



Calderdale Community Safety Partnership

Domestic Homicide review in respect
of Lily Louise who died in 2021

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List of Contents:

Pen picture	3
1. Introduction and Timescales	4
2. Confidentiality	5
3. Terms of Reference and Methodology	5
4. Scope of the Review	7
5. Panel Membership	7
6. The Overview Report	8
7. Involvement of family, friends, neighbours and wider community	8
8. Agency contributors to the review	9
9. Author of the review and statement of independence	10
10. Parallel reviews and inquiries	10
11. Equality and Diversity issues	11
12. Dissemination	11
13. Case Summary/Narrative chronology	12
14. Analysis in response to questions set in Terms of Reference and conclusions	25
15. Issues identified which were not set out in the Terms of Reference	34
16. Lessons learnt and DHR recommendations	38
Appendix 1 – Terms of Reference	42
Appendix 2 – Letter from the home Office	48
Appendix 3 – DHR Action Plan for Lily-Louise	51

Pen picture

I am Lily Louise's youngest daughter I write this on behalf of my family so that you know who my Mum was and what a wonderful person she was.

My Mum was the most beautiful soul she was unapologetically her and I am so proud of her. She was my greatest support; she was always there for her family and now she has been taken from us. When I got the telephone call saying they had found her body I lost a part of myself I know I will never be the same again. I had 20 years of knowing and loving the greatest woman in my life. My Mum gave me strength and helped me with everything.

My Mum has the most contagious laugh. She was always the life and soul of the party always confident, bubbly, and outgoing.

Mum moved at least 15 times in her life, and she did this all alone. Her home was always decorated nicely and spotlessly clean. The joke in our family was that she lived in a show house.

My mum loved family time spending time with her children and grandchildren she loved holidays abroad and enjoyed spending time with her family she always looked forward to her holidays as she knew this would allow her to spend quality time with her family.

My Mum loved walking her children and grandchildren to school/college and picking them up she loved to hear the stories they would tell describing what they did at school that day her family was her whole world.

My Mum was 4 foot 11 inches and weight 7.5 stone, but this didn't stop her doing DIY and walking at the speed of lightening. She was unstoppable.

My Mum was never embarrassed even over her questionable fashion sense! 2-inch flip flops with fluffy socks!! She would sing loudly (out of tune) with the wrong lyrics.

My Mum had time for anyone and everyone she would help OAPs with their shopping, help people with their decorating and she always had a listening ear if someone needed help (no matter what time of day).

My Mum was the person that people would rely on she was gentle kind and very easy to talk to my Mum was appreciated by everyone.

My Mum was organised and was set in her ways especially her daily routines she would get up early have coffee put the washing machine on and prepare the tea for that evening.

Everything my Mum did was for someone else she was the best most wonderful mother, daughter, sister, nanna, and auntie she was the best Mum to her three daughters; they were her world. She doted on her grandchildren. You will never know the impact that this has had on her family we do know this will affect us for the rest of their lives.

I am so proud of my Mum. She was selfless.

1. Introduction and Timescales

- 1.1. On behalf of the Calderdale Community Safety Partnership who commissioned this review, and the people who have worked on the review, condolences and sympathy are extended to the family and friends of Lily Louise.
- 1.2. Lily Louise was born in 1969 and was the much-loved mother of three children. One of her daughter's has provided a pen picture which is included at the beginning of this report in full. Lily Louise is described as having been a great support to her family who are very proud of her. They talk about her contagious laugh, and her bubbly personality. She was short and slight but energetic and active. She enjoyed spending time with her family, collecting her grandchildren from school and helping neighbours out with shopping.
- 1.3. Lily Louise had been married three times prior to meeting Richard and had experienced domestic abuse in one of these relationships. During the period under review Lily Louise had experienced problems with both her physical and mental health.
- 1.4. The couple had lived together since March 2019. At the time of her death in 2021 she had just been through a marriage ceremony with Richard, but this would appear to have been bigamous as she was still married to her third husband. Both Lily Louise and Richard were white British. Lily Louise had no religious affiliations, and it is not known whether Richard had a particular religious affiliation. There is no evidence to suggest he did and no impact of any religious beliefs on any intervention or service provision. There had been previous reports of domestic abuse during their relationship and Richard had a history of perpetrating abuse in previous relationships.
- 1.5. In October 2021 Lily Louise's body was found in a suitcase which had been left in a field. Richard was subsequently arrested and convicted of her murder at Bradford Crown Court.
- 1.6. Shortly after, the police notified the Community Safety Partnership of what was believed to be a domestic homicide and on 16th November the joint Chairs of the Community Safety Partnership (Chief Superintendent Sarah Baker and Cllr Jenny Lynn) made the decision that a domestic homicide review should be completed. Although the Domestic Abuse coordinator was involved in the review, she was not consulted about the decision making as the circumstances were seen to clearly meet the criteria. The Home Office and the family were informed by letter on the 19th November 2021.
- 1.7. The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person has died as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each

homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

- 1.8. This review began on 16th November 2021 and was concluded in June 2024. The concurrent criminal proceedings concluded in August 2022. It was not possible for the reviewer to speak with family members, the perpetrator, or professionals who were potential witnesses prior to completion of the trial. This caused a considerable delay in completion of the review.

2. Confidentiality

- 2.1. The findings of a domestic homicide review are confidential as far as identifying the subjects, their families, or professionals. Pseudonyms, agreed with the family, are used to protect the identity of the individuals. Professionals are referred to by their roles and the services involved are described in Section 9.

3. Terms of Reference and Methodology

- 3.1. Home Office guidance requires that a DHR must review the circumstances in which the death of a person 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or been a member of the same household as themselves.

- 3.2. The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

3.3. The Calderdale Community Safety Partnership set out the Terms of Reference (see Appendix 2) and methodology for this review and the methodology is compliant with national guidance. This includes identifying a suitably experienced and qualified individual to chair the panel and to provide an overview report for publication. Agencies who had significant contact with Lily-Louise and Richard provided independent management reports (IMRs) ¹ addressing the questions set out in the terms of reference as follows:

a) How well agencies considered historical events and previous incidents in risk assessments?
b) MARAC ² : The effectiveness of information sharing, record keeping, and action from the Daily Hub.
c) MARAC: Consider how risk and the effectiveness of the safety plan can still be considered even when the victim withdraws – is risk reassessed?
d) Consider how professionals share information.
e) Could the time the perpetrator is remanded be used more effectively to safeguard and support the victim. Was the opportunity to do further work with the victim whilst the perpetrator was incarcerated maximised?
f) Understanding what consideration was given to proceeding with prosecution despite the witness' withdrawal.
g) Did the former partners disclosure inform risk assessment?
h) Were opportunities missed to consider disclosure via Clare's Law?
i) Could the GP practice have been more proactive around the different, complex and persisting health conditions and were there missed opportunities to consider Domestic Abuse.

¹ The aim of the IMR is to allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards; identify how and when those changes or improvements will be brought about; and identify examples of good practice within agencies.

² A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim

j) Was the impact of COVID significant in: how agencies worked together; how agencies engaged with the family; on safeguarding assessment processes or anything else?
k) Are health inequalities and the impacts of poverty relevant in this case?

3.4. The report focuses on system-wide process. It considers service engagement and response. The approach taken with the review was proportionate and inclusive. It was led by individuals who are independent of the case and professionals have been fully involved and able to contribute their perspectives without fear of blame. The contribution of family members has informed the review. Where action is required, agencies will be accountable to the CSP for timely completion. The report is being published, and improvement monitored through the CSP.

3.5. Every effort has been made to avoid hindsight bias and outcome bias by using analysis which examines how things were and perceived to be at the time.

3.6. To ensure this review did not adversely affect ongoing criminal process, it has been managed according to the DHR arrangements which are subject to national guidance in England.

4. **Scope of the Review:**

4.1. The terms of reference were based on information known at the time but were viewed as a working document which could be revised at any point during the review, for example in the light of new information.

4.2. The time period set for the review runs from 1st June 2019 to 31st October 2021. When the period was set it was believed that this reflected the start of the relationship between the victim and the perpetrator. Family have since clarified that the relationship in fact started in March 2019. Some relevant significant events outside the set dates have been considered. Multi-agency engagement with both the victim and perpetrator are considered in the review.

5. **Panel Members:**

Independent Chair and Author – Jane Booth
Calderdale Safeguarding Partnership Manager – Julia Caldwell
Designated Nurse Safeguarding Adults, West Yorkshire Integrated Care Board (formerly Calderdale CCG) Luke Turnbull
Detective Chief Inspector, West Yorkshire Police – Samantha Lindsay

Named Midwife for Safeguarding and Domestic Abuse Lead, Calderdale and Huddersfield Foundation Trust – Alison Pollock
Assistant Director, South West Yorkshire Partnership Foundation Trust – Emma Cox
Assistant Director Supported Housing & Neighbourhood Safety & Safeguarding Lead, Together Housing – Sue Lewis
Chief Executive Officer, WomenCentre – Angela Everson
Chair of MARAC – Zaheer Abbass
Domestic Abuse Coordinator, Calderdale MBC - Nazia Mukhtar
Deputy Chief Crown Prosecutor - Jonathan Wettreich

There were 8 panel meetings held throughout this review.

6. The Overview Report

6.1. This overview report brings together and draws overall conclusions from the information and analysis contained in the IMRs, or information commissioned from other relevant interests. It covers all areas set out in the template laid out in the DHR Statutory Guidance and an Executive Summary has also been produced which outlines the review process, a summary and the key issues and recommendations arising from the review.

7. Involvement of family, friends, neighbours and wider community

7.1. Following the completion of the criminal trial the author of the report met with Lily Louise's mother, daughters, sister and stepfather on 18.08.2022. The family were supported by Advocacy After Fatal Domestic Abuse (AAFDA)³ for subsequent meetings. Their perspectives informed the content of this report and helped the author and panel to improve accuracy. Their involvement continued throughout the report writing process, which resulted in strengthened findings and recommendations. One daughter had been directly involved in an assault by Richard – her experiences are referred to elsewhere in the report and her perspective on this and on the reporting this to the police have been informative.

7.2. The author visited Richard in prison post-sentence but with an appeal still pending, enabling his comments to be taken into account.

³ Advocacy After Fatal Domestic Abuse (AAFDA) is an independent and unique organisation offering specialist and expert advocacy and peer support after fatal domestic abuse.

7.3. The author has interviewed Richard's previous partner who had tried to warn Lily Louise and her family about the risks posed by Richard.

7.4. The family have been consulted about the final report and feel the report appropriately reflects their views.

8. Agency contributors to the review

8.1. Local organisations were contacted as part of the original scoping of this review as to any contact or knowledge they had had with Lily Louise and Richard. Of those organisations, the following confirmed having information about one or both of them relevant to the review and those listed in a. to g. contributed IMRs.

- a. Calderdale and Huddersfield NHS Foundation Trust
- b. Calderdale CCG⁴ – GP
- c. South West Yorkshire Partnership NHS Foundation Trust
- d. Together Housing
- e. Calderdale MBC Housing
- f. West Yorkshire Police
- g. Staying Safe Service delivered by WomenCentre
- h. Crown Prosecution Service

8.2. Information was also provided by the Probation Service, Yorkshire Ambulance Service, Pennine Domestic Abuse Partnership, the Registration Service, and Calderdale MBC, which was included in the chronology but IMRs were not required. Relevant information included was as follows:

- Calderdale MBC - dealt with a contact from Lily Louise in 2009 regarding property repossession and fleeing domestic abuse and in 2012 with support in moving from one property to another.
- The Probation Service reported that Richard was sentenced to an 18-month suspended prison term with a requirement of 150 hours unpaid work in December 2015. This was in respect of an assault on his previous partner. A non-molestation order was also put in place. He completed 94 hours of the unpaid work requirement prior to the custodial part of his sentence being invoked in May 2016 for breach of the non-molestation order. He was

⁴ Arrangements for the management of health services have been changed during the course of this review. CCGs no longer exist, and their functions have largely been replaced by Integrated Care Boards (ICBs).

released from custody in June 2016 and made subject to licence with conditions including no contact with his previous partner. Whilst on licence he attended all appointments. Records indicate that individual work with Richard focussed on promoting healthy relationships and positive parenting, but no interventions were offered regarding domestic abuse.

- The Yorkshire Ambulance Service reported ten calls, a mixture of 999 and 101 calls, via the call centre in respect of minor medical issues for both Lily Louise and Richard. These included concerns arising from tooth ache, abdominal pain, vomiting, and diarrhoea. There was no indication in the call or the response that any link with domestic abuse was identified.
- Pennine Domestic Abuse Partnership provided the Independent Domestic Violence Advisor (IDVA)⁵ service out of office hours, and the support they offered is referred to in the main body of the report.
- The Registration Service were involved in the planning for and the marriage between Lily Louise and Richard and their contacts are included in the main body of the report.

9. Author of the review

9.1. Jane Booth was appointed to both chair and act as independent author of this review and the executive summary. She has had a career in social care spanning more than 40 years and has managed both children's and adult services. She has experience of working as a practitioner in social care and the probation service and as a senior manager in local government, Cafcass and social care inspectorates.

9.2. She has a Certificate of Qualification in Social Care, a Diploma in Social Studies and an MA in Child Care Law and Practice. She has completed numerous courses during her career and, in compliance with national guidance, has used the online toolkit and online learning re DHRs provided by the Home Office. She has acted as chair of a number of safeguarding boards and partnerships and overseen the production of numerous reviews. She has authored Serious Case Reviews, Safeguarding Adult Reviews and Local Child Safeguarding Practice Reviews.

9.3. She has had no connection with the Calderdale Community Safety Partnership. In the 1980's she worked for Calderdale Children's Social Care and in 2010 was appointed as the independent chair of the Calderdale Safeguarding Children Board, retiring from this role in 2013. She has had no involvement with agencies in Calderdale since this time.

10. Parallel reviews and inquiries

⁵ An Independent Domestic Violence Advisor

- 10.1. Criminal proceedings were concluded during the course of this review and completed in August 2022 resulting in the conviction of Richard for the murder of Lily Louise. He received life sentence with a minimum term of 21 years.
- 10.2. Following the end of the criminal trial, the coronial process concluded without the need for a hearing.

11. Equality and Diversity issues

- 11.1. Lily Louise identified as white British. Religious affiliations are not known. She had a complex health history which included both physical ill-health and periods of depression. Her family indicated that she had also suffered from Bulimia since her early teenage years. She had relocated on a number of occasions. The review has not considered her early years, and it is not known whether she experienced adverse childhood experiences. Her health issues may have constituted a disability as defined under the Equality Act.⁶
- 11.2. Richard also identified as white British. The review did not consider his childhood experiences were beyond the scope of this review and cannot assess the extent to which these influenced his relationships and belief systems. He had a history of complaints related to chest and heart as well as depression. He had also spoken to his GP about anger. He has self-reported a recent diagnosis of autism whilst in prison which he believes has affected his behaviour throughout his life. There is no reference to this in medical records accessed as part of this review but autism, if confirmed, may have constituted an unidentified disability as defined under the Equality Act.
- 11.3. Gender-based violence is violence directed against a person because of that person's gender¹. Other than the issue of gender, neither Lily Louise nor Richard appears to have protected characteristics as described in the Equality act.

12. Dissemination

- 12.1. Copies of this review have been provided to the Community Safety Partnership, the Home Office and to each organisation represented on the Community ~Safety Partnership. The review has been presented to the Calderdale Community Safety Partnership and will be published on their website.
- 12.2. The report, once approved by the Home Office, will be shared with the Police and Crime Commissioner for the Local Area and the Domestic Abuse Commissioner.

⁶ **The Equality Act 2010** was introduced to create one single legal framework for protecting the rights of equal opportunity and against unlawful discrimination, harassment and victimisation based on someone's personal, protected characteristics.

13. Case Summary/Narrative chronology

- 13.1. Some events which took place prior to the period identified for the review have also been considered as it is relevant to the circumstances of Lily Louise's death.
- 13.2. Lily Louise had continuing contact with mental health services from 2011 up to 2020 when she was discharged to the care of her GP.
- 13.3. In December 2015 Richard was convicted of a "domestic related battery" which occurred in a different police force area. The victim was a previous partner. Police records state that during an argument Richard had "repeatedly squeezed the victim around the throat and repeatedly punched her on the head." There was evidence of strangulation, bruising to her neck and wrists, and she needed stitches to head wounds.
- 13.4. The assault involving the previous partner, which took place in another area, was similar to that which led to Lily Louise's death and involved strangulation. Services in the area where she lived were involved and a multi-agency meeting (MARAC) assessed the situation as high risk. Richard received an 18-month suspended prison sentence, and a non-molestation Order was put in place to run from 9.12.2015 to 9.2.2018, subsequently extended to run until 8.12.2021 and still in force at the time of Lily Louise's death. The non-molestation order prohibited contact with the previous partner unless via the solicitor in respect of family court proceedings. Following a breach of the non-molestation Order in 2016 he was sentenced to four months imprisonment and then released on licence and post-sentence supervision until June 2017.
- 13.5. In July 2019 Richard registered with a local GP citing the victim's address. A month later Lily Louise made an application for rehousing based on "under-occupancy". She was in a three-bedroomed house and, as only her daughter was said to be living with her, she was liable for additional bedroom tax. Richard was described as a cousin who was staying with her but planning to find alternative accommodation.
- 13.6. In September 2019, following a self-referral, Lily Louise attended CHFT Ultrasound department for a pregnancy scan. Earlier in the year she had discussed cessation of contraception with her GP, stating she was not sexually active. She had been advised that should she become sexually active she should resume contraception due to the possible adverse impact on a foetus of the medication she was taking in respect of her mental health. The scan showed no evidence of pregnancy, and a pregnancy test completed was negative.
- 13.7. In October and November 2019, Richard had three GP appointments in close succession, presenting with physical issues but with underlying mental health issues, he was prescribed anti-depression medication and the dosage

subsequently increased. Family state that he hated taking his medication and that both Lily Louise and one of her daughters would often seek to persuade him to do so – even to the point of putting the tablets in his mouth.

13.8. Lily Louise's family report that his mood and aggression were much worse when he did not take his medication. They state he also accused Lily Louise of trying to overdose or poison him. Richard stated that there were issues between the couple about the taking of medication and some distrust. He stated the solution arrived at was for them to take their tablets together so that each could witness the other's compliance.

13.9. In January 2020 Lily Louise had a telephone consultation with the GP, presenting with breathlessness and anxiety. She was tearful in the consultation whilst discussing changes in the home dynamics (mum unwell, daughter moved away). There were no recorded indications of domestic abuse, but this possibility was not explored. Family report that at this time Richard's behaviour had worsened.

13.10. In February 2020 Lily Louise's daughter reported an assault against herself by Richard to the police when she intervened in a dispute between Richard and Lily Louise. The daughter reports that he grabbed her by the shoulders, pinned her up against a wall and then threw her on a bed, screaming "jealous little girl with big mummy problems". This was investigated as two potential crimes.

13.11. Lily Louise stated she had not been assaulted and denied any incident had taken place. A DASH⁷ risk assessment was completed with the risk assessed as "standard" – this would not normally lead to any further involvement.

13.12. Despite the allegation being one of a physical assault on the daughter, this was also assessed as "standard", the criteria being that this was the first incident in a 12-month period. Disclosure under Clare's Law was not considered at this stage and, as the daughter was not considered to be in an "intimate relationship" with Richard national practice suggests she would not be considered eligible for a disclosure under Clare's Law.⁸

13.13. In the same month Lily Louise submitted a Changes to Housing Tenancy Form, requesting to add Richard to the tenancy, still stating he was her cousin. She listed two prior addresses for him with reason for change of address being the break-up of relationships. The housing provider does not appear to have responded. but irrespective, the request would have been rejected as Richard had not been living in the property for 12 months or more which is a requirement for a member of the household to become a joint tenant. However, his details do

⁷ The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

⁸ The Domestic Violence Disclosure Scheme states that what constitutes an intimate relationship will vary from case to case and will depend in part on whether those involved consider it to an intimate relationship. Police records do not describe the relationship between Richard and the daughter in these terms.

not appear to have been added to the records as a household member. The housing provider has noted a practice issue here in respect of management of the tenancy and possible implications for the tenant's benefit entitlement.

- 13.14. In March 2020, at a time when GP services were operating differently due to the Covid pandemic, Lily Louise attended the GP with two physical issues but also discussed wishing to become pregnant as she was feeling a gap after her children had left home. The GP gave advice about alternative options to having another child. Later in the month the GP reviewed a copy of Lily Louise's mental health care plan, which included the following description – "diagnosis/differential diagnosis-F31 Bipolar affective disorder". The GP made the necessary amendments to the records and adjusted medication to reflect the diagnosis. Although records also indicate that at this time both Lily Louise and Richard have the same mobile phone number this would not have been obvious to the GP. This is because the GP computer system does not alert the user to the same phone number being used by two different people. The family report that Richard often took control of Lily Louise's phone and at times would hide or break it.
- 13.15. In April 2020 both parties changed to another GP. Although it is good practice to offer a "new patient" health check this does not appear to have been done, and Lily Louise is recorded as single. Both registered with the same address and the same telephone number but the GP computer system (in common with many others) does not automatically link records.
- 13.16. In the June and July, Lily Louise had 8 GP appointments and Richard also called an ambulance due to Lily Louise being breathless. On occasion it is recorded that Lily Louise's partner attended with her. Appropriate responses were made to these physical presentations but there was no curiosity as to whether such frequent contact might have been a cause for concern or indicative of other underlying issues. Family report that at this time Lily Louise was spending 24-hours a day with Richard. They report that he was insisting she worked with him all day and then complete all domestic task on return home. They believe the frequent contacts with GP practice were a cry for help.
- 13.17. The GP has indicated that it is not the normal practice for the GP to make a routine enquiry re domestic abuse. This would not be considered possible with Richard present and caution would be exercised in phone consultations due to concern that a perpetrator may be present, and this might increase risk.
- 13.18. During July Lily Louise attended the GP with what were described as infected insect bites. Swabs were taken and she was prescribed antibiotics.
- 13.19. In August 2020 there were three contacts with Lily Louise. Firstly, she attended the Emergency Department regarding insect bites to her neck. Tests were initiated but she left the hospital prior to further assessment. There is no indication that she was seen as living in vulnerable circumstances.

- 13.20. The family describe a number of marks around the back of Lily Louise's neck and on the front of her chest going down on to her breasts. They believe these were cigarette burns which they questioned Lily Louise about, but she ran away from them in tears.
- 13.21. Around this time one of Lily Louise's daughters also observed small spots on her mother's face which she discussed with her grandmother. They believed these were as a result of strangulation and discussed them with Lily Louise who became very distressed.
- 13.22. Later that month the consultant psychiatrist reviewed her mental health and discharged her to the care of her GP. The contingency plan was for re-referral as necessary. The third event was an abandoned 999 call which was traced back to the home address. Contact was made and Lily Louise said she had dialled the wrong number.
- 13.23. In early September 2020 a third party called the police reporting concern about domestic abuse of Lily Louise. She said Lily Louise had been badly beaten by Richard causing bruising to her face, which had since faded, and broken ribs. She also stated she believed Richard had a history of abusing a previous partner. An officer attended and spoke to the third party and to Lily Louise and Richard. Lily Louise was spoken to on the doorstep while Richard remained in the house.
- 13.24. Contrary to policy, the officer attending did not use their body-camera so there is no evidence as to Lily-Louise's body language. The alleged incident was denied, and Lily Louise said she had hurt her ribs gardening. There is no recorded check of police records, and no statements were taken. Consideration was not given to obtaining a formal statement from the neighbour and recording the incident on the Niche computer system as being domestic related. The police review states that at the very least the information should have been brought to the attention of the Domestic Abuse Hub and that the action taken did not meet expected practice standards.
- 13.25. During the trial the judge asked about the extent to which body language would influence a risk assessment. The judge noted that extreme fear was evident in police camera footage taken at the time of the later incident and commented on the importance of seeking to include this in assessments.
- 13.26. Family report that Richard had set up 14 CCTV cameras around the outside of the house focussing on the garden and the street which they feel could have been accessed to support the enquiries.
- 13.27. On 10th September 2020 Lily Louise called the police. She reported a serious physical assault involving strangulation to the point of unconsciousness, and

coercive and controlling behaviour⁹. She reported an incident which had just happened and a previous offence of physical assault (the one resulting in the rib injuries reported by the third party). The police dispatcher checked three police recording systems – Storm, Niche and PNC¹⁰ and relayed the information that both Lily Louise and Richard were known to the police – Lily Louise as a victim of abuse and Richard as a perpetrator of abuse, including one which took place in another area, but details of those incidents were not passed on as it is considered this would take too long on the radio. Police National Database checks, which would give detail of cases from other areas are not routinely completed at this point in an investigation but were done later by the investigating officer.

13.28. Three photographs were taken of Lily Louise's injuries and Richard was arrested. Lily Louise was keen to support a prosecution. A worker from the Pennine Domestic Abuse Partnership visited and offered support with initial safety planning and discussed options and choices available to Lily Louise. Family have indicated that Lily Louise had had previous experience of being in a refuge and would not have wanted to have to use this resource again.

13.29. The police contacted the Crown Prosecution Service (CPS) on 12th September 2020 seeking authority to prosecute. The police are recorded as still having further evidence to collect – medical evidence from the GP and a possible statement from neighbours.

13.30. CPS authorised two charges – one of Actual Bodily Harm relating to the incident on 28th August 2020 and one of Common Assault by Beating on 10th September 2020. The charging prosecutor advised that there was insufficient evidence to charge Richard with a Controlling and Coercive Behaviour¹¹ (CCB) offence which the police had requested be considered. There was considered to be insufficient detail in Lily Louise's statement to support this (the interview had not been video recorded). New regulations about offences of non-fatal strangulation were not in force at this time. The charging prosecutor reviewed Richard's criminal history and confirmed there were substantial grounds to oppose bail.

⁹ The attached link sets out more detail re recognition of coercive control.
[Coercive control - Women's Aid \(womensaid.org.uk\)](https://www.womensaid.org.uk)

¹⁰ PNC - Police National Computer which holds basic records such as previous convictions, court orders, bail conditions, licence conditions of individuals. This is checked for both the perpetrator and victim; WEBSTORM - This is a software system used by WYP to record calls for service from the public and then to dispatch officers to the incidents. This will record information given by the caller and any updates from officers etc. Also known as an incident log; NICHE - Software system used to record crime reports and intelligence. Once a crime is reported all investigation actions are recorded on this crime report and includes statements, evidence etc. The crime report will remain open and is continually updated by the OIC and supervisors during a live investigation until it is finalised. There is a separate Niche for each crime reported.

¹¹ Controlling and Coercive Behaviour means two or more acts, including, but not limited to, acts in which the stalker directly, indirectly, or through third parties, by any action, method, device, or means, follows, monitors, observes, surveils, threatens, or communicates to or about a person, or interferes with a person's property.

- 13.31. CPS sent a follow up action plan to the police which included seeking to obtain medical evidence from Lily Louise's GP, obtaining a statement from her neighbour and asking Lily Louise to complete a victim impact statement. They asked that checks be made on what support was being offered and asked for further enquiries to be made about Richard's previous offences.
- 13.32. Richard appeared in court on 12th September 2020 and was remanded in custody with a further appearance set for 17th September 2020 to allow him to make a bail application.
- 13.33. On 13th September 2020, Lily Louise phoned the police and said that with Richard in custody she felt able to talk about other offences against her and made further allegations which included an offence of rape. Follow-up was delayed for a number of reasons, including Covid restrictions on police visits to people in custody. The police records state that the rape crime may need to be dealt with separately from the current physical assault charges. Ordinarily a response unit would have been sent out in response to such an allegation but as the suspect was already in custody a decision was made that it should be dealt with by the officer already involved in the prosecution of the physical assault. The officer was not available.
- 13.34. It was also noted that Richard was to appear in court in four days' time which would not give enough time for this rape to be processed. (Lily Louise had said she wished to be dealt with by the original investigating officer.) The rationale for agreeing to delay includes consideration of the fact that the accused was in custody, that there was no requirement for forensic evidence to be collected and no medical examination required. A referral was made to the Domestic Abuse Hub.
- 13.35. Relevant agencies were invited to a MARAC discussion which took place the next day. There was also liaison between the police Witness Care Service and Calderdale Staying Safe (a commissioned service offered by the WomenCentre) to ensure support was being given to Lily Louise.
- 13.36. The police report to the MARAC meeting did include reference to Richard's breach of a non-molestation order but not the original offences which had led to that order so there was no discussion of the nature of his previous offences of domestic abuse.
- 13.37. Had his previous history been explored further it would have exposed 13 previous convictions dating back to 1994. Not all are relevant to the assessment of risk regarding domestic abuse, but a number involved violence. There were two offences of robbery and one for assault but the most relevant are a conviction for Battery in 2015 and a breach of a non-molestation order in 2016.

13.38. The police record of the battery offence describes many common elements with the assault on Lily Louise – “during domestic argument in bedroom with partner defendant has pinned the victim down on the bed and grabbed the victim by the throat. Victim has pushed him off and she has ran out of the bedroom and run downstairs, Defendant has then punched her to the head approx. 8 or 9 times and has caused two cuts which required hospital treatment. Defendant has told her to remove her blood-stained top so he can take it away with him. She has refused and he has punched her a further 4 times.”

13.39. The record of the discussion did include a note that, should Richard be released from custody then it may be necessary to consider a refuge placement, but this is not recorded in the actions.

13.40. The actions from the MARAC were recorded as follows:

- Police to update on outcome of investigation/court outcome.
- Mental Health services to be updated.
- Calderdale Staying Safe IDVA to contact Lily Louise and offer support.¹²
- All agencies to flag their records to show a high risk.

13.41. All were set as immediate actions. The IDVA made telephone contact later in the day and offered practical support to Lily Louise who had no money or food. They began a discussion about contingency plans should Richard get bail and Lily Louise said she was sure he would breach any bail conditions. The call was interrupted when a visitor arrived at the house.

13.42. Before the due court date, the IDVA from Calderdale Staying Safe emailed the court based IDVA with the following information:

- Lily Louise reported to be terrified that Richard might be released on bail.
- Richard has lots of local contacts.
- Lily Louise does not believe he will adhere to any bail conditions.
- Lily Louise still very distressed – saying she still can’t go in her bedroom where there is blood from the assault.
- Lily Louise believes Richard will be “even angrier” with her if released.
- Lily Louise wants a restraining order with conditions of no contact and exclusion from the area she lives in.
- Lily Louise said to still be supportive of prosecution but would like to give evidence via a video link.

¹² Options available in terms of support include consideration of the possible need to flee the home to a refuge or, where refuge is not something the victim wants, to consider alternative housing as a homeless person. Subject to the victim’s agreement a support plan is developed tailored to individual needs and can cover a range of issues.

- 13.43. On 15th September the police informed CPS of the further allegations made by Lily Louise though no evidence was provided as Lily Louise made further contact to say she wanted all charges dropping.
- 13.44. Richard told the reviewer that after his arrest he heard that no-one had seen Lily Louise for some time so asked his cousin to call round and see her. He states she told the cousin that she had made mistake and been confused about what had happened. He states the cousin gave her advice about how to withdraw her allegations.
- 13.45. On 17th September 2020, Lily Louise rang the police and left a message for the Investigating Officer, wishing to withdraw all allegations against Richard. Prison records show Richard called an unrecognised number on 316 occasions whilst on remand – it is not known whether this was a phone in Lily Louise's possession, but family believe this to have been the case.
- 13.46. At this time prisoners were spending long periods of time in their cells due to Covid restrictions. All prisoners were given a daily credit of £5 for phone calls and the prison believe the number of calls Richard was making would not have been unusual at that time. Calls were not recorded or monitored during this period.
- 13.47. Richard's bail application was heard the same day resulting in a further remand in custody.
- 13.48. Shortly after her call to the police Lily Louise had a face-to-face consultation with her GP. She reported feeling very stressed, saying "things came to a head last week" but there is no record that this was explored further. She was not sleeping well; said she was not feeling suicidal and was prescribed short-term medication to assist sleep.
- 13.49. The next day the court IDVA from Calderdale Staying Safe (CSS) contacted Lily Louise to inform her that Richard had been further remanded in custody, that he had entered a not guilty plea and a trial date had been set for late October with Lily Louise granted permission to give evidence via video-link. Lily Louise told the IDVA she did not now wish to proceed and wanted to retract her statement. Arrangements were made for the CSS IDVA to contact her the next day. Lily Louise also made further calls to the police and left messages for the OIC asking to withdraw her allegations.
- 13.50. Lily Louise had been in touch with Richard's previous partner intermittently since May 2020. She was aware of Richard's history with this partner and the nature of the assaults he had made on her. Following his arrest, she told his previous partner that "Richard was turning everyone against her" but that she

“loved him”. There is a strong body of research evidence which evidences the emotional hold perpetrators can exercise over their victims and Lily Louise’s response reflects this.

13.51. During the period on remand, HMP contacted Richard’s GP regarding health issues and medication. The GP has no record of the reason for Richard being in custody.

13.52. On 20th September 2020 the police officer investigating the case noted that he was aware of numerous calls from Lily Louise. He had been unable to confirm whether the IDVA had spoken to her so telephoned her, leaving a message. She did return the call but again had to leave a message. At the same time Calderdale Staying Safe called her and left a message. Lily Louise rang the police again the next day leaving a message to say that, if no-one contacted her, she would come to the police station the next day.

13.53. Later that same day Lily Louise had a telephone consultation with her GP. She discussed deteriorating mental health, poor sleep, anxiety and depression. The GP agreed that referral back to the psychiatrist was appropriate and made a referral. There is no indication that the reason for the deterioration is explored.

13.54. On 22nd September 2020 prison records state Lily Louise made a visit to Richard in prison. This was not known to any of the agencies involved in this review aside from the prison service. On that same date she made a statement retracting the allegations. Lily Louise’s family believe this followed contact from Richard’s solicitor and believe he was involved in drafting the retraction, but this is not the case. The statement was prepared according to police procedure by the officer in the case and signed by Lily Louise.

13.55. On 23rd September the Crown Prosecution Service asked the police to “warn” Lily Louise to attend court on the 15th of October. They were notified the same day that she had made a retraction statement.

13.56. On the following three days, staff from Calderdale Staying Safe and Pennine Domestic Abuse partnership separately made contact with Lily Louise offering support but it was noted that she no longer wished to accept support.

13.57. On 28th September 2020 Richard made the first of a number of calls to the phone number known to have previously been in joint use and which family confirm was still in Lily Louise’s possession. A further 31 calls were made in the following month.

13.58. On the same day Lily Louise had a further telephone consultation with the GP, reporting further deterioration and suicidal thoughts. Her daughter was staying with her. She said she was hearing voices. Based on the assessment of risk the GP made an urgent referral to the Single Point of Access for mental

health support, and they made contact with Lily Louise offering an appointment on the 30th. This appointment was declined but another one made for the 2nd of October. Lily Louise did not attend for the mental health appointment and her GP was informed of this. Another appointment was offered for the 14th of October.

13.59. On 2nd October 2020 the Calderdale Staying Safe made contact and left a message for Lily Louise to the effect that they were aware of her decision but were still willing to offer support. She was asked to contact them to confirm that she would welcome this and was told the case would be closed if she did not. Lily Louise did not make contact.

13.60. On 5th October the police provided CPS with a statement from the officer in the case setting out the degree of Lily Louise's distress and fear, in support of the prosecution.

13.61. On 10th October 2020 Lily Louise made a 999 call but hung up. When called back she said she had lost her keys but had since found them and did not need a service. It was 04.26am.

13.62. Prison records show that also on the 10th of October Lily Louise visited Richard in prison, giving his mother's address (the prison take a photo of the visitor on arrival, and it has been confirmed it was Lily Louise).

13.63. On 12th and 13th October 2020 Lily Louise made further calls to the police about her retraction but did not manage to speak to the officer in the case, and on the 14th, she did not attend the mental health appointment, her GP was notified, and the referral closed pending further referral if required.

13.64. On 22nd October 2020 police contacted Lily Louise who said she was feeling better and planned to go to court, it is not clear if the issue of her intended retraction was discussed. Prison records indicate she made a second prison visit on this date.

13.65. The next day she was served with a summons to attend court as it was the intention to continue the prosecution despite her retractions.

13.66. On 28th October Lily Louise attended court. She attended court alone and agencies who might have offered support were not aware of the date of the hearing. She was in a very distressed state and reiterated her retraction. She is recorded as having told the CPS lawyer that the prosecution was having a detrimental impact on her and that she had been re-admitted to hospital as a direct result of this. There is no evidence that this was the case. She was refusing to go into the courtroom and the lawyer took the view that it would not be appropriate to get a warrant to compel her to do so. Lily Louise's evidence would have been the key evidence in the case and without her testimony the

CPS were unable to continue to prosecute the case. Consequently, the case was dismissed. Richard returned home on release.

- 13.67. There is no evidence that further consideration was given to involving the IDVA again at this point. Systems put in place after these events now result in the IDVA services being more clearly sighted on up-coming cases and potential opportunities to re-engage.
- 13.68. The recording of the outcome of court cases is an automatic process and places information directly on police records, but this does not prompt any kind of review and there was no multi-agency process for follow-up. CPS also notified the outcome of the court hearing to witness care but there is no record in other agency records. There was no system in place to prompt consideration of a re-referral or review in MARAC and therefore no agency intervention to re-assess risk.
- 13.69. On 29th October 2020 Richard contacted the GP regarding chest pains – it is noted that he had recently been in prison, but no reason noted. He had another telephone consultation on the 2nd of November in which he refers to anger issues.
- 13.70. The GP surgery arranged a review of medication, increased the dose and provided information about local services who provide support with anger management, but Richard rejected this.
- 13.71. On the 5th of November 2020 a note was made on police records of the release from prison. No follow-up action is recorded.
- 13.72. On the 12th Lily Louise had a telephone consultation with the GP re abdominal pain. She was offered a face-to-face appointment for assessment but declined this. Richard also made contact that day with similar symptoms.
- 13.73. On 14th November 2020 the police contacted Richard regarding the allegation of rape. He had been in custody when Lily Louise made the allegations and so he had not been interviewed about them. He said he had Covid symptoms and was isolating so an arrangement was made to see him a week later. Within minutes Lily Louise contacted the police. She was extremely distressed (is described as irate) that the police had contacted Richard about allegations she had retracted. She made several calls, and these were terminated due to her demeanour. She was told the police would contact her when she had calmed down. No consideration appears to have been given to seeking to re-engage the IDVA at this point.
- 13.74. The family believe the police contact resulted in a further assault on Lily Louise. She visited family members to see her daughter and newly born grandchild at this time but was covering her face with Covid masks – one round her mouth and one round her neck. They believe she was hiding bruises.

13.75. The next recorded contact is the police record of the interview with Richard on 22nd November 2020. He reiterated Lily Louise's account of the events not having happened and the allegations having been a feature of Lily Louise's drinking and drugs. (The family have never seen any evidence of illicit drug taking). Lily Louise was spoken to and stated she was much better, happier and looking forward to Christmas. The officer who spoke to Lily Louise recorded the following "I have considered the impact that closing this occurrence will have on the victim, given her wishes and her intention to continue her relationship with the suspect, I believe this decision to NFA will be a relief and will have no negative impact on her whatsoever".

13.76. During December 2020 there were several contacts with health services re physical issues or medication reviews:

- On 4th December a call was made to emergency services by Richard re Lily Louise having had a temperature, abdominal and back pain, later vomiting – ambulance attended but Lily Louise declined to go to hospital, was later contacted by out of hours GP who gave advice.
- On 7th December Richard had a routine review with the GP. Records indicate he said he felt his mood was stable but that he was not fit for work and a further sick note was provided.
- On 23rd December Lily Louise had a telephone appointment with the practice nurse, requesting cream for her skin. During this consultation the nurse identified an anomaly with her medication and initiated contact with psychiatric services to clarify this. As a result, the GP updated her prescription the next day.

13.77. In January 2021 there were a number of contacts with police linked to Richard's previous partner. The first was a complaint made by Lily Louise against her sister. Her sister had told her that Richard had been violent towards his previous partner and encouraged Lily Louise to leave him. This resulted in a disagreement between the sisters and some threats being made.

13.78. Later in the month Richard reported that he was being harassed by his previous partner and asked police to intervene – the non-molestation order against him was still in place so he told police he could not contact her himself. WYP records state that both matters were passed to another police force as the alleged offences occurred outside the West Yorkshire boundary. The previous partner states, however, that she was contacted by WYP by phone. She states all contacts were initiated by Lily Louise or the family themselves. She states she expressed her concern for Lily Louise's safety but was advised by the WYP to have no further contact. She states she had no contact from her local police force.

- 13.79. On two occasions in early February 2021 Lily Louise contacted the Registration Service wanting to arrange a wedding – on both occasions she was told no dates were being issued due to the pandemic.
- 13.80. On 12th February 2021 Richard contacted the GP. It is documented “ongoing issues, medication (citalopram) no longer helping and would like a higher dose, not been in contact with counselling and there are anger issues”.
- 13.81. On 3rd March 2021 Lily Louise made and abandoned a 999 call. When contacted she said this was a misdial.
- 13.82. On 8th March 2021 both Lily Louise and Richard reported harassment by Richard’s previous partner complaining that she was contacting their friends and relatives.
- 13.83. During April 2021 Lily Louise made numerous contacts with the Registration Service, eventually fixing a wedding for the first available date which was in the October. Family believe Richard was putting her under lot of pressure to get married at this time.
- 13.84. During May and June 2021 there are several contacts with health services, generally in respect of physical issues and relating to Richard. Also in June, Lily Louise renewed her request for Richard to be added to her tenancy and provided evidence of him living with her for more than 12 months, so this was formally agreed after due process a month later.
- 13.85. In the following two months there were eight contacts with the Registration Service and Lily Louise seemed unable to understand the advice she was being given but was clearly anxious to move forward with the arrangements. There were also further frequent contacts with health services re physical issues for both Lily Louise and Richard. Family believe that at this time Lily Louise was being subjected to both physical and emotional abuse and under considerable pressure regarding the marriage.
- 13.86. During September and October 2021, the couple continued to make regular contact with health services, with the housing provider re repairs and with the Registration Service re the wedding. Nothing of significance is recorded.
- 13.87. The wedding took place on 27th October 2021 and is recorded by the staff as being “a lively affair” with guests arriving an hour before the ceremony and still in the building 45 minutes after its conclusion.
- 13.88. In the early hours of the morning on the 28th October Lily Louise’s daughter received a text message from Richard’s phone purporting to be from her mother saying she had lost her phone. She also received a number of texts including photos as if her mother was browsing through her phone gallery.

13.89. Richard subsequently phoned her to say Lily Louise was missing and also reported Lily Louise as missing to the police. He said she had set off to meet her daughter but not arrived. He described the searches he had made and said she did not have a phone with her. Several hours later her body was located in a field by a member of the public. Police officers attended, located the body and a paramedic pronounced life extinct. Richard had subsequently attended the police station and admitted causing the death of Lily Louise and a murder investigation commenced. Following a Post-mortem Lily Louise's cause of death was established to be blunt force head injury and strangulation.

14. Analysis in response to the questions set in the Terms of Reference and conclusions

14.1. How well did agencies consider historical events and previous incidents in risk assessments?

14.1.1. Richard had previous convictions for violent crime including abuse in a domestic setting. His previous acts of domestic abuse had been serious enough to be assessed as high risk and had been considered in a MARAC meeting in the area where he previously lived. The detail and seriousness of the incidents was not sought and did not influence risk assessment.

14.1.2. When the first allegation, a third-party allegation of domestic abuse made by Lily Louise's daughter, this was denied by both Lily Louise and Richard and resulting in no further action. This incident also involved an assault on Lily Louise's daughter, a statement was taken from her. She subsequently decided to withdraw her complaint as a result of concern she felt for the possible impact on her mother.

14.1.3. The second incident was also from a third party. The police officer going out to the incident had access to the log where prior incidents of domestic abuse were shown relating to both parties - Lily Louise had been a victim of abuse in a previous relationship and Richard a perpetrator in another area with a former partner. The allegation was dealt with as a stand-alone incident, was denied by both Lily Louise and Richard and was not pursued further and not added to the police computer to inform later risk assessments. A statement could have been taken from the third party and recorded on the Niche system and brought to the attention of the DA/MARAC hub. This may have assisted in assessment of risk subsequently.

14.1.4. Additionally, the officer did not activate the body camera so it is not possible to review Lily-Louise's body language which may also have improved the quality of the risk assessment.

14.1.5. On the third occasion all appropriate checks were made, and information passed to the officers who attended to support the assessment of risk.

14.1.6. ***Outcome: The detail of previous assaults by Richard was not sought and did not inform risk assessment. Consideration does not appear to have been given to taking a statement from the third party who reported the second incident and the lack of recording on the Niche system could have undermined the capacity of the attending officers to complete accurate risk assessments on future occasions.***

14.2. MARAC: The effectiveness of information sharing, record keeping, and action from the Daily Hub.

14.2.1. In October 2020, when Lily Louise reported a serious assault involving attempted strangulation, and coercive control, the seriousness of the incidents resulted in Richard being arrested and remanded in custody. Information was passed to the daily hub. Procedures require all agencies to collect information and share this in order to determine whether a case needs to be considered in a MARAC meeting. It also falls to the members of the hub to follow up on any actions identified as a result of a MARAC meeting.

14.2.2. In response to the seriousness of the incident, a MARAC meeting was held the next working day and records indicate that it was established that Richard was currently subject of a non-molestation Order in respect of a previous partner but no detailed information regarding previous offences was obtained and so did not inform the risk assessment.

14.2.3. The MARAC meeting was held on a Monday and considered a number of significant cases which had accumulated over a busy weekend. The multi-agency team brought information from agency records to the meeting, but it was not practice taking full minutes of the meeting, so the record was held in a table which sets out little more than actions.

14.2.4. The absence of full information re Richard's criminal record is a significant omission but the case was none-the-less assessed as high risk. One of the actions from the meeting was for agencies to flag this risk on their records.

14.2.5. The majority of GP Practices use the same computer system which enables the health representative in the team to input information relating to the outcome of the discussions directly into the GP patient records. In this case the GP Practice uses a different recording system which requires a separate email to be sent out to the GP practice to inform them of the outcome of the discussion. Unfortunately, this did not happen which meant the GP Practice had no knowledge of the risks that had been identified.

14.2.6. On the day of the MARAC meeting Lily Louise gave more information to the police about the abuse she had suffered, including allegations of rape. This was included in the report to MARAC meeting.

14.2.7. The record from the MARAC meeting does not include any safety plan or a contingency plan should Richard be released from custody and, when he was, this information was not notified to relevant agencies and not reported back to the MARAC meeting. There was no system that recognised there should be a reassessment of risk. This was a missed opportunity to discuss further safety planning options and support that could be offered to Lily Louise.

14.2.8. ***Outcome: Although the case was recognised as being one of high risk, the deficits in information sharing meant the assessment was not fully informed. The error in respect of information being passed to the GP practice meant they had no indication that Domestic Abuse was an issue. It is not possible to know whether this knowledge would have changed their response to and involvement with Lily Louise and Richard***

14.3. MARAC: Consider how risk and the effectiveness of the safety plan can still be considered even when the victim withdraws – is risk reassessed?

14.3.1. Immediately after the event Lily Louise expressed confidence in the police and was clear she would support a prosecution. Two days later she made additional allegations, stating she felt able to speak more openly now that Richard was in custody.

14.3.2. It is now known that Richard sent a relative to visit Lily Louise at this point and within a very short time she was asking to withdraw her allegations and told Richard's previous partner that two things were factors in this – that Richard was turning everyone against her and that she loved him. She told family members that his violence towards her was her fault and that he did not mean to hurt her.

14.3.3. Research provides insight into why retractions are likely and in the majority of cases are not genuine¹³. The professionals working with Lily Louise were very familiar with this and did discuss this with her. None of the professionals believed that the incidents had not happened. Consideration had not been given to preparing Lily Louise for the possibility that Richard may try, through others, to continue to coerce her and undermine her confidence via third parties.

14.3.4. WomenCentre and IDVAs were all clear with Lily Louise about the support that could be provided, including refuge access if this became necessary. She was equally clear that she wished to withdraw her allegations and did not want further support.

14.3.5. The CPS re-reviewed the case in accordance with the Code for Crown Prosecutors and their Legal Guidance. They asked the officer to provide a statement to support an application for a summons. Lily Louise was summonsed to attend court and did so. Her refusal to actually go into court and her continued insistence that the offences had not taken place, and her level of distress resulted in a decision that to force her into court via a warrant was not appropriate. The case could not proceed without her evidence.

14.3.6. The MARAC process did not have review points or escalation points built in, so no information went back into the MARAC. Providing direct support was not possible without consent and there is no suggestion that any agency felt Lily Louise lacked mental capacity to make her own decisions, however no account appears to have been taken of the possible impact of coercion on her decision-making. It would however have been clear to professionals, had the case been reviewed, that it remained a high-risk situation and multi-agency records could have been updated to this effect. This would have likely resulted in the GP being informed.

14.3.7. ***Outcome: There was no reconsideration of risk or development of a safety plan once Lily Louise withdrew her allegations nor any further review when Richard was released from prison and returned to live with Lily Louise.***

14.4. Consider how professionals share information

14.4.1. The Panel included this specifically in relation to an occasion where Lily Louise was advised to contact the police direct. The IDVA was clear that Lily Louise would need to speak directly to the police but in cases where there is risk of harm to a vulnerable person,

¹³ [Why don't women leave? - Women's Aid \(womensaid.org.uk\)](https://www.womensaid.org.uk)

professionals need to make it clear that they will also need to share information.

14.4.2. The balance between individual autonomy, the right of adults to make poor decisions and the need to over-ride consent where there is too great a risk is sometimes difficult to achieve.

14.4.3. ***Outcome: There is a risk that too great a reliance is placed on the victim and that they are left with the whole responsibility for keeping themselves safe if they do not feel they have full professional support.***

14.4.4. **Could the time the perpetrator is remanded be used more effectively to safeguard and support the victim. Was the opportunity to do further work with the victim whilst the perpetrator was incarcerated maximised?**

14.4.5. Both the police and professionals from specialist domestic abuse services worked with Lily Louise around the time the allegations were made, offering support and giving her full information about the services she could access. This support continued when Richard was remanded up to the point where Lily Louise declined it.

14.4.6. Lily Louise clearly expressed her fear that Richard would not leave her alone if he was released and the IDVA passed this information to the court based IDVA sharing the detail of what Lily Louise felt was needed to keep her safe. She was given assurance about the steps that would be put in place such as Lily Louise being able to give evidence by video link and prohibitions on contact should Richard be released on bail.

14.4.7. At the point where Lily Louise began to talk about withdrawing her allegations professionals re-iterated the offers of support, but she maintained her position. Support services are made by way of a voluntary offer and are reliant on the victim accepting that offer by consent. Lily Louise withdrew her consent within a very short period of time and did not wish to engage with the services available via Calderdale Staying Safe (WomenCentre). Contact was not immediately withdrawn, and the offer of support was repeated a number of times before the decision Lily Louise had made was accepted and support services closed the case.

14.4.8. However, police records of Lily Louise's contact with them around her decision to withdraw, describe a high level of agitation and distress. The Investigating Officer was in touch with the IDVA, and attempts were made to offer further services. The possibility that

Richard had found a way to put pressure on Lily Louise whilst still in custody was not explored at the time.

14.4.9. In addition to phone calls, the family state that after the trial they found numerous letters from Richard in the house when they were allowed access. They report that they contained detailed instructions as to what to say to the police and what to write in the retraction statement. There is no record of these being found by the Homicide and Major Enquiry Team. The family disposed of these as they saw no reason to keep them.

14.4.10. The Home Office has recently issued publicity regarding the Unwanted Prisoner Access Service¹⁴ - a service which was previously available in some prisons on request – but which does not appear to have been well-known. Agencies were unaware of the level of contact from Richard, and this was not considered.

14.4.11. The local Police now have a new system in place whereby the completion of a report regarding the possible impact of victim contact is a requirement and results in dialogue with the prison in relevant cases. The roll-out of this system has been supported by additional training.

14.4.12. ***Outcome: Despite a degree of persistence on the part of professionals in offering support, Lily Louise made the decision to withdraw her allegations within a matter of days and while Richard was in custody. Her family and Richard's previous partner both confirm that they believe from their conversations with her that she believed Richard did not intend to hurt her and that she loved him. Records evidence efforts to help Lily Louise better understand the risks and accept more support. This could not be enacted due to her lack of consent.***

14.5. Understanding what consideration was given to proceeding with prosecution despite the victim's withdrawal.

14.5.1. Following Lily Louise's withdrawal of the allegations she provided the police with a retraction statement. When this happened on 29th September 2020, the officer investigating the case informed the CPS and sent them a copy (this is a requirement where victim of domestic abuse retracts their allegations) together with a background report. He requested that prosecution be pursued "due to the severity of the initial incident plus further allegations that have come to light". CPS agreed this and a summons was sent requiring Lily Louise to attend Court. On the day of the hearing, she came to court and stated that the events subject of the charges had not happened and that she

¹⁴ <https://unwanted-prisoner-contact.form.service.justice.gov.uk/?analytics=accepted>

had been under the influence of alcohol and prescribed drugs when she had fabricated the allegation. She told the CPS lawyer that the prosecution was impacting adversely on her mental health and that as a direct result she had been admitted to hospital (she had in fact not been admitted to hospital). She was very distressed.

14.5.2. The CPS lawyer determined in accordance with the Code for Crown Prosecutors and their Legal Guidance that it would not be appropriate to obtain an arrest warrant and force Lily Louise to go into court. No evidence was offered, and the case was dismissed.

14.5.3. A police officer attended court but was never called and was later told by an usher that the case had been dismissed

14.6. **Was the former partner's disclosure used to inform risk assessment.**

14.6.1. Richard's former partner states she was contacted by Lily Louise and by one of her sisters and shared with them, at their request, information about the assaults she had suffered and the resulting conviction of Richard for violence against her. Family report that she also gave information about a similar assault on a previous partner.

14.6.2. When allegations of harassment were made against her, she states she was contacted by WYP and advised not to have further contact with the family. She states she told the police that she was seriously worried for Lily Louise's safety and that she felt Richard was capable of murder.

14.6.3. WYP records indicate that a crime was recorded on WYP system and transferred as per crime recording rules to the police force in the area where she lived. This is compliant with crime recording rules and standards. She states she has had no contact from the Nottinghamshire police force.

14.6.4. The details of Richard's previous behaviour and convictions were not known when risk assessments were being carried out and procedure did not require re-assessment as new information emerged.

14.6.5. The investigation of an allegation of harassment did not join up with the processes which concern risk assessment so significant information about past patterns of behaviour did not inform the risk assessment.

14.6.6. ***Outcome: The former partner's disclosures were not shared in any risk-assessment process and did not inform any multi-agency safety planning.***

14.7. Were opportunities missed to consider disclosure via Clare's Law?

- 14.7.1. There is no written record of discussion with Lily Louise about Clare's law or of a disclosure having been made. However, one of the police officers who attended following an incident, and the IDVA from Pennine Domestic Abuse Partnership who was with her, both clearly recall a discussion about disclosure.
- 14.7.2. Their recollection is that Lily Louise told them she knew all about Richard's history and did not want further disclosure. As a result, no formal disclosure was made.
- 14.7.3. Lily Louise's daughter was also subject of an assault by Richard and would have welcomed disclosure had it been offered. She was not offered this opportunity and there is no evidence that any consideration was given to this. It is considered that if, consideration had been given, in accordance with national guidance, she would not have been deemed to be in an "intimate relationship" with Richard and therefore would not have met the criteria.
- 14.7.4. ***Outcome: No Clare's law disclosure was made. Lily Louise did know about the domestic abuse offences against Richard's previous partner, but this information came from Richard's previous partner. It is not possible to know whether there would have been a greater impact had this information been reinforced by disclosure coming from the police. The absence of disclosure to Lily Louise's daughter may have weakened the family's capacity to support Lily Louise.***

14.8. Could the GP have been more proactive around the different, complex and persisting health conditions and were there missed opportunities to consider Domestic Abuse.

- 14.8.1. An error in the multi-agency hub regarding information sharing resulted in information about the abuse of Lily Louise by Richard, and the consequent assessment of high risk, not being shared with the GP Practice. Had this notification come through then Lily Louise's GP records would have been flagged, and this could have been taken into account in future contacts.
- 14.8.2. Enquiry into potential domestic abuse is not carried out as a matter of routine by the GP but, as per National guidance, is done in response to an indicator of potential concern. A flag on the system does prompt professional curiosity. Much of the period under review took place during the Covid pandemic and many GP contacts were by way of

phone consultation (though not all). The GP was clear about the constraints he and his colleagues would face, when working remotely, in asking about domestic abuse particularly if there were no specific pointers to raise concern.

14.8.3. The GP practice does have a system for identifying those who make frequent contacts which do not appear to arise from appropriate health concerns. These systems did not come into play for either Lily Louise or Richard as they generally presented with issues that were known to be a result of existing health conditions. Had the presence of domestic abuse been known it is impossible to know if this would have been different.

14.8.4. ***Outcome: The absence of a flag for domestic abuse reduced the GP's awareness of the issues facing Lily Louise and as a result no enquiries about domestic abuse were made. On a number of occasions Lily Louise talked about escalating pressures and Richard talked about anger – had the context of domestic abuse been known then the GP would have taken this into account, and it is possible that this would have enhanced risk assessment and management and created an opportunity for professional curiosity and led to different interventions or referrals for different services. The GP practice responded to the numerous contacts in accordance with their own procedures, A number of actions have already been completed to address these issues: -***

- ***The GP practice has recognised and addressed (in accordance with national guidance) the lack of a triggered enquiry, given the possible signs and indicators of abuse presented by both Lily Louise and Richard.***
- ***The ICB has provided further information to GP practices on recognising signs and indicators that someone may be a perpetrator of domestic abuse and offering support to address abusive behaviours.***
- ***GP annual safeguarding standards now include the training of staff in identifying perpetrator behaviours.***

14.9. **Was the impact of COVID significant in: how agencies worked together; how agencies engaged with the family; on safeguarding assessment processes or anything else?**

14.9.1. Direct engagement with Lily Louise and Richard by police and domestic abuse services was not adversely affected by the pandemic

and agencies attended the home to carry out investigations and provide support.

14.9.2. GP engagement with both Lily Louise and Richard was impacted upon by Covid and many consultations took place via the telephone. This made it more difficult for the GP to ask about domestic abuse particularly as it was not possible to know who was present in the room. However, some in person consultations did take place when the GP felt this to be necessary.

14.9.3. Practitioners who attended the learning events felt the operation of the multi-agency hub and MARAC meetings were less effective when conducted via remote meetings using video links. The sharing of information was described as becoming more compartmentalised and more formalised.

14.9.4. ***Outcome: Direct engagement with Lily Louise was provided by direct approaches and visits together with telephone follow up. GP engagement and the multi-agency aspects of work were adversely impacted upon by the pandemic.***

14.10. Are health inequalities and the impacts of poverty relevant in this case?

14.10.1. Both Lily Louise and Richard suffered both physical and mental ill-health which prevented them from taking employment. The area in which Lily Louise lived is in the bottom 20-30% of wards ranked according to deprivation in Calderdale. Lily Louise and Richard were in receipt of benefits, and it is known that Richard also worked collecting scrap metal for additional income.

14.10.2. During the time they lived together, Lily Louise reported coercive control by Richard including control over her finances. Her family believe he curtailed her freedom and prevented her from access to family members who would have given her support. This may well have impacted upon her decision-making. At the time of his arrest she needed assistance and was taken a food parcel and some toiletries by the IDVA.

14.10.3. ***Outcome: Health Issues restricted the couple's ability to take up employment. Richard's control over Lily Louise's finances and movements did impact on her and restricted her freedoms during the time they were together.***

15. Issues identified which were not set out in the original scope in the Terms of Reference.

15.1. Flagging of agency records

- 15.1.1. Procedures require agencies to flag records in order to better safeguard individuals where there are issues of domestic abuse. During the course of this review, it has become clear that for the GP practice (and probably many others across the country) this is problematic.
- 15.1.2. If the practice receives the appropriate notification of domestic abuse, it will flag the victim's record and that of linked children. There are concerns that, with the introduction of on-line access to patient records, this information might be seen by an alleged abuser and might increase risk to the victim. There is a facility to hide this information from the patients view screen to guard against this.
- 15.1.3. It is not usual practice to flag the perpetrator's record. The rationale given for this was that this is compliant with the professional advice given to GPs and flagging would raise data protection issues. Unless hidden from the patient view screen it may also increase risks to the victim.
- 15.1.4. In this case the relevant information was not passed to the GP practice but, if it had been, it would not have been flagged on Richard's record. This means that this important context would not be visible to any GP seeing him and this would undermine the GPs effectiveness in responding, for example, to Richard asking for help with anger. This could have been mitigated to some extent by further professional curiosity.
- 15.1.5. ***Outcome: The absence of flagging of perpetrators means there is no immediate alert to support the GP in providing an appropriate response which takes account of potential risk.***

15.2. Cross-boundary cases and the MARAC process

- 15.2.1. At the time of Richard's violent assault on his previous partner, the incident was discussed at a MARAC meeting in another local authority area. A risk assessment had been completed which indicated a high level of risk. The circumstances of the incident had much in common with the allegations made in 2020.
- 15.2.2. Research clearly shows that past behaviour is among the best predictors of future behaviour but there is no system which enables the existence of a prior MARAC meeting and risk assessment to be made known and shared across boundaries. It will not show on the information that is shared when police record checks are made and will only be

visible if the individual record is accessed and notes or actions from a prior MARAC meeting are found.

15.2.3. Outcome: the MARAC meeting held in respect of Lily Louise's abuse in 2020 had no information about the detail of Richard's abusive history in another area. It could be inferred from the fact that there was a non-molestation Order in place that there had been a serious incident but no check of the PND system, which would have provided some detail, was made and there is no system in Calderdale for sharing information between MARACs in different areas.

15.3. Retraction

15.3.1. After making numerous phone calls demanding her allegations be withdrawn, Lily Louise attended the police station and made a retraction statement. Lily Louise's family believe she made the retraction because of pressure being put on her by Richard and others on his behalf. Lily Louise told his previous partner that Richard was turning everyone against her.

15.3.2. Lily Louise made two prison visits, there were over 30 calls from Richard on the number the couple had jointly used and over 300 calls to an unidentified number which family believe was in her possession.

15.3.3. Professionals from Calderdale Staying Safe and the police had been fully aware of her intention to retract and had worked with her to try and support her to continue with the prosecution. They had set out in detail for her the risks and the likelihood of further abuse. They set out the options for keeping her safe in the future.

15.3.4. Domestic abuse support is provided by consent and inevitably is withdrawn when this is requested by the victim. Despite this IDVA services made two contacts with her when she was seeking to make a retraction statement, but she continued to decline support. The evidence of continuing risk was strong but did not prompt a multi-agency re-assessment of risk and was not reported back to MARAC.

15.3.5. The CPS did however continue with the prosecution. Events at court resulted in a decision being made not to compel Lily Louise to go into the court room and the case was dismissed. It is the responsibility of the court to inform the police of the outcome through a computer-to-computer notification. This did not occur for some time.

15.3.6. Outcome: Richard was released from prison unexpectedly. None of the agencies who had been trying to support Lily Louise

expected him to be released that day. He returned immediately to live with Lily Louise. There was no contingency or safety plan in place.

15.4. The role of the Crown Prosecution Service

15.4.1. On presentation of evidence by the police, it is for the Crown Prosecution Service to determine the appropriate charges and issues regarding bail. This was done in accordance with the Code for Crown Prosecution. The decision to charge with an offence of Actual Bodily Harm in respect of the incident on 28th August 2020 was appropriate. A charge of Common Assault by Beating was selected for the offence on 10th September 2020. In their review of practice, the service indicated that, having looked again at the circumstances, a charge of Actual Bodily Harm would have been more appropriate and would have given the court more sentencing powers. (The recently created offences of non-fatal strangulation or suffocation were not in force at the time).

15.4.2. On review it was also considered that the decision not to pursue Controlling and Coercive Behaviour charges was premature and that the police could have been asked to follow up reasonable further lines of enquiry. It is however noted that in reality this would have made no difference to the outcome given the retraction.

15.4.3. The decision not to proceed at court is considered to have been appropriate given the lack of supporting evidence.

15.5. Interpretation of policy and risk assessment

15.5.1. Where body camera footage of police response to calls is available, Lily Louise's demeanour is clear, and the trial judge commented that she appears to be terrified. On one occasion, contrary to policy, the camera was not used, and it appears the assessment of risk relied on a narrow interpretation of the DASH criteria. The trial judge highlighted the importance of assessment of body language and the application of professional judgement.

15.5.2. Similarly, the review has been told that the current interpretation of the definition of eligibility for disclosure under Clare's Law would not permit a disclosure to person's such as Lily Louise's daughter and this could have increased the risk to her had she remained in close contact with Richard.

15.5.3. ***Outcome: Interpretation of the guidelines and policy may have contributed to the under-estimation of risk earlier in the couple's relationship.***

16. Lessons learnt and DHR Recommendations

16.1.1. **Risk assessment:** Early police engagement with Lily Louise did not reach the expected standard of practice and, additionally, there is no evidence that the level of risk was fully informed by assessment of body language and application of professional opinion.

16.1.2. **MARAC:** The information considered at the MARAC meeting was incomplete and, although the outcome was, none-the-less, a categorisation of high risk, information about the nature and seriousness of Richard's previous offences was not sought. The record of the meeting was lacking in detail, and no safety plan was set out. Due to human error, crucial information about risk was not shared with the GP practice. There was no re-consideration of risk following Richard's release from custody. Since the events subject of this review the operation of the MARAC has been reviewed and changes made.

Recommendation 1 – West Yorkshire Police should review training and support to officers to ensure the importance of interpretation of body language and the application of professional judgement inform risk assessments.

Recommendation 2: The Community Safety Partnership should conduct an audit of MARAC practice to ensure the changes which have been introduced are sufficient to:

- ensure all relevant information is provided to inform risk assessment,
- appropriate records are kept,
- multi-agency risk management plans are developed and clearly set out,
- review points and contingency plans are agreed, and the outcome of the meetings circulated to relevant agencies.

16.2. **Retractions:** The reasons why victims might retract their allegations are well understood and it is recognised that this is often as a result of fear and lack of confidence that a victim can be kept safe alongside a belief by the victim that perpetrator "didn't mean to hurt me", or a continuing attachment. There is also the risk that the perpetrator is applying pressure and intimidation. In this case it is now known that there were phone calls and face to face contacts during the period of remand. The learning point here for WYP in respect of what can be done in conjunction with the prison to stop visits and phone calls has been actioned with the introduction of a new system to assess the risk of victim intimidation in the local police force, and new processes adopted in the prison service.

In this case Richard also sent someone to visit Lily Louise – whilst contact between victims and perpetrators is often anticipated pressure via third parties

was not considered. Members of the DHR Panel consider this needs highlighting to those who offer support to victims.

Because a retraction is often accompanied by a rejection of further support it is difficult for agencies to continue their work at a point where risk may well be heightened. At present there is no process for multi-agency re-assessment of risk when there is a retraction and no further consideration of safety measures. Such a review would provide the opportunity to ensure all possible steps to support the victim are in place.

Recommendation 3 – MARAC members should ensure that those working with cases of domestic abuse assess the risk of intimidation, including intimidation via third parties and are familiar with options available, including the ‘Unwanted Prisoner Contact’ service, and liaise with the prison service accordingly.

Recommendation 4 – Police and specialist domestic abuse services should promote staff awareness of the need to include support to victims regarding the risk of coercion via third parties.

Recommendation 5 - The Community Safety Partnership should review procedures for MARAC and consider the introduction of multi-agency review process where there is reason to believe the risk has increased, including a retraction of a statement in high-risk cases, and should ensure a MARAC takes where a perpetrator is released from custody on remand or at the end of a sentence.

- 16.3. Decisions around prosecution where the victim is no longer willing to support this:** In this case WYP and CPS followed the procedures in place setting out the need for discussion of cases where retraction of evidence occurs when Lily Louise retracted her statement. The CPS decided to continue with a prosecution despite Lily Louise’s withdrawal of her allegations and she was summonsed to attend court. The officer who had attended the call-out attended court. Lily Louise informed the Crown Prosecution Service Lawyer that she had made the allegations up when under the influence of prescription drugs and alcohol and would tell the court this. She showed considerable distress and said the process had impacted on her mental health and resulted in hospital admission. CPS presented no evidence, and the case was dismissed.

Recommendation 6 – The Community Safety Partnership should explore what services can do when a victim declines services and how continuing risk can be mitigated.

- 16.4. Clare’s law and the former partner:** History of violence is a significant factor in predicting future violence. Richard’s former partner shared information with Lily Louise and her family, but none of the professionals involved in protecting Lily Louise sought any detailed information about those previous offences. Had

they done so they would have seen a pattern of behaviour and potentially life-threatening scenario. This was an opportunity missed. Risk assessments were based only on the immediate incident under consideration.

- 16.5. Additionally, services focus on the victim and rarely engage with the perpetrator particularly prior to any conviction. Richard had raised his own concerns about managing anger with his GP, but the potential risks associated with this and the possible opportunities to reduce risk were not explored and the information not shared. Though not recorded, (contrary to force policy) it seems clear that police did offer disclosure under Clare's Law to the victim, but she refused it. Providing written information about Clare's Law is contrary to force policy and seen as potentially increasing risk to victim's or witnesses so any information would be shared orally.

Recommendation 7 - CSP should consider whether the MARAC procedures require amendment to require historical information to be explored in more detail and how this might be done.

- 16.6. **Flagging of agency records:** High risk cases which are considered in a MARAC meeting are notified to relevant agencies. On receipt, the victim's record and that of associated children are flagged. This is not the case with perpetrator records and the review was told that GP practices do not flag the perpetrator's record, and this is in accordance with professional guidance.¹⁵ Domestic abuse is a serial offence and perpetrators move around. The absence of flagging reduces the likelihood that future risk will be identified and could reduce the opportunities for GPs to risk assess and provide appropriate healthcare management. There are clearly data protection and human rights issues as well as victim safety issues to be considered but this has to be balanced with the rights of any future victim.

Recommendation 8 – The Community Safety Partnership should draw the issue of lack of flagging of perpetrator records to the attention of the Home Office suggesting they should engage with the Royal College of General Practitioners (RCGP) and encourage a review of professional guidance to ensure all possible safeguards within the law are considered when relevant information about perpetration of abuse is involved.

- 16.7. The Home Office is currently developing what is described as a comprehensive perpetrator strategy. Additionally, the Home Office and Ministry for Justice are jointly funding a project to create a new Multi-agency Public Protection System which will allow some current out-dated systems to be replaced.

Recommendation 8 – The Community Safety Partnership should share the learning from this review with the West Yorkshire Domestic Abuse

¹⁵ [Guidance-on-recording-of-domestic-violence-June-2017.pdf \(rcgp.org.uk\)](#).

Commissioner and should also request that the Home Office consider **if** the new Multi-Agency Public Protection System interfaces effectively with the MARAC systems.

TERMS OF REFERENCE

DOMESTIC HOMICIDE REVIEW

SUBJECT: Lily Louise

Version Control

Author	Date	Version
JC	January 2022	1
JH	March 2022	2

PURPOSE OF THE TERMS OF REFERENCE

These terms of reference outline the accountability and scope of the Domestic Homicide Review (DHR).

This document stands as part of the commissioning contract enabling Calderdale Community Safety Partnership (CSP) to formally scope the terms under which the review will operate.

The Terms of Reference can help the CSP and other stakeholders to determine whether the Independent Author and Review Panel have satisfactorily adhered to obligations and conditions.

PURPOSE OF THE REVIEW

The purpose of a DHR is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

METHODOLOGY AND ETHOS OF THE REVIEW

The report will focus on system-wide process, service engagement and response. The approach taken with the review should be proportionate and inclusive: led by individuals who are independent of the case; professionals fully involved and able to contribute their perspectives without fear of blame; and contribution of family members where possible. The report will be published, and improvement monitored through the CSP.

Hindsight bias and outcome bias will be recognised and reduced by using analysis which examines how things were and perceived to be at the time.

To ensure this review does not adversely affect any ongoing criminal process, it will be managed according to the DHR arrangements which are subject to national guidance in England. Other concurrent investigations will be monitored, and any learning will feature in the overview report.

The release of minutes or assessments from MARAC will be in agreement with the Chair of MARAC and the DHR Panel.

Individual Management Reviews:

The aim of the IMR is to:

- a) allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards.
- b) identify how and when those changes or improvements will be brought about.
- c) identify examples of good practice within agencies.

SCOPE OF THE REVIEW

Terms of reference are based on information known at the time. It should be noted that the terms of reference are a living document and can be revised at any point during the review, for example in the light of new information. The DHR Panel will have responsibility for agreeing any variation to the terms of reference.

The time period is from **1st June 2019 to the 31st of October 2021.**

Agencies providing chronologies. IMRs were also provided where indicated (*)

1. Calderdale and Huddersfield NHS Foundation Trust*
2. Calderdale CCG – GP*
3. South West Yorkshire Partnership NHS Foundation Trust*
4. Together Housing*
5. Calderdale MBC Housing
6. West Yorkshire Police*
7. WomenCentre*
8. Yorkshire Ambulance Service
9. Pennine Domestic Abuse Partnership
10. Registrar Office, Calderdale MBC

Panel Members:

1. Independent Chair and Author – Jane Booth
2. Calderdale Safeguarding Partnership Manager – Julia Caldwell
3. Designated Nurse Safeguarding Adults, West Yorkshire Integrated Care Board (formerly Calderdale CCG) Luke Turnbull
4. Detective Chief Inspector, West Yorkshire Police – Samantha Lindsay
5. Named Midwife for Safeguarding and Domestic Abuse Lead, Calderdale and Huddersfield Foundation Trust – Alison Pollock
6. Assistant Director, South West Yorkshire Partnership Foundation Trust – Emma Cox
7. Assistant Director Supported Housing & Neighbourhood Safety & Safeguarding Lead, Together Housing – Sue Lewis
8. Chief Executive Officer, WomenCentre – Angela Everson

9. Chair of MARAC – Zaheer Abbass
10. Domestic Abuse Coordinator, Calderdale MBC - Nazia Mukhtar
11. Deputy Chief Crown Prosecutor - Jonathan Wettreich

ISSUES TO BE EXAMINED

1. How well did agencies consider historical events and previous incidents in risk assessments?
2. Were opportunities missed to consider disclosure via Clare's Law?
3. To what extent was the former partner's disclosure used to inform risk assessment?
4. To what extent did your organisation appropriately share information with other partners?
5. How effective was information sharing, record keeping, action planning and follow up from the Daily Hub?
6. What consideration was given to proceeding with prosecution despite the witness' withdrawal of allegations?
7. What risk assessment and safety planning took place at the time Lily Louise stated she wanted to withdraw the allegations of domestic abuse / violence?
8. How could professionals have provided support to those around Lily Louise e.g., daughter, witnesses, neighbours, to assist her engagement with services following the retraction of her statement/ alleged assault/ witness to Domestic abuse?
9. Was the opportunity to undertake safety planning with the victim whilst the perpetrator was incarcerated maximised?
10. Following the release of the perpetrator from prison (on remand) to what extent were the risks to the victim considered, mitigated and monitored?
11. Could agencies have been more proactive in identifying domestic abuse through signs and symptoms presented?
12. Was the impact of COVID significant in: how agencies worked together; how agencies engaged with the family; on safeguarding assessment processes or anything else?
13. What did agencies do to build trusting relationships with the victim and perpetrator?
14. What additional interventions could agencies have provided and/or offered, to assist Lily Louise in addressing other areas of care/needs that may have made it easier for her to establish independence and ultimately escape from the

perpetrator e.g., provision of health services including mental health, support with benefits, finances, tenancy issues/rehousing

15. Could further exploration of impact of health inequalities and poverty have evidenced an increased risk of domestic abuse?

THE OVERVIEW REPORT

The overview report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests.

The Overview Report will follow the template laid out in the DHR Statutory Guidance. An Executive Summary will also be produced which outlines the review process, a summary and the key issues and recommendations arising from the review.

QUALITY ASSURANCE

On being presented with the overview report and executive summary the review panel should:

- a) ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports.
- b) be satisfied that the reports accurately reflect the review panel's findings.
- c) ensure that the reports have been written in accordance with this guidance; and
- d) be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office.

Appendix 2 – Letter from the Home Office



Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Serious Incident Review Co-ordinator Calderdale
Safeguarding Children Partnership Halifax Town Hall
Crossley Street Halifax
HX1 1UJ

17th December 2024

Dear REDACTED,

Thank you for submitting the Domestic Homicide Review (DHR) report (Lily Louise) for Calderdale Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20th November 2024. I apologise for the delay in responding to you.

The QA Panel noted the moving pen portrait which opened the report and gave insight into Lily Louise as a person, wife, mother, grandmother, and friend. There was also positive engagement with family throughout and they were supported by AAFDA.

The local health recommendations clearly address the identified learning for health in the report and provide assurance that appropriate actions have been taken to improve future practice.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Please clarify the court sentence given as the information in the report and on the data sheet do not currently match.
- Please review the section on timescales, as there are some inconsistencies between the information in the section, on the front page and in the data sheet.
- Clarification is also required regarding the delays and why it took almost a year and half to engage with the family post-trial.

- The precise date of death should be anonymised.
- Regarding the decision to undertake a DHR, please add who was involved in this decision, whether local domestic abuse specialists were consulted, when the Home Office was informed and when the family were informed.
- Please include the names of panel members and ensure that all have both job titles and their agency. It would also be helpful to include how many times the panel met.
- Please add the local Police and Crime Commissioner and the Domestic Abuse Commissioner to the dissemination list and include any other plans to disseminate the learning from this Review.
- Please review the Equality and Diversity section. There is no such thing as a person with no protected characteristics. Both Lily Louise and the perpetrator may also have had a disability as defined under the Equality Act.
- Section 7 on Quality Assurance is not necessary and the QA Panel have suggested that this could be removed.
- In paragraph 14.33 and 14.34, the word alleged is used three times in such a way that it casts doubt on the victim's disclosure; this needs amending.
- Paragraph 14.54 states, 'Lily Louise made a visit to Richard in prison. This was not known to any of the agencies.' Please clarify which agencies you are referring to here.
- Paragraph 15.8.4 states, 'Lily Louise did know about the domestic abuse offences against Richard's previous partner, but this information came from Richard's previous partner and may not have had the impact of information coming from the police.' Please provide some further analysis here, given that the victim belonged to a cohort of survivors that was likely to have a very low level of trust in the police.
- Paragraph 15.9 states, 'The GP practice responded to the numerous contacts in accordance with their own procedures and national guidance.' This is not completely true, as national guidance states that selective inquiry should take place if there are any indicators of abuse.
- Paragraph 15.9.4 states, 'Richard talked about anger'. Please consider whether this information could give rise to a recommendation for GPs to understand the ways in which perpetrators may disclose abuse.
- Paragraph 15.11.3 states, 'Richard's control over Lily Louise's finances did impact on her and restricted her freedoms during the time they were together. There are no indications that health inequalities or poverty are directly relevant in this case.' Given the references to control of finances, the QA Panel suggested it may be worth reconsidering this.

- Linked to the above, the economic abuse by the perpetrator could be addressed in greater detail.
- Paragraph 16.2.3 states, 'no system exists for sharing information between MARACs in different areas.' Please clarify that this is the case in Calderdale, rather than across the country.
- Paragraph 17.5 states, 'police did offer disclosure under Clare's Law to the victim, but she refused it. This suggests she was, to some extent, in denial which would add to the risks she faced.' There could have been a wide range of reasons why the victim declined a Clare's Law disclosure, for example because she was already aware of the perpetrator's history. This should be noted in the report.
- The report does not explore Lily Louise's eating disorders, frequent relocations, or any adverse childhood experiences and how they contributed to her vulnerability. This is similar for the perpetrator; there is a lack of information regarding his childhood and early relationships that could have shaped his belief system. The Panel suggest including more information on these areas.
- Recommendations should explore what services can do when a victim declines the service.
- Recommendation 5 should be amended as a MARAC should take place if an offender is due to be released from prison.
- Recommendations should be more specific and include who/when/how long the actions will be executed.
- The report requires a thorough proofread ahead of publication.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix 3 – DHR Action Plan for Lily-Louise

To note, this is a live document and subject to change as outcomes are delivered.

DOMESTIC HOMICIDE REVIEW ACTION PLAN – LILY LOUISE

Progress Key	Red	Tasks or outcomes have not been met or timescale slipped.
	Amber	Timescales have slipped but tasks and outcomes remain on course to be met.
	Green	Tasks and outcomes are completed or performance is on target.
	Blue	On Track

	RECOMMENDATION	ACTIONS	AGENCY	TIMESCALE	LEAD OFFICER	RAG
1	West Yorkshire Police should review training and support to officers to ensure the importance of interpretation of body language and the application of professional judgement inform risk assessments.	See below – already actioned	WYP	April 2024	REDACTED	G
		KEY MILESTONES ACHIEVED IN ENACTING RECOMMENDATION See below				
		Completion Date and Outcome The force currently uses the DASH risk assessment to assess the risk posed by DA suspects. There is no specific training package which focuses on the interpretation of body language when assessing risk, however the force has recently rolled out the Domestic Abuse Matters training programme to over 3,250 officers and staff. # DA Matters is a cultural change programme developed by the College of Policing. The programme is written and informed by those with lived experience of domestic abuse. This lived experience aids in improving officer and staff understanding with the relevant information that they need to aid their decision making. It recognised the difficult role frontline police play in dealing with domestic abuse and				

		enabled officers to develop and respond to domestic abuse situations and looked at changing skills, behaviour and attitudes by challenging inappropriate language and behaviour. The training covered areas such as coercive and controlling behaviour, understanding perpetrators, digital domestic abuse, assessing risk, male victims of domestic abuse and abuse involving older people. Real life case studies and body worn video footage is played during the course, which highlights the importance of professional curiosity to better inform risk. The force is also working closely with academics to assess the impact of the DA Matters training programme, however anecdotally we are hearing that the quality of DASH risk assessments has improved since the force invested in the training.				
2	The Community Safety Partnership should conduct an audit of MARAC practice to ensure the changes which have been introduced are sufficient to: • ensure all relevant information is provided to inform risk assessment, • appropriate records are kept, • multi-agency risk management plans are developed and clearly set out, • review points and contingency plans are agreed, and the outcome of the meetings circulated to relevant agencies.	Audit in Domestic Abuse Operational Group once MARAC members educated on learning from this DHR. KEY MILESTONES ACHIEVED IN ENACTING RECOMMENDATION Update May 2024: MARAC Chairs and Members briefed and trained with learning from this DHR. Consultation and review of MARAC Terms of Reference, membership, role expectations and Referral form underway. UPDATE 8th October 2024: MARAC Steering Group 14th November 2024 to start to plan this audit to test changes / improvements. This will include observation of MARAC by Senior Police Leads – Dave Armstrong and / or Mike Cox? UPDATE March 2025: Audit taking place 25th April 2025. Completion Date and Outcome	ALL	December 2025	REDACTED	B
3	Agencies should ensure that those working with cases of domestic abuse assess the risk of intimidation, including	Actioned already – see below	WYP	April 2024	REDACTED	G

	intimidation via third parties and are familiar with options available, including the 'Unwanted Prisoner Contact' service, and liaise with the prison service accordingly.	KEY MILESTONES ACHIEVED IN ENACTING RECOMMENDATION West Yorkshire Police - The Unwanted Prisoner Contact Scheme has been promoted internally when it was launched and also during the 16 days of action in November 2023. The force has produced a video to raise awareness of the scheme with members of the public and partner agencies working with domestic abuse victims. https://www.westyorkshire.police.uk/advice/unwanted-prisoner-contact-service CHFT - 12.02.2024 CHFT have shared information with the safeguarding team who work within domestic abuse information regarding unwanted prisoner contact. mail sent to all practitioners in the safeguarding team.  unwanted prisoner contact.msg WYICB – 28/2/24 details of the unwanted prisoner contact scheme, weblinks and signs and indicators for GP practice staff that someone may be receiving unwanted prisoner contact distributed to GP practice staff through the Calderdale primary care Teams channel (a repository for all information and guidance that is searchable), included in “Key Messages” bulletin to GP staff and to be presented to GP Practice Managers meeting in March '24.				
		Completion Date and Outcome				
4	Agencies should promote staff awareness of the need to include support to victims regarding the risk of coercion via third parties.	CSCP Calderdale Multi Agency Safeguarding Partnership Training to be reviewed. SWYFT 1. Review the mandatory level 3 training. 2. Review the domestic abuse training 3. Commission a third sector agency to deliver bespoke domestic abuse awareness training	CSCP	April 2024 1.March 24 2.March 24 3.2024/2025 4.October 23 5.March 24	REDACTED	G

		4. Embed 'routine enquiry' 5. Produce a SBAR to share the learning from this DHR				
		KEY MILESTONES ACHIEVED IN ENACTING RECOMMENDATION See below				
		Completion Date and Outcome CSCP L&I OFFICER There is a new half-day session on Coercion & Control which includes sections on abuse through a 3rd party, family friends, using family courts or other processes and authorities and also the reach the perpetrator can still have from prison directly with contact and visiting orders. This training is being delivered and will continue indefinitely. Training attendance and uptake from each agency to be monitored by the multi-agency Learning and Improvement Sub Group. SWYPFT: All complete.				
5	The Community Safety Partnership should review procedures for MARAC and consider the introduction of multi-agency review process where there is reason to believe the risk has increased, including a retraction of a statement in high-risk cases or where a perpetrator is released from custody on remand.	To arrange a reflective practice with the MARAC members to consider the case, recommendations, learning, actions.	MARAC	September 2024	REDACTED	G
		KEY MILESTONES ACHIEVED IN ENACTING RECOMMENDATION Reflective Practice session led by CSCP / CSAB Learning and Improvement Officer for MARAC Chairs held 22nd April. Reflective Practice session led by CSCP / CSAB Learning and Improvement Officer for MARAC Members held on 9th May. Agreement about when to re-refer to MARAC when risk has changed, or retraction of statement issued, or nonengagement of victim, or release from custody and others now embedded in new MARAC Terms of Reference.				
		Completion Date and Outcome This is all now embedded in the Terms of Reference – including specific reasons for re-referral back to MARAC. See below for attachments				

6	The Community Safety Partnership should consider whether the MARAC procedures should require historical information to be explored in more detail and how this might be done.	Ensure the Terms of Reference for MARAC are updated and include this once considered.	MARAC	September 2024	REDACTED	G
		KEY MILESTONES ACHIEVED IN ENACTING RECOMMENDATION See recommendation 5 to be included in this event. TOR to be ratified by next Domestic Abuse Strategic Board in August 2024.				
		Completion Date and Outcome This is all now embedded in the Terms of Reference – including specific reasons for re-referral back to MARAC.   Calderdale DRAMM and MARAC Terms of Reference 2024.docx				
7	The Community Safety Partnership should draw the issue of lack of flagging of perpetrator records to the attention of the Home Office suggesting they should engage with the Royal College of General Practitioners (RCGP) and encourage a review of professional guidance to ensure all possible safeguards within the law are considered when relevant information about perpetration of abuse is involved.	This DHR Report, Recommendations and Action Plan shared with the Home Office in June 2024. Await Home Office Response	CSP	When approved by Home Office	REDACTED	B
		Key Milestones achieved in enacting recommendations				
		Completion Date and Outcome				
8	The Community Safety Partnership should share the learning from this review with the West Yorkshire Domestic Abuse Commissioner and should also request that the Home Office consider if the new MAPPS system interfaces effectively with the MARAC systems.	As above	CSP	When Approved by Home Office	REDACTED	B
		Key Milestones achieved in enacting recommendations. This DHR Report, Recommendations and Action Plan shared with the Home Office in June 2024. Await Home Office Response				
		Completion Date and Outcome				