathering Checklist for use by Police Forces and CPS in Cases of Domestic Abuse" 2015 can be accessed here Joint Evidence Checklist

30 **"Charging (The Director's Guidance) 2013 - fifth edition, May 2013 (revised arrangements)" -**

Guidance to Police Officers and Crown Prosecutors Issued by the Director of Public Prosecutions: https://www.cps.gov.uk/legal-guidance/charging-directors-guidance-2013-fifth-edition-may-2013-revised-arrangements

31 These offences were introduced through Section 76 of the Serious Crime Act 2015. Further information is provided in the 2015 Home Office Statutory Guidance on Controlling or Coercive Behaviour in an Intimate or Family Relationship.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

16.24 However, the results of a joint inspection by the police and CPS inspectorates published in January 2020 [32] which included inspection of West Midlands CPS and Staffordshire Police, found that the handling of evidence led domestic abuse prosecutions requires improvement. A key finding was that neither the CPS or police systems identified separately, cases where an evidence-led approach had been adopted. This was therefore inhibiting robust evaluation of the effectiveness of this approach, so that lessons learned, and good practice, can be shared between the CPS and the police.

16.25 The report recommendations include the importance of police forces ensuring that training, messaging and guidance is clear that evidence led cases should benefit from the same quality of investigation, early gathering of evidence and supervisory oversight as other domestic abuse cases, particularly in cases where the victim does not support police action. It also reinforced the need for prosecutors to set out clearly at the charging stage whether an evidence led prosecution is viable and, if so, define an effective prosecution strategy.

16.26 In addition, the most recent statistics covering domestic abuse published by the CPS in July 2020 [33] has led to concerns being raised nationally by organisations supporting victims of domestic abuse. These figures showed that the number of cases referred by the police to the CPS had fallen by 12 percent in the last quarter of 2019 / 2020 compared to the previous year. [34] In addition the number of completed prosecutions had fallen by 11 per cent. [35]

Partnership Working

16.27 The College of Policing guidance on partnership working and information sharing [36] emphasises that cooperation between agencies is important to help reduce the risk of cases slipping through the safeguarding system and stopping domestic abuse at an early stage. Such multi-agency work helps to build up the whole picture, facilitating early effective risk identification,

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32 "Joint Inspection evidence led domestic abuse prosecutions" – published 23 January 2020 - HM Crown Prosecution Service Inspectorate (HMCPSI) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). https://www.justiceinspectorates.gov.uk/hmcpsi/inspections/evidence-led-domestic-abuse-prosecutions/

33 https://www.cps.gov.uk/publication/cps-data-summary-quarter-4-2019-2020

34 Pre-charge receipts from the police fell from 98,470 in 2018/19 to 86,665 Q2 RYTD - a fall of 12.0%.

35 Completed prosecutions fell from 78,624 in 2018/19 to 69,756 in Q2 RYTD, a fall of 11.3%.

36 https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/partnership-working-and-multi-agency-responses/

improved information sharing, joint decision making, and coordinated action to assess, manage and reduce risk.

16.28 The value of approaching other agencies is not just to establish if they hold further information about possible abuse which may constitute evidence, but also because on occasions they may be better placed to obtain evidence from victims – for example consenting to photographs of their injuries, or completion of body maps by medical staff at a time when they are not ready to disclose the abuse formally to the police.

16.29 This perspective is echoed in CPS guidance [37] that complainants may feel more confident and provide more personal or detailed information to a support specialist, such as to IDVA, rather than a police officer. However, in Rayann's case, it does not appear consideration was given to approaching the IDVA service to ask if through support provided to Rayann, she might be prepared to engage with the investigation.

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37 Domestic Abuse Guidelines for Prosecutors / The Crown Prosecution Service https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors

police of this development, or discuss it with the IDVA to gain her perspectives.

The IDVA's response to Rayann's retraction

17.12 In contrast to that response, the IDVA did try, albeit without success, to speak with the police OiC immediately after Rayann explained the reasons for her retraction. Although the IDVA sent an email to the police officer expressing her concern about the possible impact on Rayann, she did not pursue this further when there was no response to that email nor after Rayann provided more detail during her next visit.

17.13 It was good practice that the IDVA discussed this development with her manager but this did not result in any plan to escalate the concerns to a higher level in the police. This would have been important given the important detail that the IDVA had picked up about the contacts with Lloyd leading up to Rayann's retraction. The DHR heard that this was because at that time, the links between the IDVA service and the police were not well established. That has now changed as will be explained later in the report when describing changes to multi-agency arrangements which have taken place since this case.

Learning from this case

17.14 The above findings highlight the importance of the guidance issued by the college of policing and the CPS. These list a large number of factors which may lead to a complainant withdrawing their support or retracting their allegation. These include the following which were relevant in Rayann's case:-

- pressure from the perpetrator or other family members;
- a wish to be reconciled with the perpetrator, if not already reconciled;
- a fear of the impact on the children;
- fears that showing support for a prosecution may place them at further risk of harm;

17.15 The CPS guidance emphasises that a retraction does not mean the case should automatically be stopped and there should be careful exploration not just of the actual reasons given, but the other possible factors, particularly the possibility of coercion. A report should then be submitted to CPS, along with the retraction statement, so a decision can be made as to whether further investigation is required, and to consider any necessary options to protect vulnerable witnesses (including special measures).

17.16 That report, which may also reveal the need to consider whether further charges should be brought, or whether there has been a breach of the perpetrator's bail conditions or DVPO, should cover:-.

- the officer's views on the case, including the veracity of the statement, any suspicions of witness intimidation or pressure (if not already

included in the withdrawal statement), and a general assessment of the reasons given by the complainant;

- the officer's views on how the case should be dealt with, including proceeding against the complainant's wishes;
- how the complainant might react to being compelled to give evidence;
- details of any identified risks to the safety of the complainant, children or any other person;
- details of the support available to the complainant prior to the allegation being retracted or support withdrawn, and whether this was a reason for the change in position, for example, access to an IDVA, or other support organisation;
- whether any support organisation assisting the complainant has expressed a view; and the likely impact on the complainant and any children/dependants of proceeding or not proceeding with the case.

17.17 The other area of learning is the importance of other agencies contacting the police at the earliest opportunity when victims provide explanations for withdrawing their allegations in order to check that the police are aware of these. In addition, other agencies must escalate their concerns if they feel that their information is not being given appropriate consideration, or they have concerns that the police response may expose the victim to further risk.

18. RISK ASSESSMENT AND MANAGEMENT IN RESPECT OF RAYANN AND HER CHILDREN

Introduction

18.1 The analysis will examine in turn 4 elements of the work to assess and manage the risks to Rayann and her children:-

- the MASH processing of the referral received from the police;
- safeguarding action taken by children's services;
- risk assessment and safety planning by the IDVA;
- consideration of the case through the MARAC process.

REFERRAL TO THE MULTI-AGENCY SAFEGUARDING HUB (MASH)

18.2 It is evident from the MASH records that the latter processed the referral from the police immediately and identified that the threshold for referral to Children's Services was met. Accordingly, the MASH sent an immediate referral with the information that Rayann had alleged that she had been pushed down the stairs. At the point the referral was sent, the allegation of rape had not been received from the police. Consequently a second referral was sent with that additional information, along with the results of the DIAL, and notification of the Police decision that no further action would be taken in respect of both offences.

18.3 It should be noted at this point, that neither referral included information that Lloyd had been bailed to an address where there was a young child because

the MASH had not been informed of this by the police. The consequences in terms of action to address any potential safeguarding issues in relation to Sarah's child will be explored later in the report.

18.4 The MASH also made a referral for MARAC having identified that the threshold had been met. The assessment leading to that referral noted the seriousness of the incident, the concern that Rayann had declined to make a statement or support a prosecution, and Lloyd also declining to provide an account. The conclusion reached therefore was the likelihood that they would reconcile thereby exposing Rayann to further risk of harm.

18.5 The prompt action taken by the MASH to process the information received, and make the appropriate referrals, showed best practice to enable Children's Services to consider any potential safeguarding issues in respect of the children which required urgent follow up. This finding reflects the overall judgment contained in the most recent "PEEL" assessment by HMICFRS which rated the service as "Good". [38]

38 PEEL reports are an annual assessment of police forces in England and Wales carried out by HMICFRS assessing their effectiveness, efficiency and legitimacy.

SAFEGUARDING ACTION TAKEN BY CHILDREN'S SERVICES

18.6 Children's Services considered the MASH referral immediately it was received on the day of the incident with the decision made that an urgent assessment should be carried out. This was good practice and met the target timescale set out in the national safeguarding guidance "Working Together 2018" [39] which requires a decision to be made within one working day as to what action needs to be taken.

18.7 Accordingly the case was allocated to a social worker who was provided with a detailed list of actions to be taken. However, these did not include any timescales for completion. The finding of the Children's Services IMR was that the way in which the assessment was progressed, lacked the necessary urgency and there appeared to be a lack of insight into the seriousness of the situation, and the need to consider urgently whether it would be safe for Rayann's children to return to her care. The IMR made the observation that the information provided by the police during the first day that Rayann's injuries were not as serious as had first been thought, may also have been a contributory factor. The IMR noted that this information ought not to have impacted on the actions planned.

18.8 Although the allocated social worker did not visit the family home on the day of the incident, a visit was made by the Emergency Duty Team (EDT) that evening. However, there was no evidence of discussion between the safeguarding team and EDT to clarify the issues which needed to be the focus of the EDT visit. This may have been a contributory factor to the record of the EDT visit containing little information of any discussion in relation to contingency or safety planning for the children as would have been expected.

18.9 There was also no evidence of consideration being given to the impact of the incident for either Rayann or the children, nor exploration of any history of previous domestic abuse. The IMR finding was that the absence of a robust risk assessment, or exploration of any support networks Rayann could call on, was indicative of a lack of insight into the cycle of domestic violence and the impact for the victim.

18.10 One serious deficit in the way the assessment was progressed was that there was little direct contact or meaningful discussion in the early stages with either of Rayann's children to explore their understanding of, or feelings about the situation. Rayann's elder child was seen briefly by the EDT social worker, but that appears to have been by chance rather than a planned part of the visit. The elder child was not seen by the allocated social worker until 16 days after the incident. Rayann's younger child was not seen until 13 days after the incident, and this did not appear to have been planned as part of the assessment, but in response to a telephone call received from a teacher to share concerns that Rayann and Lloyd might be reconciling.

18.11 Given the seriousness of the incident, and the recommendation for an urgent assessment, Children's Services ought to have made immediate contact with the people who were caring for the children, and contacted all partner

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39 "Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children" – HM Government - July 2018

agencies to inform them of the incident and to make enquiries necessary to inform the assessment and plan for their safety / emotional wellbeing.

18.12 During the first visit by the social worker 3 days after the incident, Rayann made disclosures of alleged previous domestic abuse when the family lived in Birmingham, which included serious incidents of a hammer attack in 2003 and a knife attack which resulted in Rayann having to have a blood transfusion. Rayann also revealed that Lloyd was now living with a new partner and her child. Appropriate safety advice was given to Rayann not to allow Lloyd to visit while the investigation was ongoing.

18.13 However, it does not appear that Children's Services considered holding a strategy discussion with the police to share this information, and discuss the implications, both in terms of decisions to be made around safeguarding any children involved, and to enable the police to consider whether the previous no further action decision should be reviewed. This might have led to agreement to initiate Section 47 enquiries, which the Children's Services IMR explained would have been the appropriate mechanism to progress the assessment. This would have ensured that Rayann's children would have been seen as a matter or urgency, and also required timely communication with partner agencies to gather information and plan the approach to the assessment.

18.14 A strategy discussion might also have led to agreement as to what further enquiries might be initiated to check Rayann's claims of previous domestic abuse given that the DHR was informed that the police had not gathered full information about the allegations of previous abuse during its initial enquiries. Given the serious nature of these allegations, it would have been expected that Children's Services would move quickly to make enquiries to check if there was any official records to substantiate these claims to inform the assessment of risk. However, it does not appear that this happened.

18.15 The first MARAC meeting at the end of June was informed that a request had been made to Birmingham Children's Services. However, the Children's Services chronology gives the date of the request as being made 10 days after that meeting - more than a month after the alleged assaults. It is not known why this request was not progressed sooner, or whether attempts were made to speed up the response from Birmingham who in the event took a further 6 weeks to supply the records.

18.16 Although the Birmingham records had been received by the time of the second MARAC meeting, the minutes indicate that no information was shared at that meeting. Nor is there any evidence that any information was shared subsequently with either the police, the IDVA or the social workers involved with Sarah and her child. In addition, there is no indication in the social work records that the information had been drawn on to contribute to the department's approach to risk assessment in respect of either family.

18.17 It is apparent however, that the social work team adopted a dynamic approach to risk assessment as shown by the contingency plan that was drawn up following Rayann's retraction to invoke formal child protection processes if Rayann and Lloyd were to reconcile. This contingency planning, based on their assessment that Lloyd still posed a risk, was good practice.

18.18 The DHR was informed that since this case, a revised 'threshold document' has been implemented designed to promote a more consistent approach in recognising and responding to risk. There has also been considerable focus

on developing the skills of managers and practitioners in completing evidence-based assessments.

RISK ASSESSMENT AND SAFETY PLANNING BY THE IDVA

18.19 During her first visit, the IDVA responded sensitively to Rayann's distress and confusion as to why Lloyd had sexually assaulted her. The IDVA provided reassurance that it was not her fault, explaining about power and control that perpetrators seek to exercise, and that because Rayann had challenged him, he may have seen this as a threat and he needed to regain that power over her.

18.20 Although the IDVA contacted the police after this visit to check the position on the DVPO, and that a referral had been made to MARAC, the email did not include any information about the extent of Rayann's distress when sharing her allegations of previous abuse. Nor did it refer to the old injury around the eye said to have been sustained during the hammer attack. As per the earlier comments in relation to the initial social worker visit, it would have been important to check that the police were already aware of this information as it could possibly open up additional lines of enquiry.

18.21 The IDVA displayed best practice at the follow up visit in completing a comprehensive risk assessment and providing further advice on safety. This included pointing out the risks to Rayann's younger child at the times when the latter was intervening. Referrals were also made appropriately to other domestic abuse services so that Rayann could access additional specialist support.

18.22 It was also good practice that the IDVA completed a further DASH risk assessment, and immediately made a referral to MARAC, when Rayann described how her elder child's behaviour led her to believe that Lloyd was trying to control her through the children.

CONSIDERATION OF THE CASE THROUGH THE MARAC PROCESS

18.23 In considering the effectiveness of the two MARAC meetings, it is helpful that there were detailed minutes which captured all the information shared, and how this led into identification of the possible risks and the actions to address these.

18.24 Examination of the minutes revealed some issues around attendance. The first MARAC was not well attended. Although it was helpful that in addition to the police chair and police representative, the social worker for Rayann's children was present and a member of the Stoke-on-Trent Safeguarding Referral Team (SRT), it was unfortunate that the IDVA was not present to provide the victim's perspective within the discussions to supplement her written report.

18.25 At the second meeting, although the key agencies were represented, with the exception of the police chairperson, the attendees were entirely different. Although this meeting benefited from the attendance of the IDVA, neither of the social workers were present who were involved with Rayann and Sarah. Therefore the meeting was reliant on reports presented on their behalf, and the meeting outcomes being relayed back to them.

First MARAC Meeting

18.26 The first observation about the initial MARAC meeting was that although it was confirmed that the investigation into Rayann's allegations were continuing, there was no details recorded about the reasons for the no further action decision. Instead, the main thrust of the police input related to the investigation of harassment by Rayann.

18.27 The input from Children's Services included brief reference to the history provided by Rayann, and that they were waiting for Birmingham to send their records. They also addressed the reasons given by Rayann for the retraction and the difficulties she was experiencing in explaining to her children what had happened. It was noted that there appeared to be a pattern of Rayann reporting incidents, obtaining support, and then wanting to move to a new area to make a fresh start.

18.28 With regard to risk management, the minutes listed all the possible risks in respect of Rayann, and appropriate actions identified to inform the response to any further incidents. However, a gap was that there were no overall conclusions recorded in terms of how Rayann's allegations were viewed, and the assessed level of risk. However, it can be inferred that the risk was viewed as high by Children's Services given the contingency plan referred to previously.

Second MARAC meeting

18.29 There are two significant issues which require comment. The first is that the meeting took place a month after the referral submitted by the IDVA. This time interval is a concern given the extent of the dual risks to Rayann from Lloyd and her elder child reflected in the DASH high risk score of 16. This included Rayann's claim that during the August incident Lloyd had allegedly expressed regret that he had not killed Rayann and that had been "a big mistake" on his part. With the benefit of hindsight this was clearly potentially very significant information which the police and partner agencies needed to consider immediately, rather than wait for this to be drawn out at a meeting some weeks later.

18.30 The second issue relates to the IDVA sharing Rayann's explanation for her retraction, and that Rayann did not feel supported by the police. However, this was not explored further. As outlined previously, although it was confirmed that the Birmingham records had been received, no information shared as to what these contained. This was a significant gap because the DHR established that these contained important detail about the enquiries that were made into Rayann's previous allegations of abuse, and the challenges that agencies encountered in trying to establish the veracity of her allegations, and Lloyd's counter allegations. Sharing that information could have contributed to the multi-agency evaluation of the risks to Rayann, Sarah and their children.

18.31 In noting the dual risks raised by the IDVA, the Chair's concern was understandable that the case was back at MARAC, and that a strategy meeting had not been held at the time of the referral. Hence, the recommendation that Children's Services organise a professionals' meeting so that the ongoing complex safeguarding issues could be looked at in more detail given the limited time allocated at MARAC to discuss each case. This resulted in a "children in need" meeting being held ten days later in respect of Rayann's children.

Conclusions and Learning

18.32 The above analysis raises several issues about the MARAC process during that period in terms of the timeliness of meetings, the robustness of the approach to risk assessment, and the effectiveness of processes to monitor progress of agreed actions.

18.33 These have already been addressed through changes being introduced to strengthen the response to domestic abuse referrals. Following evaluation of 2 successful pilot schemes, the previous vulnerability hubs have been replaced by Harm Reduction Hubs (HRH) within each local policing area. This has strengthened multi-agency identification of people at risk of harm, information sharing and co-ordination of action to assess and manage identified risks. A major positive is that specific IDVAs are now linked into each of the hubs.

18.34 Within these revised arrangements, the police hub co-ordinator plays a key role, in overseeing the process of triaging referrals, and ensuring relevant intelligence is gathered. This includes identifying high risk cases that reach the threshold for discussion at a MARAC. They also have responsibility for ensuring all actions are completed by partner agencies to mitigate risk and improve outcomes for victims and families. The introduction of the use of Microsoft Share-point is a big advantage in enabling information on case developments, and progress of agreed actions, to be updated and viewed immediately by partner agencies.

18.35 A further important development is that revised MARAC arrangements have been rolled out across Staffordshire with the previous centralised meeting replaced by local meetings to be held weekly in each of the HRH areas. This will further enhance effective and speedy co-ordination of the response to high risk domestic abuse cases.

18.36 The impact of these changes is already being monitored through a standing agenda item at meetings of the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board, with regular updates also being provided to meetings of the Stoke-on-Trent Community Safety Partnership. This will be particularly important in respect of the two MARACs covering Stoke-on-Trent given the potential challenges arising from the high volume of referrals there compared to other policing areas across Staffordshire.

18.37 Given this existing monitoring, the DHR Panel agreed that it was not necessary to make a recommendation to address the findings from this DHR in respect of these issues.

19. AGENCY ACTION TO SAFEGUARD SARAH AND HER CHILD

Introduction

19.1 The analysis of the response of agencies to the potential risks to Sarah and her child covers 3 issues:-

- the safeguarding issues around the decision to bail Lloyd to Sarah's address;
- Children's Services contact with Sarah, her child, and Lloyd;
- application of the Domestic Abuse Disclose Scheme (Clare's Law).

SAFEGUARDING ISSUES AROUND THE BAIL ADDRESS

19.2 The decision to release Lloyd on police bail was seen as proportionate, and necessary, given that the video interview with Rayann and other investigation processes had not been completed. The custody log contains the observation that this was a serious allegation, the case needed to be progressed

expeditiously, and bail was in the interests of all parties involved to prevent the prolonged detention of Lloyd and for the safety of the victim.

19.3 It is important to highlight that the decision to impose bail represented best practice set against the context of the national concerns that had been expressed since the implementation of the Policing and Crime Act 2017. [40] A HMICFRS inspection had found that in the first 6 months after implementation, there had been a 65 per cent reduction in the use of bail in domestic abuse cases, and an increased use of "released under investigation". The latter step meant that alleged perpetrators were released pending further enquiries without the safety net for victims of conditions being imposed about residence and contact.

19.4 These concerns led to the National Police Chief's Council (NPCC) issuing updated operational guidance in January 2019, reaffirming that the use of bail was a legitimate tool to protect victims when necessary, and that the reduction in the use of bail could mean missed opportunities to protect vulnerable people and put conditions on violent offenders which could prevent re-offending.

19.5 However, although on this occasion the bail conditions preventing any kind of direct or indirect contact with Rayann provided the necessary safeguards for her and the children, the requirement that Lloyd must reside at Sarah's address was inappropriate, and did not take proper account of the need to ensure the necessary safeguards for Sarah and her child while the investigation was ongoing.

19.6 This issue was not covered in the police IMR, but from further checks made during the DHR process it was confirmed that when the decision to bail Lloyd was made, the police had not established that there was a young child living at the bail address. It has not proved possible to establish why this information was not picked up when any issues around the proposed bail address were being considered.

19.7 It was also established that although Lloyd was taken to the bail address by the Police OiC, the latter did not have any contact with Sarah at that point. The OiC did subsequently speak to Sarah inside the house 4 days later when visiting to obtain a witness statement from her and Lloyd in relation to a letter that Rayann had posted through their door.

19.8 During that visit, when Sarah's child was present in the house, the OiC noted that that no concerns were expressed by Sarah, who was said to be clearly aware of the allegations made against Lloyd, and was more than happy for Lloyd to be there. In addition, it was noted that the home conditions were good and there was no negative atmosphere. Consequently, it was not seen by the OiC as a concern for Lloyd to be under the same roof as Sarah's child.

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[40] The Policing and Crime Act 2017 introduced the presumption that suspects should be released from police detention while remaining under investigation, known as 'released under investigation', unless bail is deemed both necessary and proportionate. The Act also introduced statutory time limits and judicial oversight of extensions of bail beyond three months.

19.9 There were 2 consequences of the police not initially establishing the presence of a child at the bail address. The first was that the MASH was not aware of this when making their referral to Children's Services, which in turn meant the latter did not discover this until their first visit to Rayann 3 days later.

19.10 The second, was that it contributed to the subsequent problems which arose when the social worker made the first visit to Sarah and told her that Lloyd could not be under the same roof as her child. The fact that by that time Lloyd had been back living with Sarah and her child for several days, with in effect, the official endorsement of the police, resulted in Sarah not accepting the need for the arrangement to end, and subsequently lodging a formal complaint.

Learning from this case

19.11 When considering bail decisions in domestic abuse cases, it is vital that the police ask questions of the parties involved, and make other enquiries as necessary, to establish whether there are children at the proposed bail address. Where this is established, a full risk assessment must be carried out, that includes the police initiating liaison with Children's Services to enable joint evaluation of the implications and potential risks.

ACTION TAKEN BY CHILDREN'S SERVICES

19.12 It was 6 days before the internal referral was made to the Children's Services Safeguarding Referral Team (SRT) for an urgent assessment of the situation in relation to Sarah and her child. This was partly as a consequence of the delay before Children's Services were informed of Rayann's allegations, but then because the referral was not made until after the weekend following the visit to Rayann. This additional delay, coming on top of the original time lapse, is a concern as immediate action would have been expected given the potential high risks to Sarah and her child from the information Rayann had provided.

19.13 Prompt action was taken appropriately once the referral was received, with a visit made to Sarah the same day. Although Lloyd could not be spoken to as he was at work, the allegations were shared with Sarah, and appropriate safety advice that her child should not be in the same household as Lloyd pending further assessment.

19.14 However, the subsequent handling of the safeguarding implications of the information provided by Sarah that Lloyd had been bailed to her address was not handled well. It was poor practice that the social work team did not get back in touch with Sarah later that day. This resulted in Sarah having to contact the Emergency Duty Team (EDT) to try and establish the view that Children's Services had come to regarding Lloyd being in the home. This placed the EDT in a difficult situation as they did not have all the relevant background information, and were therefore over reliant on information provided by Sarah, and her assurances that she could protect her child overnight.

19.15 The EDT demonstrated good practice in making contact with the police to share their perspective that it would be unsafe for Lloyd to remain in the home, and to raise the issue that his leaving would be a breach of his bail conditions which EDT assumed, albeit mistakenly, were still in force at this time. It was unfortunate that the police's efforts to contact EDT were unsuccessful to share the results of their enquiries which established that Lloyd was no longer subject to bail. This meant that the decision made by EDT to allow Lloyd to remain in the home overnight was made without a strategy discussion with the police about the possible safeguarding implications.

19.16 It was also poor practice that there was no follow up contact with Sarah the next day, and it was to be a further two weeks before any further attempt was

made to speak to her during which time her child potentially remained at risk. The MARAC was informed that this was due to the social worker being on leave, and staff shortages prevented a visit being made by another worker.

19.17 Significant contextual information to mention at this point is that during this period Children's Services was going through a difficult period, and serious concerns had been identified in an Ofsted inspection about aspects of its performance which included its safeguarding work being assessed as inadequate. [41] These concerns related to the very high caseloads, the lack of joint working with other agencies, assessments not gathering sufficient information, and cases being closed prematurely without a full evaluation of risk.

19.18 In its exploration of the first visit to Sarah, the Children's Services IMR made the observation that there was clearly an apparent mismatch between the social worker's positive view of how it had gone, compared to how Sarah experienced it. The visit clearly caused her considerable anxiety and left her feeling uncertain about what would happen next. This initial negative experience, compounded by the subsequent lack of contact, appears to have been factors in her unwillingness to engage further.

19.19 The IMR also identified a number of gaps in the approach to the investigation during that initial visit which did not adhere to standard practice. First although Sarah's child was seen, the child was not spoken alone. Speaking to a child in an age appropriate way is a clear expectation in the local safeguarding procedures where children are of an age to be able to communicate.

19.20 Second, no further attempts were made to interview Lloyd. This meant that the risk analysis lacked an essential element because he had not been required to give his response to the allegations of current and past abuse. Exploring these issues was all the more important given that Lloyd had refused to provide an account to the police whose decision to take no further action meant that it was unlikely that he would questioned by them about these matters again.

19.21 Finally, although the Children's Services records show that there was liaison between the social work team supporting Rayann and the team involved with Sarah, to exchange information around day to day developments in respect of the two families, there is no evidence that this liaison included any structured evaluation of the information each held to arrive at a shared perspective on any possible risks to Sarah and / or her child. Nor was there a joined up approach in the planning to end involvement with Sarah and her child because the DHR established that this was not discussed with colleagues involved with Rayann and her children.

Decision to close the case

19.22 The rationale set out in the child and family assessment document for closing the case is concerning. This referred to the fact that an assessment had been completed, but that Sarah had refused to engage and had not been able to meet with the social work manager to discuss her complaint. It also stated that the threshold for convening a child protection case conference to ensure the case remained open had not been met. Further justification was that there had

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41 Ofsted Inspection of Stoke-on-Trent City Council Children's Services carried out in February 2019; https://files.ofsted.gov.uk/v1/file/50063436

been no concerns raised in respect of Sarah and her child since 2016, no incidents reported about Sarah and Lloyd's relationship, and no concerns raised by the school. It was also recorded that there were discrepancies in the information provided – although what these were was not specified.

19.23 The Children's Services IMR is clear that the decision to close the case was premature and that a strategy meeting should have been held given that Lloyd's account had not been obtained and evaluated, and because of Sarah's refusal to engage. The option of convening such a meeting had previously been referred to in the analysis of risk in the case record, but the social work team changed its view and concluded that the situation did not warrant one. It appears that the possible risks to Sarah and her child were minimised because of the factors described above.

Learning from this case

19.24 The above analysis underlines the importance of professionals being confident, and having the skills, to deal with situations when service users are unwilling to engage. Non engagement by families should never be a reason in itself for a case to be closed, and it is essential that the reasons for this are explored to assess whether this is impacting on the level of risk to the child.

19.25 During the period covered by the review, Children's Services already had practice guidance covering working with families who are uncooperative, hard to engage, or resistant to intervention. [42] This was based on research published by C4EO in 2010 [43] designed to promote effective practice in working with these types of responses. One significant observation in the guidance taken from the C4EO research is that:-

"Irrespective of whether they co-operate, it is worth remembering that most parents involved in the child welfare system are involuntary participants in a process they may resent."

19.26 The guidance describes 5 types of uncooperative behaviour – ambivalence, avoidance, disguised compliance, confrontation and violence – and aims to help practitioners understand the variety of ways in which these different types of non-cooperation can be displayed, the possible causes, and identify strategies for effective practice to deal with these responses. It also helps practitioners to identify where their own actions may by impacting on the ability to secure family engagement, how to maintain control of situations, and keep themselves safe. The value of this guidance is reinforced by the analysis of the difficulties in the social work team's interactions with Sarah.

19.27 The guidance is also clear about the importance of practitioners escalating concerns when planned intervention is thwarted by non-cooperation. This should first be progressed internally with line managers, and second by convening a multi-agency meeting if the following criteria are met:-

(i) that access to the child or family is denied, **or**

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42 "Working With Highly Resistant, Uncooperative and Hard To Change Families" - Version 4 Updated May 2014.

43 "Effective practice to protect children living in 'highly resistant' families" – authors Rebecca Fauth, Helena Jelicic, Diane Hart – published by Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) in March 2010

(ii) planned appointments have been missed on more than 3 occasions, **or**

(iii) there is a need to re-assess the risk to the child because of intimidation towards professionals.

Where the child is not the subject of a child protection plan [44] that multi-agency meeting, should be held within 7 working days to share information, consider the concerns and to agree a plan to address these.

19.28 It is evident that the first of the above criteria applied given that Sarah's refusal to accept Children's Services involvement when contacted 2 weeks after the initial visit, meant that further access to her child was denied. In addition, it could be argued that the third criteria was met as Sarah opted to block access by challenging the practitioner about the way the situation had been handled and then lodging a complaint. Deciding how to respond to her complaint appears to have become a more significant focus of the discussions between the practitioner and manager as to how to move the situation forward rather than the issue of risk.

19.29 It appears however, that there was a lack of awareness of the criteria for convening such a meeting, and its status, as the case recordings indicate that the discussions only considered whether the criteria were met for holding a strategy meeting or child protection case conference under the multi-agency safeguarding children procedures. The guidance however is clear that the multi-agency meeting is not dependent on the threshold being met for triggering the formal child protection processes.

19.30 The DHR established that the existing guidance is currently being reviewed and it will be important that the department satisfies itself that staff are clear about the action that should be taken.

19.31 A recommendation from this DHR is that Children's Services consider the value of adding to the existing scope of the guidance by developing an "Engaging Families Toolkit" that has been adopted in authorities such as Durham and Barnsley.

19.32 The aim of those toolkits is to provide practical advice on how to achieve effective engagement across all levels of intervention from early help and targeted services through to statutory services. The toolkit builds on research and evidence based practice that has been proved to work, and provides additional tips on recognising, understanding and responding to difficult to engage and risky behaviours.

19.33 Key messages which underpin the advice provided within the toolkit include:-

- it is the quality of the relationship between the worker and the family that makes the most significant impact on the effectiveness of the

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[44] For cases involving children already subject to a child protection plan, the guidance states that a meeting of the core group should be convened within 3 days.

engagement – an observation made in Professor Eileen Munro's review of child protection in 2011; [45]

- the persistence of workers in seeking to engage the family at the earliest opportunity is critical;
- practitioners need to adopt an authoritative approach ensuring that the child's needs and outcomes stay in sharp focus;

45 The Munro Review of Child Protection: Final Report A child-centred system - Professor Eileen Munro 2011.

19.34 The added value the toolkit brings is that it identifies in more detail what research has shown about why families may find it difficult to engage, and strategies that have provided effective in avoiding or working through these. It also provides a clearer structure for single agency and / or multi-agency collaboration when engagement continues to be problematic or access is denied. This includes the introduction of managerial "checkpoints" at set stages of the child and family assessment process, and the use of a Family Engagement Risk Assessment form to draw together information shared by all professionals involved to inform a revised engagement plan.

MULTI-AGENCY CONSIDERATION OF POSSIBLE RISKS TO SARAH AND HER CHILD

19.35 There appears to have been little discussion at the two MARAC meetings about the implications of Rayann's allegations for Sarah and her child. It was only subsequent to the first meeting that an update was provided by the SRT, which was added to the minutes, that the outcome of the social work visits was Sarah not agreeing to the request that Lloyd should not reside at the home while the assessment was ongoing. This meant that the MARAC meeting was not aware of this when identifying actions to be taken forward. Had this been shared at the meeting, this would have enabled the MARAC to consider what further safeguarding action should be taken.

19.36 The minutes of the second meeting indicate that there was no comment from other agencies on the delay in children's services following up their initial visit to Sarah and that lateral checks had still not been carried out with her child's school which could have been expected given the potential high level of risk. This was said to be due to Sarah's lack of engagement. There also appears to have been no questioning or challenge to the intention of Children's Services intention to end involvement if no further concerns were identified. This might have been expected given that the meeting had heard that the assessment was still ongoing in terms of the risks Lloyd posed to Rayann.

19.37 While acknowledging that the precipitating reason for the referral to MARAC were the risks to Rayann, it would have been expected that there would have been more focus on the possible risks to Sarah, and whether a disclosure should be made to her through the Domestic Abuse Disclosure Scheme.

Domestic Violence Disclosure Scheme

19.38 This scheme, more commonly referred to as "Clare's Law" [46] aims to prevent women or men from becoming victims of domestic abuse by sharing information about an individual who they are in a current intimate relationship with or considering starting a relationship with. The aim is to help the potential victim make an informed decision on whether or not to continue with the relationship, and to provide support if they make the decision to leave safely. This work will usually be done with the police in conjunction with an Independent Domestic Violence Advisor (IDVA).

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46 The scheme commemorates Clare Wood who was murdered by her violent ex-partner, George Appleton in her home in 2009. This case brought national focus on the issue of disclosing information about an individual's history of domestic abuse to a new partner or current partner.

19.39 The scheme provides two routes for information sharing. The individual potentially at risk has the “right to ask” for information, and agencies have the option to exercise the “right to know” where it is considered that sharing information is a justified and proportionate way of warning a person of potential risks from a known abuser. Both routes are subject to a careful assessment process by the police set down in the associated national guidance.

19.40 It is a concern that the two MARAC meetings did not establish clearly whether, and how, a disclosure would be made to Sarah under the “right to know”. At the first meeting the meeting was informed that as part of its assessment, Children’s Services assessment would be “making a full disclosure to Sarah”. The wording of the minutes leaves it unclear as to whether this was an intention to make a disclosure to Sarah under “Clare’s Law”. If that was the case, it is also unclear as to whether this action had been discussed and agreed with the police.

19.41 Even more concerning is that at the second MARAC meeting, the only reference to considering applying “the right to know” was if Lloyd was to enter into a new relationship. There did not appear to be any acknowledgement that he was already in a new relationship with Sarah, that there still had been no shared evaluation of the risks Sarah or her child may be exposed to, and whether consideration should be given to making a disclosure to Sarah.

19.42 It is possible that this was not raised because there was an assumption that this had already been done given the statement made at the first meeting that Children’s Services would be making a full disclosure to Sarah. However, that was not a step that was included in the list of actions listed at the first MARAC. Therefore the question of whether a disclosure had been made to Sarah, or needed to be considered, should have been addressed in the second MARAC and recorded in the minutes either as an action that had been, or would be, taken.

Learning from this case

19.43 The DHR received figures from Staffordshire police showing that there has been an increasing use of the scheme and information sharing through the two possible mechanisms. These confirmed the positive finding in the 2018 PEEL inspection of Staffordshire Police by FRICS that the force displays a clear commitment and was using the scheme well to protect potential victims. [47]

19.44 In examining the confusion that arose in this case, it is important to note that the Police and Staffordshire Children’s Services have reached a formal agreement, that the latter can provide information under the “right to know” to a new partner where they have current involvement and this step has been discussed with the police. Guidance has been issued to social work staff accordingly. The advantages of this arrangement is that it avoids

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47 In the 12 months to 31 March 2019, there were 122 applications to the ‘right to know’ scheme and the force made 96 disclosures. There were also 133 applications to the ‘right to ask’ scheme and the force made 53 disclosures.

unnecessary, and time consuming, work for the police, and often the information is best shared by the social worker who may have more opportunity to develop a working relationship with the individual at risk.

19.45 However, at the time of this case, the same arrangements had yet to be formally agreed with Stoke-on-Trent Children's Services which may explain the lack of clarity within the MARAC discussions as to whether there was joint agreement that information should be shared with Sarah and how this would be done. This has now been addressed in the light of the DHR findings, with the same protocol being agreed and implemented by Stoke-on-Trent Children's Services and the police, and guidance issued to their respective staff.

20. RESPONSE TO LLOYD'S REPORTS OF BEING A VICTIM

Police Response to Allegations of Harassment of Lloyd by Rayann

20.1 The police responded to 6 incidents reported by either Lloyd and / or Sarah. When the immediate advice given to Rayann during the first 3 incidents did not bring an end to her contacting them, police action was stepped up into a formal investigation, a voluntary interview, and ultimately her being arrested and charged following Lloyd's report of being assaulted.

20.2 It is interesting to note that as part of the police response to incidents reported by Lloyd, he was twice provided with information about how to contact the National Centre for Domestic Violence (NCDV) for support and once referred to Victim Gateway and Glow. [48] This was a quite different response to that given to Rayann. On the several occasions that police officers had reason to intervene and give advice to Rayann, it does not appear that she was advised to speak to her IDVA. Nor does it appear that consideration was given to informing the IDVA directly who may have been able to provide support to Rayann to try and avoid further repetition, and the possibility of further police action.

20.3 Although the attending officers may not have been aware of the IDVA's involvement, it might have been expected that this would have been picked up from interrogation of the various police systems when secondary reviews were carried out by a more senior officer. It would appear that once Rayann was viewed as a perpetrator, there appears to have been a lack of awareness, or consideration, that she was also a victim.

The response to counter allegations

20.4 The accounts given by Lloyd and Rayann of the alleged assault of Lloyd in August were quite different. It is evident from the record of the paramedics' attendance, that the injury sustained by Lloyd was minor which required no further treatment. It is also apparent that Lloyd himself did not view the injuries as serious given his comment to the paramedics that he had wanted the police to respond rather than them. The low level nature of the alleged assault was also reflected in Lloyd not being spoken to by the police until a week later. It was good practice that a DIAL was completed (score of 11) at that point and a referral made to Children's Services in respect of his children.

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48 At that time known as Arch Domestic Abuse Services

20.5 However, it does not appear that the police explored further Rayann's description of that incident when she denied the alleged assault, and her report that she had been injured by Lloyd.

20.6 It is important to make the observation at this point that it appears that the police were never informed of Rayann's subsequent hospital admission, and that the discharge letter had referred to the injury to her finger being caused by a human bite which would support her version of events. UHNM did not report this to the police for the reasons outlined earlier in this report, nor did the social worker who was informed of this by the hospital. In addition, although Rayann agreed to the IDVA contacting the police about her account and injury, this was not followed through.

Action following Rayann's arrest

20.7 Following Rayann's arrest, Lloyd made a statement withdrawing his support for any prosecution of Rayann because of his concerns about the possible impact on their children. He also stated that the outcome he really wanted was a non-molestation order. However, despite this, the police decided to pursue matters further which resulted in a file being submitted to the Crown Prosecution Service (CPS) albeit with a recommendation for no further action.

20.8 The decision to seek a CPS decision was in marked contrast to the police response to Rayann's original allegations in June 2018, and her subsequent retraction. On neither occasion was an approach made to the CPS. The DHR did not receive any perspective from the police as to the reasons for this difference in approach.

20.9 It is a concern that there was a 10 month gap between the original offence and the decision being made by CPS that a prosecution should not be pursued. This meant Rayann endured a lengthy period of uncertainty as to whether a court case would follow. The anxiety about this added to the other worries she was already having to contend with in respect of the children.

20.10 In exploring the reasons for this delay, the DHR established that after the file was submitted to CPS in August 2018, the standard checklist was sent back to the police identifying further actions and additional evidence required to enable a charging decision to be made. Following the statement being obtained from Lloyd, who wanted no further action to be taken, the file was re-submitted to the CPS in mid September.

20.11 However, the file was again rejected because not all the points contained within the original action plan had been addressed, and further information was required about Lloyd's retraction. According to the CPS, although a target date of the end of September was set for resubmission, the remaining material requested was subsequently supplied piecemeal by the police with the final item arriving later in January 2019. Prioritisation of work meant it was a further 3 months before the CPS made its decision that no further action should be taken against Rayann.

Learning from this case

20.12 The impact of the above sequence of events underlines the importance of the police and CPS each minimising delay in carrying out their respective roles to prevent avoidable uncertainty and anxiety for the subjects of the investigation – particularly where the person under investigation has previously been a victim of domestic abuse.

20.13 It also reinforces the importance of College of Policing [49] and CPS guidance [50] on the need to probe the circumstances of incidents carefully and avoid "jumping to conclusions" as to which of the parties in the relationship is the victim and which the perpetrator. It cites various scenarios where claims of self defence and counter allegations make it difficult to identify who is the primary victim and primary aggressor.

20.14 Consequently counter-allegations require police officers to evaluate each party's complaint separately, and carry out a risk assessment on both, where each claims to be the victim. Scenarios which need to be borne in mind include the possibility that:-

- the primary aggressor is a victim of previous abuse and has retaliated against the perpetrator;
- the possibility that the relationship is a mutually abusive one;
- a manipulative perpetrator may be making a false counter allegation to try and draw the police into colluding with the perpetrator's continuing control or coercion of the victim.

Accordingly, a thorough investigation should be conducted into the background of the relationship between the complainant and alleged perpetrator to ensure that the full context of the incident is understood.

LLOYD'S APPLICATION FOR A NON-MOLESTATION ORDER

20.15 Examination of the sequence of events around Lloyd's application for an order is included because it highlights some of the difficulties alleged victims of domestic abuse can experience when seeking to defend themselves against counter allegations brought against them by their alleged perpetrator.

20.16 It is not known but assumed that Lloyd received help from the National Domestic Violence Agency in preparing his application with him representing himself at the subsequent hearing. The IDVA recorded that Rayann had been stunned when it was served on her, and the latter's view that Lloyd's version of events was "all lies". The IDVA told the author that she was surprised that his application had not been rejected by the court.

20.17 The description provided to the DHR Author by the IDVA of events at court provide some significant insights into Rayann's level of fear of Lloyd, and his behaviour. Prior to the hearing, Rayann was said to have had her back to the front entrance, and when she became aware that Lloyd was walking towards her, she started trembling visibly. During the hearing itself in chambers, the IDVA's perception was that Lloyd displayed an aggressive and intimidating pose with his legs spread wide.

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49 Section 3.5 in College of Policing Guidance "Major investigation and public protection - First response" – https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/first-response/

50 **See section on self defence and counter allegations in the "Domestic Abuse Guidelines for Prosecutors" published by CPS last updated 20th April 2020.** https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors

20.18 It was good practice that the IDVA arranged for a free consultation and legal aid assessment with a solicitor, and her ongoing support included taking photographs of Rayann's scars for the solicitor with the manager's approval. However, the solicitor's failure to give advance notice that she would not be attending, and had not submitted Rayann's statement prevented her counter application to be considered. This was poor practice and the IDVA quite appropriately raised her concerns in her email to the solicitor that her failure to follow through on action agreed had placed Rayann in a very difficult situation. While in the event, this did not result in any adverse consequences for Rayann, such an outcome in other cases could have resulted in the victim being exposed to further risk.

21. OVERVIEW OF MULTI-AGENCY WORKING AND RISK ASSESSMENT

Introduction

21.1 In the light of the DHR findings on agency responses to key events, this section of the report seeks to provide an overview of the effectiveness of multi-agency working and risk management.

Referrals and Information Sharing

21.2 There were several examples of good practice in respect of referrals made, for example:-

- the immediate referral made by the police to the MASH;
- the referral for IDVA support made by a UHNM nurse;
- the IDVA's referrals for Rayann to access additional support.

21.3 Similarly there were examples of good liaison, including:-

- The police keeping the IDVA informed about the DVPO;
- The liaison between the IDVA and social work team involved with Rayann;
- UHNM's contact with the social work team during Rayann's hospital stay in September.

21.4 However, there were a number of occasions when important information was either not shared, or not shared as promptly as the situation warranted to ensure other agencies could consider what action might be required to protect Rayann, Sarah, and their children.

21.5 These included several situations where the multi-agency assessment of risk would have been enhanced if the social worker and IDVA had shared potentially important information that emerged from their contacts with Rayann - for example regarding the previous abuse, the evidence of old injuries, and the alleged coercion from Lloyd which contributed to her retracting. Sharing observations also about the level of Rayann's distress or emphatic nature of her assertion that the original allegations were true, would have been important context to inform consideration of how her claims should be viewed. Equally, there were several occasions where it would have been helpful for the police to keep the IDVA and children's services in the loop about developments and police decisions.

21.6 It would also have been important for partner agencies to have been informed about the continuing difficulties being experienced by children's services in engaging Sarah. This would have allowed an opportunity for joint discussion of the implications arising from this and might have avoided the unilateral decision to close the case before a full assessment had been completed, and information had been shared with Sarah through the use of "Clare's Law".

21.7 The latter was one example of a recurring issue that agencies did not sound out partner agencies about significant decisions they were about to make in order to check if partners had information or perspectives which should be taken into account. Other examples include the police decision to take no further action in respect of the alleged physical and sexual assault, or the plan, later dropped, to invite Rayann for a video interview regarding the reasons for her retraction.

Risk Assessment

21.8 It was good practice that the police completed DIAL forms when responding to each incident. It is a concern however, that the description in the police record / IMR that Rayann refused to co-operate with the DIAL process suggests insufficient awareness of the possible reasons why a victim might be reluctant to engage which were described earlier.

21.9 The IDVA applied best practice in completing DASH risk assessments at all appropriate points, including a review to check whether Rayann felt safe and agreed to the support ending.

21.10 The stark contrast in the approach to risk assessment of the two social work teams is concerning. The extensive involvement of the social work team with Rayann, and the contingency planning, shows an awareness of the continuing possibility of risk. Given this, a similar approach would have been expected from the team involved with Sarah and her child. However that was not the case and throughout there was an absence of the necessary urgency to address the possible safeguarding issues, and closure of the case before all the essential elements required to achieve a sound risk assessment had been completed.21.11 It is a concern that no strategy discussion was ever held between Children's Services and the police following Rayann's allegations which would have been expected given the seriousness of the allegations. A consequence of this gap is that both agencies then carried out their respective statutory responsibilities in isolation. While it is positive that Children in Need meetings started to be held from October onwards, albeit these could have been expected to start at an earlier stage, these did not involve the police.

Impact of recent developments

21.12 It was reassuring that the DHR heard that since the transfer of the domestic abuse services to New Era, considerable progress has been made in strengthening joint working, for example the links that have been developed between the IDVA service and the Police Vulnerability Hubs. These links are providing the pathways for closer joint working, whether that is to escalate concerns, or mobilise additional support for victims. Similarly, the changes to the MARAC arrangements should address the gaps in risk assessment, and co-ordination of protective action that were apparent in this case.

22. FINAL CONCLUSIONS

22.1 Sarah's murder came as a terrible shock to the family because until the final week when Sarah told them she had ended the relationship, there had been no indication of major problems in the relationship or that Sarah had suffered any domestic abuse. It is clear from information provided by some members of the family, that they noticed a marked change in Sarah's demeanour and for the first time she was expressing some anxiety about Lloyd's reaction to the ending of the relationship.

22.2 In addition some family members had been struck by the change in Lloyd's behaviour and his anger during telephone calls about care arrangements for Sarah's child which was in marked contrast to the quiet, polite and shy behaviour they had experienced through out the relationship.

22.3 Sarah had shared with work colleagues that she was fed up with Lloyd's jealous and controlling behaviours, and was frustrated that she could not get him to leave after ending the relationship. Again however, the impression they formed was that Sarah was not unduly troubled by Lloyd's behaviour and that Sarah appeared able to handle this. It was only just before the murder that she disclosed that Lloyd was giving her "a lot of hassle".

22.4 Another important fact to note is that there had been no agency involvement with Sarah, or information coming to any agency's attention, since Children's Services closed the case in October 2018 some 8 months earlier. It was only through the police investigation after the murder that more information was revealed from the witness statements about the attempted coercive control that Sarah experienced from Lloyd. A significant observation made by the police about this during the DHR was that Lloyd influenced outcomes by not supporting further police activity around incidents once the immediate behaviours had been reported. This extended to incidents where Sarah was the complainant or injured party.

22.5 It will never be known whether events might have developed differently if the work had been more thorough in looking into Rayann's allegations of previous abuse to inform the assessment of risk to Sarah, and further efforts had been made to warn her of the possible risks Lloyd might pose by sharing information through the "right to know" process of the Domestic Abuse Disclosure Scheme.

22.6 It is evident that a comprehensive assessment of risk to both Rayann and Sarah was never achieved because insufficient enquiries were made to establish if there was medical or other evidence to corroborate Rayann's claims of previous domestic abuse. Such enquiries would have been additionally important given that the Birmingham records suggest that their enquiries had also stopped short of making further enquiries with the GP or hospitals about injuries that Rayann claimed to have sustained. The DHR did however establish that Rayann did show the social worker and IDVA some scars which may have been indicative of injuries sustained during those alleged incidents.

22.7 The DHR heard that the challenge that the police faced throughout their dealings with Rayann was that she kept changing her story, which together with the discovery of the text messages that Rayann had sent to Lloyd, led to the police ruling out the prospect of pursuing the prosecution of Lloyd because Rayann was not viewed as a credible witness. The differences in Rayann's accounts were also apparent when comparing information she shared with other professionals.

22.8 The Author's observation in relation to these challenges faced by professionals is that in his meeting with Rayann, she presented as an emotional person who could become quite agitated in describing incidents and her relationship with Lloyd. This led to some differences in her accounts as the meeting progressed. This observation is not made to cast doubt on the veracity of Rayann's reports of being abused, but to highlight two issues. The first is to acknowledge the difficulty for the police in that her varying accounts could be a potential problem in evidential terms. Second, that the difficulties in the relationship, and Lloyd's coercive and controlling behaviour over many years, would inevitably impact on her ability and willingness to support police action.

22.9 With regard to Sarah, and with the benefit of hindsight, the decision to close the case before information was shared with her through Clare's Law may have been a pivotal moment in the case. Had information been shared, it would have enabled her to make an informed decision whether to continue the relationship. As it was, Sarah had only heard Lloyd's version of past events in his relationship with Rayann, and the latter's claims of previous abuse which Sarah may have regarded as an attempt by a jealous former partner to break up the new relationship given that Rayann had stayed with Lloyd despite the alleged abuse.

22.10 As now known from the Birmingham records, Lloyd almost always denied Rayann's allegations and raised counter allegations. That contributed to the comment recorded in assessments at that time that the challenge for agencies was that unpicking these was made more difficult because of "the high levels of deception" presented to professionals.

22.11 The observation also needs to be made that Sarah did not seek to exercise her "right to ask" through Clare's Law. This may have been because she was unaware of that option, or she was reassured by Lloyd's explanations. It will never be known if Sarah's lack of engagement with Children's Services reflected her experiences of contacts with a range of agencies in the past, and / or her determination to be independent and sort things out for herself.

22.12 During this DHR, the picture that emerged of Sarah was of a vibrant, kind and loving young woman, with a good sense of humour, who adored her child, and had rebuilt strong relationships with her parents, step-parents and siblings after some difficult times during her childhood. Her murder at such a young age, and the particular circumstances, was tragic, and the author extends his condolences to her family for their loss. It is hoped that the depth of this review provides them with reassurance that all the relevant issues have been explored, and action has been identified to implement the learning that is summarised below.

23. SUMMARY OF THE KEY LEARNING

Partnership Working

23.1 The findings from this DHR underline how multi-agency working is vital to respond effectively to reports or indicators of domestic abuse in order to ensure all relevant information is gathered to co-ordinate action to assess, manage and reduce risk both to the victims, other who may be at risk such as new partners and any children involved.

23.2 The DHR has identified the following key learning points:-

Police Investigations

- police officers adopt a proactive approach in gathering evidence that can build an evidence-led case that does not rely on the support of the victim;
- early consultation with the CPS guidance to explore the evidential difficulties and identify additional possible lines of enquiry which might be pursued;
- the importance of establishing as much information as possible about past abuse to inform the current investigation and the assessment of risk;
- early police contact with other agencies should be contacted to establish if they have relevant information, including medical evidence, or can provide support in gathering evidence from the victim and encouragement to support the investigation.
- other agencies must be equally proactive in informing the police of any disclosures of abuse or other relevant information provided by victims, and not assume that the police are already aware of these.

Police approach to dealing with withdrawal of allegations

- the above points equally apply to the response to retractions;
- a retraction should not mean that the investigation should be stopped until there has been careful exploration of not just of the actual reasons given, but the many other possible factors listed in national guidance, including the possibility of coercion.

Police approach when dealing with counter allegations

- a thorough investigation should be conducted to probe the circumstances of incidents carefully and avoid “jumping to conclusions” as to which of the parties in the relationship is the victim and which the perpetrator;
- the investigation includes an evaluation of each party’s complaint and a risk assessment in respect of both parties;
- exploration of the background of the relationship between the complainant and alleged perpetrator to ensure that the full context of the incident is understood.

Multi-agency action to safeguard children

- when making decisions about bail, where children are living at the proposed bail address, a full risk assessment is essential which must include the police initiating liaison with Children’s Services to enable joint evaluation of the implications and potential risks.

Response to non engagement by families with Children’s Services in domestic abuse cases

- non-engagement by families should never be a reason in itself for a case to be closed, and it is essential that the reasons for this are explored to assess whether this is impacting on the level of risk to the victim of abuse or the children.

- the importance of practitioners being equipped to understand the different types of uncooperative behaviour, the ways in which these may be displayed, the possible causes and being able to apply a range of intervention strategies to deal with these.
- it is the quality of the relationship between the worker and the family that makes the most significant impact in securing effective engagement, and the persistence of workers in seeking to engage the family at the earliest opportunity is critical.
- practitioners need to adopt an authoritative approach ensuring that the child's needs -and outcomes stay in sharp focus.
- managerial "checkpoints" at set stages of the child and family assessment process, and the use of a Family Engagement Risk Assessment form are essential to draw together information shared by all professionals involved to inform a revised engagement plan.
- a multi-agency meeting should be convened where there are concerns that continuing non engagement, or denial of access to the child(ren) may be exposing them to risk so that a plan can be identified to address the non engagement and mitigate any continuing risks.

Multi-agency risk assessment

- early multi-agency consideration of high risk cases through the MARAC process is essential, supported by effective information sharing and tracking systems which enable professionals to provide immediate updates on new developments and progress to be monitored on the implementation of actions agreed.
- the need for a dynamic approach to risk assessment and contingency planning that takes account of changes in the situation.

Multi-agency challenge and escalation

- all professionals should challenge partner agencies, and escalate their concerns, if they feel that information they have provided is not being given appropriate consideration, or they have concerns that actions taken / not taken by a partner agency may expose the victim or children to further risk.

Multi-agency processes in respect of the Domestic Violence Disclosure Scheme

- the need to ensure there is a clear shared understanding, and audit trail, between the police and children's services as to who will take responsibility for sharing information through the "right to know" process, and that the information shared has been agreed and is proportionate.

Response of health professionals to possible domestic abuse

<u>Primary Care</u>

- GPs need to be proactive in finding appropriate opportunities to probe sensitively with patients any indications of possible domestic abuse, including information contained in hospital discharge letters or from other agencies.

- the importance of evaluating the impact of training that has been delivered to GPs to establish if this is leading to improvements in their approach.

UHNM professionals

As set out in the UHNM IMR:-

- where domestic abuse is disclosed or suspected, a full account should be included in the medical notes, including the victim's demeanour, emotional state and behaviour, with details of what actions have been taken to inform the police and other relevant agencies.
- wherever possible, body maps should be completed to note any current injuries, or signs of healed injuries which may confirm allegations of past abuse.
- hospital discharge letters should include a full account of any disclosures made regarding domestic abuse and any actions taken.

24. RECOMMENDATIONS

1. Staffordshire Police and West Midlands CPS should provide evidence to the Stoke-on-Trent Community Safety Partnership that the possibility of progressing an evidence-led investigation / prosecution in domestic abuse cases, as recommended in national guidance, is always considered, and that this includes effective partnership working with other agencies to establish if they have information and / or potential evidence to assist the investigation.
2. The Stoke-on-Trent Community Safety Partnership should seek assurance that there is effective information sharing and partnership working to assist full exploration by Staffordshire Police of the possible factors which may be leading to an alleged victim of domestic abuse seeking to withdraw their allegations, and / or to investigate reports of abuse where counter allegations are made.
3. Staffordshire Police and Stoke-on-Trent City Council Children's Services should ensure that there is liaison and joint evaluation of any potential safeguarding risks to children when the police are considering whether to impose police bail or release an alleged perpetrator under further investigation;
4. The Stoke-on-Trent Safeguarding Children Partnership should assure itself that:-
   - there is multi-agency guidance available to all professionals that covers work with families who are hard to engage, or resist professionals' intervention, and that this is being applied effectively;
   - professionals are clear about the criteria and arrangements for convening a multi-agency meeting in order to assess risk, and formulate a revised plan of intervention to safeguard children, where there is continuing non engagement and / or access to a child is denied.
5. The Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should assure itself that there is evidence that professionals are aware of the processes that have been put in place for escalating concerns, and / or challenging decisions made by partner agencies

where it is considered that these may be placing victims of domestic abuse, and / or their children, at further risk.

6. The Stoke-on-Trent Community Safety Partnership should seek assurance that there is evidence that:-

   (i) within the multi-agency processes to assess risk in domestic abuse cases, consideration is always given to a disclosure being made to the new partner of an alleged perpetrator through the “right to know” provisions within the Domestic Abuse Disclosure Scheme;

   (ii) the protocols agreed by Staffordshire Police and Stoke-on-Trent City Council Children’s Services for the latter to make these disclosures are being applied.

7. University Hospital North Midlands (UHNM) should, when disclosures of domestic abuse have been made, always attempt to complete body maps, with the patient’s consent, to note relevant or significant injuries.

8. University Hospital North Midlands (UHNM) should ensure that hospital discharge letters sent to GPs include a full account of any disclosures made by patients regarding domestic abuse and any actions taken to explore these.

9. Stoke-on-Trent CCG should provide evidence to the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board of the impact of Domestic Abuse Awareness Training provided to GPs and other professionals.