South Nottinghamshire Community Safety Partnership

Working together to make Broxtowe, Gedling and Rushcliffe Safer

Domestic Homicide Review into the death of Rachel

Overview Report

Date of Death: April 2024

Report Chair and Author: Carolyn Carson

Report Completed: 28th July 2025

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‘Rachel[1]’ as described by those who loved her.

Our beloved ‘Rach’

Her boys said - Mum was the most beautiful, wonderful and strongest woman we knew and could have ever wished for. She was a best friend and had such a special bond with each one of us. No love in the world will ever come close to the love we shared with her, we will forever cherish our memories with her.

There are simply not enough words to describe how much we loved her and how much she will be missed.

Rachel was loved by everyone in her huge extended family and everyone in her community. People who knew her would describe her as a ‘friend to everyone’

Rachel dedicated her life to her 3 boys, and you would often find her spending time supporting them in their various activities, whether this be at school cake sales or serving hot drinks by the side of a football pitch early on a Sunday morning. Rachel was a fine cook and baker, and she often had a list of people waiting for her scones and lemon curd tarts.

Rachel always greeted everyone with a smile and would light up the room particularly at family events, she was truly the heart of the family. She was vibrant, selfless and the most caring person, she would help everyone she could. Rachel was the ‘little sister’ to her 2 brothers whom she had a very close bond with and was a huge part in her nieces and nephews’ life. She was the aunty that everyone would truly turn to. She had several groups of friends, some which were lifelong.

Once her boys left school, Rachel took up a part time job in a cafe which she loved. Her work colleagues have been left devastated by her loss and celebrated her 1st anniversary by completing a sky dive to raise money for women’s aid. Local schools and her workplace have benches in memory of Rachel and local pubs and organisations continue to hold events in her memory.

She is sorely missed by everyone that knew her.

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[1] **Note to Home Office QA panel:** Rachels family have requested that her real name is used through out this report and are aware of the implications of that for data protection purposes and privacy, especially from the media, and that Rachels experience will be openly available for all to see, forever. The family do not wish to see Rachels name replaced with a pseudonym.

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1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Rachel, a resident of Eastwood, Nottingham, prior to the point of her death in April 2024.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer for those subject to domestic abuse.

1.3 Timescales

This review began on the 22nd May 2024 and concluded on the 28th July 2025. Due to a delay whilst a criminal trial was undertaken, this has extended beyond a six-month period. There followed a further short delay to ensure Rachel's family could fully engage prior to completion.

1.4 Confidentiality

1.4.1 The findings of each review are confidential. Information is available only to participating professionals and their line managers through the process. At the time of the homicide Rachel was 53 years of age and Dean, 60 years of age. Both are white British citizens. Rachel's family have requested that Rachel is known by her real name, Rachel, specifically asking that she is not anonymised. The review respects this and has complied with their choice. Dean, however, is anonymised, with his name chosen by the review Chair to closely align with Deans age and demographic without specifically identifying him.

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2 Terms of Reference

2.1 Examine what professionals understood about Rachel's living circumstances and understand the dynamics within Rachel's immediate family, including with her estranged husband, Dean.

2.2 Examine how professionals reviewed wider issues within Rachel's family circumstances. Consider if the family were considered narrowly through the lens of their middle child's diagnosis of autism or were wider issues considered and explored.

2.3 Examine how any identified substance misuse within the family impacted on family dynamics and understand if professionals were aware of issues of paranoia that could have affected the family.

2.4 Examine issues relating to mental health within the family and understand how this was assessed and managed by professionals. Ascertain if mental health issues were identified and how they may have affected the family dynamic.

2.5 Seek to understand how Rachel may have perceived her situation as a victim of domestic abuse through the scoping period. Understand if professionals had an opportunity to help her identify as a victim and to help her to access support.

2.6 Seek to understand how well understood the family's / community's approach to, and /or recognition of domestic violence was throughout the scoping period.

2.7 Ascertain what services could have been available to the family through the scoping period had there been an identification of Rachel's abusive relationship.

2.8 Ascertain how well known about, accessible and responsive were support services that may have been available to the family.

2.9 Seek to understand how families such as Rachel's, know where to go for support and help when domestic abuse is a feature. Understand what needs to change to ensure awareness of vital protective support for victims of all forms of domestic abuse in the community.

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2.10 Seek to understand what barriers existed that prevented the reporting of abusive and violent incidents in Rachel's home.

2.11 Examine if professionals were aware of any trauma faced by Dean due to reported post childhood sexual abuse. Understand if professionals were aware of any anger issues that Dean may have exhibited. Where apparent, understand what, if any, support was offered to Dean to manage his trauma and/or anger.

2.12 Understand if there were any opportunities missed by professionals to spot potential indicators or abuse and/or to identify risk of harm at any stage.

2.13 Understand if there were any barriers to accessing support for wider issues affecting this family.

2.14 Examine whether communication and information sharing, within and between agencies could have been improved during the scoping period. Understand if any opportunities existed for multi-agency referrals for vulnerability or risk of harm and/or risk management meetings.

2.15 Examine if any professional had an opportunity to exercise professional curiosity.

2.16 Establish if appropriate support was offered post the domestic homicide to living relatives, in particular through the DHR process.

2.17 Identify examples of positive practice, both single and multi-agency through the scoping period.

3 Methodology

3.1 The Broxtowe Community Safety Partnership (CSP), were notified of the need to consider a domestic homicide review via a Potential Domestic Homicide for Consideration form received from East Midlands Serious and Organised Crime Unit on the 9th May 2024. This was disseminated to statutory partners within the CSP for information and decision to proceed, and following a majority agreement, the decision to undertake a DHR was made by the Broxtowe CSP on the 22nd May 2024, and the Home Office informed.

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3.2 The Chair and Author were identified, engaged and contracts signed before the Initial trawl documents were requested. Due to a lack of agency information apparent initially, a decision was made to speak to Rachel's family to ascertain their insights on how Rachel engaged with agencies and to understand her lived experience, prior to a scoping meeting. A Scoping meeting (and first panel) then convened, followed by an IMR Authors briefing and reports received. A learning event (and second panel) was held on the 29th January 2025, which incorporated family information and included practitioners and specialists, and a full discussion of events was held. This resulted in the draft overview report, followed by a further panel discussion.

3.3 Having reviewed version 2, the panel met to specifically agree an action plan. Consequently, on the 28th July 2025, the CSP submitted the Overview Report, Summary Report, Action Plan and Data Collection Document to the Home Office.

3.4 The scoping period was agreed to be from January 2020, until Rachel's death in April 2024.

3.5 The review has been undertaken by means of an open and enquiring approach, with an emphasis on family information, and practitioner involvement at the learning event. A review panel of statutory partners and specialist domestic abuse agencies have effectively supported the process. In total, 4 panel meetings have been held, sufficient to ensure the panel were able to effectively discharge their statutory duties and support the review author to complete the overview report.

3.6 The Summary Report will be published on the Broxtowe CSP website[2]together with any comments made by the Home Office at the conclusion of the process.

4 Involvement of Family, Friends and wider Community

4.1 Rachel's Mother and eldest son were initially supported by the specialist advocacy Victim Support Homicide Service, through the Criminal Justice and

[2] https://www.broxtowe.gov.uk/for-you/crime-safety-emergencies/domestic-abuse/

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commencement of the DHR processes. [3] [4] Once the criminal trial was complete, a caseworker facilitated a meeting between the review chair and the family in August 2024. This meeting provided valuable information that would not have been known to the review without the family's generous time to share their thoughts and perspectives at such a difficult and recent time of grieving.

4.2 Later in the process, Rachels family were effectively supported by Advocacy After Domestic Abuse (AADFA[5]), who facilitated a review of the final Overview Report, and ensured the family were able to make changes where they believed it was important, with full agreement of the Chair and Panel. The family have also had an opportunity to review the Action Plan.

4.3 From within the community, the review chair has contacted the local family lawyer who supported Rachel through her divorce proceedings prior to her death, as per the interactions outlined in the chronology. The lawyer spoke generically to the review about the role of family lawyers in safeguarding but did not feel able to speak directly about Rachel. A request to seek permission from the family to allow a direct conversation was not responded to.

5 DHR Panel and Contributors to the Review

Members of the DHR Review panel were drawn from local agencies, both statutory and non-statutory. Some provided information from contact with Rachel, whilst others were supporting the panel in an advisory capacity. From the statutory agencies, all panel members were independent from having worked directly with Rachel and her family. It is not always possible for this to be the case with smaller non -statutory agencies due to their wider professional role, however, any information provided was subject to supervision by a line-manager.

[3] Homicide Service - Victim Support

[4] ttps://www.victimsupport.org.uk/wp-content/uploads/2023/11/P2557-1_Guidance-for-Domestic-Homicide-Review-Chairs_1023.pdf

[5] AAFDA - https://aafda.org.uk/AAFDA has over a decade of experience advocating for families after the homicide, suicide or unexplained death of their family member or friend, following domestic abuse. AAFDA was established in 2008 by Frank Mullane in memory of his sister Julia Pemberton and her son Will, whose murders in 2003 resulted in the pilot Domestic Homicide Review being conducted.

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NAME	AGENCY	STATUS	IMR, Report or Information
Carolyn Carson	Independent Chair/Author	Panel	
Marice Hawley	Broxtowe Borough Council	Panel and DHR Support	
Lorna Peltell	Nottinghamshire County Council Childrens Service	Panel Member Report Author	IMR
Nick Judge	Integrated Care Board	Panel	Provided Information
Maggie Westbury	Nottingham University Hospitals NHS Trust	Panel and Report Author	
Steph Clarke	Nottingham University Hospitals NHS Trust		Advised at learning event.
Chris Harris	Broxtowe Women's Project	Panel	
Hannah Albis	Broxtowe Women's Project	Panel	
Chelsea Lambert	Victim Support	Panel	
Richard Idle	Sherwood Forest Hospitals NHS Trust	Panel	Summary Report
Kerry Sullivan	Equation	Panel	Summary Report
Joanna Elbourne	Police	Panel	
Fiona McVey	Police	Panel	
Rob Wells	Police	Report Author	IMR
Charlotte Binney	Police		Practitioner Input
Helen Pritchett	Nottinghamshire Healthcare NHS Trust	Panel	
Ginnette Smedley	Nottinghamshire Healthcare NHS Trust	Report Author	IMR

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Thomas Worrell	Change, Grow, Live (Substance support)	Panel	Summary Report
Harry Lees-Manning	Broxtowe Borough Council	Panel	
Claire Konsek	Broxtowe Borough Council	Panel	
Novlette Holness	Nottingham Sexual Support Service	Panel	
Ross Leather	Nottingham County Council Adult Services	Panel	
Sam Bennett	Juno womens domestic abuse commissioned service	Panel	
Mark Beeby	Nottinghamshire Probation Service	Panel	

6 Author and Chair of the DHR and Overview Report

6.1 Carolyn Carson is an Independent Safeguarding Reviewer and has undertaken DHR's since 2013 across England and Wales. Carolyn retired as a Police Superintendent in 2012, having specialised extensively in Safeguarding through her service, at both a practitioner and senior manager level. Carolyn served in, and remains based in, Leicestershire. As such, she has not worked directly with any of the agencies involved with Rachel or the Broxtowe Community Safety Partnership. Carolyn has undertaken the Home Office training for DHR Chairs and recently, in February 2025, was certificated having successfully completed the revised Chairs training provided by AAFDA .

7 Parallel Reviews

7.1 The DHR was initially delayed awaiting the prosecution of Dean through the criminal justice system. On the 12th July 2024, Dean pleaded guilty to the murder of Rachel and sentenced to life with a requirement to serve 23 years and four months in prison before consideration of parole. The Coroner has been informed about the DHR and will be updated once the review is completed to ensure they can fulfil their duties.

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8 Equality and Diversity

8.1 Rachel and Dean were married, white and British. In terms of Protected Characteristics, marriage is a specific characteristic within the Equality Act 2010 and is important to prevent direct or indirect discrimination due to being a married person.[6] In relation to domestic abuse, the Crime Survey for England and Wales estimates showed that a significantly lower proportion of people aged 16 years and over who were married or in a civil partnership experienced domestic abuse than those who were either cohabiting, single, separated or divorced for year ending March 2025[7]. In addition, Rachel was a woman, and Dean was a man. An individual's sex is also a protected characteristic within the Equality Act 2010[8], important to prevent direct or indirect discrimination and to prevent victimisation and harassment due to an individual's sex. In relation to domestic abuse, both men and women can experience domestic abuse, but female victims experience higher rates of repeated victimisation and are more likely to be seriously hurt or killed than male victims.[9] For every three victims of domestic homicide, two will be female[10].

8.2 Rachel and Dean lived in a former mining community, which is described [11]as being insular and a close-knit community by professionals who perceive that the community will often resolve their own issues without redress from agencies such as the police. Rachel lived in a family centred, close, community, predominantly white and middle class. The 2021 Census findings show clearly

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[6] https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2

[7] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/latest

[8] https://www.bing.com/search?q=equality+act+protected+characteristics+sex&cvid=7b8f9308e7424b65bc8f57a874155ec8&gs_lcrp=EgRlZGdlKgYIABBFGDkyBggAEEUYOdIBCTE5NDA0ajBqNKgCCLACAQ&FORM=ANAB01&adppc=EDGEESS&PC=LCTS010/marriage-and-civil-partnership

[9] Women's Aid, 2024

[10] https://www.ncdv.org.uk/domestic-abuse-statistics-uk/

[11] Panel discussion from locally based professionals

that Eastwood is a predominantly white community, with the UK as the primary country of birth[12].

8.3 Assessing Rachel through the lens of Intersectionality, Rachel was a dedicated wife and mother in a middle class all-white family. She had been married to Dean for 25 years. Her family were her whole world and although she and Dean had been separated for 4 years prior to her death, she was faithful to Dean and remained hopeful of a reconciliation through most of that time, despite his abusive behaviour. She was proud of her 5-bedroom family home and did not want to lose it for her children. Rachel cared about her family remaining as a unit and was motivated to stay married. These factors help to understand Rachel and her particular situation. Sadly, they also helped to prevent her from identifying her relationship as being one of coercion and control, or that she was a victim of domestic abuse by violence.

9 Dissemination

9.1 Once agreement for the final report has been given by the Home Office Quality Assurance Board, an Executive Summary of this Domestic Homicide overview report will be available on the council website. The report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

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[12] https://www.citypopulation.de/en/uk/eastmidlands/nottinghamshire/E63001910__eastwood/ :
Country of Birth (C 2021)
UK 18,158
EU 376
Europe (other) 32
Middle East & Asia 101
Africa 163
Other country 71
Ethnic Group (C2021)
White 18,125
Asian 225
Black 140
Arab 18
Mixed/multiple 322
Other ethnic group 48

9.2 Upon publication, all partner agencies, locally or nationally, will be made aware, and the action plan will be shared with the agencies involved. In addition, a copy of the final report will be provided to the Office for Police and Crime Commissioner and the Domestic Abuse Commissioner.

9.3 The review has been assured by Broxtowe Community Safety Partnership that the learning will be disseminated by means of partnership training and developed guidance.

9.4 Rachel's family have been given the opportunity to review the Overview Report and Action Plan, and comment appropriately. Prior to publication, Rachel's family have been consulted on the Home Office feedback and consulted as to actual date of publication.

10 Background Information

10.1 The victim, Rachel, lived in Eastwood, Nottinghamshire, a civil parish within the Broxtowe district, approximately 8 miles north-west of Nottingham City. Rachel was killed in the family home she had shared with Dean for their married life. They had been together since 1994, when Rachel would have been 24 years old and Dean, 33 years old. At the time of the homicide, Dean was not living in the home, instead, from early 2020 he chose to move out to reside on a narrow boat on the nearby canal network. However, he would still visit the family home daily for his meals and continued to run his business from there, thereby spending long periods of time at the family home on a daily basis.

10.2 Dean killed Rachel when he knew she would be at home alone in the morning. It was pre-planned, and he entered the property and strangled Rachel with a shoelace, previously modified to act as a garrotte. A shoe was subsequently found on his boat missing the lace. On leaving the address, Rachel's eldest child was just arriving home and Dean admitted having killed their mother. Dean surrendered to the police the same morning.

10.3 The cause of death is recorded as strangulation.

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10.4 Living at the home with Rachel at the time of her death were her three children, aged 23 years, 21 years and 18 years respectively.

10.5 Dean was charged with Rachel's murder for which he subsequently pleaded guilty and was sentenced to life imprisonment.

11 Chronology

11.1 **Prior to the scoping period,** the family were known to the NHS Foundation Trust who were supporting Rachel and Dean to obtain a diagnosis for their middle child for autism spectrum. In March 2012, when their child was 11, a formal diagnosis for Autistic Spectrum Disorder was made. In addition, due to difficult behaviour, work was also undertaken on an on-going basis by the Child and Adolescent Mental Health Service (CAMHS) And Nottingham County Council Children's Service, Family Service. There was no indication of the existence of any abuse in the family at this time.

11.2 The family inform the review that around 2016, Dean's Dad died and that this affected him profoundly. A year later in 2017, Dean's uncle died in Ireland, and it was disclosed by an affected family member that the uncle had sexually abused them, and Dean, during family visits to Ireland when they were boys, for a period of 10 years whilst under the age of 14. From the point of disclosure, Dean's behaviour was reported to deteriorate and became erratic. He consumed large amounts of cannabis (an increase of an existing habit), but now also started to drink excessively.

11.3 A Paediatrician referred the middle child to the Family Service to help the family manage their symptoms of Autism Spectrum Disorder. In consequence, between August 2017 and August 2018, the child was open to Nottingham County Council Children's Service Family Service. It was reported that Rachel sought support to manage the behaviours because it was impacting her youngest child. They fought and couldn't be left home alone together. During this period, Rachel is recorded as not having a positive relationship with the child's school and Rachel and Dean removed their child from school. They felt

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the child was being bullied and kicked out of lessons and being left in isolation as a 'naughty child' without consideration of their issues. An Education Health Care Plan had been commenced. Rachel and Dean tried another school but that was also unsuccessful, and the child left college at 16.

11.4 The murder investigation has identified that between January and March 2019, Dean self-referred to a commissioned counselling service, the finer details of which are not available to the review.

11.5 **The scoping period commences in January 2020.** Nottingham City Council Children's Service report that the middle child had an Education Health Care Plan still open, and remained so until October 2020, but because he had ceased to attend a college placement, it was closed with no additional detail added in this period. The situation for the middle child has been discussed by the review panel and there was no identification of, or concerns of, domestic abuse in the family through this period. As such, the children are not subject to further analysis in this review to protect their privacy.

11.6 In January 2020, GP records identify that Dean saw his GP and outlined his history of sexual abuse and symptoms of anxiety. He outlined that he was living on a narrow boat and separated from Rachel, although visiting the family daily. He stated he has 'got it into his head that Rachel does not love him even though she says she does'. A few weeks later, Dean had a GP Depression interim review and having commenced medication, reported feeling a lot better.

11.7 In February 2020, Rachel saw her GP for HRT medication.

11.8 The police criminal investigation has identified that in May 2021, Rachel attended a locally based family solicitor for advice concerning her relationship, outlining that she had been separated from Dean for 18 months on a trial basis, but that Dean was still coming to the house. Rachel's family state that Rachel wanted this to stop because of her concerns about his behaviour.

11.9 Between July 2021 and September 2021, Rachel saw her GP for minor ailments 7 times. In February 2022, Rachel was again seen by her GP for an HRT check, and

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it was noted that her blood pressure was raised. Rachel described ‘some stress’, but no further detail was recorded as to why.

11.10 An out of hours 111 call was made by Rachel in November 2022, but no further details are available to the review.

11.11 On the 1st of February 2023, Rachel returned to her Solicitor[13] and reported that Dean was still ‘coming and going’. She had been hoping for a reconciliation up to now but realised that it wasn’t going to be the case. Dean wants a divorce, and Rachel is now seeking advice on this and how to keep her house.

11.12 On the 9th of February 2023, Rachel was seen for a blood pressure check which was raised and required home monitoring. No other detail is recorded.

11.13 On the 3rd March 2023, Rachel had a GP check-up for her blood pressure and prescribed medication due to it being high. No other detail recorded as to why.

11.14 In July 2023, Rachel reported to two family members that when Rachel was at home in the garden, sitting by the firepit in the early evening, Dean rushed into the garden through the back gate suddenly, and without warning he grabbed her arm and pushed her whilst kicking the firepit. Dean accused her of ‘being a liar’ and that he would ‘have her’. Rachel immediately ran to her mother’s where she decided not to report the assault to the police, stating that it would ‘only wind him up more’ and ‘nothing would keep him away from the house’. Bad bruising to Rachel was evident.

11.15 On the 21st August 2023, Dean had a further GP consultation, during which it is recorded that:

- Dean started to forget things.
- Split up from wife 4 years previously and doesn’t have happy memories.
- States Rachel was controlling him and now controls youngest child.
- Middle child has autism, and Rachel argues with them and causes stress.
- Rachel tried to turn two children against the third.

[13] Information from Police criminal investigation

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- Dean states that Rachel has been physically abusive 3 to 4 times over 26 years; on one occasion breaking his thumb, but not in front of the children.
- Dean very emotional.
- Currently drinking 12 bottles of beer a night and smoking cannabis. Declined professional support for this and advised not to withdraw suddenly.

11.16 Rachel's family report that at some point in approximately September 2023, Dean entered Rachel's home at 7 in the morning whilst Rachel was still in bed, shouting at her that 'she was evil' and a 'narcissist'.

11.17 During the autumn of 2023, the family report that Dean began not paying bills, resulting in the internet being cut off in October. Rachel's family took steps to try to find a solution for Rachel to move to another house but were not successful due to a lack of mortgage ability and the belief by Rachel that 'wherever she went, Dean would get in'.

11.18 On the 22nd of November 2023, Rachel's solicitor sent a letter to Dean to indicate Rachel would not oppose a divorce and suggested arrangements for Rachel to keep the house. A reminder was sent in early December, but no response was received. Rachel's family strongly believe that Rachel informed the solicitor about the assault in July.

11.19 On the 19th of December 2023, GP records show that Rachel's blood pressure was nearly normal.

11.20 On Christmas Eve 2023, Rachel told her family that she wanted to try again with Dean and on the 10th of January 2024, Rachel emailed her solicitor to halt divorce proceedings as 'building their relationship as friends and seeing where it goes'. However, having gone out for a meal with him in January 2024, Rachel told her family that all he wanted was to regain control and stop her seeing a solicitor. He informed her that if you keep seeing me, 'I'll pay the bills'.

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11.21 On the 9th February 2024, Dean saw his GP for a consultation during which he outlined his previous marital history (Rachel was second wife) and stated that Rachel was narcissistic and puts him down. He is drinking more and smoking cannabis. He disclosed his childhood abuse but no thoughts of hurting himself or others. No delusional thinking. The GP discussed 'red flags for crisis mental health'.

11.22 On the 12th of March 2024, Rachel had her final GP appointment, for a blood pressure check, which was slightly raised.

11.23 Rachel's family report that In March 2024, Dean started to reduce his payments towards the household bills. He cancelled Rachel's car insurance and tax, and Rachel could not afford to pay these bills as she was now paying for more household bills. This resulted in her having to sell her car. Dean continued to pay £140 per week for food shopping as he ate all his meals at the home address and also made his lunch there each morning. He threatened to cancel this once the youngest child turned 18. Whilst Rachel had always contributed to the bills, her monthly income from her waitressing job was not enough to cover all the household bills on her own. At the time her youngest son was only 17 and still studying.

11.24 On the 19th of March 2024, Rachel emailed her solicitor to say that reconciling is no longer what she wanted, and Dean had unexpectedly had the house valued which had disconcerted her. Three days later, on the 21st of March, Rachel informed her solicitor that Dean had cancelled insurance direct debits and sought advice. Also, asked how she stood in relation to him coming and going. The solicitor recorded that Dean is allowed 'reasonable access', but that attending without notice and using facilities is unreasonable and she could ask him to change his habits to ensure her right to privacy.

11.25 On the 26th March 2024, Dean was seen by his GP and reported that since the 9th February disclosures, he had been getting flashbacks and vivid memories whilst sleeping. He is unsure as to why but worse at night and struggling to sleep. He reports having post-traumatic stress disorder from a previous abusive

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relationship. Dean was referred to the practice specialist mental health practitioner and was waiting to be allocated an appointment at the time of the homicide.

11.26 Later the same day, Dean's GP followed up by sending him a text message to provide a link to mental health support services.[14]

11.27 In April 2024, Rachel was murdered by Dean. Rachel's family report that on reflection it appears that there were significant signs of planning by Dean. In February he became upset that he could not have 'one last holiday' with the boys. He also started sending text messages to his eldest son late at night which was out of character. 2 weeks prior to the incident Dean had approached his friend and made arrangements for his dog to be taken care of 'should anything happen to him.' On the morning of the 19th April Dean arrived at the house and sent his employees out on a job as usual. He spoke with his middle son about the purchase of some equipment that morning but then parked up the road until his youngest son left the house. He then entered the house and completed his invoices before proceeding to kill Rachel.

11.28 Following Dean's arrest for murder, he was seen in custody by the NHS Foundation Trust Liaison and Diversion Scheme where it was noted that Dean was calm and showed no signs of paranoia. He stated he had been drinking 16 cans of beer a night and the primary risk identified was one of alcohol withdrawal.

12 Overview of Known Information

12.1 The key source of information known about Rachel and Dean during the scoping period by statutory agencies was the GP surgery, where both Rachel and Dean were registered. It is notable that Rachel's notes are very sparse whereas Deans are comprehensive. Dean had been forthcoming about his past issues of being

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7 https://mind.org.uk/informnation-support/types -of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/treatment/

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sexually abused as a child and was diagnosed with anxiety and depression. He disclosed heavy use of alcohol and cannabis. Dean also reported an unhappy marriage with Rachel; alleging having been abused by her to the extent of emotional and physical abuse. At the time of the homicide, Dean was waiting for an appointment to see a mental health specialist. Rachels family would like to attest that at no time did friends or family see Rachel being abusive to Dean.

12.2 A key source of information known about Rachel comes from recorded interactions with a family divorce lawyer. Rachel disclosed financial abuse, and reports on three occasions that Dean kept entering her home after he had moved out. Rachel's family believe Rachel informed her solicitor about the physical abuse.

12.3 Rachel's family describe Rachel and Dean as originally a happy couple who met and lived together quickly, moving into Dean's previous married home, before marrying a few years later, with no fuss because Rachel was a 'practical person'. Dean's first marriage ended acrimoniously after his wife left with his money, for someone else, after a year of marriage. Dean and Rachel would regularly spend time together without the children, going out every Saturday evening. Rachel was very close to her mother, children, family members and friends, and turned to them for support. She kept them updated on her relationship with Dean, telling them directly about his behaviour whilst also observing controlling, and violent, behaviour themselves.

12.4 In addition to information in the chronology, Rachel's family report that Dean has always been intransigent, for example, always deciding where the family would holiday (a friend's caravan in Devon), and without fail, he spent every Friday evening with his friends in one of the friends shed.

12.5 When Rachel had concerns about their middle child's development Dean would not allow him to be seen because he was ashamed of his issues and the family report that this caused arguments between them. Rachel was very concerned about their child being bullied at school and not developing properly and

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proactively worked to prevent the bullying and with support from a paediatrician team, she was able to commence the child's diagnosis.

12.6 The family described Dean as once having been a 'perfect Dad', taking care of the family, and providing for them. He was described as very loyal and protective and would deal with any issues that arose with the family, such as arguments his children may have had with others, in a 'calmy aggressive manner' in that he always remained calm but would determinedly challenge in a focused and planned way. He would do anything for his family, but he would not call the police, preferring to resolve any matters himself. However, the family saw a big change after his father died and his experiences of sexual abuse became known. He consumed cannabis all the time and began to drink. Dean told the family that he had undertaken counselling and saw the Nottingham Sexual Violence Unit. The family state that Rachel emphatically did not want Dean to tell the boys about the abuse, but he did so, sitting them down to explain; an event the children describe as a strange evening, with a belief that he only told them because Rachel didn't want him to, to take control back.

12.7 The eldest children describe their relationship with Dean to be generally good but could also be up and down because he often started arguments. Dean had a more difficult relationship with his youngest child who would challenge his behaviours and attitude to Rachel. The children feel a late trigger for Dean may have been the fact at the end of March, they were taking the youngest child on a holiday abroad on turning 18, as a first friend's trip. Dean asked if he could go, and they tried to explain that it was a young person's trip and so he couldn't. Dean appeared depressed by this and whilst they were away sent strange text messages. The family stated that at times, they have been worried about Dean having suicidal thoughts.

12.8 Prior to her death, the family report that Rachel had taken steps to get divorced and started planning to do things with friends and family. Although short of money, she still cared about herself. At the time of her death, Rachel had only £2.50 in her purse and no other money. She had put her last £20 in her niece's birthday card.

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13 Analysis

13.1 Rachel's Lived Experience

13.1.1 From information known to the review, Rachel had been married to Dean from the age of 27. Whilst presenting as a happy family, evidence of early control can be seen when Dean did not want their middle child seen by professionals, to the detriment of his development, resulting in arguments. Further control is evident when Dean insisted on spending his own time on a Friday evening and took responsibility to address any family issues. He paid most of the bills and controlled the money. Also, when he disclosed his sexual abuse to the children despite Rachel not wanting this.

13.1.2 Following the disclosures of childhood abuse, Dean changed and left the family home, wanting to separate from Rachel through his own choice, removing the funds from their joint account to buy a narrow boat to do so. This controlled choice from Rachel, who had wanted to stay married, and he further controlled by continuing to visit the family home as and when he pleased. The family advise that Rachel still supported Dean with the business and washed his clothes. Dean would continue to enter the house each morning for a shower, sometimes taking a cup of tea and discussing a future together but on other occasions would enter and call her names – 'evil and narcissist'. On one occasion, Dean was physically violent. To manage this, during the last months, Rachel would go to her mother's address whenever Dean was present at the house to avoid any conflict and avoid upsetting him. Rachel encouraged her children to also try to not upset him. Rachel was unable to leave the property as she would not be able to afford a house big enough for her and 3 nearly adult children. Dean was aware that she would not be able to afford all the bills so cancelled them one by one. He also told her that money will only be provided if she still saw him. As

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such, Rachel was living on eggshells, a victim of coercive and controlling behaviour[15], whilst also subject to physical domestic violence.

13.1.3 Whilst separated, Dean continued to exert control over Rachel by reducing the amount of money he provided to her. Also, he told her he wanted her back, which effectively stopped her contact with a family solicitor. Rachel became aware of this and commenced divorce proceedings again, taking control of her future. She began planning for her future with family and friends. Despite this, by the time of her death, Rachel remained subject to on-going financial abuse and had no personal money, no internet and no car. She remained helpless to prevent his behaviour until he chose to murder her. Her family describe her situation as being 'trapped'.

13.1.4 Information known to the family as inputted to this review shows the nature of domestic abuse suffered by Rachel from her husband but not identified as such, and which went unidentified by statutory agencies. On analysis, Rachel's experience with Dean very closely aligns with the risks of homicide identified through research, the '8 step Timeline to Homicide'[16], as published by Dr Monckton Smith in 2018: These steps can be paralleled as follows:

1. *A pre-relationship history of stalking and abuse by the perpetrator:* The review panel took the decision not to speak to Dean's first wife given the time lapsed and intrusion into a private life that would have been caused. However, information available from Rachel's family would indicate a short marriage, and Dean's former wife allowing Dean to keep the family home after she left for

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[15] Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Domestic abuse isn't always physical. Controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. Coercive and controlling behaviour of a spouse became a criminal offence in 2015.

[16] Do you know the 8 Step Timeline in Domestic Abuse Homicides? Research published by Dr Monckton Smith in 2018, reviewed domestic violence killings in the UK which showed an 8 stage timeline of events before a homicide takes place. To conduct her study, 575 homicide cases involving women killed by men (femicide) were identified using the Counting Dead Women database (Ingala Smith 2018). There were found to be 372 femicide cases from 2012 to 2015 . Every case was reviewed using published media and homicide reviews to establish the history and circumstances of the homicide, and to identify common and consistent themes. The eight steps were identified to be present in almost all of the murders studied. If one was missing, it was most likely to be step 1.

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another.

2. *The romance develops quickly into a serious relationship:* This was verified by Rachel's family.

3. *The relationship becomes dominated by coercive control*: This is evidenced through the chronology and Rachel's outlined lived experienced.

4. *A trigger threatens the perpetrator's control - for example, the relationship ends or the perpetrator gets into financial difficulty:* Although Dean ended the marriage, he was still controlling Rachel's ability to instigate divorce proceedings until one month before her death, when she took steps to initiate proceedings and showed signs of moving on.

5. *Escalation - an increase in the intensity or frequency of the partner's control tactics, such as stalking or threatening suicide:* Dean escalated both personal violence, financial abuse and coercive control. He intruded on her personal space without challenge. At times the family were worried about potential for his suicide.

6. *The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide:* Rachel reported that Dean seemed happy just before her death. Her murder was pre-planned.

7. *Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone:* Dean knew that Rachel would be alone at that time of day and went prepared with a shoelace removed deliberately in advance.

8. *Homicide - the perpetrator kills his or her partner and possibly hurts others such as the victim's children:* Dean showed no remorse at the harm he was causing to

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their shared children and wider family.

13.1.5 Lesson 1

Rachel's lived experience is demonstrably that as a victim of domestic abuse through violence, financial abuse, coercive and controlling behaviour and ultimately as a homicide victim. The perpetrator behaviour of Dean paralleled the recognised '8 step domestic homicide timeline'.

13.1.6 Interrupting perpetrator behaviour is critical to preventing a domestic homicide. To do so, agencies need to be aware of abuse. However, in this case, agencies were not aware of the existence of domestic abuse or of the risks posed by Dean. This review will examine why that was the case.

13.2 Identification of Domestic Abuse

13.2.1 Rachel did not report domestic abuse to a statutory agency for reasons the review is not able to establish. She regularly met her GP but there are no disclosures recorded, and she chose not to report a physical assault to the police, believing it would only wind him up and not prevent his entry to the house. Rachel's family believe that Rachel 'in no way' would have identified herself as a victim of domestic abuse. She would not have called the police believing they wouldn't be able to do anything. Rachel did though, consult a solicitor when she was financially insecure and worried about where she would live, after Dean said he was divorcing her. The thought of being seen as abused would have caused her shame; she was private and aware that everyone knows everything in her community.

13.2.2 Lesson 2

RACHEL did not see herself as a victim of domestic abuse which was a barrier to having an opportunity to seek support from agencies.

13.2.3 Discussion at the review learning event outlined that Eastwood is a former mining town and professionals' perception is that it often remains hierarchical with a man primarily providing financially for the house. It is not a socially mobile

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community, with communities living for generations in the same area. There is an element of the community who will not turn to the police for support, preferring to resolve issues themselves. The review has identified that this was the case within Rachel's family. A police representative outlined that culturally in the community, the police can be seen as 'someone who will take you away if you do bad things', rather than to help, although they highlight that is not unique to just Eastwood.

13.2.4 The police also reported that whilst there is reluctance to involve the police, the reporting of crime generally is no lower in Eastwood than neighbouring communities. This is reflected by the specialist Broxtowe Women's Project, a charity that supports victims of domestic abuse, who stated that reporting numbers for domestic abuse are pretty even across Eastwood compared to two neighbouring communities. Unfortunately, there is insufficient data recorded locally to ascertain how reporting rates for domestic abuse in Eastwood compare nationally.

13.2.5 A key report published by 'Standing Together'[17], in January 2025 titled 'Fixing a Broken System: Landmark Report Demands Action on Domestic Abuse', highlights that:
"Only 1.7% of perpetrators of domestic abuse are convicted, with just 4.6% of reported cases leading to conviction. The low reporting rate of domestic abuse, under 20%, underscores a systemic failure to build trust with survivors, many of whom face fear of retribution, inconsistent police responses, and societal stigma".

13.2.6 The Standing Together report demonstrates that under reporting of domestic abuse is an issue and this is reflected in Rachel's case. Whether culturally or by choice, and for reasons known only to Rachel, she did not feel she could report her assault to the police.

[17] https://www.standingtogether.org.uk/news/dac-report-stada-response-lrspz-8z7ft-tmp55-z6kkj-3entz
Standing Together are a national charity with a role to bring communities together to end domestic abuse.

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13.2.7 Lesson 3

Research indicates that only 20% of victims report abuse. Like many, Rachel did not report a physical assault to the police thereby preventing direct identification of domestic abuse.

13.2.8 Although the review cannot ascertain the full details of Rachel's relationship with Dean, another barrier to reporting could be reinforced by feelings of wanting to support Dean. This is evident by wishing to stay married and still being in love with him. A cause of this attachment may be evident when looking at the features of a Trauma Bond[18], which Rachel may have formed. The features are that, despite the existence of domestic abuse, including coercive behaviour, a victim will seek to take comfort from the abuser. Rachel had been committed to Dean for emotional support for many years in their marriage. A victim may make excuses for their partners behaviour or blame a poor childhood. Dean did have a difficult childhood, having been sexually abused as a child, and he had a reportedly poor relationship with his mother. A trauma bond can be very hard to break, and research indicates that if a victim does manage to break free from the trauma bond, the abuser will commonly revert to the courtship phase to win her back and she will be very vulnerable to his efforts. The more a victim reaches out to the abuser for love, recognition, and approval, the more the trauma bond is strengthened. This also means staying in the relationship when the abuse escalates, perpetuating the destructive cycle. Because a perpetrator is the one abusing a victim and making her feel terrible, a victim will often see him as the only person able to validate her and make her feel okay again.

13.2.9 These circumstances are reflected in Rachel believing that Dean wished to reconcile, a few months before her death, and her willingness to do so, as she reported to her family.

13.2.10For Rachel, another barrier to reporting domestic abuse was the simple fact that she did not see herself as at risk as a victim. She did not recognise her situation

[18] https://broxtowewomensproject.org.uk/trauma-bonding/

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as being coercive or understand that she was being financially abused. Her family believe strongly that she didn't think of herself as a victim even after an assault and when they asked her, she stated she wasn't afraid of Dean, believing that he would never hurt the mother of his children.

13.2.11Rachel did seek some support when consulting a solicitor after Dean instigated the divorce or controlled further by getting the house valued without her knowledge. She sought advice about Dean continually coming into her home on three separate occasions. She also outlined her worry about Dean reducing the finances, reporting that he had cancelled direct debits. Her family also strongly believe that Rachel told her solicitor about the assault. The review has been unable to evidence that the solicitor identified her situation, and this was a missed opportunity for a professional to identify domestic abuse and support Rachel to break the chain of events leading to the homicide. Whilst Rachel's mindset may have been on responding to Dean wanting a divorce and concerns about the home and finances, the reality was that Rachel was being coercively controlled and financially abused, and this is apparent in the disclosures she made to the solicitor. Unfortunately, it has not been possible to discuss this further with the solicitor's practice.

13.2.12 The only statutory agency who came into contact with Rachel was her GP. Both Rachel and Dean were at the same surgery and had been for many years. The surgery knew both Rachel and Dean. Staff have been deeply affected by Rachel's death as they knew her well over many years within their close community. Staff at the surgery report having no idea at all that Rachel was a victim of domestic abuse and have been deeply shocked at what happened to her.

13.2.13 Of note in the GP interactions with Rachel is the paucity of information recorded concerning Rachel. She was well known but despite this, Rachel did not disclose what was happening within her marriage, again for reasons known only to herself, and she had many appointments over the scoping period, including after her physical assault, where she had an opportunity to speak about what had happened to her, but she chose not to. She saw a GP regularly and was

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treated for high blood pressure, reporting she was subject to 'some stress' but no further information was requested or recorded.   This is an example of how hidden domestic abuse can be in the community.

13.2.14Lesson 4

Rachel faced barriers to reporting abuse, namely the likelihood of a trauma bond with Dean and that she preferred to seek support from within her family and not agencies, including the only agency to have come into contact with Rachel, her GP surgery where she was well known.

13.2.15 Rachel's records are in stark contrast to the GP records in relation to Dean's interactions with a GP. His notes are comprehensive and include a full history of his issues on three occasions. Dean freely outlined that he had been sexually abused and was suffering anxiety and mental health issues, and that he consumed cannabis and alcohol excessively.

13.2.16 Of note is in August 2023, when Dean told the GP that he had not had a happy marriage and alleged Rachel having been abusive to him to the extent that she had broken his thumb on one occasion. He relayed concerns about her behaviour within the family towards their children. Whilst a positive attention to detail for Dean, there is however little professional curiosity displayed to understand more about the allegations or to understand safeguarding implications for the family. Again, the family wish to record that at no time did they witness Rachel being abusive to Dean.

13.2.17 The GP surgery have explained that they knew the family and did not have any concerns that Rachel posed any risk to Dean and did not ask any more questions about the allegations. They were aware that the couple were separated and not living at the same address and this reduced their concerns. Their focus was on Dean and manging his mental health presentation, especially in March 2023. They accept that there was a lack of professional curiosity, and they have commenced reminding staff of the need to be curious in relation to safeguarding and allegations of abuse.

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13.2.18 Given the nature of the allegations, the GP could have signposted Dean, or, with consent, directly refer Dean to the specialist service for men, ‘Equation’. This should have happened and was a missed opportunity for specialist services to have an opportunity to work with Dean.

13.2.19 Lesson 5

Dean alleged domestic abuse to his GP but there was a lack of professional curiosity, and this was not explored, resulting in a missed opportunity for Dean to be referred to a specialist service.

13.2.20 It is important to note that this review has found no evidence at all which supports Dean’s allegation against Rachel other than his disclosure to the GP, who immediately dismissed it as a risk from personal knowledge. At his sentencing, the trial Judge stated:

‘There was no justification for her death and no history of her treating you as the victim. All of this was in your own warped mind’.”

13.2.21 The role of a GP in identification of domestic abuse victims is critical given they are often, as in this case, the only agency a victim may come into contact with. Discussion by the panel at the learning event highlighted a general lack of referrals, locally, by GPs into MARAC. In terms of identifying domestic abuse, the GP surgery state that they would contact, or refer to, a specialist support service such as Women’s Aid, rather than complete a DASH[19] risk assessment themselves. As such, they wouldn’t directly refer to MARAC. This would appear to be the case across many GP surgeries in Nottinghamshire. A reason for this could be that funding for the IRIS program was withdrawn to Nottinghamshire GP surgeries which prevents GP surgeries from engaging in a specialist IRIS training programme[20]. The surgery felt that the fact that Rachel and Dean were living separately was a safety factor whereas it is known that separation is a key risk factor for domestic violence, as discussed later in this review. Also, when the

[19] DASH: Domestic Abuse, Stalking and Harassment risk assessment for use by safeguarding agencies to identify levels of risk of harm.
[20] https://irisi.org/what-is-iris/ IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices

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allegation was made, one of the children in the family was still under 18. A refresh of safeguarding practices, including known risk factors, when to make a child protection referral and the value of professional curiosity would be of benefit and reassure agencies that GP's are considering domestic abuse and safeguarding issues.

13.2.22 Lesson 6

To enhance the identification of domestic abuse and to reassure partners, GP surgeries should ensure staff receive up to date domestic abuse training to identify risk factors and understand the importance of wider safeguarding referrals and professional curiosity.

13.2.23 Equation highlight that GP's can, in addition to a referral, also signpost to specialist support services for domestic abuse. They point out that their organisation is commissioned across Nottinghamshire to produce a range of information cards and posters to enable signposting that would assist GP's to do so. The review notes that as a result of this review, the GP surgery has ensured that Equations information cards are available to patients[21].

13.3 Management of Domestic Abuse by Agencies

13.3.1 There was no support for Rachel by agencies, for domestic abuse, within the scoping period. Rachel managed her situation herself, primarily by not winding Dean up. She was supported by her family who sought ways to extricate Rachel from the home. A key issue for the review is identifying ways for families of domestic abuse victims to know what services are available where they have identified domestic abuse as a trigger to seeking support. As the family stated, 'How do they know?'

13.3.2 The review has noted that there is a great deal of information about domestic abuse and support services available when conducting a generic web search for the Nottingham areas. There are many support agencies listed as available to help and this is good practice. Also, specialist services have posters displayed in

[21] Information cards cover Women, Men, LGBT+

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local GP surgeries, chemists and the local pubs. This is also good practice. However, a key issue for the public is identifying that their situation is actually domestic abuse and identifying that they are a victim in the first place.

13.3.3 The Policy paper 'Shifting the scales: Transforming the criminal justice response to domestic abuse,' published by the Home Office in January 2025, [22] identifies a barrier to reporting domestic abuse is that 'Victims and Survivors do not identify with terminology around domestic abuse'. It states:

'Although victims and survivors will identify that something is not right in their relationship, or even that they are experiencing harm, they may not directly associate this with the language of 'domestic abuse' or with a particular index offence. This may be the result of any number of factors, including blame and gaslighting from the perpetrator, as well as deeply ingrained societal myths and misconceptions about what domestic abuse is, and who can be a victim or a perpetrator.'

It continues:

'*research from Victim Support indicates that domestic abuse being normalised or not understood is one of the key factors in victims and survivors not reporting to police'.*[23] *This is supported by data from the Crime Survey of England and Wales, which indicates that 43 percent of victims who had experienced domestic abuse did not report it to police because they felt the incident was too trivial or not worth reporting'.*

13.3.4 Panel discussion at the learning event identified that messaging, locally, to the public needs to change to encompass tangible situations that a victim may recognise rather than directly asking if someone is a victim of domestic abuse, a concept that many, such as Rachel do not relate to. An example is messaging

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[22] https://www.gov.uk/government/publications/transforming-the-criminal-justice-response-to-domestic-abuse/shifting-the-scales-transforming-the-criminal-justice-response-to-domestic-abuse-accessible#fn:8 12 Recommendations for change in the criminal justice system for a multi-agency response

[23] Mayes, A, Moroz, A. and Thorsgaard Frolunde, T. (2017) Survivor's justice: How victims and survivors of domestic abuse experience the criminal justice system. London: Victim Support. ↩

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about someone's experience at having their money reduced to the extent that they are worried about how they will manage. Messaging can explain that this is identifiable financial abuse. Likewise with coercive behaviours. Such enhanced campaigns based on relatable triggers of behaviours may help women in Rachel's situation to identify domestic abuse in the future.

13.3.5 Panel discussion also felt that support services should be available for third parties who are worried about a family member or friend, with enhanced ability to search for support where worried, and show options available to them. Messaging could specifically target specific demographics too, such as grandparents. It is noted that local support services are now looking to add a specific section directly aimed at friends and families on their respective websites.

13.3.6 Nationally, there are campaigns that promote how to recognise concerning behaviour in a relationship, a red flag, and to know how to support victims, a green flag. A 'Red Flag, Green Flag'[24] campaign was recently deployed in London and aimed to highlight the number of deaths by domestic homicide each year whilst identifying that not all victims are obvious. A similar approach may be useful in Nottinghamshire.

13.3.7 Lesson 7

A barrier to management of domestic abuse for Rachel was the lack of understanding that her situation was abusive, a fact mirrored nationally. Research identifies that many victims do not relate to the concept of domestic abuse as that which they are experiencing.

13.3.8 Rachel had been subject to a physical assault and advised by her family to report this to the police. Rachel declined believing there was nothing they could do. Had she felt able to, there is much that could have supported her.

[24] https://www.londonworld.com/news/london-agency-launches-nationwide-campaign-to-stop-the-horrors-of-domestic-abuse-across-the-uk-4848329 Oct 31st 2024: Collaboration between Mediazoo and the Employers Initiative on Domestic Abuse (EIDA). Flags were planted by the memorial to the Great Fire to compare the 6 deaths from the fire versus 247 domestic homicides between April 2022 and March 2023.

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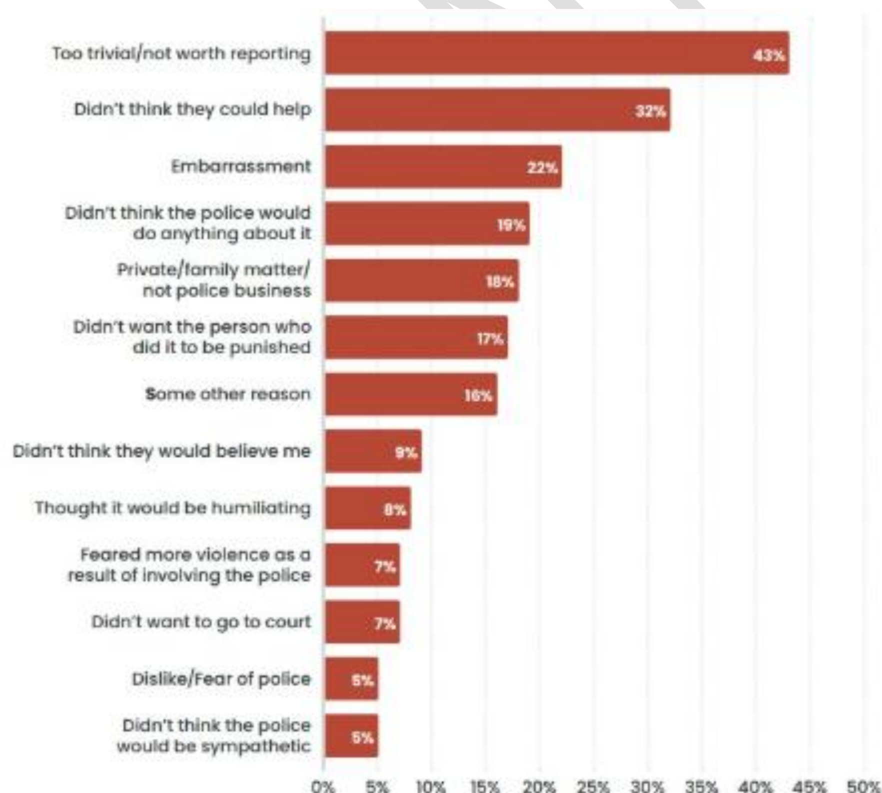
13.3.9 The policy paper 'Shifting the scales: Transforming the criminal justice response to domestic abuse,'[25] highlights that the police are often the first professionals told about domestic abuse, and this opens a range of support to victims, when police work with partners. The report states that:

'*The criminal justice system has the potential to be transformative for victims and survivors of domestic abuse – a place to find justice, safety, and support.*'

13.3.10 It is important to note that that the police are just one element within the wider criminal justice system. However, in relation to the police, the report outlines research into the reasons why victims did not tell the police about partner abuse[26]:



13.3.11The top finding is that victims consider their domestic incident as too trivial to report. Messaging to the public needs to work to contradict this perspective

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[25] https://www.gov.uk/government/publications/transforming-the-criminal-justice-response-to-domestic-abuse/shifting-the-scales-transforming-the-criminal-justice-response-to-domestic-abuse-accessible#introduction

[26] 12 months to March 2023 - Office for National Statistics (2023) Partner abuse in detail, England and Wales: year ending March 2023 – Table 13: Why the victim did not tell the police about the partner abuse

together with highlighting the value of reporting to the police. The review panel support this but highlight that there is no specific funding available locally to do so.

13.3.12 It is important that the public are aware of what the police can do when they receive a direct report of abuse. For Rachel, initially, even if she did not wish to prosecute Dean, the police would have recorded her injuries on body worn cameras and witnessed her bruising, thereby validating and identifying her as a victim. A DASH[27]risk assessment would have been completed routinely, during which specific questions would have been asked that could have identified coercive behaviour. Dean killed Rachel by strangulation. Of note is that a question concerning use of previous strangulation would have been asked as part of the DASH to highlight the additional risks strangulation poses. Research published in 2024, which studied 75 domestic homicides committed by strangulation,[28] highlights that in 72% of the cases, there had been previous domestic abuse. In 68% of cases coercive behaviour had been a feature. Non-fatal previous strangulation had occurred in 59% of cases. Whilst the review has no way of knowing if strangulation had occurred previously in Rachel and Dean's marriage, it is apparent that fatal strangulation presents a significant risk indicator of previous abuse.

13.3.13The police have a duty to make victims safe. The College of Policing outlines the duty of the police to take positive action[29] at every domestic incident and provides guidance to officers attending a report of domestic abuse on the use of a protective order called a Domestic Violence Protection Notice (DVPO).[30] A DVPO can remove responsibility from a victim for taking action against a perpetrator because it can be used without the victim having to make a formal complaint. It removes a perpetrator from the family home for a set amount of

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[27] https://safelives.org.uk/resources-for-professionals/dash-resources/

[28] https://ifas.org.uk/wp-content/uploads/2024/10/DHR-Series-Report-4-A-Comparative-Analysis-17.10.24.pdf

[29] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/leadership-strategic-oversight-and-management#duty-of-positive-action

[30] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/using-domestic-violence-protection-notices-and-domestic-violence-protection-orders-make-victims-safer

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time to give space to victims to make decisions about their future and to allow specialist support services to work with a victim, if they wish for support. For Rachel, it could have removed Dean from the family home without her having to make a statement or attend court. Validation of a physical assault would have provided grounds for an application to a family court to consider an Occupation Order, effectively ensuring Rachel's sole right to enter the family home for a set period. An Occupation Order is an injunction available under the Family Law Act 1996[31] as is a Non-Molestation Order, an injunction aimed at stopping harassment from an ex-partner. Both were relevant to Rachel and could have been used to support her.

13.3.14 An extra value of civil injunctions is that where they are breached, the police have a power of arrest that again, removes victim responsibility and doesn't require a victim to have made a statement or attend a station. A DVPO, Occupation Order or a Non-Molestation Order would have been an effective tool to prevent Dean 'coming and going' and being verbally or physically harassing to Rachel; thereby breaking his chain of controlling behaviour, and the chain to the homicide. It is vitally important that the public understand the value of reporting domestic abuse to the police and the help they can provide and understanding that victim wishes and choices can be honoured albeit where positive action is taken to directly protect victims. This is particularly important in communities such as Eastwood who may not see the police as an obvious means of help and support.

13.3.15 Lesson 8

Reporting to the criminal justice system has the potential to be transformative for victims and survivors of domestic abuse – potentially a place to find justice, safety, and support. A direct report to the police opens a range of support to victims and risk assesses the need for immediate and on-going protection from harm.

[31] https://www.gov.uk/injunction-domestic-violence

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13.3.16 A DASH risk assessment would have highlighted risk and signposted Rachel to specialist local services. It would have been completed routinely by the police. Full guidance in the use of a DASH risk assessment is available locally to all professionals within safeguarding agencies through an accompanying guidance document and flow chart to the DASH[32] itself. Panel discussion of the situation for Rachel, in hindsight, indicate that a medium risk[33] would have been the most likely outcome and therefore, Rachel would not have been referred through to MARAC. Where Medium Risk has been identified, the guidance provides helpful advice and links for practitioners to ensure victim safety, shows where to signpost and encourages the reporting of a crime to the police. It is a valuable resource to support all front-line staff.

13.3.17 Whilst a focus on the value of reporting to the police is important, victims also need to know that reporting doesn't have to be directly to the police. Support services can directly support victims to be safer and a key mechanism is through the use of the DASH risk assessment to highlight what safety measures are needed.

13.3.18 The DASH risk assessment is a multi-agency tool for use by all safeguarding agencies to support the identification of domestic abuse and the level of services assessed as necessary to manage presenting risks. It is not intended solely for the police to use. There is great value in completing a DASH and can help victims identify their situation. Practitioners report many 'lightbulb' moments for victims when answering the DASH questions as realisation hits that what is happening to them is, in fact, domestic abuse. As such, DASH must be encouraged to be used by all agencies. For Rachel, the only agency she

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[32] DASH-RIC Guidance is held, for professionals, on the Equation website: https://equation.org.uk/marac-resources/ where you will find direct links to the DASH-RIC itself : https://equation.org.uk/product/dash-ric/ and the associated guidance : https://equation.org.uk/product/guidance-to-questions-on-the-dash-ric/ Guidance to Questions on the DASH RIC | Equation. Also, agency specific guidance/flow chart for MARAC process for South Notts / Juno : https://equation.org.uk/product/south-nottinghamshire-marac-flowchart/ Additionally there are DASH-RIC for LGBTQ+ male survivors

[33] Medium: 7 – 13 ticks
There are identifiable indicators of risk of serious harm. The perpetrator has the potential to cause serious harm but is unlikely to do so unless there is a change in the circumstances (trigger).

presented to was her GP but as she did not disclose abuse, there wasn't an opportunity to consider use of DASH in her case.

13.3.19 As a result of this DHR, it is noted that a local review of the use of DASH has been undertaken where it was identified that different versions of the DASH were being used by different agencies. This has now been rectified and staff across agencies reminded in its use.

13.3.20 Lesson 9

There is good advice available to local safeguarding agencies through the DASH Risk assessment guidance which if utilised, can enhance the identification and management of domestic abuse.

13.4 Risk Identification and Management

13.4.1 To manage Dean's risk of harm, the need to do so must be identified. In this case, there was no engagement with Dean as a potential abuser by any agency. There was no indicator of risk identified, and the review will assess why this was the case.

13.4.2 Dean was open with his GP about his mental health issues through the scoping period, with his last appointment three weeks prior to the homicide. Dean's issues included the existence of post-traumatic stress disorder, flashbacks, childhood sexual abuse, depression, anxiety and sleeplessness. As already analysed, Dean's GP did not consider there were any risks of domestic abuse in the family but did identify his worsening mental health. In August 2023, Dean's GP advised Dean on how to manage acute mental health issues, including risk of suicide, through making him aware of red flags and telephone helplines. However, by March 2024, Dean's GP diagnosed that more help was needed and positively referred him to direct support from a mental health specialist within the practice for support and a review of his needs. The GP surgery outline that it is usually a month before an appointment is offered so the delay in being seen is in line with expectations and not unusual. Such an appointment would have led to consideration of medication and specialist trauma informed psychiatric counselling.

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13.4.3 Dean had been subject to trauma as a child through sexual abuse, the existence of which re-surfaced as an adult. Due to Dean not having undergone any assessments prior to the homicide, it is not possible to understand how his childhood trauma impacted on his mental health as an adult. However, research published in October 2024 from a specialist organisation who support adults abused as children, 'Survivors in transition'[34] recognise that:

'Experiencing sexual abuse in your childhood can have a wide range of effects on you in adulthood. Some adult survivors experience no or very few mental health problems, while others experience many and severe mental health problems. Sexual abuse is a kind of trauma and the effects of trauma include a complex combination of factors.'

In relation to the psychological effects, their research identifies that:
'whilst some survivors may experience no or few issues related to the abuse, survivors of sexual abuse are generally more likely to develop psychological disorders in adulthood. This may include one or a combination of the following:

- *Depression or feeling 'low'*
- *Post Traumatic Stress*
- *Low self esteem*
- *Eating disorders*
- *Drug addiction or alcohol use / dependency*
- *Suicide attempts / self-harm and self-mutilation*
- *Anxiety*
- *Dissociative disorders or episodes of dissociating or 'splitting out'*
- *Personality Disorders*
- *Psychosis*
- *Bi-polar disorders*

[34] https://survivorsintransition.co.uk/resources/the-impacts-of-childhood-sexual-abuse/

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- *Adults with a history of abuse as a child, especially sexual abuse, are more likely than people with no history of abuse to become frequent users of GP, emergency and medical care services.*

13.4.4 DEAN reflected many of these attributes and a referral by the GP at least would have been a start in recognising how his childhood trauma impacted him. The offered appointment was an opportunity for DEAN to get some help but sadly, he did not wait for the appointment but instead chose to kill Rachel in the interim.

13.4.5 The risk of harm posed by Dean through his mental health is a complicated picture. At his sentencing, Dean wrote a letter to the court stating that 'he could not escape his mental health or see another way out'. His perspective was refuted by the trial judge who stated:

'It is clear from the letter you have written you are still, to some extent, labouring under the illusion to suggest your mental state was such that you had no alternative. To say you had no alternative than to kill her is frankly ludicrous'.

13.4.6 Dean's GP was aware of heavy substance use by Dean and whilst this does not cause domestic abuse, it can contribute to a loss of control. Heavy use of cannabis can contribute to paranoia. Dean's GP did, helpfully, offer a referral for substance use but Dean declined so there were no opportunities for professionals to work with him. Dean's GP report having taken steps to support Dean to reduce his consumption, but he declined a referral, preferring to manage this himself, stating that he would cut down (he did not). Again, the GP did not believe there were any risks in the family and so not unreasonably did not consider a link between excessive substance use and enhanced risk through any potential loss of control.

13.4.7 Experts in the management of substances, Change, Grow, Live, inform the review that the role of cannabis in perpetrators of domestic homicide is a complex and nuanced issue. Research on this topic has produced varied results, and the relationship between cannabis use and violent behaviour, including

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domestic homicide, is not fully understood. The latest available quantitative analysis of drug use in domestic homicide reviews October 2022 to September 2023, indicated illicit drug use being a feature noted in relation to perpetrators in 28 % of reviews during that period. However, illicit drug is terminology for a wide range of substances which can have different psychoactive effects on a person, the available data does not break down further information about types of illicit substances. It is understood that the Psychoactive compound found within cannabis, THC , (Tetrahydrocannabinol), can overstimulate the part of the brain that regulates fear and anxiety, which can lead to paranoid thoughts. Additional factors such as genetics, THC content and individual brain chemistry can influence the likelihood of experiencing paranoia. From the available information available to the review, it is suggested that Dean experienced paranoid thoughts, although it cannot be confirmed due to a lack of assessments. His focus on Rachel as being 'a narcissist', is not at all consistent with the picture formed of Rachel through the review. However, paranoia was not noticed immediately after his arrest when seen by professionals when in custody.

13.4.8 In relation to use of alcohol, Dean disclosed consuming approximately 16 units per evening. Change, Grow, Live inform the review that the latest available quantitative analysis of themes from domestic homicides indicates that problematic alcohol use features in perpetrators in 26 % of reviewed cases. Alcohol consumption can impair judgment, reduce inhibitions, and increase impulsivity, leading to aggressive behaviour. This is particularly relevant in domestic settings where conflicts can escalate quickly.[35]

13.4.9 Dean also reported to his GP that he suffered memory loss. Change, Grow, Live advise that heavy cannabis use has been linked to impairments in working memory,[36] and persistent use can lead to long-term changes in brain function.[37]

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[35] Alcohol and Violence - Institute of Alcohol Studies) https://www.ias.org.uk/uploads/pdf/Women/bs_alcohol_violence.pdf

[36] New MRI Study Reveals How Cannabis Alters Brain Activity and Weakens Memory https://scitechdaily.com/new-mri-study-reveals-how-cannabis-alters-brain-activity-and-weakens-memory/

[37] https://www.aol.com/cannabis-affect-memory-largest-study-173000151.html?guccounter=1

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13.4.10 Excessive use of alcohol can also cause brain damage leading to short term and long term loss.[38] For DEAN, it is possible that he experienced withdrawal from alcohol and cannabis, especially when working in the day. Change, Grow, Live advise that alcohol withdrawal can significantly impact memory and cognitive function.

13.4.11 It is noted that whilst Dean told his family that he had attended the Nottingham Sexual Violence service for support concerning historical sexual abuse, there is no record that he did so and so the review concludes that he didn't seek help. This prevented any work with Dean on the effects of trauma when his trauma resurfaced as an adult.

13.4.12 Lesson 10

The situation in relation to the risks posed by Dean through the impact of childhood trauma and excessive use of substances cannot be properly established. Efforts were made by his GP to help Dean manage his issues through direct support and an appropriate referral, but agencies were not able to engage with him prior to the homicide through choices he made. As such, Dean did not engage with mental health services and continued to rely on substances with no apparent awareness of the impact this may have had on his potential for risk.

13.4.13 A missed opportunity to manage the risk from Dean came from his GP not referring Dean as an alleged victim of domestic abuse. Discussion at the learning event highlighted that Equation work with male victims, and that occasionally referred/ self-referred victims are identified as primary perpetrators during support. Equation report that it is possible that a referral to Equation for Dean might have provided him with additional support with regards to his specific support needs, thereby mitigating some risks, or potentially identified him as being abusive, in which case Equation would offer referral options with regards to perpetration. Where possible Equation will also attempt to refer non-abusive partners into local support services.

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[38] https://www.alzheimers.org.uk/about-dementia/types-dementia/alcohol-related-brain-damage-arbd

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13.4.14 Victims of domestic abuse in Nottinghamshire are supported through a range of provision including IDVAs for women, men and lgbt+ victim survivors, a 24-hour helpline for women and helpline for male/ lgbt+ survivors, as well as specific provision in Eastwood. An IDVA is a specialist domestic abuse worker who works directly with victims. In particular, an IDVA will:

- Listen and validate experiences/Provide emotional support
- Discuss feelings and emotions
- Assess needs and create tailored support plans
- Support with safety planning
- Risk assess and review risk every 6 weeks and after any further incidents
- Refer any cases assessed as High Risk of domestic abuse to the Multi Agency Risk Assessment Conference (MARAC)
- Represent the survivor at MARAC – provide them with a voice at the Conference and an opportunity to access multi agency support
- Provide practical support i.e. housing, benefits, referrals to other specialist agencies
- Tell survivors about criminal and civil remedies, e g Occupation or Non-Molestation Orders
- Tell survivors about the Domestic Violence Disclosure Scheme
- Liaise and share information with partner agencies accordingly
- Provide specialist support around LGBTQ+ specific barriers and experiences, and signposting around gender and sexual identity

13.4.15 Overall, the allegations made by Dean to his GP could have been referred to Equation with Deans consent. Or information about Equation's support service could have been provided to Dean for his consideration as to acceptance. A referral, (self or GP) would have provided an opportunity for an expert agency to enquire into Dean and Rachel's relationship and potentially enable access to other relevant services which may have mitigated risk.

13.4.16 Lesson 11

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A referral to Equation for Dean by the GP, or information provided, where accepted, could have been an opportunity to support the family and identify and manage risk to Rachel, and risk from Dean.

13.4.17 The review panel do not believe that Dean would have been assessed as a high risk offender and so would not have been eligible for consideration of direct management as a Potentially Dangerous Person[39]. The Home Office 'Quantitative Analysis of Domestic Homicide Reviews October 2022 to September 2023[40]' outlines that 55% of perpetrators were not known to agencies as an abuser prior to the homicides. This highlights the risks that exist where abuse is not able to be identified and referred to agencies. Interestingly, of the perpetrators analysed, the existence of a mental health issue was present in 46% of the familial cases, with depression and psychosis as the most prevalent factors. This further reinforces the need for GP's to be vigilant when managing depression within families, especially where domestic abuse has been alleged.

13.4.18 The consideration of the impact of the different risk factors affecting Rachel's family could have prompted safeguarding considerations through 'Think Family'[41] by the family GP. Relevant factors are the existence of an under 18-year-old in the household, another child known to have autism, an allegation of domestic abuse, and the existence of known mental health and excessive substance use issues. A Think Family approach could have served as a prompt to speak directly to Rachel to understand the family dynamics and could have been an opportunity to identify risk to Rachel.

13.4.19 Lesson 12

Due to the number of factors affecting RACHEL's family, the GP could have considered a 'Think Family' approach as a means of speaking directly to

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[39] https://www.college.police.uk/app/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/potentially-dangerous-persons
[40] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/quantitative-analysis-of-domestic-homicide-reviews-october-2022-to-september-2023-accessible#characteristics-of-perpetrators
[41] https://safeguarding-guide.nhs.uk/context-of-NHS-safeguarding/s2-05/

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Rachel to discuss the impact on the family which would have been an opportunity to assess risk.

13.5 Role of a Family Solicitor

13.5.1 This review has engaged with Rachel's experienced family solicitor, who works within a local practice near to Rachel in the heart of Eastwood. The solicitor informs the review that most of their work is through word of mouth, with the local community having used their services for many years.

13.5.2 The family solicitor is the eyes and ears of divorcing people in the community. They are in a unique position to identify and manage domestic abuse. They may seek legal aid to ensure there is no fee for domestic abuse applications for civil injunctions[42]such as an Occupation or Non-Molestation Order. They can access these orders on an emergency basis where immediate help is assessed as being necessary.

13.5.3 The chronology shows that Rachel had five interactions with the solicitor. Rachel sought advice on the bills being stopped and Dean's 'coming and going'. Whilst respecting the solicitor was focused on the information presented by Rachel, it is apparent that the solicitor did not have any conversations with Rachel about domestic abuse. Rachel did not openly disclose but as this review has ascertained, Rachel did not identify as a victim. Nor it seems did the solicitor identify Rachel's situation as being one of coercion and control and financially abusive and take steps to protect her through advice or the securing of civil injunctions.

13.5.4 Whilst sympathetic for the need for the review, Rachel's family solicitor does not believe they can share information about her to the review concerning specifics. This is disappointing but it is respected that they are bound by certain information sharing measures. The solicitor's regulation authority[43]outlines that a solicitor may not disclose confidential information without a person's consent,

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[42] https://www.gov.uk/guidance/apply-for-a-domestic-abuse-protection-order-in-a-county-court

[43] https://update.sra.org.uk/solicitors/guidance/confidentiality-client-information/

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and that this general duty to confidentiality '*continues despite the end of the retainer or the death of the client when the right to confidentiality passes to the client's personal representatives'.* A request to the solicitor to seek such consent from Rachel's family has not been responded to.

13.5.5 Client confidentiality also extends to safeguarding unless disclosure is necessary to prevent a serious offence or serious harm to another, but not after the event; and so would not support family solicitors sharing safeguarding information to a domestic homicide review.

13.5.6 Although there was no discussion as to specifics, the solicitor did helpfully provide generic information on training. In this case, the solicitor states that much development of domestic abuse matters, such as the introduction of the offence of coercive and controlling behaviour in 2015, has taken place after their initial training. Whilst they are aware of coercive behaviour, any updates to knowledge comes from training provided by the practice, or continuing professional development, or, as in the solicitor's case, by being members of standing bodies such as 'Resolution.'[44] Interestingly, Resolution[45]have recently published a report into Domestic abuse in financial proceedings where: '*research found that 80% of family justice professionals believe domestic abuse and specifically economic abuse is not sufficiently taken into account in financial remedy proceedings'. Resolution's view is that the current approach of the courts to s25(2)(g) of the Matrimonial Causes Act 1973 i.e. conduct leads to unfair outcomes for some victim-survivors of domestic abuse.* Rachel did not get as far as the courts for her divorce, but it does highlight the importance of understanding the impact of financial abuse on victims during separation and matrimonial proceedings.

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[44] https://resolution.org.uk/ Resolution was founded in 1982 by a group of family lawyers who believed that a non-confrontational approach to family law issues would produce better outcomes for separating families and their children.

[45] Found by the author of this review on the Resolution website: Domestic Abuse in Financial Remedy Proceedings. Considering the relationship between domestic abuse and the division of finances on separation and/or divorce/dissolution.

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13.5.7 Research into domestic abuse routinely highlights that victims are at a heightened risk from harm at point of separation. DVACT-PAI[46], a team of professionals who work together to help keep children safe from domestic abuse, conducted a 'post-separation abuse awareness and safety planning week' in September 2024. They highlight:

'*Post-separation abuse is a key indicator in domestic abuse risk assessment and indicates an increase in risks to ex/partners and their children. The 2021 Femicide census identified that 53% of women killed by men that year were killed by a current or former partner. 52% of women killed by a partner/former partner were taking steps towards leaving or had left the relationship. The end of a relationship is a trigger event included in the 8-step homicide timeline.*'

13.5.8 DVACT-PAI also advise that:

'*As of April 2023, Post-Separation Abuse became a recognised offence under the Serious Crime Act of 2015 and is defined as a pattern of abuse that continues after a relationship has ended. However, many victims and experts feel that this type of abuse is misunderstood, ignored or dismissed. Those working within the family courts system believe that poor recognition of post-separation abuse can lead to the courts unwittingly permitting or facilitating ongoing abuse and control, particularly through child contact arrangements.*

13.5.9 Poor recognition of post-separation abuse is apparent in Rachel's case by the family solicitor. A generic discussion with the solicitor highlighted that solicitors do not have training about risk, or knew about or would consider use of, a DASH risk assessment. The solicitor was of the opinion that even if Rachel had disclosed abuse, they could only take steps as advised by their client's instructions and whilst they 'must be alive to what isn't said, they must act without assumptions'.

13.5.10The review respects a family solicitors' position but would aver that family solicitors have a key role in identifying post separation abuse and all forms of

[46] https://www.dvact.org/post/post-separation-abuse-awareness

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domestic abuse. They are speaking to divorcing members of the public, routinely, but this shouldn't be a routine process but an understanding of a client's situation. Dean abused Rachel post separation for 4 years, before killing her, unchallenged. It is vitally important that family solicitors are up to date with domestic abuse training and understand their ability to identify and protect victims. Whilst they may only act on instructions and disclose without consent where there is an urgent, current, need, identifying abuse and advising on options through the lens of being a victim of domestic abuse, may enhance victims understanding of the reality of their relationship, and consequently, enhance safety.

13.5.11 Given the enhanced status of the testimony of persons in the community to contribute to a DHR, the Home Office should consider taking steps to engage with relevant bodies such as the Family Law Society to agree an approach that supports the inclusion of specialist family lawyers to understand how they may help prevent harm by contributing to a DHR. Whilst there are very real issues concerning client confidentiality, being aware that families may consent after a death, and understanding the value of their contributions to victim safety, may enable greater contributions in the future.

13.4.12Lesson 13

Family solicitors are the eyes and ears of divorcing individuals in the community. They are in a unique position to identify abuse, in particular, post-separation abuse, and take active steps to protect victims. Updated training in domestic abuse would enhance their ability to identify and protect victims.

13.4.13 Lesson 14

The contributions of professionals into DHR's such as family solicitors working with domestic abuse victims in the community would greatly enhance learning for the future prevention of harm.

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13.5 Support for the family, post homicide.

13.5.1 Rachel's mother, children, wider family and friends have been devastated by her death. Necessarily, a domestic homicide review was commenced very quickly after Rachel was killed but put on hold pending the outcome of a criminal trial. Unexpectedly, Dean pleaded guilty to Rachel's murder in July, just 4 months after the homicide, which ensured the review commenced again quickly but at a point where the family was still grieving.

13.5.2 Rachel's family initially had the support of a Family Liaison Officer (FLO), but this relationship broke down and a second FLO appointed. The family felt they had not been kept properly informed and learnt of key information from newspaper reports.

13.5.3 The family were supported by a specialist Victim Support worker from their Homicide Service throughout the criminal trial process and this was a very positive relationship. The Homicide Service have a role to support families through the criminal justice process and where they have a relationship, they also continue their support through a domestic homicide review. As such, the same worker supported the family at the commencement of the DHR.

13.5.4The Homicide Service specialist liaised with the independent chair of this DHR and they planned a visit to speak to the family to gain their insights into the relationship between Rachel and Dean. The joint visit took place quickly after the trial, mainly because there was very little information available from agencies on which to base a meaningful set of terms of reference. All Rachel's close family and friends wanted to input, and the support worker arranged a single visit which garnered much vital information, providing information not available to agencies. The family's information provided valuable substance to the DHR.

13.5.5 However, sadly, the family felt the interaction was not a positive experience for them. Feedback from the Homicide Service worker relayed that they were not comfortable with a focus on Dean and felt responsible for Rachel not seeking

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help. In consequence, the family did not wish to further engage directly with the review although they remained supported by The Homicide Service.

13.5.6 The chair sends sincere apologies that the family feel the review hasn't been a positive experience. Despite planning and a joint visit, there was insufficient explanation of the role of the DHR and the purpose for asking questions about the relationship. In particular, discussions about the help that could be available to victims should they report to the police, could have been more fully explained within the context of trying to help others and not intended for the family to feel blame in any way. Having too many people together prevents a close focus and is a barrier to forming relationships on which to base sensitive discussion.

13.5.7 Going forwards, there needs to be a focus on the primary trauma suffered by families in their loss and understanding of grief. The emotional reaction to trauma can be anger, fear, sadness and shame and this is reflected in how the family felt. There needs to be a clear plan to prevent secondary trauma, caused, albeit unwittingly, through exposing the family to the death again, especially so soon after a tragedy. DHR's should follow the advice of AAFDA[47] and ensure the impact of trauma is considered at a first panel meeting and adequately planned for. A key question is to ask 'What do this family need?' rather than a generic approach. A delay to speaking to families until a suitable plan is in place, informed by specialist support workers and/or introductory meetings to build relationships, is important going forwards, to alleviate concerns and ensure families are prepared.

13.5.8 Unfortunately, after the family visit, the Homicide Service worker felt they were unable to attend panel meetings on the family's behalf, and the family received no further information about the progress of the review. This situation deteriorated when the current support worker left the service. The Chair requested a referral to AAFDA at the point of leaving, but this was declined, and a temporary Homicide Service worker was allocated. However, unbeknown to the Chair and panel, this would prove to be a holding position only and telephone

[47] Advocacy After Fatal Domestic Abuse – 7 step approach to working with families

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based. Sadly, the temporary worker also left, and a further temporary worker allocated. During this period of temporary support, the Chair sought to meet the family to discuss the findings, especially due to the concerning allegations made by Dean to his GP. The Chair also forwarded both version 1 and version 2 of the Overview Report, neither of which were seen by the family due to a breakdown in communication. In consequence, on this occasion, the role of the Homicide Service in the DHR process was ineffective and there should have been an earlier referral to AAFDA.

13.5.9 The Chair requested referrals at different points of the process, but the Homicide Service preferred to hold the case themselves. This was to the detriment of the family who did make their own referral at a point when the final report was close to completion. The Chair recognises the role of AADFA and thanks them for their role in ensuring the family are now fully engaged with the Overview Report.

13.5.10 Families are extremely important to DHR's, and their contributions must be maximised to ensure valuable learning is included, but also that the experience is a positive one, wherever possible. This review respects the role of the Homicide Service through the criminal justice process but highlights that the trial process is very different to a DHR process with vastly different outcomes for families. Key learning in this review is to ensure that an independent referral to AAFDA from a review panel is made at the commencement of every review, regardless of other support in place.

13.5.11 Lesson 15

DHR's should plan effectively and work with specialist support professionals to ensure that families can engage fully and with confidence to a DHR, with the effects of secondary trauma mitigated as much as possible.

13.5.12 Lesson 16

A referral to AAFDA is necessary at the commencement of every DHR to ensure families have access to appropriate advice and support.

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14 Conclusions

14.1 Rachel had been in a family centred, long marriage to Dean, during which they had three children, all of whom were living with Rachel at the time of her death. They lived in what had previously been a mining community, in their own 5 bedroomed property.

14.2 There were early signs of control in the family, with Dean making all major decisions and being in control of much of the finances. Dean changed after disclosures, 8 years before the homicide, that he had been sexually abused by an uncle as a young boy. This impacted Dean leading to an increase in cannabis use and a high level of alcohol consumption. Dean chose to end the marriage and moved out of the family home 4 years prior to the homicide. His mental health suffered, and he was treated for depression. He was referred for support for his mental health and was waiting for an appointment, three weeks prior to the homicide.

14.3 Post-separation abuse was a feature of Rachel and Dean's relationship prior to the homicide. Dean continued to visit Rachel as he wished. He reduced the monies available to Rachel, and cancelled direct debits, leading to the loss of internet and Rachel's car. She had very little money of her own. Dean stated his intention to divorce but controlled Rachel by taking steps to prevent her doing so. He entered Rachel's home uninvited and was abusive and on one occasion, was violent, causing injury to Rachel. This was unreported to agencies.

14.4 Throughout, Rachel stayed loyal, demonstrating a parallel to the features of a trauma bond, a situation that is very hard to break from, and often needs specialist help to do so. Rachel did not believe Dean would ever hurt her. A key issue for the review is the fact that Rachel did not identify as a victim of domestic abuse, and she did not wish to report abuse to the police when physically harmed. Rachel relied on her family for support and as a family, and reflected in the community, did not always want to involve the police. Had a report been made and abuse identified, there were many opportunities to directly support

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Rachel, and through the application for civil orders, prevented Dean from being in the family home.

14.5 Dean has demonstrated a classic homicide timeline, with his behaviour escalating. His timeline to the homicide continued uninterrupted and he remained in control until Rachel took steps to progress a divorce and move on with her life, at which point he killed her.

14.6 No agency was aware of the domestic abuse suffered by Rachel and so were not able to interrupt Dean's behaviour. Her only contact was with her GP, and she did not disclose her abusive situation even though she was well known at the surgery. This reflects the hidden nature of domestic abuse.

14.7 Dean, however, disclosed to his GP that his marriage had been unhappy, and alleged that Rachel had been abusive to him. This is contrary to all the information available to the review that overwhelmingly show Rachel to have been a dedicated wife and mother. Given the nature of his allegations, a referral should have been considered, or signposting, to a specialist support agency. Had a referral been made, this would have been an opportunity for an assessment of the relationship to take place, with the potential to identify Rachel as a genuine victim.

14.8 Another opportunity existed to disrupt DEAN, through Rachel disclosing information to her local family solicitor that amounted to financial abuse and coercive and controlling behaviour, including seeking advice about Dean continually coming to the home. Sadly, domestic abuse was not discussed and identified and direct support to protect Rachel not considered. Family solicitors do not have to contribute to a DHR, and this is a missed opportunity to understand Rachel's interactions with the solicitor, or to highlight the role of family solicitors as the eyes and ears of divorcing individuals, in a unique position to support directly through application of civil orders. In particular, Occupation and Non-Molestation orders, available free of charge to domestic abuse victims, and designed to prevent access by an abuser, can be swiftly applied for through the solicitor where risk is identified.

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14.9 Dean murdered Rachel in a planned way. He had opportunities to manage his mental health and substance use but he chose to kill Rachel before a vital mental health appointment was available. Agencies did not have an opportunity to work with him and in consequence his risk of harm was not able to be identified and managed.

14.10 It is vitally important that victims of domestic abuse understand the situation they are in and understand that support and help is available. Being able to relate to abusive actions outside of the concept of domestic abuse is necessary to recognise their situation. Victims need to see the risks they are facing, and understand the potential for harm from their abuser, and to know how to access the wide support networks available in the community. The value of reporting to the criminal justice system and the police should be publicised to promote confidence to do so and for victims to know steps will be taken to protect them.

14.11 Agencies and professionals need to take every opportunity to identify abuse by being professionally curious. Victims, and their families and friends, need support to know how to identify abuse and to know where to go for support, and have confidence that they will be helped and their wishes valued, to prevent this tragedy happening to someone else in Rachel's position.

15 Lessons Learned

15.1 Lesson 1

Rachel's lived experience is demonstrably that as a victim of domestic abuse through violence, financial abuse, coercive and controlling behaviour and ultimately as a homicide victim. The perpetrator behaviour of Dean paralleled the recognised '8 step domestic homicide timeline'.

15.2 Lesson 2

Rachel did not see herself as a victim of domestic abuse which was a barrier to having an opportunity to seek support from agencies.

15.3 Lesson 3

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Research indicates that only 20% of victims report abuse. Like many, Rachel did not report a physical assault to the police thereby preventing direct identification of domestic abuse.

15.4 Lesson 4

Rachel faced barriers to reporting abuse, namely the likelihood of a trauma bond with Dean and that she preferred to seek support from within her family and not agencies, including the only agency to have come into contact with Rachel, her GP surgery where she was well known.

15.5 Lesson 5

Dean alleged domestic abuse to his GP but there was a lack of professional curiosity and this was not explored, resulting in a missed opportunity for Dean to be referred to a specialist service.

15.6 Lesson 6

To enhance the identification of domestic abuse and to reassure partners, GP surgeries should ensure staff receive up to date domestic abuse training to identify risk factors and understand the importance of wider safeguarding referrals and professional curiosity.

15.7 Lesson 7

A barrier to management of domestic abuse for Rachel was the lack of understanding that her situation was abusive, a fact mirrored nationally. Research identifies that many victims do not relate to the concept of domestic abuse as that which they are experiencing.

15.8 Lesson 8

Reporting to the criminal justice system has the potential to be transformative for victims and survivors of domestic abuse – potentially a place to find justice, safety, and support. A direct report to the police opens a range of support to victims and risk assesses the need for immediate and on-going protection from harm.

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15.9 Lesson 9

There is good advice available to local safeguarding agencies through the DASH Risk assessment guidance which if utilised, can enhance the identification and management of domestic abuse.

15.10 Lesson 10

The situation in relation to the risks posed by Dean through the impact of childhood trauma and excessive use of substances cannot be properly established. Efforts were made by his GP to help Dean manage his issues through direct support and an appropriate referral, but agencies were not able to engage with him prior to the homicide through choices he made. As such, Dean did not engage with mental health services and continued to rely on substances with no apparent awareness of the impact this may have had on his potential for risk.

15.11 Lesson 11

A referral to Equation for Dean by the GP, or information provided, where accepted, could have been an opportunity to support the family and identify and manage risk to Rachel, and risk from Dean.

15.12 Lesson 12

Due to the number of factors affecting Rachel's family, the GP could have considered a 'Think Family' approach as a means of speaking directly to Rachel to discuss the impact on the family which would have been an opportunity to assess risk.

15.13 Lesson 13

Family solicitors are the eyes and ears of divorcing individuals in the community. They are in a unique position to identify abuse, in particular, post-separation abuse, and take active steps to protect victims. Updated training in domestic abuse would enhance their ability to identify and protect victims.

15.14 Lesson 14

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The contributions of wider professionals to a DHR, such as family solicitors, working with domestic abuse victims in the community would greatly enhance learning for the future prevention of harm.

15.15 Lesson 15

DHR's should plan effectively and work with specialist support professionals to ensure that families can engage fully and with confidence to a DHR, with the effects of secondary trauma mitigated as much as possible.

15.16 Lesson 16

A referral to AAFDA is necessary at the commencement of every DHR to ensure families have access to appropriate advice and support.

16 Recommendations

16.1 Recommendation 1

Broxtowe Borough Council should review and revise domestic abuse procedures to ensure messaging to the public incorporates an understanding of what situations are abusive, to enhance identification and management of domestic abuse by victims and agencies.

16.2 Recommendation 2

The Nottinghamshire Domestic Abuse Board should review and revise how the domestic abuse victims in the community report abuse, to enhance confidence in the benefits of the criminal justice system and/or support agencies.

16.3 Recommendation 3

Broxtowe Borough Council to commission the development of a community domestic abuse package to share with non-agency professionals who work with domestic abuse victims locally, to directly enhance victim safety.

16.4 Recommendation 4

Home Office to consider a national review of professionals in the community

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who work with victims of domestic abuse and evaluate how best to engage to enhance contributions to a DHR.

16.5 Recommendation 5

Home Office to consider a national campaign to raise awareness aimed at helping victims to realise that the presenting and tangible features of their relationship may be domestic abuse and that where identified, there is help available to victims in their community.

16.6 Recommendation 6

Broxtowe Borough Council should make a recommendation to the South Nottinghamshire Community Safety Partnership that a specific 'learning the lessons' event is held locally for safeguarding partners and key stakeholders with a focus on the homicide timeline which led to Rachel's death, to promote learning and wider awareness raising arising from the tragic circumstances of Rachels death.

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Appendices

App 1 Single Agency Recommendations

1. The ICB to support GPs to consider self-reflection on professional curiosity and to ensure staff receive current domestic abuse training to ensure identification of risk factors and a Think Family approach.

2. Equation to ensure that their team are reminded of the importance of recording date of birth and address details at first contact where possible, or record where not possible.

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