Safer Cornwall
Domestic Homicide Review

Michaela Hall – June 2021

Overview Report

DHR Chairs

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1 FAMILY TRIBUTES

From Michaela's eldest child

I can honestly say I had the best mum ever, not a day goes by without thinking how amazing and caring she was.

No matter if we were low on money my mum always found a way to treat me and my [sibling]. If it was just a day to the beach, lunch, or a trip to Lego land it was always made special by mum.

My mum was always the best gift giver ever. Me and my [sibling] were always spoiled when it came to our birthday or Christmas. Both our birthdays being close to Christmas must have made it difficult with money, but we always had the best gifts. She put so much effort into everything she did with me and my [sibling].

Losing my mum was very difficult, I had to say goodbye to so many things that day, like her amazing smile and her sarcastic humour. The nicknames she gave me and my [sibling] such as Pom and Pommy (which I have no idea where they come from, but I will never forget).

I will forever miss her voice and the warmest hugs she gave me. But I'll never forget all the amazing memories me and my [sibling] shared with her.

I will never forget my amazing mum.

From Michaela's youngest child

I remember Mum used to call me "cuddly X", because she always used to give me lots of cuddles. I never knew why but she also used to call me POM all the time.

I remember when we went to the beach, Me, Mum, my [sibling] and my dog Frank and we went surfing. I enjoyed doing that with Mum, she used to watch as we went surfing.

She also took me and my [sibling] to Legoland and I remember Mum and I eating this really yummy hot dog together! We had such a good day then.

She was always really nice to me, even though she didn't use to have loads of money, she used to try really hard to give us things we wanted. Like we went to football golf, which was fun! I came first, my [sibling] came second and Mum came last.

I also remember listening to music with Mum in the car, on the way to and from school we would have the radio on, and we used to sing all the songs; I really like that. And now I hear songs and they remind me of Mum, like songs by Maverick Sabre, whenever I hear songs by him it reminds me of Mum.

I really enjoyed cooking with Mum, we used to make this dish that you put in the slow cooker and added coca cola, I think it was gammon. That was a good dinner she used to make.

From Michaela's parents

Michaela was our first child and we have always been proud to call her our daughter. As a child Michaela was bright at school, liked to read, played the piano and grew plants on her bedroom windowsill. She won a school prize and passed the entrance exam to a private secondary school. Growing up around lots of family, Michaela was a happy and loved cousin and granddaughter. There was a particularly strong bond with her paternal grandmother, Molly.

All the family knew how meticulous she was, immaculately presented and could be relied upon to organise or sort out any situation. Everything Michaela did was carried out with attention to detail. As a teenager her standards were very high, and she liked to organise her own room and do her washing separately from everyone else; no one else could be trusted. Michaela would always tell the truth and was honest and straightforward about everything.

From an early age Michaela showed concern for others and gave support to people who needed help. She was the person who bought coffee and sandwiches for the Big Issue seller or went out of her way to pick up children with no transport to school.

Michaela was the family fashion expert and when her brother got married, she wore a beautiful outfit with carefully chosen accessories. There was always a bit of added sparkle.

Her chosen career in the airline industry suited Michaela perfectly; the smart uniform, red nail polish, organised working rota, travel - but she also took the chance to assist people less fortunate. When she went to India Michaela would take small gifts for girls who were desperate for simple toiletries they couldn't buy. Michaela took her parents and siblings to America and helped other family members with tickets to places around the world. Her own travels took her to South Africa, Japan, USA, India, Singapore, Australia, Hong Kong, and many parts of Europe. Her common sense and bravery carried Michaela through the occasional drama on a flight, but she always stayed calm and professional.

As a mature student Michaela studied for a law degree and was able to defend herself in the Family Court against a barrage of false accusations and harsh treatment, being extremely articulate and intelligent.

Her biggest achievement was as a wonderful mummy to her two children. She invented 'family comfys' when everyone changed out of their day clothes, got comfortable and settled down for some relaxation and cuddles. They adored her.

Life with Michaela was never dull or meaningless, she always found something new and exciting in life and carried it through with those flashing dark eyes, lots of fun and enthusiasm. Her ability to filter out what was pompous and unimportant meant she saw clearly what needed to be done without worrying about the things that held others back.

The last time we saw Michaela is a treasured memory. We talked about her approaching 50th birthday and her current employment as a fundraiser with RNLI. Michaela wanted to join a wild swimming club and was looking forward to new things in her life while watching her children grow up in Cornwall, the place where she was born and loved living.

Michaela, we love you. No words can describe how life feels without you, our caring, intelligent, beautiful girl.

A personal message from Michaela's father

We could say a lot about our beautiful daughter Michaela, as a child a teenager and watching her grow it to an adult, but we are most proud of her as a mother.

Having read what her two children have said about her here, they have beautifully remembered her as she would have wanted them to. In them, we see her laughter, sharp wit, caring and compassion, her generosity and love of life. She will never see them grow up, or be a grandmother, but we know she would be very proud of them and will always be remembered by us all.

Michaela was meticulous in everything she did, she became annoyed when things were not done correctly and frustrated when people did not do their jobs properly. If she was with us now, she would be witness to some extraordinary failings of so many.

Unforgivable!

From Michaela's sister

Micky, My Big Sister 💖
You bought such joy and laughter to everyone who ever met you.
A heart of gold and a quick tongue of immense sarcasm.
You lit up a room with your wit and infectious laugh, the life and soul of a party or family dinner.
Always glamorous in your very unique style. Generous to a fault, putting others before yourself.
I looked up to you and envied the amazing life you led and your incredible one liners.
I will make people remember the person you were and keep your memory alive with your two most important people.
Be the Twinkliest brightest star 🌟
I LOVE YOU ❤️

From Michaela's Brother

If only one thing gets conveyed about my sister Michaela, it's that she lived to help others.

Selfless throughout, there's nothing she wouldn't do for someone she cared about.
One of my earliest memories of this is when I was in Cubs getting my 'collecting badge'. Michaela was an air stewardess and in the months leading up to my badge, every trip she took she'd buy me a keyring. Eventually, I got my badge, showing off my display of unique keyrings from all over the world. The one I remember most was from Japan, a leather keyring made into the shape of a sumo wrestler.

Throughout most of my school years Michaela would bring me back clothes from my favourite brand, Abercrombie & Fitch, only available in the US. I don't think anyone else in Cornwall at the time had any clothes from them, but that was what being Michaela's brother meant.

I remember in my Nan's final years she became quite unwell and arguably difficult to care for. Whilst the whole family was involved, Michaela was unquestioningly leading our efforts, devoting as much time as she could possibly give. There would have been no ask, no coordination around this, it was just Michaela doing what was most natural to her.

Michaela did have some quirks to her personality, and on reflection I'm confident she was on a neurodivergent spectrum, most likely autism. In many ways as I've gotten older and understand myself more, I relate to many of these characteristics myself, just in a less extreme way.

Her brain was unflinchingly rigid. If we were supposed to pick her up for dinner at a certain time but were late, or if we decided to go to a different restaurant than agreed, this caused chaos in her mind and lead to what most people would perceive as wildly disproportionate reactions. I think really though, her brain found comfort and peace in routine and structure, so when that got broken it caused distress.

She also had an obsessive personality. Talking to her could sometimes be frustrating as she was hyper fixated on a singular train of thought, unable to perceive any alternative opinion.

There were no half measures with Michaela though, if something was going to be done it wouldn't be any less than 100%. God knows how many meticulously planned Christmas Day outfits I saw. Earrings and nails, shoes and jewellery all perfectly came together around the centrepiece of that year's tacky Christmas jumper. She once (and I mean once) tried gig rowing, but she couldn't have just turned up and given it a go. She had to have bought the appropriate leggings, gloves and Helly Hansen coat, so that when she got it that boat she looked the part.

It's no wonder she was so successful with Virgin Atlantic. What job could have required such high attention to your presentation, but such rigid following of procedure and routine.

She was incredibly sharp witted and had a zero tolerance for bullshit, never afraid to speak her mind. Whilst she certainly had a side you didn't want to find yourself on, Michaela was a very happy and outgoing person. At social events she would have everyone smiling and laughing, with countless stories of how she'd dealt with unruly passengers on economy flights (be glad it wasn't you).

I'd ask you not to make assumptions or judgements about Michaela, based on some of her seemingly questionable actions you'll hear about. These paint a false picture of her life and who she really was. These uncharacteristic behaviours are what happens when a person with all the right intentions and selflessness heart gets taken advantage of and their love is used against them.

Michaela was an intelligent, loving, and always beautifully presented sister. Nothing was too much to ask of her and she gave all that she had to her family and friends. She cared deeply about helping people, could bring happiness to anyone's day and was loved by all that knew her.

2 FOREWARD

The ultimate aim of any Domestic Homicide Review is to prevent future deaths through identifying what went wrong, why it went wrong and what needs to happen to improve practice in the future. In some reviews it cannot be said with any certainty that different actions might have prevented the death of a loved family member. This is not one of those reviews.

The circumstances that led to the death of Michaela touched on almost every public body, yet the system designed to protect Michaela and manage the risk of B1 did not keep her safe.

For this reason, this report is unequivocal in identifying where practice decisions and actions failed Michaela. It moves beyond placing the sole fault or blame on any one individual. Instead, this review seeks to understand why and how Michaela and B1 challenged the whole system beyond its capabilities – and what needs to change universally to prevent similar deaths.

Michaela's death must lead to systemic change. The system failures in this review should not be repeated.

This review has received and analysed a large amount of information from family, friends, and agencies. This report has been structured to ensure the learning, findings and recommendations are as accessible as possible and in doing so it does not follow the traditional format for domestic homicide review reports. This is deliberate. The authors have taken this decision to ensure that the detailed analysis of what happened does not detract from the overarching findings and call for changes to a system that failed to keep Michaela safe.

Michaela's parents, siblings and children have asked that her name is not anonymised for this DHR. We wish to respect this request and have therefore used her name in this document. They believe Michaela's life and death should not be depicted under a pseudonym. Rather, what happened to Michaela should spearhead much needed change to protect future victims of high-risk domestic abuse.

Michaela's partner is referred to as B1 for the purposes of this report.

3 INTRODUCTION

3.1 Michaela Hall was murdered by her partner (B1) in her home in June 2021.

3.2 At 22.19 in May 2021, an anonymous telephone call from outside the UK was placed to Crimestoppers, who subsequently called Devon & Cornwall Police at 22.31. The original caller had stated that there was an ongoing domestic incident at the home address of Michaela, who was being strangled by her partner, B1. They stated that they could hear screaming and sounds of disturbance and B1 had only recently been released from prison after serving a custodial sentence for assaulting Michaela.

3.3 The call was graded by Devon and Cornwall Police for an immediate response and police officers attended the address at 23.23. They found the house in darkness, with the curtains closed and no signs of disturbance. They did not gain an answer when knocking on the front and back doors and did not speak to any neighbours. They left the property without forcing entry or making any further enquiries.

3.4 The following day, at 14.50 and 19.01, officers made two further welfare visits to the property, finding the curtains open this time but again gaining no reply from the address.

3.5 At 20.24, Michaela's mother contacted the police to report her concern that Michaela was late telephoning her children and that they could not make contact with her. She stated that this lack of contact was very unusual and also disclosed a history of domestic abuse from B1 towards her daughter.

3.6 At 22.21, Michaela's mother contacted police again to request that they force entry to her daughter's property. She said she was concerned that Michaela was injured inside after learning that B1 had beaten her up the previous day.

3.7 At 22.38, a neighbour contacted police to state that Michaela's father had entered the property and found his daughter, possibly deceased, with serious facial injuries having been subjected to a violent attack.

3.8 Officers arrived at 22.55 hours and shortly afterwards at 22.56 hours Michaela's life was pronounced extinct by paramedics. A forensic pathologist later confirmed that Michaela died from a single unsurviveable stab wound.

3.9 A major investigation commenced and her partner, B1, was arrested on suspicion of her murder the following day. After a full trial, B1 was convicted of Michaela's murder and sentenced to a minimum of 21 years in prison.

3.10 At the time of her death Michaela's two children were age 9 and 13. Her oldest child is subject of a care order and lives with his aunt and her youngest child with his father subject of a child arrangement order.

3.11 Domestic Homicide Reviews are statutory reviews under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 and must be carried out when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by: (a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

3.12 Michaela was in an intimate relationship with B1, was living with him at the time of her death and had been the subject of previous Multi-Agency Risk Assessment Conferences (MARACs). As a result, the criteria for a Domestic Homicide Review was met and the Safer Cornwall Partnership commissioned two independent chairs to undertake this review and the subsequent report.

Equality and diversity

3.13 Michaela was 49 when she was killed by B1. She was a white British national and had two children from previous relationships. Her records do not contain any information to suggest Michaela was discriminated against based on any of the protected characteristics of the Equality Act 2010 (e.g., disability, sex (gender), gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation, age, marriage, or civil partnership.) It should be noted, however, that as a woman, Michaela was disproportionately more likely to experience some form of abuse in her lifetime in the UK[1].

3.14 B1 was a white British national, religion unknown. He was 43 at the time of the homicide. He had one son from a previous relationship who was the subject of a care order. There are no records containing any information to indicate that B1 was discriminated against based on any of the protected characteristics of the Equality Act 2010.

4 THE REVIEW PROCESS

4.1 The review process has followed the Home Office Guidance for Domestic Homicide Reviews and has been supported by a panel of senior representatives from agencies in Cornwall. Their names are set out in appendix one. The final agreed terms of reference for the review are set out in appendix two.

Family friends and colleagues' involvement

4.2 For bereaved families, Domestic Homicide Reviews are yet another process to be navigated alongside criminal proceedings, the inquest, and other statutory obligations. It can be hard to for them to understand the resources that are available

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018

after a homicide that appear not to have been available to prevent the death occurring. Families have described this investment and focus as 'back to front'. This is an extremely valid point, and the chairs of this review are extremely grateful to Michaela's family for the time they have given to helping us understand more about Michaela, her life, and the feelings of family members desperately worried about her safety. This involved them revisiting their own painful memories to provide insights and understanding. They did this knowing it was too late for them, but in the hope that it will inform future practice and change the experiences of future families. We have worked alongside Michaela's family throughout all stages of this review, listening carefully to their views and using their valuable insights to shape the terms of reference, recommendations and systemic changes outlined in this report.

4.3 Michaela's two children were invited to participate in the review as important contributors. Michaela's eldest child expressed a firm wish to have his experiences heard as part of the DHR process, particularly as the opportunity was not afforded to him as part of the criminal justice process. He is a crucial witness to 'what went on behind closed doors' as he remained living with his mother for longer than his younger sibling. Michaela's eldest son was able to share important insights that have helped the review to better understand why some professional approaches failed in their effectiveness. Without his bravery and astute observations, this review would be missing pivotal information about Michaela as a mum, a partner, a person, and a victim. He has given his consent to include his experience and views in this report, supported by those who care for him.

4.4 Michaela's youngest son lives with his birth father and has been kept informed about this review.

4.5 The review chairs also arranged meetings with a colleague of Michaela's who worked with her near the time of her death and the friend with whom she had been in contact with throughout her relationship with B1 and who made the final call to Crimestoppers. Both contributors helped the review to understand more about Michaela and her relationship with B1.

4.6 The decision was taken to offer B1 an opportunity to contribute to the review. This was discussed with Michaela's parents and the decision was not taken lightly. The chairs and panel would like to stress that the focus of this report is Michaela. B1 was responsible for her death, and nothing changes his culpability in this respect. However, if we are to consider how to best prevent future deaths, we must consider the effectiveness of our work with perpetrators of domestic violence and abuse. B1 originally agreed to contribute and speak to the chairs. The chairs visited him in prison but on arrival B1 explained that he no longer wished to participate. A brief discussion enabled the chairs to explain the purpose of the review and invite a written contribution at a later date if he wished. To date, this has not been forthcoming.

Information Gathering

4.7 The review process has involved:

- Meetings with family members, friends, and co-workers to inform the development of the Terms of Reference (ToR). This is a document that sets out the scope of the review.
- Agreement of the Terms of Reference with the panel and family
- Submission of initial agency chronologies (a dated catalogue of events)
- Panel discussion to agree which individual agencies were required to undertake a full individual management review (IMR). This is a self-reflective critique of their own agency's involvement.
- Analysis of individual agency reviews and panel discussions to inform the findings, conclusions, and recommendations.
- Liaison with parallel reviews to identify gaps in knowledge.
- Continued discussion with family throughout the process.

4.8 Individual management reviews (IMRs) have been received from:

- Children and Family Services – a brief narrative
- Devon and Cornwall Police
- First Light Safer Futures
- NHS Kernow Clinical Commissioning Group- now NHS Cornwall and Isles of Scilly Integrated Care Board, supporting the participation of the 3 GP Practices, one of which was an employing practice.
- Royal Cornwall Hospitals Trust (RCHT) & Cornwall Partnership NHS Foundation Trust (CFT)
- Southwestern Ambulance Service NHS Foundation Trust
- We Are With You Cornwall (WAWY) Also referred to in this report as the substance misuse service.
- Probation Service
- MARAC
- Adult Social Care
- Julian House (Former Employer)

4.9 The chairs asked for sight of the minutes of MARAC meetings but were informed that minutes were not on file and were therefore not available. This is because MARAC agencies all access a live, central IT system that can be updated prior to and after a MARAC, therefore no separate minutes were produced for each meeting at the time. Audio recordings of the meetings were available and transcribed by Safer Cornwall and these transcripts were used to inform the detail within this report regarding each MARAC meeting.

4.10 In light of the parallel coronial process the DHR chairs have liaised with the coroner in order to dovetail the review and inquest. The chairs attended the Pre-Inquest Hearings (x 6) and met with HM Coroner for Cornwall and the Isles of Scilly on two occasions to reduce the likelihood of duplication and ensure each process has full sight of all available information required to produce informed conclusions. The information received highlights the importance of a close working relationship with

HM Coroner and information sharing between the inquest and DHR. The review has been able to receive and analyse information that would not have been available from IMRs alone.

This report

4.11 This report has been informed by the following:

- Information from family and friends of Michaela:
  - Michaela's parents
  - Michaela's sister
  - Michaela's brother
  - The father of Michaela's youngest child
  - Michaela's friend and original caller to 999
  - Michaela's last work colleague and friend
  - Michaela's oldest child
- Agency chronologies
- Agency individual management review (IMR) reports
- Additional discussions with Devon and Cornwall Police
- Discussion with Crimestoppers
- Discussions with B1's social worker and their manager (for his own child)
- Coroners bundle (including the Independent Office for Police Conduct report and statements)
- Updated coroner's bundles received January and June 2023
- Virtual attendance at the trial of B1
- Internal Serious Incident Reviews (Cornwall Foundation Trust and Probation).
- A comprehensive list of B1's previous offences
- Additional information from children's social care involved with B1's son
- A review of relevant academic literature.

4.12 The dovetailing of information across the coronial inquest and DHR has been a very positive aspect of this review. Without access to the information contained within the coroner's bundles this review would have been based on incomplete information and significant learning would have been lost. It is concerning that some agency chronologies submitted to the DHR missed important details and these details only came to light when the DHR Chairs read the inquest statements.

4.13 The report deliberately does not follow the usual format for DHR report. As information was gathered and analysed for this review, it became clear that Michaela could not be kept safe by the system designed to protect her and there had been many missed opportunities to disrupt the course of events which ultimately led to Michaela's death. There is a vast amount of information from various sources and the aim of this report is to help the reader focus on Michaela, the circumstances that led to her death and why there was such a serious failure to protect her. This includes what needs to happen to minimise the likelihood of similar deaths in the future.

4.14 We have shared the report with Michaela's family at each stage of the process and our ultimate aim has been to ensure that they are content that the report format and content provides an accurate reflection of Michaela's life and the complexity of the factors that contributed to her murder.

4.15 The report sets out:

- Background information on Michaela and B1 in order to provide a context for later events.
- A summary of events in chronology form to help the reader gain an overview of what happened.
- A summary of learning to provide a succinct focus on the findings of this review.
- A detailed description of events and evaluation of practice at each stage – this section aims to help the reader understand the information that informed our final analysis and findings.
- Review findings linked to recommendations for future improvements.

4.16 The episodes analysed within this report are:

- Michaela's employment at Julian House
- The assessment of risk, engagement with Michaela and safety planning during Michaela's relationship with B1
- Management of B1's offending
- The incident/events in the final 24 hours.

Limitations of this report

4.17 In line with DHR guidance this review has drawn information from individual management reports written by senior managers in the organisations who had known Michaela. There has been no direct practitioner input into the review as standard DHR practice is this has been channelled through the IMRs, which are variable in their approach to engaging with front line staff. This means that it has been hard to fully appreciate from a practitioner perspective what the barriers were to providing the right help to Michaela and what might improve practice in the future. Front line practitioners are often best placed to reflect on solutions at both an individual and organisational level that might really make a difference. With this in mind, the review must accept that without direct practitioner contact, it is possible that the perceptions and real-time experiences of those operating 'on the ground' may be filtered or lost. This is learning for the DHR process and Safer Cornwall may wish to consider how practitioners can be more meaningfully be involved in future reviews.

5 MICHAELA

5.1 She was the eldest of four children and her family describe a happy childhood with the siblings all enjoying a private education.

5.2 Michaela had a bubbly personality, was very caring, smart, organised, articulate and able to communicate eloquently with people from all walks of life. She had a strong sense of social justice and a real desire to help people. Her family described a person with a hint of vulnerability who tended to be "all or nothing" and "too empathetic" in her responses to people and situations. She often cared too much and could not refuse help to people in need. Michaela's sibling reflected on a sister with 'Florence Nightingale syndrome' – an urban term used to describe people who overhelp and over-give to save/heal/fix/help people, making themselves central to their change and recovery. In their eyes, Michaela truly believed and imagined the ways in which she could change B1 and 'save him from himself'.

5.3 Michaela was a "fun mum" who adored her two children and loved to spend time with them. She was thoughtful and considered carefully, meaningful gifts, that they could treasure forever. She surprised them with trips to adventure parks and worked hard to make Christmases perfect. She spent pay days buying their favourite foods and indulging them in fun activities. Michaela enjoyed a close and open relationship with both of her children.

5.4 After leaving school Michaela worked in the airline industry for many years as a senior crew member in charge of first-class passengers on long haul flights. During this time, she met the father of her oldest child. Neither Michaela nor her child had any further contact with the father after the child's birth.

5.5 Michela left her job as cabin crew in 2009 having started a new relationship. She moved in with her new partner and her youngest child was born.

5.6 The breakup with the father of her youngest child was extremely acrimonious and in 2015 Michaela was issued with a non-molestation order and occupation order[2] (ex-parte [3]). Subsequent court proceedings instigated by her ex-partner, resulted in Michaela being issued with an indefinite restraining order. This offence resulted in Michaela being assessed as meeting the criteria for a DASSP (Domestic Abuse Serious and Serial Perpetrator)[4] and this marker was placed on her police record to be reviewed in April 2016. Due to a report of a further breach of the non-molestation order, the marker remained after review in 2016.

5.7 Michaela's close family have questioned the appropriateness of these orders and her DASSP status (given that Michaela was not a serial perpetrator and therefore would not have met the eligibility criteria). They feel that the orders that were made were a

[2] An Occupation Order is an Order that a Court can make, under Section 33 of the Family Law Act 1996, to determine who can remain living in a property.

[3] Ex- parte means a legal proceeding brought by one party in the absence of and without representation of or notification to the other party.

[4] The significance of Michaela's DASSP status is considered later in this report.

disproportionate response to her attempts to seek the same orders against her ex-partner. Her ex-partner strongly disputes this point of view.

5.8 Michaela was then arrested in 2016 for a breach of the restraining order which when heard in court resulted in a 12-month conditional discharge. This followed two previous breaches being dismissed by the court. She was assessed by the Criminal Justice Liaison and Diversion Service who noted Michaela's need for emotional support as well as a history of OCD and depression. It was agreed that Michaela would self-refer to mental health services (Outlook Southwest) for interpersonal therapy.

5.9 Both of Michaela's children remained living with her, and after the break-up of her relationship, Michaela started work at a holiday complex where they all lived. She latterly moved to the area of Cornwall where she lived at the time of her death. She started a law course, inspired by her own experiences as a single mother who articulately and coherently represented herself at family court proceedings without legal aid.

5.10 In December 2017, Michaela was interviewed and offered the role of a volunteer mentor for the Prison Advice and Care Trust (PACT). PACT is a voluntary organisation providing support to people leaving custody in order to help them with their immediate resettlement needs. During December and January 2018 Michaela completed two full days training including safeguarding and professional boundaries training and started work alongside an experienced mentor.

5.11 Michaela co-worked six cases and during April 2018 worked five cases as the main worker. During work on a further case in May 2018, PACT received reports of a number of incidents which suggested that Michaela was having difficulty in maintaining professional boundaries and a decision was taken to speak to her in detail about these incidents.

5.12 It was during May 2018 that Michaela was arrested for breaching a restraining order against her ex-partner, and as a result did not meet a service user as expected. PACT was informed about the arrest by a friend of Michaela's, and it was this incident, combined with the concerns about maintaining professional boundaries, that led to the decision to suspend Michaela from her volunteering role.

5.13 Michaela told her family during this time that she could not cope with the way some people were treated when they were released from prison. She found the lack of compassionate care emotionally challenging and was unable to align some policies (such as ex-offenders being given temporary tents to live on the streets) with her personal values. This theme of Michaela's inherent nature is explored further in the report.

6 B1

B1 was born 1978. He was 43 at the time the homicide. B1 was a white British national, religion unknown. He had one son from a previous relationship who was the subject of a care order. There are no records containing any information to indicate that B1 was discriminated against based on any of the protected characteristics of the Equality Act 2010.

6.1 He left school without qualifications, briefly spent time in the navy but has never had a prolonged period of employment. He was described at his trial as witnessing domestic abuse as a child and his father being 'a fighter' and a perpetrator of domestic abuse. This description is not consistent with records held within a neighbouring local authority who have been involved with B1 for many years. Information from the trial states that he started taking drugs at the age of 10 and had been abusing heroin since he was 16, along with other Class A drugs such a crack cocaine. He also consistently abused alcohol and described 'drink and drugs' as being at the root of his difficulties.

6.2 Another local authority in the southwest have children's social care records relating to B1 with evidence of domestic abuse towards previous partners. Their records detail police involvement in two domestic violence incidents in 2005 which were notified to children's social care as children were in the household. A further incident in 2007 resulted in B1 being charged with common assault and criminal damage. Two incidents later in 2007 led to his partner moving to a women's refuge. B1 completed one Integrated Domestic Abuse Program (IDAP) with Devon and Cornwall probation in 2008 but failed to complete another program or unpaid work. This led to a note in the children's social care file that B1's probation officer "*is unable to say that his risk of reoffending should he form another relationship is reduced".* It is as a result of this serious and serial domestic abuse that B1 met the criteria for DASSP (Domestic Abuse Serious and Serial perpetrator) status.

6.3 B1 also has an extensive offending history, for drug related or acquisitive crimes, and a pattern of noncompliance with court orders. A 2010 battery offence involved B1 assaulting his four-year-old son by striking him twice on the face and once on the hands whilst on a public bus and under the influence of alcohol or drugs. Probation records for 2010 note that B1 "*accepted that probation would not be able to reduce his level of risk within a relationship as he has not learnt the skills to manage those feelings".*

6.4 In 2017, B1 was sentenced to a total of 35 months custody at Plymouth Crown Court for non-violent offences. It was as a result of his release from prison and subsequent recall for not complying with a curfew, that he met Michaela.

6.5 B1's son was made subject of a care order and as a result he has continued to have involvement with another children's social care department. B1 has been described by social workers who have known him well throughout this time as often appearing

compliant and passive, frequently allowing others including his mother and Michaela to advocate on his behalf.

7 MICHAELA AND B1'S RELATIONSHIP

7.1 It is only with the benefit of hindsight and the invaluable contribution of family and friends that this review has been able to learn about the intimate nature of Michaela and B1's relationship. Due to neither party engaging with professional agencies, much of their relationship (cited in records) was an enigma peppered with assumptions.

7.2 Family and friends that knew either Michaela or B1 independently have told the review that they, were extremely perplexed by their relationship and could not fathom how they became attracted. B1's previous partners appeared far more similar to him in his past trauma and long-standing substance misuse and their relationships had become co-dependent due to their shared coping mechanisms and priorities. Meanwhile, Michaela had a more economically privileged upbringing, with a private education. She enjoyed a successful career and had a glamorous disposition, taking great pride in her appearance and her home. While Michaela could communicate eloquently and articulately, B1 had communication deficits worsened by his habitual use of drugs and alcohol. Michaela was outgoing, vivacious, headstrong, and assertive. Instead of being charismatic and charming, B1 was solemn, quiet, and withdrawn with a victim mindset. It was a disconcerting match from the outset, challenged by different socioeconomic classes, educational background, and life experiences.

7.3 Rather than understanding this relationship being a case of 'opposites attract', the review tried to understand the deeper psychology of how and why Michaela became so beguiled by B1, and why B1 became so dependent but excessively violent with Michaela – and how this reached heights of extreme danger that tested the system and its ability to respond.

7.4 We stress that this approach to understanding what happened does not absolve B1 from any responsibility for his crime. This was a clear case of male violence against a woman. However, if we are to learn and move forward to prevent future deaths we must move from simplistic explanations to a deeper understanding of how we can provide the right help and support to victims of male violence against women.

7.5 The review has considered this from the perspective of:

- Michaela as a person who liked to help others, and who believed in giving people the benefit of the doubt and second chances – someone who liked to be needed and to care/fix/heal those she believed to be 'broken' or disadvantaged.

- B1 as a person who wanted to be cared for, looked after and who relied on others to advocate for him.
- Michaela as an advocate, organiser, and 'fixer' – someone who crossed personal and professional boundaries in pursuit of a social ideation where happiness and equality is afforded to all.
- B1 as a person who used Michaela and took advantage of her good intentions to fund his drug and alcohol use, his financial independence, and his accommodation needs.
- Michaela, as a victim of financial abuse.
- The dangerous combination of Michaela's need for B1 to change, and B1's violent and aggressive rebellion of change.
- Michaela's ability to articulately communicate and resolve conflict with succinct verbal reasoning.
- B1's inability to resolve conflict without violence, and the impact of Michaela's communication skills on his self-esteem.
- Michaela's strong and firm resolve
- B1's lack of responsibility, empathy, and reflection
- Their joint dislike and mistrust of statutory agencies and especially the police
- Their cognitive and biological responses to risk/fear/danger
- The power dynamic between carer/cared for.

7.6 Michaela met B1 when she was in a professional position of trust and had responsibility for his resettlement plan back into the community after prison. It is not known how or why the relationship crossed over from a professional one to an intimate one, but Michaela never really abandoned her sense of responsibility for B1, and she often acted in an advocacy role, championing his needs, and liaising with agencies on his behalf. She took or assumed responsibility for his protection, appointments, family affairs, banking, and his accessibility to alcohol. At times she even told professionals that she was responsible for administering drugs to counteract sanctions that would force their separation. B1 appeared to accept this supporter role and even encourage it at times when it suited him. However, the review can only speculate on whether they shared an emotional connection, or if manipulation (on B1's part) or other psychological reasons underpinned their union.

7.7 It is difficult to know what went on behind closed doors when Michaela and B1 were alone, however, the review has been able to establish that money, B1's laziness, and his addictions were continuous triggers for daily arguments, often fuelled by Michaela's frustration. We know that she was not afraid to speak her mind and instigate an argument if B1 did something she did not agree with, but we do not know whether this aspect of her character was dampened over time due to the severity and escalation of violence against her. Testimony from friends shows she was often the victim of unprovoked sustained violence when B1 could not get what he wanted or when she was unable to meet his money/addiction needs. Body worn footage from police callouts show a visible change from an assertive and protective

figure to one who appeared tired, frustrated, and defeated in latter episodes of domestic abuse. She took less care in her appearance and her coping potential waned. Although professionals believe Michaela remained loyal to B1 until the end, the family do not agree. In their view, Michaela was reaching a place of wanting the relationship to end. She was showing signs of exhaustion; jaded and embarrassed by the constant injuries. They believe, with a little more time, Michaela would have ended the relationship and accepted help. This review has considered whether B1 also became receptive and attuned to this change in Michaela, leading him to his eventual fatal actions.

7.8 Michaela and B1's relationship was not unique insofar as domestic abuse is concerned. It is sadly a scenario affecting an estimated 2.4 million adults each year in the UK. However, despite all of the resources and expertise allocated to domestic abuse nationally, Michaela and B1 seemed to challenge the system to the point where it felt it was stuck, depleted of options and unable to protect her. This is an important perception to acknowledge. Agencies report being unable to reach Michaela or change her mind about B1. They believe she was knowledgeable about the risks and the danger to her life, yet continued to be resolute in her belief she could change him. Criminal justice agencies struggled to stop their contact through a range of different sanctions, including custodial sentences. Michaela even communicated that she knew she was 'B1's meal ticket' and that she 'was addicted to him' but that this may not be reciprocated. She lost so much to the relationship that it became futile (in her belief) to give up. Even though the risk of death was communicated and understood, and Michaela had the mental capacity to make decisions for herself, even if those decisions were unwise decisions, possibly influenced by fear, leaving her too threatened to be able to leave. Legislation around this delicate area of human rights hindered options through other safeguarding avenues.

7.9 The question for this review is "If Michaela challenged the system beyond its capabilities" (as quoted by a panel member) "What change or additional capabilities are required to transform the outcome, should a similar case present itself today?". It is not enough to conclude that the system was challenged or put the emphasis on Michaela (who was the victim) to protect herself. This review must look towards an urgent remedy to prevent future deaths when a person falls through the net of safeguarding legislation.

8 IMPACT OF DOMESTIC ABUSE ON MICHAELA'S CHILDREN

8.1 In 2021, the Domestic Abuse Act formally recognised children as victims of domestic abuse in their own right. This critical change in legislation ensures that children affected by domestic abuse are now automatically classified as victims, irrespective of whether they were directly present during violent incidents. Consequently, this recognition guarantees that children exposed to such environments are entitled to

access necessary support services, including mental health and safeguarding resources.

8.2 This legislative change was enacted subsequent to Michaela's death; therefore, the professional response at the time was based on a different legal framework. The primary focus of children's services was the immediate safety of the children. This approach aimed at minimising their exposure to domestic violence, resulting in the removal of both children from Michaela's care.

8.3 Michaela's eldest child was placed with a maternal relative, as a positive alternative to foster care and remained under the local authority's supervision, while her youngest child was placed with their biological father without ongoing agency support. The younger child's earlier removal is believed to have shielded them from the abusive behaviours that the elder child was exposed to for a longer period. Despite this timeframe, reports from interactions with Michaela's family indicate that the eldest child experienced significant instability in their living arrangements. However, the panel recognises that the impact of domestic abuse on Michaela's eldest child will be long-term.

8.4 Upon reviewing the chronologies, Independent Management Reviews (IMR) from children's services, and transcripts of Multi-Agency Risk Assessment Conference (MARAC) meetings, it is evident that while professionals were diligent in prioritising the immediate safety of Michaela's children, the records lack comprehensive detail on the broader and long-term impacts of domestic abuse.

8.5 In light of this, it is recommended that the MARAC chair works in partnership with children's services and other relevant agencies to include a child impact report for all identified child victims of domestic abuse. This report should recognise the social and emotional and attachment issues, together with the behavioural, cognitive development and educational progress, and the environmental impacts on the child. To ensure consistency and standardisation across Cornwall and the Isles of Scilly, the development of a unified template for these reports is advised. This approach will facilitate a more comprehensive and informed response to the needs of child victims of domestic abuse, thereby improving the effectiveness of professional interventions and long-term support strategies. **Please see Recommendation 12**

9 SUMMARY OF EVENTS

	Michaela	B1
Dec 2017	Became volunteer for Prison Advice and Care Trust (PACT)	Extensive offending history. Prior to the end 2017 there is a record of 48 offences or breaches of orders. Including evidence of previous domestic abuse.

May 2018	Suspended from volunteering role with PACT	
Oct 2018	Started employment at Julian House	Released from prison on a home detention curfew, recalled and released again in November.
Nov 2018		Released from custody having served a 35-month sentence for burglary in a dwelling.
Dec 2018	Michaela was assigned to B1 as his caseworker	Arrested (racially aggravated harassment) – 6-week sentence
Jan 2019		Released from custody on license. Reoffended (having an article with a blade or point in a public place) - further 8-week sentence
Feb 2019		Released on licence but recalled 8 days later due to non-compliance.
March 2019		Released on license and moved to Julian House
April 2019	Michaela and B1's relationship started. Michaela suspended and then resigned from role at Julian House.	
May 2019	Michaela completed DASH risk assessment -medium risk	B1 arrested for assaulting Michaela. Released on police bail with conditions. Recalled to prison for breaking terms of previous license.
July 2020	Michaela resumed relationship with B1	B1 released from prison and gave release address as Michaela's accommodation. He was not subject to Probation Supervision from date of release having served his sentence.
August 2020	Michaela seen with a bruised eye during routine police visit – denied this was domestic abuse.	
Sept 2020	Michaela assaulted by B1. Did not wish to engage with police. Medium risk refused DASH	B1 arrested on suspicion of assault.
Oct 2020	Michaela assaulted by B1 – multiple punches to the head. Set fire to her pillow and threatened to burn the house down. 2x High risk refused DASH assessments	B1 arrested. Issued with Domestic Violence Prevention Notice. DVPN breached and transferred to Domestic Violence Prevention Order. Arrested for breaching DVPO – fined £50
28th Oct 2020	First Multi Agency Risk Assessment Conference (MARAC)	

7th Nov 2020		Arrested for beaching DVPO – 14 days prison sentence (served 6 days) This sentence does not attract Probation Service involvement.
17th Nov 2020	Michaela assaulted by B1 – pushed her to the ground, kicked her, kicked the dog, and killed the gerbil. Michaela did not wish to make a statement to police, High risk refused DASH.	B1 arrested. CPS did not authorise charge. DVPN and DVPO issued.
18th Nov 2020	Second MARAC	B1 living in travel lodge
23rd Dec 2020	Michaela assaulted (B1 had "*smashed her face in*") fled to neighbours and asked for B1 to be removed from her property. Michaela did not wish to engage with police. High risk refused DASH	B1 arrested and bailed with conditions
30th Dec 2020	Third MARAC	
31st Jan 2021		B1 made threatening phone calls to Michaela's father. B1 charged.
13th/14th Feb 2021	Michaela assaulted by B1 – kicked in head. Told police that a few days before B1 had *kicked her to the head and had strangled her to the point that she believed that she was going to die and passed out.* High risk refused DASH	B1 arrested, denied offence, and released on bail with conditions
24th Feb 2021	Fourth MARAC	B1 "sofa surfing" in Plymouth
7th March 2021	Michaela assaulted by B1 when visiting him in Plymouth. Pulled her hair, kicked, and punched her. Next day she was seen with a "black eye" – she denied assault by B1. High risk refused DASH	Police recorded crime of ABH. Taken into custody – charged with assault and ABH. Remanded in custody to Exeter prison.
17th March 2021	Fifth MARAC	

12th April 2021		Court case adjourned for pre-sentence report. B1 pleaded guilty to common assault x2 (as alternatives to original ABH charges), and criminal damage. He had already pleaded guilty to harassment.
14th April 2021	Sixth MARAC	
14th May 2021		B1 sentenced to Community Order & Restraining Order. Remand in custody ceased. Released from prison and gave Michaela's address as release address.
Last week in May	Michaela tells a friend that she has horrific bruises	
Last week in May	Michaela calls a friend (who was abroad). She told her friend B1 had tried to strangle her the day before. Friend heard B1 attack Michaela. This prompted the sequence of events that led to Michaela being found deceased by her the following day.	

10 SUMMARY OF LEARNING

This section of the report provides a summary of the key learning points from this review. The detail underpinning learning is contained within the main body of the report and learning is cross referenced to the findings and recommendations set out in section 14.

10.1 There is significant learning emerging from this Domestic Homicide Review for all organisations responsible for preventing and responding to domestic abuse. This report is unlikely to become a public document until many months after the review has concluded, primarily due to the time taken to complete the quality assurance process within the Home Office. This does not mean that implementation of learning at a local level should be delayed, and Safer Cornwall has assured the report authors that it is committed to considering the review findings and working with partner agencies to improve practice. An appendix to this report sets out the changes that have taken place in Cornwall since Michaela's death.

10.2 The ultimate aim of any Domestic Homicide Review is to prevent future deaths through identifying what went wrong, why it went wrong and what needs to happen to improve practice in the future. In some reviews it cannot be said with any certainty that different actions might have prevented the death of a loved family member. As the foreword states, this is not one of those reviews.

10.3 It is clear that there were times when different actions should have been taken to identify the risk that B1 posed to Michaela and positive action taken to address those risks. These occasions span the whole time period of this review up until the day of her death. Throughout the period of Michaela's relationship with B1, although positive action was taken to protect Michaela's children, risks to Michaela were not managed well enough, and opportunities were not taken to understand Michaela's vulnerability and perspective or to work alongside her to try and keep her safe. The system was too rigid, and crucially not flexible enough to hear the concerns of Michaela's family and involve them positively in safety planning.

10.4 For this review to make a difference it is vital to understand *why* the system could not keep Michaela safe. This report aims, through its findings and recommendations, to articulate the underlying causes and to make suggestions for further improvement. At the heart of the findings in this DHR is a system which is fragmented and cannot handle multiple needs and perspectives when they come together in one place. Safeguarding systems for both children and adults can struggle to give equal value to the voice of families[5] and in this case there is evidence that the views and

[5] See for example the national review into the deaths of Arthur Labinjo-Hughes and Star Hobson Page 87 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf

perspectives of professionals were privileged over information from Michaela's family. Assumptions were made about the motivations of Michaela's family without professionals taking sufficient time to really listen to their worries and fears and understand their actions in trying to help her.

10.5 The practice described within this report took place within a context of challenges within public sector services. There had been many years of financial constraints. Covid-19 had placed an added pressure on many agencies and meetings that had previously been face to face became virtual events. There was also significant structural change within the probation service due to come into effect in the weeks after Michaela's death. Agency stressors do not excuse poor practice, but they do serve as a reminder that responsibility for change lies at both a local and a national level.

10.6 The learning from this review is summarised below and explored in detail in the findings section of this report.

Safe recruitment practice

10.7 Michaela met B1 whilst working at Julian House and whilst she did not meet all of the criteria within the person specification, she presented well at interview and Julian House believe that she could develop into the role with the right training and support. This was within a context of a shortage of suitable candidate for this type of role. However, a candidate's application and interview forms only part of the recruitment process - safer recruitment also relies on supplementary information from other systems including references and employment checks.

10.8 A common and concerning practice within recruitment is that previous employers may decide to give skeleton "no comment" references for fear of legal action against them. In this instance, this led to insufficient curiosity/scrutiny when there was a no comment answer to key questions on the reference form completed by PACT. More information as to why there was no comment could have caused Julian House to carefully consider their offer of employment.

10.9 A general learning point that has emerged from this review is that whilst Julian House carry out safer recruitment practices, the process can be challenging with regards to Disclosure and Barring Service (DBS) checks. High-risk offenders are not classed automatically as 'vulnerable' by definition for the purposes of DBS checks in the same way as other groups, such as older people or children. Therefore, organisations such as Julian House can at times experience push-back from the DBS service and have to justify why the enhanced check is necessary.

10.10 When Michaela was known to have breached professional boundaries by forming an intimate relationship with B1, the focus was on his risk to her children and her potential impact on him**.** Even so, there was no referral to the 'Local Authority

Designated Officer under the Person in Position of Trust' procedures, and this may indicate a need for more awareness of this process in third sector organisations. In addition, safeguarding policies and procedures need to be clear that in situations such as this there is a duty to consider the risk to all parties, including the staff member (whether they remain employed or not).

10.11 Recruitment processes in other job roles were also not fit for purpose and could have harmed either Michaela or clients of the service. References obtained prior to Michaela starting work at a GP surgery were not from the most appropriate sources and in addition DBS checks were not requested. Also, when Michaela started work for the RNLI The recruitment process was via Facebook, and no background checks were carried out (as Michaela's role did not qualify for vetting) or references taken. This was a face-to-face public role, and it would seem to be prudent to have obtained references from previous employers.

The issue of recruitment is explored further in Finding One

A whole family approach.

10.12 Families may be a potentially lifesaving resource for victims of domestic abuse, yet professional systems seem designed to exclude their involvement in safety planning and support. This cuts off the opportunity for vital information to be absorbed *into* the risk management system and *out of* the system into the community that surrounds the victim. Michaela's family were desperately worried that B1 would harm her but were not aware of professional efforts to help her taking place at the same time. It is therefore understandable why Michaela's family believe their voice was not heard or acted upon, and why a full picture of the risk was never achieved.

10.13 This is a complex area as family relationships are not straightforward and professionals need to balance the adult victim's right to privacy and confidentiality with actions needed to keep them safe. In this case, professional information sharing went ahead even though Michaela did not want agency interference, but this did not extend to speaking with concerned relatives who knew her best. As a result, vital information that could have helped safety planning was not heard. These included aspects of Michaela's unique personality which would have provided some insight as to why certain interventions were not effective. In addition, a lack of engagement with her family meant that the system inadvertently isolated Michaela further by not sharing appropriate safety advice with the family that may have mitigated some of the risk.

10.14 Working with the whole family also involves balancing the rights and needs of children with an approach which builds relationships with victims, minimising their isolation. This must involve using existing multiagency forums to bring the network together to establish a consistent approach to safety planning.

10.15 In addition, a whole family approach, which is domestic abuse informed, will need to hold abusers accountable whilst offering them support to change.

This issue is explored further in Finding Two

"Working with" victims rather than "doing to"

10.16 Opportunities were missed to ensure that Michaela's voice was heard and understood, and assumptions were made by many agencies about her views and reasons for her actions.

10.17 Engagement with Michaela was viewed through the lens of informed choice i.e., Michaela knew the risks but chose not to leave. This was a simplistic minimisation of the situation and did not acknowledge the complex interplay between Michaela's innate need to rescue B1 and the psychological tactics used by B1 to keep Michaela in the relationship. The solutions imposed by the system only served to distance Michaela further from formal support. The system was not flexible enough to provide one person who could form a positive helping relationship with her where she did not feel judged as a mother and partner.

10.18 Her 'unwillingness to engage' was then framed as a problem assigned to Michaela, rather than the system reflecting on its own limitations. It became victim blaming rather than galvanising professionals to try and find creative solutions. There was no consideration of how to support Michaela and B1 together or work with them to make sense of the emotional underpinnings of trauma that contributed to B1's behaviour and Michaela's tolerance of his abuse. Agencies who could have helped disengaged during periods of low risk rather than seizing the opportunity for intensifying support and building trusting relationships. This approach was in some instances driven by a need to manage priorities but resulted in a system which was reactive, rather than proactive and facilitative.

This issue is explored further in Finding Three

Risk Assessments and Safety Planning for victims of domestic abuse

10.19 The review has found that risk assessments were not effective in identifying the level and nature of risk to Michaela from B1. There was no coherent outcome focused multi-agency plan which drew on all available information and was evaluated to assess whether risks had been reduced. The limitations of risk assessment stemmed partly from limitations in information gathering and sharing which resulted in B1's past history of domestic abuse not being known to agencies assessing risk to Michaela. Warning markers were not used consistently and there are different methods of assessing risk in agencies and each has a different meaning. For example, a DASH assessment is understood as referring to immediate risk whereas the OASYs assessment within probation refers to risk in the future. Short cut language referring to high-risk or medium risk may mean different things to different people.

10.20 MARAC has no statutory footing, but it is the prime means by which agencies come together to manage risk in cases of domestic abuse where the risk of serious harm is imminent and potentially irrevocable. Although Michaela was discussed at six MARAC

meetings, not all information was known to those around the table. This included extensive information known to a neighbouring children's social care department about B1, significant information (including video evidence) known to the Cornwall children's social worker, police knowledge that Michaela had been a victim of non-fatal strangulation and Michaela's contact with her GP. Subsequently, MARAC decisions were not based on a full picture of the risk posed to Michaela.

10.21 MARAC meetings are working at the interface of different agency risk assessment processes and different criteria for rating risk. They discuss several cases and there is insufficient time to focus on the detail and complexity of cases, develop safety plans focused on clearly defined outcomes as well as reviewing and monitoring previous actions. The current work in Cornwall in developing a system whereby "repeat MARACs" will be reviewed separately is to be welcomed.

The issue of risk assessment and safety planning is discussed further in Finding Four

Financial abuse

10.22 With the benefit of hindsight, it is now clear that Michaela was a victim of financial abuse by B1, but this was not named in any of the risk assessments or MARAC discussions. She borrowed money to fund his substance misuse and at least one incidence of violence was linked to her inability to buy him the alcohol he was demanding. Her requests to borrow money from colleagues caused dismissal from a job and she also became involved in providing money for B1's son during the time B1 was in prison. Although much of this information was not known to professional agencies there were opportunities to be curious and on at least one occasion Michaela confided in a children's social worker. Better engagement with family and friends would also have brought this issue to light.

10.23 When concern about risk of serious violence is high it may be easy to miss the possibility that financial abuse may contribute to risk. This is an area for further development across all agencies.

The issue of financial abuse is discussed in Finding Five.

Coercive Control

10.24 There is no doubt that Michaela was subjected to threatening and humiliating behaviour that resulted in her modifying her life and routine to avoid physical and verbal abuse. This was purposeful and relentless. Its impact was devastating for Michaela who lost her children, her jobs, very nearly her home, her financial independence and eventually her life. However, the depth of the psychological influence and duress B1 held over Michaela was never really named, analysed, and addressed.

10.25 The evidence from this review confirms that there is not enough knowledge within the system to critically review domestic abuse behaviours from a biological,

psychological, and sociological perspective to identify the underlying motivations of harmful behaviours, particularly where a dynamic of coercive control exists.

10.26 Whilst the system seeks to manage domestic abuse behaviours through punishment and deterrence, it does not draw on overwhelming and unequivocal research that associates aggression and coercive control with trauma. Therefore, the whole system needs a 'sea change' towards more trauma-responsive approaches - which means that interventions need to be trauma-reducing, not trauma inducing.

The issue of coercive control is discussed in Finding Six

Working in situations where the statutory system can no longer keep an adult safe.

10.27 Although there were ways in which individuals and agencies could have worked differently with Michaela and B1, ultimately the situation became 'stuck' with professionals really worried about her but unclear as to what to do next. This was compounded by Michaela being over 18, having mental capacity and being able to provide informed consent. However, nobody was able to establish if coercive control, duress, or undue influence from B1 impeded Michaela's ability to protect herself and make informed decisions. At the point when MARAC reaches a position whereby the system feels unable to protect a victim such as Michaela (and can prove it), there needs to be a route of escalation, nationally. The review has identified that the use of Inherent Jurisdiction may be of help in such cases.

This is explored further in Finding Seven

Risk management and high-risk offenders

10.28 It is not sufficient to focus only on risk assessment and safety planning with victims of domestic abuse as this gives a message that they are somehow responsible for their own safety. There must be an equal emphasis on accurate assessment of the risk posed by offenders and effective services and support in place to reduce offending behaviour. Aside from criminal justice sanctions imposed by the police, there was no consideration of behaviour modification programmes or domestic abuse intervention programmes until about halfway through the review period in May 2020. Evidence from other recently published reviews and inspections into the probation service have evidenced the need for systemic issues to be addressed nationally[6].

10.29 B1 had a long history of offending which did not adequately inform the pre-sentence report which resulted in B1 being released from custody just before he murdered Michaela. This report was not carried out by a suitably qualified probation officer, and they did not receive sufficient supervision and management oversight. As a result, B1 was wrongly assessed as medium risk and a non-custodial sentence given. There was then inadequate consideration given to his accommodation arrangements, Michaela's

views, and potential risk to her. These are issues addressed within national reviews of probation practice.[7]

10.30 Alongside the inadequacy of formal risk assessments within probation there is also a general issue of how well the system recognises and responds to coercive and controlling behaviour. There is evidence that this was a subtle feature of B1's behaviour, yet it was not named or addressed in any of the agency records. Although this behaviour is not new, it is a relatively new criminal offence (since 2015). This review raises concerns as to whether the system is ready to recognise and respond. A culture based on identification of "incidents" appeared to influence the professional response to Michaela, which was unlikely to pick up duress or other subtle tactics often linked to coercive and controlling behaviour, such as financial abuse. This was an aspect of Michaela's life that was not well understood.

The issue of identifying and responding to high-risk offender behaviour is explored in Finding Eight

Reporting crimes from outside the UK – the role of Crimestoppers

10.31 This case has identified a loophole in reporting an emergency when the caller is based outside of the UK. This places victims at greater risk of significant harm in a crisis.

10.32 The original call to the police at the time of Michaela's murder came from a friend outside the UK. Michaela had called the friend in a state of distress. As she was unable to call 999 from abroad the friend resourcefully called Crimestoppers but the charity's focus on anonymity meant that in this case, assumptions were made about the origins of the emergency call. These assumptions had a direct effect on the action (or inaction) of the police when they responded later that evening.

This issue is further explored in Finding Nine

Police response to critical incidents

10.33 When the police were alerted that Michaela could be being harmed by B1 they did not enter the house. This was investigated by the IOPC who found that police powers of entry (when there is a potential risk to life) were not used appropriately and officers should have made further enquires at the time to satisfy themselves that Michaela was safe. Not immediately entering the property delayed finding Michaela and apprehending B1.

10.34 Warning markers (for MARAC[8], weapons and DASSPx2[9]) on the police system for Michaela and B1 did not appear to sway the decision in preference of forcing entry

[7] https://www.justiceinspectorates.gov.uk/hmiprobation/inspections/domestic-abuse-2023/

[8] Multi Agency Risk Assessment Conference (MARAC) warning markers show that a victim has been the subject of a MARAC within the last 12 months, meaning that they are at high risk of significant and imminent harm.

[9] Domestic Abuse Serial and Serious Perpetrator (DASSP) warning markers were placed on the county's most prolific domestic abuse perpetrators. In this case both B1 and Michaela had a DASSP marker.

on the evening of the critical incident. This raises the issue of the purpose of warning markers if they do not influence the analysis of risk and decisions made. In relation to DASSP this may have been because the system was discontinued in approximately 2017, although at least one of the officers attending had been in an operational role before that time. Until a more recent change of recording system (from Unify to Niche) previous markers were still visible. [10]

10.35 The legislation governing police powers of entry is complex and open to individual interpretation which could place victims of domestic abuse at risk of significant injury or death. Appropriate practice in such situations is both a local and a national issue.

This issue is further explored in Finding Ten

A reactive system

10.36 A recurring theme throughout this review has been the tendency of the system to react to incidents rather than address the root causes of violence through early intervention and effective work with perpetrators. This is a national issue.

10.37 Alongside this there is a need to seize opportunities to work creatively with victims when perpetrators are in custody rather than wait until release and risks raise once more. For Michaela, services withdrew when B1 was in prison for over a year and later, the opportunity was not taken to find out what Michaela really wanted when B1 was released from custody in the weeks before her death.

This is explored further in Finding Eleven

Sections 10-13 of this report contain detailed descriptions of key episodes and events and include an evaluation of practice at each stage.

11 MICHAELA'S EMPLOYMENT AT JULIAN HOUSE

11.1 On 19th August 2018, Michaela applied for the position of criminal justice casework coordinator with Julian House. Julian House is a charity providing a range of support to vulnerable and at-risk people, mainly across the Southwest of England. The project that employed Michaela provides supported housing for offenders deemed to be at high-risk of reoffending. The job description identified the purpose of the post as *"providing high quality direct support and housing management to clients with experience of the criminal justice system and to and work with a multitude of agencies to deliver and develop the service working closely with Devon and Cornwall Integrated Offender Management".*

[10] These markers are no longer visible on the new Niche Police database.

11.2 Michaela's application disclosed one offence of breaching a restraining order and this was also subsequently noted on her Disclosure and Barring Service (DBS) check. When asked about this, Michaela attributed it to her relationship breakdown and issues concerning access to her children, which had been resolved. Julian House had some sympathy for her explanation of the circumstances surrounding the breach and were satisfied that this offence did not bar her from applying for the role (See para 11.9 below). There are differing views regarding the significance of the restraining order. The order was a court decision and Michaela's ex-partner believes it was warranted given her behaviour at the time. However, Michaela's parents have told the review that the breach of a condition reported on her DBS check is listed without context and in their view, the order had been an unnecessarily harsh sanction for the events that took place.

11.3 When Michaela applied for the role at Julian House, five people applied, and she was the second-choice candidate on the day. The contemporaneous notes of the interview are not available, but a retrospective analysis of the person specification against her application confirms that she did not fully meet all of the essential criteria for the post - although the organisation assessed that her interview and personal statement demonstrated potential to achieve the necessary knowledge, skills, and attributes with support. Michaela has been described to the review by her family as an intelligent, eloquent communicator and it is likely that she was able to present very well at interview.

11.4 A positive reference was received from a university lecturer who had known Michaela for three years during her university law course. Michaela also approached PACT in September 2018 to ask them to provide a reference for her and they explained that they would do so but would need to be honest. The resulting reference form completed by PACT described her as 'honest, communicative, and able to manage personal responsibility'. The reference from PACT was headed 'Confidential Reference' and all twelve questions allowed tick box answers. PACT made the statement 'I do not wish to comment' exclusively for one question. On two other questions they combined positive statements with 'I do not wish to comment' including declining to comment when directly asked about personal and professional matters, the areas of the job that she would find challenging, and whether they would re-employ her.

11.5 The PACT information for the DHR highlights the dilemmas faced by organisations who are concerned about being liable for loss of earnings if they give an inappropriately harsh reference. In this case, PACT's view was that there was no documented evidence of incidents involving Michaela to suggest she might pose a risk in her new role. This is why they chose not to comment on specific questions. The alternative would have been not to provide a reference at all, which may have been a preferable way forward and triggered Julian House to enquire further.

11.6 It was not uncommon for Julian House to receive a purely 'no comment' reference from previous employers. The two references received by Julian House provided

more information than most references they generally received at the time, and since. Consequently, they did not contact PACT for further information about why they did not wish-to comment on specific aspects of the reference request.

11.7 This tension between employers receiving sufficient information to make a reasoned judgement about a person's suitability for a job, and fears of employment claims for damages if a person feels an unfair reference has been given, is explored further in **Finding One** of this report.

11.8 Michaela's employment at Julian House as a casework coordinator was confirmed on 5th October 2018 and her contract started on 22nd October 2018. She was supported on a day-to-day basis by her line manager, service development manager, and direct colleagues. She and also received regular supervision and training on IT /internal processes, first aid and drug and alcohol awareness.

11.9 When the central HR department of Julian House received the full enhanced DBS certificate in November 2018, the service development manager was asked to discuss this with Michaela. On 30th November the service development manager confirmed via e-mail to the HR department that Michaela had been spoken to and that following consideration it had been decided that Michaela should remain in post as she was not considered to be a risk to vulnerable clients or to Julian House as an organisation. Her line manager was to monitor her behaviour.

The start of Michaela's relationship with B1 and her subsequent resignation

11.10 Michaela's diaries confirm that her first contact with B1 was around the end of December 2018, and she visited him in him in prison on 2nd January 2019.

11.11 On 13th February 2019, B1 was living in Bed & Breakfast accommodation after his release from prison. He had been accepted by Julian House for a service but before he could move into Julian House accommodation he was recalled to prison for breaching the "be of good behaviour" license condition. He was eventually released on 19th March 2019. When Michaela collected him from prison, he moved into accommodation at Julian House.

11.12 B1 was seen by his GP on the day of his release "with his support worker" (presumably Michaela) and there was a new diagnosis of chronic alcoholism. By 24th March 2019 B1 was seen in hospital with worsening mental health and hallucinations. The GP spoke to his "support worker" the next day and prescribed enough medication for two days. The GP agreed to see him again to discuss medication on 29th March.

11.13 Michaela's diary indicates that her relationship with B1 started around 1st April and on 4th April 2019, Michaela spent the night with B1 at his address which was accommodation managed by Julian House. She disclosed this breach of policy the next day to her line manager who asked her to call the service development manager.

Disciplinary processes were initiated. Michaela was not immediately suspended but she was prohibited from contacting B1 or entering his residence. On 7th April 2019, Julian House human resources team and the operations director confirmed that Michaela should be suspended on full pay pending investigation in relation to an allegation of gross misconduct.

11.14 On 11th April 2019, Michaela submitted her resignation to Julian House with immediate effect. On 12th April, Julian House completed a safeguarding alert in respect of B1, highlighting a concern that the relationship with Michaela could have *"a negative effect on his presentation".* There was no consideration of a safeguarding referral for Michaela as although they considered the risk to Michaela's children they did not deem Michaela to be a vulnerable adult or a potential victim of domestic abuse at this time.

11.15 Julian House notified B1's probation officer on 18th April that Michaela had resigned, B1 was regularly staying at her house in Cornwall and there were concerns that their relationship could have a negative impact on B1. The probation officer was also notified that Michaela had two children and this prompted a safeguarding referral from probation to Cornwall children's social care. Police records also noted that Michaela was now in a relationship with B1.

11.16 B1's new casework coordinator at Julian House received regular updates from probation regarding further offences committed by B1. There continued to be concerns about Michaela contacting Julian House staff and visiting the premises whilst she was prohibited from doing so. She was informed that if she continued, a POVA (Protection of Vulnerable Adults) referral would be made.

11.17 Julian House became aware of a recent assault by B1 in May 2019 (explored further below) and encouraged Michaela to engage with support for herself which included private health care confidential counselling sessions (x6) funded by Julian House.

11.18 By June 2019 there were further concerns that Michaela had contacted another Julian House client wanting to procure a smart phone to provide to B1 in prison.

11.19 In August 2019, Julian House was asked to provide a reference as Michaela had applied for a job with Cornwall Housing. Michaela contacted Julian House upset that the reference had not been supportive and made a formal complaint to their CEO. Michaela was informed that Julian House would continue to give full and honest references to all employers that made a request**,** which included sharing the breach of professional boundaries with the Disclosure and Barring Scheme. This referral was made on 19th November 2019. The information sent to the Disclosure and Barring Scheme stated that, "while professionally responsible for B1, Michaela and B1 initiated an intimate relationship potentially putting both adults and Michaela's children at risk".

Evaluation of practice -Michaela's employment at Julian House

Julian House did not have full sight of all of the available background information via the two references received. The issue of inadequate references and inappropriate background checks before starting employment was not confined to Julian House and indicates that this issue may not be indicative of an individual error by Julian House, but representative of a wider, and more concerning culture within employment practice nationwide.

Michaela did not fully meet all of the essential criteria for the post that she was employed for, which highlights the problem of finding sufficient high-quality candidates for the work. This is particularly concerning for employees expected to work with high-risk offenders. A more general analysis of this issue is set out in **Finding One.**

When Michaela's relationship with B1 was known to Julian House, consideration could have been given to a referral to the 'Person in a Position of Trust' process. Michaela was a 'Person in a Position of Trust' (PiPoT) and although there may have been some discretion as to whether the criteria for a referral had been met, it would be good practice to do so in these circumstances. The local authority would then be responsible for making the decision as to whether the Position of Trust procedures should be pursued. This may be an area where more awareness is needed within third sector organisations, within Cornwall and nationally.

Throughout this episode the safeguarding focus by Julian House was on risks to B1. However, his records were clear that he posed a risk to adults, was known to carry bladed weapons, suffered from chronic alcoholism and continuously breached bail conditions (all of which are considered high risk factors within abusive relationships). Safeguarding policies and procedures need to be clear that in situations such as this, there is a duty to consider the risk to all parties, including the staff member (whether they remain employed or not). Whilst it was positive that Julian House went above and beyond their responsibilities as an employer to fund private counselling through its employee benefits scheme, this did not address the risk that B1 could pose to Michaela and put the onus on her to protect herself. Julian House have reflected on why this happened and believe that they became caught up in Michaela's accusations that they had done her a disservice in the way that they had responded to requests for references after she had left their employment. From their perspective this is what Michaela wanted to talk about (rather than her own needs) and the relationship between Michaela and Julian House had broken down. This became the focus of their interactions with her, rather than proper consideration being given to any potential risks.

It was positive that probation referred to children's services but with the benefit of hindsight it can now be seen that Michaela was becoming increasingly isolated and that risks posed by B1 were not being addressed.

Julian House have introduced many changes/improvements since Michaela's death. These are outlined in Appendix One

12 RISK ASSESSMENT ENGAGEMENT AND SAFETY PLANNING

12.1 On 24th April 2019, probation had contacted children's social care to advise them that Michaela was in a relationship with B1. They outlined a history of his previous offences including an assault on his own son. This correctly prompted a child and family assessment, and it is positive that children's social care child were focused on keeping the children safe. This approach seems to have come from a position of concern due to B1's history with his own son and did not include consideration of his risk to Michaela.

12.2 Knowledge that B1 had a son in the care of Plymouth children's social care could have prompted further enquiries as to any risks posed by B1 including domestic abuse. It is now known that he had a domestic abuse history, involving seven historic police callouts, that did not result in a criminal conviction. This history was not known to agencies in Cornwall.

12.3 It was known that from 2015 he had a flag as a DASSP on police records (domestic abuse serial and serious perpetrator[11]) but this was apparently not integrated into the child and family assessment to inform a view about his risk to Michaela. Nor did it trigger involvement of domestic abuse services. Michaela also had a DASSP marker which was not noted. The limitations of DASSP markers is explored under Finding Four of this report.

12.4 The child and family assessment did prompt contact between the social worker and Michaela's previous partner and father of her youngest son who recalls being told that B1 was a habitual cocaine user and had been involved in assaults and knife crimes. He told children and family services that there was a child arrangement order in place and that he would like this reviewed by the court and for his son to live with him. He also called the police concerned about the welfare of Michaela's children and when the police saw Michaela she said that B1 did not live at the property. Michaela told officers she was well aware of B1's past and believed in giving people a second chance. The police officer submitted an amber ViST[12].

12.5 On 13th May 2019, B1 was served a final warning letter by probation for failing to attend two appointments. On one of these occasions' probation records note that B1

[11] This was a Devon and Cornwall police initiative that monitored the forces Domestic Abuse Serious and Serial Perpetrators.

[12] Vulnerability identification Screening Tool (ViST) form is submitted whenever a police officer identifies a person (adult or child) with care or support needs and / or is at risk of abuse or exploitation.

was seen drinking in a pub in Plymouth with Michaela on 10th May 2019 when he had claimed he was not in the city and could not attend his meeting.

The first incident of domestic abuse

12.6 On 20th May 2019, Michaela called 999 to say that B1 had hurt her by throwing a purse at her face and he had damaged her car. She told the police that she thought he was having a drug-induced psychotic episode. B1 was outside and could be heard telling Michaela that she was *"shit".* Michaela told the call taker that her 11-year-old son was asleep upstairs, and she had a friend with her (this was never verified). The police record noted that B1 was climbing through the window. He was heard saying, *"I don't love you; I don't like you; I don't want to be with you anymore".* Michaela replied, *"you can say what you want to me, but I have a duty of protection. It's not your fault, it will be OK I promise"*. Officers arrived and arrested B1 for assault and taking a vehicle without the owner's consent.

12.7 A DASH[13] was completed with Michaela and assessed as medium risk – in this she said she was frightened during the incident as he was holding a serrated bread knife throughout. No ViST[14] was completed which would have been expected practice as Michaela had disclosed that her 11-year son was asleep upstairs. A referral was sent to First Light Safer Futures[15].

12.8 Michaela refused to engage any further with the police. B1 was assessed by the Criminal Justice Liaison and Diversion Service (CJLDS) as having no evidence of a mental disorder and the usual criminal justice procedures could continue. CJLDS informed B1's GP of the domestic abuse episode and that his current risk to others was medium. The GP practice have acknowledged that although B1 had not been convicted they could have coded this within the records.

12.9 B1 refused to be interviewed in custody and was released on police bail with conditions not to contact Michaela directly or indirectly and not to attend her home address. Following further enquiries the police considered an evidence-led prosecution, but the decision was that there was insufficient evidence in this case to proceed without the support of Michaela.

12.10 As a result of this assault, children's social care started to make plans for Michaela's children to be cared for by paternal grandparents on a short-term basis. This changed when Michaela told her social worker on 21st May that she would have nothing more to do with B1 and it was then confirmed by probation that he would be recalled to prison as a result of this assault.

12.11 Probation records note a request for a recall on 20th May 2019. B1 was arrested and bailed on the 21st May 2019 and recalled again on the 22nd May 2019. He was

[13] Domestic Abuse Stalking and Harassment (DASH) Risk Assessment

[14] Vulnerability identification Screening Tool (ViST) is submitted whenever a police officer identifies a person (adult or child) with care or support needs and / or is at risk of abuse or exploitation.

[15] First Light Safer Futures is a specialist domestic abuse service for victims.

detained at Exeter prison on 23rd May 2019. This recall was because B1 had been released from prison on license for a previous offence and had broken the terms of this license. (This expired 14-months later on 13th July 2020 when he was once more released).

12.12 First Light Safer Futures had sent an introductory letter to Michaela on 21st May. She did not respond and would probably have received this around the time B1 was recalled to Prison.

Evaluation of Practice – the first domestic abuse incident

This was a significant episode as it was the first opportunity to formally assess the risk that B1 posed to Michaela. Until this point, agencies in Cornwall knew that B1 was a prolific offender but had not understood the degree to which his behaviours included incidents of domestic abuse. This information was well known to a neighbouring children's social care via police records (121A's) of a child coming to their notice following incidents including domestic abuse. These are available on the neighbouring children's social care files and were not readily visible unless they were specifically search for on the general police system. Probation protocol is that police are asked for information about offences two years previously and although there were probation (OASys) assessments which would have contained this information about domestic abuse and attendance at ICAD, these assessments are not routinely interrogated when assessing later offences.

Although the DASSP system had previously provided a means of identifying and managing domestic abuse perpetrators, this system had been discontinued in 2017, although the marker remained on records. This could have informed decisions about B1's risk to Michaela, and similarly Michaela's risk to B1, as she also had DASSP status.

During the 999 call Michaela could be heard saying, *"I have a duty of protection···it's not your fault, it will be okay I promise".* These words can be interpreted in different ways i.e., Michaela believed she had a duty to protect her child who was upstairs at the time, or she believed she had a duty to protect B1. Given that Michaela's family believe Michaela's caring nature made her more vulnerable to B1, there is a possibility Michaela had fallen into a belief system that needed to be sensitively challenged. Michaela may have taken on the responsibility of 'rescuing' or 'saving' B1 - a naïve undertaking and role she was inadequately prepared for – or, she may have succumbed to a tactic often used as part of a cycle of psychological abuse. For example, many perpetrators remorsefully plead after periods of aggression for the victim to stay with them, help them and work with them to overcome their behaviour. They blame external factors or portray a 'good side' and a 'bad side' persuading their victims that separate versions of the same person exist, but that healing will only occur if they stay with them. Some perpetrators take this a step further by explicitly stating the consequences if they don't support them (e.g., suicide or self-harm). It is vital in these cases, when these

sorts of statements are recorded in notes, that professionals seriously consider the severity of psychological abuse. Rather than view Michaela's beliefs as evidence of her unwavering support for B1, professionals should have been concerned by her belief system and the potential effectiveness and entrenchment of psychological abuse.

The chairs of this review have questioned whether the DASH risk assessment should have been graded high risk rather than medium risk as Michaela acknowledged that she was afraid, and that B1 had been holding a serrated knife throughout the ordeal – both of which are high risk factors. A knife in a public place is a criminal offence whereas there is no similar offence in a home environment which seems to have contributed a higher level of acceptance of a weapon being used to incite fear within this domestic abuse context. It is unlikely that the same behaviour would be classed as medium risk if the same scenario was transplanted into a different environmental context (i.e., being held by B1 in a public place or whilst arguing with a member of the public, or with a police officer). This is relevant because a high-risk grading would have resulted in an early opportunity to consider Michaela's situation at a MARAC meeting.

The police view remains that since the reports only said that B1 was 'holding the knife', not threatening Michaela with a knife, there was no information to suggest that he made any threats to harm Michaela with it. The chairs of this review believe that there is important learning here as:

A) B1 had a previous conviction for carrying a bladed weapon in public. He had not used it, but it was found in his possession. The law states[16] a weapon carried on a person, even if concealed from sight, or not intended to be used, could be produced in a moment of irritation or anger (therefore making it an offence, and not a reasonable excuse (R v Povey and Others [2008] EWCA Crim 1261). B1's previous conviction shows that probation acted swiftly and proactively, recalling him to prison for the offence. The police argue that the above incident was different because B1 and Michaela were in the kitchen at the time, thus making it reasonable for him to be using a knife. However –

B) Michaela and B1 were arguing at the time and Michaela told professionals she was frightened during the incident. Victim perception is a high-risk factor on the DASH risk assessment.

C) The police stated that if threats had been made, the risk status might have been high. The reviewers challenge this position (i.e., threats needing to accompany a weapon in the face of a victim's perceived fear) and would support further work to clarify expectations in this area of risk assessment and management.

[16] https://www.cps.gov.uk/legal-guidance/offensive-weapons-knives-bladed-and-pointed-articles

The lack of a notification from the police to children's social care (via a ViST) was an oversight, but child and family services did hear of the incident via other channels and were able to take it into account in their work with Michaela's children.

Although there was no comprehensive multi-agency safety plan, there was an opportunity for support to be provided to Michaela via the referral to First Light, however, as a medium risk referral, this required Michaela's consent.
It is positive that an evidence led prosecution was considered even though the decision on this occasion was that there was insufficient evidence.

From this point forward the challenge was how to take a whole family approach which was domestic abuse informed. The development of this approach is considered further in Finding Two of this report.

B1's time in prison May 2019 – July 2020

12.13 On 24th May 2019, Michaela was seen by the GP for a depression interim review.

12.14 On 5th June 2019, a Spousal Assault Risk assessment (SARA) was completed by the prison probation officer and B1 was assessed as medium risk of further violence against his partner. The OASys assessment[17] assessed low risk of serious harm to Michaela in the context of domestic abuse. This was later identified as a mistake and readjusted to medium risk.

12.15 The First Light helpline attempted to make telephone contact with Michaela on two occasions on 14th June and followed these calls up with a text message the same day. There was no response, and the case was closed the same day. Michaela's GP practice were aware of concerns and discussed Michaela at the regular practice safeguarding meeting.

12.16 Whilst B1 was in prison the child and family assessment continued. It was clear from a conversation with the children that they were worried about their situation and concerned that they were relying on money from grandparents for food. They also told the social worker that they would keep a secret about their mother's relationship with B1 if she asked them to. Michaela confirmed to the social worker that she was still in a relationship with B1 and there was e-mail correspondence between probation and Julian House regarding Michaela's efforts to obtain accommodation for B1 on his release. On receipt of intelligence from Julian House, probation also contacted the prison to alert them to concerns about Michaela attempting to provide B1 with a mobile phone whilst he was in custody.

[17] Prison and probation services use a tool called the Offender Assessment System. This is often called OASys. Staff use OASys to complete a risk and needs assessment.

12.17 On 3rd September 2019, a Section 7 report[18] was completed by the children's social worker in relation to child arrangements for Michaela's youngest child. This recommended that Michela's youngest child should move to live with his father; and have contact with Michaela. This was subsequently agreed by the court and her youngest child moved in with his father in March 2020. A prohibited steps order was put in place to prohibit Michaela's youngest child from having any contact with B1. Her oldest child remained living with her as he had no contact with his own father. The case was then closed to children's social care as B1 was in prison and risks were assessed as being reduced. A further referral was requested from probation should the relationship resume on B1's release from prison.

12.18 Michaela continued to visit B1 in prison, but Cornwall children's social care were not aware that Michaela was visiting B1. Had this been known, it is likely that the case in respect of Michaela's oldest child would have been reopened.

12.19 Michaela's parents remained very concerned about her continued contact with B1 including sending him money. They were also very worried about her involvement with B1's son and believed that B1 had manipulated Michaela into building a relationship with his son who was in the care of a neighbouring local authority. They knew that Michaela had purchased a telephone, computer games and possibly sent him money and this contact is confirmed by records held in Plymouth. This prompted e-mail correspondence between Michaela's parents and B1's son's social worker, who informed them that he shared their concerns about Michaela's obsessive behaviour and contact with B1's son. He reassured them that he would be speaking to Michaela.

12.20 Around this time Michaela secured employment at a doctor's surgery as a receptionist. The surgery has confirmed that two references had been received. These were from a Cornwall staff agency dated 17th November 2019, which confirmed she had worked as a temporary worker from 1st November 2019. The second reference was from a retail store dated 29th October 2019 which confirmed that she had worked for them for 6 weeks from 1st September 2019. The surgery has told the review that although these references met the minimum requirements for two references at the time, they would now find these to be inadequate and would request an earlier and more long-term reference. At the time Michaela was employed by the surgery, DBS checks were not obtained for non-clinical staff although this does happen now. Consequently, Michaela's previous restraining order was not known or able to be discussed with her. It is not known if the report made to The Disclosure and Barring Service by Julian House (reporting a breach of professional boundaries) has been added to Michaela's DBS, but if it has, this would also have been missed.

12.21 On 24th June 2020 children's social care received a referral from both maternal grandparents and probation regarding B1's imminent release from prison on 13th July

[18] Section 7 reports (often referred to as a Welfare report) relate to private law proceedings when the Court is wanting information about a child's welfare, that is to say, what course of action will be best for the child in question.

2020 after completing his sentence. Michaela intended to resume their relationship. A child and family assessment started. At this point B1 was not subject to probation.

Evaluation of Practice- B1's time in prison May 2019 -July 2020

From the perspective of Michaela's family, during the time that B1 was in prison Michaela was much more like her "old self". She visited her parents and appeared happier. It is also indicative of a more positive outlook that Michaela managed to secure employment at a doctor's surgery, albeit in a way that would not now be considered to have involved a satisfactory process for obtaining references. The issue of employment references is explored further in **Finding One.**

The Spousal Assault Risk assessment (SARA) medium risk status and the adjustment of the risk status via the prison OASys assessment is significant for two reasons:
1) Assuming the assessor was presented with the same information about the breadknife incident as the police, the initial SARA risk assessment (and the revised OASys) does not adequately consider the victims perspective or B1's previous use of weapons.
2) It highlights that risk assessments are subjective and different conclusions can be reached from the same information even when using accredited risk assessment tools. The issue of risk assessment tools is further explored in Finding Four.

First Light Safer Futures were not successful at engaging with Michaela immediately following the incident that led to B1 being recalled to prison. The follow up phone calls were made 16 working days after the initial referral and only one attempt was made prior to closure. By this time the crisis had passed, which could have influenced Michaela's perception of danger, as she was no longer afraid of B1 and the opportunity to use the crisis had passed.

Rather than use the periods of time B1 was in custody to work together resourcefully and collaboratively to establish who was best placed to engage with Michaela, her refusal to 'engage' with First Light or a criminal prosecution was viewed as a barrier to all forms of support. An opportunity to communicate with Michaela, or at least try to understand her reasoning for not wanting professional input, was not proactively explored. Instead, professionals were reassured by B1's recall to prison.

B1 was in prison for over a year, and it was known that Michaela was continuing to visit, even trying to illegally smuggle a mobile phone into him to continue their relationship. This signals a growing psychological dependence and a boundary that had been crossed, whereby Michaela was determined to continue the relationship, even risking her own freedom. There was also knowledge that Michaela was in regular contact with B1's son who was in the care of another authority. At this time there is no evidence that children's social care in Cornwall were aware of this contact or the extensive information about B1 known by another local authority in the southwest region.

Once again, during this period, Michaela and B1 were left to intensify their relationship, and the system permitted letters, calls, and visits between them. There was no consideration that coercive control may have been at the root of Michaela's behaviour and the prison system appears to be somewhat powerless to prevent this from continuing via ongoing contact even though coercive control is now a criminal offence. In this instance, despite being incarcerated, it now seems possible that B1 was able to use his power and influence to persuade Michaela to break the law. This is explored further in **Finding Six.** It remains a source of frustration for family and friends who saw this time as an opportunity for professionals to intensify their support for Michaela, thereby weakening the power and allure B1 had over her.

Whilst B1 was in prison, there were no attempts to use the time to address his offending behaviours through therapy or alternative interventions. This could have been a good opportunity to introduce intensive support for him as a domestic abuse perpetrator and to work on the issues in B1's life that triggered his addictions and emotional rages. This was not considered for B1 for two reasons –

1) Building Better Relationships was not running due to COVID-19
2) Because his index offence leading to his prison sentence was not domestic abuse related he did not receive a specific domestic abuse conviction. Subsequently, he did not meet the criteria for the Building Better Relationships programme in prison.

It should be noted that the Building Better Relationships Programme is not the only rehabilitation intervention for perpetrators of domestic abuse. Change4U is a programme that operated throughout Covid-19 and B1 may have been benefited from a designated Change4U worker. Even though Change4U does not operate in prisons, there may have been an opportunity to meet with B1 prior to release to start the process of discussing a referral.

In relation to children's social care, it is reasonable to argue that the case should have been kept open and a multiagency child in need plan developed. This would have meant that the time that B1 was in prison could have been used to confirm that the relationship was not continuing and understand Michaela's perspective when B1 was not in the home. A plan focusing on the future would have been preferable to a more incident-led approach when concerns were only addressed at a point of heightened emotion. The issue of how best to enable a whole family multi agency approach to domestic abuse is an important one in situations where the threshold for MARAC has not been reached. This is explored later in this report.

B1's release from prison

12.22 On 3rd July 2020 the children's social worker visited Michaela and her oldest child at home to discuss plans for B1's planned release from prison. Michaela reported that she would collect him from prison and stay in Plymouth for the night. She said she would like B1 to live with her but understood that he needed his own flat as there was a prohibited steps order in place to prevent her youngest child having contact with him. She told the social worker that she wanted a normal peaceful relationship with B1 "without the interference of her family". She believed that her parents thought she had mental health issues.

12.23 On 7th July 2020, Michaela advised the children's social worker that she would allow her oldest child to stay at her parents' house for two weeks when B1 was released from prison. This would enable B1 to stay with her whilst waiting for his own accommodation. Michaela's parents were very worried about his release and Michaela informed the social worker that they had previously told her that they would seek a court order to have her oldest child live with them if B1 was in Michaela's home.

12.24 On 9th July 2020, the pre-release information was shared by the prison with the offender manager. This described his release address as Michaela's accommodation. B1 was released on 13th July with no ongoing supervision from probation as his non-statutory end of licence release did not require mandatory probation input. Subsequently, information that he was living with Michaela was not shared with any other agency. B1 was open to the Integrated Offender Manager (IOM) scheme on a flexible basis when he wanted additional support.[19]. In this case, there was evidence of some coordination between the Plymouth and Cornwall Integrated Offended Management Unit to determine where B1 could collect prescriptions, etc. The first unannounced IOM visit did not take place until a month after B1's release from prison but it should be noted that there was no statutory obligation to engage with B1 after his release, and any work with him was above and beyond a statutory requirement to do so.

12.25 On 16th July 2020, the children's social worker visited Michaela and B1 at home in Cornwall and they confirmed their intention was to live together. B1 and Michaela admitted that on the day of B1's release from prison he had drank almost a bottle of Jack Daniels in the hotel room. During the same evening B1 met a friend and used crack cocaine. This information is confirmed by the Harbour Drug and Alcohol services in Plymouth. B1 had failed a drugs test for heroin and confirmed consuming a 70cl bottle of Jack Daniels. He was given a seven-day prescription as he informed staff that he would be with Michaela for a week (although she was described as being *'at pains'* to say he would not be staying with her in the longer term). It was suspected that this was untrue and only being said because of the involvement of child and family services.

[19] An IOM is a Police Officer whose role it is to facilitate a cross agency response to crime for the most persistent and problematic offenders - https://www.gov.uk/guidance/integrated-offender-management-iom

Evaluation of Practice – B1's release from prison

There appear to be several key issues at this stage:

1. There was ineffective multi -agency planning across probation and children's services at the point of release. There was a vulnerable child living within a household where a known violent offender was going to live. At the very least this should have been communicated to children's services.
2. B1 did not fulfil the criteria for ongoing probation input as he had completed his sentence as was not on license. This is unsatisfactory and there is a move within probation to challenge this approach and consider risks when planning for release whether or not there are license conditions.
3. It seems that B1's situation and risks to Michaela were not being looked at from a housing perspective. There is a 56-day window before release from prison when a referral should have been made to the local authority known as the 'Duty to Refer' and would have triggered the local authority and probation to work together, make appropriate referrals to supported housing and make a plan that avoided a No Fixed Abode release. This is important as Michaela had said that she wanted B1 to have his own place so that her children could visit. Also, as a persistent and problematic offender who had been referred to an Integrated Offender Manager, B1 could have been in priority need. By the first visit from the Integrated Offender Manager, he was already living with Michaela.
4. During B1's time in prison and on release the theme continues of how best to respond to the concerns of Michaela's parents. What appears to have happened is that there was increasing polarisation between Michaela and her extended family which only served to isolate her more. As this is a tactic often orchestrated by domestic abuse offenders to create a 'them and us' dependency, it would have been good practice for child and family services to have explored this dynamic within their assessments at the point of B1's release.
5. Panel members have highlighted that Michaela's voice is clear as she told the social worker that she wished to proceed with the relationship without her parents' 'interference'. This raises another important observation – Michaela also voiced her wish to live without interference from the police, social workers, an Independent Domestic Violence Advocate (IDVA) and other agencies, yet, due to her risk status professionals continued to discuss safety plans and risk management strategies without consent because they had a responsibility to prevent future harm to Michaela. When professionals raised concerns about Michaela's mental health, it was not viewed as coming from a place of bad intentions. Yet, when Michaela told professionals her family held the same views, her interpretations of this being wrong were immediately accepted and respected without any prompting or enquiry. Furthermore, judgements about their 'interference' were viewed adversely, which carried through records without context. This is not an issue isolated to this DHR. There are a number of reasons why different standards are

assigned to families, and GDPR interpretations are one major cause (particularly when their loved ones are adults with capacity). However, GDPR is clear that safeguarding overrides consent if someone is at risk of serious harm. It does not mention the issue of including or excluding relevant and proportionate communication with families and in the absence of specific guidance, consideration needs to be given to the possibility of a biased professional culture that excludes families – even though families can help to mitigate risk of harm to their loved one. This is further explored in **Finding Two.**

6. There does not appear to have been sufficient consideration of the risk of B1's drug and alcohol use on his relationship with Michaela. Although the Plymouth drug and alcohol service were aware of his propensity to use heroin, crack cocaine, and drink spirits, they did not explore whether this was a trigger for violence or psychosis, and how the couple might manage this potential risk given their previous experiences. Nor did any agency consider how his addiction would be funded and the potential for financial abuse**.** Domestic abuse enquiry should be routine practice in these situations, which could have been achieved by speaking to Michaela discreetly or enquiring if B1's substance misuse caused conflict in the relationship. Instead, the drug and alcohol service seemed to be more concerned with whether Michaela was trying to manipulate professionals. It is concerning that her vulnerability as a victim of domestic abuse was not considered.

Escalating concerns after B1's release from prison August- September 2020

12.26 On 18th August 2020 Michaela told the children's social worker that her employment at the doctor's surgery had been terminated due to concerns about her behaviour within earshot of patients, including taking calls from B1 and asking a colleague for money. Her manager was worried about her lifestyle and thought the money was to buy alcohol for her partner. Information sharing protocols meant that the social worker did not discuss this information with the GP practice concerned, although they could have considered referring to the Local Authority Designated Officer. This did not happen. The GP Practice have told this review that they had no knowledge or evidence at this time that would have prompted them to refer to the local authority designated officer as although Michaela's behaviour was felt to be inappropriate for the workplace it would not have triggered such a referral.

12.27 On 20th August 2020 B1 was referred to the We Are With You (WAWY) drug and alcohol service in Cornwall from Harbour drug and alcohol service in Plymouth.

12.28 B1 was visited by the Integrated Offender Manager (IOM) on 24th August 2020. The police officers who visited noticed that Michaela had a bruised left eye which she said was a result of an accident. With little other option open to them, officers submitted a ViST (rated amber) for her as they noted that there had been a history of domestic

abuse, and it was *'known that Michaela will lie for him'.* They noted that they believed that B1 had been drinking heavily and that he was still using controlled drugs on top of his prescription. They also noted that Michaela's oldest child was still in bed at 1300 in the afternoon. As well as submitting a ViST the police officers contacted the family's social worker directly to express their concerns. The ViST was shared on the CARA[20] for the information of partner agencies.

12.29 As a result of information from the police the children's social worker spoke to Michaela on the phone. Michaela explained her bruised eye as being an accident during "bedroom activities".

12.30 On 25th August 2020, the WAWY keyworker was informed that a member of the Integrated Offender Manager team had visited B1 yesterday and he was drinking heavily as well as using illicit substances on top of his prescription. The officer was also concerned as Michaela had a "black eye" and she had a child in the house. B1 was seen by the WAWY keyworker on 28th August with Michaela. His medication was discussed as was cutting ties with his peer group in Plymouth. There is no evidence that there was any enquiry regarding domestic abuse nor any proactive action by the WAWY practitioner regarding the safety of Michaela.

12.31 A child protection strategy meeting was held on 1st September 2020. This agreed that the threshold for s47 enquiries had been met and that this should be a single agency investigation by children's social care.

12.32 On 2nd September 2020, police received a call from a neighbour reporting an ongoing domestic dispute in Michaela and B1's accommodation. There was screaming and shouting, and the children were crying. Police officers attended and found Michaela, B1, and an adult friend of theirs in the property. They were informed by all three that no domestic incident was ongoing but in fact the friend had been having a heated argument on the phone with someone else. Their friend was staying with them for support as a result of a court case the following day.[21]As all three adults gave the same account the police log was closed with no further police action. There was no update as to whether or not there were children present and no ViSTs were completed. If the children were not present, force policy states that a ViST is not required. If they were present, it was a significant oversight as the children were currently the subject of a child protection investigation.

12.33 The next day, on 3rd September 2020 an intelligence entry was appended to the police records stating that Michaela and B1 had attended the local Crown Court to hear a case with their friend who had been staying with them. It was noted that MH had *two* black eyes that seemed to be fading. (The previous injury had been described as one black eye and it is unclear whether these were the same injuries).

[20] The CARA is an automated download of all red, amber and 3 green in 3 months (escalating concern) ViSTs for a particular area.

[21] It should be noted that at B1's trial, Michaela's friend said that during this incident B1 was assaulting Michaela.

12.34 On 9th September 2020, B1 had his first mental health review with the GP having recently registered with the same practice as Michaela. It was documented that B1 was struggling with his mental health and requesting medications and a referral to a community mental health team. He reported he was 'under a psychiatrist' prior to going to prison and his previous GP notes, especially medication history, were requested urgently. The GP did not refer for a secondary mental health assessment as it was not felt to be clinically indicated at that time.

12.35 B1 saw his WAWY keyworker on 14th September and said he was "in a good place, pleased to be in Cornwall with the opportunity to build a new life with his partner".

12.36 On 18th September there was a telephone conversation between the children's social worker and Michaela. Michaela reported there had been a number of verbal altercations between her and B1 who was reported to be clean of drugs but was now drinking three bottles of wine throughout the day. She disclosed there had been a verbal argument on the previous Wednesday which resulted in her assaulting B1 and him retaliating to protect himself. Michaela had a bruised eye which her oldest child had seen.

12.37 On 22nd September 2020, the children's social worker was advised of a conversation between Michaela and Michaela's father who said that during a phone call Michaela had told him that she had slit her wrists but had called very soon after to say this was a lie. Whilst the children's social worker was speaking to Michaela's father, Michaela and B1 called a further nine times, being abusive, shouting and screaming. This resulted in the police being asked to carry out a welfare check. There is a different emphasis in the police chronology (see below) which refers to an assault.

12.38 When speaking to the police the children's social worker also passed information about the assault on 18th September. A crime was recorded of assault (actual bodily harm -ABH), but neither Michaela nor B1 knew of police involvement at that stage. Whilst the crime was in the early stages of decision making as to how best to proceed, the police were called by an anonymous neighbour to explain that they could hear a domestic argument ongoing and named the male as B1. They said that there were regular domestic incidents at the address. Police officers visited the address and arrested B1 on suspicion of assault (ABH). Police records note that Michaela declined to engage with them in any way and refused to provide a statement, allow her injuries to be photographed or complete a DASH risk assessment. They noted that she had significant swelling and bruising to her right eye and a fresh injury to her wrist. Police completed a medium-risk-refused DASH[22] for her and an Amber ViST for the eldest child who was present at the time. An Operation Encompass[23] call was made to the child's school.

[22] This is a DASH risk assessment rating allocated by an officer without the victim offering any answers.

[23] An alert system between police and education. Operation encompass will contact the key adult in the school the next school day following a domestic incident where police are called, and children are present or live in the house.

12.39 The crime was investigated, and B1 was interviewed under caution during which he adamantly denied assaulting MH or causing any criminal damage inside the property (there were signs of some disturbance including a broken picture frame). The investigation was assessed by a Police Evidence Review Officer who considered an evidence-led prosecution but found in this instance that the evidential test was not met. They directed that the crime be filed with no further action being taken.

12.40 A child protection conference on 23rd September 2020 made both children subject to child protection planning.

Evaluation of Practice - Escalating concerns after B1's release from prison August- September 2020

Almost immediately after release from prison there were concerns about B1's substance misuse and injuries to Michaela and these correctly prompted child protection enquiries. It would have been very important for child and family services to be aware of all incidents that may have an impact on the safety and wellbeing of any child in the home, but it does not seem that relevant information was always being shared. B1's GP practice has confirmed that they had not been informed that he was registered to a household where a child was subject of s47 enquiries, and the GP practice system notes that he was registered as living at a Plymouth address by himself until he officially left the practice in September 2020.

Child protection enquiries and the subsequent conference and plan were an opportunity to bring together the whole network around the child and take a whole family approach including considering risks associated with Michaela becoming isolated from her wider family network. A family group conference at this stage would have provided an ideal opportunity to engage positively with the wider family network.

In this case, the evidence also suggests that child protection processes could have been used more effectively to take a domestic abuse/trauma informed approach and also focus on prevention through direct work with B1. There was also an opportunity to understand the reasons why Michaela was so adamant about not speaking to professional organisations. The situation in Cornwall has developed since this time and nine new specialist domestic abuse positions in the Family Assessment Service (FAS) will bridge this gap between social workers, the family/victim and specialist domestic abuse services. This service is being independently evaluated and it will be important that it is linked into the MARAC to ensure information known to children's services is consistently shared with MARAC agencies.

The incident leading to Michaela being unable to state how she sustained bruised eyes could be understood as an attempt to minimise her abuse rather than 'lie for B1' as recorded in the police records. This is an important distinction as

minimisation is a coping strategy often observed in domestic abuse survivors. It may be a way of distancing themselves from the attack, convincing themselves that they are loved by their partner, are deserving or culpable for the abuse, or as a consequence of their partner also minimising the assault. Minimisation can be a survival strategy and a way of communicating to professionals that the time is not right to leave, or that intervention will make matters worse. It can also increase the risk if a person does not recognise the danger they are in. It is important that professionals know the difference in order to ensure that responses take account of dynamics of domestic abuse and avoid placing the responsibility for safety on the victim.

Given the history and visible injuries it is hard to understand why the DASH was rated medium rather than high-risk. A high-risk rating would have meant a referral to MARAC and an opportunity to consider a safety plan for Michaela at an earlier stage. Since Michaela's death, practice has developed and practitioners should be clear that MARAC accepts situations where there have been three incidents in the previous 12 months, even if the rating is medium. Even so, the medium rating on this DASH meant that important information about Michaela's minimisation, together with the demise in her mental health (i.e., self-harm attempts) were not shared with health agencies. This would have been an extremely distressing act for Michaela's child to witness and demonstrated a worrying level of escalation, whereby Michaela and B1 were unable to recognise the impact of their behaviour on the child. Self-harm has been recognised as a 'red flag' within domestic abuse relationships with victims three times more likely to consider suicide due to feelings of despair[24]. As such, consent to share this information should have been overridden, and this would have been possible with a high-risk MARAC referral.

Michaela's concerns for her own safety – October 2020

12.41 There continued to be evidence that B1 was using illegal drugs as he disclosed to his substance misuse keyworker he had been to Plymouth, stayed overnight, and smoked £20 worth of heroin. This use of illegal drugs was at the root of an assault on Michaela which had occurred after Michaela had found that B1 had brought heroin back to the house and had been smoking it in the property. B1 had been asleep but when he woke, he could not find his heroin and proceeded to punch Michaela to the head multiple times in what was described as a sustained attack. Michaela had asked her oldest child to call the police, but the child hadn't because of a fear it would make things worse. On 12th October 2020, Michaela told the children's social worker about the assault but said she did not want the Police to be informed and did not consent to her details being shared with the IDVA service. Michaela told the social worker that

[24] https://www.birmingham.ac.uk/news/2023/research-identifies-suicide-risk-factors-for-domestic-abuse-survivors

B1 was getting out of control, but she did not know what to do. She said that she had considered ending the relationship and was going to consider this option further.

12.42 Even though Michaela had not wanted police involvement the social worker correctly overrode this due to safeguarding concerns and spoke to the police who considered carefully if an approach to Michaela should be made, given that she did not know that the police were aware of the incident. A decision was made that the crime would be allocated to an officer and attempts would be made to speak with her. A number of telephone calls to her went unanswered and no message was left as it was not clear to the police if the phone number they had for her was considered a safe one.

12.43 The social worker also updated the substance misuse worker. B1 was seen by his WAWY keyworker on 16th October 2020 who discussed B1's use of heroin. The notes record that he was defensive when challenged but did agree to a referral for residential detox.

12.44 On 15th October 2020, Michaela phoned the children's social worker. There had been tensions within the home relating to B1 and her children. During the conversation the social worker suggested plans for Michaela's child to spend the night elsewhere. Michaela was very distressed and screamed that she was the one 'going to be in danger now'. This was the first time that the social worker had heard Michaela articulate concerns for her own safety, and she called the police. The police records explain that the police control room spent some time establishing the best way to proceed with this call as they feared that an unannounced visit might exacerbate the situation for Michaela. Approximately an hour later, following supervisor advice, it was decided that a welfare visit would be made to the address.

12.45 From the social workers perspective, they were not aware that the police would be visiting the home, and the social worker therefore called Michaela and B1 again on the 15th October 2020. B1 disclosed in a slow and slurred speech that Michaela had driven him to Weymouth to meet a dealer so he could buy £600 worth of heroin to sell and make money. He claimed this had been initiated by Michaela. Michaela admitted driving to Weymouth but said B1 had not sold the heroin but had started using it, so she had flushed it away in protest. She described using her rent money to buy the drugs and she was in debt and felt like slitting her wrists. Michaela told the social worker that she was now *"financially fucked",* declaring, *"I fucked my life up so much".* Michaela continued that she wished, *"he would smash my head in"* stating, *"I don't give a shit what happens to me; I've had issues for years and I've had enough".* Michaela informed the social worker that B1 was now drinking 5 bottles of wine a day. She said she liked her job but said, *"it's embarrassing going in with black eyes all the time".* Michaela agreed to contact her GP the next day.

12.46 The social worker then received a voicemail message three minutes later from Michaela reporting that B1 was drunk and *"off his head on something",* had set fire to her pillow and threatened to burn the house down. He was spitting and dropping ash all around her house. She was heard calling B1, *"pathetic".* The social worker made a further call to the police.

12.47 It took many hours to resource a police visit to Michaela and as a result officers found the address in darkness with no signs of movement or disorder. The log was deferred for a more suitable time to visit. In the meantime, the reporting social worker was spoken with again. Police records have noted that the social worker stated that she feared police attendance might make matters worse again.

Evaluation of Practice – Michaela's concerns for her own safety October 2020

This episode is significant as Michaela expressed concerns for own safety and wellbeing. It demonstrates the intricate balance between sensitive enquiry and risk management. The police were wise to consider how their intervention would or could escalate the risk for Michaela whilst also balancing the danger she was in.

The question could be asked as to why police did not enter the property using their powers under s17. In this instance this was not an emergency call from a member of the public but a welfare concern from a social worker and the police were able to talk to the social worker and gain further information to enable them to make an informed decision not to enter the house. The importance of information gathering to inform decision making in these circumstances is discussed later in respect of the police response in May 2021.

Given that Michaela had expressed concerns for her own safety this was an opportunity to respond swiftly to capitalise on a window of opportunity to work with her and provide a "single point of trust" (i.e., someone who Michaela felt she could trust to support her). This issue is explored further in **Finding Three** of this report.

Michaela was clearly distressed by the financial abuse happening in her life and the fact that she had used her rent money to fund illegal drug activity – a money raising enterprise that backfired due to B1's own agenda. There is no consideration of how this situation was going to correct itself, particularly as Michaela could have potentially lost her home. This disclosure explained the helplessness and frustration that led to Michaela's self-harm and feelings of despair. Although she was encouraged to speak to the GP about her feelings, there was no guarantee this would happen, particularly as Michaela had already indicated that she was embarrassed. This highlights the importance of building a supportive community around victims of domestic abuse, and for them to feel that help is facilitative rather than judgemental. It also raises the important conversation of family engagement in risk management and safety planning - as they may prove to be a vital asset in keeping victims safe and emotionally comforted. However, this relies on them being aware in the first place. This issue is explored further in **Finding Two.**

Events leading to the first MARAC and MARAC meeting October 2020

12.48 The social worker spoke to Michaela and B1 on 16th October. They said that B1 was thinking of leaving and although neither wanted to end their relationship it could not continue. The social worker told Michaela that the police would be visiting to make sure she was OK. She said she would not let them in.

12.49 The police considered whether their attendance might increase risk but made the decision to visit the home. When they arrived, Michaela declined to engage with the officer. The officer noted that she had two black eyes and whilst they were aware of the assault on the 12th October reported by the social worker, they believed that something additional had occurred on the 14th October and recorded another crime of assault. An amber ViST was submitted for Michaela's oldest child. This prompted another Operation Encompass call to the child's school, but no further sharing was undertaken by the police as it was clear children's social care were already involved (they reported the matter to the police in the first place).

12.50 B1 was located on the morning of the 18th October and arrested on suspicion of assault ABH. In custody, B1 asked to speak to the Criminal Justice Liaison and Diversion Service (CJLDS) about his mental health. Following a review of previous records B1 was assessed via telephone in his cell. He engaged well but did not identify any needs that required a referral to other services as he was already linked in with the drug and alcohol services and was seen in custody by the WAWY substance misuse worker who covers the custody suite.

12.51 B1 was investigated for both assaults, but neither were able to be proven to the required standards. He left custody after being issued with a Domestic Violence Protection Notice (DVPN[25]) on the evening of the 18th October 2020. This meant that he should not return to Michaela's address. As Michaela did not wish to complete a risk assessment the police submitted a refused red (high-risk) DASH and a red ViST for Michaela and her eldest child. A multi-agency risk assessment conference (MARAC) referral was also made for Michaela for the first time.

12.52 Police were then called by a passing member of the public to a report of screams coming from inside Michaela's property. B1 had been released from custody less than one hour before. B1 was found by police hiding inside a wardrobe in Michaela's home. He was arrested and charged with breaching his DVPN. Following a court appearance, the DVPN was formally transferred to a Domestic Violence Protection Order (DVPO) which prompted an enquiry to be created by the police regarding ongoing victim management for Michaela. This is standard practice and used as a place to collate any relevant contact.

12.53 A referral from the police was received by First Light on 19th October, the case was referred directly to the IDVA, and contact was attempted within 24hrs. There was no

[25] A DVPN is a civil order which can be issued by the police to a perpetrator when attending a domestic abuse incident. It is effective from the time of issue but within 48hrs of it being served an application to a court for a Domestic Violence Prevention Order must be heard.

reply from Michaela's phone and no voicemail was left as this could have placed her a further risk. This is standard practice.

12.54 The DASH process was once again refused by Michaela, but officers followed policy by submitting a refused DASH with the (very) limited information they had. They deemed the risk to be high. As a result of the high-risk DASH, police completed another MARAC referral.

12.55 B1 moved to a friend's house and on the 21st October 2020 B1 called his WAWY worker complaining about the wait for residential detox, saying that he wanted to detox straightaway. He called the Plymouth substance misuse service intoxicated saying no one was helping him and he was *"going to get a gun and kill himself".*

12.56 Michaela's GP records note that the GP received an e-mail from Michaela's mother on 22nd October 2020. This raised concerns about Michaela being in a relationship with B1. The GP record notes that the e-mail said, *'He is a drug user and is currently taking drugs and drinking four bottles of wine per day. [Michaela] has been beaten at least six times since his release and currently she cannot work due to her dreadful facial injuries. I have not been able to see the rest of her body. Social services are involved with regard to the care of her [child], has lost jobs, her car and also has an eviction notice because of his behaviour. I hope that the police have contacted you regarding [B1] as they have put a domestic violence protection order in place. Apart from her physical injuries my concern is [Michaela's] mental health. Sadly, [Michaela] will not press charges and appears unable to rationalise the current situation. This is alarming everyone who has contact with her. [B1] is living locally until his bail conditions end on November 11th. I am aware that [Michaela] has contacted the surgery by telephone but has not clearly explained her current situation.'*

12.57 The friend who was housing B1 has since said that she allowed him to stay to keep him away from Michaela, although B1 insisted that Michaela should come over and see him. There was then an altercation as Michela refused to buy him alcohol. The next day the friend asked him to leave, pushed for him to go back to Michaela's address and rang the police so that he could be arrested for breaching his DVPO.

12.58 The same day, and before the police visited Michaela's address, B1 was seen by the integrated offender manager. B1 said that he wished to engage and wanted to make changes to his lifestyle. He said that he understood the DVPO was in place for 28 days and that he intended to adhere to the conditions but thought that they would get back together when that period was over.

12.59 At 20.18 hours that same day, the police received a call to report that B1 had been seen going into Michaela's property. Police attended and located B1. He was arrested and charged with breaching his DVPO. At court, B1 was fined £50, payable within 28 days for this breach and reminded that further breaches may result in imprisonment.

12.60 Around this time there is evidence of discussions between Cornwall and the neighbouring local authority who held a care order for B1's son. Records in the

neighbouring local authority note that a joint visit was planned between the two social workers on 23rd October 2020. There is no evidence that this took place and plans may have been interrupted by recent events. However, this should have meant that information about B1's long history of domestic abuse was available to agencies in Cornwall.

The First MARAC

12.61 On 28th October 2020 Michaela was discussed at a MARAC meeting. (First MARAC). The meeting noted the accumulation of risks to Michaela, including B1's failure to adhere to the DVPO, his alcohol use and Michaela's view that this fuelled his violence, her isolation from her family and Michaela's wish not to engage with the IDVA service. Concerns for Michaela's mental health, including self-harm, were noted and the current risk that she could be evicted due to financial problems.

12.62 The transcript of the meeting does not contain any mention of the discussions between children's social workers and Michaela on the 15th October 2020 where Michaela states that she is in financial trouble and B1 had set fire to her pillow, and she wishes B1 would *'smash her head in'*. There was a representative from children's services present at MARAC, and information from the children's social worker had been uploaded onto the HALO recording system but there was no analysis of this during the meeting.

12.63 The meeting did discuss that Michaela had told the police that she did not want a DVPN as she had to administer B1's methadone, but the substance misuse service was able to confirm that this responsibility was the pharmacist's job and B1 was under a supervised consumption. This clarified that there was no need for any restrictions on the DVPO and the responsibility for managing B1's methadone use was clearly placed on services rather than Michaela.

12.64 The outcome of the MARAC was that:

- Housing was to assist with B1's housing need in order to stop him returning to Michaela's address. B1 had no local connection to Cornwall, but it was felt that due to a safeguarding duty this could be looked at and flagged as urgent. The main aim was to mitigate the risk but also enable Michaela to feel less responsible for B1.
- Probation was to check why HMP Exeter allowed B1 to be collected by someone he was not supposed to have contact with, and to check whether he was under a DVPO when released in July 2020 (he was not). In addition, probation was actioned to ask the prison for evidence of phone contact during his sentence.
- The adult social care representative (who was not present at the meeting) was to be asked to make a safeguarding referral to adult social care.

12.65 As Michaela did not want support from the IDVA, the case was closed to First Light. There was an opportunity for the specialist IDVA to give advice and guidance to the

social worker working with the family at that time, but this possibility was not explored.

Evaluation of practice -Events leading to the first MARAC and MARAC meeting October 2020

Events leading to the first MARAC highlight the challenges in bringing perpetrators of domestic abuse to justice. It is positive that the police used the available powers within the Domestic Violence Prevention Notice/Order processes to try and protect Michaela, but the penalty of arrest and court appearance for a breach was unlikely to deter B1. B1 had a long history of offending, a pattern of non-compliance and was familiar with custodial sentences - all of which increased the likelihood that he would ignore an order that Michaela also disagreed with. By the time he commenced a relationship with Michaela, B1's substance misuse and associated patterns of criminal behaviour had become entrenched, although the extent of this history, and information known within the neighbouring local authority, was not conveyed to MARAC by police, probation, or children's social care. The need for MARAC to be aware of the whole history in order to properly assess risk and develop effective responses where behaviours are entrenched is explored further in Finding Four

Michaela had experienced many serious assaults before a high-risk domestic abuse referral to MARAC was made. This first MARAC was an opportunity to think about a robust and creative approach to engage with Michaela. There was, however, little focus on what Michaela's views were and what she would like to happen. The approach (which was replicated through subsequent MARACs) was generally on what professionals *thought* her needs were.

A pattern, repeated in subsequent MARACs, is a lack of a clear outcome focused plan – the approach is instead a series of actions set for various people rather than clarity about what needs to be achieved, what contingency planning should be in place if this this cannot be achieved, and what the expected outcome will be. The action set for adult social care to make a safeguarding referral when they had not been present in the meeting was not appropriate as the referrer was not able to include the content of the meeting discussion. It would seem more sensible for referrals to agencies to be made by the MARAC chair who had an overall view of relevant information and risk factors. The MARAC process is explored further in **Finding Four** and improvements made since Michaela's death are set out in Appendix One**.**

B1's frantic and forceful requests for immediate residential detox came at the same time he had been forced to leave the property. Michaela's tolerance for his behaviour began to wane and she admitted to the social worker that the relationship could not continue. His attempts to seek help were likely a further tactic to convince Michaela that he would seek help, and to keep her committed to the relationship. Where these types of tactics exist, MARAC practitioners could have

considered the offer of joint support to improve the health of their relationship and the way they resolve conflict together. This may not be the ideal intervention, but in the face of no engagement, it may pose an opportunity to build trust and offer lifesaving advice to Michaela through indirect support.

It should also be noted that professionals attending MARAC do not engage with family members without consent and therefore Michaela's mother, who had raised desperate concerns about Michaela's welfare to her GP, was completely unaware of the MARAC meeting. This led to frustration and further concern that agencies were not doing enough to protect her daughter. The issue of whether consent should be overridden in order to involve families in managing risk and safety planning is explored further in **Finding Two.**

Events leading to the second MARAC and MARAC meeting November 2020

12.66 The day after the first MARAC meeting, the adult social care representative made a safeguarding referral. As they had not been at the meeting this referral was populated by transcribing information from the MARAC HALO recording system. An entry on HALO submitted by the children's social worker prompted a call by the adult social care triage team to the children's social worker for more information. This exchange of information identified both Michaela and B1 as DASSPs (Domestic Abuse Serious and Serial Perpetrators). This was the first time that Michaela was identified as having a DASSP marker too - but linked to her ex-relationship with the father of her youngest child. The entry reads; *"Professional judgement is that the risks of serious harm are HIGH and imminent. Michaela and [B1] are both considered to be DASSP Domestic Abuse Serious and Serial Perpetrators, (relating to previous partners) therefore both are believed likely to be capable of causing the death of others or themselves.*

12.67 A further referral entry on the 4th November 2020 states "Michaela is reported to have alcohol and substance misuse difficulties". This was incorrect as Michaela did not have any substance misuse or alcohol addiction issues.

12.68 On 4th November the conclusion of adult social care was that the threshold set out in s42(1) of the Care Act for a statutory safeguarding response was not met. However, it was agreed that due to the level of concern, the case should progress to a non-statutory enquiry and a needs assessment. The social worker's concluding paragraph highlighted the risks and the need for adult social care to be part of a multi-agency plan: "*Consideration needs to be given to a multi-agency action plan involving but not limited to ASC, Children's services, IDVA and GP. Consideration needs to be given to identifying a suitable professional/agency to explore risks and options with Michaela in order to support her to make informed choices.*

12.69 During this period, due to concerns about escalating violence and because Michaela would not pursue complaints with the police, the local authority obtained an Interim Care Order (9th November) for Michaela's oldest son, and he was placed with his maternal aunt. He was allocated a new social worker (SW2), but the previous social worker (SW1) continued to have some contact as it was recognised that she had a better relationship with Michaela.

12.70 Soon after the MARAC meeting, the police received two calls from a neighbour eight days apart with information suggesting that B1 was inside the property. Michaela had told the children's social worker that B1 was spending time at the address but sleeping in the car. When the police visited the home after the second complaint B1 was arrested, charged, and sentenced to 14 days imprisonment for breaching his DVPO. He served three days of this 14-day sentence and after release there was no probation involvement as he was not subject to license.

12.71 Due to this breach, the police made a referral to MARAC as a "high risk repeat" case. On the day of his release (13th November 2020) the children's social work records confirm that Michaela picked him up from prison and paid for him to stay in a travel ledge in Cornwall before returning to the family home on 16th November when the DVPN had expired. Michaela told her son's social worker that B1 started drinking on the day of his release and quickly became abusive. He refused to give her the car and house keys and she walked almost 9 miles home. He laughed when she called and asked him to pick her up, but eventually agreed and drove her car (with no licence tax or insurance) to collect her. From this point the abuse and belittling of Michaela continued.

12.72 Michaela was again referred to First Light. The IDVA from First Light telephoned Michaela who was in the car at the time. Michaela declined support and it was only later that the IDVA found out that during this call B1 was present in the car with Michaela. The substance misuse service also became aware (via an abusive call from B1) that he was living back with Michaela.

12.73 Three days after B1 was released (16th November 2020), the police received a call from Michaela's mother with concerns for her daughter. She explained that there had been a history of domestic abuse between her daughter and B1, and they had lost contact with her because of this. They wanted to visit Michaela to check on her but were concerned that she may be aggressive if they did. Instead, they asked if a welfare check could be completed by the police. This resulted in officers visiting Michaela, but she slammed the door in their face shouting that she was fine. No visible injuries were noted.

12.74 Late evening on the same day (16th November 2020), the police received a call from a member of the public to report Michaela screaming for help in the street. Officers visited the home and spoke with her. B1 had already left the property. Michaela explained that B1 had punched her to the nose, smashed a glass inside the property and killed the family gerbil. B1 was located at a nearby shop and arrested. Michaela refused to provide a statement or complete a DASH risk assessment, although a high

risk refused DASH was submitted based on the information known to the police officers. When Michaela told the family social worker about this incident she said that she would not make a statement, saying, *"No way, I don't feel safe doing it – he threatens all day – when he gets out, he will do all sorts".*

12.75 In interview, B1 denied the offences completely and when the police approached the CPS asking for charging advice, they declined to authorise a charge on the basis of the evidential test not being passed.

12.76 As a result of the high-risk DASH, a police domestic abuse officer made direct contact with Michaela on the phone. Michaela explained that she had collected B1 from prison but his behaviour towards her in the car, and at home since, had been abusive. He was bragging to her about his violence towards her and comparing it with other prisoners in the wing. As part of the conversation, Michaela identified that she still wanted to be in a relationship with B1. She knew he was a high-risk abuser and had an awareness of the abuse patterns and why he did what he did. The domestic abuse officer described Michaela as feeling a responsibility towards B1 to 'help him save him from himself'. She explained that she had invested a lot in the relationship and 'lost a lot' as a result, so did not feel able to give that up. She believed that without her, B1 would have nowhere to go and would not survive.

12.77 The domestic abuse officer noted, 'she also knows that she is at serious risk of harm or death from him. He is unpredictable, has no remorse for his actions, and in her words, can hit her without a second thought or care. She understands that the situation will not change unless she accepts help and support, which she has agreed to do.' The domestic abuse officer updated records to note that a SIG warning[26] had been placed on her property, the IDVA was hoping to engage Michaela, a cocoon watch[27] had been implemented and neighbours had already called the police and provided statements. They also noted that Sanctuary support[28] and an alarm had been refused by Michaela.

12.78 The same day, the police made a referral to First Light. When the IDVA telephoned Michaela she did seem more receptive, but the call was cut short when Michaela's parents arrived at the house. The IDVA agreed to call back in a couple of days and advised that it would be good if Michaela could let the IDVA know if B1 was present, and suggested using a code word if he was in earshot/with her. Michaela chose not to take this advice saying it would be okay as B1 would not be at her house.

12.79 Upon leaving custody, B1 was issued with another DVPN and moved to accommodation in a local hotel. It was noted that neither Michaela nor B1 were agreeable to this course of action. Michaela said that the police should leave B1 alone

[26] SIG = Street index gazeteer (the database of addresses on Police systems)

[27] Cocoon watch – where police speak with (normally the direct) neighbours to be alert to any issues at the address and encourage them to call 999 with any concerns.

[28] Sanctuary support is security and safety measures that can be put into place for victims of Domestic Abuse to remain in their own home.

and leave her to help him so that she could cure him of his ways. She also said that she needed him to go to jail so that he could have a decent detox. In a call with the previous family social worker, B1 came onto the telephone and said he was sorry for the previous incident. Michaela said that she felt the police had been unhelpful in issuing the DVPN as she would have to take B1 to the magistrates' court as he had no other way of getting there.

12.80 A full DVPO was granted by the magistrates' court with an expiration date of the 16th December 2020.

12.81 Unaware of the actions on 4th November by adult social care, Michaela's mother referred to adult social care on 17th November 2020 raising significant concerns about the incident of domestic abuse the previous day. She gave details of events including the killing of one of Michaela's pets and this information was sent to the team manager responsible for the safeguarding enquiry, and the manager responsible for the needs assessment. The decision about next steps was made after the second MARAC meeting on 18th November.

The second MARAC

12.82 A MARAC was held on 18th November 2020 and identified that the case was severe and escalating. Michaela had spoken extensively to her previous social worker from children's social care about B1's behaviour and the social worker (in her statement for the coronial inquest) provided a very detailed e-mail that was submitted to MARAC. The e-mail confirms the events immediately after his release and that Michaela had told the social worker of significant physical violence from B1 and had shown the social worker a big bruise on her lower back. The social worker had discussed with Michaela concerns that she could "end up dead" and although Michaela was adamant that she did not want to make a statement to the police, she did agree to speak to an IDVA. This e-mail contains a great deal of information which is helpful in understanding risks to Michaela. There is no evidence from the MARAC transcripts that this was discussed during the meeting, nor was the information submitted to the research form on the Halo system discussed. A representative from children's services was at the MARAC meeting but did not provide a verbal update to members on behalf of the social worker.

12.83 Discussion at the MARAC focused on establishing factual information including Michaela's lack of contact with the IDVA, B1's DVPO status, his current abode, and the lack of engagement with probation and no current involvement by adult social care. The adult social care safeguarding manager was in attendance and confirmed that the case would be closing and there were no care and support needs. There was no mention of the agreed needs assessment. The ineffectiveness of the DVPO was also discussed – evidenced by repeated breaches. It was agreed that there was a need to talk to the pharmacy where B1 was accessing his methadone to ask them to alert the WAWY team if Michaela attended with him. There was also discussion about the role that prisons could play in flagging situations where a prisoner is picked up by

someone they are not meant to be in contact with. Probation was asked to check why the prison allowed Michaela to pick up B1. An action was also set for housing to assist B1 in order to stop him returning to Michaela's address. These were a repetition of the previous recommendations from the first MARAC.

Evaluation of Practice: Events leading to the second MARAC and the MARAC meeting November 2020

The period is a further example of the ineffectiveness of the system designed to manage high risk domestic abuse and prevent escalating violence. Individuals took steps to reduce risk but collectively the sanctions and measures available to them to prevent B1 from harming Michaela lacked teeth. The police arrested B1 when they had cause to do so but could not take prosecution further without the evidential threshold being met. The sanctions that were available via a DVPN/O were totally inadequate in the face of B1's refusal to comply, and Michaela's overwhelming wish to support him.

Child and family services were able to remove Michaela's oldest child and did attempt to be flexible in their approach by making sure that Michaela's previous social worker remained in touch. The e-mail sent by the social worker to MARAC evidenced the degree to which Michaela was confiding in the social worker about the abuse from B1 and it is surprising that there was not more discussion about how children's social workers should be integrated into an overall safety plan.

The recommendation made by the adult social care social worker that there should be a multi-agency action plan was a sound one but was not taken up. MARAC would have been the ideal forum to coordinate such a plan and the consequence of not having a clearly documented multi-agency safety plan setting out roles, responsibilities, expected outcomes and contingency plans, is evident. Once again, the MARAC meeting ended with a series of actions, several repeating those agreed at the first meeting. The severe and escalating nature of the abuse was recognised but there was no obvious solution or way forward to escalate concerns. The current MARAC chair has informed the review that they always review previous actions and explore why an action has not been achieved. The chairs' responsibility to do this is now included in the new operating protocol.

It is important to note that considerations and actions of the MARAC were focused on practicalities and possible ways to 'catch' Michaela and B1 together so that further criminal justice sanctions could be taken. However, these sanctions had shown little effect up until this point. There was little consideration of the psychological underpinnings of B1's behaviour or Michaela's belief system and her need to 'save' B1, although there was information in the social workers e-mail that could have helped this discussion. Without work on the psychological root causes, there was little hope of anything changing dramatically. Whilst incarceration may have bought 'breathing space', B1's previous incarceration of over 12 months demonstrated that Michaela was prepared to wait (and the system did little to

prevent 'absence making her heart grow stronger'). To some extent, the MARAC transcripts showcase a system that was trying to 'chase and contain the horse after it had bolted' rather than thinking proactively about how to modify the behaviour through facilitative support. This had consequences, as the behaviour was only likely to stop if the relationship ended (but the behaviour moved to the next relationship), B1 was detained for a prolonged period (as a consequence of serious harm already being inflicted), or there being a catastrophic fatality.

The fear expressed by Michaela's mother in her referral to adult social care did not feature in the meeting discussions and was a lost opportunity to consider how to work together with Michaela's family. The comment made by Michaela to a social worker indicating that she did not feel safe making a statement was not discussed at the second MARAC. This was in addition to the officer's comments that Michaela knew she was at serious risk of harm or death from him. These comments from Michaela represented her voice – something that had been largely missing from the MARAC process – yet her voice did not evoke a response or a consideration for a safeguarding referral. This was a missed opportunity to consider a different narrative – one that was not centred on Michaela saving or staying with B1 out of loyalty or love, but one that was underpinned by fear and intimidation.

Events leading to the third MARAC and the MARAC meeting December 2020

12.84 The DVPO meant that for 28 days B1 could not live with Michaela, and he was found accommodation at a local Travel Lodge. Cornwall housing subsequently accepted that B1 should be housed at least 20 miles away from Michaela's property.

12.85 Whilst he was at the hotel Michaela's mother called the police concerned that Michaela had breached his DVPO by having Michaela with him in his hotel room. Police visited but couldn't find any indication that she was there. Michaela's parents have told this review that during the time that B1 was staying in the hotel, they were extremely worried and were dismayed to discover that one evening Michaela left the hotel and walked nine miles home with her dog and a small suitcase because B1 would not give her the car keys.

12.86 In B1's contacts with other agencies, including the substance misuse service and the integrated offender manager, he denied current contact with Michaela but said their relationship would resume after the DVPO expired - although he intended to find his own accommodation.

12.87 During this time the IDVA had attempted to call Michaela on two occasions and then closed the case after receiving no reply.

12.88 Meanwhile on 25th November 2020 the team manager in adult social care (responsible for the response to the safeguarding enquiry) completed an action form stating that there was no need for safeguarding action as appropriate agencies were

supporting Michaela. The exact nature of this support was not recorded on this form, but this view may have been informed by the manager's attendance at MARAC. As a result, the record was closed as 'NFA' (no further action) without any further conversations with Michaela's mother or Michaela. There is no evidence that the referral from Michaela's mother informed any further assessments or decisions. As identified in the adult social care individual management review, insufficient weight was given to family concerns. The adult social care needs assessment (via telephone) did not take place until four months later on 3rd March 2021 and the explanation given for this delay is that adult social care was facing unprecedented demand due to Covid-19.

12.89 B1 contacted the substance misuse keyworker on 16th December to confirm that he was moving back with Michaela and asking for his script to be transferred back to a pharmacy near her home.

12.90 On 20th December 2020, police received anonymous reports that B1 was attacking Michaela and trying to take her car. Police officers attended the address and found no evidence to corroborate the reports. B1 and Michaela were spoken to separately. Neither party gave any indication of any argument taking place. Michaela said that she had been working at home all day and that B1 had taken strong painkillers for a back condition. Officers had no cause to disbelieve either of them, and there was no evidence to suggest that Michaela was covering for B1. No further Police action was taken.

12.91 On 21st December 2020, B1's GP records note that they were contacted by Michaela and significant concerns were raised by her about B1 (i.e., That the police had been involved and that she had an IDVA). Michaela asked specifically for certain medication to be withheld from B1 due to him abusing it. Michaela was adamant that the GP should not mention the conversation to B1 as she would be at risk from him if he found out. The GP asked if she was safe, and she said that she was not safe the previous night but she '*feels safe now'.* The GP noted; '*she is adamant she does not want any input from us/police regarding this at this stage - she has capacity, so I will respect her wishes'.* The GP raised a safeguarding alert within the practice in order to notify GP colleagues should Michalea call in again.

12.92 On 22nd December 2020, the police received intelligence that Michaela was a victim of domestic abuse from B1 and that there is *'lots of shouting coming from the property'.* On the 23rd December 2020, Michaela called her GP. She told the GP that B1 was being verbally and physically violent to her. He had been drinking that morning and alcohol was associated with him being violent towards her. She told the GP that she asked B1 to leave the house, but he threatened to smash glass in her face and verbally abused her. Michaela had fled the property and was safe at a neighbour's house but did not know what to do as it was not safe to return. The GP advised Michaela to call the police and have them remove B1 from the property. Michaela indicated that she knew 'things could not go on like this' and advised the GP that she was going to call the police, the emergency social worker and an IDVA.

(NB Later that day she called the GP to confirm that she was safe and living at a friend's house).

12.93 Michaela phoned the police and told the police call taker that B1 had smashed her face and *'smashed all her nose in'* causing her to have two black eyes. He had also taken her phone away from her so that she could not make any phone calls or contact anyone. Michaela explained that B1 had threatened to smash her face in again that morning and now believed that he would be smashing the house up, unhappy that she had left to use the phone. She described her bedroom carpet as being *'covered in blood'* from the assault.

12.94 B1 was then arrested on suspicion of assault ABH. He was interviewed under caution and denied assaulting Michaela. Michaela was spoken with at length by one of the attending officers, but she declined to have her injuries photographed and would not provide a statement of any sort. In order that further efforts could be made with Michaela, B1 was bailed to return to the police station on the 19th January 2021 with conditions not to enter her street or to have any contact with her either directly or indirectly.

12.95 The case was reviewed by a domestic abuse officer. They noted that the DASH risk assessment had seven high-risk indicators and this score would normally be considered medium risk depending upon other aggravating and mitigating factors. However, they exercised professional judgment on this occasion and rather than downgrade to medium, retained the DASH as high and another MARAC referral was completed.

12.96 The domestic abuse officer also attempted contact with Michaela but was unable to speak with her. They left her a message with safeguarding advice and details of the bail conditions encouraging her to report any breaches. It appears that this message may have been left on a mobile phone which was in police possession due to a dispute between the two of them over its ownership. This was later realised, and a phone call was made to Michaela's landline which went unanswered. One further message was left. There was no evidence that a further visit to Michaela in-person was made by either the domestic abuse officer or the officer in the case.

12.97 The domestic abuse officer spoke directly with the IDVA who indicated that they would attempt contact with Michaela too (they did attempt to do so but were unsuccessful). The domestic abuse officer also spoke with B1's integrated offender manager to keep them informed.

12.98 A red ViST was submitted by the police for Michaela which was assessed by the police central safeguarding team but correctly not shared any further as a result of IDVA services already being informed and aware. On the body worn video, Michaela is critical of the police for not properly informing her of the previous DVPO conditions and timeframes and the IDVA services for not following up with phone calls when they said they would. She also mentioned that she spoke with B1's GP and

asked them not to give him Pregabalin medication anymore because he becomes violent with her when he takes this with alcohol.

12.99 This was the first occasion that Michaela called the police herself to report abuse by B1. The police chronology notes that with a different, more victim-centred approach, officers initially in attendance or the officer in the case may have gathered further evidence that could have allowed a police decision-maker to explore an evidence-led prosecution with the Crown Prosecution Service (CPS).

The Third MARAC

12.100 Michaela was discussed at MARAC on 30th December 2020. The meeting noted the recent events and that the abuse is severe, ongoing, and escalating. Specifically, Michaela's isolation was noted in that she had lost her job, had lost her children and was now at risk of losing her home. A statement was made by the MARAC chair that Michaela *"needs support to end this relationship",*

12.101 During the meeting there appeared to be some confusion over the difference between the probation officer and the integrated offender manager and whether they had seen B1. In fact, B1 was not open to probation at that time and would not have had a probation officer. As a Prolific Persistent Offender, he had been allocated a police integrated offender manager.

Evaluation of Practice: events leading to the third MARAC meeting December 2020

This was a significant moment when there might have been an opportunity to engage with Michaela.

It was good practice that police officers escalated the risk and made a referral to MARAC after the incident in December 2020. However, the comment that the 'DASH was classed as medium due to seven high risk factors' indicates that officers were still using scores to classify risk and make decisions about onward referrals. It is reassuring that within this counting culture the specialist domestic abuse officer used their professional judgement to escalate the risk to high. A new DARA risk assessment, which is likely to be used in the future, should prevent this approach, however whatever tool is used it is vital that all professionals continue to listen and prioritise the victim's perspective. Michaela had indicated to officers in November that she was scared of repercussions if she spoke to professionals and she knew she was at serious risk of death from B1 as he was unpredictable and attacking her without care, even bragging about it. This required a professional response, and it was right to discuss the risk at MARAC.

The call Michaela made to B1's GP on 21st December in which she disclosed that B1 was abusing his medication was significant as it is possible that this was an attempt by Michaela to mitigate risk to herself. B1's GP responded by requesting a pop up

on B1's notes that he should not be prescribed drugs with a potential for abuse. It was also noted that Michaela was adamant she did not want any engagement with services, and they decided to respect these wishes as Michaela had capacity. B1's GP should have considered whether Michaela was at high risk of serious harm and whether consent could be overridden by safeguarding duties. In this instance, liaison with the domestic abuse service for advice, may have identified Michaela as an active MARAC client. In which case, this information could have been submitted to MARAC and agencies could have discussed the implications of Michaela's call, including whether fear was the reason she was keeping professionals at arm's length.

The MARAC meeting along with the previous two MARACs continued to miss an opportunity to hear the voice of Michaela. This was noted within the MARAC IMR in relation to the comment that *she needs support to end this relationship* (assuming this is what Michaela wanted). There could have been more exploration of *why* Michaela was not engaging - could this be because agency agendas did not match her own? This once again may have been an opportunity to work alongside her to explore whether there were ways to keep her safe within the relationship?

The issue that needs careful consideration is that if all efforts to engage Michaela failed, and all statutory powers failed, and all voluntary intervention was refused by BOTH Michaela and B1, MARAC should have registered a stage whereby all parties agreed that the 'system' could no longer protect Michaela. This would not have been an absolute endpoint as risk is always dynamic and subject to change, but it would have registered a point in time when the risk was so severe that professionals did not think they could protect Michaela's life.

The High-Risk Behaviour Panel, whilst consulted, was not available as Michaela was not a vulnerable adult with a social care need. Therefore, other possibilities needed to be considered. Even though MARAC now carefully considers the management of repeat MARAC's following the death of Michaela, escalation routes after MARAC (when all legal and practical options have been exhausted) remain unclear today. Inherent Jurisdiction may be one route, and this is explored in **Finding Seven.** This measure needs to be considered as a possible route for 'stuck' MARAC cases where there remain clearly documented and evidenced beliefs that a person is at risk of serious and imminent harm.

Events leading to the fourth MARAC meeting in February 2021

12.102 Although B1's bail conditions meant that he should not be with Michaela, on the 5th January 2021, the integrated offender manager for B1 identified that although B1 said he was residing in Plymouth, he had recently picked up his prescription from a pharmacy near Michaela in Cornwall. Police officers visited Michaela's address and she said that B1 was inside and that she was completely unaware of any bail conditions and did not want them to be in place. B1 was removed and seen onto a

train to Plymouth with a one-way ticket. Both Michaela and B1 in the following days made efforts to speak with the officer in the case to have the bail conditions removed. Michaela refused to provide any evidence to support a prosecution of B1. A police evidence review officer found that there was insufficient evidence to provide a realistic prospect of conviction at court and filed the case with no further action as a result of the evidential test not being passed.

12.103 Two days later, the substance misuse worker called B1 who said he was in the house with Michaela as there were no bail conditions, and she wanted him there.

12.104 On 18th January 2021, Michaela initiated contact with the IDVA and discussed her fears about losing her children, her parents' offer to support her financially if she finished her relationship with B1 and her desire to stay with him. There was discussion about B1's motivation to change and the possibility that he would engage with the Change 4U programme.

12.105 On 22nd January 2021, B1 saw his WAWY keyworker and was described as 'in a bright mood and looking healthy'.

12.106 Meanwhile children and family services were in care proceedings regarding Michaela's oldest child and exploring options for a long-term placement with family members. On 26th January 2021, Michaela's mother and father received a copy of the viability assessment undertaken by children and family services. They were upset both at the content of the report and also that they had not seen the report prior to the family court hearing. In particular, they were upset by a judgement in the report that stated Michaela's parents were 'estranged' and had an "abnormally high relationship with their daughter". They believe these comments were inaccurate, unfair, lacking context and dismissive of their daughter's vulnerability and risk. This report was not submitted to court as by the time of the hearing Michaela's parents were not seeking to care for Michaela's oldest child but were supporting Michaela's sister to care for them.

12.107 On 31st January 2021, following a conversation with his daughter, Michaela's father received two threatening phone calls from B1 in which he called him a *'pussy'* and said, *"I'm going to fuck you up. I'm going to come over and burn your house down and burn you. I know where you live and where your cars are. I'm going to fuck you up."* This left him and his wife fearing for their safety.

12.108 An investigation was undertaken, and B1 was subsequently charged with an offence contrary to section 4 of the Protection from Harassment Act 1997.

12.109 On 1st February 2021, Michaela's IDVA called her as previously agreed. Michaela told the IDVA that she and B1 had discussed a way forward and decided that they would remain in a relationship, but he was going to move out and obtain his own accommodation. She said they had decided this was the best way forward in respect of the social care assessment and Michaela wanting her oldest child to return home. The IDVA pointed out that social care would still be concerned whilst Michaela was

still in a relationship with B1, and she will need to be able to demonstrate that she could safeguard her child and have a safety plan in place. Michaela agreed to complete a DASH and there were seven positive 'yes' responses to questions pertaining to domestic abuse behaviours. The IDVA discussed safety advice in respect of calling the police if Michaela felt at risk, Michaela said she would, but maintained that she did not feel at risk from B1.

12.110 Before the offence was heard in court, on 13th February 2021, police received a call from a neighbour reporting a possible domestic incident at Michaela's home address. Officers attended and spoke with Michaela at the door. She told them that there had been no disorder and asked them to leave. They persisted, asking if she had been assaulted to which she replied that she had not. They asked if they could enter the property to speak with her, but she refused them entry. Officers described Michaela as 'rude', insisting that she did not wish to speak with them, which resulted finally in her slamming the door in their face. B1 was not seen at this time.

12.111 Police received another call approximately three hours later (now 0300 hours in the morning of 14th February 2021) from a neighbour reporting that Michaela had turned up at her address covered in blood after being assaulted by B1. It was reported that the assault had taken place in the last hour as the blood on Michaela was fresh.

12.112 Officers attended and spoke with Michaela who stated that she had been punched in the face and also that she had been kicked in the head recently. More police attended to arrest B1 who was found inside the bedroom of the property having barricaded himself in. He told officers that he had a Stanley knife and would use it if anyone came in through the window. Following further negotiations with B1, he eventually came out from the bedroom and was arrested shortly after 05.00 hours.

12.113 Michaela declined an ambulance for her injuries. She was deemed to have capacity to refuse treatment. The ambulance service report that an email was sent to 'safeguarding' and Michaela's GP. Michaela's GP records note receipt of this e-mail and information from the minor injuries unit that they had spoken to Michaela's social worker who was fully aware of the situation. After Michaela's death her mother was informed by the GP that the GP record noted that the social worker for Michaela's child was the "case handler" for Michaela.

12.114 Michaela also refused a DASH risk assessment, and a high-risk refused DASH was submitted by the police.

12.115 Whilst B1 was being dealt with in custody a domestic abuse officer made contact with Michaela and spoke with her for over an hour. They discussed all elements of safety planning and made efforts to help Michaela understand that this was not her fault. This was good practice. Michaela explained that she would like her child back in the house but knew this would not happen whilst she remained in a relationship with B1. The domestic abuse officer agreed with Michaela that they would be referring her to both MARAC and IDVA services – which they did. Whilst speaking with her, Michaela's father arrived at the address which left the domestic abuse officer further satisfied

regarding Michaela's immediate safeguarding as she was described as 'very low' and intimating thoughts of harming herself.

12.116 B1 was interviewed by police, denied the offence, and was released on bail with conditions not to contact Michaela or her father or go to her address. He was also given a DVPN with the same conditions. This incident contributed towards charges being secured through CPS for an evidence-led prosecution which resulted in B1 being sentenced on 14th May 2021. In the papers submitted by the police to the CPS there was a statement regarding the events on 13th February which read:

She was not able to detail how she was assaulted or how her injuries were sustained other than to say that she had been thrown to the ground and she was then covered in blood. She also told the officer that a few days before this the defendant had kicked her to the head and had strangled her to the point that she believed that she was going to die and passed out. She was very emotional and upset but has refused to provide a statement or support a prosecution at this time.

12.117 On 15th February 2021, an intelligence entry was appended to police records to state that B1 had spoken with his integrated offender manager and explained that he was sleeping rough. He indicated that he understood the conditions of his bail and his DVPO but did not consider his relationship with Michaela to be over.

12.118 B1 called his WAWY keyworker on 15th February 2021 reporting that he was in Plymouth after an incident with Michaela. He wanted his script moved to Plymouth. He stated during the call that he had used heroin since he had been in Plymouth.

12.119 Also, on 15th February 2021, Michaela spoke with her children's social worker (SW2). This social worker asked Michaela's previous social worker (SW1) to speak with her as she was perceived SW1 to have a better relationship with Michaela. Michaela told SW1 that she was really depressed, and she was really frightened by everyone saying that B1 could kill her and how this would impact her children. Michaela described *"horrific black eyes – the worst I've ever had"* and a bleeding nose after B1 had hit her as she tried to leave the house. During the conversation, Michaela blamed herself, stating*, "I am as much to blame···I give him as much back verbally, not physically".*

12.120 On 16th February 2021 Michaela's mother informed the GP that B1 had been arrested and asked that Michaela's injuries were documented on Michaela's medical record. This was added to the medical record.

The Fourth MARAC

12.121 Michaela was discussed at MARAC on 24th February 2021 (4th MARAC) as a "high risk repeat". The history was outlined but the more recent information regarding non-fatal strangulation (see 11.116 above) that had been gathered during the police enquiries was not shared at this meeting. At the meeting much discussion focused on establishing factual information regarding where B1 was accessing his methadone script and where he was living. Bail conditions were in place until 1st April 2021 with

restrictions not to contact or to enter the area where Michaela lived. A DVPO was in place until 14th March 2021. Discussion focused on the views of the IDVA about the problems in engaging with Michaela and supporting her to acknowledge the risks. The IDVA shared that they thought Michaela was a little 'naive' about the social care system, in that she thought she could stay with B1 and have her child live with her again, which the IDVA found surprising given Michaela's previous job. The IDVA reported, "*I don't know what to do or say to make her realise*". It was acknowledged that if B1 was in Plymouth the risks were reduced, but if not, *"we are in exactly the same situation".* The MARAC concluded with the comment, *"let's hope the unofficial [local] community police help to cocoon her a little and share information in".*

Evaluation of practice – events leading to fourth MARAC meeting and the fourth MARAC February 2021

During the period leading up to the fourth MARAC there was an incorrect assumption by the GP that the social worker allocated to Michaela's son was acting in a 'case-handler' capacity for Michaela. This was not accurate as Michaela did not have her own social worker. This assumption seems to have influenced information sharing by the GP with a reliance on the social worker to share the information with relevant parties.

B1's continuous denial of any domestic abuse or violence towards Michaela shows a complete lack of accountability, remorse, and moral conscience. This may be indicative of prolonged exposure to Class A drugs (which have been known to dampen moral judgement[29]), however, without remorse or an acknowledgement of wrongdoing, it was a clear signal to professionals that B1 was not going to change his behaviour. If he did not think what he was doing was wrong, there would have been no point in asking for help. However, during a call to an IDVA (initiated by Michaela) on the 18th February 2021, Michaela indicates that B1 would be open to a Change4U programme. It is not known if she had discussed this with B1 or if it was something she wanted to embark on together. Either way, this very slim opportunity to follow-up this lead, and consider a referral or even further information on Change4U, was not forthcoming.

The note by police officers that Michaela was "rude" to officers and slammed the door in their face (13th February 2021) lacks context. There are many reasons why victims behave defensively, and fear is one of them. Michaela's family believe that Michaela was well known to local officers due, in part, to her dealings with police officers during her previous relationship. Michaela believed that her ex-partner was able to convince police, and on occasion the courts, that she was an irrational and threatening person. Her family told the review that he seemed to carry some influence with local officers and feel that he was able to 'play the system' to influence the risk matrix that resulted in a DASSP marker being added to Michaela's records in 2015 and again in 2016. Michaela wrote in her diary that the police were

[29] https://www.sciencedaily.com/releases/2016/07/160713114945.htm

friendly towards her ex-partner and responded urgently to any report he made, despite many of his claims being unfounded by the courts. This context was not explored at MARAC. It would have been helpful when police shared information on Michaela's past interactions with the MARAC (such as her restraining order), for professionals to have considered how this adversarial relationship might affect her trust of agencies and impact her engagement with support services. Michaela did not have good experiences of the system – a belief that prompted her to study law so she could better protect herself in the future – therefore, it is understandable why she may have behaved in a defensive manner when confronted by professional agencies.

The comment made about Michaela's parents having a higher-than-normal relationship with their daughter is completely lacking context for the situation they found themselves in. They were terrified for their daughter and were desperate. They tried everything to support her. They provided financial and emotional support, a place of safety for her and her children and accesses to external support when necessary (i.e., legal advice and therapy), therefore it is understandable why they were hurt by this subjective opinion. The professional system recognises that not all families are benign, however, it must also make an effort to ensure it is not starting from a place of suspicion and bias. Michaela's parents acted as most parents would in a situation that was serious and escalating and should have received a compassionate response. Significantly, professionals need to acknowledge the dynamics of domestic abuse and how important it is to try and reduce isolation. It was understandable that Michaela's parents were present in her life during this time and to present this in a negative frame suggests an area of learning and development within the assessment process.

This was now the fourth MARAC and consideration should have been given to reviewing the case outside the MARAC process in order to look in more depth at risk and ways of mitigating further harm to Michaela.

The most significant issue at this point was the fact that MARAC were not aware of the information about non-fatal strangulation (NFS) which was known to the police. The information about this serious escalation in behaviour was not available to MARAC as it was not present in a searchable way on the Unifi Police system and was not a criminal offence at that time. This, alongside Michaela's description of her injuries as the '*worst I have ever had*' represented a change in B1's modus operandi (MO). The fact that Michaela lost consciousness indicated that she was very close to death[30]. The panel considered whether this oversight was a result of individual error caused by a lack of knowledge about the significance of non-fatal strangulation or a procedural issue. The police have assured the review that it was not a system issue. This has been resolved by the creation of non-fatal strangulation being made

[30] https://www.futuremedicine.com/doi/10.2217/fnl-2018-0031#:~:text=Strangulation%20can%20have%20immediate%20and,disorder%20of%20consciousness%20%5B37%5D.

a standalone offence in 2022 with a penalty of up to 5 years in prison, demonstrating the seriousness of the crime[31].

However, at the time of the strangulation of Michaela, there had been an extensive training programme across Cornwall (since 2013) highlighting the risks of non-fatal strangulation within a domestic abuse context and there is no reason why this event should not have been recognised as being important information to be shared with MARAC. Furthermore, it is concerning that this incident was not uncovered until the late stages of the DHR and did not come to light during the IMR process. The explanation provided by Devon and Cornwall police is that this incident did not make it onto the electronic system and was therefore not accessible to the IMR author. This is a significant oversight, as this incident took place just three months prior to Michaela's death and was a significant signal of escalation that should have been heard immediately at MARAC.

The significance of this incident of non-fatal strangulation becomes clear on the day before Michaela's death when Michaela reported to a friend that she had horrific bruising from a strangulation attempt. She was in fact trying to share the photos of these injuries in May 2021 when B1 burst into the room and attacked Michaela again. The resulting Crimestoppers call from Michaela's friend reported that B1 was strangling Michaela, and this was in fact the third reported incident of strangulation since February 2021. However, the significance of the grave and escalating risk could not be recognised or assessed as the incidents of non-fatal strangulation were not recorded in such a way that they could be seen as significant.

Overall, there was a general sense of fatigue from the fourth MARAC, whereby practitioners were frustrated by Michaela not taking steps to avoid the risk she was in. MARAC was running out of ideas and there was a vague hope that it would be resolved if Michaela might come to her senses and end the relationship. Although all MARAC representatives receive training which aims to enhance understanding of the complexities of domestic abuse, in this case the focus remained on practical remedies rather than exploring why Michaela was so resolute in remaining with B1.

Events leading to the fifth MARAC meeting March 2021

12.122 After the fourth MARAC meeting:

- B1 told his substance misuse keyworker that he was sofa surfing and not having contact with Michaela.
- The IDVA sent a text message to Michaela asking if Michaela would like a call or was there anything the IDVA could do.

[31] https://www.gov.uk/government/news/new-non-fatal-strangulation-offence-comes-into-force

- the adult social care locality case coordinator attempted to complete a needs assessment, but Michaela declined the assessment during a phone call. She told the social worker that she was feeling fine and that her father was paying for her to speak to a psychologist in America. Michaela said she would contact adult social care if anything changed in the future.

12.123 Michaela admitted to the social worker from children's social care that she was having telephone contact with B1 and had arranged for him to have accommodation through 'spare beds'. B1's mother was reported to be paying for his accommodation.

12.124 Children's social care records also note that Michaela was having therapy privately funded by her parents and that she was not finding this helpful and was thinking of ending it. Michaela's parents have confirmed that they arranged therapy with a qualified psychologist as they were so worried about Michaela. At the start of therapy, Michaela, her father, and the therapist signed a document to agree that information could be shared between the three parties (seen by the reviewers). Michaela also gave permission for the therapist to contact the children's social worker. This last point is significant as, after Michaela withdrew from therapy, her remaining sessions were allocated to her parents for vicarious trauma. During these sessions, information was shared that raised the psychologist's concerns around Michaela's cognitive ability to recognise risk. The implications of this are explored later in this report.

12.125 On 7th March 2021, police were called by the landlord of a property in Plymouth where B1 had been staying to say that he had given his partner a "black eye" and they had both now left the property stating they were going back to Cornwall. After multiple checks at the Plymouth address and Michaela's Cornwall address, Michaela was located in Cornwall the following day. She said that the black eye had happened the previous day, refused to say how it had happened but was adamant that it was not caused by B1. Michaela said that she had been with B1 in Plymouth the previous day and that she had no idea that there were bail conditions and a DVPO in place to prevent this.

12.126 Officers were not satisfied that the injury had not been caused by B1 and recorded a crime of ABH. Michaela refused to complete a DASH risk assessment and the police officers submitted a high-risk refused DASH for her. It was good practice that arrest attempts began for B1 for the ABH and the breach of the DVPO.

12.127 Michaela attended Camborne and Redruth Community Hospital Minor Injury Unit on 8th March 2021 with facial injuries. The injuries noted were a left eye injury, and injury to the back of her left hand. The assessing doctor took a full history that captured the longstanding domestic violence in the relationship, and the circumstances of the incident. There is no documented evidence that the information regarding these injuries was shared with integrated safeguarding services or the MARAC. The doctor did speak to the children's social worker who reassured the doctor the children were safe, and police were aware of the relationship. The doctor was reassured that

nothing more needed to be done in relation to the children. The doctor recorded a warning in relation to Michaela, which read, *'her partner could potentially kill her'.* Michaela stated she found it difficult to stay away from him. There is no documented evidence of onward referrals having been made for Michaela and no evidence on safeguarding databases that the adult safeguarding team were contacted.

12.128 As a result of the contact from the hospital, the social worker for Michaela's oldest child (SW2) asked the children's previous social worker (SW1) to speak to Michaela. During this conversation she told the SW1 that B1 had 'hit' her again the previous day. She explained that she had visited him in Plymouth; but could tell he was *'out of it'* when she arrived; and it was evident that it was more than just alcohol. Michaela later discovered B1 had taken lots of pregabalin tablets before she arrived. Michaela told the social worker that B1 had pulled her hair to get her on the floor and then punched her seven to ten times which resulted in the landlord of the property attending, due to the noise. Michaela said that B1 had been angry because she had no money to give him, but after going out, he had returned to the house at 3am with a bottle of wine. Michaela told SW1 that the following day, B1 had kicked her and verbally abused her. Michaela told the social worker that she and B1 were *"addicted to one another";* but then rephrased this saying, *"I am addicted to him"* but told SW1, *"I am just his meal ticket."* During this conversation Michaela told the social worker she had sent police pictures of bruising to her face, hand, and knee along with a video of B1 where he sat drinking wine and spitting on the floor. At one point in the video, B1 can be heard to say the words *"...stab you..."*. She said she took the video as she had wanted to play it back to him. Michaela sent that video to the social worker along with a photograph of her face on that day following the assault. Police records do not have a copy of this video although they do contain three photographs apparently taken by Michaela of her injuries. Note: The DHR has not been able to establish what happened to the video.

12.129 B1 was located at an address of an associate in Plymouth and taken into police custody. He engaged with a Criminal Justice Liaison and Diversion Service (CJLDS) assessment, accepted offer of a homelessness referral and a referral to Outlook Southwest for counselling and support. B1 gave his mother's landline as a temporary contact number. B1 did not engage with Outlook Southwest following the referral.

12.130 A domestic abuse officer and an IDVA made efforts to speak with Michaela. On this occasion, Michaela did make a statement but later wished to retract the statement and again would not engage with a prosecution or IDVA support. The case was referred back to MARAC for discussion on the 17th March 2021.

12.131 Even though Michaela did not agree to a prosecution, B1 was charged with both assault ABH and criminal damage (spitting in a police van and cell). He appeared at Plymouth magistrates court on 9th March 2021 and gave a Plymouth home address. Bail was initially granted with conditions of an electronic tag assigned to a Plymouth address, no contact with Michaela and no right to enter Cornwall. The prosecution appealed and B1 was remanded to Exeter prison.

12.132 In early March Michaela had started training with the RNLI for a role as a fundraiser.

12.133 On 10th March 2021 Michaela was once again discussed at the GP practice regular safeguarding meeting. The practice safeguarding lead confirmed at that meeting that police, social care and First Light were supporting Michaela. Her GP also confirmed that he would be contacting her.

12.134 On 15th March 2021 Michaela's private psychologist sent an e-mail to Michaela's parents and children's social care. This set out a clear rationale as to why the therapist considered that Michaela might be on the Autism Spectrum, which he believed may impact her ability to make safe decisions and interpret risk. This e-mail noted developmental issues whilst Michaela was growing up and *"striking loyalty, the need to rescue people, obsessive tendencies, a need for order and frustration if plans are changed or do not go according to plan".* It also commented on a *"Lack of expected emotion and lack of empathy in certain situations where this might be expected"* and that *"she would flourish in an institutional setting -such as cabin crew- where rules and order are in place".*

12.135 The psychologist recommended that this information should be given to Michaela by someone local and qualified to do so and that specialist assistance should be sought. The e-mail also requested that Michela's GP was informed and that "*a critical incident team is allocated to Michaela to assess her safety"* and there should be *"an immediate referral to a local ASD assessment centre."* Following this e-mail, the social worker spoke to Michaela about the possibility of ASD. Michaela reacted angrily and called her parents in distress, believing that confidentiality had been breached.

12.136 The children's social care IMR notes that within children's social care, '*It is understood that the relationship between the psychologist and Michaela had broken down because she was concerned that information was being shared with [her parents] without her consent. The private psychologist suggested Michaela needed psychiatric evaluation and suggested the social worker make contact with her GP. This could not happen without consent and there had been no indication that Michaela lacked capacity'.*

12.137 On 16th March 2021, social work records note that Michaela reported she had ended her therapy. She said she had *'cut her wrist a bit, but not a lot'.* The social worker spoke to Michaela's father and discussed mental health support for Michaela through her GP. The same day Michaela's parents had a consultation with her GP to explain their fears for Michaela's safety.

12.138 The GP record for 17th March 2021 notes a consultation with Michaela which was cut short as Michaela was unable to continue the call due to a family court hearing (B1 was on remand at the time). A double appointment was booked for 19th March, during which Michaela spoke of the private psychologist and said that this was "not useful". She told the GP that he had suggested narcissism and co-dependency which she did not feel were issues that she needed to read about further. The GP offered

support and counselling, but this was declined. The GP noted that she seemed calm and happy.

The Fifth MARAC

12.139 Michela was discussed at MARAC on 17th March 2021 (5th MARAC). Discussions centred on:

- Michaela needing ongoing emotional support, pattern changing work and help to end the relationship.
- Michaela did not recognise risk and "*this cycle may not be broken until there is a serious injury or serious custodial sentence". NB:* There is no evidence that this meeting was aware of the autism spectrum concerns raised by the private psychologist to children and family services.
- The decision by police to investigate other substantive criminal offences alongside the B1's breach of his DVPO to increase the likelihood of him being remanded in custody.
- Michaela's admission that she was often abusive to B1, but this was likely to be in self-defence or to get violence out of the way. Professionals recognised that Michaela may not engage in domestic abuse services because she did not identify solely as a victim (i.e., *"I am just as bad").*
- For behaviour change and mental health conditions to be considered under any type of sentencing or community order – an action was given to probation to consider sentencing disposals and restrictions on entering Cornwall (acknowledging that this was unlikely to be imposed, unless as a licence condition) as well as behaviour change programme, specifically recommending Change4U. This action was written in the probation notes.

12.140 Once again the meeting did not have the information about the non-fatal strangulation incident, and this did not inform any discussion of risk. There is also no evidence that the discussions held between children's social workers and Michaela on the 15th February 2021 and the 8th March 2021 were shared at MARAC, nor was the video containing the threat ("…stab you…") or the photos of her injuries discussed.[32]

12.141 An assumption was made during the conversation at MARAC that because of Michaela's professional history she should understand the risk. The additional information regarding possible ASD was also not available to the meeting to inform a deeper understanding of Michaela's responses.

Evaluation of Practice – events leading to the fifth MARAC meeting March 2021 and the fifth MARAC

[32] NB Photos are not routinely shared at MARAC.

The assumption that Michaela was aware of risk was a dangerous one. The MARAC IMR notes that *if she was aware of this assumption it might also deter her from engaging with agencies.*

The importance of being aware of our own assumptions is a cornerstone of good practice in assessing and managing risk [33] and reflective supervision is key in minimisation of bias. It is not clear from the documents received for this DHR what opportunities there are for MARAC attendees to reflect on the process and consider how assumptions or biases might be affecting their own and group responses.

The MARAC noted that the cycle of abuse would not stop until there was a serious injury or a serious custodial sentence. This is somewhat limited in its observation. There were other opportunities to resourcefully consider Michaela and B1's wider needs. Discussions around appropriate interventions for B1 were notably absent and little thought was given to the root causes of his behaviour or addictions from a trauma informed perspective. Michaela believed he needed help and understanding (describing him 'worthy of a second chance') and tried resolutely to fulfil this role, perhaps because no other person or professional in his life was trying to understand his 'why'. A compassionate and non-judgemental approach to both of them to work through their trauma (together or separate) without attaching it to conditions, blame or judgement may have provided a more frictionless alternative. B1 suggested he was open to Change4U and at times considered counselling through Outlook Southwest, but these focused on him addressing his behaviours rather than him understanding and making sense of his complex and upsetting emotional trauma.

A MARAC alert was added to the IT system for all minor injury units including Camborne and Redruth Community Hospital and the Royal Cornwall Hospital Trust (RCHT) and was clearly visible to the clinician at the time, but not acted upon. This was identified as a learning outcome within a separate health serious incident (SI) report. At this stage, the treating clinician could have received advice and information from the IDVA. If the clinician was concerned enough to write that Michaela's partner may kill her, there was a responsibility to escalate the case to Adult Safeguarding, First Light or MARAC.

It is a shame that the information provided by the independent private psychologist was not shared by children's social care or the GP with the MARAC meeting as information sharing is expected practice at MARAC to assist in high-risk management. This was relevant intelligence that should have been shared and debated. The description of Michaela set out within the psychologist's e-mail is congruent with characteristics of someone on the autistic spectrum and the clinical

[33] https://www.justiceinspectorates.gov.uk/hmiprobation/wp content/uploads/sites/5/2021/12/Academic-Insights-Kemshall-1.pdf

concern of a private psychologist should have been given some value and credibility. Even if Michaela refused further assessment, this knowledge could have helped to plan a more appropriate response. If Michaela did meet the clinical criteria for autism spectrum disorder, MARAC could have considered how this condition irregulates fear responses; dampens, or even mutes, the detection of danger; and the ability to effectively identify safety contexts[34] [35]. The failure to act on the information within the psychologist's e-mail indicates a lack of understanding regarding ASD and the significance of the traits that were being described.

It should be noted that the private psychologist did not attempt to diagnose Michaela himself. He only requested that she might benefit from an assessment by a professional who was more qualified to do so. He did not disclose any other conversations or content shared between himself and Michaela. His concerns were not discussed with the GP by the social worker due to lack of consent to do so from Michaela and his views about the need for urgent assessment and potential risks were very quickly dismissed by all parties, including Michaela. In hindsight, and with the benefit of understanding Michaela's particular character traits, her need for structure and other repetitive behaviours, it may have been a helpful action if there had been more consideration as to how to introduce the psychologists concerns to her and manage the situation differently.

Events Leading to sixth MARAC meeting April 2021

12.142 The case was rescheduled for the 14th April 2021 and MARAC requested that probation provide an update on the outcome of the Court hearing for B1 on the 12th April. The probation court team and the PSO who completed the subsequent pre-sentence report were therefore aware that Michaela and B1 had been discussed at MARAC and that excluding B1 from the area where Michaela lived had been discussed and actioned. Their view was that this was unlikely to be approved by the courts although it could be considered as part of a Prohibited Activity Requirement.

12.143 On 23rd March 2021, Michaela's GP records note an e-mail from the private psychologist and that this was discussed the next day with Michaela. She said that her son's social worker had called her to inform her of an ASD diagnosis and she was "*staggered and upset*" about the lack of communication and that her parents had been copied into the e-mail too. She told the GP that she was aware that people thought she was coming to harm's way because of possible underlying ASD and that people with ASD were wired differently. She told the GP that B1 only assaulted her when under the influence of alcohol or substances and that a custodial sentence would not help him recover. She also told the GP that she had accepted a job with the RNLI and was feeling very positive. The GP noted that they had no issues regarding her capacity and that the GP would refer to outlook SW after further

[34] https://www.sciencedirect.com/science/article/abs/pii/S2451902216000926
[35] https://link.springer.com/article/10.1007/s10803-011-1415-6

discussion. The practice have informed the review that Outlook Southwest can provide the paperwork to a patient and complete a neurodiversity assessment if necessary, and Michaela could have self-referred to this service if she wanted to.

12.144 On 8th April 2021 Michaela started work for the RNLI as a face-face-fundraiser. At the time of her interview for the role in March 2021 Michaela had a bruised eye and said this was because she had fallen from her horse. The bruised eye was also noticed by a RNLI colleague who did not feel there was any reason to question the explanation. Michaela began to work regularly fundraising on the beaches with this colleague who got to know her well and remembers her as someone friendly, outgoing, well presented and fun to work with. Michaela did not mention domestic abuse and was excited that her boyfriend was coming out of prison.

The Sixth MARAC

12.145 Michaela was discussed at MARAC on 14th April 2021 (6th MARAC). At the meeting the list of cases was very long as the chair had just returned from leave. The chair did not have a chance to research the cases before the meeting. The police, with the chairs' agreement, offered to streamline two cases quickly and Michaela was one of them. The IDVA stated that Michaela continued to not engage with support but knew how to if she needed it. The decision was taken to close the case for the time being as B1 was in custody until the 14th May and the risk was reduced whilst he was not around. Before the case was closed, the MARAC chair asked adult social care to check with the High-Risk Behaviour Panel if a referral would be appropriate on the basis that Michaela knew how to protect herself but chose not to. Adult social care was to liaise with the IDVA on the outcome.

Evaluation of Practice - Events Leading to sixth MARAC meeting April 2021

As this was a high-risk case that had been heard five times previously it should not have been streamlined. It would have been more appropriate to have a meeting outside the MARAC process and to consider carefully how it might be possible to engage with Michaela whilst B1 was in custody. Although custody decreased the immediate risk, professionals should not have used the time to reduce the need for urgent discussion. Instead, it should have been grasped as an opportunity.

Michaela was continuing to minimise her abuse. She was becoming more isolated from her family, not helped by the way the ASD concern (expressed by the private psychologist) was communicated to Michaela by the social worker from children's social care. Michaela's family and professionals began to work against each other rather than together in a coordinated approach. Her family were working 'blind' without any knowledge whatsoever of the six MARACs or any of the support from First Light and other agencies. They were desperate to protect their daughter and tried to help Michaela in any way they could. At times this seems to have been misinterpreted by professionals who kept her parents at arm's length. The issue of the assessment by the private psychologist is a good example of misunderstanding

and miscommunication that only served to isolate Michaela further as she stopped talking to them after this episode**.** Michaela's family have told the review that they had taken this route because of their extreme worry and distress and with no knowledge of anything that was being done to help their daughter. Their plan had been to talk Michaela through the psychologists' findings gently and sensitively. The relaying of information by the social worker over the phone to Michaela only served to upset her and cause more of a rift between her and her family.

The consequence of not working together with family members in high-risk cases is that actions can be taken in isolation with the best of intentions but can inadvertently have the opposite effect. In this instance, a focus on Michaela's confidentiality and capacity impeded professionals from debating the context of the psychologists' concerns, which focused on how neurodivergence could impact Michaela's ability to interpret danger. The social worker who told Michaela did not appear to think through the potential consequences of information sharing from a risk perspective. Given Michaela's fragile mental health at the time, it may have been safer to withhold this information until such time as it could be discussed with specialists at MARAC. Ultimately, the way Michaela discovered the information, drove a wedge between her and her support network which had a detrimental effect on her safety options.

The discussion at MARAC highlights misunderstandings at that time about the role and purpose of the High-Risk Behaviour Panel. The review has been told that the panel had been operating outside its policy framework in some instances which had led to some of the confusion. In fact, the High-Risk Behaviour Panel is only for vulnerable adults with care and support needs.

12.146 On 28th April 2021 the IDVA called and spoke to the High-Risk Behaviour Panel[36] chair querying whether there was any merit in referring Michaela to the panel. The IDVA raised concerns already discussed during MARAC that perhaps the High-Risk Behaviour Panel (HRBP) was not the right forum for discussion. The chair confirmed that the panel was unlikely to be able to assist as, usually, a functioning multi-disciplinary team was already around the client and the client was self-neglecting or vulnerable. The chair explained that the HRBP was useful in terms of intervention, for example if an assessment need pushing forward or there was a housing need. This was not applicable to Michaela.

12.147 On 28th April 2021 SW2 was reallocated as the social worker to Michaela's youngest child as his father had returned the private law matter to court so that contact arrangements could be amended.

[36] The High-Risk Behaviour Panel provides *"a framework for professionals around safeguarding adults who are displaying high risk behaviours and at high risk of self-neglect."* Multi Agency High Risk Behaviour Policy - March 2018 (cornwall.gov.uk).

12.148 On 29th April 2021 following discussion between the IDVA and their team manager it was agreed to close Michaela's case due to lack of engagement. The IDVA was to make a further attempt to contact Michaela and email professionals involved to let them know the case was being closed. Michaela was informed via text that the case was closed and was encouraged to get in touch with the IDVA or the helpline should she need help in the future.

Summary Evaluation of Practice: Risk Assessment Engagement and Safety Planning

This two-year period from April 2019 through to April 2021 was crucial for Michaela. She was in a relationship with B1 and knew she was at risk of serious harm or even death. B1's ability to control Michaela through her desire to help him and a belief that it was her responsibility to do so left her isolated from her children and extended family. The system designed to help her failed to fully hear Michaela's voice, understand the situation from her perspective and work with her to find solutions that could keep her safe. Individual practitioners tried to help but did not know how best to respond to what appeared to be an intractable situation.

Specific issues that need to be considered and might inform learning and future practice are:

- The need for MARACs to always consider the voice of the victim, their wishes and feelings and develop safety plans that take this into account.
- Taking a whole family approach to the assessment and management of risk. In this case there appeared to be minimal cross over between child protection planning, ongoing work with the children and safety planning for Michaela. The danger of increasing the isolation of the victim through child protection action needs to be named, whilst always ensuring the safety and wellbeing of the children. Within a whole family approach, understanding the dynamics of the extended family and listening to the concerns of family members might prevent the polarisation that happened in this case.
- The need for challenge within the system where there are repeat MARACs which are repeating the same actions with no observable reduction in risk.
- Developing clearer outcome-focused safety plans to provide a benchmark for assessing progress and identifying desired outcomes.
- Using the time when offenders are in prison more proactively to facilitate engage with victims and provide a better foundation for work when they are released.
- Using the time offenders are in prison or subject to DVPOs to proactively focus on engaging with them, providing treatment programmes, measuring their impact, and working together across domestic abuse and probation services. (The First Light IMR noted minimal communication between First Light and probation)

- Working with family and friends in high-risk cases (where it is safe and appropriate) to improve knowledge, risk management, safety planning and engagement.

13 MANAGEMENT OF THE OFFENDER APRIL -MAY 2021

Pre-sentence risk assessment

13.1 On 12th April 2021, B1's court case was adjourned for a pre-sentence report. Probation records note that B1 had pleaded guilty to common assault x2 (as alternatives to original ABH charges), and criminal damage. He had already pleaded guilty to harassment (domestic abuse, not for the first time). An application for a restraining order was to be made, which was to be opposed by B1.

13.2 At the point that a pre-sentence report was requested, probation records contained police call out information about eight incidents in the last 24 months which evidenced significant domestic abuse, B1's use of violence and intimidation and that Michaela had not been in support of police involvement. The probation records also contained information from the substance misuse service that B1 had been drinking heavily prior to his arrest. There was also information from the integrated offender manager which evidenced ongoing alcohol use and B1's lack of adherence to external controls such as the DVPO.

13.3 There is no evidence that the full previous history of domestic abuse towards previous partners within the Devon and Cornwall police records were disclosed to probation to inform their assessment. Even though the abuse occurred some 15 years earlier, it was significant and would have been relevant to any domestic abuse assessment in the future.

13.4 The preparation of the pre-sentence report was allocated to an experienced probation services officer (PSO). A PSO is not a qualified probation officer and therefore has not received the same level of training as a probation officer. If a PSO is allocated a report for which they feel underqualified to complete, they should confer with a senior probation officer and ask for support from a probation officer, or for the case to be re-allocated. At the time of this allocation the current guidance regarding expected domestic abuse training for PSO's was not in place. (Current guidance issued May 2021).

13.5 On 29th April the PSO preparing the pre-sentence report interviewed B1 via video link to the prison. The PSO noted that he was not willing to take full responsibility for what happened, minimised his behaviour and had pleaded to a lesser crime. He described his relationship with Michaela as 'strong' and said they wanted to remain together. He was adamant that he would be returning to live with Michaela when he was released. B1 was open to interventions from probation in dealing with difficult

relationships. He admitted that 'drinking to excess' escalated his behaviour adding that mental health services had not been to see him in prison, despite previously being diagnosed with drug induced psychosis, anxiety, and paranoia. He told probation he had been prescribed quetiapine and propranolol. The PSO concluded that they had no doubt B1 would assault Michaela again but did not think it would happen immediately on release, therefore they assessed B1 as posing a medium risk of serious harm (ROSH) to Michaela.

13.6 On 4th May 2021 a Care Order made in relation to Michaela's oldest child and for him to remain in the care of his maternal aunt as his specific foster carer.

13.7 On 13th May 2021, the PSO completed a Risk of Harm Assessment (ROSHA) for the pre-sentence report and sent this to the court manager, a senior probation officer, for countersigning. The assessment was lacking in detail and the analysis and conclusions did not match the known information about B1's history of violence and the likelihood that he would live with Michaela. The assessment acknowledged that B1 would pose a high risk of serious harm and would assault the victim again but did not think this would happen immediately on release and therefore the overall ROSHA assessment was rated medium. One factor influencing the assessment was that it was based on convictions rather than an overarching view of coercive and controlling behaviour where there had been no charge. When considering B1's recidivism score (over 3%) and his likelihood of reoffending within the following two years (82%), taken in conjunction with the high-risk factors identified by the PSO, the outcome of the overall ROSHA (medium) was a distorted assessment. The assessment noted that the case was to be managed through MARAC and as this was a lesser offence he would not be looked at by MAPPA.

13.8 It is not absolutely clear whether the court team senior probation officer read the assessment before countersigning. The senior probation officer cannot recall doing so due to workload pressures at the time. The senior probation officer believed there had been an agreement with the head of the Probation Delivery Unit (PDU) that the senior probation officer could provide countersignature without reading the assessment during busy periods. The head of PDU could not recall giving the instruction and has reiterated that it is indefensible not to read a report before countersigning. The senior probation officer has since agreed that if this report was read ahead of submission to court, the ROSHA for B1 would have been assessed as high.

13.9 The probation services officer's final recommendation in the pre-sentence report was a 30-month community order with a 29-week building better relationships programme and 25 rehabilitation activity requirement days and 300 hours of unpaid work. The PSO considered a custodial term but due to the amount of time B1 had spent on remand for the offences for which he was being sentenced, it was likely he would be released 'as time served'. The PSO's rationale for a Community Order was that more effective support could be put in place than a short licence period and

post-sentence supervision. The PSO also observed that custody had previously had little impact on B1's behaviour.

13.10 The PSO considered the request from MARAC[37] for a prohibited activity requirement preventing B1 from residing at Michaela's address but because B1 was clear that the relationship would continue the PSO did not feel they had the right to prevent this from happening. Subsequently, no restrictions were recommended to prevent B1 from having contact with Michaela.

Evaluation of Practice: pre-sentence risk assessment

The pre-sentence report is a pivotal moment in this case. The probation service acknowledges that this report should not have been allocated to an unqualified member of staff even if they were experienced in working with domestic abuse. Subsequently, the assessment lacked detail and it was not clear where some of the information had been obtained. The PSO commented on a poor domestic abuse history but did not provide further information around the context of his behaviour. There was a dichotomy between the acknowledgement that B1 would pose a high risk of serious harm (ROSH) to Michaela if they were to live together and yet the overall ROSH assessment was rated 'medium' despite B1 insisting he would reside with Michaela if given a community disposal (and the PSO believing B1 would assault Michaela again but not knowing when). In addition, non-convicted behaviours such a domestic abuse call outs and MARAC intelligence were not assessed, with an emphasis on convictions. This gave a distorted picture of the risk of serious recidivism and the likelihood of further offending.

Of significant importance was the failure to consider (and include within the report) the incident of non-fatal strangulation and how this level of escalation could impact the risk of further violence against Michaela. This oversight demonstrated the PSO's lack of understanding of domestic abuse risk and how perilously close to death Michaela had been. The consequence of this was that B1 was never challenged or educated about the act of strangulation. This likely resulted in B1 becoming more confident and complacent in his abuse of Michaela which can be seen in the further two documented offences of strangulation against her (in rapid succession) when he was released. B1 had an increasing disregard for Michaela's life. If his modus operandi (MO) for strangulation continued, it was only a matter of time before Michaela died at his hands. The system error within probation which did not ensure the risk assessment was carried out by a suitably qualified person and properly scrutinised by a senior officer likely contributed to B1's perception that he could 'get away with it'.

[37] NB The probation IMR notes that MARAC was referenced in the pre-sentence report, and this should not have happened as B1 had access to the report and should not be aware of MARAC as it may have suggested that Michaela had made a disclosure against him.

The PSO did consider a restraining order but did not think that B1 would comply or that they had the right to prevent the relationship from resuming. Again, not imposing sanctions on B1 under the auspices that he would not stick to them anyway, had the potential to increase his confidence and empower his offending behaviour.

The pre-sentence report referred to MARAC although policy[38] at the time stated that mention of MARAC should not be included in reports as B1 would have access to the pre-sentence report. Offenders should not be made aware of the involvement of MARAC as MARACs are in place to support the victim. This error could have resulted in retribution if B1 believed Michaela was actively engaging with professionals.

Once the assessment was completed, there was then insufficient management oversight of the final assessment and report. Workload appears to have been a significant driver at this time with the senior probation officer apparently believing that they had permission to countersign without thoroughly reading every report. The overall result was that there was insufficient reflective supervision/discussion with the PSO completing the report and the wrong risk rating was allocated to B1. A recent document[39] highlights the importance of professional curiosity with the probation service and this is relevant in improving assessment practice in similar cases. The importance of time and space alongside emotional support when undertaking this work was significantly lacking in this case.

Michaela's family believe that the catalogue of errors from probation services placed B1 in Michaela's home on the night of her death. They believe that Michaela should have been contacted and asked if she wanted the relationship to continue, and if she was happy for B1 to return to her home on his release (There is some indication she was not). Michaela's voice was completely missing from the pre-sentence report and the family believe B1's wishes as the offender were placed above Michaela's as the victim.

The issue of accuracy of risk assessments has been highlighted in several recent cases in England[40] and is considered further in **Finding Eight** as the evidence suggests that this is a systemic issue reaching beyond Cornwall

Post trial management of risk

13.11 On 14th May 2021, B1 was released from prison and was sentenced at Plymouth Crown Court to a 36-month Community Order with three requirements:

[38] Stipulated in Handling Sensitive Information Practitioner Guidance

[39] https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/07/Academic-Insights-Phillips-et-al.pdf

[40] Joseph McCann, Damien Bendell, Jordan McSweeney, and the London Bridge case

- Building Better Relationships – 29 sessions
- Rehabilitation Activity Requirement – 25 days
- Unpaid Work – 300 hours

13.12 B1 was also made subject to a Restraining Order which prohibited him from:

- Contacting directly or indirectly, by any means whatsoever, Michaela's father
- Being in the area near the father's home in Cornwall for 2 years.

13.13 The Judge commented that he was in a difficult position as his hands were tied on the length of sentence he could impose due to B1 pleading to the lesser offences of common assault and Michaela not engaging with authorities to pursue a prosecution. The Judge made it very clear that Michaela needed protection from B1, stating: "*if I hear you have caused any harm to [Michaela] in the future, I am reserving this case to me and if you come before me again, I will do all I can to punish you to the full extent of the law. I expect you attend all appointments and engage, and I take this route as you have been in custody for the equivalent of 4 months already".*

13.14 The Judge informed probation afterwards that this was a "hair trigger case" and any breaches whatsoever, the case MUST be brought back to court immediately and reserved to the same judge.

13.15 On 14th May 2021 the prison transfer record noted that B1 received a community order and had provided his domestic violence victims address as his intended release address. It noted that this information had been provided to Cornwall Domestic Abuse Unit, who expressed concerns but accepted that they do not have authority to insist that he does not reside there. The record also noted that the court had been advised of concerns raised by police colleagues, as when in court, the belief was that he would be returning to a Plymouth address.

13.16 On 14th May 2021, the substance misuse service received an update from the integrated substance misuse service at Exeter prison informing them that B1 had received a community order and provided Michaela's address as his intended release address.

13.17 On 17th May 2021, probation records show an email trail between a case administrator in Plymouth and a senior probation officer in Cornwall with reference to the allocation of B1's case. The Plymouth case administrator stated the case was initially accepted in Plymouth as a Plymouth address was listed, however, the courts team made a mistake, and it was now known that B1 had given an address in Cornwall where Michaela lived. A reallocation was requested for a probation officer within the Cornwall Community Rehabilitation Company team as soon as possible. The decision that this was a case for the Community Rehabilitation Company rather than the probation service was correct as B1 had been assessed as medium risk with a Risk of Serious Recidivism score below 6.9.

13.18 The same day B1 was allocated to a probation officer in the Community Rehabilitation Company (CRC) Cornwall team. The senior probation officer allocating the case noted the probation officer already had 43 cases, but this caseload was deemed manageable as the expected caseload for probation officers at that time was approximately 60. However, the probation officer was due to take annual leave the following week and did not have time to fully understand the case before going on leave. This was not raised by the probation officer or the senior probation officer who reallocated the case. There was no cover for the probation officer's annual leave.

13.19 Probation also received an e-mail from children's social care advising of a change of social worker for Michaela's eldest child. This was not recorded on the probation record keeping system.

13.20 On the 18th May 2021, B1 received a text from probation informing him of his initial induction appointment by telephone call on Friday, 21st May 2021. At this time face-to-face meetings had resumed after COVID-19, especially for riskier cases but there were difficulties with office availability and timing.

13.21 On 19th May, B1 had a keyworker appointment with the substance misuse service in Cornwall. The conversation included the need to comply with all legal expectations. He reported drinking only in the evenings (1.5-2 bottles of wine).

13.22 On 20th May 2021, the probation officer received a telephone call from the integrated offender manager asking to sit in on the next office meeting with probation. The probation officer explained that B1 had not yet been spoken to and the first office meeting would be after the probation officer returned from annual leave on 1st June 2021. It was agreed that the probation officer and integrated offender manager would liaise when the probation officer returned to work.

13.23 On 21st May 2021, B1 spoke to the probation officer on the phone for the induction appointment. He confirmed that he had returned to live with Michaela and that two children were residing with relatives. The probation officer also spoke with Michaela during this call, and she was adamant that she wanted B1 home with her. B1's methadone script and supervised contact with the substance misuse service was noted and plans discussed for commencement of the building better relationships programme. B1 was informed that the unpaid Work Unit (UPW) would be in contact in due course to advise of his 'Starting Blocks' appointment. The probation officer noted that *"overall, I formed the impression that B1 is motivated to work with probation".*

13.24 On 24th May a text message was sent to B1 by the unpaid work team with instructions to attend a Starting Blocks induction session on 26th May 2021. He did not attend this appointment, but no warning letter was sent, because the alert went to the probation officer who was on annual leave, and there was no cover in place. As a consequence, the judge who had specifically asked to be notified of any breaches was not informed.

13.25 On 25th May 2021, as Cornwall police were aware that B1 had been released from prison intending to live with Michaela at her home address, the police integrated offender manager for B1 made an unannounced visit to Michaela's home address to check on B1 and discuss his release. Police records note that Michaela was particularly unhappy about an unannounced visit and both her and B1 stated they did not wish to speak with the officer.

13.26 The social worker for Michaela's youngest child saw Michaela and B1 on 27th May 2021 to complete a S7 report**.** [41] The social worker saw them together and describes them as being in good spirits and planning for the future. Concerns about B1's alcohol consumption were discussed, and the social worker raised the concern that this could be a trigger for domestic violence as B1 said he could not give up alcohol as well as drugs.

13.27 On Friday 28th May, B1 obtained three days' worth of methadone from the pharmacy due to the closure of the pharmacy over the bank holiday weekend.

13.28 B1 had an appointment at the probation office at 14.00 on 1st June to meet his allocated probation officer. He failed to attend. No notes were added to the case management system and no action was taken to follow up the non-attendance. This response was technically within expected national standards for probation officers which determine that when an offender fails to attend an appointment the probation officer must make contact within two working days to request a reason. Although there was no technical breach of standards the action did not take account of the previous breach on the 24th May 2021 or the Judge's request that issues regarding noncompliance should be brought back to him at the earliest opportunity. The Judge had the opportunity to reserve breaches of this order to himself, however the breach would still have taken the usual course as set out in the legislation.

Evaluation of practice – post trial management of risk

Although it was appropriate to refer this case to a probation officer, the initial risk rating was medium which once decided was not revised. Consequently, the risk assessment started as a wrong assessment and remained so.

An additional issue was that it was inappropriate to allocate this case to a probation officer who was due to take imminent annual leave, without a contingency plan. This had serious consequences. The probation officer took annual leave without arranging cover which meant that when B1 breached the conditions of his Community Order, probation services did not follow national guidelines and produce B1 with a final warning on the 26th May 2021. Because B1 was an Integrated Offender Manager case, a final warning letter would usually be shared with other agencies but because no cover was in place, no other agency was informed of this

[41] A section 7 report is ordered by the court in private family court proceedings to provide information on a child's welfare.

breach. This had an impact on what was knowable to police on the night of Michaela's murder although it cannot be assumed that this would have directly affected decision making on that night. The breach also did not prompt an urgent MARAC referral, which would have been a requirement given the change in circumstances.

The context for the work at this time was that the Community Rehabilitation Company would have been used to dealing with lower risk cases and officers would not have automatically thought about referring directly to MARAC. This situation has now changed with the National Probation Service reassuming responsibility for work with all offenders who are subject of probation.

Once again, it is likely that B1's confidence grew as he was not being held to account for his behaviour or his blatant disregard for authority.

Michaela's family are concerned that B1 was able to obtain three days' worth of methadone on the Friday of a bank holiday weekend. The review have been informed by the drug and alcohol service that this was unlikely to have exacerbated B1's violent behaviour as the effects of a high dose would be calming rather than aggravating. However, it is impossible to know whether this script was sold for a substitute drug which could have had a negative effect on his presentation, or alcohol, which was known to escalate B1's violence towards Michaela. Michaela's family do not believe this practice should be permitted for someone on a supervised script and ask that the professional system considers the use of other dispensing venues (such as supermarket pharmacies or health clinics) when a bank holiday forces the closure of local independent pharmacies. The panel have discussed this issue at length and the consensus of opinion is that change would be very difficult to achieve and needs to be understood within the context of many other risks. Risks associated with no easy access to methadone might increase violence and there are other circumstances where money might be easily available to fund an addiction, such a back payments of benefits.

Information from Michael's family is that during B1's time on remand in prison Michaela began to change back into her "old self". Her son recalls her dressing more smartly and he believes that she was moving towards ending her relationship with B1. Although this paints an opposite picture to the social worker's recollection that Michaela was happy and future focused with B1, this presentation cannot be relied upon as B1 was present during the assessment. It is important that practitioners are reminded that victims of domestic abuse are not always in a position to be authentic and honest if they fear reprisals.

It is tragic that five days later, B1 went on to attack Michaela fatally, leaving her deceased in the property whilst he absconded. Subsequently, he did not attend his probation appointment again in June 2021 and due to the probation officer still being on annual leave, there was no follow up in line with national protocol.

Understandably, Michaela's family are angry and bewildered at the Community Rehabilitation Company's response to risk at this time. It is a shock to them that offenders such as B1, who posed such a serious risk to women, could be free to do as he pleased without any immediate reprimand – or that a judge's specific orders could be ignored. Their confidence in the state's ability to keep their community safe has significantly reduced as a result.

Summary evaluation of probation responses

There are many similarities between this case and other high-profile cases[42] and more general issues are explored in **Finding Eight.**

- B1's case was given to the wrong grade of staff to complete the pre-sentence report.
- The pre-sentence report did not contain an analysis of all available information and specifically the author missed the information about non-fatal strangulation.
- The risk status was wrong (it should have been high risk) meaning there was weaker risk management options.
- Staff supervision was either non-existent or ineffective in picking up and correcting errors.
- There was an ineffective escalation process from the community rehabilitation company to the probation service because of the split between agencies.
- Probation staff in the community rehabilitation company did not know that medium repeat cases could go to MARAC.
- Because of the sentence given there were no powers available to any agency to stop B1 going back to Michaela's address
- When he breached the requirements of his order, the probation service could not have got him in front of a judge in time to make a difference. This raises the question as to whether the national guidelines for a two day follow up are appropriate and take full account of high-risk cases such as this where the judge has made a specific request to be informed of any breaches immediately.

[42] For example https://www.theguardian.com/uk-news/2022/nov/18/man-29-pleads-guilty-to-murder-of-zara-aleena

14 THE INCIDENT

14.1 Evidence from Michaela's friend is that in the week before her death, violence from B1 was escalating. Her friend, who lived abroad, had lost her bank card, and had a replacement sent to Michaela's address along with some family photos. She asked a friend to collect them, and it was B1 that went to the car to hand them over. When Michaela later spoke to her friend she confirmed that she had not gone to the car because she had "horrific bruises".

14.2 It is of note that after B1's release from prison Michaela introduced him to her work colleague and he describes feeling that they were like "chalk and cheese" – Michela was friendly and outgoing whereas he was reserved and quiet. Michaela had begun to reduce the days that she worked and although there was no obvious cause for concern he did feel that something did not seem right. He did hear after Michaela's death that Michaela had confided that she was being abused by her partner to a female co-worker. This person has now left the service after a personal tragedy, and it has not been possible to find out more about this event and there is nothing recorded on Michaels's RNLI records, but it is further evidence of the abuse perpetrated by B1 though this period.

14.3 During the day and early evening, information from the police investigation is that Michaela exchanged messages with her work colleague from the RNLI regarding work the next day and that B1 visited a local shop to purchase wine.

14.4 Information from the criminal trial confirms that on the evening, Michaela and B1 argued over a meal she had prepared. By this stage, B1 had consumed four or five bottles of wine and later that evening between 6 and 8pm had taken heroin.

14.5 At 22.10 Michaela called her friend abroad. Her friend has informed the DHR that Michaela told her that B1 had "strangled her" the day before. Michaela asked her friend to phone the police, but she was concerned about the timing because it could make it worse for her. Michaela was just planning to send photo evidence of her injuries when her friend heard B1 attack her. Her friend was so scared for Michaela's life, she told her she was calling the police and put the phone down. She tried calling 999 but it would not connect to the UK from abroad. She tried inputting +44 and then adding 999 but that would not work either. She knew she had to help Michaela, so she called Crimestoppers in the UK and explained the urgent situation and asked them to make the 999 call on her behalf. The friend recalls that the responder for Crimestoppers said that they had to consult their manager first which delayed the situation, but eventually Crimestoppers *"agreed to call 999".* This may have been a misunderstanding as Crimestoppers have told this review that they cannot call 999 as they are not local to the potential offence. They could call 101 and ask to be put through to Devon and Cornwall Police.

14.6 Crimestoppers records show that a report of the call was created at 22.26pm and Devon and Cornwall police were called at 22.31pm. Written information was sent via a pdf document at 22.54pm.

14.7 The police transcript of the call from Crimestoppers confirms that information was given concerning a serious attack happening on Michaela at her home address. B1 was named as the attacker, and he had recently come out of prison for a previous attack on the same female. The police control room asked who the call was from and Crimestoppers said it was an anonymous call. The police officer commented *"So, I guess it might be a neighbour or someone nearby".* Crimestoppers answered, *"not sure".* The DHR has been informed that Crimestoppers work from the basis of complete anonymity and will never reveal the source of their information. They would never confirm or deny an assumption.

14.8 Between 22.47 and 22.53 the police call handler classified the call as a domestic incident in progress. They carried out a search and identified Michaela and B1 and the following warning markers in relation to B1: '** MARAC, drugs x2, mental health, DASSP, conceals x2, violent x2, location ban x4 weapons x4, ailment, risk to child, no more PNDs 6, escaper **'

14.9 The call was risk assessed for an immediate response and at 23.23hrs two police officers arrived at the address (Officer A and Officer B). Officer B had been domestic abuse trained ("Domestic abuse matters" in 2016). Officer A had transferred from another police force and had received initial domestic abuse training input during their probationary period.

14.10 As they approached Officer B stated: "Well with the history and stuff, I think if she got any fresh-looking injuries, he's just going to have to come in⋯she ain't going to tell us anything". The property appeared to be silent and in darkness and Officer B knocked on the front door before going to the rear of the property and knocking on a rear window with closed curtains. The officers discussed speaking to a neighbour but concluded that it was probably the neighbour who had called Crimestoppers.

14.11 Officer A later stated to the IOPC that he was aware there had been *spurious calls* to the address previously and explained that he was unable to verify the Crimestoppers information. He stated that he could see a light on in the property immediately next to Ms Hall's address but knew the resident to be elderly and *'through previous dealings is very scared and reluctant to get involved in any incidents involving [Michaela] and [B1]. I assumed that this must be the caller to Crimestoppers as this is the only property that is connected to [Michaela's address].'*

14.12 Officer A also explained that the lateness of the hour was a factor in this decision, and so they decided not to make any enquiries with the neighbour for that reason. There is no indication that they considered making enquiries at other houses or considered contacting hospitals, Michaela, or relatives by telephone, or that they sought advice from a supervisor.

14.13 The officers knocked again at the front door and looked through the letterbox and a small window to the left side of the front door. They could not see anything knocked over and Officer B commented, *"We ain't got enough for power of entry have we?".* Officer B shone their torch through a gap in the curtains by the front door and then walked away from the property. They had spent seven minutes at the address.

14.14 At 23.30hrs, Officer B passed on a radio update which included the comment that they were reluctant to knock on the neighbour's door because *"they've obviously gone through Crimestoppers for a reason"*. The log noted that the call would be deferred for another check in the morning and Officer B commented." *We have visions···like her lying there with···him covering her mouth and stuff. What can you do if she don't, she don't help herself, even if we could get in she wouldn't speak to us···and having spoken to her quite a lot before, he normally does, is drink and drink and drink until he falls asleep so it might be that he's finally just drunk himself into a···"*

14.15 Officer B gave a statement to the IOPC investigation explaining that they understood the power to enter a property under section 17 of the Police and Criminal Evidence Act 1984 to save life and limb or to prevent serious damage to property and that they had done so before and been present when their colleagues had done so. On this occasion Officer B believed that they did not have enough information to exercise this power and when they updated the control room they were not instructed by Force Control or a supervisor to force entry into the property.

14.16 During the time that the officers were at the property it is now known that Michaela had been attacked by B1 and was either seriously wounded or deceased in the bedroom. B1 had then carried on drinking. He phoned his mother six times between 04.00 and 04.20hrs, but she did not answer. He then passed out in the other bedroom. When he woke the next morning he realised that Michaela was dead, and he left the property about 7am. He told the police that he bought vodka and then returned to the house to change his clothes and remained there for some hours. He collected Michaela's phone and got the bus at 10.58am. He then went to the local town to buy drugs. In town B1 was observed on CCTV holding the hand of another woman and carrying her rucksack. He also told a Big Issue seller about his ex-dead girlfriend saying he was *"already on a murder charge".* This was to frighten the seller into giving him money. Just after 13.00hrs, B1 took phone calls from his mother who described him as *"out of it"* saying Michaela was dead but that he had not killed her, and that he had stabbed two men. She told him if he did not go to the police she would do so.

14.17 At 7.42 am the following morning the police log was activated to a status of further enquires required. This was normal practice at the start of a new working day.

14.18 Police officers (Officers C and D)[43] visited the home at 14.50pm. They spent one and half minutes knocking on the front door. They noted there was usually a dog present although this was outdated information because Michaela's dog had been removed by the RSPCA some weeks before. Officer C updated the control room saying that the curtains were open, everything looked in order and nobody was answering the door. They suggested the visit could be deferred for the late shift.

14.19 Later that day, at 17.58, a sergeant passed information to the call room saying that two officers would visit the address when they had finished tidying up some paperwork.

14.20 At 19.14 hrs Officers E and F visited the property (Officer F had attended 'domestic abuse matters' training in 2016). The officers knocked on the front door, looked through the window and noted that the dog was not present. They could not see any signs of disturbance. They then checked the rear of the property and left approximately 3 minutes after they had arrived. After switching off his body worn camera, Officer F was approached by a neighbour who identified himself as an ex-police officer. According to Officer F's statement to the IOPC the neighbour said that "*he had seen the female go out that day and that the male was also around".* Officer E recalls this slightly differently saying they spoke to two male neighbours one of whom was a retired police officer and one of the males said they had seen Michaela and B1 walking out of the house that morning. The statement of the neighbour to the IOPC confirmed that the last time he had seen Michaela was at 11.30am on 30th May 2021 and he remembered telling the police officer that he had seen her "*the day before".* At 17.27hrs Officer F passed an update to the control room saying there was no answer at the door and a "*neighbour saw [Michaela] go out this morning".*

14.21 Michaela's mother then called the police at 20.24hrs. She told the police that Michaela was involved with a criminal and had been beaten up several times, that she was supposed to have telephoned her child at 18.00 had had not done so and that none of the family could get hold of her. Michaela's father said that they could not check the property as they believed B1 to be there, and there was a restraining order against him. The call handler found warning markers against B1. A log update from Officer F stated that they would re-attend the address shortly and that "*neighbours had seen Michaela and believe B1 go out quite happily together today".*

14.22 Michaela's mother again called the police at 20.21 saying she was at the property. She and her husband had been told by a neighbour that "*she is probably in there injured".* The neighbour also said that they had seen B1 leave the property earlier that day. The call handler told Michaela's father that they could not enter the property without a warrant, and they were going to re-attend shortly. Before the police arrived Michaela's father obtained a key from the landlady and entered the

[43] Neither had been 'Domestic Abuse Matters' trained as they had joined the force after 2016 when DA matters was rolled out. Their DA training in initial recruitment was modelled on DA Matters.

property and found Michaela deceased in a bedroom. A second call was made to police from a neighbour to report the discovery at 22.38pm.

14.23 B1 was arrested at 11.55am the following day.

Evaluation of Practice - The incident

Domestic Homicide Reviews would not usually cover events *after* the death of the victim, however, the sequence of events for Michaela's death falls within the remit of the DHR as:

- The exact time of death has not been determined and it is therefore impossible to say with any certainty whether Michaela was alive when the officers called at the property. It is a source of great distress to her family that she may have been alive and died alone.
- The delay in apprehending B1 potentially put others at risk, specifically Michaela's family, who had a restraining order against him.
- It is the right thing to do to reassure residents of Cornwall that every effort is being made to embed learning and protect future victims of domestic abuse in the county.

Practice issues emerging from this sequence of events are:

1. The process for making urgent crime reports from outside the UK needs urgent attention as there is no evidence that there would be a different response if the same incident happened tomorrow.
2. There is a need for greater understanding of the remit and limitations of Crimestoppers referrals and the impact of absolute anonymity on information sharing. From a lay person's perspective, the role and response of Crimestoppers is confusing. It appears that:
    - Crimestoppers prioritised their own company ethos over the life of another and did not pass on the callers' information even though the the caller did not want to be anonymous and was happy to talk to police. The only reason they had called Crimestoppers was because 999 did not work from abroad and she asked Crimestoppers to place the 999 call for her.
    - Crimestoppers are unable to place a 999 call in a particular area, so they put it through 101 but only after taking 20mins to check this approach with their management.
    - They did not correct assumptions made by the police operator which had a direct effect on decisions made by first response officers.
    - The system protected the caller but failed Michaela yet the anonymity of Crimestoppers places them above reproach and there is no system in place for them to learn from DHRs.
3. The interaction between the police control room and Crimestoppers led to assumptions being made about the source of the information which influenced the decision making of officers on the ground. (i.e., rather than there being an understanding that this was first-hand information from

Michaela to her friend the assumption was that this was information from a neighbour and another "spurious referral". This contributed to the decision not to knock on the neighbour's door or undertake further enquiries. Michaela's parents rightly question why the cocoon watch that was in place did not ensure that neighbours were immediately spoken to understand whether they had relevant information.

4. The decision not to enter the property – whilst there are alternative arguments and interpretation of the legal basis for this decision - are explored in detail in **Finding Ten**. It is not unreasonable for members of the public to expect an emergency call to a high-risk domestic abuse victim with six MARAC hearings and the alleged perpetrator only released from prison in the last 14 days, with significant warning markers should meet the threshold for 'life and limb', particularly following reports of previous non-fatal strangulation.
5. There was no reflection and discussion with a supervisor and the officers state that the lack of direction from a supervisor to enter influenced their decision. They also omitted to make further enquires such as talking to neighbours, contacting family, or checking with local hospitals that would have helped them to make an informed decision. This seems to indicate the need for an expectation that there should always be a discussion with a supervisor which prompts consideration of the full range of enquiries that should be carried out and evaluates the known information when a decision is being made whether or not to use section 17 powers. The panel have been informed that the decision whether to enter is the responsibility of the individual police officer, but it would not be unreasonable for officers to feel that they could access advice and supervisory discussions to help them make such an important decision.
6. The importance of supervision discussions is confirmed by the comments by the police officer which raise important issues about the way in which responses may be influenced by biases and assumptions. All practitioners will bring their own biases to decision making, especially when required to make swift decisions, and it is important that organisations recognise this and provide training and supervision to support effective decision making. Training alone is rarely sufficient, which is why in this case the lack of discussion with a supervisor at a crucial decision-making point increased the risk of a bias driven response. In this case although an officer had received domestic abuse training, their understanding of coercive control/escalating risks (particularly linked to reports of non-fatal strangulation) was insufficient. Victim blaming statements are clearly evident: the IOPC report also found these comments unacceptable and asked for them to be addressed through reflective practice with the individual officer concerned. The chairs have been informed that these comments were likely to have been a demonstration of frustration by officers who wanted to help, but, whatever the cause, this is not satisfactory for officers with a mandate of

protecting high risk domestic abuse victims. The DHR chairs have not had the opportunity to talk to practitioners to fully understand the attitudes, values and culture that may lay behind the statement and it will be important to evaluate the broader effectiveness of domestic abuse training in the future. Michaela's family have found it extremely difficult to comprehend how any professional with the mandate of protecting the public could have visions of a woman being held with a hand over her mouth, and still walk away. This, in particular, has been extremely upsetting for the family to know, and they want assurances that Devon and Cornwall Police will commit to training their entire workforce regularly to understand domestic abuse psychology, with clear expectations around section 17 powers. There is also the additional possibility that the officer's thoughts and beliefs about Michaela was influenced by Michaela's DASSP status, as the officer had been employed during the time the DASSP scheme was in full operation. A discussion with a supervisor to reflect on why the decision was made not to enter the property or speak to neighbours may have uncovered some of the biases in play at that time.

7. The sequence indicates that there was an opportunity to clarify with the neighbour the exact time that they last saw Michaela and B1. There is a discrepancy between the statements of the police officers and the neighbour, and it is unfortunate that the body worn camera was switched off. Officers did not believe there was any uncertainty about when Michaela was seen alive and therefore did not probe more deeply to make sure that everyone was clear about what was being said. The assumption that she had been seen '*this morning'* appears to have lessened the degree of urgency to find out where she was at that time.
8. Overall, the confusion surrounding the Crimestoppers call detracted from the original message, which was that Michaela was being attacked and strangled. This in itself indicated a risk to life as it takes only 10 seconds for a victim to lose consciousness[44]. Being greeted by a dark and quiet house should have caused concern, not offered reassurance. The IOPC have recommended reflective practice for individuals, but consideration should be given as to whether this is a training requirement for the force.

In response to the Home Office Quality Assurance Panel, Devon and Cornwall Police confirmed the following training has been put in place since Michaela's death.

- 2022 – Domestic Abuse Matters Mentor training – delivered to over 700 officers and staff
- January 2022 – June 2024 – Training of nearly 500 Domestic Abuse Matters Champions

[44] https://www.strangulationtraininginstitute.com/strangulation-can-leave-long-lasting-injuries/

- 2024 – Dynamic role-play scenario-based training that incorporates section 17 PACE powers of entry delivered through the annual Officer Safety Training Requalification – this is delivered to every frontline operational officer
- 2024 – Homicide Timeline Training – Bespoke training sourced through Professor Jane Monckton-Smith. This is in the process of a targeted roll out with over 140 officers and staff completing the full package to date. Over 350 will be enrolled on the training package with a further assessment due in terms of how further it will be offered once the initial phase is concluded.
- 2024 – DA Matters Safe Lives training – so far delivered to over 250 officers and staff, largely concentrating on Domestic Abuse investigators
- Planned for 2024 – Police perpetrated Domestic Abuse
- Planned for 2025 – Frontline Domestic Abuse training.

15 FINDINGS AND RECOMMENDATIONS

Finding One

Recruitment processes did not follow best practice, and the national framework for safer recruitment lacks clarity and consistency.

Michaela met B1 whilst working at Julian House. When she was recruited the process of giving and receiving references did not provide the information needed to make an informed decision about her suitability for the role. Recruitment processes in other job roles were also not fit for purpose and could have harmed either Michaela or clients of the service.

Context to support recommendation 1 -

15.1 The events surrounding Michaela's appointment at Julian House raise a potential conflict between employment law and safe recruitment. This is not a new problem. Historically there has been a national issue where people who wished to harm others have gained employment with vulnerable groups such as children, and adults with support needs. Although in this case the issue was risk of harm to Michaela rather than her risk to others the lessons regarding the importance of safer recruitment still apply. Namely the importance of:

- Detailed application forms
- Self-disclosure
- Robust interviews that cover safeguarding, equality, and diversity
- Reference checks
- A thorough induction process
- Verification of qualifications and experience
- Risk assessments

- A probationary period once the person is in the role and regular safeguarding training that includes safeguarding adults at risk.

(*Source: Ann Craft Trust*).

15.2 Even where safer recruitment practice is followed, best practice in asking for and giving references can be inconsistent with some employers fearing that they can be open to legal challenge if they disclose details of any concerns they had about an employee's performance. The review heard that for groups who are within the vulnerable category the current situation regarding references is that only skeleton references are given, and the situation is now risker than it was at the time Michaela was employed. Guidance regarding sharing information through references and checking references when there are any gaps or ambiguous information is insufficient in these circumstances and it is significant that PACT have noted concerns associated with legal action if a "bad reference" is given. This means that common practice is to give very brief factual information.

15.3 Julian House received a very positive reference from Michaela's University. The PACT reference combined positive comments with 'I do not wish to comment' in response to three of twelve questions. Julian House was insufficiently curious as to why these specific questions had elicited that answer.

15.4 The issue in this case is compounded by the fact that the clients of Julian House (ex-offenders) are not deemed to be vulnerable by legal definition (i.e., "*someone aged 18 or above who may need community care services for reasons like mental health issues, disability, age or illness*"[45].) despite robust evidence showing that one in three people journeying through the criminal justice system are neurodivergent and many have complex mental health needs[46], high-risk offenders have a lifetime prevalence of psychiatric disorders (between 70-90%), intellectual disabilities suspected in over 50%[47] (although true numbers in the UK are unclear[48]). Consequently, Julian House reported that they occasionally experience 'pushback from the Disclosure and Barring Service' on individual cases when asking for checks on future employees. They always make sure they receive the DBS check but have to justify their reasoning on a case-by-case basis, which takes time and resource. This is a position that requires national review as there is a risk of some organisations working with offenders appointing inappropriate staff.

15.5 This is significant as there is a potential risk to clients through exploitation from employees, and a potential risk to staff members working with people with complex needs. Agencies working in this area need a recruitment system and DBS process that recognises the risks of working with this client group balancing the legalities of

[45] https://www.legislation.gov.uk/uksi/2002/446/regulation/2/made
[46] https://www.uservoice.org/wp-content/uploads/2021/07/Neurodiversity-in-the-Criminal-Justice-System.pdf
[47] https://www.sciencedirect.com/science/article/pii/S1752928X16000585
[48] https://www.sciencedirect.com/science/article/pii/S0891422211004379

employment law with the obligation to protect employees working with high-risk groups.

15.6 Michaela's parents are concerned that Michaela was not suitably qualified for the role at Julian House and that employment processes did not identify her vulnerability linked to her desire to help others. This would appear to be borne out by the emerging concerns at PACT about Michaela's inability to maintain professional boundaries. Scrutiny of her application confirms that she did not fully meet the person specification or essential requirements. Although it was not unreasonable to consider supporting her to develop 'on the job', there were a combination of factors that led to Michaela becoming at risk from B1. These factors were:

- Insufficient information sharing at the point of references – from PACT and follow-up after receipt of the reference by Julian House.
- Withdrawal of the first-choice candidate leading to Michaela's appointment without meeting the full person specification.
- Induction processes and training at the time not equipping staff to recognise risk posed by grooming behaviours.
- Supervision and support not identifying Michaela's propensity for emotional connection and the nature of her personality that increased her risk of overstepping professional boundaries.

15.7 It was positive that Julian House completed an Occupational Health check (via questionnaire) at the point of recruitment, however this did not identify any valuable information that could ensure that the right support was in place from the start.

15.8 Michaela's appointment to a receptionist role at a GP surgery is another example of lack of clarity and consistency regarding employment practice where staff are being employed in situations where they have contact with vulnerable people. It seems there is a need for clearer guidance to GP surgeries regarding best practice in obtaining references and DBS checks for non-clinical staff. Specifically, it should be made clear that DBS checks are required and that a reference from an employment agency is not suitable. An employment agency is not an employer and has a conflict of interest as they are placing the candidate in the job for a fee.

15.9 Later Michaela went on to work for the RNLI as a face-to-face fundraiser, talking to the public on local beaches. The recruitment process was via Facebook, and no background checks were carried out (as Michaela's role did not qualify for vetting) or references taken. This was a face-to-face public role, and it would seem to be prudent to have obtained references from previous employers.

15.10 Safe employment practice is inextricably linked to effective induction and training and specifically, training in recognising and responding to concerns about potential domestic abuse in workplaces in important. Whilst working for the RNLI, Michaela confided in a work colleague that she was being abused by B1 and another female colleague it is significant that her male colleague told the review that had Michaela confided in him he would not have known about domestic abuse services in Cornwall.

He is concerned about how to respond when he sees people on the beaches who he is worried about (e.g., women with bruises and children appearing fearful). The RNLI do give out beach safety leaflets and his view is that it may be helpful to add something about domestic abuse services as well as thinking about other opportunities to give information when they are worried that someone might be at risk of abuse.

Recommendation 1 – All panel agencies

Safe employment practice should be reviewed in light of the specific learning from this DHR to improve the safety of workers and service users. This should include as a minimum -

- Full references for positions requiring employees or volunteers to work with vulnerable individuals empirically proven to have higher rates of complex trauma.
- Clarity around employment law to debunk the myth of it being illegal to provide a 'bad reference'.
- DBS checks on all paid and unpaid candidates that are employed in agencies where contact with vulnerable and high-risk individuals would be expected.
- Specific and enhanced guidance within employment policies for recruiting paid or unpaid workers who may have their own vulnerabilities. This is particularly important as the positive benefits of employing staff with 'lived experience' is now recognised.
- Enhanced recruitment, training, mentoring, managerial support, and reflective supervision for workers operating in roles that may increase the risk of vicarious trauma.
- A mechanism for reporting significant breaches or incidents of gross misconduct to the Disclosure and Barring Service or another national body.
- Active campaigning to extend the DBS definition of 'vulnerable' to include specific groups that are evidentially known to have higher rates of complex trauma

Finding Two

The professional system designed to protect adults from domestic abuse struggles to achieve a whole family approach and excludes families, cutting out a potentially life-saving resource.

This case is an example of how important it is to work with victims to reduce their isolation from sources of support within their family and friend's network. For Michaela, assumptions were made about family relationships, safety plans did not include the voice of family members or address the factors driving the behaviour of the abuser.

Context to support recommendation 2 -

15.11 Michaela's family were desperately worried that she would be seriously harmed by B1, their concerns were not heard, and they were also oblivious to most professional efforts that were taking place to keep Michaela safe. This not only created a great

deal of stress within Michaela's wider family but was also a missed opportunity to identify risks and positive ways to work with the wider family system to improve safety for Michaela.

15.12 Family relationships may be complicated, and adult victims have the right to self-determination and control over who knows information about their life. However, in a domestic abuse context, careful consideration also needs to be given to the potential for the abuser to be exerting control and influencing the views of the victim and isolating the victim from sources of support.

15.13 Practitioners need time to reflect on whether this may be happening, alongside all the factors that might be influencing their approach. Research into the DHR process[49] identified that the testimony of families is not always given equal weight to the testimony of professionals, and we need to consider how far this mirrors our day-to-day work. In all cases it is important for practitioners to receive professional challenge which includes the extent to which they may be biased in the information they seek and their professional responses. This is explored further in relation to risk assessments in **Finding Four.**

15.14 In complex domestic abuse situations where there are many competing perspectives it is vital that we move to a position where families are heard and worked *with* rather than excluded. Even where there are fractured family relationships, families should be kept in mind throughout assessments and safety plans and offered specialist advice as to how best to support a relative experiencing coercive control or interpersonal violence. If this does not happen they may inadvertently act on ill-informed advice and (albeit through good intentions) escalate the risk.

15.15 GDPR may be cited as a reason for not involving families without the express consent of the victim. However, recent guidance[50] from the Department of Health and Social Care (introduced following repeated complaints from families bereaved by suicide that practitioners were reluctant to take or share information with them), states that the duty of confidentiality is not a justification for not listening to the views of family members and friends, who may offer insight into an individual's state of mind or predisposing vulnerabilities which may aid support. It also states that data protection law does not prevent sharing personal data in an emergency situation, including to protect a person from serious harm, or to prevent the loss of human life. In an emergency, data sharing must be necessary and proportionate, but the guidance states it may be more harmful not to share data than to share it.

15.16 The DHSC guidance adds that providing families with non-person-specific information in their own right, such as how to access services or specialist advice in a crisis is good practice. Although this guidance was a response to concerns where a

[49] Rowlands, J & Cook, E (2022) 'Navigating Family Involvement in Domestic Violence Fatality review: Conceptualising Prospects for Systems and Relational Repair' in *Journal of Family Violence* **37** pp559-572

[50] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement

person had taken their own life, there is no reason why this guidance should not be applied to homicide risk. Bereaved families of homicide victims have repeatedly told the reviewers that they did not know who to speak to, or that they were oblivious to multi-agency involvement. This cannot continue. It is causing distress, trauma, isolation, and more concerningly, a misinterpretation of the 'bigger picture'. Information sharing policies need to be reviewed in light of the DHSC guidance for information sharing with families to determine if the same prevention principles apply to homicide risk.

15.17 A whole family approach to domestic abuse where children are involved also involves working together across agencies to balance the rights and needs of the children and maintain a focus on risk to Michaela. In this case child and family services were resolute in their approach to keeping the children safe from B1 and did try to provide access to a social worker where Michaela could be open about any experience she had of domestic abuse from B1. Where Michaela did open up, her isolation from her extended family appears to have been taken as a given rather than potentially engineered by B1. An additional factor that needed to be addressed in both planning for the children and work with Michaela was the challenge of how to hold B1 accountable and offer him support to change.

15.18 There appears to have been no family group conference during care proceedings which would have been an opportunity to engage with the family system as a whole. It is beyond the remit of this review to explore the detail of proceedings in the family court but the potential role for family group conferences in situations of domestic abuse may be an area for further exploration.

15.19 It is now recognised in Cornwall that children's social workers cannot be solely responsible for working across the whole family system and need support in working with complex domestic abuse and the new domestic abuse specialists with the family assessment service is a welcome development. There will need to be an independent evaluation of the service and a clear measure of outcomes so that the commissioner can evaluate success and secure repeat funding. The panel heard that similar roles within the GP service have been extremely successful, but this only has short term funding. One key factor will be how far these developments are able to provide advice and support to extended family members.

15.20 A national overview of a multi-agency approach to safeguarding children in situations of domestic abuse[51] noted the importance of such a whole family approach and described this as, "*Interventions are focused on holding abusers accountable and offering them support to change. This approach means all services understand and account for all risks, not just physical violence, and risk assessments incorporate information from children and about abusers as well as information from non-abusing parents. Being domestic abuse-informed means not taking an incident-based*

[51] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107448/14.149_DFE_Child_safeguarding_Domestic_PB2_v4a.pdf

approach but focusing on the continuous patterns of behaviour by the person causing the harm. …"

15.21 A whole family approach is a complex area of practice as this case demonstrates. Agencies have their own focus: children's social care on the safety and wellbeing of the children, domestic abuse services[52]on the safety and needs of the victim, and probation on the needs of the perpetrator and the risks they pose to others. Within this network there is no one person or agency responsible for engaging and working with extended family members and friends who are desperately worried and do not know how best to offer their support. The impression is that the information from families is not valued and they in turn feel excluded from the system that is trying to keep their loved one alive. Victims do not exist in isolation – they are part of a community – and as such, it makes no sense to exclude the community (and specifically family members, where it is safe to do so) from safety planning strategies. There needs to be a sea change in the culture of how families are viewed by the professional system and there is an urgent need to open up the currently closed channel between families and the professional system. One potential avenue would be providing family advocacy, and the development of this approach is an important recommendation from this review.

15.22 There are potentially two forums where a whole family approach supported by family advocacy could be promoted.

15.23 Firstly, where child in need or child protection plans are in place, this should provide an opportunity to understand the whole family context and make sure that all family members are listened to and that their information influences planning to keep the victim safe. Any plans should include a focus on addressing the patterns of behaviour of the person perpetrating the abuse, but working across the whole family network may not be straightforward and might be affected by differing views as to the best approach to keeping both the child and victim safe. Children's social workers will be navigating complex family relationships and in some circumstances it may be unrealistic to expect them to provide the support and space needed by each individual within the family.

15.24 Secondly, MARAC is another obvious place where safety planning could take a whole family approach and consideration given to working alongside families in a positive way – taking account of the specific circumstances of each situation and the views of the victim.

15.25 There is a danger that MARACs assume that professionals hold all of the information needed to assess risk and develop a safety plan and this is rarely the case as recent DHRs have identified. All too frequently, friends and family hold vital information that is not known to professionals. Family testimony should carry the same weight and value as professional knowledge, therefore, there is a question of inclusivity and whether family and friends should be included in safety planning discussions when it

[52] In Cornwall this is provided by First Light.

is safe to include them. This does not mean family should be invited to MARACs but the opportunity for open dialogue should exist. The current interface between MARAC and the victim's 'extended community' is tenuous, if not entirely absent. Many family members are in a unique position to help, particularly in sharing safety information when a person is not engaging with professional agencies. Failure to act on this learning could cut off a vital protective asset for future victims.

Recommendation 2 – All panel agencies

The whole system of working with families/communities requires an immediate review to ensure that vital information is provided and received to aid safety planning and risk management in cases of domestic abuse. This should include as a minimum –

- A dedicated helpline number for 'affected others' to encourage friends, families, co-workers, and others to report concerns about domestic abuse or seek expert advice on how to support their loved ones/colleagues.
- The production of a standard proforma to obtain general information about the nature of concerns, alongside specific questions on unique character traits or aids/barriers to communication and engagement.
- The ability to provide a unique log number to enable affected others to add real time information.
- A dedicated county-wide webpage for all agencies to signpost affected others for essential safety information.
- A mandatory requirement to include whether family members have been engaged on all MARAC referrals (and if so, a specific space for including their contribution).
- A mechanism for obtaining a consensus statement which provides consent and the names of trusted others who can be contacted and engaged in safety discussions in the event an escalation of serious harm or a sudden disengagement without explanation/contact (similar to the DHSC consensus statement for suicide and self-harm).

Finding Three
The professional system 'did to' rather than 'did with'.

Opportunities were missed to ensure that Michaela's voice was heard and understood, and assumptions were made across some agencies about her views and reasons for her actions. The system was not flexible enough to provide one person who could form a positive helping relationship with her.

Context to support recommendation 3

15.26 A strong theme running through this review is a system (and individuals within it) that tried to help Michaela, offered support, enacted powers at their disposal, but became

frustrated that she remained at risk of harm from B1. It seems that there was little focus on working alongside Michaela to listen to what she wanted and believed could make a positive difference to her life. Assumptions were made about what engagement with services looks like and little evidence that any practitioner had the opportunity to reflect in supervision on the extent to which their responses might have been unconsciously driven by their frustrations and belief that she did not help herself.

15.27 Children's social care did provide a social worker who appeared to have a good relationship with Michaela, but Michaela's parents believe that from Michaela's perspective, the remit of this social worker was to gather information proving that she could not care for her children and the involvement of statutory services meant that she had to choose between her children and B1. For Michaela this was an impossible choice. Although the intentions behind providing the extra social work support may have been more positive than was perceived, it did not take into account that people will self-select who they trust, and it was unlikely that Michaela could really trust the agency that had removed her children. She also did not wish to engage with other domestic abuse services, possibly because once again she would have perceived that they would wish to persuade her to give up B1. Michaela needed to be given an opportunity to identify who she could trust as a source of help and support. This may have been a good opportunity for joint work between children's social care and the IDVA.

15.28 There was a brief discussion with her GP about whether she wanted more help, but this remained outside the domestic abuse system as GP practices are not part of the MARAC process.

15.29 Michaela was being asked to fit into the services already in place rather than services fitting her needs. The fact that she "did not engage" should have prompted the question as to why this was happening and whether services needed to have a different focus. There were windows of opportunity when Michaela expressed fear, and this could have been a point when, rather than immediately assuming separation was the answer, a discussion could have been had about how to remain together with safeguards in place. Specifically, how her family and friends might be part of the solution could have been an important approach as discussed in Finding Two. Alternatively, there may have been opportunities to discuss in more detail how B1 could be supported with accommodation and other practical help so that Michaela felt less responsible for providing him with a roof over his head when he left prison. It remains unclear to Michaela's family, when B1 was released from custody, who was responsible for asking whether Michaela wanted him back or did this become the default position because there was nowhere for him to go?

15.30 The danger of an approach which "does to" rather than "works with" the victim and becomes frustrated at their lack of response is that, unwittingly, the victim becomes blamed for their own abuse.

15.31 Another issue was the potential for reflecting on the outcome of Michaela's contact with the psychologist who recommended an autism assessment. Not all agencies were aware of this outcome, and a referral for an assessment was not pursued because Michaela was upset at the way she had been informed about the psychologist's views and told the GP that no assessment was needed. The issue is not whether the request for an assessment was right or wrong. Rather, it is about a good professional knowledge base (in this case about the implications of Michaela's possible neurodivergence), rigorous information sharing, professional curiosity, and healthy multi-agency debate. The concerns shared by the psychologist did not generate any inquisitiveness or exploration as to whether this possibility could inform professional responses. The complete absence of discussion about the subject prevented MARAC from questioning the impact of neurodivergence on a victims' fear responses and anticipation of danger. It removed contextual intelligence and a potential reasoning for Michaela's perceived inability to recognise the danger she was in. Mostly, it removed the opportunity to just stop, reflect and revise thoughts, decisions, and actions. This is an important area of learning for all agencies and indicates an area of development.

Recommendation 3 – MARAC

The MARAC Steering Group should immediately review MARAC practice in light of this DHR and respond to the learning identified. This includes (but is not limited to) -

- Incorporating strategies for providing greater opportunities to listen to the victim/perpetrator and what they feel would help them.
- A mechanism for establishing which practitioner has the best relationship with individuals and a means to liaise with the employing agency to secure practitioner time and resource to enable them to act as the trusted liaison for the duration of MARAC involvement.
- The creation of an escalation stage beyond a standard MARAC hearing that draws on extended expertise to think resourcefully and creatively to resolve 'stuck' cases.
- Careful recording (with details) of the action taken, by whom and with clear outcomes for all statutory and non-statutory interventions/efforts. This record should be easily downloadable and available at short notice to be used as an evidential document to demonstrate how all possible avenues to protect the victim and manage the perpetrator have been exhausted.
- A clearly defined policy for consulting legal counsel on an application for Inherent Jurisdiction when all professional avenues of intervention have been exhausted. This should include an accessible and standalone protocol on how to apply to the High Court for Inherent Jurisdiction.

Finding Four

In this case, the risk assessment and safety planning methods were unsatisfactory for the level of potential harm.

The multi-agency system was not effective at coming to a collective conclusion about the level and nature of risk or working together to implement an outcome focused safety plan. Specifically, information was not always shared, warning markers were not effective and arbitrary timeframes added to historical information impeded professionals from assessing the bigger picture.

Context to support the recommendation 4.

Information gathering

15.32 Assessing risk and effective decision making in complex cases is a crucial aspect of keeping people safe and requires the right systems and processes to support practitioners in the task, as well as equipping them with a high level of knowledge and skill in the assessment and management of risk. MARAC is a vital part of this system and does successfully manage risk and support victims in many cases annually. However, this case highlights areas where this did not work well for Michaela and provides an opportunity to reflect on areas where improvement is needed in the future.

15.33 Risk assessment is a process which involves gathering the best possible information in order to evaluate static and dynamic factors[53]. MARAC should provide a forum where information can be brought together, and risks evaluated, but this did not work well for Michaela. Curiosity is vital to effective information gathering and there is no evidence of any curiosity about B1's history as a parent and the likelihood that a neighbouring local authority would have information that would help an assessment of his risk to Michaela. Within Cornwall, information known within children's social care did not routinely inform MARAC discussions although this should have been possible as children's social care is represented at MARAC.

15.34 Children's social workers were not fully integrated into MARAC discussions and safety planning, highlighting the absence at that time of a robust multi-agency approach to assessments and plans. The children's social worker submitted important information to MARAC via e-mail, but the opportunity to use this information to understand Michaela and work together on an integrated safety plan, was lost.

15.35 The DHR review process itself has revealed some of the problems in gathering together all relevant information about past incidents of domestic abuse. B1's domestic abuse history with a previous partner was known to Devon and Cornwall Police but not included in the information for the DHR as it related to incidents n 2005-7. However, these incidents were serious, and on one occasion resulted in B1 being charged with common assault and criminal damage and his partner moving to a refuge. This indicates the need for a shift in understanding regarding the significance of past domestic abuse incidents, and a practice culture which ensures

[53] A static risk factor is one that can't change, for example historical factors such as childhood abuse or previous history of violent behaviour, whereas a dynamic risk factor is one in which the level of risk can fluctuate over time, and therefore has the potential to change,

that all previous domestic abuse is shared at relevant points in both case management and review processes, supported by a relevant terms of reference.

15.36 Probation records also contain reference to risk of domestic violence to partners going back to 2007 contained within OASys assessments although the review has been told that it would not be usual practice for court officers to trawl through all previous assessments when completing a pre-sentence report. It is also of note that when probation officers request police information in respect of domestic abuse they are restricted to asking for information relating to the last two years except in exceptional circumstances. There is the issue of proportionality in information sharing. However, in cases of domestic abuse the default should be that *all* past incidents are relevant if current risk assessments are to be as accurate as possible and specifically understand the degree to which abusers have engaged in treatment programmes. In the case of B1 there is evidence that he did not complete all of the IDAP programme in 2008.

15.37 Another fundamental issue for the system is the integration of GP information into the MARAC process and the sharing of safety plans with GPs. During the period of this review GP practices did not have access to the HALO system and there was little, if any, information sharing between GP practices and MARAC.

Up to date knowledge about risk – nonfatal strangulation

15.38 Effective analysis of risk requires up to date knowledge informed by research and practice. In this case, it is clear that assessments of risk at that time across all agencies did not recognise the seriousness of non-fatal strangulation, indicating that there is a need for a focus on staff development and training. The review has been told that some training had already taken place within Devon and Cornwall police, but this case indicates that this needs to be refreshed, extended to all agencies, and evaluated to determine the outcome of these staff development activities on practice.

15.39 Risk warning processes in relation to nonfatal strangulation also need reviewing at a national level. It is concerning to the reviewers that Non-Fatal Strangulation (NFS) does not lead to a warning marker on the national police system, particularly as it became a criminal offence in June 2022. Whilst the reviewers appreciate that there are many serious crimes that do not have a warning marker, the reviewers are concerned that future victims of non-fatal strangulation might not be kept safe. Although there may be individual factors that lower risk (for example if the suspect had died or moved overseas) immediate action is needed to make sure that where a victim had lost consciousness or experienced a loss of bodily function during an incident of NFS, they are automatically considered high risk on a DASH risk assessment (without the need for any other risk factors).

Warning markers

15.40 One element of risk assessment is understanding the significance of the various warning markers that may be placed on a person's records. This is important in the ongoing assessment of risk as well as in situations where there is an immediate

danger to the victim. In this case, warning markers were not used consistently, and their significance was not understood by all practitioners involved with Michaela.

15.41 B1's GP did not, for example, upload a warning marker on his records identifying him as a violent offender. Both Michaela and B1 had been assigned DASSP (Domestic Abuse Serious and Serial Perpetrator) status and this was noted in a conversation between the children's social worker and adult social care. It was also conveyed to the attending police officers on the night they attended Michaela's property. However, Devon and Cornwall police have informed the review that as far as the police were concerned the use of DASSP was discontinued in 2017, as they were not deemed to be an effective way of managing risk. This review has been unable to clarify (without direct conversations) with the practitioners involved as to the sense they made of this marker and how it might have influenced their understanding of risks – specifically as both parties were assigned this status.

15.42 Although MARAC is not a warning marker as such, the fact that there were six MARAC meetings in the space of four months should have provided a clear indication of a high level of risk, specifically on the night police officers were called to her property. All members of MARAC, (of which Devon and Cornwall Police are consistent attenders), know that the Home Office criteria for a MARAC is "an imminent risk of serious harm – the risk is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible"[54]. Therefore, this marker/notification must carry weight when it is observed on individual IT systems. The issue of identifying the significance of repeat MARACs has been identified in Cornwall and the response is explored in appendix one.

Risk assessment and the meaning of risk

15.43 More generally, risk assessment remains a challenge in a multi-agency system that uses a range of methods to reach a conclusion about severity and then what should happen as a result of the assessment.

15.44 In this case:

- Michaela's risk of harm from domestic abuse was rated after each incident via a Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) risk assessment tool. Although this can be used by any practitioner trained in its use, in this case it was exclusively used by police officers, often using their own judgement as Michaela refused to be involved. This assessment focused on immediate risk of harm and was linked to the decision whether to refer to MARAC – in Cornwall high risk cases are automatically referred. This risk assessment has the potential to encourage an incident-based focus rather than an assessment of the overall picture of risk over a prolonged period of time.
- The risk posed by B1 to Michaela and others was assessed by probation via an OASys assessment. This includes an assessment of needs and risk to self and others. This is

[54] https://www.devon.gov.uk/dsva/information-for-professionals/marac/

an assessment that looks beyond the immediate "here and now" risk to the best way of working with the offender in the future.

- Within the OASys assessment B1's risk of serious recidivism was assessed using the RSR tool[55]. This predicts the likelihood of someone committing a seriously harmful offence that results in conviction over a 2-year period, beginning at the start of a community order or release on licence.
- Childrens social care assessed the risks to Michaela's children via a child and family assessment, and this assessment informed their decision to instigate care proceedings for Michaela's oldest child. This assessment is not via an actuarial tool but an approach which gathers and analyses a wide range of past and present information from the child, family, and wider community to reach a decision as to whether they are safe from harm and how their needs can be met.

15.45 Unless everyone in multi-agency meetings understands the process and meaning of the various risk assessments there is the potential for confusion and error. It is extremely difficult to make sense of the risk rating systems if you are a victim, perpetrator, family member or friend. Indeed, a lay person may ask why similar questions, such as "risk to others" are rated differently based on the same incident.

15.46 Even though professionals may feel that they understand the intricacies of risk assessment processes, the danger exists whereby the headline of low/medium/high risk is what is heard by other agencies without them having a full understanding of the nature or context of the assessment or the degree of professional judgement used at any point in time. It is particularly important when a second risk assessment by another agency reduces the headline risk assessment, that everyone understands what that was based upon, and what may have changed in the intervening time.

15.47 Any assessment will (rightly) include a degree of professional judgement and cannot be totally free from bias and error.[56] Reflective supervision for all practitioners is vital in reducing the impact of this including unintended outcomes for the victim. MARAC could play an important role in promoting professional debate and is the forum where it is most likely that the various assessments will come together. There is the need for a robust discussion where different risks assessments can be challenged and understood in order to ensure that the resulting plans are effective in mitigating risk. This situation will also work best where MARAC has all the available information: this did not happen consistently in this case.

15.48 A review of evidence into risk assessment and decision making in children's services[57] made the important comment that the extent to which children and families are

[55] RSR stands for Risk of Serious Recidivism.

[56] https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/12/Academic-Insights-Kemshall-1.pdf

[57] https://whatworks-csc.org.uk/research-report/improving-the-quality-of-decision-making-and-risk-assessment-in-childrens-social-care-a-rapid-evidence-review/

directly involved in decision making should itself be seen as a key indicator of quality. MARAC is the ideal opportunity to challenge each agency and make sure that the voice of the victim is centre stage. Sadly, in relation to Michaela, too many assumptions were made rather than really trying to understand her situation from her perspective.

15.49 The above evidence also confirmed the difficulty making decisions on crucial issues in conditions of uncertainty, often under considerable pressure in terms of time and workload, and on the basis of information that is incomplete or may be changing rapidly. Practitioners need to be able to both integrate the formal and practical knowledge that has accumulated over time alongside rapid assessments and decisions during periods of volatility or crisis. This demand a high level of professional expertise in order to avoid overly intuitive approaches, which carry the risk of bias, or overly procedural approaches, which may be insensitive to contextual information. Use of unqualified staff in highly sensitive complex cases is unlikely to result in the level of expertise required.

15.50 There is good evidence that in this case probation practitioners did not always have sufficient time; workloads were high and expertise in crucial aspects of working with domestic violence was lacking and this is explored further in Finding eight.

15.51 In addition, tools they were using may not have been tailored for assessments in domestic abuse situations. The RSR guidance[58] for example notes that, *"…{t]he tool, however, is not specifically designed to predict all behaviours associated with domestic abuse, such as coercive control, stalking and less serious violence, i.e. that which is not included in the list above. Police domestic abuse checks may tell us an individual is repeatedly offending but is not convicted, or we may be aware that there are convictions that have involved plea bargaining and therefore practitioners need to be mindful that the RSR score could be an underestimate in these situations."* In the case of B1, most of his convictions were nondomestic abuse related although there was ample evidence of the serious and escalating harm towards Michaela.

15.52 A safeguarding adult review in 2018[59] involving the same local probation service raised the issue of risk assessments and use of unqualified staff. This DHR has not been able to ascertain how effective that review had been in improving local practice. Multiple reviews arriving at the same conclusions over time would point to a system

[58] Risk of serious recidivism guidance - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1060610/Risk_of_Serious_Harm_Guidance_March_2022.pdf

[59] The SAR into the death of Adrian Munday https://devoncc.sharepoint.com/sites/PublicDocs/AdultSocialCare/DevonSafeguardingAdultsBoard/Forms/AllItems.aspx?id=%2Fsites%2FPublicDocs%2FAdultSocialCare%2FDevonSafeguardingAdultsBoard%2FSAR%20Z%20report%20%2D%20FINAL%20%2D%20pdf%2Epdf&parent=%2Fsites%2FPublicDocs%2FAdultSocialCare%2FDevonSafeguardingAdultsBoard&p=true&ga=1 https://nationalnetwork.org.uk/2018/SAR%20Z%20report%20-%20FINAL%20-%20pdf.pdf

that is not successful in learning and moving forward. Any barriers to practice improvement need to be understood and acted upon.

MARAC and risk assessment and safety planning

15.53 The important role of MARAC is highlighted above, but MARAC meetings are also affected by lack of time for in depth reflection and discussion. Several cases will be discussed at one meeting, allowing for little more than a superficial approach to exploring the detail and formulating an agreed assessment and plan. Safety plans are generally no more than a list of actions rather than a plan which identifies specific outcomes, how they will be measured, how risks will be mitigated if change does not happen, and who will be accountable for ensuring implementation and evaluation of outcomes. Action is needed to give MARAC's the time and resources to develop more detailed plans, which take account of the victim's views, the possibilities for support from the family and friend network and clarity about what needs to be achieved and how progress will be measured.

15.54 In Cornwall, there is now a system for identifying repeat incidents and taking a deep dive exploration of what worked, what didn't work and common themes, as well as arranging more multi-disciplinary discussions if needed. However, it must be recognised that risk can't always be reduced through agency intervention. Multiple vulnerabilities and lack of criminal justice outcomes can still result in repeat referrals to MARAC.

15.55 In summary the disparity of risk ratings between agencies for the same case is concerning and could be considered confusing and unsafe by a lay person. Currently, all agencies attend MARAC and unilaterally agree that the case meets the Home Office definition of high risk (i.e., *'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible. The potential event is more likely than not to happen imminently, and the impact could be serious. There is most likely a need for immediate intervention'*). Alongside MARAC, each agency has the autonomy to return to their agencies and assign a lower/different risk rating through their own agency-specific risk assessments. The reasoning offered is that each agency assesses different things. However, where a question is the same (i.e., risk to others), this is hard to understand, and professionals need to be prepared to justify this reasoning to bereaved families.

15.56 The misallocation of an appropriate risk status in this case is an echo of similar homicides in the UK, resulting in too many innocent deaths, and therefore, there must be a review of the risk assessment system for MARAC-attending agencies. If a unified risk rating is unachievable for active MARAC cases, then the justification for maintaining the status quo must be communicated to the families of these bereaved relatives, because the current system makes no sense to those not involved in the system on a regular basis.

Recommendation 4 – All panel agencies

The whole system of risk identification, assessment and management should be reviewed in response to the learning from this DHR. Specifically, this should include as a minimum –

- MARAC Flags being added to the victim, children, AND perpetrator's records on IT systems and case/clinical records to enable practitioners to identify when a perpetrator's risk is being managed within a formal multi-disciplinary system.
- Recruit the assistance of relevant parliamentary offices or national bodies to overcome barriers or concerns related to adding warning markers to perpetrator records.
- A mechanism for routinely requesting past and present cross-border checks for victims/children/perpetrators with known professional contact in other areas before deciding on the level of risk.
- Removing all arbitrary timeframes on historic events to ensure longitudinal assessments of risk can be made (including disclosures under Claire's Law)
- An investment in reflective supervision to improve decision making by front-line practitioners, with a clear working protocol for mandatory reflective supervision for all MARAC representatives.
- A clear mechanism for arriving at a consensus on the status/level of risk for all MARAC referrals, which is then applied across all agencies for the period of MARAC involvement.
- Active use of the Home Office definitions of risk levels in risk assessments (i.e., High = *A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible. The potential event is more likely than not to happen imminently, and the impact could be serious. There is most likely a need for immediate intervention*').
- An active campaign to raise public awareness of non-fatal strangulation and how to report it.
- Upgrades to IT systems within Probation, the Police and GP Services to enable practitioners to undertake simple search functions of key terms against a person, (not individual record entry)

Finding Five

The knowledge and skills that practitioners need to recognise the risk of financial abuse require further development.

Much of the information about the risk of financial abuse has become clear after Michaela's death. There were some opportunities to exercise curiosity and ask questions which could have helped practitioners incorporate this understanding into their risk assessments and plans.

Context for the recommendation 5 -

15.57 Although the recognition of financial abuse cannot be separated from effective risk assessment practice, it is presented as a standalone finding. This is because unlike the clear risk of violence posed by B1, the possibility that Michaela was a victim of financial abuse does not feature in the discussions about risk. This is partly because much of the information was only known to family and friends and is yet another reminder of the importance of developing working relationships with people in the victim's network.

15.58 Additional material within the coroner's bundle points to potential financial exploitation – These relate to:

- B1 informing his probation officer on 18th March 2021 that he will not be needing any support to claim benefits whilst in the community because Michaela was supporting him.
- Continuous requests from Michaela to friends, co-workers, and family to borrow money (from £5-£100) between April 2020 and May 2021, including requests to pay money to B1's prison card and buy expensive items of clothing on Clear Pay.
- Statements from friends in October 2020 witnessing B1 attack Michaela, grabbing her by the hair and yelling "you don't know how hard it is to be addicted to drugs", when she did not have the money to purchase his wine.
- A statement from a friend who would borrow money from Michaela when she got paid to ensure she could feed it back to her throughout the month because B1 would otherwise take it and leave them without electricity or food.
- Friend's knowledge that Michaela was buying B1 up to 12-13 bottles of wine per day and had a tab at the local post office and shop.
- Michaela took a job in a factory in the Autumn of 2020 to earn more money because B1 was spending it – even attending with bruised eyes because she needed the money so much – however, Michaela had to stop work as B1 damaged her car.
- Michaela would ask to borrow money just days after being paid.
- Evidence in June 2020 showing that Michaela had given B1's child her bank card details, and he had taken advantage by overspending. Two days later, more money was taken from Michaela's account when she realised that her PayPal account was linked to the card and had also been used.
- Testimony from a friend evidencing that Michaela had opened multiple bank accounts to try and get overdrafts.
- B1 taking Michaela's laptop and phone after she asked him to leave.
- Michaela being dismissed from her employment due to (amongst other reasons) asking to borrow money from staff.
- Michaela told a children's social worker that she had stopped paying rent to fund B1's drug business. This was because they did not have enough money to cover the rent and needed to earn more to avoid homelessness.

- The social worker for B1's child received an email from Michaela's mother expressing concerns about financial abuse.

15.59 This information indicates that Michaela was likely the victim of financial abuse, and if further questions had been raised by professionals, the full picture of Michaela's financial activities may have been established. It is now clear, that Michaela took responsibility for funding B1's substantial alcohol addiction, and she also assumed responsibility for pleasing his child who was in the care of another authority. Michaela became stuck in a cycle of starting every payday in debt and was unable to escape the practice of excessive borrowing to support B1. It is not known how many accounts she opened or if she used credit card facilities, however, the review has established that she borrowed from a range of different people and set up a 'tab' with local convenience stores and the post office. We also know that Michaela was the victim of physical attacks when she could not meet B1's financial demands.

15.60 Financial abuse, if recognised by professional agencies at the time, may have opened options within the Care Act 2014 and a further safeguarding referral to adult social care. Some of these concerns would have been knowable to MARAC if information had been gathered from Plymouth children's social care, full information had been shared into MARAC by the Cornwall children's social worker and a real effort had been made to engage with Michaela's family to hear their concerns.

Recommendation 5 - Safer Cornwall and MARAC

There should be an agreed strategy for improving the identification and response to financial abuse through awareness raising, a staff development programme and case audit to confirm that this activity has had a positive impact on practice.

Finding Six

The professional system is not yet effective at recognising and working with coercive control in practice.

This is not the first domestic homicide review in Cornwall that has identified limitations of the professional system in identifying and responding to coercive control and the extent of B1's psychological control over Michaela was not named, analysed, and responded to.

Context to support recommendation 6

15.61 The evidence from this review confirms that there is not enough knowledge within the system to critically review domestic abuse behaviours to identify the underlying motivations, particularly where a dynamic of coercive control exists. Specifically:

- The available perpetrator programme (building better relationships) that B1 was referred to as part of his Community Order does not adequately address coercive control and is not effective for this typology[60]
- Risk assessments are insufficient as they often focus on the 'here and now' of specific incidents.
- There is still an incident-based culture and response from most agencies.
- Physical assaults still receive a greater response (or weighting) than a call to report subliminal coercive control.
- Victim blaming may be more prevalent when professionals do not understand the complex biological, psychological, and sociological factors underpinning domestic abuse.
- The system downgrades risk when legal sanctions are taken, or separation occurs - when this in fact escalates the risk in coercive and controlling relationships.
- MARAC has no statutory footing to ensure coercive and controlling perpetrators are monitored.
- Officers on the ground do not know the totality of the risk and there is no warning marker for coercive control.
- Courts cannot act quickly enough (weekends) for breaches of orders/license conditions.

Recommendation 6 – Safer Cornwall with all panel agencies

A training and development strategy (led by Safer Cornwall) should be developed focused on improving recognition and response to the psychological aspects of coercive control. This strategy should include as a minimum:

- Cascading the learning from DHRs and the use of case studies to embed knowledge and understanding.
- Specific examples of insidious, subtle, and covert psychological tactics of coercive control designed to unsettle and unground an individual's sense of reality.
- Enhanced training for supervisors to support practitioners to be curious and proactive in reporting seemingly innocuous behaviours that could be concerning.

Finding Seven

There is no meaningful escalation procedure in place when the system (statutory legislation and non-legal services) is no longer able to keep someone safe.

Agencies individually and collectively were very concerned about increasing risk to Michaela but were unsuccessful in developing a working alliance with her. Her family were

[60] https://www.russellwebster.com/coercive-control-in-domestic-violence-perpetrator-programmes/

also terrified that she would be harmed but felt powerless to stop it. In these circumstances opportunities for escalation need to be clearly identified including legal action if needed.

Context to support recommendation 7

15.62 Situations where a victim, who has the mental capacity to make their own decisions, does not want to accept any help yet appears to be in grave danger presents challenges for practitioners and family members. Making unwise decisions is not the same as lacking mental capacity or having an impairment of the mind or brain (under UK law). However, the debate is whether the nature of domestic abuse changes a person's ability and freedom to assess their own risk and make their own decisions due to fear, duress, and undue influence. In Michaela's situation it seems she swung between a belief that she could make a real difference to B1's life and extreme fear of his actions when he was under the influence of drugs or alcohol.

15.63 In extreme cases such as Michaela's where there is a serious risk to life, practitioners and family members can feel helpless and powerless to protect loved ones/adults at risk, particularly when they observe escalating physical violence. This can lead to desperate referrals to adult safeguarding (as seen in this case), but these seldom meet the thresholds for intervention if the person does not have social care needs. Best practice advice in this situation is to make safe enquiries, build trust, use legal tools (to give space for action) and empower the person to make their own decision using the least restrictive option.

15.64 Although this is best practice, it does not make the situation any less horrifying for concerned loved ones and highlights the far-reaching traumatic impact of domestic abuse. It is important that this extended victimisation is acknowledged within the professional system with care, compassion and support offered to concerned friends, family, and professionals wherever possible.

15.65 One rare legal option, when all other legal and support avenues have been exhausted, is an application to invoke the inherent jurisdiction of the High Court. 'Inherent jurisdiction' is a term used to describe the power of the High Court to use its inherent jurisdiction in accordance with Human Rights legislation to assist professionals in gaining access to assess a named vulnerable adult and give them time and space to ensure decisions are being made with free, real, and genuine consent.

15.66 This is not a straightforward route as the courts will always strive not to undermine the principles in Section 1 of the Mental Capacity Act, especially in relation to unwise decisions[61]. Inherent jurisdiction can only be exercised where there is no other avenue. It is a last resort option and cannot be used by social care or safeguarding practitioners without a court order. MARAC would need to prove that it had

[61] Cases relating to unwise decisions in relationships often make reference to Sheffield City Council v E [2004] EWHC 2808 (Fam) [2005] 1 FLR 965

exhausted all statutory powers to intervene and protect the named vulnerable adult. The purpose is not to overrule the wishes of the named adult with mental capacity, but to ensure that the named adult is making decisions freely without fear, intimidation, constraint, or exploitation from the third party[62].

15.67 There are three criteria to satisfy the threshold for inherent jurisdiction[63] which are summarised below.

- **Criteria 1:** The named person meets the definition of vulnerable (i.e., a vulnerable adult who is unable to protect themselves from harm or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent"[64]. It is this coercion, or abuse, that renders a person vulnerable.
- **Criteria 2:** The named vulnerable person has mental capacity (i.e., they do not have any cognitive impairment or disturbance in the functioning of their mind).
- **Criteria 3:** All other less restrictive, more proportionate statutory powers and non-legal interventions have been exhausted. Before considering an application to the High Court, MARAC must first consider whether all other avenues - which may be less restrictive, and therefore more proportionate - have been exhausted. The court cannot use inherent jurisdiction where it explicitly conflicts with an existing statute.

15.68 In Michela's situation, it is possible that she met the first two criteria, but the reviewers would suggest the final criteria would be difficult to prove as the MARAC did not accurately record an outcome-based safety plan, nor did it seek to include Michaela's voice. Similarly, not all statutory powers and non-legal interventions had been explored for B1.

15.69 Future victims may benefit from an application for Inherent Jurisdiction however, this requires clear evidence of a failure of previous planning to minimise risk and in order to provide this Cornwall will need to review the way that safety plans and their outcomes are evaluated and recorded. Cornwall's MARAC has evolved to include a secure multi-agency information sharing form (Halo) which ensures accurate knowledge sharing as well as all communications being accessible within one system and linked back to the client record. This includes conversations about actions needed to reduce risk from the moment a referral is received. This does not necessarily constitute a safety plan with clear measurable outcomes and the current record would be improved by a standard framework that could be submitted with an emergency application to the high court at a moment's notice. The chairs have

[62] Re SA [2005] EWHC 2942 (Fam) (para. 77)

[63] https://www.scie.org.uk/safeguarding/adults/practice/gaining-access

[64] (Re SA [2005] EWHC 2942 (Fam) para. 77).

provided an example of how this may be used by completing a template form for the MARAC chair to consider (See example at Appendix 5). Initial feedback is that the format of this form is useful and more importantly that it allows for MARAC to evidence how all avenues have been exhausted. The intention is to include the form in the MARAC Operating Protocol.

Recommendation 7 – MARAC, Adult Social Care, CFT and Safer Cornwall

A small working group should be formed to research the feasibility of using Inherent Jurisdiction as a last resort option for individuals who 'fall through the net' of existing statutory capabilities to preserve life. A feasibility paper should be produced which outlines its utility as a last resort option, and the work required to enact the escalation route within standard working practices in Cornwall.

Finding Eight

Risk management of offenders needs urgent improvement both within the prison system and in the community.

Even whilst in prison it seems that B1 was able to exert power over Michaela, but the most significant error was the conclusion of the pre-sentence report which resulted in the Community Order two weeks before Michaela was murdered. The quality of probation risk assessments in situations of domestic abuse extends beyond Cornwall and in this case occurred due to the wrong person being allocated the task and inadequate supervision thereafter.

Context to support recommendations 8a, 8b and 8c -

15.70 The issue of risk assessment and management of violent offenders by the probation service replicates issues noted in other local and national reviews and Michaela was badly let down by the service in her local area, but evidence suggest that this is a systemic failure reaching beyond the southwest of England. A (July 2023) thematic inspection of domestic abuse work by HM Inspectorate of Probation [65] provides evidence of this issue extending beyond Cornwall with only 28% of assessments in the sample providing a sufficiently thorough and clear analysis of risks of domestic abuse and noted that there were few opportunities for staff to engage in multi-agency training to work and understand the roles and responsibilities of other agencies.

15.71 Structural causes for errors across the system are noted as capacity, workloads, insufficient training, and supervision. The changes to the system as a result of the Offender Rehabilitation Act (2014) and the creation of Community Rehabilitation

[65] https://www.justiceinspectorates.gov.uk/hmiprobation/inspections/domestic-abuse-2023/

Companies (CRCs) to work with low-risk offenders has also played its part. This caused disruption to the system and a reliance on accurate risk assessments to identify who should be deemed high risk (and therefore managed by the national probation service). At the time of Michaela's death there was yet more imminent structural change with the CRCs being disbanded and staff brought back within the National Probation Service. Any significant structural change is likely to be unsettling, and without really effective leadership and focus on maintaining quality, will have a negative impact on those relying on the service.

15.72 It is now clear that leadership within probation at the time of the pre-sentence report was ineffective. B1 was allocated to an unqualified worker, there is no evidence of supervision and quality control of their work. They were set up to fail with disastrous consequences for Michaela. The independent review into the death of Joseph McCann noted that*: It takes experience, time, and support to develop the skills of reflective practice. It also requires a stable organisational structure and a high level of professional support* (p50). Also, *Probation staff managing high-risk individuals require well developed skills: to interview effectively; to seek out and analyse information from a range of sources; to see beyond superficial compliance. They also need their managers to provide good oversight, investigative supervision, and effective support* (P3). The recommendations for the National Probation Service from that review are equally applicable in this case.

15.73 Other issues relating to risk assessments noted in the case of Joseph McCann chimes with this case. This is the highly skilled task of balancing an analysis of historical information, including previous convictions (static factors) with more recent context, and attitudes and behaviours that can change (dynamic factors). Problems with accessing information on previous convictions and properly analysing these can lead to too much emphasis on immediate presentation and in the case of B1 his extensive offending history with persistent lack of compliance did not sufficiently influence the final risk assessment. It seems there is a national issue that needs addressing, both in the way information can be accessed and ensuring the right level of skill to carry out the task.

15.74 In addition, risk assessments need to lead to intervention and criteria for access to services should not work against getting the right help to the right person at the right time. In this case, B1 did not reach the criteria for a Building Better Relationships programme as his index offence did not relate to domestic abuse even though there was evidence of this being a feature of his offending behaviour. It is possible to override this decision, but it raises an important issue as to the way our system is focused on the last incident rather than a holistic view of the whole person. This is not conducive to an approach which focuses on early intervention and prevention.

15.75 It is now known that when B1 was in prison he continued to exert power and influence over Michaela, encouraging her to break the law by procuring a mobile

phone for his use[66]. If contact was not wanted by Michaela, there is a system to intervene, however, where a victim still welcomes contact, no such process exists. This is due to Article 8 of the Human Rights Act (The right to respect for your private and family life) and is a complicated area of legislation that requires specific national attention in relation to the crime of coercive control. Research and statutory guidance [67] (on one hand) recognises the seriousness of coercive and controlling abuse and its association with patterns of behaviour that intimidate, isolate, and regulate their victims, depriving them of their liberty and autonomy[68]. It also acknowledges that the insidious nature of these behaviours can influence a victims' ability to give true and free consent, particularly when they are subjected to undue influence, coercion, or duress. Yet, the system appears wholly under-prepared and powerless to stop it. No consideration was given to whether Michaela's decision-making and willingness to seek ongoing contact was impaired due to duress or undue influence. It is difficult to understand why this was not considered in a criminal context and was given the freedom to continue unchallenged.

Recommendation 8 a – Probation

It is essential that Probation Services in Cornwall act speedily upon any relevant recommendations deriving from the Internal Review, Michaela's inquest, current national cases (subject to reviews and preventing future death reports) and subsequent changes in national practice. Additionally, Probation Services in Cornwall should -

- Work with partners to improve access to behaviour change programmes at an earlier stage.
- Ensure victims are engaged in decisions about a perpetrators' living arrangements on release from prison and questions are asked about risks of financial abuse, duress, and fear.
- Proactively challenge coercive control of victims from within prison.

Recommendation 8 b – Probation and MARAC

Probation Services in Cornwall must ensure it has at least two representatives that have responsibility for attending MARACs across Cornwall. These individuals should be supported by regular reflective supervision and an appropriate time allocation in which to carry out the role in a safe and meaningful way.

Recommendation 8 c– Probation Head of Service

[66] This information was reported by another service user in Julian House and therefore may be considered 'untested intelligence'.

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

[68] https://www.stopvaw.org/uploads/evan_stark_article_final_100812.pdf

A letter should be sent to the courts and Judges operating in the county sharing the learning from this DHR with a courtesy reminder to Judges to be mindful of using language that may misinform expectations of what can be legally achieved.

Finding Nine

A loophole in reporting an emergency outside of (UK based) 999 places victims at greater risk of significant harm in a crisis.

There is no effective process for emergency calls concerning a resident in the UK to be made from abroad and Crimestoppers rigid focus on anonymity meant that in this case there were misunderstandings as to the origin of the call and this affected later police action.

Context to support the recommendation 9.

15.76 There are two very specific issues raised by the findings of the DHR. Both are significant as they contributed to the delay in the police responding to Michaela's call for help and the assumptions that were made about her safety when they arrived.

15.77 There needs to be a well-publicised method for making an emergency call into the UK from abroad. A google search offers confusing and contradictory advice and would not help in an emergency. In this case, Michaela's friend was resourceful in contacting Crimestoppers, but this did not result in an immediate response. The person receiving the call checked with a manager about next steps and it was approximately 20 mins before the call was taken by Devon and Cornwall Police.

15.78 Crimestoppers were initially reluctant to participate in this DHR due to their code of anonymity meaning that they will never confirm or deny that they had involvement in a case. However, their involvement with Michaela's friend became public knowledge at B1's trial and they agreed that it was appropriate for them to contribute to the learning within this DHR.

15.79 At the heart of the problem in the issue of anonymity and strict requirement never to name a source. In criminal cases this makes complete sense, but in this situation their failure to tell the police that the call had come from Michaela's friend meant that the police officers made assumptions that the neighbour had called. Michaela's friend would have been happy to speak directly to the police and would have been able to give valuable information about the call from Michaela and the risk that she had been very seriously harmed. This may have made the difference when police officers were deciding whether to enter the property.

15.80 Overall, the current situation is not satisfactory in an emergency, and the same scenario could be repeated today, placing other victims at risk. Whilst the Crimestoppers charity has secured an arrangement that protects its sources, the CEO believes this arrangement also protects its standing as an organisation. This should

never prevent the charity from learning when it can be evidenced that their policies contributed in some way to an outcome resulting in death. No professional agency should be above learning from statutory reviews, but in order to ensure learning is reflected in improvements, it requires all stakeholders to be open and willing to engage in the reflective process. It is disappointing that Crimestoppers were only willing to defend their position, rather than to join the reviewers, to reflect on it from a risk perspective.

Recommendation 9 – Safer Cornwall Partnership Chair and Panel Agencies

There is a need to immediately investigate the mechanism for making an emergency call from an overseas caller for a resident based in the UK. As a minimum -

- Panel agencies should communicate the method of contacting their emergency services from overseas.
- Panel agencies should publicise this method on all contact information.
- The SCP chair should write formally to the Chairman of Crimestoppers (Lord Ashcroft) to share the learning from this DHR and to request a unique waiver for callers who wish to disclose their identity due to an exceptional set of circumstances (such as the ones evidenced in this DHR) and who are content to be contacted for further information.
- If anonymity cannot be overridden, the SCP chair should formally ask Lord Ashcroft to provide Crimestoppers operatives with international numbers for reporting an emergency in the UK from abroad – and to share this information with callers without delay.

Finding Ten

Individual interpretation of complex legislation during an immediate crisis could place victims of domestic abuse at risk of significant injury or death.

Police powers of entry where there is a potential risk to life were not used appropriately in this case which delayed finding Michaela and apprehending B1.

Context to support recommendation 10

15.81 Michaela's parents have been extremely distressed by the police response to the Crimestoppers call and particularly comments made by officers such Michaela "not helping herself". Much groundwork is required to convince them that Devon and Cornwall Police are prepared and capable of protecting other women like Michaela in the future.

15.82 Each time police visited the home during this episode no one knew whether Michaela was alive, and it is important within this DHR to reflect on any learning from a review of police actions. These have been subject of an Independent Office of Police Conduct (IOPC) investigation which found that police actions in respect to the power of entry on the night they attended Michaela's property were unacceptable. It is not

the place of this review to repeat the IOPC inquiry, but it is within the DHR remit to ask why this was the case.

15.83 In this instance, the officers had not been in receipt of supervisory support which provided oversight of the decision-making process, and had not made further enquiries to ascertain Michaela's whereabouts. This contributed to a misinterpretation of Section 17 powers under PACE legislation.

15.84 The decision not to enter Michaela's property without a warrant was guided by Section 17 (1)(e) of the Police and Criminal Evidence [PACE] Act 1984 (of saving life or limb) which requires a real-time incident-based assessment of whether there are grounds to enter a property without a warrant. Notably, subsection (1)(e) is the only subsection that does not require 'reasonable grounds'. PACE does not state explicitly what grounds are required in order to exercise the duty of saving life and limb. Therefore, this is open to (mis)interpretation.

15.85 The threshold for forced entry to a person's private home has been set exceedingly high by parliament and caselaw (Syed v Director of Public Prosecutions [2010] EWHC 81 (Admin); [2010] 1 Cr App R 34) specifies that an existing concern for welfare is not a sufficient basis for exercising this duty under Section 17(1)(e). In the case of DPP v Syed, the Judge ruled that the concern for welfare (of someone inside the property) was not sufficient to justify forced entry. It is significant that the judge expressed sympathy for the problems faced by the police and said, *'In a sense they are damned if they do and damned if they do not, because if in fact something serious had happened, or was about to happen, and they did not do anything about it because they took the view that they had no right of entry, no doubt there would have been a degree of ex post facto criticism'.*

15.86 This highlights that Section 17 powers are restrictive in the sense that existing markers such being an active MARAC case, does not provide a sufficient basis for forcing entry. It also raises the vastly subjective nature of this power.

15.87 This judgement has been fiercely interrogated as part of the review given its continued reference in regard to the decisions made by officers attending Michaela's property. It must be noted that there is not a shared consensus between the police panel members and the review chairs.

15.88 The police panel member raised the case law of DPP v's Syed as an example of the complexity of S17 powers. The independent chairs of the DHR, have noted three key differences between that case and Michaela's situation.

- the operator in the Syed case only reported a verbal argument.
- the caller did not disclose that the occupants had been injured or harmed in any way.
- the occupants opened the door to officers.

15.89 Subsequently, the Justice's view in the DPP v's Syed case was that *"the welfare of the people in the property was sufficient".* This was distinctly different in Michaela's case.

The emergency call from her friend in May 2021 reported that B1 was attacking and strangling Michaela. The caller identified a terrifying scream before the phone went dead, and when police arrived, there was no answer from the occupants.

15.90 Police panel members believe the legislation is appropriate and sufficient but agree that it is open to interpretation and places a great deal of responsibility on responding officers often under difficult circumstances. However, they are confident that police officers are trained to exercise professional judgement and use the national decision-making model (NDM) to inform their decisions and actions. This is not necessarily a view shared by all police officers, and the DPP v's Syed case is reported on police forums as being poorly understood[69].

15.91 The potential for misinterpretation is further evidenced by the first responding officers, who reported that they found the address 'silent and in darkness', and therefore decided they did not have enough to form a genuine belief that Michaela's life may be in danger[70]. Finding the house in darkness is not a reason to doubt Section 17 (1)(e) powers as the court in the DPP v Syed case identified that officers only need to believe *'what had happened in the premises, or what might happen in the premises, would involve some serious injury to an individual therein'.* The status of the premises is somewhat irrelevant as the focus of attention is on saving life and limb, and that may include someone who is inside unconscious or being held captive.

15.92 However, finding a property silent and in darkness may be an important consideration under a different subsection of Section 17. For example, subsection (c)(b) 'recapturing a person unlawfully at large' would require reasonable grounds to suspect the person is in the property. Finding a property silent and in darkness and without a response, may be sufficient to withhold exercising Section 17 powers. This is mentioned only to highlight the complexity of legislation and how easily Section17 powers (and the caselaw surrounding it) can be misinterpreted. It is almost bewildering that the testcase includes the judge's opinion that '*police are damned if they do and damned if they don't'.*

15.93 Notwithstanding the difficulties with the legislation, in this case the accumulation of previous concerns about Michaela's safety could reasonably be expected to have prompted a more proactive response. At the very least action should have been taken to contact neighbours, family, and local hospitals to try and locate Michaela. This did not happen, and the panel was told that there is no expectation of discussions between officers and their supervisors in such situations. Effective supervisory oversight at any stage could have led to a consideration of all previous information, known risks and actions that needed to be taken to confirm that Michaela was safe. As it stands the lack of action seems to undermine the whole principle of MARAC, risk management, multi-agency safety planning and warning markers on police systems.

[69] https://www.ukpolicelawblog.com/can-i-come-in-the-perils-of-summary-entry-to-a-home/ Although it should be noted that the legitimacy of contributors has not been verified.

[70] Reported in the IOPC decision making letter.

15.94 It may come as a great surprise and a shock for victims and families to know that officers on the ground were not aware of the totality of risk because it was not presented in an easy to search format. If knowable information about welfare concerns is inaccessible to officers and cannot be considered in an emergency situation to save life and limb, the government must consider whether different legislation is required to safeguard victims of high-risk domestic abuse. The current status quo failed Michaela and it will continue to fail other victims in the future if it is not simplified.

Recommendation 10 – All panel agencies

It is imperative that the MARAC Flag system is understood and acted upon by all professionals working in Cornwall. All panel agencies, as a minimum should –

- Share the learning from this DHR with relevant practitioners via a briefing paper, highlighting the areas for improvement (i.e., acting on MARAC flags, escalating concerns etc.)
- Communicate the meaning of a MARAC flag (i.e., There is imminent risk of serious harm. The risk is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible').
- Ensure MARAC flags carry weight in their organisations and lead to appropriate responses for the level of risk identified.
- Ensure IT systems are updated, and MARAC alerts are appropriately applied and understood by all IT users.
- Clearly communicate the agency's internal procedure for acting on a MARAC flag within its domestic abuse working practice document.
- Make sure the domestic abuse working practice document is easily accessible to all practitioners with contact details for the agency MARAC representative for their organisation.
- Ensure all operational practitioners know how to escalate concerns to supervisors, management, their MARAC representative, or the MARAC Chair.
- Create a culture of support to encourage practitioners to act on instinct and communicate their reasons for doing so (within the remit of the law).

Finding Eleven

The system designed to work with domestic abuse is reactive rather than proactive.

There is no evidence of preventative work to address the emotional underpinnings of B1's behaviour and MH's tolerance and desire to rescue B1. Agencies did not effectively seize the opportunity to intensify support during periods of low risk.

Context to support recommendation 11a and 11b

15.95 Domestic abuse is a complex, multi-faceted crime. Evidence has shown that perpetrators may have experienced significant childhood trauma resulting in changes in the biological and cognitive structures of the brain and it would be naïve to believe that it can be eradicated or reduced simply with punitive criminal justice measures. Whilst these can help, they are often reactive to an incident, or the crime having come to the notice of professionals. There is a need for the whole system to consider early intervention/prevention schemes that respond proactively to the deep-seated causations of domestic abuse, in conjunction with risk management remedies.

15.96 This review identified a number of reactive practices that are not conducive to early identification or a trauma-informed approach:

- The behaviour change programme for domestic abuse (Building Better Relationships) does not accept a referral unless there is a conviction for domestic abuse (without a clinical override). As this case highlights, the threshold for charging is often high, and therefore, an opportunity to intercept low-level behaviours and prevent them from escalating, is lost.
- Nobody considered offering them support together (the system forces separation). This would have enabled the professional system to build trust, listen to their views, observe their relationship, and identify areas of specific support/treatment in a facilitative way.
- Services did not proactively try to engage with Michaela when B1 was detained believing the risk would be dormant whilst he was physically absent. A proactive approach would have been to intensify efforts to build Michaela's trust in support services, and to help her rebuild her connections with her 'community'.
- Opportunities to understand and make sense of the complex emotions and underlying trauma underpinning B1's impulsive and excessive use of violence were absent. Periods of incarceration did not lead to any interventions within the prison system that might have been helpful.
- Drug and alcohol treatment was about risk management, but little work was done to understand why it helped and what alternative coping methods could be adopted. Residential detox was not available when it was requested.
- Nobody tried to understand the triggers for B1's physical rages. Was he able to communicate verbally with Michaela or did her communication abilities make him feel inferior? Did he suffer with low self-esteem? The review has not learned anything about the source of the arguments and how or why they escalated or happened so frequently. The incidents are recorded, but the context was almost always missing.
- The professional system in this case waited until a crisis (and a high-risk status) before allocating intensive specialist resources. Low level abuse is left until it escalates and then it receives professional attention.

15.97 A member of the Panel has noted that there is no assertive IDVA service commissioned in Cornwall where the principles of relationship building, and

persistence taken from a Mental Health Assertive Outreach model could be adopted. This will be an area for consideration going forward.

15.98 However, addressing this issue extends beyond local services to the development of a national drive to put early intervention and prevention at the heart of domestic abuse services. This must involve understanding the motivations and needs of the perpetrator as well as how best to support the victim of abuse. The current criminal justice system achieved little over many years to address the deep-seated issues that drove B1's offending, and by the time he met Michaela his behaviours were entrenched.

15.99 In addition, proactive practice would have included concerted efforts to work with Michaela at times when risks were lowered, and B1 was in custody. This is particularly relevant during B1's last period on remand when Michaela's family believe that she did not really want B1 to move back in with her and she may have been open to alternative solutions.

Recommendation 11 a – Safer Cornwall Partnership

Safer Cornwall should continue to develop its prevention and early intervention services for perpetrators of harmful behaviours and ensure commissioned services address the root cause of behaviours and reduce domestic abuse recidivism through statutory and non-legal interventions. This should include but not be limited to:

- A specific programme of education to empower practitioners to engage in courageous conversations that challenge individuals who engage in perpetrating behaviours.
- Awareness raising activities around bystander interventions and public awareness campaigns for reporting abusive behaviours.
- Faster access to behaviour change programmes (without the requirement to have a criminal conviction).
- Improved complex care pathways.
- Access to trauma informed support, psychoeducation, or therapy to understand the emotions and human needs underpinning harmful behaviours.
- Support to understand maladaptive coping mechanisms and how to manage them.
- Intensification of support during periods of incarceration
- Adoption of strength-based interventions to increase resilience and agency.

Recommendation 11 b – Home Office

A domestic abuse register is required for individuals with a history of domestic abuse (that fall outside of the requirement of a 12-month prison sentence) which places a legal responsibility on known abusers to notify agencies of a change of address and a change of relationship within the new creative powers of the DAPO system.

Finding Twelve

The review identified that, although immediate safety concerns for Michaela's children were appropriately addressed, there was a gap in understanding and documenting the broader, long-term impacts of domestic abuse on their well-being.

Addressing this gap through comprehensive assessments would be in line with recognising children as victims of domestic abuse in their own right, as established by the Domestic Abuse Act 2021. This approach ensures that child victims receive the necessary care to address the full spectrum of their needs.

Recommendation 12

The MARAC chair should work in partnership with children's services and other relevant agencies to develop a child impact report for all identified child victims of domestic abuse.

This report should recognise the social and emotional and attachment issues, together with the behavioural, cognitive development and educational progress within the context of the environmental impacts on the child. To ensure consistency and standardisation across Cornwall and the Isles of Scilly, the development of a unified template for these reports is advised. This approach will facilitate a more comprehensive and informed response to the needs of child victims of domestic abuse, thereby improving the effectiveness of professional interventions and long-term support strategies.

16 SUMMARY OF RECOMMENDATIONS

RECOMMENDATION ONE: All panel agencies should review their safe employment practice in light of the specific learning from this DHR to improve the safety of workers and service users.

RECOMMENDATION TWO: The whole system of working with families/communities requires an immediate review in Cornwall to ensure that vital information is provided and received to aid safety planning and risk management in cases of domestic abuse.

RECOMMENDATION THREE: The MARAC Steering Group should immediately review MARAC practice in light of this DHR and respond to the explicit learning identified.

RECOMMENDATION FOUR: Each panel agency should undertake a whole system review of their risk identification, assessment, and management protocols in response to the explicit learning from this DHR.

RECOMMENDATION FIVE: There should be an agreed strategy for improving the identification and response to financial abuse through awareness raising. This should be

accompanied by a staff development programme and case audit to confirm that this activity has had a positive impact on practice.

RECOMMENDATION SIX: A training and development strategy (led by Safer Cornwall) should be developed focused on improving recognition and response to the overt psychological aspects of coercive control.

RECOMMENDATION SEVEN: MARAC, Adult Social Care, CFT and Safer Cornwall should form a small working group to research the feasibility of using Inherent Jurisdiction as a last resort option for individuals who 'fall through the net' of existing statutory capabilities to preserve life. A feasibility paper should be produced which outlines its utility as a last resort option, and the work required to enact the escalation route within standard working practices in Cornwall.

RECOMMENDATION EIGHT A: Probation Services in Cornwall should act speedily upon any relevant recommendations deriving from the Internal Review, Michaela's inquest, current national cases (subject to reviews and preventing future death reports) and subsequent changes in national practice. Locally, they should improve access to behaviour change programmes at an earlier stage; engage with victims over living arrangements post perpetrator release and challenge the perpetrator's ability to continue coercive behaviour from within prison.

RECOMMENDATION EIGHT B: Probation Services in Cornwall must ensure it has at least two representatives that have responsibility for attending MARACs across Cornwall. These individuals should be supported by regular reflective supervision and an appropriate time allocation in which to carry out the role in a safe and meaningful way.

RECOMMENDATION EIGHT C: The Probation Head of Service for Cornwall should write a letter to the courts and Judges operating in the county sharing the learning from this DHR with a courtesy reminder to Judges to be mindful of using language that may misinform expectations of what can be legally achieved.

RECOMMENDATION NINE: All panel agencies need to immediately investigate the mechanism for making an emergency call to their services from an overseas caller for a resident/service user based in the UK.

RECOMMENDATION TEN: It is imperative that the MARAC Flag system is understood and acted upon by all professionals working in Cornwall.

RECOMMENDATION ELEVEN A: Safer Cornwall should continue to develop its prevention and early intervention services for perpetrators of harmful behaviours and ensure commissioned services address the root cause of behaviours and reduce domestic abuse recidivism through statutory and non-legal interventions.

RECOMMENDATION ELEVEN B: The Home Office should introduce a domestic abuse register for individuals with a history of domestic abuse (that fall outside of the requirement of a 12-month prison sentence) which places a legal responsibility on known abusers to

notify agencies of a change of address and a change of relationship within the new creative powers of the DAPO system.

RECOMMENDATION TWELVE:

The MARAC chair should work in partnership with children's services and other relevant agencies to develop a child impact report for all identified child victims of domestic abuse.

18 APPENDIX ONE: ORGANISATIONAL CHANGES SINCE MICHAELA'S DEATH

JULIAN HOUSE

Recruitment

18.1 Safer Recruitment policy and procedure reviewed and updated.

18.2 HR Team trained on safer recruitment including verification of references and employment dates.

18.3 Regular auditing of the recruitment process to ensure that the necessary checks are being carried out and escalated where appropriate.

18.4 Escalation processes now involve Safeguarding Lead for DBS checks and any anomalies with references.

18.5 Robust interview questions including safeguarding and equality & diversity, focussing on testing candidate's approach, their decision making and their readiness to take on a role where they are supporting vulnerable clients.

Operational

18.6 Thorough induction process with all new staff attending mandatory, externally provided professional boundaries training alongside an extensive, regular and thorough training calendar. Grooming training is mandatory for all staff supporting ex-offenders.

18.7 All staff are provided with externally facilitated Reflective Practice with a clinical psychologist or equivalent.

18.8 JH Safeguarding Adults policy was reviewed by Bristol City Council's safeguarding lead in 2021, with minor updates recommended and implemented as a result, and the policy is reviewed and updated annually.

18.9 A PIPOT (Person in a Position of Trust) referral will automatically be made for a professional boundaries breach.

CORNWALL MARAC

18.10 Multi Agency working is key to tackling the complex issues associated with domestic abuse, and in particular, cases that are perceived as "high risk". The MARAC is a person-centred method of providing a proportionate response to individuals considered to be at high risk of harm, by focussing on their safety and the safety of their children/family members and associates. The interventions and actions that

result from the MARAC will take into consideration the needs and safety of all those directly associated with, or impacted by, the individual in an abusive relationship, for example their children/family members and close friends.

18.11 The purpose of the MARAC is to provide a confidential forum where agencies are able to share information which will increase the safety, health and wellbeing of individuals and children related to the case. This will take place through the sharing of information, expertise and resources, and the development of multi-agency plans which identify appropriate interventions or other actions to safeguard individuals and their children. The MARAC seeks to reduce the threat of further harm and repeated domestic abuse to the individual and their family members, through the agreed actions of the partner agencies.

18.12 The MARAC has no authority or responsibility in statute and is intended to enhance existing arrangements rather than replace them, however, it is considered best practice in responding to high-risk domestic abuse cases. As the MARAC is not an official body it does not own the risk associated with any particular case, but by discussing cases at a MARAC, all the constituent agencies assume some responsibility for that ongoing risk. The MARAC will utilise support services within Devon & Cornwall to support the individual, reducing the level of risk to said individual and maximising their safety and general wellbeing.

18.13 The MARAC will identify, where possible, whether the individual engaging in abusive behaviours poses a continuing significant threat to the individual in relation to the MARAC or the wider community; making referrals where appropriate, for example to the MAPPA (Multi Agency Public Protection Arrangements), Local Policing teams, or referral to agencies in order to mitigate risk.

Cornwall MARAC Governance structure

18.14 The MARAC is a multi-agency meeting that involves the active participation of all of the key statutory and voluntary agencies who might be involved in supporting a person experiencing domestic abuse. This is captured in the Cornwall MARAC operating protocol.

18.15 The MARAC is co-chaired by Devon and Cornwall Police and Cornwall Council's Community Safety Team. A multi-agency MARAC steering group ensures the smooth operational running of MARAC, implements learning and addresses and escalates risk where necessary. The MARAC Steering Group reports into the Domestic Abuse and Sexual Violence Partnership Board and where appropriate to the multi-agency Joint Commissioning and System Optimisation Group. More information on the roles and responsibilities of MARAC chairs and agency representatives can be found in the Cornwall MARAC Operational Protocol. Domestic Abuse Professionals - Safer Cornwall

Practice improvements since Michaela's case, which address the learning identified in the DHR.

18.16 **DHR14 finds that the professional system designed to protect adults from domestic abuse struggles to achieve a whole family approach and excludes families, cutting out a potentially life-saving resource.** Cornwall MARAC does not currently involve the person experiencing abuse, nor their family members. By not doing so, this allows a safe space for frontline professionals to discuss cases openly and transparently. The importance of the voice of the victim and the family is recognised which is why the specialist domestic abuse services, (IDVA's and DASA's) have always aimed to work with the victim prior, during and after MARAC to really understand what it is the victim wants, bring the voice of the victim to MARAC, and how agencies can support this. The safety plan is devised with this as its core and this process of working with the victim is recognised within SafeLives best practice guidance. In this case the IDVA was unable to engage Michaela. Since Michaela's death we have implemented the following with an aim to improve engagement with victims and to better capture vital information known to families:

- Safer Cornwall have commissioned an assertive outreach domestic abuse service. This team have low caseloads and can work flexibly to support people who services traditionally are unable to engage. This team often work in a team around the professional approach to safety plan and hear the voice of the victim through a professional in which the victim is engaging with.
- Adjustments are being undertaken to improve the information gathered for MARAC cases via the HALO system to more formally capture the voice of the victim and family with additional text boxes on the MARAC Research Form that captures wishes and feelings of the abused.
- The commissioned domestic abuse service (Safer Futures) is currently reviewing their practices around family involvement and looking at ways to improve how they approach consent and employ curiosity around service users' more comprehensive support networks. This review will be concluded by February 2024, following which the recommendations will be implemented. Where there is consent, the Information Commissioners Office (ICO) and GDPR guidance will be utilised to show that the information gathered and recorded from the family is captured on a lawful basis. This information will then be fed into the safety planning process through MARAC. The victims expressed wishes would be listened too and considered alongside risk. It is the aim of the MARAC to empower victims to have a voice and some control over the process, after so many have often lost control in many aspects of their lives due to the domestic abuse they have experienced.
- Safer Cornwall, with Safer Futures, are exploring a pilot around affected other groups which would provide support to family members of those impacted by domestic abuse. This is in its infancy and an evaluation would sit alongside the pilot, but it is hoped this would provide much needed information and advice

to family members to enable them to feel more confident in supporting their loved ones. We will also be looking at whether information for families can be accessed via the Safer Futures website to enable them to gain information and advice on how to support their family members.

18.17 **The review found that opportunities were missed to ensure that Michaela's voice was heard and understood, and assumptions were made across all agencies about her views and reasons for her actions. The system was not flexible enough to provide one person who could form a positive helping relationship with her. The professional system 'did to' rather than 'did with'.** Learning from this case identified the need to ensure time is given during MARAC to explore creative ways to engage with those who are difficult to engage with, consider any barriers to engagement and work to overcome them and in doing so, ensure practitioners are mindful of any biases/ assumptions that victims should understand the risks posed to them. This shows why a safe professional space created by the MARAC is important to allow practitioners to voice and explore any such barriers and as an environment where constructive challenge is encouraged to ensure any bias is confronted. Since Michaela's death we have implemented the following changes within the MARAC:

- MARAC Chair now challenges assumptions and provides a reflective time following each MARAC where reps are invited to stay on for debrief.
- At each MARAC a team around the professional approach for each appropriate case is now discussed. This means that, if the victim has one trusted professional, other agencies can work with that professional to support them and the victim.
- Safer Cornwall has now Domestic Abuse Support Advisors (DASAs) who are attached to GP surgeries who regularly attend MARAC. This provides a link for the GP DASA's to feed information back to practices regarding patients being heard at MARAC and allows the victim to access support via GP surgeries. Any actions created during MARAC for the GP will be shared with the GP via the MARAC Health Rep/ DASA. There have been some positive outcomes as a result of this programme, including supporting three people to access behaviour change programmes.
- Since Michaela's death a DASV outreach team has been commissioned. This team works intensively with people who traditional service provision often struggles to engage. This includes those with multiple vulnerabilities. They have low caseloads so they can offer flexible support in a way that meets the needs of the individuals. A commissioning intention is to bring outreach teams for domestic abuse, drugs and alcohol, homelessness together as one system, so there is one trusted practitioner who progresses the relationship with the individual and a team around the practitioner (such as Family Domestic Abuse

Support Advisor and IDVA). This requires a culture shift, but it is a current focus of commissioned services in Cornwall.

18.18 **The review highlighted that risk assessment and safety planning methods were unsatisfactory for the level of potential harm.**

18.19 The review highlighted that 'Police Officers on the ground are not privy to all available information regarding risk. They would not have known about Michaela being an active MARAC case'. All new police recruits are required to work with the D&C Police specialist domestic abuse unit Moonstone Team *(correct at the time of writing*) and will start to observe MARAC within that so they can better understand the process and how risk is managed and assessed.

18.20 Within the new operating protocol for MARAC, all agencies have signed up to improvements to address these concerns – such as, every meeting begins with a follow up on previous actions due to have been completed, with designated time to discuss incomplete actions, allowing for further actions or extended time frames where appropriate. Cases referred to MARAC include risk of escalation, based on additional vulnerabilities and professional judgement – see point 7 Referral Process in MARAC Operating Protocol which states:

"Each partner agency has the authority to refer cases to the MARAC based on the appropriate actuarial assessment, on professional judgement or as a result of an escalation of incidents or the professional judgement of the likely escalation of harm."

18.21 An overarching Research and Information Form has been developed, and is in use (as of March 2020), applicable to all agencies referring into the MARAC.

18.22 The threshold for referral to a MARAC is set by the MARAC Steering Group and is consistent across Cornwall. The current threshold for the actuarial assessment is 14+ positive responses to the DASH Risk Assessment Checklist. It is, however, best practice to prioritise professional judgement.

18.23 Comprehensive MARAC training is being delivered to all agencies that should be attending MARAC, and focusses on:

- Information sharing within safeguarding guidelines.
- Referral process
- Actions process
- Risk Assessment
- Professional judgement & Actuarial assessment tools
- Risk Categorisation and definitions in real life context
- Escalation of risk

- Inter-agency learning of service specific provision, capacity, threshold and processes.

18.24 The training started in August 2022 and has been oversubscribed. Training continues to be rolled out, and for those where need is specifically identified, i.e. Adult Social Care representatives following service transformation.

18.25 MARAC awareness training lunch and learn events are also being delivered by the MARAC Chair twice per year and started in March 2023. This in an introduction to MARAC supporting the whole system and covers aspects such as MARAC thresholds and referral pathways.

18.26 There is a requirement that all MARAC reps are trained in understanding the complexities of DA and an expectation of MARAC reps to contribute to all discussions in all cases to help explore a variety of approaches. This is made clear in the MARAC Rep training. It addresses concerns raised in the DHR about professional fatigue where practical steps taken in this case to reduce risk were ineffective. This further emphasises the complex psychological challenges that underpin domestic abuse, and the importance of MARAC rep training in the complexities of DA.

18.27 **The DHR was concerned that there is no meaningful escalation procedure in place when the system (statutory legislation and non-legal services) is no longer able to keep someone safe.**

18.28 A MARAC steering group was set up in July 2022 to ensure the improved operational running of MARAC, to implement learning and to address and escalate risks where necessary to the Cornwall Domestic Abuse and Sexual Violence Partnership Board (which discharges the duty in s.58 of the Domestic Abuse Act 2021 Domestic Abuse Act 2021 (legislation.gov.uk)) and the Joint Commissioning and System Optimisation Group.

18.29 A MARAC repeat review process was also set up in August 2022 which is triggered if a case is heard at MARAC 3 times within a 12 -month period, this will initiate a Review Meeting by the relevant agency representatives from the MARAC Steering Group. Individuals will complete an Individual Management Review and come together to discuss the case, identify themes and learnings and escalate where appropriate. See MARAC Operating Protocol (point 7.3). Following a review meeting, if the group agree the risk cannot be reduced or there is no further action, but risk remains high then a Multi-Disciplinary Team Meeting (MDT) with the relevant senior leads will be arranged to discuss the issues. The process for each review case will be documented and kept by the MARAC Chair. Any further escalation required will be via the MARAC Steering Group.

18.30 Inherent Jurisdiction process and allocated funding are being considered by the MARAC Steering Group. When all other legal and support avenues have been

exhausted, an application to invoke the inherent jurisdiction of the High Court may be possible. 'Inherent jurisdiction' is a term used to describe the power of the High Court to use its inherent jurisdiction in accordance with Human Rights legislation to assist professionals in gaining access to assess a named vulnerable adult and give them time and space to ensure decisions are being made with free, real, and genuine consent.

CHANGES IN POLICE PRACTICE

18.31 Since 2023 non-fatal strangulation is an offence under Section 70 Domestic Abuse Act 2021. Information is now recorded, and it features as a question in the DASH risk assessment tool. A PowerPoint was circulated to staff when nonfatal strangulation was designated as an offence.

19 APPENDIX TWO: DHR PANEL MEMBERS

Role	Organisation
Designated Nurse Safeguarding Children	Cornwall and Isles of Scilly Integrated Care Board
Operations Manager	We Are With You
Safeguarding Service Senior Manager	Cornwall Council, Adult Social Care
Locality Manager	Cornwall Council, Adult Social Care
DASV Implementation Lead	Cornwall Council, DASV Team
MARAC Chair and DASV Coordinator	Cornwall Council, DASV Team
Safeguarding Adult Reviews and Development Manager	Cornwall & the Isles of Scilly Safeguarding Adults Board
Director of Domestic Abuse Services	First Light
Independent Adult Safeguarding Investigator (RMN) & Prevent Lead	Royal Cornwall Hospital Trust and Cornwall Foundation Trust, Integrated Safeguarding Team
Nurse Consultant for CFT/RCHT Integrated Safeguarding Services	Royal Cornwall Hospital Trust and Cornwall Foundation Trust, Integrated Safeguarding Team
Operations Director Safeguarding lead	Julian House
Detective Sergeant Criminal Case Review Unit	Devon and Cornwall Police
Detective Chief Inspector CID & Moonstone - CIOS	Devon and Cornwall Police
Senior Probation Officer – East Cornwall OM Team	Probation
Head of Children's Rights and Safeguarding	Cornwall Council, Children and Family Services
Statutory Assurance, Policy and Practice	Cornwall Council, Adult Care and Support Operations
Team Leader	First Light
Head of Children's Social Care – Mid Cornwall	Cornwall Council, Children and Family Services
Team Leader	First Light

20 APPENDIX THREE TERMS OF REFERENCE

Introduction

A Domestic Homicide Review (DHR) is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship, or

(b) A member of the same household as herself, held with a view to identifying the lessons to be learnt from the death.

This Domestic Homicide Review has been commissioned following the death of an adult female (Michaela) in June 2021. An adult male (B1), the partner of Michaela, was arrested the following day after a large-scale search.

B1 denied murdering Michaela. He was charged with murder in July 2021 and sentenced to life in prison in January 2022. He must serve a minimum of 21 years before he can be considered for parole.

There is a parallel investigation being undertaken by the Independent Office for Police Conduct (IOPC), of which, the findings will be incorporated into the DHR.

Overall Aim Domestic Homicide Reviews (DHRs)

The purpose of a DHR set out in statutory guidance[71] is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

Conduct of Domestic Homicide Reviews

DHRs should:

71 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

- Illuminate the past to make the future safer, be professionally curious and find the trail of abuse including which agencies had contact with the victim, offender, and family.
- Involve family, friends, neighbours, community members and professionals who knew the victim in reviews and seek to understand the victim's reality through their own lived experience.
- Identify any barriers the victim or family faced in seeking support or reporting abuse and learn why any interventions did not work for them.
- go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure/policy was sound and operating in the best interests of the victim, offender, and family members.
- be transparent about the way data is collected and analysed; and make use of relevant research, local and national learning from previous reviews and case evidence to inform the findings.
- Consistently articulate the purpose(s), process(es), and outcome(s) of family and panel involvement within the DHR system, value testimonial knowledge, uphold epistemic justice and aid systems-and relational-repair[72]

Family Involvement

The family of Michaela will be informed that a Domestic Homicide Review has been commissioned and offered an opportunity to participate as integral members of the review. They will have a degree of agency regarding the scope of the review and there will be clear transparency as to the purpose(s), process(es) and outcome(s) of family involvement from the outset.

The family will be invited to assist in the diagnosis and identification of system failures leading up to the death of their loved one and in generating potential solutions that may prevent future domestic homicides. As integral members of the review, family experiential knowledge and insight will be given equal value to the testimony of practitioners. They will have the opportunity to tell their story, make sense of what happened, and have their questions answered.

To support the principle of systems-repair, families will have an equal stake in demonstratable systems-change and community safety solutions to improve public confidence in the state's ability to protect its citizens. They will contribute to, see, and comment on the final report and the monitoring and implementation of recommendations.

Review Timeframe

[72] https://link.springer.com/article/10.1007/s10896-021-00309-x

The time period under review will focus on the duration of Michaela's relationship with B1 and the phase immediately prior to their union, namely events between the 1st June 2018 until June 2021. Agencies are also requested to include any additional information outside of this time period that might be pertinent to the purpose of the Domestic Homicide Review.

The Process of this Review

The independent chairs of the Domestic Homicide Review will be Jane Wonnacott and Martine Cotter.

The independent chairs will be supported by a Review Panel (*Final panel set out in Appendix two above)*

Independence

The independent chairs are completely independent of the Safer Cornwall Partnership and any associated organisations. They have not had any contact, personally or professionally with Michaela, B1 or any other persons associated with the domestic homicide review.

The review panel and IMR authors had no line management responsibility for either the service or the staff who had immediate contact with Michaela, B1, or their family members.

Confidentiality and data protection

The findings of this review will remain confidential and restricted until the Home Office Quality Assurance Panel approve the overview report for publication. Information will be available only to the family, participating professionals and their line managers, the coroner and interested parties, before final authorisation.

Domestic Homicide Review Statutory Guidance (2016) required that this report be anonymised to protect the victim, perpetrator, and family's identity. The family expressly wished for Michaela's real name to be assigned to the report on the basis that the inquest and media coverage had not used a pseudonym and Michaela's name was already in the public domain, alongside details of the circumstances that led to her death.

Data collection

Initial chronologies were requested from relevant agencies (below) in Plymouth and Cornwall to determine who had contact with Michaela or B1

- Police
- Probation/Rehabilitation Companies/Julian House Resettlement
- Drug and Alcohol Services
- Mental Health
- Children and Family Services
- Commissioned Domestic Abuse/IDVA services (PDAS for Plymouth)
- Primary Care (GP)
- Hospital Trusts

- Anti-Social Behaviour Teams
- Housing
- Refuge Providers

Once it has been established which of the above agencies were involved in the care, support, supervision or management of Michaela and/or B1, specific agencies will be asked to provide a full analysis of their involvement, through the creation of an Individual Management Review (IMR), focusing on the general Terms of Reference (ToR) questions, specific ToR questions and explicit family questions.

General ToR Questions for the Review

1. What are the facts about events leading up to the death of Michaela before June 2021?
2. What were the roles of the organisations involved in the case and the appropriateness of single agency and partnership responses?
3. What factors were driving responses at an individual and organisational level?
4. What role did Covid-19 play in accessing and delivering expected levels of care and management during periods of national lock-down?
5. Are there lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard Michaela's wellbeing and manage B1's risk?
6. As a result of these lessons is there a need for changes in organisational and/or partnership policy, procedures, or practice in Cornwall to improve our work to better safeguard victims of domestic abuse and their families?
7. Were all opportunities taken to identify that Michaela may need help and support to stay safe? If opportunities were not taken, why did this happen – were there any barriers at an organisational or practice level?
8. How effective was the professional response to the family's concerns and attempts to seek professional support for Michaela and keep her safe?
9. Was there sufficient professional curiosity in all agencies about the relationship between Michaela and B, and any implications of this relationship for the wellbeing or safety of Michaela and her children?
10. What was known and understood about B1's risk towards others and any implications this may have had for the safety of Michaela?
11. Were Michaela's support needs understood by professionals and responded to appropriately?

12. How were issues of confidentiality understood by professionals and did this understanding affect the assessment of Michaela's vulnerability and safety?
13. How effective is the system at providing advice and support to friends and family who may have concerns about risks to an adult in their area?
14. Establish whether there is learning from these circumstances which will include considering the way professionals from across the range of services worked together as a collective and review the whole system function.

Explicit Family Questions*

*Some family questions may sit outside of the scope of the review; however, families should have the opportunity to ask questions that are important to them, and agencies should try to help families make sense of these issues, providing answers where it is possible and proportionate to do so. The following questions have been developed with Michaela's mother, father and brother and further questions may be generated by other family members in due course.

15. What qualifications and experience did Michaela have to be employed to work with vulnerable and dangerous ex-offenders?
16. What recruitment practices were in place at Julian House to ensure that vulnerable employees were not employed into positions that could expose them to manipulation or risk?
17. What training was in place to prepare Michaela for working with ex-offenders and what supervision was offered to help Michaela explore conflicting or confusing feelings towards company policy or clients?
18. How do Julian House protect employees from potential coercive and controlling abuse from clients leaving prison?
19. What attempts did Julian House make to seek advice and support for Michaela after dismissing her for starting a relationship with B1? Did they raise concerns for her safety with any other agency? Did they raise a child safeguarding alert?
20. When family members are deeply concerned for the safety and wellbeing of a relative, believing them to be vulnerable, but the loved one has mental capacity or is classed as a 'functioning adult', what avenues exist to engage professional services in effective safety strategies or wellbeing assessments?
21. Patient/client confidentiality was experienced as a 'brick wall barrier' for concerned family members, however, Michaela was murdered in the most despicable way and our worst fears were realised, showing that our concerns were not only valid, but they were also accurate. How will agencies overcome confidentiality in the future to

protect other families from experiencing the anguish pain and distress we continue to endure from being right?

22. Why is so much money, time and expertise invested into the aftermath of a homicide, rather than proactive and preventative action when concerns are consistently raised by friends, families and victims?

23. When both boys were removed from Michaela's care, why were we told to choose between our grandchildren and our daughter? Why were we told that Michaela's children were the 'only victims'?

24. Why were the grave concerns of a leading private psychologist not acted upon by Children and Family Services?

25. Why was the request to refer Michaela for an ASD assessment by the private psychologist not acted upon by Children and Family Services?

26. We feel that making a complaint against the insensitivity and manner of particular social workers will result in serious consequences and further access restrictions to our grandsons. What assurances can Children and Family Services provide to ensure complaints are independently and objectively reviewed?

27. When B1 was handed a community order to carry out unpaid work for his abuse of Michaela, who was monitoring his compliance? When was it supposed to start? What consideration was given to Michaela's safety in the interim period?

28. How was private and confidential information about Michaela (not in the public domain) shared with an ex-police officer and neighbour in Michaela's community?

29. In May 2021 police attended Michaela's house after concerns were raised about her safety. Michaela and B1 were well known to the Police; however, no attempt was made to enter the property or call family members to enquire about her whereabouts or safety. Why?

30. The following day, Police Officers attended Michaela's property on two further occasions and still did not enter the property despite no response from Michaela in over 12 hours. Why?

31. Michaela believed that the Police had contempt for her and where very friendly with her ex-partner. What assurances can be given that the lack of concern for Michaela's whereabouts in May and June 2021 were not due to prejudicial views held by local officers?

32. When we finally entered Michaela's house and discovered Michaela's body, we asked attending officers if our lives could have been at risk had B1 still been in the property, to which we were told 'we should never have gone into the house'. But when would Police Officers have entered Michaela's house if we had not?

33. Even though B1 was 'at large' for the evening and into the following day, we did not have a police car assigned to our house, despite previous threats to kill us by setting fire to our house. Why, if B1 was suspected of the murder of Michaela, were our safety needs not considered to be important?

34. After Michaela's homicide, our family was not contacted for over 12 hours and we have never received a call or email from the Police and Crime Commissioner, the Chief Constable, or our local MP to express their condolences or pledge to tackle domestic abuse and improve community safety. Why did the victims of the Plymouth shooting receive all of this support, yet we didn't?

35. We were offered compensation of £5,000 to pay for Michaela's funeral, however we were informed that the claim would take 12 months to be processed. How do you expect families to sustain this fee in the interim? How do you think it will affect family members to have a cheque arrive without notice 12-months after the homicide? Why was the community of Keyham in Plymouth offered £1m to help them recover from the shootings without having to wait? And why is their grief and needs any different to ours?

36. We believe Michaela would be alive today if certain professionals acted on our concerns. Will there be any accountability?

Review output

- A succinct, clear, and relevant narrative summary and detailed chronology of the events leading up to the incident to identify any problems in the delivery of care.
- A final report that is anonymised, suitable for publication with a set of measurable and meaningful recommendations leading to demonstratable change, having been legally and quality checked, proofread, shared, and agreed with participating organisations and family members.

Timescales for completion

The completion of the domestic homicide review was paused pending the outcome of the coronial inquest, which was scheduled over three weeks in March 2024.

Quality Assurance

The Independent Chairs will be supported by the Review Panel throughout the course of the review who will assure the quality of the work.

The review and associated action plan will be impact assessed and quality assured by the Community Safety Partnership Board prior to final sign off.

The final report will be submitted to the Home Office as required by statutory guidance.

Responding to Inquiries from the Media/ Communications Strategy

All media requests will be directed to Laura Ball at the Cornwall Community Safety Partnership.

All press releases will be suitably anonymised to protect the identity of the victim, perpetrator, relevant family members, staff, and others to comply with General Data Protection Regulations (2018).

21 APPENDIX FOUR: THE DHR CHAIRS

Jane Wonnacott qualified as a social worker in 1979 and has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed well in excess of 200 child safeguarding reviews, many of national significance. She has previous experience of completing Domestic Homicide Reviews and is currently co-chairing chairing seven active DHRs. Jane has been a recent member of the National Child Safeguarding Practice Review Panel pool of reviewers and in this role completed thematic analyses of safeguarding practice and contributed to the national review into the deaths of Arthur Labinjo-Hughes and Star Hobson. Jane's publications include an analysis of safeguarding practice in education, and she is the author of 'Mastering Social Work Supervision', and 'Developing and Supporting Effective Staff supervision' published by Jessica Kingsley Publishers and Pavilion.

Martine Cotter holds an MSc in Neuroscience and Psychology of Mental Health from Kings College London and a Level 7 Post Graduate Diploma in Strategic Leadership. She is a Fellow of the Chartered Institute of Management and a member of the Association of Applied Neuroscience. Martine is a member of the National Child Safeguarding Practice Review Panel pool of reviewers and a sessional assessor for DV-ACT with over 19 years' experience working in the field of domestic abuse and sexual violence. She has a specialist interest in psychotraumatology and the biopsychosocial effects of adverse childhood experiences (ACE). Martine has previously chaired and published four Domestic Homicide Reviews. She is currently chairing seven active DHRs.

22 APPENDIX FIVE: EXAMPLE TEMPLATE FOR INHERENT JURISDICTION

This document sets out the decision-making process of the Multi-Agency Risk Assessment Conference (MARAC) in Cornwall and the actions taken by professionals to protect a high-risk victim of domestic abuse through existing statutory powers and non-legal interventions.

A threshold has been reached whereby the MARAC has exhausted all statutory powers to intervene and protect the named vulnerable adult who, under Re SA [2005] EWHC 2942 (Fam) (para. 77) is believed to be subject to coercion, control, and undue influence. The purpose of this document is not to overrule the wishes of the named adult with mental capacity, but to ensure that the named adult is making decisions freely without fear, intimidation, constraint, or exploitation from the third party.

This is a last resort action, requiring the High Court to use its inherent jurisdiction in accordance with Human Rights legislation to assist professionals in gaining access to assess the named vulnerable adult and give them time and space to ensure decisions are being made with free, real, and genuine consent.

This document must satisfy three criteria to satisfy the threshold for inherent jurisdiction –

Criteria 1: The named person meets the definition of vulnerable *(i.e., a vulnerable adult who is unable to protect themselves from harm or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent" (Re SA [2005] EWHC 2942 (Fam) para. 77).* It is this coercion, or abuse, that renders a person vulnerable.

Criteria 2: The named vulnerable person has mental capacity *(i.e., they do not have any cognitive impairment or disturbance in the functioning of their mind).*

Criteria 3: All other less restrictive, more proportionate statutory powers and non-legal interventions have been exhausted

Named vulnerable adult	**Name:** **DOB:**	**Address:**
Third party (offender)	**Name:** **DOB:**	**Address:**

Summary of circumstances

Criteria 1: The named person meets the definition of vulnerable.

State how this criterion has been reached and why.

Criteria 2: The named vulnerable person has mental capacity.

State how this criterion has been reached and why.

Criteria 3: All other less restrictive, more proportionate statutory powers and non-legal interventions have been exhausted.

Inherent jurisdiction can only be exercised where there is no other avenue. It is a last resort option and cannot be used by social care or safeguarding practitioners without a court order. Before considering an application to the High Court, MARAC must first consider whether all other avenues - which may be less restrictive, and therefore more proportionate - have been exhausted. The court cannot use inherent jurisdiction where it explicitly conflicts with an existing statute.

This section sets out the steps taken by MARAC practitioners to assure criteria 3 (above) has been met. This is recorded via a RAG rating.

Red = The service has been offered and has not been successful in mitigating the risk, reducing harm, or achieving a meaningful outcome

Amber = The service is still involved, and engagement/action is ongoing, but it is unlikely to change the status quo or mitigate the risk further

Green = The service has not been offered **or** is not applicable. The reasons for which are recorded in the table.

NON-LEGAL ADVOCACY AND SUPPORT	**STATUS**		
	RAG	**INPUT**	**OUTCOME**
Specialist domestic abuse services and Independent Domestic Violence Advisors (IDVAs) *(v)*			

Change4U Behaviour Change Programme *(v)*			
Drug and Alcohol Services			
Sexual Assault Referral Centre *(v)*			
Single person of trust (advocacy)			
Women's Refuge *(v)*			
Victim Pattern Changing Programmes			
Talking to the individual alone and in a confidential way[73]			
Victims voice and desired outcomes sought from the safeguarding process[74]			This action is required before submitting the application for Inherent Jurisdiction

(v) = voluntary

Use this section to prove there are no powers to intervene in a statute.

[73] Being able to talk to the individual alone and in a confidential way is particularly important before using the inherent jurisdiction (Norrie et al., 2018).

[74] It is important to ensure the person's voice is heard and, where possible, the orders sought work towards the outcomes that they want from the safeguarding process.

STATUTORY POWERS	STATUS		
	RAG	INPUT	OUTCOME
Prosecution using criminal law			
Domestic Violence Protection Notice/Order under sections 24 or 27 of the Crime and Security Act 2010			
Offence of controlling or coercive behaviour in an intimate or family relationship under section 76 of the Serious Crime Act 2015			
Restraining Order			
Bail Conditions			
Building Better Relationships Programme			
Application for an antisocial behaviour order (ASBO) under the Crime and Disorder Act 1998			

Injunction under the Housing Act 1996.			
Non-molestation order (section 42 of the Family Law Act 1996)			
Protection from harassment injunctions under section 3A of the Protection from Harassment Act 1997			
Mental Capacity Act 2005			
Care Act 2014			
Multi-Agency Risk Assessment Conference MARAC *(N/S)*			
Multi-agency discussions [75]			
Domestic Violence Disclosure Scheme (Clare's Law)			
Children's Act 1989			
Other		Specify:	

[75] Have practitioners accessed the support available to them within their department to discuss this option? For example, have they discussed this option at team meetings, or with supervisors? Are records of any meetings or notable events, assessments, or safeguarding enquiries full and complete?

N/C = Non statutory

Subject of Inherent Jurisdiction

Please state if the order sought under the inherent jurisdiction is directed towards the person or persons 'doing' the abusing or coercing, or the person being coerced*?

Victim (person being coerced) ☐

Offender (person doing the abusing) ☐

Both ☐

*The aim of the jurisdiction should be facilitative, not dictatorial. For an order to be facilitative, where feasible, it should be directed towards the person doing the abusing or coercing as it is likely to be a less restrictive option and therefore more proportionate. However, there is no rule against applying for an order which is predominantly directed towards the person being abused as long as the additional criteria is met.

If the order is sought for the victim, explain why.

Additional criteria

The High Court requires the body seeking the injunction to show, and provide supporting evidence, that they have considered:

i) whether the name person is likely to understand the purpose of the injunction
ii) whether the named person will receive knowledge of the injunction
iii) whether the name person will appreciate the effect of a breach of the injunction[76]

Please state what evidence you have to show the above requirements have been considered*.

.

*Save in exceptional circumstances and for clear reasons, orders under the inherent jurisdiction in respect of vulnerable adults should not be made without notice to the individual.

Proportionality declaration

The use of the inherent jurisdiction may be perceived by the person being abused or coerced as an unwanted interference. For this reason, the order sought must be necessary, proportionate, and the least restrictive measures to preserve the person's rights and freedoms.

Is it necessary and proportionate to seek this order? ☐

Are the measures sought reasonable and proportionate to the circumstances? ☐

Are they the minimum necessary measures in order to safeguard the person being abused. ☐

Timeframe

[76] Redcar & Cleveland Borough Council v PR [2019] EWHC 2305 (para. 46)

The inherent jurisdiction is, as expressly stated by the court, unlikely to be used to deprive a capacitous person of their liberty on anything more than a temporary basis.

How long is required to assess whether the named person has the space and time to make free and informed decisions?

How will the inherent Jurisdiction be used?

What realistic, purposeful, and facilitative intervention is proposed during the timeframe above*?

What are you trying to achieve? (i.e., saving life, preventing financial abuse, safeguard wellbeing etc.)

The inherent jurisdiction cannot be used to reverse the outcome of another statutory power which deals with the same issue on the basis that the court disagrees with the statutory outcome[77].

Family Engagement

Has sufficient information about the use of the inherent jurisdiction been given to the individual and families involved?

Yes ☐

[77] JK v A Local Health Board [2019] EWHC 67 (Fam) at paragraph 57, per Lieven J.

No ☐ Reason: _____

Specify what actions have been taken to ensure the families understand the legal context surrounding professional decision-making.

I understand that this document will be submitted as evidence to the High Court for consideration of an inherent jurisdiction order.

Signed by _____

Print name: _____

Position _____

On behalf of _____

Date _____

23 APPENDIX SIX: MULTI AGENCY ACTION PLAN

Up to date Action Plans are published on the Safer Cornwall website, alongside the report.