Overview Report:

Domestic Homicide Review into the Death of

‘Michelle’

Date of Death October 2016

AUTHOR: JAN PICKLES OBE

COMMISSIONED BY THE BOURNEMOUTH COMMUNITY SAFETY PARTNERSHIP

DATE: 15.1.18

Foreword by the Chair of the Review

Tonia Redvers Chair

As the Chair of this panel I would like to add my deepest sympathies, along with those of the panel, to Michelle's family and all who have been affected by her death. I would like to thank members of the family who have taken their time to meet us and contribute to this report. Thank you for your time, your patience and your cooperation.

I would like to thank all members of this panel for the professional manner in which they have conducted the review and the Independent Management Review Authors for their attention to detail, their honesty and thorough assessment and analysis in reviewing the conduct of their individual agencies.

Lastly may I thank the efficient administration that has guided us all through this review and the Author for their time and commitment in bringing the information together to offer a picture and giving Michelle a voice within this exacting but necessary review.

It is only right that Michelle's voice should be here at the beginning of the review and her parents shared that although she struggled emotionally as a child and had low self-esteem they feel that their family ties remained. There were difficult periods of time when Michelle was a teenager that they feel left her vulnerable as an adult. Her parents continued to love and support Michelle to live independently and eventually she started her own adult relationships.

As you read this report you will see that Michelle was a caring and loving mother, she was a victim of repeated violence and abuse and had worked hard to change her life, to break free from abusive relationships and to give herself and her children a bright and positive future.

It is a great sadness that she will not see that future she had planned for her children.

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1. The circumstances that led to and the timescales of this review

1.1 In October 2016 Michelle was found dead from multiple stab wounds at her home address. It is thought she died on the previous evening before midnight. It is believed that her body was partially hidden in a carpet overnight and that this was witnessed by a child. In April 2017 at Winchester Crown Court Simon was sentenced to life imprisonment with a recommendation he serve a minimum of 21 years in custody for the murder of Michelle.

1.2 The initial investigation identified that domestic violence did play a significant part in this death. For that reason and in accordance with the statutory Guidance relating to Section 9 of the Domestic Violence, Crime and Victims Act (2004), Bournemouth Community Safety Partnership commissioned a Domestic Homicide Review (DHR).

1.3 The Review was Chaired by Ms Tonia Redvers and the panel first met in May 2017. I was appointed as author of the DHR and as the independent person whose role was to liaise with family members in June 2017 and attended my first meeting in July 2017. I am a qualified and registered social worker with over thirty-five years' experience of working with offenders and victims of domestic abuse and sexual violence, both operationally and in a strategic capacity. In 2004, I received an OBE for services to victims of domestic abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the concept of Independent Domestic Violence Advisers (IDVAs). In 2010, I received the First Minister of Wales' Recognition Award for the establishment of services for victims of sexual violence. In my career, I have held roles as a Probation Officer, Social Worker, Social Work Manager, Human Rights Charity Director, Assistant Police and Crime Commissioner and as a Ministerial Adviser in Government. I currently am an Independent Board member on a NHS Trust and a member of the National Independent Safeguarding Board for Wales. I have completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

1.4 I am not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under review.

2. Purpose of the Domestic Homicide Review

The purpose of the Domestic Homicide Review (DHR) is to:

- Ensure the voice of Michele is at the centre of the review process;
- Establish the facts that led to Michelle's death in October 2016, and to identify whether there are any lessons to be learned about the way in which professionals and agencies, both locally and across borders, worked together to safeguard the individuals involved;
- Listen to family, friends and relevant others in the community who have views on this tragedy and to ensure these views are reflected in the report;
- Establish whether the agencies or inter agency responses were appropriate leading up to at the time of Michelle's death.
- Understand the context in which professionals made decisions and undertook actions considering their culture, training, supervision and leadership arrangements.
- Establish whether the agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes because of the review process;
- Identify what those lessons are, set out how they will be acted upon and explain what is expected to change as a result;
- Publish the findings in accordance with the Home Office Guidance to enable the lessons learned to be widely shared.

3. The process followed

This section summarises how the DHR panel sought to manage the review process, including the membership and operation of the panel, keeping the family central to the process, the scope and methodology, reporting and communications.

3.1 Membership and operation of the review panel.

A Domestic Homicide Review Panel (the 'Panel') was established from a core group of statutory Services in the Bournemouth area. This included:

1. Dorset Police (also representing Devon and Cornwall Police)
2. National Probation Service now known as the National Prisons and Probation Service
3. Dorset Health Care University Foundation Trust
4. Dorset Clinical Commissioning Group
5. Bournemouth and Poole Adult Safeguarding Board.
6. Bournemouth Borough Council (Local Authority)

The panel heard directly from the Ministry Of Defence GP regarding the perpetrators medical background.

The panel's membership is noted in Appendix 1.

The panel met on three occasions from May 2017 to October 2017, I was appointed as the author of this review in June 2017 and immediately planned to meet the family and a friend of Michelle's. I wrote to the perpetrator, the letter offering an interview was hand delivered by a Probation Officer in the Prison with an explanation of the DHR process but this offer was not taken up.

As a guiding principle, the panel sought to involve the family of the victim as early in the process as possible, taking account of who the family wished to have involved as lead members and to identify other people they thought relevant to the review process. The next of kin for the family was identified as Michelle's mother, who gave permission to view Michelle's medical records as part of the review**.** The Health records of the perpetrator are under the Department of Health 'Striking a Balance' (2012) available to the review as confidentiality can be waived where there are grounds that a person caused the death of another.

https://www.gov.uk/government/news/striking-the-balance-guidance-on-information-sharing

4. The reviews contact with Michelle's Family and a friend.

4.0 In July 2017, I visited Michelle's mother and step-father at their home and they were kind enough to share their memories of Michelle as a child and young woman and their thoughts on the events that lead to her death. During this interview, Michelle was described a loving and much-loved daughter and sister who was missed by them every day. They, as a family have not only to live with their grief but also are bringing up Michelle's baby son, a daily reminder of their daughter Michelle. They were determined to contribute to this review in the hope of preventing this from happening to another family.

4.1 In August 2017, I visited Michelle's father who since separating from her mother when Michelle was young maintained a loving and close relationship with her. Michelle's father describes Michelle as a happy child who grew up with low self-esteem and because of this chose to have relationships with vulnerable men who she wished to 'rescue'.

4.2 In July 2017, I met with Michelle's close friend who witnessed much of the abuse Michelle suffered at Simon's hands. As a close friend, her pain at Michelle's' loss was palpable, she described Michelle as "an amazing mother who always put her children first".

4.3 The reviews contact with the perpetrator.

4.3 In June 2017, the panel wrote to Simon, the perpetrator who was aged twenty-six years old at the time of the murder. He was found guilty and sentenced to a Life Sentence with a minimum term of 21 years by Winchester Crown Court. The letter requesting an interview was delivered by hand via the Probation Service in the Prison with an explanation of the process. Simon chose not to participate in the review.

4.4 In reporting the views of individuals who witnessed the actions of the services involved, the Review Panel is not endorsing those views as an accurate or as a fair assessment of the services provided. They are the views and opinions of the family and friends and should be considered with respect, in that they may offer lessons for the services involved.

4.5 Terms of Reference and methodology

Whilst respecting Michelle and her family the review sought to do the following:

- Consider the period of thirty months (June 2013 - October 2016) prior to the death of Michelle subject to any information emerging that prompts extending the review to earlier incidents or events
- Consider the way in which information was exchanged between agencies
- Request Independent Management Reviews from each of the agencies defined in Section 9 of the Act and to invite responses from any other relevant agencies or individuals identified through the review process;
- Seek the involvement of the family and relevant friends and the perpetrators to provide a robust analysis of the events;
- Take account of the Coroner's Inquest, criminal proceedings and other relevant enquiries.
- Produce a report that summarises the chronology of the events, details the actions of the agencies involved with analysis and comment, and makes recommendations for safeguarding individuals where domestic abuse is a feature;
- To aim to produce a final report by the end of November 2017. The final report will be shared with family members prior to being presented to the commissioning authority Bournemouth Community Safety Partnership. Once accepted by the Bournemouth Community Safety Partnership the report will be submitted to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

NB: It should be noted that it is **NOT** the purpose of a Domestic Homicide Review to either establish how the victims died, or to identify who is culpable for their deaths. These are matters for both the coroner's and criminal courts. Equally, it is not the purpose of the review to apportion blame to agencies or individual practitioners. Instead, the purpose of the review is to **identify lessons** that can be learned to improve awareness and agency responses that may ultimately prevent others from becoming victims of domestic violence in the future.

4.6 Reporting of this review.

It is the Chair and panels intention that the report is shared with Michelle's close family and that they have had the right to comment on it. If they express a difference of opinion on anything contained in the report, this will be clearly noted in the final report that is circulated to the Home Office before publication. Once agreement has been given to the final draft of the report by the Home Office quality assurance panel, the review will be available on the Council website. The review will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998. A copy of the finalised review will be sent to the perpetrator Simon.

4.7 Media and communication.

As this Domestic Homicide was of national interest with articles in several national newspapers it was agreed at an early meeting of the panel that the management of all media and communication matters was be undertaken by The Local Authority Media team. As previously stated, an executive summary of the completed review report will be published on the Bournemouth Borough Council website to which all agencies will be able to create a link to their intranets, with an appropriate press statement available to respond to any enquires. All written communication from the Panel will use all agency logo's. Panel members also commit to distributing the recommendations of the review via their own websites and the Domestic Abuse Strategic and Operational groups, and to raise in learning forums with other partner agencies involved with responding to domestic abuse.

5. Background to the Review

5.0 At the time of her death Michelle was a 26-year-old woman who was a loving mother to two small children, her daughter and her baby son. Michelle was a victim of repeated violence and abuse at the hands of her partner and had also been a victim of violence from her previous partner. Michelle struggled emotionally as a teenager and this resulted in conflict in the family home. Concerns about her low mood, self-harm and suicidal feelings were documented. Many years before her death Michelle had repaired her relationship with her parents and was very close to them.

5.1 The perpetrator, Simon grew up in a family in which violence was endemic and seen as an acceptable means of resolving issues. Simon's parents separated when he and his brother were small children. Simon's mother moved to Australia a few years ago. The impact on him of this is not documented but Michelle's family and friend describe him having significant issues around abandonment which may have been relevant to his behaviour. Their father had served in the Belgian Army and Social Work records from 2004 when Simon and his brothers were aged seven to eight years old note that weapons such as knives and an axe were accessible to them in their father's home. His father made a point of showing the children how to use knives and they were routinely left around the house, an axe was left by the bed. Simon and his siblings all have criminal records and a reputation within the area for violence some involving partners, family members and the public.

5.2 Although the terms of reference for this review are limited in time to the thirty months preceding her death her biological father believes Michelle's low self-esteem as an adolescent was a significant factor in her repeatedly finding herself in and remaining in abusive relationships, this was not a view shared by her mother who describes her as insecure but confident. To understand Michelle and the events that led to her tragic death I will need to briefly outline relevant events that occurred in her early years.

5.3 Michelle's parents had separated when she was two years old, with Michelle remaining with her mother, though she had continued to see her father on a very regular basis throughout her childhood despite him living over a hundred miles away. Both of her parents went on to establish long-term relationships with other partners and have further children. Michelle throughout her childhood had regular contact with her father and his family and was close to all her half siblings. As a child, Michelle moved with her mother and step-father to the Bournemouth area. Her mother and stepfather went on to have twin sons. They tell me Michelle then aged seven years "doted on them". They describe Michelle as a child as having a lovely gentle nature and being happy in spending time with her family.

5.4 Michelle was educated at a local Private Primary school, moving to a Secondary school at eleven years of age. Her mother reports that in year 9 (about 14 years old)

she became more challenging and began pushing boundaries both at home and at school. On one occasion, she and a group of friends attended school under the influence of alcohol. Michelle's mother felt this to be no more than teenage boundary testing but it was difficult for the whole family to live with and Michelle's mother did her best to establish acceptable behaviour. Her mother and step-father describe it being difficult to control her, and when they grounded her by making her stay in at home she would leave the house once by jumping out of a window. Michelle's mother was aware in retrospect of the clash between her own strict beliefs about how children should behave and Michelle's behaviour at the time. Managing this was made more difficult by the fact that every other weekend Michelle would spend the weekend with her biological father, in which according to Michelle's mother, she enjoyed a more relaxed regime spending more one to one time than was possible in Bournemouth in a busy family home with three children. According to her biological father it was at this time that Michelle began to express the thoughts that she was 'unloved', although Michelle's mother does not recognise this. This feeling may have been symptomatic of a more general feeling of confusion that is common at this stage in life.

5.5 Her mother and stepfather describe going to significant lengths to maintain a relationship with Michelle and always tried to include her in ordinary family life. Her behaviour made this difficult for them, they experienced it to be damaging to the well-being of the rest of the family. Michelle's mother describes the efforts she made to resolve these difficulties including her and Michelle having counselling together. However, after a heated argument Michelle decided and insisted despite her parents attempts to dissuade her to move to live with her father and his family. At 14 years Michelle moved to live with her father, his partner, and her half-sister. During this time, she enrolled at a local school and was on track to take five GCSE's. However, after nine months with them she became homesick for her life in Bournemouth and returned to live with her mother and step-father, who willingly welcomed her return.

5.6 Michelle first came to the attention of services in the area in 2006, aged approximately 15 years old. She was referred to the Child and Adolescent Mental Health Service (CAMHS) because of concerns expressed by her mother and stepfather about her moods and behaviour in the home. The referral from her General Practitioner (GP) describes her "as morose, miserable and only happy when out with her friends". It was felt by the CAMHS worker involved that she was alienated from her mother and stepfather. Michelle was quoted at that time as believing "professionals made things worse".

5.7 Michelle was unable to return to the School she had previously attended and instead enrolled at different Secondary School in Year Ten. She did not settle there. Her attendance became poor and her parents felt rather than force the issue Michelle could leave school and continue her education at a local college under an apprenticeship at a nearby hairdressers organised by her mother. Her mother and step-father describe her meeting a boyfriend around this time who they believe to

have spent periods in prison. It was at this point that her parents felt her behaviour both at home and outside deteriorated further. Due to the worsening atmosphere in the home her parents felt it was not possible for Michelle to live at home with them. Her mother and stepfather asked the local Children's Services Department for help with Michelle and she was placed in the YMCA from where she moved to 'St Anthony's' a shared house supported by Social Services. This accommodation broke down quite quickly according to her family due to Michelle not following the house rules. As a result, Michelle then returned home. She was aged seventeen. On her return, it quickly became obvious to all that the arrangement was not working. Michelle and her parents as a solution agreed that Michelle would move into a flat and that her parents would pay the rent for her. Her mother tells me she visited Michelle each week and re-stocked her fridge, and Michelle would visit their home whenever she needed, and that this arrangement worked well. It was on this semi-supported basis that the family were able to move forward.

5.8 Michelle began a relationship with 'Matt' in 2008, and in 2009, their baby daughter was born. During the first year of their daughter's life five domestic abuse incidents were recorded by the Police who notified the GP and the Health Visitor. The Police describe 'a pattern of domestic abuse' in the relationship with Matt being abusive to Michelle. At this time, Michelle told the Health Visitor that she was reluctant to call the Police, but referrals were made to Children's Social Care. The case was later closed by Children's Services according to the Health Visiting records as Michelle was felt to be not co-operating with them. This decision failed to recognise that she was a young mother who had experienced significance domestic violence and she and her baby where at risk of further violence.

5.9 In 2011 as a result of an assault on Michelle, Matt was made subject to a Probation Supervision Order with a condition that he attend the Integrated Domestic Abuse Programme (IDAP). As part of that programme Michelle would have been offered specialist domestic abuse support from the Victim's worker attached to the programme. The Probation Service no longer holds these records (deleted at five years as per National guidelines) and the review therefore cannot see what support was offered and/or whether Michelle engaged. This is significant as it was the only point where Michelle could have had contact with a specialist domestic abuse service.

5.10 Throughout 2011 there were a further four domestic abuse incidents. Michelle left this relationship finally in approximately late 2012 or early 2013. Michelle shared with a close friend, Rachel, that Matt, had been verbally and physically abusive to her throughout their relationship. Rachel said she had witnessed phone calls and overheard the "vile" way in which Matt spoke to Michelle calling her "fat and stupid". Rachel states that Matt was unreliable in terms of contact with their daughter but Michelle would always cover up for him to protect their daughter being upset or disappointed.

5.11 Rachel describes Michelle as an “amazing Mum” who always put the children first. She also told me that Michelle’s daughter had been brought up to be polite and well behaved, and that Michelle wanted her to have “a proper childhood.” An example of this was when Matt, against her wishes gave their daughter an electronic device to play on. Michelle restricted the time and content that the child could access the device as Michelle felt allowing a child to play devices like this to be “lazy parenting”. Despite the ongoing violence, Rachel describes Michelle as being a very protective parent. On one occasion Michelle’s daughter was having difficulties with other girls in her class and had not been invited to a birthday party at ‘Jungle Gyms’ a local indoor play area. Michelle with Rachel, knowing she would be upset by this took her daughter to the party with a present and helped her to join in with the others and make friends with the other children. Michelle according to Rachel always felt that she was not accepted by the other mums and that she was never included in any of their conversations at the playground.

5.12 After nearly a year of being on her own in 2013 Michelle met Simon whom she had known from school, and according to her mother, father and Rachel “fell head over heels for him”. Michelle was working for an insurance company and she is described as a very able mum to her daughter. Although Michelle was busy her parents and Rachel believed that she desperately wanted a long-term partner. Michelle’s mum thinks that Michelle felt immediately close to Simon as they both had something in common in having a young child. Simon was working in Tesco’s as a manager and was keen to better himself and fulfil his lifetime ambition of joining the army

5.13 Michelle’s mother felt that the relationship with Simon was ‘tempestuous’ from the outset with Michelle discovering him accessing pornographic websites on his laptop and had evidence of him visiting prostitutes. Their relationship was marked by a pattern of brief break ups and reconciliations, with regular arguments and Michelle always suspicious of him being unfaithful. She often checked his phones etc. for evidence of affairs. However, her mother and step-father believe she was drawn to Simon due to his desire to better himself, that he took responsibility for the care of his child even after he had separated from the mother despite his vulnerability due to difficult family life and childhood. Michelle would repeatedly return to him following any separation during this period.

5.14 Simon had previously been in a relationship with another woman with whom he had a daughter. Health records show that a Health Visitor was involved due to Simons baby daughter and that domestic abuse was recorded and known to exist in their relationship, the full extent of it only emerged after Michelle’s death. Simon joined the Army in 2015 and was stationed in Plymouth returning to be with Michelle during his leave periods. During this time, Michelle became pregnant with Simon’s child. Rachel believed the pregnancy was Simon’s way of keeping Michelle. Michelle’s parents describe how Michelle hoped they would marry and live in an Army house with their children.

5.15 Health Services became involved with Michelle in August 2015 when she was pregnant with Simon's baby. She was known to have been a victim of domestic abuse in her previous relationship by all services. However, fatally the link between Simon's history of being a domestic violence perpetrator in a previous relationship was not made. Michelle gave birth to her son in September 2015. The Health Visitor made regular visits to Michelle all of which focussed on the baby's progress which was largely positive. In November 2015 Michelle disclosed to the Health Visitor that there was 'some stress in the relationship.' The Health Visitor knew that the baby's father was stationed away in the Army. There was a further visit in January 2016 with no reference to Michelle's previous disclosure of 'stress in the relationship' being made, and then in March 2016 there was a domestic abuse incident recorded by Dorset Police and a Single Combined Assessment of Risk Form (SCARF) copied to the Health Visitor which noted Michelle as victim and Simon as Perpetrator and acknowledged the children were present. An unsuccessful attempt to contact Michelle by the Health Visitor by phone was made three days later. This was not followed up by any means despite the baby boy failing to be brought to his ten-month check in July 2016. Simon brought the baby boy to clinic in August 2016. The earlier domestic abuse incident notified to Health Services by Dorset Police was not raised with him at that meeting. The review has been informed this is in line with best practice promoted in current Health training.

5.16 The relationship between Michelle and Simon was not known to Services to be abusive until the March 2016 Police call out. Michelle had made that call to the Police, initially a silent call, as she wished Simon to leave the home as he was drunk. Again, the children were present and a SCARF, which includes a Domestic Abuse, Stalking and Honour Based Violence assessment (DASH) was completed. What has emerged as a result of the investigation since Michelle's death has been a catalogue of serious violence carried out by Simon some of which was experienced and witnessed by Michelle, possibly the baby boy and significantly Michelle's daughter, who witnessed a protracted and serious fight between Simon and his twin brother, in the family home. After this incident, which one can assume to have been traumatic and long lasting in its effects on her, Michelle's daughter was brave enough to disclose the violence to a teacher at her school. It was dealt with as an internal matter and the information not shared with the relevant services as it should have been in line with statutory Child Protection Procedures.

5.17 Michelle and Simon separated in early summer 2016. Michelle's family describe Michelle as slowly beginning to recover from her relationship with Simon. She found a new job, flat and a car with their help and started to make a new home for her and her two children. However, despite now having a close and loving relationship with her family, she was lonely. Her family believe she had lost many of her friends due to a misunderstanding between her and her friends. This isolation was compounded as her close friend, Rachel had moved away from the area, and the demands of two young children left her with little time in any event. Rachel believed that Simon had

actively worked to isolate Michelle from her circle of friends. Michelle felt, according to her father, that she would often not be invited to social events even after she and Simon had separated due to the fear people had of him. This, it is possible increased her sense of loneliness significantly.

5.18 Michelle's family believe that Simon, after the separation was slowly working to regain Michelle's trust, this was helped by the fact he was a dutiful father and that they would all go on family outings together. This arrangement slowly developed into one in which Simon would baby sit whilst Michelle went out with friends, and he would stay overnight at Michelle's flat. Michelle's parents later found out, Michelle never told them, that she and Simon had begun sleeping together again. They believe that during this time Michelle wanted Simon and her to reconcile and become a family again. Her mother became suspicious when Michelle took her children to Longleat Safari Park, which was something she would not have done on her own. When questioned, Michelle stated it was in the children's best interests that they saw Simon, just as she had maintained contact between her eldest daughter with her father.

5.19 In early September 2016 Michelle approached The British Pregnancy Advisory Service (BPAS) for a termination of pregnancy. At this point she stated the pregnancy was due to a one-night stand with her ex-partner, Simon who was in the Army and away from the area and that the relationship had ended as he was unfaithful to her. BPAS records note when asked if she felt safe at home she replied that she did.

5.20 One significant factor appears to have been a rape allegation that was made against Simon and an Army colleague. The alleged Rape occurred in May 2016 and following an unsuccessful initial investigation Devon and Cornwall Police released an image to which Simon and a colleague responded in early August 2016, he was interviewed in August 2016 by Devon and Cornwall Police. Michelle did not know of this Police investigation but was made aware of it on the day of her death when Simon was notified that his bail was being cancelled and by her researching local press coverage shared on social media. Michelle on that day was distressed and angry. She called a friend of Simon's about the allegations, and left an angry voice mail message. She told her mother who was away on holiday by phone and text of her intent to challenge Simon about the allegations she had heard. At this point, Simon was at Michelle's home. Michelle's mother says this call was made at 10:55 pm and that she was killed five minutes later. This Michelle's mother believes indicates that Michelle did challenge Simon about the rape allegations and this led to her death. Whether she did this is not definitively known and could only be confirmed by Simon who has refused to co-operate with this review.

6. Background to the Perpetrator

6.0 Simon was from a local family, one of three siblings. All went on to have convictions for violent crime. He was known to Children's Social Care for the first eleven years of his life, although his parents were separated, he spent time with his father who admitted to a Social Worker in 2004 that he was" a bit violent when he drank". The children grew up around weapons such as knives and axes and were shown how to use them by their father. Simon and his siblings came to the notice of the Police during their teenage years and the Police were called on several occasions to their home during this period. There was an incident in 2008 which is out of scope for this review but relevant as it sheds some light on Simon's nature where he assaulted his then partner, then returned to his family home and then assaulted his step father all within an hour and a half. Domestic abuse was ongoing in his relationship with his then partner with whom he had a child; two further incidents were later recorded by the Police.

6.1 This information was not known by services at the time but provides some insight into Simon. Rachel felt Simon was 'a cruel man'. She describes him being cruel to animals -relating an incident in which he decided not to feed his pet fish and watched as they died. Simons brother had told Rachel that as a child Simon liked to hurt birds. Rachel described Simon as being the older but physically smaller brother, and that he had "a chip on his shoulder" about this. This view was also held by Michelle's family. Rachel describes Simon as controlling Michelle's behaviour - keeping her locked in the flat and being very jealous if she went out. Rachel, and Michelle's father believe Simon got Michelle pregnant so she would stay at home when he went on his Army Basic Training. Michelle's mother however believes that Michelle wanted to have children with Simon and that her becoming pregnant was a joint decision and not part of Simon's controlling strategy. Rachel also states he was strategic in his control of his physically stronger brothers, for example, getting them drunk so that he could assault them. Rachel believed Simon felt persecuted. He loved Nazi memorabilia, knives, old guns and uniform, and she was shocked that he was able with these interests, and his known background of abusive and violent behaviour to join the Army. Before he met Michelle, Simon had confided in Rachel that he used prostitutes for sex as he "could hurt them during sex".

6.2 Simon was also responsible for additional incidents of violence not involving Michelle during this period. In October 2015, a month after his son's birth, under the influence of alcohol he assaulted two men in a nightclub. This was described as an 'unprovoked attack'; head butting one male to the face, the victim received cuts and swelling to his mouth and lips, a second male was punched to the head, causing swelling to the right side of his face. When interviewed, he stated that he had drunk five pints of cider and he declined to give any explanation in relation to the assault. When showed the CCTV footage of the incident he admitted his actions, although he

could not explain them. He was dealt with by Devon and Cornwall Police by way of an Adult Caution.

6.3 In February 2016 it was alleged he had hurt a young woman known to him in a Public House in Dorset, she suffered bruising but refused to make a complaint against him. In April 2016 when Simon and a brother were arrested for Affray at a house party, after he had assaulted a number of people at the party he made threats to kill the people present and trash the flat. The Police treated this as a fight between brothers, and there was no further Police action. The alleged rape occurred in Plymouth in early May 2016, Simon coming forward after being named following the publication of a press release in August 2016 in the Plymouth Herald.

6.4 In May 2016 Simon was a victim of a serious head injury which led to him being placed in medically induced coma. His brother was investigated for the offence of Grievous Bodily Harm but Simon refused to give evidence and the investigation did not proceed. His grandmother in response to the incident stated, “boys will be boys” suggesting she saw this behaviour as normal.

6.5 It seems that Simon targeted family members, Michelle’s and his own, Michelle’s friends and also members of the public not known to him in random, apparently unprovoked attacks. Alcohol was often but not always present as were emotional factors such as possessiveness, frustration anger and jealousy. Michelle’s father felt that his violent behaviour often “came from nowhere”.

6.6 Much of Simon’s abusive and violent behaviour to Michelle was not known until the trial, it was not shared by family and friends prior to this and so a true picture was not available to services involved at the time. At the trial a significant incident was disclosed by Rachel which happened to Rachel and Michelle when she drove her and Simon home one evening. She describes him as being so threatening to Michelle that Rachel decided to drop Simon off instead of them both and drove off at speed in panic taking Michelle to a Police Station for her own protection, but that Michelle would not leave the car when they stopped outside the station. Simon’s violence and assaults were not reported to the Police by any of the victims probably due to ensure Simon’s army career was not jeopardised and possibly due also to a misplaced sense of loyalty to Michelle or a fear of Simon. Her father agreed not to report Simon as he feared to do otherwise would risk him losing his relationship with Michelle. However, we can now surmise all may have been fearful of Simon and that alone could have prevented others from becoming involved and not reporting their own experiences of his violence

6.7 Simon’s Army career appears to be a significant factor in this review. Simon had for several years a strong ambition to join the Army. Despite his history of violence and interest in Nazi memorabilia he was accepted by the Army as a Gunner and undertook training for the Marines. Although he failed the Marine training, Simon was keen to try again. The Army were aware that he had issues with his brothers and his

use of alcohol and the combination of these could result in violence, but felt these were manageable. This remained the position following the assault of two unknown males in a Nightclub in Plymouth in October 2015.

7. Analysis

In this section of the review the panel wish to identify themes which may have contributed to Michelle's death.

7.1 Michelle's lack of confidence in services and services ability to engage with her.

Michelle was referred to CAMHS in 2006. However, the Service was unable to engage her in working with them. She had become at that time according to her family and her GP an angry and sad adolescent, having been a loving and happy child. At that time Michelle felt services were of no use to her and this experience may have led to her feeling indifferent towards or suspicious of help from state services. Michelle did not appear to be able to engage with any professional from health, social care, education or the Police. Her family's view is that she presented as a strong and 'feisty' individual who may have been perceived as difficult to work with. Additionally, as a victim of domestic abuse at the hands of her previous partner we do not know the impact on Michelle when Social Services closed her case despite her having a young baby. It is worth noting that she was not referred to a specialist service where she may have received useful information and/or support. Services knew she was a repeat victim of domestic abuse and they should have the skills to seek to engage with those who may appear hard to reach or even actively hostile. This review has identified that Michelle kept Simon's violence hidden so he could join the army. Family and friends also were persuaded to collude with this for fear of damaging their relationship with Michelle, and in the hope that once he was away in the army she may move on and leave him.

7.2 Michelle's isolation, confidence and low self-esteem.

Michelle has been described to me as a beautiful young woman who throughout her adolescence and early adult life appeared to have thought little of herself, often comparing herself to others. Her mother and step-father describe her as having a large group of friends that gradually fell away due to a misunderstanding between the friendship group, and the author believes as she had children with abusive partners. Her biological father and believe her lack of self- esteem led to her forming relationships in which she saw herself as the 'rescuer' with vulnerable partners whom she felt would need her more than she needed them, although her mother does not recognise this view. This led to a vicious cycle of her becoming more isolated as time went on. Although isolated from support, Michelle was motivated to

be a good mother. Her friend Rachel believes Michelle was highly motivated to ensure Simon saw his son and that this was at the heart of her seeing him after their separation before her death.

The family believed she was a strong and feisty young woman and it would appear services also viewed her in this way too. She voiced concerns about her body image, fearing she was losing her 'looks' and fearful that she would then lose her partner and be on her own. It would appear to all her family that on the night of her death Michelle had no idea of the danger she was in as she challenged Simon over the rape allegation.

7.3 Early opportunities to inform Michelle about the nature and dynamics of domestic abuse.

Michelle met Matt in 2008; her parents (this is confirmed by the Independent Management Reports) describe Matt as having a troubled background. Her mother described an earlier boyfriend as having spent time in prison. They believe that Michelle was drawn to people that needed help as it made her feel better about herself, and gave her security, thinking they needed her so much that they would not leave her. Michelle's step father believed she wanted a baby, someone of her own and not one with Matt necessarily. They feel that once Michelle was pregnant with her daughter 'she settled down'. However, the Health Visitor was aware of domestic abuse in the Ante-natal period and had referred Michelle to Children's Social Care.

Through the time of this relationship there is no evidence of this abuse and the impact of it being explored with Michelle by either Health Visitor, Children's Social Care or her GP although there was substantial contact with Michelle. The focus appears to have been on concerns about possible neglect of the child and the home situation. The reasons for this are not clear at the point of writing this report.

7.4 Health Services.

Within five weeks of her giving birth to her first child in April 2009 the Police recorded a domestic abuse incident described as a 'verbal altercation', but two days later she was seen by a Health Visitor who described her having a 'black eye' which the Health Visitor stated Michelle had told her had happened when Matt had assaulted her some five days before the Police recorded incident. Children's Services were alerted as a result. From existing records available to the Review, the ongoing abusive nature of Michelle's relationship with Matt did not result in Michelle receiving domestic abuse specialist advice from Health or any other agency despite being a young mother with a difficult background with a young baby and therefore vulnerable.

The Police call out in March 2016 identified that the children were present during a verbal altercation between Simon and Michelle. This was only followed up by an unsuccessful phone call, despite an infant under one year being present. At a later opportunity in August 2016 when Simon brought the baby to clinic the issue of his abusive behaviour was not raised with him, because the training the Health Visitor had received advised against this. This was to be the last contact before the death of Michelle. The model of 'Making every contact count' may prove useful, as may training to increase skills and confidence in talking to men about the impact of their domestic abuse on their children.

The Police notifications SCARF are routinely shared with the relevant Health agency. The Independent Management Review from Dorset Health identified at the time that the GP may not have had sight of the repeated SCARF notifications on their computer system but that due to this review this has now been remedied.

7.5. Probation.

Following a serious assault in 2011 Matt was sentenced to Probation Supervision and attendance on the Service's Integrated Domestic Abuse programme (IDAP). As part of that programme a Women's Safety Worker (WSW) should contact the named victim, and if consent is gained engage with them and ensure that her safety is monitored during the Programme. However, the Probation Service could not confirm whether Michelle was visited by the WSW or not. This information is key as attendance on Programmes such as IDAP can impact on risk in terms of increasing or decreasing the risk to the victim. In Michelle's case, it may have been the only opportunity the review has identified that she could have met with a specialist domestic service.

7.6. The school.

Michelle's daughter shared a serious violent incident (at home) in her school initially with a friend and then later with a staff member. She disclosed to the staff member specific details such as the adults fighting, the presence and amount of blood and the proximity of the violence to her. She stated when questioned that it had all happened a long time ago. This disclosure was dealt with as an internal matter and the information not shared, as it should have been in line with 'Working Together' the National Child Protection Procedures. It seems that the school at the time took at face value the assurances that Michelle provided when spoken to by the school that such an event would never happen again. The School Nurse was informed of a later domestic abuse incident via the SCARF in March 2016.

7.7 The level of ongoing violence in the wider family and community.

The violence within Simon's family does not seem at any point to have been treated as serious or looked as a whole by the services involved. The violent incidents within the family meet the Home Office Definition of Domestic Abuse and should have been risk assessed and information shared as such. This would have identified Michelle and the children in the home as at significant risk. There had been a recent alleged violent incident between Simon and a brother resulting in serious injury to him. A charge of Grievous Bodily Harm as a result of this offence could not be proceeded with due to Simon refusing to support the prosecution of his brother.

Although Michelle did not report his violence it was known that Simon had been violent and abusive to his former partner and Michelle's father, unknown members of the public and a female friend of Michelle's in a local night club. The violence is commonly described as 'unprovoked'. Michelle and Simon were given a lift by Rachel after they had been out drinking, Rachel was so concerned at the violent threats he was making to Michelle that she dropped him off and then immediately took her to a Police Station for her protection, but Michelle would not leave the car. These violent events were either not reported or minimised to protect Simon's army career by all involved. The motives for this silence are not clear. One possibility may be loyalty to either Simon or Michelle or of course fear of Simon and his violence. However, both explanations fall into the definition of 'coercive control'.

7.8. The impact of the Rape allegation.

A significant factor appears to have been an allegation of Rape in May 2015 and for which Simon and an Army friend were interviewed in August 2016 by the Devon and Cornwall Police. Michelle did not know of the Police investigations but on the day of her death became aware of the rape allegation involving Simon. She texted a friend and his brother, appearing angry and distressed and told her mother, who was out of the country on holiday, by phone that she intended to challenge him about this as soon as she saw him. From the court proceedings it is known that she did challenge him. Michelle had dwelled on the allegation, was very angry and oblivious of the risk she was taking in challenging Simon.

8. Missed opportunities to intervene

The Home Office guidance for Domestic Homicide Reviews warns authors to be aware of 'hindsight bias and therefore it is critical that this report reflects what was known at the time as well as the policy and procedural framework in place at the time.

8.1 Early intervention by Health.

Michelle was seen by a range of Health Services, the Health Visiting Service, her GP, Sexual Health and the British Pregnancy Advice Service which although is a Registered Charity is commissioned to deliver the Termination of Pregnancy Services for the Dorset Clinical Commissioning Group. These services are not co located and do not all receive SCARF notifications, for instance at the time Michelle's GP did not have access to them. In reality this meant that no individual Health service had a full overview of Michelle's situation

Although outside of the terms of reference I note that when Michelle gave birth to her first child when aged eighteen years old in April 2009, Health Visitors were aware of eight incidents of domestic abuse via the SCARF system within the first eighteen months of her daughter's life which clearly identifies Michelle as a victim of domestic abuse. In 2009 the Health Visitor describes Michelle as "minimising the effect of domestic violence" and "risk to her baby" and "reluctance to engage with support service." There is no record of any support being offered to Michelle, for instance a referral to a specialist service or a follow up visit, nor of any follow up with Michelle despite her becoming pregnant again in October 2010 demonstrating a lack of professional curiosity, knowledge and skills around the dynamics of domestic abuse and understanding of victim behaviour.

During the scope of the review Michelle was seen on six occasions by the Health Visiting Services who had again became involved with Michelle in August 2015 when she became pregnant with Simon's baby. It was recorded then that she was a previous victim of domestic abuse. The link between Michelle as a previous victim and Simon being a perpetrator in a previous relationship was not made as the record keeping for Health Visiting follows the mother and so does not allow the Health Visitor to monitor serial perpetrators who have children with new partners. A baby boy was born in September 2015. At this point the Health Visiting Service knew Michelle was a previous victim of domestic abuse.

In November 2015 Michelle disclosed to the Health Visitor 'some stress in the relationship", a significant disclosure by Michelle given her known reluctance to seek help, this was acknowledged as such by the Health Visitor who had known her for some years and was aware of her reluctance to share information. The Health Visitor knew the father was stationed away in the Army and accepted that the stress

was due to the long-distance relationship. There was a further visit in January 2016 with no reference to the earlier disclosure being made, and then in March 2016 there was a domestic Abuse incident recorded by Dorset Police and copied to the Health Visitor involving Michelle and Simon. The Health Visitor knew that in calling the Police, though she gave a negative response to DASH, Michelle must have been frightened as she was usually very reluctant to call the Police. An unsuccessful attempt to contact Michelle by phone was made by the Health Visitor the following day. This was not followed up by any means despite the Health Visitor acknowledging the significance of Michelle calling the Police and there was no contact with the family until Simon brought the baby boy to clinic in August 2016. The issue of the call out was not raised with him at that meeting as the Health Visitor had reportedly been told in training not to raise issues of domestic abuse with perpetrators. However, this incident had generated a SCARF and Simon we surmise had known that the Police had attended. As a repeat perpetrator of domestic abuse, he could have known that information had been shared with the Health Visitor.

At no point was a DASH undertaken by a Health professional with Michelle who was seen as initially “quite hostile but did eventually become engaged”. She was seen as “mistrustful of professionals and displayed superficial engagement”. The principles of Disguised Compliance where not referred to in the recording of contact or the Independent Management Review.

8.2 Dorset Police.

During Michelle’s previous relationship, the Police were called on numerous occasions and did not manage to engage Michelle. In June 2013, the Police were called after threats to Michelle from her previous partner. A Harassment warning was not issued despite text threats. In November 2014, the Police were called as Simon has assaulted Michelle’s father who later withdrew from making a statement. A year later in December 2015 a call was received alleging that an individual was ‘causing trouble’ at his brother’s home and that a baby was present. A later call stated that the individual had left and the situation was resolved. The Review acknowledges that this individual was only identified as Simon after Michelle’s death. The next day when Police attended only Rachel was at the address and she was able to reassure the Police that all had been resolved. Neither a SCARF nor DASH had been completed in response to this incident and it was dealt with as a ‘Breach of the Peace’. This meant there was no further power of arrest once the Breach was concluded as the perpetrator had left the property, leaving the police with fewer powers than it could have had over Simon.

During Michelle’s relationship with Simon there were missed opportunities to complete SCARFs and/or DASH forms and a slow response to an incident where an infant was involved with the Police attending eighteen hours after it being reported.

Simon was also threatening and violent away from the home and to ensure Police Officers make the link between violence outside of the home and domestic abuse a reminder has been issued to all staff following this case. This is to encourage those who are dealing with violent behaviour in the night-time economy to consider the partners and children they may return home to.

8.3 Devon and Cornwall Police.

Following a press release with information about the alleged Rape in Plymouth Simon and an Army colleague contacted Devon and Cornwall Police. They were offered an appointment for an interview with the Police thirteen days after their call. In the meantime, no attempt was made to collect any potential evidence, such as their phones or a search within the Barracks. However, the Review understands that at the victim's request an internal review of the case under the Victims Right to Review supported the outcome of the Investigation.

8.4 Education .

A significant disclosure was made to school staff by Michelle's daughter. This disclosure was not dealt with according to the statutory guidance 'Working Together to Safeguard Children' or in line with the 'Keeping children safe in Education' Statutory guidance both issued in March 2015 by the Department of Education. A referral to Children's Social Care was not made as it should have been. The relevant policy current at the time of this incident and which should have been followed is outlined in Department of Education 'Keeping Children Safe in Education March 2015'.

> https://www.gov.uk/government/publications/keeping-children-safe-in-education--2

That the school believed Michelle's response to their concerns that she was able to control her partner's behaviour and prevent any future violence and keep her children safe demonstrates a very limited understanding by staff at the school of the nature and dynamics of domestic abuse. The review was informed by the school that they operate the 'Emotional Literacy support assistant' (ELSA) model where teaching assistants are trained to provide emotional and social skills support to children.

Since then the School has undertaken an internal review of its processes in relation to Safeguarding recording and reporting. This involved representation from the Multi -Agency Safeguarding Hub (MASH) team and a Local Authority safeguarding representative. The integration of 'MyConcern' (online system) enabled the school's safeguarding team to record details of all calls made, received and missed. Michelle persuaded the school to not refer her daughter's disclosure as she had previously

been involved with social care and was wary of them becoming involved again at this time.

The Review Panel are aware through the School's IMR response that a lack of awareness of the dynamics and prevalence of domestic abuse still exists within the school. It is also concerned that assumptions about prevalence being linked to socio economic and cultural factors continue and could lead to further instances not being identified correctly and speedily by the school

The LSCB is in agreement that the disclosures made by the child should have been notified promptly to Children's Social Care, through the MASH. The school's IMR does provide assurance that the opportunity to learn from this case has led to improvements to systems, processes and staff awareness. We have evidence to confirm that a manager from the MASH and the Safeguarding in Education Adviser from the Local Authority have carried out a thorough and robust review of processes in relation to Safeguarding reporting and recording at the school and of all safeguarding procedures and practices. They have supported the school in reviewing the outcomes and in developing best practice.

The Designated Safeguarding Leads (DSLs) Forum is held termly, with regular briefings, training and updates for DSLs on domestic abuse. This has included 'Escape the Trap' training and input on the Domestic Violence protocol. The DSL for the school has participated in this forum regularly.

There is also detailed guidance on Safeguarding, and specifically Domestic Abuse, which is promoted to schools and regularly updated on their website: http://pandorsetscb.proceduresonline.com/chapters/document_lib.html

8.5 The National Probation Service.

In 2011 Michelle's previous partner attended the IDAP Programme and Michelle would have been offered a Women's Safety Worker. As all records related to the role of Women's Safety Worker are destroyed after five years the review has been unable to address if Michelle engaged and the value of such support. This would have been the only contact Michelle had with a specialist domestic abuse service and opportunity to receive specialist advice designed to ensure her safety.

8.6 Children's Social Care.

Children's Social Care had little contact with Michelle during the period identified by the Terms of Reference of this review. They were not asked to provide an Independent Management Report so I am unable to comment on the work undertaken by them. They would have received repeat SCARFs from the Police

during Michelle's relationship with Matt and are referred to in the Health Visitor notes as closing a case due to Michelle's lack of co-operation.

8.7 Family and friends.

This review has identified that Michelle's low self-esteem coupled with a lack of knowledge about the risks she was living with meant that she remained in and endured these abusive relationships. Her family and friends also had limited knowledge of the dynamics of domestic abuse, perceiving her as strong and therefore not a victim. Michelle's mother had previously felt able to speak to both Michelle and Matt about what was best for their daughter. She tells me she felt able to intervene in this relationship as she was concerned about the effects of the abuse for Michelle and her baby daughter. However, the family felt unable to intervene between Michelle and Simon. Michelle's father was a direct victim of Simon's violence and witnessed bruising on her face on another occasion. The pressure from Michelle to collude was great, whether motivated by her fear of him or of losing him. The family feel that had they known more about the coercive control element of domestic abuse they may have intervened. All for their own reasons wanted Simon away from their locality and into the Army. Michelle's friend drove her to a Police Station but could not make her report the abuse.

9. Recommendations

9.1 A campaign to educate and raise public awareness to enable early identification by potential victims, friends and family of risk factors and signs of abusive, controlling and coercive behaviour.

A local publicity campaign to educate the public regarding Domestic Abuse that addresses:

- What domestic abuse is
- The profile, behaviour and motivations of perpetrators, who they target and why
- The nature of coercive control is and why it is so dangerous
- What you can do to protect family, friends, colleagues or others if you suspect they are in an abusive relationship.

9.2 The Local Safeguarding Children Board (LSCB) strongly encourage the promotion of Healthy Relationship Education within the curriculum so that all young people in the area receive age appropriate education on healthy relationships and use the annual safeguarding audit process to provide quality assurance.

This review notes that Michelle was a victim of considerable abuse during her relationships, her family believe she thought wrongly that she could manage her abusive partners. They do not know what education if any she had on the issue of domestic abuse, but think that young people should receive this formally to build resilience in them. Therefore, the Review recommends that the LSCB as part of its prevention strategy encourage the uptake of 'Healthy Relationships' education in its schools, academies and colleges to ensure all young people have an age appropriate understanding of abusive relationships, the concept of 'consent' and be empowered to understand and exercise their rights as citizens in personal and public relationships with others. Sex and Relationship Education (SRE) became mandatory in all schools in England, including Academies and Free schools from March 2017. The Government will be holding a public consultation on what should be taught and when, so the new SRE curriculum is not likely to come into effect until 2019.From that point it will be possible for the LSCB to be reassured by an audit process that children and young people in their area are receiving appropriate and timely education on these issues

9.3. The Local Safeguarding Children Board (LSCB) work in partnership with schools and Academy Trusts to ensure that the relevant Safeguarding

legislation and guidance are followed. In addition, that any local well-being initiatives introduced to secure the safety and well-being of children in their care do not comprise nationally agreed procedures.

- The relevant legislation and guidance are Section 10 of the Children's Act 2004, Keeping Children Safe in Education (2016) and Working Together to Safeguarding Children (2015)

- Under section 14B of the Children Act 2004 the LSCB can require a school or college to supply information in order to perform its functions. The LSCB seeks reassurance from Governing bodies and proprietors of all schools and colleges that their safeguarding arrangements take into account the procedures and practice of the local authority as part of the inter-agency safeguarding procedures set up by the LSCB.

- Section 175 of the Education Act 2002 puts a duty on local education authorities, maintained (state) schools and further education institutions, (including sixth form colleges) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils and students under 18 years of age; in the case of schools and colleges. The same duty is put on independent schools, including academies, by regulations made under s157 of that Act.

- Legislation maintains that all providers of training in relation to Safeguarding in Education for staff and designated leads address the prevalence and the presentation of domestic abuse, the multi -agency management of domestic abuse and the part schools or Academy Trusts can play in protecting children who witness domestic abuse.

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9.4 Health Service agencies adopt best practice for the assessment and management of domestic abuse.

- That a whole system review of how Health Visitors and other Health staff address Domestic Abuse be undertaken
- That Health staff know how to 'ask and act' about domestic abuse and are confident to discuss these issues safely with patients known to be victims and/or perpetrators.
- Current training on engaging potential perpetrators of domestic abuse to be reviewed as this review has identified current training advises professionals not to address domestic abuse with the perpetrator even when they have been notified officially by the Police of a recorded incident. This approach

could be interpreted by the perpetrator as collusive behaviour by the professional and increase their sense of power over their victims.

- That an approach which identifies 'making every contact count' particularly with hard to reach and/or superficially engaged young people and young adults with children should be considered.
- Training of Health Visitors on Disguised Compliance to include the learning from Serious Case Reviews on this presentation https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/
- An understanding of and using the tools of managing 'Disguised Compliance' should be an integral part of such an approach.

9.5 All GP practices across Dorset, Bournemouth and Poole to identify a lead for domestic abuse within the surgery and to embed the RCGP domestic abuse pathway.

Michelle's pattern of seeking emergency appointments meant that the GP practice that Michelle attended could not offer a consistent GP in her care. Managing patients who attend in this manner can only be done with consistent, full and reflective recording. At that time, the attending GP did not have 'easy sight' of the available SCARFs and this hampered recognition of the warning signs that were present. As a result of the review undertaken by the practice this Review has been assured that this has been remedied with the new Public Protection Notifications (PPNs) which replaced the SCARFs. The GP practices all now have a named domestic abuse lead in place and facilitated workshops are planned for GPs in November 2017. However, recent changes separating Health Visitors from GP Practices will mean the GP will no longer be able to rely on Police information being shared through this route and therefore further reassurance is necessary that a route of communication from the Police to GP practices will imminently be in place.

In the six months before Michelle was killed she had no contact with the Police as incidents as described earlier were not reported. Such behaviour is not unusual in relation to abusive, coercive and controlling behaviour. It is therefore critical that professionals who work with the public are at the moment of contact able to create a relationship in which a dialogue about the person's safety and wellbeing is undertaken and if needed appropriate advice given or referral made.

In the Department of Health's latest domestic abuse guidance for Health professionals – 'Responding to domestic abuse' published in March 2017, the responsibilities for commissioners and local strategic partnerships are clearly outlined. This resource draws on the National Institute for Health and Care Excellence multi-agency guidelines on domestic violence and abuse. It replaces two earlier Department of Health documents- 'Domestic Violence: A Resource Manual

for Health Care Professionals' (2006) and 'Improving Safety, Reducing Harm: Children, Young People and Domestic Violence – a Practical Toolkit for Front-line Practitioners' (2010). All of these documents acknowledge that the role of Health professionals is to identify domestic abuse as early as possible, to make appropriate referrals to specialist services and to work closely with other agencies to ensure that the safety of the patient is paramount.

www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

The Royal College of General Practice -Responding to domestic abuse: Guidance for general practices was published in March 2013. This guidance produced was to enable general practices to respond effectively to domestic violence and abuse (DVA) in primary care and develop their DVA policy. This guidance is in line with the National Institute for Health and Care Excellence multi-agency guidelines on domestic violence and abuse. All of these documents direct General Practice towards an evidence based model for the identification and onward referral of patients that are victims of domestic abuse.

9.6 Dorset Police review police non-engaging victim procedure to provide clarity on how police identify, assess and manage a repeat domestic abuse victim where either the police are not able to offer a service that the victim can engage with or the victim is not able to engage with the service offered. Procedure to cover the roles and links between initial response, investigation, Maple Team and referring to wider partners.

The Maple project run by Dorset Police is victim focussed and the Domestic Abuse Investigation Team deal with alleged offenders. The Dorset Police Service was aware of Simon's wider violent behaviour and that there was a pattern of many alleged victims - partners, family members, friends or members of the public who chose not to report incidents they were aware of either as victims or witnesses. The Police Service had contact with Michelle over several years and during these contacts was unable to engage with her. That SCARFs were not completed as they should have been would mean that the Maple project would not contact the alleged victim. The review recommends that the current arrangements are reviewed in relation to hard to engage victims

9.7. Ministry of Justice review the storage policy of Women Safety Worker records

Probation Women's Safety Workers records were absent in this case having been destroyed after five in storage in accordance with current guidelines. I know this to be an issue for other DHRs and the Review requests that the Ministry of Justice review this guideline to better enable review of practice in such cases.

Appendix 1: membership of the review panel

Agency Representative	Name	Role
	Tonia Redvers	Chair
	Jan Pickles	Author
Dorset Police	Stewart Balmer	Force Review Officer, Dorset Police
Community Safety Partnership Officer, Bournemouth Borough Council	Sian Jenkins	Link to Community Safety Partnership
Named Nurse & Lead Safeguarding Children, DHUFT	Liz Balfe replaced by Janice Carswell for final part of review.	Panel member
Head of Quality Improvement, Quality Directorate, Dorset CCG	Pam O'Shea	Panel member
Bournemouth & Poole Adult Safeguarding Board	Anne Humphries (for the first 2 meetings only)	Panel member
Dorset Police	DCI Joan Carmichael , replaced by DCI Gavin Dudfield part way through review.	Adult Public Protection, Dorset Police

HMPPS	Tina Ridge	Head of Dorset National Probation Service
Dorset Police	Caroline Garrett,	Note Taker, Dorset Police
MOD	Dr. Douglas Reid	Army GP Attended May 2017 Panel meeting only

Appendix 2: methodology for the overview report

Data gathering

Reports and documentation accessed

This report is based on the Individual Management Reports commissioned from professionals who are independent from any involvement with the victim, her family or the alleged perpetrators. The Individual Management Reports author has indicated whether there is confidence in the findings of an Individual Management Report. The Individual Management Reports have been signed off by a responsible officer in each organisation. The agencies' Individual Management Reports were integrated into an overarching chronology of events that led to death of Michelle.

Data analysis

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked 'Official'. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the report in full to remain OFFICIAL and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.