

Calderdale Community Safety Partnership

Executive Summary

Domestic Homicide Review in respect of Lily Louise who died in 2021.

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Completion: June 2024

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# 1. THE REVIEW PROCESS

* 1. This summary outlines the process undertaken by Calderdale Community Safety Partnership domestic homicide review panel in reviewing the homicide of Lily Louise who was a resident in the Calderdale area. Pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members.
  2. Victim – Lily Louise was 53 at the time of the fatal incident. She identified as white British and had no religious affiliations. 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.
  3. Perpetrator - Richard also identified as white British and no religious affiliation. 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 and he believes autism has affected his behaviour throughout his life. There is no reference to this in medical records accessed as part of this review.
  4. On 16th November 2021 the Community Safety Partnership decided to commission this domestic homicide review which concluded in June 2024.

# CONTRIBUTORS TO THE REVIEW

* 1. All agencies who potentially had contact with Lily Louise and Richard were asked to confirm their involvement. Eleven agencies confirmed contact with the victim and/or perpetrator, each secured their files and the list below contributed Independent Management Reviews (IMRs) prepared by agency managers who had no prior involvement with the service delivered to Lily Louise and Richard and no involvement in decision making.

* 1. Calderdale and Huddersfield NHS Foundation Trust
  2. Calderdale CCG[[1]](#footnote-1) – GP
  3. South West Yorkshire Partnership NHS Foundation Trust
  4. Together Housing
  5. Calderdale MBC Housing
  6. West Yorkshire Police
  7. Calderdale Staying Safe Service delivered by WomenCentre
  8. Crown Prosecution Service
  9. Information, in the form of a chronology. was also provided by the Probation Service, Yorkshire Ambulance Service, Calderdale Pennine Domestic Abuse Partnership, the Registration Service, and Calderdale Metropolitan Borough Council (CMBC), but IMRs were not required. Towards the end of the review further relevant information was obtained from the prison service and this is also included in the report.
  10. Lily Louise’s family made a significant contribution to the review and were supported by Advocacy After Fatal Domestic Abuse (AAFDA). Their perspectives informed the content of the report and helped the author and panel to improve accuracy.
  11. The author visited Richard in prison post-sentence enabling his comments to be taken into account.

# THE REVIEW PANEL MEMBERS

* 1. A review panel was established to ensure agencies fully cooperated, ensure the review progressed on a timely basis and met appropriate quality standards. The agencies listed below formed the Panel and were represented by senior officers who had no direct involvement in delivery or management of services provided to Lily Louise and/or Richard.

|  |
| --- |
| Independent Chair and Author – Jane Booth |
| Calderdale Safeguarding Partnership Manager – Julia Caldwell |
| Designated Nurse, Adult Safeguarding, West Yorkshire Integrated Care Board (formerly Calderdale Clinical Commissioning Group) – 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 Abbas |
| Domestic Abuse Coordinator, Calderdale MBC – Nazia Mkhtar |
| Deputy Chief Crown Prosecutor – Jonathan Wettreich |

* 1. The panel met on 8 occasions.

# AUTHOR OF THE OVERVIEW REPORT

* 1. Jane Booth was appointed to both chair and act as independent author of this review. She has had a career in social care spanning more than 40 years. 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 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. 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.

# TERMS OF REFERENCE FOR THE REVIEW

* 1. Terms of reference for the review are attached as Appendix 1 to the Overview Report and outline the accountability and scope of the Domestic Homicide Review (DHR). Key issues to be examined were set out by way of a list of relevant questions considered in Section 7.

# SUMMARY CHRONOLOGY

* 1. **Background**
     1. Lily Louise had been married three times prior to meeting Richard and had experienced domestic abuse in one of these prior relationships. Lily Louise had experienced problems with both her physical and mental health for many years.
     2. Richard had significant physical and mental health issues. He had a history as a perpetrator of abuse in previous relationships. In December 2015 he had been convicted of a “domestic related battery” which occurred in a different police force area. Police records state that Richard had “repeatedly squeezed the victim around the throat and repeatedly punched her on the head.” Richard received an 18-month suspended prison sentence, and a Non-molestation Order was put in place and subsequently extended to run until 08.12.2021 - still in force at the time of Lily Louise’s death.
     3. Both Lily Louise and Richard were white British. Lily Louise had no religious affiliations and there is no evidence that Richard had any religious affiliation. They met in March 2019. Lily Louse’s family describe Richard as having been very controlling from the start and believe that significant events such as moving further away from family, making him a joint tenant, seeking to become pregnant and getting married were all because of pressure he put on Lily Louise. He is believed to have held her phone and controlled her access to money and they spent all their time together. Lily Louise and her family were aware that Richard had a history of domestic abuse towards a former partner.
  2. **Health issues**
     1. There were frequent contacts with medical services with both physical and mental health issues. Both were reliant on regular medication. Appropriate responses were made to these 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.
     2. During medical appointments there were no recorded indications of domestic abuse, but this possibility was not explored. 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. The family believe the frequent contacts with GP practice were a cry for help.
     3. Although their individual records indicate that both Lily Louise and Richard have the same mobile phone number this would not have been obvious to the GP. When both subsequently registered with a new GP giving the same address and the same telephone number the GP computer system (in common with many others) was not able to automatically link records
     4. Lily Louise/s family state that Richard 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. 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.
  3. **Allegations of abuse**
     1. Prior to the fatal assault there had been three occasions when there were reports to the police of domestic abuse. The first, reported by Lily Louise’s daughter, involved Lily Louise and her daughter being assaulted by Richard. Lily Louise denied this, and her daughter declined to pursue a prosecution due to concerns about the impact on her mother. No offer of disclosure under Clare’s Law[[2]](#footnote-2) was made. This would have confirmed Richard’s significant history of prior abuse.
     2. The second report came from a third party and was again denied by Lily Louise. 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. 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 incident was denied. There is no recorded check of police records, and no statements were taken. 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.
     3. On 10th September 2020 Lily Louise herself called the police and reported a serious physical assault involving strangulation to the point of unconsciousness, and coercive and controlling behaviour[[3]](#footnote-3). She also reported a previous offence of physical assault (the one resulting in the injuries previously reported by the third party). The police dispatcher checked three police recording systems – Storm, Niche and PNC[[4]](#footnote-4) 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. 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. Her 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.
  4. **The prosecution, Multi-Agency Risk Assessment Conference system and perpetrator pressure on victim**
     1. The Crown Prosecution Service (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 police had requested that an offence of Controlling and Coercive Behaviour be considered but the charging prosecutor advised that there was insufficient evidence to charge Richard. 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 confirmed that there were substantial grounds to oppose bail and 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. Richard was remanded in custody with a further appearance set to allow him to make a bail application.

* + 1. Two days after the incident, 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 reports which included an offence of rape. The police informed CPS of this further reported offence.
    2. Follow-up was delayed for a number of reasons, including Covid restrictions on police visits to people in custody. It was also noted that Richard was to appear in court in four days’ time which would not give enough time for this reported rape to be processed. (Lily Louise had said she wished to speak with the original investigating officer.) A referral was made to the Domestic Abuse Hub.
    3. 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 provided to Lily Louise.
    4. The police report to the MARAC meeting did include reference to Richard’s previous breach of a non-molestation order but no detail of the original offences which had led to that order so there was no discussion of the nature of his previous offences of domestic abuse. Had his previous history been explored further it would have exposed 13 previous convictions dating back to 1994.The most relevant are a conviction for Battery in 2015 and a breach of a non-molestation order in 2016. The police record of the battery offence describes many common elements with the assault on Lily Louise.
    5. A number of immediate actions were agreed, and 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. The Independent Domestic Violence Advocate (IDVA) made telephone contact later in the day and offered practical support to Lily Louise. They discussed 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. The IDVA from Calderdale Staying Safe emailed the court based IDVA with an update.
    6. 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 stated that 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. Subsequently, Lily Louise rang the police and left a message for the Investigating Officer, wishing to withdraw all allegations against Richard.
    7. 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. At this time prisoners were spending long periods of time in their cells due to Covid- 19 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.
    8. Following Richard’s further remand in custody, the court IDVA from Calderdale Staying Safe (CSS) contacted Lily Louise and told her that he had entered a not guilty plea and a trial date had been set 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 investigating officer asking to withdraw her allegations.
    9. Prison records state that at this time Lily Louise made a visit to Richard in prison. This was not known to any of the agencies involved in the review. On that same date she made a statement retracting the allegation which was prepared according to police procedure by the officer in the case and signed by Lily Louise. The Crown Prosecution Service asked the police to “warn” Lily Louise to attend court on the 15th October. They were notified the same day that she had made a retraction statement.
    10. 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.
    11. Richard made 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.
    12. On 2nd October 2020 the Calderdale Staying Safe service 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. 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. Prison records show that 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). She subsequently made further calls to the police about her retraction but did not manage to speak to the investigating officer.
    14. 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. The next day she was served with a summons to attend court as it was the intention to continue the prosecution despite her retractions and 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.

* + 1. There is no evidence that further consideration was given to involving the IDVA again at this point. Systems put in place subsequent to these events now result in the IDVA services being more clearly sighted on up-coming cases and potential opportunities to re-engage. 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 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.
  1. **Contacts from October 2020**

* + 1. 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 November in which he refers to anger issues. 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.

* + 1. On 14th November 2020 the police contacted Richard regarding the allegation of rape. 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. 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.
    2. The next recorded contact is the police record of the interview with Richard on 22nd November 2020.The denial of the rape was reiterated and 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”.
    3. During 2021 there were a number of contacts with police linked to Richard’s previous partner and both her and Lily Louise’s family’s attempts to warn Lily Louise abut Richard’s history which were presented by the couple as harassment.
    4. Also, during 2021 Lily Louise made numerous calls to the Registration Service wanting to arrange a wedding. Bookings were not being taken due to Covid restrictions– on both occasions she was told no dates were being issued due to the pandemic.
    5. The wedding eventually took place and was 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. The marriage was bigamous as Lily Louise was still married to her previous husband.
    6. Some days later Lily Louise’s body was located in a field by a member of the public. Richard subsequently attended the police station and admitted causing the death of Lily Louise and cause of death was established to be blunt force head injury and strangulation. Richard was convicted of her murder and following the trial, the date of Lily Louise’s death was amended on the death certificate to be the date of the wedding.

# KEY ISSUES ARISING FROM THE REVIEW

* 1. **Agency consideration of historical events and previous incidents in risk assessments:** The full detail of previous assaults by Richard did not inform risk assessment. No statement was taken 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.
  2. **MARAC (1) - The effectiveness of information sharing, record keeping, and action from the Daily Hub:** The case was recognised as being one of high risk but the deficits in information sharing meant the assessment was not fully informed. An 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
  3. **MARAC(2): Consideration of how risk and the effectiveness of the safety plan can still be considered even when the victim withdraws – is risk reassessed**: There was no reconsideration of risk nor the development of a safety plan when Lily Louise no longer felt able to support the prosecution, nor any further review when Richard was released from prison and *returned* to live with Lily Louise.
  4. **Professional information sharing (specifically related to expectations placed on the victim):** There is a risk that too great a reliance is placed on the victim to share information directly themselves and that they are left with the whole responsibility for keeping themselves safe if they do not feel they have full professional support.
  5. **Consideration of whether the time the perpetrator is remanded could have been used more effectively to safeguard and support the victim and the extent to which the opportunity to do further work with the victim whilst the perpetrator was incarcerated maximised**? 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. 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.
  6. **Understanding what consideration was given to proceeding with prosecution despite the victim’s withdrawal:** Following Lily Louise’s withdrawal of support for the prosecution she provided the police with a retraction statement. When this happened, the investigating officer requested that prosecution still be pursued “due to the severity of the initial incident plus further reports of incidents 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 attended court and stated that the events subject of the charges had not happened and that she had been under the influence of alcohol and prescribed drugs when she had fabricated the allegation. 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.
  7. **The extent to which the former partner’s disclosure was used to inform risk assessment:** 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. Although known to the family, the details of the nature of Richard’s previous behaviour and convictions were not known to professionals when risk assessments were being carried out and procedures did not require re-assessment if new information should emerge. The former partner’s disclosures were not shared in any risk-assessment process and did not inform any multi-agency safety planning.
  8. **Were opportunities missed to consider disclosure via Clare’s Law?** A Clare’s law disclosure was offered by the police and the IDVA and declined by Lily Louise. Lily Louise did know about the domestic abuse offences against Richard’s previous partner, but this information came from Richard’s previous partner herself and may not have had the impact of information coming from the police. Police disclosure may not have provided her with new information, but it is possible that it may have re-enforced the seriousness of her situation and encouraged her to continue with the prosecution. The absence of disclosure to Lily Louise’s daughter may have weakened the family’s capacity to support Lily Louise.
  9. **The extent to which the GP could have been more proactive around the different, complex and persisting health conditions and consideration of any missed opportunities to consider Domestic Abuse:** The lack of information sharing with the GP leading to the absence of a flag for domestic abuse on medical records 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. 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. Action has already been taken to address the issue of the lack of a triggered enquiry given the possible indicators of abuse and the ICB has provided further information to GP practices regarding recognition of possible abusers and the offering of support to address abusive behaviours. GP safeguarding standards also now include training on identifying perpetrator behaviours.
  10. **The impact of COVID on how agencies worked together; how agencies engaged with the family; on safeguarding assessment processes or anything else:** Direct engagement with Lily Louise and Richard by the police and domestic abuse services was not adversely affected by the pandemic and agencies attended the home to carry out investigations and provide support. 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. 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.
  11. **The extent to which health inequalities and the impacts of poverty relevant in this case:** Both Lily Louise and Richard suffered both physical and mental ill-health and health issues prevented them from taking up employment. The area in which Lily Louise lived is in the bottom 20-30% of wards ranked according to deprivation n Calderdale. Lily Louise and Richard were in receipt of benefits, and it is known that Richard also worked collecting scrap metal for additional income. Lily Louise reported coercive control by Richard including control over her finances and family contacts and this may well have impacted upon her decision-making, and at the time of his arrest she needed assistance and was taken a food parcel and some toiletries by the IDVA. 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.
  12. **Flagging of agency records:** For the GP practice (and probably many others across the country) the flagging of records is problematic. GPs do flag the victim’s record and that of linked children where there is a risk of domestic abuse but express 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.) 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. 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.
  13. **Cross-boundary cases and the Multi-Agency Risk Assessment Conference (MARAC) process:** 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 Police National Database, which would have provided some detail, was made and no system exists in Calderdale for sharing information between MARACs in different areas.
  14. **Retraction:** The reasons victims might seek to make retractions of allegations are well-researched and well-understood. In this case Liy Louise continued to be under pressure by the perpetrator even when he was in custody. 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. The CPS continued with the prosecution but 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. This resulted in Richard being 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. **The role of the Crown Prosecution Service:** 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). 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. The decision not to proceed at court is considered to have been appropriate given the lack of supporting evidence**.**
  16. **Interpretation of policy and risk assessment:** 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. Similarly, the current national interpretation of the definition of eligibility for disclosure under Clare’s Law would not permit a disclosure to persons such as Lily Louise’s daughter which could have increased the risk to her had she remained in close contact with Richard. Interpretation of the guidelines and policy may have contributed to the under-estimation of risk earlier in the couple’s relationship.

# CONCLUSIONS, LESSONS AND RECOMMENDATIONS

* 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.
  2. **MARAC:** The information considered at the MARAC meeting was incomplete and, although the outcome was, non-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.

**Retractions:** The reasons why victims might retract their allegations are well understood and 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 a continuing risk that the perpetrator is applying pressure and intimidation. The learning point here for West Yorkshire Police in respect of what can be done in conjunction with the prison to stop visits and phone calls has already been actioned. A new system to assess the risk of victim intimidation has been introduced by WYP, 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. 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.

**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 place where a perpetrator is released from custody on remand or at the end of a sentence.

* 1. **Decisions around prosecution where the victim is no longer willing to support this:** WYP and CPS followed the procedures in respect of cases where retraction of evidence occurs. 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.

* 1. **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. 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 Lily Louise, but she refused it. This suggests she was, to some extent, in denial which would add to the risks she faced. No information about Clare’s Law is provided in writing in accordance with force policy as it is seen as potentially increasing risk to victim’s or witnesses so any information would be shared orally.

**Recommendation 7** - The 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.

* 1. **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.[[5]](#footnote-5)  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 must 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 in involved.

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 9** – 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 Multi-Agency Public Protection System interfaces effectively with the MARAC systems.

1. 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). [↑](#footnote-ref-1)
2. 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. [↑](#footnote-ref-2)
3. 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/information-support/what-is-domestic-abuse/coercive-control/) [↑](#footnote-ref-3)
4. 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. [↑](#footnote-ref-4)
5. [Guidance-on-recording-of-domestic-violence-June-2017.pdf (rcgp.org.uk)](https://elearning.rcgp.org.uk/pluginfile.php/170659/mod_book/chapter/376/Guidance-on-recording-of-domestic-violence-June-2017.pdf). [↑](#footnote-ref-5)