SAFER MK

Milton Keynes Community Safety Partnership

Domestic Homicide Review

Draft Overview Report into the death of Debra (May 2016)

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1. INTRODUCTION

The key purpose for undertaking domestic homicide reviews (DHR) is to enable lessons to be learned from homicides in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. 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.

This domestic homicide review was commissioned by Milton Keynes Community Safety Partnership (SaferMK) following the death of Debra, a white British woman. Her partner was found guilty of her murder and in November 2016 he was sentenced to life imprisonment and ordered to serve a minimum prison term of 20 years.

This report examines the contact and involvement that agencies had with the perpetrator, Debra and her children between January 2013 and her death in May 2016. In addition to the agency involvement, this report also examines any relevant past history of abuse and incorporates the views, thoughts and questions raised by Debra's family. The panel wishes to express their condolences to Debra's family and friends following her death. The panel also would like to thank all those who have contributed to the review.

1.1. Timescales

SaferMK was notified of Debra's death on 19 May 2016. The Community Safety Partnership reviewed the circumstances against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2013) and recommended to the Chair of Safer MK that a domestic homicide review should be undertaken. The Chair ratified the decision to commission a domestic homicide review on 22 May 2016 and the Home Office was notified on 22 May 2016. An independent chair/author was commissioned in April 2017 to manage the process and compile the overview report.

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Panel.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

Debra – victim (deceased) aged 31

Perpetrator – Debra's partner aged 42

Debra's daughter – from a previous relationship aged 11

Debra and the perpetrator's son – aged 6

Debra and the perpetrator's daughter aged 3

Age at the time of Debra's death

2. THE REVIEW PROCESS AND TERMS OF REFERENCE

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004).

2.1. Time period

The panel decided that the review should focus on the contact that agencies had with Debra, her children and the perpetrator between January 2013 and the time of Debra's death in May 2016. This should capture information about the domestic incident in 2013 and Debra's referral to the multi-agency risk assessment conference (MARAC) in May 2013. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included in the individual management review.

2.2. Contributors to the review

The independent chair wrote to Debra's family via the police family liaison officers to explain that a domestic homicide review was taking place. Debra's two sisters (on behalf of the entire family) helped to develop the terms of reference and asked to be involved throughout the review process. They were supported by a support worker from Advocacy After Fatal Domestic Abuse (AAFDA).

The independent chair also contacted the perpetrator in prison but he declined the opportunity to contribute to the review.

2.3. The thoughts and feelings of Debra's family

Debra came from a close family. She was the youngest of five children. She had two sisters and two brothers. She had lived in Hertfordshire most of her life and at the time of her death she was working as a receptionist.

Following Debra's death, her children disclosed information to suggest food was withdrawn as a punishment. Indeed, they said it was common practice to be sent to bed with no tea. Debra's sisters thought that when young, Debra's older daughter may have stolen money to buy food. Debra's daughter also described (on one occasion) having to stand on the stairs all night for a minor misdemeanour; the perpetrator got up every now and again throughout the night to check she was still standing there. She then had to go to school the following day. One of Debra's sister's children described being hit by the perpetrator with a wooden spoon for talking at bedtime.

It was evident that the perpetrator used to "*dangle*" the promise of a wedding to keep Debra from leaving him. At one point, the wedding date and arrangements were all made but he cancelled them without telling her.

The main issue Debra's sisters asked to be clarified was why had Debra's older daughter attended so many different schools (between eight and ten) by the age of 11 and what reasons were documented for her frequent change of schools. Debra's sisters wondered

whether she changed schools regularly to prevent her disclosing domestic abuse in the household.

The thoughts of Debra's sisters are reflected throughout the review.

2.4. Agencies and other contributors to the review

Individual management reviews and chronologies were requested from:

- Dacorum Borough Council, Hertfordshire (housing)
- Education – schools in Hertfordshire, Yorkshire and Milton Keynes
- General Practitioners (Hertfordshire and Milton Keynes)
- Hertfordshire Children's Social Care
- Hertfordshire Community NHS Trust (health visiting)
- Hertfordshire Constabulary
- Hertfordshire multi-agency risk assessment conference (MARAC)
- Victim Support

Chronology and information reports were requested from:

- Milton Keynes University Hospital
- Thames Valley Police
- West Hertfordshire Hospital

All the authors of the individual management reviews and the information reports were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved. All agencies included any relevant information about both Debra and the perpetrator as well as their children.

2.5. Key lines of enquiry

The individual management reviews and information reports addressed both the 'generic issues' set out on pages 31 – 32 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Debra might be at risk of abuse, harm or domestic violence (including financial abuse) and how did your agency respond to this information?
- If your agency had information that indicated that Debra might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals?

- If your agency had information about domestic abuse in the family, how did professionals seek to protect the children? What referrals were made?
- What indications were there to suggest that the children may have been witnessing domestic abuse or living in a household with domestic abuse? How did your agency respond? Was this information shared and if so, with whom?
- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or might cause harm to someone and how did your agency respond to this information?
- If your agency had information that indicated that the perpetrator was violent, abusive or might cause harm to someone, was this information shared? If so, with which agencies or professionals?

2.6. Specific issues for agencies

In addition to the key lines of enquiry, the following agencies were also asked to address some specific issues:

- Hertfordshire Constabulary

Hertfordshire Constabulary should review the contact with family between January 2013 and Debra's death in May 2016. In addition, the Constabulary should review its contact with the family following the incidents of domestic abuse in 2007 and 2010.

- Dacorum Borough Council – Hertfordshire (housing)

Dacorum Borough Council (housing) should set out the circumstances of Debra's rent arrears and review its response to Debra as a victim of domestic abuse between 2007 and 2015 when contact with her ceased.

- Hertfordshire schools

The schools in Hertfordshire should each set out the dates that Debra's older daughter attended. In addition to the key lines of enquiry, the review should establish the reason why she moved schools so frequently. It should detail whether any safeguarding concerns were raised and if so, what action was taken by the school.

- Hertfordshire Community Trust – health visiting

Hertfordshire Community Trust should outline the contact the health visitor had with the family, from Debra's son's birth in January 2010 until the family moved to Milton Keynes in March 2015.

- Hertfordshire Children's Social Care

Hertfordshire Children's Social Care was asked to review all the interventions with the family including the referrals in 2007, 2010 and 2013. They were asked to include any information about the application to be foster carers in August 2009 and the information requested from the Ofsted Regulatory Team in November 2014.

2.7. Review panel

The review panel met 5 times and had an additional panel meeting with Debra's sisters. All the members were independent of the case i.e. they were not involved in the case and had no direct line management responsibility for any of the professionals involved in the case. The review panel comprised:

- Eleanor Stobart, Independent Chair and Author
- Colin Wilderspin, Head of Community Safety, SaferMK
- David Pennington, Safeguarding Adults; Mental Health and Learning Disability Lead, NHS
- Jane Harrison, Head of Communities, Milton Keynes Council
- Jo Hooper, Head of Safeguarding, Children & Families, Milton Keynes Council
- Lisa Lovell, Community Safety Safeguarding Officer, SaferMK
- Nicola Lobendhan, Dacorum Borough Council (housing) Hertfordshire
- Nicole Murphy, Detective Chief Inspector, Thames Valley Police
- Sarah Taylor, Partnerships Manager; Domestic Abuse, Hertfordshire County Council
- Sophie Ward, Secretarial Assistant, SaferMK
- Sue Burke, Chief Executive Officer, MK-Act (Domestic Abuse Services)
- Tracy Pemberton, Detective Chief Inspector, Hertfordshire Constabulary

2.8. Author of the overview report

The chair and author of this review has been a freelance consultant for 18 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. During this time, Eleanor has been appointed to undertake projects for a wide range of organisations including (amongst others) the Department of Health, the Association of Chief Police Officers, Interpol, Forensic Science Service, Amnesty International, National School of Government, Home Office Immigration Enforcement, ECPAT UK and the British Medical Association.

Examples of her work include being commissioned to research, develop and write the national statutory and multi-agency guidelines for practitioners handling cases of forced marriage for the Forced Marriage Unit (Foreign & Commonwealth Office and Home Office Unit). The NSPCC appointed Eleanor to develop a service model and accompanying manual to assist NSPCC practitioners working with South Asian children and families. Following the death of Victoria Climbié, the Department of Education commissioned Eleanor to investigate the scale and extent of child abuse linked to a belief in "spirit possession" and "djinns" in the United Kingdom.

Eleanor has also undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Local Safeguarding Children Boards. She has

chaired and authored over 18 serious case reviews/domestic homicide reviews. Eleanor has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011).

She is independent of, and has no connection with, any agency in Milton Keynes: although she was employed as the Business Manager for Milton Keynes Safeguarding Children Board for ten months during 2010. Eleanor has completed one previous domestic homicide review for Milton Keynes Community Safety Partnership (SaferMK).

2.9. Parallel reviews

At the time of the domestic homicide review, there were no parallel reviews taking place.

2.10. Equality and diversity

All the family members are of white British origin. All aspects of equality and diversity were considered throughout the review including age, race, gender, disability and religion. To ensure the review process considered issues around domestic violence and abuse there was a representative from Women's Aid on the panel.

2.11. Dissemination

In addition to the organisations contributing to this review (listed in paragraph 2.4), the following will receive copies of this report for learning within their organisations:

- Hertfordshire Constabulary
- Hertfordshire Domestic Abuse Partnership Board
- Hertfordshire Health and Wellbeing Board
- Hertfordshire Police and Crime Commissioner
- Hertfordshire Safeguarding Children Board
- Milton Keynes Safeguarding Children Board
- SaferMK
- Thames Valley Police and Crime Commissioner
- Yorkshire Independent Domestic Abuse Service

3. THE FACTS

On 3 May 2016, Debra was reported missing by her mother. Her work colleagues also raised concerns. Her partner told police that she had left home on 1 May 2016 to "*clear her head*" following a disclosure to him that a work colleague had raped her. Debra was considered a 'high risk missing person' and on 4 May 2016, her partner was arrested on suspicion of her murder.

He refused to disclose where Debra was, and her body was found in woodland three weeks later (22 May 2016). He was subsequently convicted of Debra's murder in November 2016, and he was sentenced to life imprisonment with a minimum term of 20 years.

At the time of her death, Debra was 31 years old and the perpetrator was 42 years old.

4. BACKGROUND

Prior to meeting Debra, the perpetrator was known to police and had three convictions. He had been convicted of possessing an offensive weapon (1991), using threatening, abusive or insulting words/behaviour (1997) and failing to surrender to custody (1997).

During the police investigation into Debra's murder, concerns were raised over the perpetrator's treatment of animals. A previous partner said the perpetrator had told her that he had killed a dog with a hammer and filmed it (although she had never seen the video). Another ex-partner described how the perpetrator's mother's cat had killed a bird, so the perpetrator put the cat in a bin liner and took it to the woods. He also told his ex-partner that when his neighbours annoyed him, he threw drawing pins into their pond and watched their goldfish eat them. She said that he had "*an evil way about him*" and an obsession about hitting people over the head with hammers. He told her that in the past he had hit someone over the head with a hammer and then killed his dog.

5. CHRONOLOGY OF SIGNIFICANT EVENTS

In November 2004, three months after Debra's daughter was born, Debra returned to live in Hertfordshire. Before this she lived in Ministry of Defence accommodation with her then husband who was in the Royal Navy. When their marriage broke down, Debra and her daughter moved in with Debra's mother in Hertfordshire. Debra made a homeless application to Dacorum Borough Council and in February 2005 she was given a tenancy in her sole name. She kept the tenancy, despite meeting the perpetrator in 2007 and moving into his home.

July 2007 – assault on Debra

In July 2007, the perpetrator was arrested for actual bodily harm (ABH). It was recorded that on 15 July 2007 in the early hours of the morning, the perpetrator assaulted Debra by throwing a mobile phone at her. It struck her forehead and caused "*swelling and cuts*". Debra did not report the incident until 25 July 2007 because the perpetrator had "*threatened to kill her*". Arrangements were made for officers from Hertfordshire Constabulary to see her at her rented property the following evening.

At 10pm on 26 July 2007, Debra called Hertfordshire Constabulary because the perpetrator was at her house threatening to "*kick the door down*". The perpetrator left before the police arrived. His details were circulated to patrol officers as being wanted for arrest for "*threats to kill, assault, threats to cause criminal damage and harassment*". The perpetrator was subsequently arrested and interviewed. He admitted having an argument with Debra but denied the offences. He was released on police bail for further enquiries with conditions not to contact Debra or go to her address.

On 30 July 2007, Debra called the police because the perpetrator had turned up at her home to talk to her through the letterbox. Debra made a statement and the perpetrator's details were circulated as wanted for arrest for witness intimidation. He was arrested at his place of work. He was interviewed and denied the offence. Debra was spoken to by specialist officers from the Sunflower Centre[1] and a referral was made to children's social care. Debra later contacted the officer in the case because she no longer wanted to support a prosecution.

August 2007 – common assault (not Debra)

On 13 August 2007, the perpetrator was arrested for common assault. He had grabbed the steering wheel of a car while a woman was driving and made the car swerve while stating "*Lets fucking die then*". He then grabbed the woman by the neck and pushed her face against the window and threatened her before she escaped. The police report showed that the woman was not Debra but was described in police records as his "*partner*".

On 3 September 2007, Hertfordshire County Council Children's Social Care received the domestic abuse notification (medium risk) from the police concerning the incident on 15 July 2007. The records stated "*No concerns for* [daughter]" and the incident was recorded as "*information only*" and no further action was taken by children's social care.

September 2007 – change of name

In September 2007, Debra informed Dacorum Borough Council Housing Department that she had changed her surname by Deed Poll[2] to the perpetrator's name. Despite this, her tenancy remained solely in her name and she continued to live at the perpetrator's property.

November 2007 – alleged rape (not Debra)

The perpetrator was arrested on 11 November 2007 for the alleged rape of an ex-girlfriend. She had gone to his house (that he shared with Debra) and he offered to show her Debra's daughter's bedroom, he then took her to a spare room and raped her vaginally. The woman was seven months pregnant. The case was discontinued by the Crown Prosecution Service.

On 12 November 2007, Hertfordshire County Council Children's Social Care received a referral from Hertfordshire Constabulary which stated that the perpetrator had been arrested for the alleged rape of a previous girlfriend. The referral also included information that the perpetrator's ex-girlfriend said that the perpetrator told her that he had had sex with Debra's daughter then aged 3. When his ex-girlfriend challenged him, he said it was a "*joke*".

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[1] The Sunflower Centre was a joint agency team whose remit included domestic abuse.

[2] A Deed Poll is a legal document. It is a form of legal contract but it differs from legal contracts between two or more parties in that it only concerns one person (and it is only signed by that person in the presence of a witness). Although Deed Poll documents are used for various purposes relating to an individual or a company legally committing themselves to doing something, they have one generally accepted meaning and usage i.e. for officially recognising a change of name – for further information see www.deedpoll.org.uk/WhatIsADeedPoll.html - accessed online 1 August 2018

An initial assessment was instigated the same day. The assessment did not find evidence of abuse towards Debra's daughter and concluded that she was in a stable environment, and Debra had the support of her own mother. The case was closed on 31 January 2008.

Rent arrears

After January 2007, the rent arrears at Debra's property started to increase. At the end of August 2007, Debra had not complied with her repayment agreements so her case was brought before the County Court. A suspended possession order was made for her to pay her current rent plus £5. Then in November 2007, Debra defaulted on the suspended possession order. She had a meeting with the rent officer and a new agreement was reached. Nevertheless, by April 2008 there were reports from her neighbours that her property was empty.

On 19 December 2008 and again on 20 January 2009, children's social care received referrals from the housing management services informing them that an eviction application was being considered in respect of Debra. Following further enquiries, children's social care established that the eviction was not finalised and there was no eviction date set. A letter of "*advice*" was sent to Debra and the case was closed.

In August 2009, the perpetrator and Debra applied to a private fostering agency to be foster carers. The agency contacted children's social care for any relevant information and were informed of the history of domestic abuse.

December 2009 – Debra evicted from her rented property

After many months of negotiating repayments of her rent arrears, a warrant for Debra's eviction was made on 1 December 2009. Debra was not present and the property was fully furnished. Dacorum Borough Council staff noted that there was a lot of nearly new belongings such as children's clothes at the flat and arrangements were made for Debra to clear her belongings on 8 December 2009. The rent arrears were approximately £4,000. No referral was made to children's social care at the time of the eviction, despite Debra being heavily pregnant. Debra's son was born in February 2010.

December 2010 – domestic argument with Debra

On 15 December 2010, Debra called Hertfordshire Constabulary stating that she and the perpetrator had argued because the perpetrator thought she was having an affair. The perpetrator had threatened her, taken her mobile phone and driven off in his car. Officers arrived at the perpetrator's house an hour later and spoke with Debra. A DASH[3] risk assessment was completed which was graded as medium risk.

The police made a referral to children's social care and to the health visitor. The referral included details of the incident, the perpetrator's convictions, the rape allegation from 2007

[3] Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) Risk Identification and Assessment and Management Model – for further information see www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf accessed online 1 August 2018

and the allegation of common assault from 2007. A referral was also made to the domestic violence officer, who left three messages on Debra's phone. As there was no response to the calls and no further incidents, the Harm Reduction Unit[4] closed the case, this was authorised by a supervisor on 17 January 2011.

On 16 December 2010, Debra's daughter's school requested a safeguarding consultation with the children's social care child protection liaison team. The school had concerns because Debra's daughter had disclosed on 29 November 2010 that her father had "*dragged her mother upstairs*".

Hertfordshire County Council Children's Social Care received the police domestic abuse notification on 23 December 2010. It was sent to the assessment team who "*made attempts to contact Debra with no success*". A letter was therefore sent to Debra giving her advice about the impact of domestic abuse on children. The case was closed the same day.

February 2012 – housing application

On 8 February 2012, Debra made an online application to Dacorum Borough Council for housing. On 22 February 2012, Debra contacted Dacorum Borough Council's customer service unit to ask about her housing status. She told staff that she had left the perpetrator's property because he had been violent towards her the previous evening. She had taken the children and gone to stay with her mother. On this occasion she did not call the police because she "*thought something else may have happened*" by the time the police arrived.

The homelessness officer gave Debra advice about occupation and non-molestation orders and how these could be used to reinstate her and the children in the perpetrator's property. Debra was also told that because of her previous rent arrears she would not be considered for the Council's 'deposit guarantee scheme' but she could find a private rental property and make a claim for housing benefit. On 5 March 2012, a letter was sent to Debra confirming that her housing application had been successfully registered and informed her that she could bid on properties.

Debra's younger daughter was born in December 2012.

May 2013 – domestic argument with Debra

On 17 May 2013, Debra's neighbour called Hertfordshire Constabulary because Debra's older daughter (aged 8) had gone to the neighbour's house stating that "*dad was hitting mum*". Debra had told her to do this.

Officers arrived at the perpetrator's house fifteen minutes later and spoke to both Debra and the perpetrator. The officers concluded that it was a verbal argument and no offences were disclosed. The perpetrator and Debra's other two children were in the house (aged 3

[4] At the time of the first three incidents domestic abuse incidents were investigated by the then Harm Reduction Unit (HRU) which subsequently changed to the Domestic Abuse Investigation and Safeguarding Unit (DAISU) in January 2016. Uniformed officers would inform the Harm Reduction Unit (HRU) of any incident where appropriate. Their remit included the safeguarding of all victims (intimate and non-intimate) for high risk incidents or where there had been four or more incidents in a twelve-month period.

and 6 months). Neither the neighbour nor Debra's daughter witnessed the perpetrator hitting Debra. A DASH risk assessment was graded as standard and the incident was recorded as a 'non-crime domestic violence'.

The police took Debra to her mother's house in Hertfordshire. The perpetrator was not "*happy*" with this and stated that he would be making a complaint. There was, however, no record of a subsequent complaint. Referrals were made to children's social care, the health visitor, the Sunflower Centre and the independent domestic violence advisor (IDVA) at Victim Support.

On 20 May 2013, the independent domestic violence advisor (IDVA) service received the referral from the police. An advisor contacted Debra the same day. Debra disclosed that, rather than being a verbal argument, the perpetrator had "*poked her in the eye and smacked her around the back of the head with a bottle filled with water*". Debra explained that this was not the first incident of domestic violence. Debra disclosed further information that led the independent domestic abuse advisor (IDVA) to conclude that she was a high-risk victim of domestic abuse.

Hertfordshire County Council Children's Social Care received the domestic abuse notification from the police on 28 May 2013. The following day, children's social care contacted both parents to provide them with "*advice and guidance around the impact of disputes on children and provided them with strategies on managing disagreements*" and closed the case. Children's social care contacted the health visitor who stated that there were no concerns about the children, "*they attend clinic regularly and their immunisations are up to date*".

On 3 June 2013, the independent domestic violence advisor (IDVA) asked Debra to call when Debra returned from holiday. Having heard nothing, the independent domestic violence advisor (IDVA) tried to call Debra on 13 June 2013 but got no response. The worker therefore sent her a text asking Debra to call her. The following day Debra called to say that she had gone back to live with the perpetrator at his property. The independent domestic violence advisor (IDVA) ensured a warning marker for domestic abuse was placed on the perpetrator's address. It stated "*this is a very high-risk victim of domestic violence please treat all calls as urgent*". On 18 June 2013, the independent domestic violence advisor (IDVA) made a referral to the multi-agency risk assessment conference (MARAC)[5].

The multi-agency risk assessment conference (MARAC) was held on 25 June 2013. Following this the independent domestic violence advisor (IDVA) called Debra on 28 June and 2 July 2013. Each time there was no response. When Debra returned the call on 2 July 2013, the worker explained that she was ringing to update Debra about the multi-agency risk assessment conference (MARAC) but "*the phone went dead*". The worker called twice more using Debra's mobile and landline numbers; and left a message.

[5] This is a multi-agency risk assessment conference at which local agencies meet to discuss confidentially high-risk victims of domestic abuse. The aim is to identify what safety measures and support mechanisms could be put in place for Debra and her children.

The independent domestic violence advisor (IDVA) called Debra again on 9 July and 11 July 2013 before closing the case as she was unable to make contact.

January 2014 – Debra and children moved to Yorkshire

At the beginning of January 2014, it appeared that Debra and the children moved to Yorkshire. Debra contacted the independent domestic violence advisor (IDVA) service on 7 January 2014. She sent a text asking for a letter that she could forward to the local authority housing department in Yorkshire to prove she was a victim of domestic abuse. A letter was sent to Debra at her sister's address on 13 January 2014. On 15 January 2014, Debra's daughter started at school in Yorkshire. Health visiting and school nursing services were also transferred to Yorkshire. In April 2014, the perpetrator notified Dacorum Borough Council that Debra had moved to Yorkshire on 16 December 2013.

July 2014 – Debra and children moved back to Hertfordshire

On 14 July 2014, the health visiting team was informed that the family had moved back to Hertfordshire. The health visitor spoke to Debra on 29 July 2014 and she confirmed that they were living with the perpetrator and that they were "*getting on okay*".

On 17 November 2014, Ofsted contacted Hertfordshire County Council Children's Social Care for information because the perpetrator and Debra had applied to work in a child care setting. Ofsted was advised about children's social care involvement with the family.

May 2015 – Debra, the perpetrator and the children move to Milton Keynes

In May 2015, the perpetrator bought a house in Milton Keynes (in his sole name). The two older children both moved to schools in Milton Keynes and health visiting was transferred to Milton Keynes. Debra had one contact with Thames Valley Police in September 2015 following a minor road traffic accident.

On 3 March 2016, Debra was taken by ambulance to the emergency department at Milton Keynes University Hospital Foundation Trust. She had felt unwell and dizzy at work, and had fainted twice. She did not require any treatment and was discharged the same day. Debra told a work colleague that the perpetrator had punched her in the stomach. Debra however did not disclose this to staff at the hospital and no safeguarding concerns were raised.

During March 2016, Debra went on holiday with one of her sisters. She only had £100 for the entire holiday for her and her children. At this time, Debra told both her sisters that her relationship with the perpetrator was over and she had separated from him.

In an email to Debra's daughter's school on 29 April 2016, Debra described her older daughter feeling "*sensitive*" because Debra had recently "*split up*" with the perpetrator. Two days later, Debra was reported missing.

6. ANALYSIS

6.1. Dacorum Borough Council Housing

Debra made a homeless application to Dacorum Borough Council in November 2004. On 28 February 2005 her tenancy commenced in her sole name. During the period of her tenancy (February 2005 to December 2009) there was a lot of contact with the income department because of rent arrears. However, little of the contact with Debra was face-to-face. At the time, the housing officers had large 'rent arrears' caseloads with targets to reduce rent arrears. The emphasis was on securing a payment arrangement, rather than exploring the causes of tenants' financial difficulties.

Rent arrears were not a significant issue with the tenancy until January 2007 when they started to increase. Debra said she was working but had other debts. The agreements to pay were not complied with and the matter was brought before the County Court in August 2007. A suspended possession order was made for Debra to pay her current rent plus an additional £5 per week.

In 2008, neighbours reported that Debra was not living at her property. Then in September 2009 Debra told staff that she had suffered a miscarriage in August 2008, which meant she had been in and out of hospital; and had then stayed at her sister's in Yorkshire for a while. This explanation for long periods of absence from the property was accepted and thus the reports of non-occupancy were not explored. Had the issue been investigated further, it would have provided housing with a better understanding of what was happening within the household. Ultimately, Debra was evicted in December 2009.

Normally, it is good practice to inform children's social care if an eviction is taking place and a child lives at the property. At the time this was not part of a formal procedure. A referral was not made because Debra and the children were living with Debra's mother and were therefore not considered at risk of homelessness through the eviction.

In February 2012, Debra approached housing because her relationship with the perpetrator had broken down due to domestic abuse. Debra met with the Homelessness Officer to discuss her options. The homelessness officer gave Debra advice about occupation and non-molestation orders and how these could be used to reinstate her and the children in the perpetrator’s property whilst long term provision was made i.e. a transfer of the property to benefit the children or the sale of the property. It was noted that Debra was not keen to pursue these options. Debra was also told that because of her previous rent arrears she would not be considered for the Council’s Deposit Guarantee Scheme (DIGs) but she could find a private rental property and make a claim for housing benefit. This meant she would need to find her own deposit for a property.

As Debra had disclosed domestic abuse, she was provided with information and the contact details for the Sunflower Centre and Women's Aid. Although Debra said that the children were present during an earlier incident of domestic abuse, no DASH risk assessment was

completed, no referral was made to the multi-agency risk assessment conference (MARAC)[6] and no safeguarding report was made to children's social care. No concerns were ever raised, or enquiries made, about financial abuse.

Despite the advice given being correct, there was significant emphasis placed on Debra's existing rent arrears and how this would have a detrimental effect on her current housing application. Debra may well have felt concerned that she would not receive help from Dacorum Borough Council with her housing because of her former tenancy debt. Ultimately, a letter was sent to Debra (5 March 2012) confirming that her housing application had been successfully registered and it informed her that she could bid on properties. The case was closed on 3 December 2012.

Practice has improved since Debra was evicted and since her approach for advice following the domestic abuse incident in February 2012. In 2012 inclusion officers were introduced in order to support families experiencing difficulties in managing their tenancies. This service was extended in October 2014 when Dacorum Borough Council introduced a 'tenancy sustainment team'. This team supports families at risk of losing their home due to rent arrears or breach of tenancy. Debra would have been referred to this team for additional support and some intensive work would have been undertaken to try to help her maintain her tenancy and explore the causes of her tenancy related issues.

All potential evictions are now considered by a multi-skilled housing panel. This panel reviews cases to ensure that all avenues and options have been exhausted before a family or individual is evicted. The review of eviction cases includes a section that specifically focuses on domestic abuse and safeguarding. All cases, or disclosures, of domestic abuse are followed up by the case officer and cases are not closed without the case officer contacting the victim.

All frontline staff now attend a one-day training course on domestic abuse. This accredited course covers all aspects of domestic abuse including financial abuse. All officers who may come into direct contact with victims also attend DASH training, which is provided by an external organisation specialising in violence against women and girls. This training focusses on coercive control, stalking and harassment and explains in detail the importance of the risk assessment.

Dacorum Borough Council and the Community Safety Partnership now employ a domestic abuse case worker to support victims who do not meet the threshold for the multi-agency risk assessment conference (MARAC). The housing team attends all MARAC meetings and there is a formal procedure for sharing information appropriately with other departments and services. Victims of domestic abuse are risk assessed and offered access to the domestic abuse case worker and given contact details for support groups.

[6] During the period under review, Dacorum Borough Council Housing did not routinely attend the MARAC meeting.

There are formal safeguarding procedures and all frontline officers attend safeguarding training. All reports of domestic abuse where a child is present are reported to children's social care. A central record of all safeguarding referrals is maintained.

6.2. Hertfordshire Constabulary

On 25 July 2007, Debra reported that the perpetrator had assaulted her on 15 July 2007. She had not reported the incident earlier because the perpetrator had threatened to kill her. The perpetrator was arrested and denied the assault. Later he turned up at her flat and spoke to Debra (contrary to his bail conditions). The perpetrator was subsequently arrested again, this time for witness intimidation. He denied the offence and provided an alibi. As there was no evidence of witness intimidation, he was released without charge. Later Debra informed the officer in the case that she did not want to support a prosecution. The officer arranged for Debra to be spoken to by specialist domestic abuse officers at the Sunflower Centre. This was the first reported incident of domestic abuse between the perpetrator and Debra, and Debra told officers that she had ended their relationship. The detective chief inspector reviewed the case and authorised no further action. Debra was informed of the decision.

The second incident occurred on 15 December 2010, when Debra called the police to report a verbal argument with the perpetrator. A DASH risk assessment was undertaken which identified that Debra was frightened; that the perpetrator constantly sent texts to her and checked her mobile, email and Facebook accounts, and that he had made threats to kill her and assaulted her in the past. She said that the perpetrator had thrown the cats down the stairs because they were scratching at the doors, and that he had been diagnosed with borderline personality disorder. It was confirmed that they were not married but Debra had changed her name by Deed Poll to the perpetrator's. The risk assessment graded Debra as at medium risk of harm and therefore she did not reach the criteria for a referral to the multi-agency risk assessment conference (MARAC). Nevertheless, referrals were made to children's social care and health visiting. The referrals included details of the incident, the perpetrator's past convictions, the alleged rape and the assault in 2007. A referral was also made to the domestic violence officer, who left three messages on Debra's phone. As Debra did not respond, the case was closed. Clearly, considering the content of the risk assessment, the domestic abuse officer should have made a greater effort to speak directly with Debra. This would be current practice within the Domestic Abuse Investigation and Safeguarding Unit (DAISU). As it was, there had been no reported incidents between Debra and the perpetrator since the 2007 assault allegation; and there did not appear to have been any escalation in violence against Debra since the 2007 assault.

The third incident occurred in May 2013. A neighbour called the police after Debra's daughter had gone around to explain that "*dad was hitting mum*". When the police arrived, neither Debra nor the perpetrator disclosed any offences and no one witnessed any offences being committed. A DASH risk assessment was graded as standard and Debra was taken to her mother's house. On 14 June 2013, a warning marker for domestic abuse was placed on the perpetrator's address giving the perpetrator, Debra and the children's details.

A comment on the marker read "*This is a very high-risk victim of domestic violence, please treat all calls as urgent*".

As there were children in the household a referral was made to Hertfordshire County Council Children's Social Care and the health visitor. Debra was also referred to the Sunflower Centre. On 18 June 2013 the independent domestic abuse advisor (IDVA) made a referral to the multi-agency risk assessment conference (MARAC) and the police disclosed all the relevant information including full details of the incident and the perpetrator's police records to children's social care, the health visitor and the multi-agency risk assessment conference (MARAC). There were no police actions from the multi-agency risk assessment conference (MARAC) meeting.

There was no obvious audit trail within the police records to establish why the incident in May 2013 was initially graded as low risk and then subsequently escalated by the independent domestic abuse advisor (IDVA). It was unclear whether it resulted from new information or a review of the current information. Whatever the case, it led to a marker being placed on the address, albeit a month after the incident. If the escalation was in fact as a consequence of reviewing information already available, the marker should have been placed much sooner.[7]

6.3. Hertfordshire Children's Social Care

Hertfordshire County Council Children's Social Care did not receive the police domestic abuse notification of the incident in July 2007 until six weeks later (3 September). The notification stated that the perpetrator had been arrested and there had been no incidents in the previous 12 months. It also stated that Debra would be contacted and offered support (although it did not state by whom) and there were no concerns for Debra's daughter, as she had been seen by police and "*appeared safe and well*". Children's social care accepted all the information and did not check who would be offering Debra support. As children's social care considered the domestic abuse notification was for information only, there was no liaison with police and the case was closed. Had children's social care contacted the police, they would have established that the perpetrator had been arrested in the meantime (August 2007) for an assault on another woman, who was also described as his partner. As it was, because there were no concerns raised about Debra's daughter, no further action was taken.

In November 2007 an initial assessment was instigated following an allegation of rape against the perpetrator. The victim alleged that the perpetrator had told her that he had had sex with Debra's daughter (aged 3). When she challenged him, he said it was a "*joke*". A strategy discussion took place between children's social care and the police. Debra's GP was

[7] When a warning marker is placed, the requesting officer is informed when it will be removed (normally six months) and the officer is responsible and accountable for its removal or retention. The Police National Computer (PNC) Unit send email reminders to the initial requesting officer/staff when the "*weeding*" date for a marker is approaching. Additional reminders are not sent out if there is no response to the first request. This warning marker remained in place until August 2017, when the author of the Hertfordshire Constabulary individual management review made enquiries about the marker with the Police National Computer (PNC) Unit. This does not appear to be an isolated incident of a marker being retained when no longer required.

contacted, who raised no concerns. A social worker visited Debra and Debra explained that the perpetrator had never been violent towards her. This known inaccuracy was not challenged. The social worker informed Debra about the concerns regarding the perpetrator, and Debra said she would "*act cautiously until the outcome of the police investigation*". The case was closed on 31 January 2008 because the assessment concluded that Debra's daughter was living in a stable environment. This was based on fact that Debra's mother was supportive and the perpetrator's bail conditions prevented him from contacting Debra. There was no evidence to suggest that children's social care had considered any of the other incidents within this assessment e.g. the previous domestic incident (July 2007) or the common assault (August 2007).

Practice has now changed and a case of this nature would be considered by Hertfordshire Children's Services Joint Child Protection Investigation Team. This is a co-located team of senior social work practitioners and police child abuse investigation officers. The team undertakes joint s.47 investigations in cases of suspected sexual or physical abuse. The strategy discussion would discuss the concerns raised in the referral, consider actions for all agencies, and record the decisions systematically. Actions may include interviewing a child, a medical examination, sharing further information and conducting further assessments.

Social workers are now also trained in undertaking direct work with children using a range of tools appropriate to the child's age and development. In this case, the strategy discussion was limited and not well documented. Information sharing has improved since 2007. For example, Hertfordshire Children's Services has an established a multi-agency safeguarding hub (MASH) where cases are reviewed between children's social care, police, health, probation, community rehabilitation company[8], education, children's centres and any other relevant professionals to review all relevant current and historical information. Strategy meetings now include, as a minimum, health, police, children's social care and any other relevant professionals involved in the case.

On 16 December 2010, Debra's daughter's school contacted the Child Protection School Liaison Officers[9]. On 29 November 2010, Debra's older daughter had disclosed to a teaching assistant that her mother had called the police because "*her father had dragged her mother upstairs*".[10] The outcome of the consultation was that the school should speak to Debra and then consider making a referral to children's social care.

On 23 December 2010, children's social care received a domestic abuse notification from Hertfordshire Constabulary. It concerned a verbal argument between the perpetrator and Debra that had taken place on 15 December 2010, during which the perpetrator accused Debra of having an affair. It was sent to the Assessment Team who "*made attempts to contact Debra with no success*". A letter was therefore sent to Debra giving her advice about

[8] The Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company (BeNCH CRC)

[9] The Child Protection School Liaison Team had access to children's social care records and provided advice to schools when concerns were raised their pupils.

[10] When checked for this review, there was no record of a call being made to Hertfordshire Constabulary on that date

the impact of domestic abuse on children. The case was closed the same day. It was not clear why Debra was sent a letter and not the perpetrator. In light of the information received from the police about the perpetrator's offending history there was no rationale provided in the individual management review about how many attempts were made to contact Debra, as it appeared the referral was received the same day that the case was closed. There was no evidence of liaison with other agencies or even any triangulation of the information known to children's social care. If there had been, it would have showed that the incident that Debra's daughter disclosed on 29 November was discrete to the incident on 15 December 2010.

On 28 May 2013, Hertfordshire County Council Children's Social Care received a domestic abuse notification from the police. It concerned an incident that occurred on 17 May 2013. The following day, children's social care contacted both parents to provide them with "*advice and guidance around the impact of disputes on children and provided them with strategies on managing disagreements*" and closed the case. Children's social care contacted the health visitor who stated that there were no concerns about the children, "*they attend clinic regularly and their immunisations are up to date*" although it was mentioned that the perpetrator had a "*personality disorder*". There was no information to suggest that anyone considered what this personality disorder might mean and how it might affect the lived experience of Debra and her children.

Furthermore, there was no evidence of wider liaison with other agencies. By the time children's social care had received the notification, Debra had been identified as a high-risk victim by the independent domestic abuse advisor (IDVA) and her case was going to be heard at the multi-agency risk assessment conference (MARAC). Despite Debra being referred to the multi-agency risk assessment conference (MARAC) and children's social care being asked to "*revisit the case*", there was no reference to this within the individual management review. This is covered in greater detail in section 6.6.

It was clear that there was a significant time delay between referrals being made by Hertfordshire Constabulary and them being reviewed by children's social care. This delay appeared to have a detrimental impact on the support and advice offered to Debra. Practice has improved and cases would now be considered by the Hertfordshire multi-agency safeguarding hub (MASH). A MASH worker would now speak to parents to discuss the concerns and seek consent (in cases that do not reach child protection thresholds) to review the historical and current information available from a number of agencies including children's social care, police, probation, health, schools and other relevant agencies. This provides an overview of what is occurring within the family. The expectation is that decisions and rationales are recorded clearly and concisely detailing the options available and the reasons for reaching those decisions.

Letters are no longer routinely sent out to victims and perpetrators of domestic abuse. Instead, Hertfordshire children's social care has now developed and adopted the Family Safeguarding Model. It aims to help reduce domestic abuse by working with perpetrators and offering assistance to victims. There are co-located multi-disciplinary teams comprising independent domestic abuse advisors (IDVA), mental health and substance misuse

specialists. Discussions take place with both parents in order to assess their suitability and commitment to change. This enables professionals to identify how best to work with the family.

6.4. Hertfordshire Community NHS Trust (health visiting)

Hertfordshire Community Trust provided universal health visiting and school nursing services to the family from the time of Debra's older daughter's birth in 2004 until Debra and the children moved to Yorkshire in 2014. The same services were reinstated between August 2014 and May 2015, when Debra and the children returned to Hertfordshire before moving to Milton Keynes.

The health visiting service received the first police domestic abuse notification on 4 January 2011. It related to an incident that occurred on 14 December 2010. The delay in receiving the notification was not unusual because the system relied on the manual transfer of information from the police to health. Staff in the Clinical Commissioning Group (CCG) would then manually forward the notification to the Hertfordshire Community Trust safeguarding team. The system has now significantly improved with an automatic email notification.

Following the notification, the health visitor visited Debra at home three days later. Debra informed the health visitor that the perpetrator had a "*mild personality disorder*" and some stress issues for which he attended counselling.[11] Debra was sign-posted to domestic abuse support services. There was no evidence in the records that the domestic abuse notification was shared with the family's GP. This would have been useful as the perpetrator was reported to have mental health issues with associated stress. No information about the perpetrator's (supposed) personality disorder was shared with any other agency.

Debra's younger daughter was born in December 2012. A new birth home visit took place on 10 January 2013. The perpetrator was registered as Debra's partner but there was no indication as to whether he was present during the visit. Debra subsequently took her younger daughter to the child health clinic. Both these visits would have been good opportunities to have a conversation with Debra about her well-being, her relationship with the perpetrator and to ask about his stress and emotional well-being.

Hertfordshire Community Trust received a police domestic abuse notification on the 29 May 2013 for an incident that occurred on the 17 May 2013. The health visitor called Debra on 21 June 2013 to complete a domestic abuse template. The follow up should have occurred within 5 days of the notification being received. It was unclear why this was delayed.

The multi-agency risk assessment conference (MARAC) conference took place on 25 June 2013. There was however no record of it within Debra's records. The minutes would not only have provided vital information to help the health visitors understand the risk Debra faced but also showed what information was known by each agency. This would have assisted health visiting services to make clear, informed and safe plans.

[11] There was no evidence that the perpetrator was ever diagnosed with Borderline Personality Disorder or attended counselling for issues with stress

On 27 June 2013 the health visitor contacted the team leader and safeguarding nurse to discuss the difficulties she was having contacting Debra. A risk assessment that was made during the discussion concluded that it was not safe to undertake an unannounced visit to the home. The team leader then allocated the case to another health visitor via email, asking her to follow this up on her return to work the following week. It was unclear why a new health visitor was asked to follow up. On 5 July 2013, this health visitor called Debra and spoke to the perpetrator. He said Debra was at work and no further conversation was recorded. The health visitor planned to call Debra after her return from annual leave (10 days later) but she continued to receive no response from Debra, and no further attempts were made. There was no evidence that the difficulties that health visitors were having contacting Debra were ever shared with children's social care or the police.

Following this period Debra was next seen when she brought her younger daughter to the child health clinic twice in September 2013. This could have been a good opportunity to discuss the Debra's relationship with the perpetrator, given that there had been a referral to the multi-agency risk assessment conference (MARAC) and there had been concerns over lack of engagement, due to calls not being returned by Debra. The health visitor reviewed Debra's younger daughter's record a week later (September 2013) and concluded that she was no longer a vulnerable child. She had been seen by the health visitor services with Debra on a number of occasions and there were no new concerns.

The records showed that Debra and her children moved to Yorkshire in January 2014. The health visitor twice attempted to contact her counterpart in Yorkshire. The health visitor in Yorkshire ultimately left a message on 19 March 2014 stating that they knew about the history of domestic abuse. The health visitor therefore ended the care in Hertfordshire.

When Debra returned to Hertfordshire, a standard transfer in letter and information pack was sent by the health visiting team to her at the perpetrator's home address on 15 July 2014. It provided information about the local health visiting team and services. As Debra's younger daughter was over one year old, a routine home visit was not indicated. Nevertheless, the health visitor contacted Debra on 29 July 2014 and ascertained that she was living with her "*husband*" again.

A home visit took place on the 7 August 2014 during which Debra explained that both she and the perpetrator had lost their jobs. Debra disclosed that arguments were still occurring and that their son was exhibiting challenging behaviours, which his school and the special educational needs coordinator (SENCO) were monitoring.[12] She said that the perpetrator had borderline personality disorder and that there was a strong family history of attention deficit hyperactivity disorder (ADHD) on his side of the family. Debra was given open access to the health visiting team and the health visitor established that Debra had the details for domestic abuse support. It did not appear that the health visitor asked Debra whether this information could be shared with the school and school nurse.

[12] There was no school record for Debra's son in Hertfordshire and therefore no mention of the SENCO coordinator

The health visitor called Debra again on 25 November 2014. Debra told her that there were no problems with her "*husband*" but Debra's older daughter was being bullied at school. Debra's younger daughter had not been taken to two physio appointments and a paediatric appointment. This was unusual and indicated a change in behaviour. The health visitor followed it up and new appointments were organised and she was taken to them.

On 11 March 2015, the health visitor spoke to Debra who explained that the family was moving to Milton Keynes. They had bought a new house. Debra said she had no concerns with her relationship. A verbal handover to Milton Keynes health visiting team took place on 29 April 2015 which included the history of domestic abuse. It was unclear whether the perpetrator and Debra's records were available to Milton Keynes at this point.

Little was known by Hertfordshire Community Trust about the perpetrator. His name was added to Debra's son's record in February 2010 (when her son was born). He was not, however, registered to Hertfordshire Community Trust for care until 2013 when Debra's younger daughter was born. Although Hertfordshire Community Trust had no direct contact with the perpetrator, his records contained the details of the police domestic abuse notification in May 2013. Nevertheless, there was no record of the domestic abuse incident which took place in December 2010 recorded on the perpetrator's record as he was not registered for care at this time. Receiving this notification should have prompted the health visitor to register him for care at Hertfordshire Community Trust or to add the notification to his records. The health visitor should have reviewed the perpetrator's records and considered Debra's son (10 months) in the risk assessment for this incident. The entries in Debra's record did not indicate whether the perpetrator was present or not when the children were seen at home.

Since the time that Debra, the perpetrator and the children moved from Hertfordshire there have been many changes within Hertfordshire Community Trust which have contributed to improving many of the areas of practice that have been identified in this review:

- Domestic abuse training is mandatory for all health visitors and school nurses. This should be completed within the first year of appointment. All newly qualified health visitors and school nurses undertake domestic abuse training as part of their preceptorship
- Guidance on domestic abuse is now within a policy which sets out requirement for staff compliance. Adherence is audited regularly and action plans monitored via the Trust's governance arrangements. Significant non-compliance is also monitored and reviewed through the incident reporting process
- The domestic abuse policy has been updated. The policy now includes clear guidance around the assessment of children age 0-5 years, the victim and includes the requirement to share information where relevant. This also requires the review and assessment of all adult records
- Schools now receive all medium and high rated domestic abuse notifications from the Domestic Abuse Investigation and Safeguarding Unit (DAISU). This ensures that

all schools are aware which children are experiencing domestic abuse in the home and enables this to be taken into consideration when there are concerns with regards to their behaviour/educational attainment

- Health providers are partners within the multi-agency safeguarding hub (MASH) which ensures timely assessment of all information, and sharing of health information where there are domestic abuse referrals from the police
- The Hertfordshire Community Trust movement in and out process for children is included in the Trust's safeguarding children policy and the standard operation procedures within the Trust's universal services
- The multi-agency risk assessment conference (MARAC) process continues to be overseen by the Trust's safeguarding team and is now managed centrally across Hertfordshire, enabling centralised processing of all referrals, information sharing and distribution to health visiting and school nursing teams across Hertfordshire
- The safeguarding team now ensures that information shared with the multi-agency risk assessment conference (MARAC) is recorded in records
- Changes to the safeguarding supervision process ensures that practitioners prepare for supervision with a focus on risk factors, which includes domestic abuse. The template includes a function which requires all cases that are brought to supervision have all parents and carers registered for care.

6.5. Victim Support

In Hertfordshire Victim Support ran the Hertfordshire independent domestic violence advisor (IDVA) service from 2008 to 2016. This consisted of a service manager, two senior independent domestic violence advisors and ten independent domestic violence advisors. During this time the service worked with 'high risk' victims.

On 20 May 2013, the Victim Support independent domestic violence advisor (IDVA) service received a referral from Hertfordshire Police. The referral stated that there had been a verbal altercation between the perpetrator and Debra and they had taken Debra to her mother's address. The referral described that the perpetrator was causing "*problems about the children"*, but it did not state the exact nature of the problems. In the referral it clearly stated that Debra "*said that she wants further help*".

An advisor contacted Debra the same day. Debra explained that there had been an incident on 17 May 2013, when the perpetrator had told her that he was working away but when she called his work, they said he was off. Debra thought he might have been unfaithful and this led to an argument. Despite telling the police that it had been a verbal altercation, Debra disclosed that during the argument, the perpetrator had "*poked her in the eye and smacked her around the back of the head with a bottle filled with water*". Debra explained that this was not the first incident of domestic violence. In the past, he had spat at her, hit her, thrown a mobile phone at her face and had been investigated for the "*attempted rape*" of a woman. She said that the perpetrator had "*borderline personality disorder*".

During the risk assessment carried out on 23 May 2013, Debra told the worker that she had changed her surname to the perpetrator's surname by Deed Poll in 2009. The house was privately mortgaged but in the perpetrator's name and that although she could use his car, she owned nothing but the "*baby's cot and a few clothes*". She said that she worked part-time as a teaching assistant and that she had debts of around £3000 that she owed to Dacorum Borough Council Housing. Debra explained to the independent domestic violence advisor (IDVA) that she felt safe as she was staying with her mother and was going to the coast on holiday for a week but would not be able to stay with her mother long afterwards. She said that she had told the perpetrator that their relationship was over, but she was not scared as he had not been calling her or following her as he had done in the past. Debra told the worker that she had two sisters living in Yorkshire. The independent domestic violence advisor (IDVA) advised her to present as homeless in Yorkshire. The risk assessment scored 15 and graded Debra as high risk. The worker sent Debra a text containing the worker's contact details and the number for the national refuge line. She was advised to get a non-molestation order and was given the details of the National Centre for Domestic Violence.[13] She was also advised that the worker would write a letter of support for legal aid if Debra required it.

It was clear from the records that the independent domestic violence advisor (IDVA) contacted Debra on the same day that the police referred her case. This initial contact was thorough and a comprehensive history was taken and a risk assessment carried out. The multi-agency risk assessment conference (MARAC) process was explained and she was provided with safeguarding advice e.g. to stay with her sister in Yorkshire, apply for a non-molestation order and to contact the school over her concerns that the perpetrator might try to pick up the children from school.

On 14 June 2013, once it was established that Debra had moved back in with the perpetrator, the worker rightly requested that a warning marker was placed on the address and referred the case to the multi-agency risk assessment conference (MARAC). Nevertheless, the independent domestic violence advisor (IDVA) did not manage to maintain contact with Debra after the MARAC and closed the case. There was no evidence within the records that the police were informed that Debra had disengaged. Workers should inform the referring agency if someone disengages. Equally as calls to Debra were being cut off, the case should have raised safeguarding concerns and should have been discussed with the designated safeguarding officer, the school, the police, children's social care and the health visitor. There was no evidence that this was done or considered. There was no evidence of safety planning. Furthermore, the case should have been discussed with senior independent domestic abuse advisor (IDVA) or the manager prior to it being closed. Again, there was no evidence that this was done.

[13] The National Centre for Domestic Violence (NCDV) provides a free, emergency injunction service to survivors of domestic violence regardless of their financial circumstances, race, gender or sexual orientation. For further information see www.ncdv.org.uk – accessed online 1 August 2018

In 2016 Victim Support began a national programme to attain SafeLives[14] Leading Lights accreditation. This is nationally recognised accreditation for independent domestic abuse advisor (IDVA) services who operate at best practice level. Practice has therefore improved and a number of changes have taken place. For example:

- A referring agency would be notified if a client disengages and it would be documented on the MODUS system
- If calls were being "*cut*", this would be discussed as a possible safeguarding concern with the Designated Safeguarding Officer
- Cases are now discussed with the senior independent domestic abuse advisor (IDVA) or manager before a case is closed.

6.6. Multi-agency risk assessment conference (MARAC)

Hertfordshire multi-agency risk assessment conference (MARAC) was asked to provide an individual management review for this domestic homicide review. Nevertheless, they declined on the ground that it was a multi-agency meeting and there was no one who could provide an overview. The Chair and panel of the review had access to the original minutes and therefore this section has been written from information gleaned from the minutes.

Debra's case was heard at the Western multi-agency risk assessment conference (MARAC) in Hertfordshire on 25 June 2013. This conference covered Watford, Three Rivers and Dacorum Community Safety Partnership areas.

At the meeting there were representatives from:

- Adult Social Services Hertfordshire
- Children's Social Care – Dacorum
- Children's Social Care – Watford
- Community Mental Health Team Watford and Three Rivers
- Dacorum Borough Council
- Dacorum Borough Council Anti-Social Behaviour Team
- Hertfordshire Community NHS Trust
- Hertfordshire Constabulary
- Hertfordshire Probation Service
- Independent Domestic Violence Advisor (IDVA) Service
- Spectrum (Drug and Alcohol Service) Dacorum
- Spectrum (Drug and Alcohol Service) Watford

[14] Safelives is a national charity dedicated to ending domestic abuse. For further information see www.safelives.org.uk – accessed online 1 August 2018

- Three Rivers District Council
- Thriving Families Team Hertfordshire
- Watford Borough Council
- West Hertfordshire Hospitals NHS Trust

The information shared between these agencies focussed on the 'non-crime' incident that occurred on 17 May 2013. The independent domestic violence advisor (IDVA) provided a lot of background information which was detailed in the minutes.

*I spoke with victim and she stated a DV incident occurred **17/05/13***

She said her partner poked her in the eye and smashed her on the back of the head with a bottle filled with water

She said he told he was going to do work in Cambridge but when she rang his work they said he has the day off. She believes he is having an affair

She said it is not the first incident of DV

She said he has thrown a mobile phone at her, spat at her and hit her

She said he suffers from border line personality border.

She stated that he has previously been investigated for an attempted rape of another female.

She said she has been with [the perpetrator] *for 7 years and they have 2 children*

She said she has one child from a previous relationship aged 9

She said she is living with offender in his property and it is in his name sole and she has no belongings of her own

She said she works part time as a teaching assistant

She said she debts from DBC of about £3000 – I believe they are arrears

She said she was going to go on holiday and was considering moving to Yorkshire with her sister when she returns.

I explained that she can present herself as homeless and about the MARAC process

I gave her the refuge number and how to get NMO

*I rang her **14/06/13** and she confirmed that she was back living in the property with offender*

She said she was living at her mum's address but there wasn't enough room for her and the children

She said they are still separated but things are ok since she has been back

She said she has one month left on her work contract and may consider moving to Yorkshire after that.

From risk assessment she said last incident had been NFA'd [no further action] *and had injuries from incident, she feels isolated from family and friends, she has had a baby within the last 18 months, the abuse happened more often, he is controlling, he has thrown objects at her including mobile phone he has said "I just want to kill you", there are financial issues; she relies on him for money, he has*

attempted to commit suicide in the past, he hasn't stuck to his bail conditions in the past and he has a criminal history.

The outcome and actions from the meeting were:

i. The health visitor should check which school Debra's eldest daughter was attending

ii. Dacorum Borough Council should check for any money owed by Debra

iii. The independent domestic violence advisor (IDVA) should check previous addresses for the perpetrator and Debra and try to establish whether there were any new partners

iv. Children's Social Care (Dacorum) was asked to "*revisit the case*"

There was no information as to the rationale for requiring any of these pieces of information although all the actions were completed and dated. The independent domestic violence advisor however reported that Debra was "*no longer engaging*" despite the worker phoning her four times. It appeared that children's social care passed Debra's case to the Targeted Advice Service[15] who closed the case having recorded:

"TAS telephoned both parents and advised them of the impact their disputes may have on their children. TAS reiterated to them that these disputes may impact on a child at any time of their life.

TAS gave strategies should another argument occur, TAS suggested they talk about this when things are calm and come to an agreement that one of them remove themselves from the situation for a while until things calm down.

TAS telephoned the HV - spoke to [team leader]*, she advised they have no concerns, the children attend clinic regularly and immunisations are up to date. She advised the last incident was in Dec 2010 and Mum was spoken to then, Mum advised them that it was a one off and explained that her husband had a personality disorder but things were fine"*

The course of action by the Targeted Advice Service (TAS) appeared to completely disregard the history provided by the independent domestic violence advisor (IDVA). This information showed a pattern of escalating behaviour. It was evident that the perpetrator was physically abusive, financially controlling and emotionally controlling. Debra excused his behaviour by suggesting that he has borderline personality disorder but this was never explored. She described having no possessions and being in debt. Other concerns included that she had recently had a baby, the perpetrator had made threats to kill her and he had a criminal record and had been arrested for an alleged rape in the past.

The Targeted Advice Service (TAS) appeared to minimise the abuse that Debra was suffering by suggesting she should simply talk to the perpetrator when he was calm. Inevitably such an inappropriate response may have made Debra more hesitant to report domestic abuse on future occasions, or even minimise the abuse herself.

[15] The Targeted Advice Service was part of children's social care and provided an initial triage and consultation service

Hertfordshire County Council provided some information about the multi-agency risk assessment conference process. In 2013 there were three separate MARAC areas across Hertfordshire. The coordination was managed by Victim Support as part of the same contract that included the independent domestic violence advisor (IDVA) service. Each MARAC was chaired by a detective inspector from the (then) Harm Reduction Unit. The development and quality assurance for MARAC rested with the Domestic Abuse Strategic Programme Board and was overseen by the county's domestic abuse coordinator based within the County Community Safety Unit. In 2014, as the result of an HMIC (Her Majesty's Inspectorate of Constabulary) inspection and a local review of domestic abuse in Hertfordshire changes were made to the local MARAC structures, criteria and coordination along with overall MARAC management. Thus, after January 2015, there were five MARACs operating across Hertfordshire.

Hertfordshire Constabulary took over the responsibility for MARAC. A central MARAC team was formed with a permanent Chair and Deputy Chair. A MARAC sub group was formed which had clear aims and objectives. The frameworks and processes relating to referrals, risk management of MARAC cases, monitoring and quality assuring of MARAC have all been updated. In addition, Hertfordshire Constabulary created the Domestic Abuse Investigation and Safeguarding Unit (DASIU) which replaced the Harm Reduction Unit. This has centralised the previously fragmented structure for handling cases of domestic abuse. Currently, Hertfordshire is implementing a system called MODUS to improve the management of MARAC cases and improve information sharing pathways.

6.7. General Practitioners

GP Surgery, Hertfordshire

All the family members were registered at a GP Surgery. The perpetrator's records showed that he had minimal contact with the GP Surgery and was last seen for a cough in January 2015. His past medical history included "*intentional self-poisoning by exposure to a noxious substance*". This followed a relationship "*problem*" in 1990. In December 2010, there was a notification in his records concerning "*alleged domestic abuse in the household*" – although the individual management review then stated "*There was nothing in his notes to predict any violent nature…..*"

Debra was last seen at the surgery in January 2015 for back pain. None of Debra's or her children's attendances appeared related to domestic violence or abuse. Nevertheless, there were notifications about domestic violence in the household. These were dated April 2006 and 2010.

In August 2014, the GP was asked to complete part of a 'health declaration form'. This form needs completing before someone can register with Ofsted to look after or care for children.[16] A GP phoned Debra about the domestic abuse in 2006 and 2010, and spoke to Debra on 8 August 2014. Debra told the GP that both incidents involved a previous partner and were no longer relevant.

[16] For further details see https://www.gov.uk/government/publications/become-a-childcare-provider-health-declaration - accessed online 1 August 2018

There was no information within the individual management review to explain how procedures have changed. For example, whether domestic abuse notifications are flagged on victims' and perpetrators' records; and whether staff would use this information to initiate routine, targeted or selective questioning around domestic abuse with patients.

Medical Centre, Milton Keynes

The family registered at Parkside Medical Centre in April 2015. The perpetrator attended twice for minor ailments and Debra went to the medical centre six times for minor ailments. None of Debra's or her children's attendances appeared related to domestic abuse or potential injuries she may have sustained.

6.8. Schools

Debra's family was particularly keen to understand why Debra's older daughter attended so many different schools up to the time of her Debra's death. Each school was individually asked to provide information but, in many cases, this was not forthcoming.

From records it appeared that Debra's daughter attended between eight and ten schools by the time she was 11 years old. The majority of the schools were in Hertfordshire. Most of the schools in Hertfordshire were unable to provide any records, information or even anecdotal recollections about Debra's daughter. Thus, it was impossible to establish the reasons she left a particular school, whether there were any concerns about her academically and developmentally, or why she attended so many different schools.

Infants School, Hertfordshire

January 2008 – September 2009. Aged 3 – 4. No further information available

Primary School (1), Hertfordshire

January 2009 – December 2009. Aged 4 – 5. No further information available and it was unclear why the dates overlapped with her previous school

Primary School (2), Hertfordshire

September 2008 (?) – October 2010. Aged 4 – 6. No further information available and it was unclear why the dates overlap with her previous two schools

Primary School (3), Hertfordshire

November 2010 – September 2012. Aged 6 – 8. No further information available

Junior School, Hertfordshire

October 2012 – December 2013. Aged 8 – 9. No further information available

Primary School, Yorkshire

Debra's daughter (aged 9) attended a primary school in Yorkshire between January and May 2014. She was remembered as being "*well-kept and happy*". There were no concerns over parenting and she only missed two days. Her attendance was documented as "*poor*" (71%) because the family relocated back to Hertfordshire but Debra's daughter remained on the school register in Yorkshire, as a school had not been found for her in Hertfordshire.

Primary School (2), Hertfordshire

June 2014 – Debra's daughter (aged 9) returned to Primary School (2) at the end of the Year 5 school year. A complaint was made by another child that Debra's daughter was "*taking lunches from boxes*". The school concluded that this was not true, as another child said that this had been happening before Debra's daughter arrived at the school.[17] On another occasion Debra's daughter apparently called another pupil "a B******* and someone else a C***. There were also some accusations of bullying. During the summer term, Debra's daughter described being bullied and said "*I am just lonely and they bother me asking me things they do not need to know*". Then in July 2014 there was an incident when Debra's daughter and another pupil threw paint at each other – each blamed the other for the incident. Debra made a complaint and her daughter's school shirt was replaced by the school "*as a gesture of goodwill*".

An altercation occurred between Debra and the other pupil's mother and Debra threatened to keep her daughter off school saying that she might not return for the next term.

In September 2014, Debra's daughter "*tripped up*" the same pupil – and ten days later the pupil tripped up Debra's daughter. In October 2014, the same pupil called Debra's daughter a "*tramp*" – it appeared that she had found a pair of sunglasses at a bus stop and worn them to school. The pupil apologised. Allegations and counter allegations of bullying continued throughout October and the perpetrator wrote a letter of complaint to the school, copying in the local MP and Ofsted. The perpetrator and Debra agreed to suspend the complaints procedure while a full investigation took place. All the incidents were discussed in full at a meeting between the perpetrator and the Chair of the Governors. During the meeting it was stressed that Debra's daughter should not be moved to another school, as she needed stability. Ultimately, the complaint went to the Governing Body Complaint Panel and it was heard at a formal hearing on 27 November 2014. The complaint was not upheld and the head teacher commented that "*it was a vexatious complaint, resulting in a huge amount of staff time that could have been better employed in improving children's education*".

As part of the investigation at this school into Debra's daughter being bullied, her teacher contacted her previous schools. It was apparent that she had left two previous schools because of bullying (although it did not state which schools).

Primary School (3), Hertfordshire

No further information available

Academy, Milton Keynes

In September 2015, Debra's daughter (aged 10) attended an Academy for two weeks before moving to another school in Milton Keynes. During her time at the school no concerns were identified or raised. The school had no record of any of Debra's daughter's files being sent to them.

[17] Nevertheless, in discussion with Debra's sisters it became apparent that food was sometimes withheld as a punishment for the children

School, Milton Keynes

September 2015 – May 2016. Debra's daughter (aged 11) moved to this school where there were very few concerns about her. She arrived two weeks into the start of year seven, so was a little "*timid*". She settled in well and quickly made friends. Her previous school was unable to supply any of Debra's daughter's previous school records. The school in Milton Keynes did however receive some basic records from Primary School (2) in Hertfordshire where Debra's daughter attended years 5 & 6. As part of her records there was a 'child missing from education' form from the primary school in Yorkshire. This form stated that the school in Yorkshire thought that Debra's daughter was at Primary School (3) in Hertfordshire.

Church of England School, Milton Keynes (Debra's son)

Debra's son attended a Church of England School in Milton Keynes. The school was unaware of the history of domestic abuse. Debra was described as being "*defensive*" in any matters relating to her son and sometimes sent "*abrupt*" emails in response to requests e.g. for more reading practice. Both parents attended parents' evening and sports days, and he responded well to both parents but seemed particularly close to Debra. "[Debra's son] *never disclosed anything of concern. He could sometimes get into trouble but no more than any other child and always for age appropriate things – nothing suggested any issues at home*".

7. EMERGING THEMES AND LESSONS LEARNT

On the face of it, this case involved three incidents of domestic abuse each separated by three years. Although it might appear difficult for agencies to connect these three apparently disparate and discrete incidents, there were signs available to professionals and opportunities missed by professionals that could have helped build a better understanding of Debra's life.

7.1. Missed opportunities

SHARING INFORMATION

There were missed opportunities to share information. For example, when the perpetrator was arrested for common assault in August 2007, the police did not inform children's social care. This meant that children's social care did not consider this information when they received the domestic abuse notification in September 2007.

This review also showed that various professionals had difficulty contacting Debra. There were times when she did not answer, or the phone "*went dead*". None of the professionals who had difficulty engaging with Debra (health visitor, independent domestic abuse advisor (IDVA), social workers or police) shared these difficulties with other agencies. This resulted in increasing Debra's vulnerability especially after the multi-agency risk assessment conference (MARAC) in June 2013 when the independent domestic abuse advisor (IDVA) closed her case.

QUESTIONING, TRIANGULATING AND CORROBORATING INFORMATION

In September 2007, when children's social care received the first notification of domestic abuse from the police of the incident in July 2007, no further information was sought. Had information been sought, it would have become apparent that the perpetrator had been arrested in the meantime for an assault on another woman. This information would have helped children's social care build a picture of a pattern of behaviour around the perpetrator's predilection for abusing women. This in turn would have meant that when future domestic abuse notifications were sent to children's social care, it may have triggered a more appropriate response.

In May 2013, children's social care received another domestic abuse notification. Again, no attempt was made to question or triangulate the available information. Therefore, this was a missed opportunity to identify that Debra had by that time been assessed as at high risk of harm (assault or murder). The result was an inappropriate response from children's social care i.e. they contacted both parents to provide them with "*advice and guidance around the impact of disputes on children and provided them with strategies on managing disagreements*" and closed the case.

Throughout the period under review, no professional recognised that Debra's daughter was frequently moving schools. There did not appear to be any questioning from the schools as to why this was happening.

CHALLENGING AND EXPLORING SELF-REPORTED INFORMATION

There were also missed opportunities to challenge and explore the self-reported information that professionals were given. For example, in November 2007 when the perpetrator was arrested for rape, Debra told the social worker that he had never been violent. At the time, children's social care had information about domestic abuse in the household but did not challenge Debra. Similarly, when Debra told professionals that the perpetrator had borderline personality disorder, no one explored what was meant by this, whether it was a formal diagnosis and what impact it had on the lives of Debra and her children. Professionals sometimes appear hesitant to challenge the information that victims provide, yet this is important. Had Debra been challenged about the perpetrator's personality disorder, professionals may have learned more about whether he was using it as an excuse for his behaviour, or whether Debra was trying to minimise/rationalise his behaviour.

7.2. Recognising economic abuse

The missed opportunities to share, explore and question information meant that agencies did not identify that she was vulnerable because she was in debt. Debra's debts started rising when she met the perpetrator, mainly because she continued to rent a property even after she moved into his house. It is not clear whether she did this so she had a "*bolt hole*" to escape to, or whether the perpetrator had insisted. Whatever the case, it meant that Debra struggled to pay the rent, which resulted in rent arrears of £3,000 to £4,000.

Research[18] shows that financial abuse is complex and Sharp[19] identifies four different types of financial abuse:

- Interfering with employment
- Controlling access to financial resources
- Refusing to contribute to financial costs
- Generating financial costs

A perpetrator may demand to know how money is spent and make a victim continually ask for money. They may refuse to contribute to the household bills whilst spending money on other things and building up debt for the victim. It is common to see financial sabotage i.e. not letting the partner work or study. Inevitably, these all contribute to making the victim more dependent on the perpetrator. Furthermore, financial abuse creates a barrier to leaving and it exposes women to other types of abuse such as sexual violence (e.g. having to perform sexual favours for money). Studies show that women are three and a half times more likely to suffer domestic abuse if they cannot find £100 at short notice.[20]

It appeared that the perpetrator denied Debra and the children access to basic resources such as clothing, food and transportation. In May 2013, Debra told the independent domestic abuse advisor (IDVA) that she lived in a privately mortgaged house but it was in the perpetrator's name and although she had access to the car it also belonged to the perpetrator. She disclosed that all she owned was the "*baby's cot and a few clothes*". It was not possible for the panel to establish if the financial abuse went further, for example whether he refused to financially support their children.

7.3. Domestic abuse and housing

We do know however that Debra attempted to leave the perpetrator in February 2012 following a violent incident. She made a housing application to Dacorum Borough Council. Significant emphasis was placed on her existing rent arrears and how this would have a detrimental effect on her application. Debra returned to live with the perpetrator and later that year her third child was born.

She again tried to leave and in January 2014 moved to Yorkshire. There was no record of her presenting as homeless and a victim of domestic abuse but ultimately, she again returned to live with the perpetrator. The combination of financial abuse, debt, part-time work, financial insecurity and dependent children inevitably makes women more vulnerable to remaining in

[18] See for example: Dr Nicola Sharp-Jeffs "Supporting Survivors of Financial Abuse: Learning for the UK, 2016
[19] Sharp, N. (2008) "What's Yours is Mine" The different forms of economic abuse and its impact on women and children experiencing domestic violence. London: Refuge – also see Postmus, J. L., et al (2012) Understanding Economic Abuse in the Lives of Survivors Journal of Interpersonal Violence. 27(3) 411-430
[20] Walby, S. and Allen, J. (2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey London: Home Office Research Study 276 cited in Sharp-Jeffs, N (2016) "Supporting Survivors of Financial Abuse: Learning for the UK

abusive relationships. Perpetrators use financial abuse to limit partners' options and make them financially dependent.[21]

Furthermore, although Debra was working and clearly contributing to the household, the perpetrator ensured that both the house and car were in his name. Thus, when he killed Debra, the house remained in his name and he has since been able to rent it out whilst in prison. This situation is intolerable and offensive considering Debra's sisters are caring for his children. The panel considered that such situations could be usefully addressed in the current Government consultation on "Transforming the Response to Domestic Abuse" so that perpetrators who financially abuse their victims cannot benefit from killing them.

7.4. Avoiding scrutiny or being prevented from engaging?

As professionals did not challenge or share information, they did not recognise that Debra's daughter was moving school frequently. During the course of the review, it was not possible to establish from education within Hertfordshire why Debra's daughter changed schools so frequently. There was some suggestion that she was being bullied at various schools; although Debra's daughter does not recall being bullied. The panel considered whether she was moved from school to school in order to ensure that she did not disclose what was happening in the household. Changing schools to avoid scrutiny is not an uncommon tactic and both schools and councils should be alert to such practices. Therefore, it is concerning that this review could not be provided with any significant information from Hertfordshire about Debra's daughter's schooling, including her academic and developmental records or any child protection concerns.

Disengaging from services and not answering calls is also a tactic for avoiding scrutiny. It appeared that on some occasions the phone "*went dead*" when professionals tried to call Debra. It is not possible to establish whether the perpetrator ended the calls but professionals should have considered this, which in turn should have increased their concerns for Debra's welfare; especially as Debra was disclosing information within risk assessments that highlighted her vulnerability i.e. she was "*frightened*" of the perpetrator, he constantly texted her, checked her mobile, email and Facebook account – made threats to kill her and had assaulted her in the past (DASH risk assessment 2010). Then by May 2013, she disclosed that the abuse was happening more frequently, he was controlling, she relied on him for money, she was isolated from her friends and family, and she had recently had a baby. It is therefore concerning that the independent domestic abuse advisor (IDVA) closed Debra's case after the multi-agency risk assessment conference (MARAC) meeting.

7.5. Minimising domestic abuse

The result of professionals failing to share, corroborate or challenge information and not identifying the specific vulnerabilities that Debra was facing made it appear that they were minimising the abuse that she was suffering. For example, each time she disclosed domestic abuse, she was sent a letter explaining that it could have an impact on her children.

[21] DuMonthier, A and Dusenbery, M. 2016 Intersections of Domestic Violence and Economic Security, Institute for Women's Policy Research, Briefing Paper – accessed online @ www.iwpr.org 1 August 2018

Sometimes, these letters were sent to her rather than the perpetrator, almost implying that it was her fault. Indeed, following her referral to the multi-agency risk assessment conference (MARAC), the targeted advice service from children's social care telephoned both the perpetrator and Debra. They suggested that Debra and the perpetrator "*talk about this when things calm down and come to an agreement that one of them remove themselves from the situation for a while until things calm down*". This is clearly inappropriate advice to a victim who is considered to be at high risk of harm (assault or murder). Furthermore, this simplistic view of domestic abuse may well have contributed towards Debra minimising the abuse she was suffering and the danger she might face.

7.6. The danger of separation

Many victims, their families and indeed professionals continue to believe that once a victim has separated from their abusive partner, the abuse will stop. However, post-separation violence and abuse is an issue for a significant number of victims of domestic abuse (and their children). One research study[22] showed that 76% of women who had separated suffered further abuse and harassment from their former partner.

In the days before her death, Debra informed her daughter's school that she and the perpetrator had separated. Debra told the perpetrator their relationship was over and that she had met someone else. Research shows that women are at greater risk of violence and being killed after separating from abusive partners.[23] Debra may not have realised that separation might increase the risk that the perpetrator posed to her.

8. CONCLUSION

Undoubtedly Debra was a loving mother who cared deeply about her children. The perpetrator was manipulative, physically abusive and financially controlling. Despite only three calls to the police concerning domestic abuse over a nine-year period, it was evident that Debra disclosed information to professionals that suggested her and the perpetrator's relationship was abusive. She tried to leave him a number of times but she had financial debts (amongst other things) that may have prevented her. Throughout the time under review, professionals had the opportunity to be more enquiring about Debra's circumstances and they missed opportunities to explore, triangulate and corroborate information. When Debra disengaged from agencies this was accepted too easily.

It is evident that practice has changed over the years since Debra disclosed that the perpetrator was abusive. Amongst other things, Hertfordshire has introduced a multi-agency safeguarding hub (MASH) and agencies work more closely together. Nevertheless, there remain concerns about the accountability of the multi-agency risk assessment conference (MARAC) and the record keeping of schools within Hertfordshire.

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[22] Humphreys, C and Thiara R, Neither justice nor protection: women's experiences of post-separation violence, Journal of Social Welfare and Family Law, Volume25, Issue 3, 2003 – accessed online 1 September 2015

[23] See for example https://www.womensaid.org.uk/what-we-do/campaigning-and-influencing/femicide-census/ - accessed online 1 August 2018

9. RECOMMENDATIONS

1. The Hertfordshire multi-agency risk assessment conference (MARAC) sub-group should consider which organisation, agency or individual is best placed to undertake an independent review the MARAC records and produce an individual management review for any potential future domestic homicide reviews.
2. Hertfordshire Child Protection School Liaison Team should provide a report to the Hertfordshire Safeguarding Children Board setting out what system is in place to identify any pupil who is frequently moved between schools and the reasons for those moves
3. The learning from this review should be brought together with the learning from other domestic homicide reviews in Milton Keynes to inform strategy and practice
4. The learning from this review should be brought together with the learning from other domestic homicide reviews in Hertfordshire to inform strategy and practice
5. SaferMK should review the governance arrangements around violence against women and girls (VAWG) and the domestic homicide review process within Milton Keynes
6. The Government Domestic Abuse Bill (currently out for consultation, March 2018) should ensure that when a perpetrator uses financial/economic abuse, they cannot then benefit financially from killing the victim
7. Hertfordshire Domestic Abuse Partnership should facilitate a meeting between Debra's sisters and managers from the multi-agency safeguarding hub (MASH) and the multi-agency risk assessment conference (MARAC). This should ensure that Debra's sisters understand the changes that have been made since their sister's death and are reassured that positive improvements have been implemented.

10. SINGLE AGENCY RECOMMENDATIONS

HERTFORDSHIRE CONSTABULARY

1. Hertfordshire Constabulary Information Management PNC (Police National Computer) Unit to consider reviewing the process for removing warning markers when they are no longer required

HERTFORDSHIRE HEALTH VISITING

2. To ensure Hertfordshire Community Trust staff are aware of the record transfer process for adults
3. To ensure that the supervision prompt list for discussion includes cases heard at the multi-agency risk assessment conference (MARAC)

4. To seek assurance that the multi-agency risk assessment conference (MARAC) notes are attached to the record by the individual practitioners
5. To ensure professional curiosity and challenge is included in all Hertfordshire Community Trust training around domestic abuse
6. To ensure that domestic abuse policy adherence is audited regularly with particular focus on partners/ father's records and the sharing of domestic abuse information by health visitors to GP's for the victim and perpetrator
7. To ensure that Hertfordshire Community Trust universal services include the necessity to record which adults are present at each contact
8. To review Hertfordshire Community Trust universal services process for movement in and out reflects Safeguarding Policy and includes record sharing guidance.

DACORUM BOROUGH COUNCIL

9. The review of eviction cases by the Housing Panel will be reviewed to include a section that specifically deals with domestic abuse and safeguarding – the template will be updated to reflect this and will be an essential part of any report
10. Staff who come into direct contact with victims (housing officers, ASB officers etc.) must attend the DASH training so they are familiar with the risk assessment process and can identify coercive control at the earliest opportunity
11. All cases involving victims of domestic abuse, or where there is a reference or concern about domestic abuse should be followed up by the case officer and not closed without the case officer making contact with the victim
12. To ensure that all victims of domestic abuse are risk assessed using the MARAC/DASH assessment process
13. To ensure that all victims of domestic abuse are offered access to the Domestic Abuse Case Worker and given contact details of women's organisations (including culturally specific organisations).