Overview report

Chelmsford CSP

A Domestic Homicide Review (DHR) concerning the death of Rachel (pseudonym)

(April 2023)

Author – Jackie Dadd

Date completed – August 2025

The Domestic Homicide Review Panel and the members of the Chelmsford Community Safety Partnership would like to offer their sincere condolences to the family of Rachel, who have lost their loved one in tragic circumstances.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Domestic Abuse Act 2021 and the Home Office define Domestic Abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling behaviour is:

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour 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. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

Glossary

AAFDA – Advocacy After Fatal Domestic Abuse

ASC – Adult Social Care

CFSC – Children and Family Social Care

CSP – Community Safety Partnership

DASH – Domestic Abuse Stalking and Harassment Ris Assessment

DHR – Domestic Homicide Review

ESAB – Essex Safeguarding Adult Board

HMP – His Majesty's Prison

IOPC – Independent Office for Police Conduct

MAPPA – Multi-Agency Public Protection Arrangements

MPS – Metropolitan Police Service

NCDV – National Centre for Domestic Violence

SETDAB - Southend, Essex and Thurrock Domestic Abuse Board

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review examines agencies responses, provisions and support provided or available in the Chelmsford area and wider County of Essex to Rachel, a 37-year-old female with two children prior to the point of her death, having been murdered at the home address of her ex-partner, Noel, having received substantial head injuries and strangulation.

1.1.2 Due to the knowledge of previous domestic abuse history within the relationship on police record, a referral was promptly made for consideration for a Domestic Homicide Review (DHR) to the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB). Following a meeting, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.3 Following an investigation, Essex Police charged Noel with murder to which he was subsequently found guilty following a trial at Chelmsford Crown Court to which he received a life sentence with a minimum to serve of 16 years.

1.1.4 Contributors to the review

Agency	Contribution
Essex Police	IMR, panel member
Essex Partnership University Foundation Trust (EPUT)	Summary report
GP Surgery	Scoping, Panel member
Strategic Housing Service Chelmsford City Council	IMR, panel member
Clarion Housing Group	IMR, panel member
IDVA, The Next Chapter	Panel member
Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)	Oversight, panel member
Essex Probation Service	Summary report, Panel member
Adult Social Care	IMR, panel member
Chelmsford Community Safety Partnership	Panel member
Victim Support	Panel member
Provide	Scoping
Essex Children and Families Social Care	Summary report, panel member
NHS Mid and South Essex Integrated Care Board (MSE ICB)	Panel member

Review Panel

1.1.5 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied:

1.1.6 The panel comprised of the following:

Name	Area of responsibility	Organisation
Val Billings	Senior Domestic Abuse Coordinator	Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
Ifthahar Ahmed	Minute taker	Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
Spencer Clark	Public Protection Manager	Chelmsford CSP
Beverley Jones		The Next Chapter
Cheryl Gerrard	Associate Designated Nurse Safeguarding	Mid & South Essex ICB (MSE ICB) - Mid Alliance
Ben Pedro-Anido	T/DI Head of Operational Development, Strategic Vulnerability Centre	Essex Police
Alison Hawkins	Housing Solutions Manager	Chelmsford City Council
Emily Batch	Tenancy Specialist Manager	Clarion Housing Group
Ruth Cherry-Galal	IDVA Service Manager	The Next Chapter
Rebecca Walsh	Clinical Specialist for Safeguarding	Essex Partnership University Foundation Trust (EPUT)
Sara McParland	Senior Caseworker	Victim Support
Sarah Davies	Senior Caseworker	Victim Support
Carole Eden	Service Manager	CFS
Emma Barker	Detective Chief Inspector	Essex Police
Emma Bundy	Service Manager	Adult Social Care
Ilona Benjamin	DHR Project Officer	Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
David Messam	Head of Probation Delivery Unit	Probation Service

1.1.7 All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR, and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided. Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

Author of the Overview report

1.1.8 The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

1.1.9 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed the new Home Office DHR Chair training and obtained the qualification of an ONC level three certificate.

1.1.10 Mrs Dadd has completed and published several DHRs.

1.2 Purpose of the review

The purposes of a DHR are to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for the coroner and criminal courts, respectively, to determine as appropriate. DHRs are not part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

This review will ascertain whether domestic abuse could have been the cause or a contributory factor to the death of Rachel. It is not to apportion blame, but to view the circumstances through her eyes.

1.3 Timescales

1.3.1 Following the commencement of the criminal investigation, Essex Police made a referral for a consideration for a DHR to SETDAB within the same week of Rachel's due to the circumstances surrounding the death and previous recorded history of domestic abuse.

1.3.2 A Core Group Meeting was held in June 2023 and in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified the same day.

1.3.3 Mrs Jackie Dadd was commissioned to provide an independent Chair and Author for this DHR on 9th June 2023. Three separate panel meetings then took place. The completed report was handed to the SETDAB on 06/08/25.

Table outlining timeline of review:

April 2023	Death of Rachel
May 2023	Essex Police make a referral to SETDAB for consideration of a DHR
06/06/23	Decision to commission a DHR by SETDAB
06/06/23	Home Office notified of decision to commission a DHR
09/06/23	Jackie Dadd commissioned as Chair and Author
13/07/23	First panel meeting
13/12/23	Second panel meeting
11/06/25	Third panel meeting
06/08/25	Completed report handed to SETDAB by Author

1.3.5 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Due to the Criminal investigation and judicial process, the DHR was significantly delayed and only re-commenced following the sentencing of Noel at Chelmsford Crown Court in February 2025.

1.4 Confidentiality

This report has been treated as Official Sensitive and dissemination kept to those outlined at 1.9.

The pseudonyms used in this report were chosen by the Author to protect the identity of those referred to throughout the report. Full details are found at 1.6 of this report.

The Chelmsford CSP, SETDAB and the Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

1.5 Terms of Reference

1.5.1 The Full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

1.5.2 It was agreed that the main areas of focus and discussion would be based on the following:

a) Were there adequate risk assessments and support for safeguarding measures for both Rachel and her children

b) Is the correlation between domestic abuse and carers recognised amongst agencies within Chelmsford

c)The recognition of Children as victims of domestic abuse

Methodology

1.5.3 Initial scoping was completed, and it was evident that there had been contact with a number of agencies by both Rachel and Noel. The Senior Investigating Officer (SIO) for the murder investigation attended the first panel meeting to provide additional insight. During this meeting, the Terms of Reference areas were agreed. The panel were provided guidance by the SIO on who could be approached for further information and/or an IMR and who should be delayed due to the Judicial process.

1.5.4 The family were initially informed of the DHR, but the Author was not able to establish inclusion until after the judicial proceedings had been concluded. Panel meetings were held to provide discussion, debate and confirmation of actionable recommendations. All panel members were sent the report to read and have opportunity to comment and amend prior to submission to the Home Office.

1.5.5 Internal agency action plans, shared with the review panel have been ongoing throughout this review to ensure that learning identifies has been addressed in an expeditious manner.

1.5.6 The Author made contact with Noel via letter to His Majesty's Prison (HMP) to ascertain whether he wished to partake in the review, but no response was made.

1.6 Subjects of the review/Family and friends' involvement

1.6.1 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Rachel's death).

Rachel – The deceased. A white, British female aged 37 years old.

Noel – Husband of Rachel. A white, British male aged 39 years old. Convicted of the murder of Rachel.

Kerry – Eldest child of Rachel in their Teens.

Jody – Youngest child of Rachel in their Teens.

1.6.2 Following the initial letter and Home Office leaflet being sent from the Chelmsford CSP to the mother of Rachel, of whom now both children of Rachel lived with, the Author received an email from her sister (Rachel's Auntie) requesting that she be the point of contact early in the review and was responded to via email from her sister, requesting that she be the point of contact as her sister was not able to deal with things at that time. Family viewpoints made in the initial contact are outlined at 3.1 of this report.

1.6.3 The author re-contacted Rachel's Auntie following the conclusion as was agreed and was informed that the family did not wish to take part in the review as 'after nearly two years, it is time to get on with our lives the best we can'. The panel respected this request. Consent to speak with the children had been asked by the Author to obtain the voice of the child within the review, but consent has not been provided. The family were informed and reminded of the opportunity for AAFDA support and sent a leaflet but did not feel they required this as they were supported by a Homicide Case worker from Victim Support.

1.6.4 They were not sent a copy of the report for family scrutiny and feedback as was their wishes. In 2023, Rachel's mother released a short statement through Essex Police stating

"I have not only lost my daughter, but I have lost my best friend too. She was a fantastic mother to her children, and she was loved by everybody"

1.7 Parallel reviews

Independent Office for Police Conduct (IOPC)

1.7.1 A referral was made by Essex Police to the Independent Office for Police Conduct due to the fact that at the time of Rachel's murder, there was an active missing person report for Rachel. This has now been concluded with a reflective learning outcome for one individual officer. No organisational learning was identified by the IOPC.

Coroner

1.7.2 Due to the conclusion of the criminal trial and the sentence received, the family did not wish for an inquest to take place which was agreed by the coroner.

Serious Further Offence – Probation

1.7.3 This has now been completed with an action plan that identified six separate areas of learning. These included the necessity to increase professional curiosity and ensure the case officer is fully conversant with all aspects in order to appropriately risk assess. Also, the need

to take children in the home into consideration and recognise them as victims of domestic abuse.

All actions are being addressed with a number having been completed in December 2024. Any relevant findings that are subject to the Terms of Reference of this review have been incorporated within the recommendations and analysis at the end of this report.

1.8 Equality and Diversity

1.8.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Equality Act 2010, The Care Act 2014, The Disability Act 2016 and the Human Rights Act 1998.

1.8.2 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.8.3 Key considerations for the panel that were felt relevant to this review were age, sex and disability.

1.8.4 As a female, national statistics show that one in four women suffer domestic abuse during their lives. Rachel was the mother of two children. The Office for National Statistics estimates that around 1% of children are likely to experience the death of their mother before they reach the age of 16 years. This data research was completed up until 2000 with nothing more recent. Rachel died at the young age of 37 years. Data supplied from 28 police forces showed that over 50% of police recorded violence against the person offences against women in age groups between 20 and 44 years were domestic abuse related.[1]

1.8.5 Disability is relevant to this review due to the panel considering whether the disabilities of Noel, which included a number of physical conditions and a personality disorder, overshadowed the incidents of domestic abuse and agencies considerations and responses to these.

[1] Home Office statistics - ONS 2023

1.8.6 Although not listed within the Equality Act 2010 as a 'protected characteristic,' questions have to be asked in relation to the role of Rachel as a carer as it needs to be identified if agencies within the Essex area understand the correlation between the heightened risk of domestic abuse when a carer is in the home.

1.8.7 Marriage and sexuality are a consideration within this report due to the comments made by Noel in relation to his sexuality and the consideration of whether the marriage was one of convenience in order to claim additional carers allowances.

1.8.8 Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. Diversity is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.9 Dissemination

Recipients who received copies of this report prior to publication:

Relevant members of Chelmsford CSP and SETDAB

Essex Police and Crime Commissioner

Domestic Abuse Commissioner

Panel members as at 1.1

Section 2 – The Facts

2.1 Background information

Rachel

2.1.1 Rachel has two children from a previous marriage, with their relationship being between 7-10 years. Children's Social Care records show that the children were first known to them in 2010 with intermittent contact over the next three years.

2.1.2 At the time Rachel separated from her first husband, he had been diagnosed with a brain tumour and there are records of two standard risk domestic incidents. There were also disputes over child contact with the father making applications to the court for contact and later residence of the children. Rachel informed Social Care that there was no physical abuse, but she was experiencing verbal and emotional abuse.

2.1.3 On 6th October 2010, the father raised concerns over his children due to Rachel being in a relationship with Noel who he claimed used drugs. He raised these concerns with both Essex Police and Children Social Care. Rachel had known Noel since they were 15 years old as they had met at school.

Noel

2.1.4 Noel was in a previous relationship which Social Care first became aware of in December 2002 when concerns were made in regard to domestic abuse in the relationship. His partner had a child. There were then repeated concerns and incidents, but his partner was reluctant to move to a refuge as she had a network of family support near her and she was young at that time.

2.1.5 In March 2005, records note that there had been 28 separate incidents between them with Noel receiving custodial sentences and was recalled whilst on licence. He made threats to kill her and her child. It is believed that she ended the relationship around 2004 but continued to receive abuse from Noel for the next five years until he began his relationship with Rachel.

2.1.6 A search of available police records and databases revealed that Noel, between 2002 and 2023 received seventeen convictions arising from eighty-two offences and included convictions for theft, fraud, drugs, and offences against the person.

2.1.7 Of particular note are a series of investigations and convictions between 2005 and 2009 arising out of an abusive domestic relationship between Noel and his partner at the time. Convictions during this period included harassment, threats to kill, failing to surrender into custody and the breach of a Restraining Order (Protection from Harassment) issued by the courts in 2006 (remains in place to this day in order to protect Noel's former partner and her family).

2.1.8 During this period, he received a number of custodial sentences the most notable of which was a conviction for threatening to kill his former partner resulting in a three-year custodial sentence in 2009 (varied on appeal to 12 months).

2.1.9 Available records indicate that between 2005 and 2008 Noel was initially managed at Level 1[2] later raised to Level 2[3] in 2008 within the Multi-Agency Public Protection Arrangements (MAPPA) process. It is not clear under which offender category[4] he was managed at the time, but it is likely he would have been referred into the process at Category 2 (Violent Offender).

2.1.10 In 2009 Noel and his former partner were heard within Multi-Agency Risk Assessment Conferences (MARAC) with Noel being considered a very high-risk domestic abuse perpetrator[5].

[2] Level 1 – Ordinary agency management
[3] Level 2 – Active multi-agency management
[4] **Category 1** (Registered Sexual Offender), **Category 2** (Violent Offender), **Category 3** (Other Dangerous Offender)
[5] MAPPA Minutes June 2009

2.1.11 Noel has been known to Essex County Council Adult Social Care since 2011 with initial contact and support in relation to his visual impairment as he was seeking support to enable him to access the community and manage his personal and household tasks. By 2020, it was established that he had eligible needs under The Care Act (2014), and he was receiving a Direct Payment from Essex County Council, enabling him to arrange his own care and support.

2.1.12 Noel's records with numerous agencies describe him as being registered blind, suffering from diabetes and epilepsy and suffering from a personality disorder, with frequent periods of stress and bulimia.

Combined chronology

2.1.13 Children Social Care (CSC) records show that Rachel and Noel married in June 2011 in which Rachel later stated that it was based on the fact that she was Noel's carer and they lived separately until 2015.

2.1.14 Three separate referrals were made, one in each year between 2011 to 2013 from initially, the father, then the paternal grandmother and then the school, all in relation to injuries and comments made by the eldest child, Kerry, that she had received these injuries from Noel. CAFCASS also noted in 2011 that the child had stated; 'Pupa (Noel) pushes me and punches mummy. Pupa and mummy are always fighting and arguing.' No further action was taken in relation to the referrals as there were differing accounts of the child and Rachel and it could not be corroborated that the child had been deliberately hurt.

2.1.15 Rachel contacted Adult Social Care (ASC) in 2014 when she requested respite care, based on her substantial caring duties for Noel whilst looking after two children. Within those contacts, Rachel was described as a friend/house partner and carer but it is noted that in 2011, Noel refers to her as his cousin. Irrespective of these anomalies, based on her being present 24 hours per day, she was considered an informal carer under the Care Act 2014.

2.1.16 Following a carers assessment, Rachel received a carers direct payment of £2815.56, which she continued to receive until 2017, when it was determined that it should be part of Noel's support plan as replacement care which Rachel appeared happy with. He also had a personal assistant who was a member of the family for which he received financial support.

2.1.17 ASC continued contact with Noel each year for his annual review in relation to benefits and personal circumstances through to 2021. By this stage, Noel had a support dog as well as his PA and Rachel, who completed his care support package. Rachel stated that she was benefiting from respite care and although it was not recorded, it was reported by the reviewing officer that she declined a carers assessment.

2.1.18 As a couple, Rachel and Noel first came to the attention of Essex Police in November 2022. A2 02.16hrs, a 999 call was received from Kerry, who was 14 years old at the time. She reported that she was at home with her mum (Rachel) who was being assaulted by her partner Noel. Officers attended and Rachel stated that she was Noel's Live-in carer and that they were not in a relationship. Noel had been argumentative throughout the previous day

during which he had grabbed Rachel by the throat (although not causing a shortness of breath or injury) and she managed to push him away.

2.1.19 However, during the early hours of the morning, Rachel had gone to bed and Noel followed, trying to speak to her in which she refused because it was late and he had become violent, jumping on her and hitting her with a remote control from the television, causing reddening to the leg. Kerry saw all of this happen.

2.1.20 Due to the fact that Rachel had stated that she wasn't in a relationship with Noel, officers determined that it was not domestic related and did not complete a DASH risk assessment. Noel was arrested and Rachel provided background information that some 12 years previously, they had been in a relationship for about a year and when it ended, she remained his primary carer, moving into a shared house along with her two children.

2.1.21 It was due to these circumstances, that the incident was re-evaluated as a domestic incident and a DASH was completed with the risk being assessed as medium, which was later downgraded to standard following a supervisory review. Whilst at the police station, ASC liaised with the police to consider accommodation options if he were to be released and spoke with Noel. The Police informed ASC that Noel had previously been incarcerated at Chelmsford HMP which ASC had not been aware of. This effected their risk assessment as they received information from Chelmsford HMP with details of 68 previous offences which included two offences against the person. Therefore, residential care was not viable.

2.1.22 Noel denied the allegations and was charged with common assault and intentional strangulation and was remanded in custody until a trial date six weeks later, just prior to Christmas. Rachel had contacted Adult Social Care Connect (ASCC) the same day requesting that they find alternative accommodation for Noel on his release and explaining what had happened. She stated that she could no longer care for him as she could not cope with his aggression and it was unsafe for the children. ASC explored a number of options for emergency care for Noel in the event that he was not remanded in custody.

2.1.23 Having completed a lengthy conversation with Noel whilst he was in the Court cells in which he denied strangling Rachel, Social Workers then attended his home address to collect his belongings where Rachel handed them money, his bank cards and a bag of clothing along with medication. There was a discussion around his guide dog and his mobility car, and they advised Rachel to contact Chelmsford City Council to discuss her housing situation. Rachel made contact with ASC the following day and commented that she did not like how she had been spoken to and pointed out that no-one had asked how her or the children were and the focus for caring centred around Noel.

2.1.24 Rachel disclosed that her and the children were not sleeping as they were in fear of him returning and hurting them and that the children did not want to go to school as they did not want to leave her on her own. Rachel requested a Social Worker of her own to support her and her children and was informed to contact Children and Family Services.

2.1.25 On 10th November 2022, Adult Social Care contact Chelmsford City Council enquiring if Noel would have priority over the property as the tenancy was in his sole name initially

and had been adapted to meet his needs. Social Workers visited him in HMP in which he made allegations of abuse from Rachel including physical and emotional abuse. He had informed the Social Worker that their marriage[6] was not a conventional one and that he was gay.[7]

2.1.26 This allegation was progressed to a s42 investigation (Care Act 2014) and an email was sent to the police enquiring how they should progress this alongside the police investigation.

2.1.27 Noel and his grandmother were given assistance and advice in relation to an Occupancy Order and spoke with her about how Rachel neglected Noel. Noel had been re-assured that his needs would be met when released.

2.1.28 Probation liaised with ASC as to who was living at the property and were informed that a friend and her two children were, but the report does not state that they were informed the 'friend' was Rachel, the victim.

2.1.29 On 13th December 2022, Children and Families Social Care (CFSC) received a referral from a domestic abuse practitioner from Next Chapter requesting support for Rachel and her children following the incident in November as she was concerned Noel would be released from custody and return home. Rachel was spoken to and the children were offered counselling, but no further action was taken as Rachel had stated she was accessing support. She stated that she would take the children to a refuge if Noel returned home.

2.1.30 On 22nd December 2022, Noel appeared before Chelmsford Magistrates Court for trial for the offences of ABH and non-fatal strangulation. The police had obtained a statement from Kerry but only served it on the defence that same morning and therefore, the defence were granted an adjournment until April 2023 and Noel was given bail to stay at his grandmother's address in Chelmsford with bail conditions not to contact Kerry or Rachel or go to their home as per Rachel's request. Noel contacted ASC the same day to inform them that he had been released and request support with housing and collation of his belongings.

2.1.31 Noel's Social Worker contacted him on 23rd January 2023, and his phone was answered by his nan and passed to his cousin who informed her that Noel had gone to Rachel's mothers house in a taxi to obtain his bank details.

2.1.32 On 24th January 2023, Rachel made a 999 call to Essex Police where she was still residing at the same address. She informed them that on answering a knock at her door, she saw Noel on the doorstep which was in breach of his Court bail conditions. He had left prior to police arrival and Rachel told them how she had also received abusive and threatening phone calls from him on a daily basis. She was also receiving calls from a withheld number with a faint female voice. A DASH was completed as medium risk.

[6] The marital status of Rachel and Noel was at odds with what Essex Police had been told by both of them at the time of the investigation. Following the murder of Rachel, enquiries by the Major Investigation Team has established that Rachel and Noel were married.

[7] This was explored in the murder investigation and found not to be true.

2.1.33 Noel was arrested at his grandmother's home for harassment and breach of bail. He accepted he had breached his bail conditions in interview but stated that he had received multiple calls and sexualised images from Rachel over the past month. He was kept in custody due to the breach of bail and remanded in custody.

2.1.34 The police referred the incident to CFSC and Rachel was spoken to and a conversation took place in relation to moving Noel from the tenancy and obtaining a Non-Molestation Order. Rachel did not consent to them contacting the children's school and no further action was taken.

2.1.35 On 6th February 2023, Noel pleaded guilty to the offence of battery from the incident in November as the charge of intentional strangulation had been withdrawn and he received a fine and a Protection from Harassment Restraining Order for 12 months not to harass, alarm or distress Rachel in anyway. His Barrister contacted ASC requesting an urgent care needs assessment informing them that Noel was returning to his address

2.1.36 Noel remained on police bail for the allegations made during the January incident. As Noel had now been released from prison, Rachel fled her home with her children to stay at her mother's home which was not too far away, as she feared for her safety. Two days later, she contacted Chelmsford Police station to report that she was receiving threats from Noel and later, explained to an officer who attended her mother's address that he had made a series of phone calls in which he made threats of violence towards her, her mother and her children that he would kill her, littered with expletives. He accused her of being in a relationship with a Police Officer and said that 'she knew what was coming'.

2.1.37 During the month of February, both Noel's Social Worker and his Probation Officer changed and contact between agencies is recorded with attempts to clarify details over who was the carer and were there any children involved.

2.1.38 A statement was obtained from Rachel and a DASH risk assessed as medium. On this occasion, a secondary assessment of risk was not undertaken by a supervisor, as per process. Noel was not arrested immediately and was placed on PNC (Police National Computer) as wanted.

2.1.39 A day later, Noel was arrested and having denied offences in interview, he was charged with breaching his restraining order and sending a communication conveying an indecent/offensive message and was remanded in custody until 13th March 2023 whilst awaiting sentence. A report was logged in relation to the Noel's disclosures to the social worker whilst in HMP but Noel was not spoken to about them at that time.

2.1.40 On 12th March 2023, the officer dealing with the previous allegations in January 2023 received a call from Rachel stating that she had received a number of phone calls from Noel's mother since he had been remanded in custody making threats and stating she hoped Rachel would die. A DASH was completed as standard risk with no secondary risk assessment completed.

2.1.41 On 13th March 2023, Noel was sentenced to 26 weeks imprisonment (wholly suspended for twelve months) and was required to undertake rehabilitation activity. He was

released from custody and moved back into their home as Rachel and the children were now living with her mother. A week later, the police filed the investigation into the phone calls from Noel's mother on the basis that no further enquiries would be conducted due to her age and health.

2.1.42 During April 2023, Noel's new Social Worker attended his home address to complete a review. During a conversation, he informed her that he and Rachel had been married for twelve years. A care agency was currently completing 17 hours a week, and a referral was made to his GP relating to medical issues and anxiety.

2.2 Circumstances of the death of Rachel

2.2.1 During April 2023, Essex police received a 999 call at 00.19hrs from Rachel's mother reporting that her daughter had left home about 15.50hrs the previous day and had not returned. Her children had tried to contact her by phone, and she had not answered which was out of character for her. Her mother was extremely concerned for her.

2.2.2 The incident was initially risk assessed as low by the inspector but three hours later, following further enquiries with the family, it was raised to medium risk, and initial enquiries were conducted throughout the early hours in order to locate Rachel.

2.2.3 About 05.09hrs that morning, the Metropolitan Police contacted Essex Police stating that Noel had attended Ilford Police station stating that something had happened to his wife and he had placed a blanket over her to make it look like she was asleep. He appeared confused and not making much sense and as a result of this, they contacted Essex Police for urgent welfare checks at his home address.

2.2.4 The Police attended his home twenty minutes later and found Rachel inside with head injuries and was unresponsive. An ambulance arrived but Rachel was declared deceased at the scene.

2.2.5 Noel was arrested on suspicion of murder and subsequently charged. The investigation established that CCTV captures Rachel approaching the house at 16.09hrs. The care agency had attended four visits to Noel that day and at teatime, he had stated that he was not feeling well so the carer did not stay long. When the carer returned for the bed visit, they were met at the door and did not enter as Noel stated that he did not need anything and was going to go to sleep. Noel was seen entering a nearby pub at 18.50hrs that evening where he concealed Rachel's phone in the toilets. He then went on to visit a family member and then two massage parlours prior to going into Ilford Police Station.

2.2.6 He was sentenced at Chelmsford Crown Court where he received a life sentence with a minimum 16 years to serve.

2.3 Individual management reviews (IMRs)

Essex Police

2.3.1 Essex Police are currently undertaking a review as part of 'Domestic Abuse Matters'[8] change programme which is an independent review into how Essex Police currently undertake investigations involving domestic abuse with the aim to identify areas for improvement and current good practice.

2.3.2 Domestic Abuse investigation Teams (DAIT)
Located within each LPA the DAIT are a team of Domestic Abuse Specialist Investigators (DASI) responsible for the investigation of all domestic abuse related crimes assessed as Medium Risk or High Risk.

During the period under review the Chelmsford DAIT had three teams comprising of one sergeant and six constables (recently there has been an uplift in staff with eight constables per shift) with one Team being on rest days with the other two teams covering a period between 0700hrs to 2300hrs daily.

The DAIT are subject to abstractions for court, leave, training and occasionally staff vacancies leading to reduced capacity.

DAIT is a detective[9] and uniformed posting and during the period of review only one constable was an accredited detective with the remainder being police constables. During the period under review the majority of staff within the Chelmsford DAIT had less than two years police service. This remains the case.
Officers assigned to DAIT attend a 5-day Domestic Abuse Investigators Course. The overall purpose of this course is to equip specialist Domestic Abuse investigators with the knowledge, skills and understanding to effectively investigate a range of domestic abuse offences and to better support victims through this process. At the time of this review a significant number of officers within Chelmsford DAIT had yet to attend this course.

At the time of undertaking the IMR Chelmsford DAIT had over the previous rolling twelve months (August 2022 to August 2023) undertaken a total of 1006 investigations into Medium and High-risk domestic abuse and currently (August 2023) are investigating 268 live investigations. This is typical of the workload undertaken and managed on a yearly and daily basis.

2.3.3 Central Referral Unit (CRU)
The now disbanded CRU was located at Essex Police HQ with the primary purpose of identifying and managing risk to protect vulnerable people. The unit implemented safeguarding and provided tactical advice and support to officers whilst maintaining and developing partnership responses.

[8] For police: Domestic Abuse Matters | Safelives

[9] PIP 2 Accredited having undergone a period of training and workplace assessment

All domestic abuse investigations assessed as High Risk were referred to the Central Referral Unit (CRU) where multi agency safeguarding plans were considered and referrals made to partners such as the National Centre for Domestic Violence (NCDV)[10]. Staff from the CRU would subsequently represent Essex Police at MARAC's held for individuals it was felt met the criteria for inclusion within the MARAC process.

It should be noted that the CRU were not responsible for undertaking investigation. Functions previously undertaken by the CRU have now largely been moved to the local DAIT's who now hold responsibility for both investigative and safeguarding relating to medium risk and high-risk cases.

In July 2023 the Domestic Abuse Review Team (DART+) was established. This is a new team responsible for the completion of secondary risk assessments of all Medium/High risk DA (including Stalking, Harassment and Honour Based Abuse (HBA)). The team aims to further professionalise the assessment of risk in DA cases, ensuring a consistent approach to risk management.

In addition, DART+ liaise and share information with internal and external agencies, partners, departments, and other police forces in respect of the initial safeguarding of victims, children, and vulnerable adults. The CRU no longer exist meaning ultimately the continued management safeguarding of the involved parties, following the initial DART+ assessment, will be the responsibility of the OIC working closely alongside an IDVA or any other relevant partner agencies.

2.3.4 Essex Police Missing Person Database (COMPACT)

Essex Police utilise COMPACT to manage reports of missing people.

Following the initial management of the missing person report on STORM the management should, as soon as is practicable (ideally within three hours of the initial report), be transferred to COMPACT. This normally takes place following officers attending the informant's address and obtaining the full details of the circumstances under which the individual went missing and an assessment of risk having taken place.

The LPA Inspector will assume responsibility for the initial assessment of risk and management of the missing person investigation until such time (usually within 24 hours) that a team is nominated to take responsibility for the ongoing investigation and will continue to investigate until the person is located, or the investigation otherwise declared inactive. Once COMPACT has been created the STORM incident should be closed.

[10] The newly formed DART+ now undertake the initial referral process but now falls to the Case Officer to ensure relevant referrals have been and are made.

2.3.5 Domestic Abuse Investigations

Essex Police Policy and Procedure[11] sets out the organisations expectations as how staff will approach the investigation of domestic abuse incidents and the safeguarding of the victims and family members, including a proactive approach to bring perpetrators to justice. It draws on existing legislation, best practice and guidance as set out in the College of Policing APP and is subject to regular review.

Essex Police Procedure B1701- Provides officers and staff with a definition of Domestic Abuse drawing upon the Domestic Abuse Act 2021.

Essex County Council Adult Social Care

2.3.6 Noel needed support in meeting outcomes in respect of managing and maintaining nutrition, maintaining personal hygiene, managing toilet needs (at night), making use of his home safely, and accessing the community and was unable to meet these outcomes as defined in Care Act (2014), without assistance.

2.3.7 Between the dates identified for the review January 2020 and April 2023, both Noel and Rachel were under the Mid Essex Physical and Sensory Team (PSI), which is based in County Hall in Chelmsford. This is a team of 13 staff, which includes 1 Team Manager, 1 Deputy Team Manager, 3 Senior Practitioners, 5 Social Workers, 2 Community Social Workers and a Social Work Apprentice. The team hold approx. 505 cases and within their function they perform duties as determined under Care Act (2014) which includes; assessment, reviews, safeguarding enquiries (s42) and case management, for adults 18yrs and above, who have either physical and/or sensory impairment and this can also include associated mental health needs or cognitive impairment.

2.3.8 Referrals into the team will primarily come through the Adult Social Care Connect (ASCC) service, which is the Council main front door and the main contact point for the public in relation to ASC enquiries. The PSI team are also supported by a Centralised Duty Team, who will manage calls from the public and the Emergency Duty Team, who cover after 17:00 until 09:00.

2.3.9 Full time equivalent caseworkers hold a case load of between 15 – 20 cases and unallocated cases sit at 44 on average and during the period where there was an increase involvement from ASC (from November 2022) there was approx. 15% vacancy. Whilst this is a team that has a low turnover of staff, this was a period where the retirement of a senior social worker, maternity leave, unplanned leave of the team manager between October and November 2022, had an impact on team, however they were supported by an experienced team manager who covered in the absence of the usual team manager. The PSI team, work in a hybrid approach, as do all the ASC teams in ASC, and spend 2 days per week working in and from the office. All staff have monthly supervision which is undertaken by Team Managers and Deputy Team Managers.

[11] **Essex Police Policy B1700** – Domestic Abuse, **Essex Police Procedure B1701** – Domestic Abuse initial Grading and attendance, **Essex Police Procedure B1702** – Domestic Abuse Investigations

Next Chapter

2.3.10 Rachel first became known to Next Chapter due to a referral from Clarion Housing following an incident of non-fatal strangulation in November 2022. This case was assessed as medium risk.

2.3.11 At the time of the incident and during the support provided to the victim, Next Chapter were in receipt of a rising number of referrals. Domestic Abuse Practitioners (DAP) and Independent Domestic Violence Advisors (IDVAs) had individual caseloads which were at the upper end of recommended levels. Despite the high levels of referrals and high caseloads for individual practitioners there was no undue delay in allocating cases.

2.3.12 Rachel shared background information on Noels previous offending and that he had been physical, mentally and verbally abusive towards her which had escalated since she had become his fulltime carer and particularly within the past two years. Rachel was allocated to a community Domestic Abuse Practitioner (DAP) who made almost immediate contact. Following a lengthy discussion, a referral was made to NCDV.

2.3.13 Over the next few weeks, the DAP assisted with liaison and obtaining updates from the police on the investigation and the bail situation of Noel and had regular contact with Rachel. The DAP discussed with Rachel the issue of Kerry giving evidence in Court and Rachel expressed her frustration at how housing and ASC were handling things with what appeared to be their lack of understanding of domestic abuse.

2.3.14 The DAP continued to liaise with a number of agencies to obtain information for Rachel and had many issues with speaking to the officer in the case from the police. Rachel was clearly additionally distressed over the lack of assistance and recognition she was receiving over the housing complexities.

2.3.15 Next Chapter report a complete absence of partnership working with the police, given that they were supporting Rachel for one of their investigations. There was a lack of support for both her and Kerry in the Criminal Justice process.

2.4 Summary reports

Essex Children and Families Social Care

2.3.16 The information relating to 2011 and 2013 as outlined at 2.1.14 of this report would have been first recorded on a legacy system (an electronic recording system which predates the one currently used). This requires the user to expand their search parameters on the electronic file as the information is held elsewhere to where they could expect to find this on the contemporary records. The Hub staff accessed the historic records from 2011 and 2013 for the purposes of this review. No action was taken in 2022 and 2023 as it was recorded that Rachel was receiving support.

Clarion Housing

2.3.17 Clarion Housing owned the property in which Noel and Rachel were joint tenants. During the review period they were joint tenants on a 5-year fixed assured shorthold tenancy. Up until November 2022, there had not been any involvement with the family past the normal contact regarding obligations under the tenancy agreement such as rent increases and repairs.

2.3.18 Following the attack on Rachel in November 2022, a tenancy specialist was dealing with the incident and referred Rachel to the National Centre for Domestic Violence (NCDV) for support due to the tenancy being joint and Clarion Housing having to remain impartial as Rachel required a legal service.

2.3.19 Next Chapter were in contact with Claron Housing to assist Rachel and Rachel was informed that they were unable to offer her a management transfer as due to the tenancy being joint, Noel would also have the same offer, but she was advised as to what legal orders she should consider.

2.3.20 In March 2023, Rachel advised that she had fled from the address due to Noel being released. The case was sent to ASB Action who Clarion use to review cases to see if there were any other options available. ASB Action advised that the joint tenancy could be ended via Section 21[12] and once that process was completed, consideration for either a management transfer or Rachel to be offered the property if it was safe to do so. This was discussed thoroughly with Rachel due to the increased risk this could pose. She did not want the reports she had made to be a reason for the section 21 so it was agreed that the reasoning being used would be due to Noel under occupying. A break Notice[13] was sent to Rachel via email and Noel via post on 23rd March 2023. No response to this was received.

2.3.21 Disclosure was requested from Police but refused however this point does not appear to have been challenged with a more senior officer.

2.3.22 Timely action and contact were taken following every report made by Rachel. The correct policy and procedures were followed; however joint tenancies do present a difficult situation as a management transfer is not an option that can be utilised. Legally, they are unable to remove someone from the tenancy which means that currently they have no powers to stop a joint tenant being at the property unless there is a specific court order or bail conditions in place.

2.3.23 Clarion Housing has not progressed to DAHA accreditation. This was formally reviewed during 2023/24 and the decision at that time was not to proceed with accreditation. This was due to several factors, including complexities around supported housing stock where Clarion owns the land but is not the landlord, meaning they are unable to amend managing agents' policies and practices to meet accreditation requirements.

[12] Proportionality, Section 21 and starter tenancies - Nearly Legal: Housing Law News and Comment

[13] A formal notification that a tenant or the landlord wants to end a fixed-term tenancy agreement before it's end date, as permitted by a break clause in the contract

2.3.24 Despite this decision, work was undertaken to assess our position against the DAHA standards. A gap analysis carried out between May 2023, and February 2024 showed an improvement from 71% to 94% compliance, with actions completed to strengthen our approach to supporting victims and survivors of domestic abuse. The DAHA standards have since changed and are no longer publicly available in the same format, meaning further benchmarking is not currently possible.

2.3.25 There is no current plan to progress to accreditation at this time. However, the value is recognised in reviewing this again in the longer term, and this is something they would look to consider as part of future service planning.

Strategic Housing Service – Housing Solutions

2.3.26 Chelmsford City Council's involvement with Rachel was under its statutory homelessness duties, with contact being made with the service via an evening self-referral on 3rd February 2023 and a statutory homelessness application allocated to a case worker and commenced the next working day. Caseloads for the Housing Solutions Officers who carry out statutory homelessness prevention and assessments are very high. However, all statutory requirements were met in this case and there were no delays in meeting statutory timeframes.

2.3.27 Although the homelessness application was correctly taken and followed through and interim accommodation was twice offered to Rachel following the Council accepting a "relief of homelessness" duty, she felt unable to take this up as she felt it was too far to travel to her work and children's schools, and she elected to make her own arrangements with family/friends in the interim. She was engaged with Next Chapter Domestic Abuse support, but a Refuge had also not been found as an option for her or the same reasons of suitability. It is not known whether, if something nearer to, or within Chelmsford could have been offered to Rachel, she would have accepted it.

2.3.28 It should be noted that the current severe housing crisis greatly impacts the ability of Councils to source even temporary accommodation in or near to their districts. It should also be noted that the only current ECC commissioned refuge near Chelmsford is in Colchester which is 20 miles away and that DA victims are, in great numbers, accommodated in homelessness temporary accommodation rather than in "safe accommodation" while their housing options/actions to enable them to safely remain at home or elsewhere are explored. The commissioning of additional safe accommodation by ECC would be welcomed. With domestic abuse being consistently in the top three categories for the threat of homelessness, the availability of and access to "safe accommodation" would seem to be crucial and in need of wider review in the locality/region and should form part of decisions made with regard to Tier 1 funding form central government for the commissioning of domestic abuse services. The complete housing crisis means that for support to be provided to domestic abuse victims in "safe accommodation" there has to be the appropriate accommodation. This case shines a light onto the seriously limited safe accommodation for domestic abuse victims in the locality/region.

2.3.29 The Council's consideration of Rachel's statutory homelessness application met all requirements and timeframes outlined in the Housing Act 1996 Pt VII) as amended) and the associated code of guidance.

North Essex Probation Service

2.3.30 The Probation Service did not have any involvement with Rachel. Noel was being supervised by North Essex Probation Service at the time of Rachel's death.

2.3.31 Noel was subject to concurrent community-based sentences. On the 06/02/2023 Noel was convicted of Assault by beating between 06/11/2022 and 08/11/2022 and sentenced to 12-month Community Order with the following requirement: Rehabilitation Activity Requirement (RAR) – up to 10 days. He was also made subject to a 12-month Restraining Order (RO) which prohibited him from harassing, alarming, or distressing Rachel in any way.

2.3.32 The completion by the Probation Service of structured and comprehensive risk assessments at court is typically facilitated through a Pre-Sentence Report (PSR). In this case, Noel was sentenced on 6 February 2023 without a PSR, and therefore only a limited court-based assessment, including a Risk of Serious Recidivism (RSR) score, was completed. This provided an indicative assessment of risk but did not constitute a full Risk of Serious Harm (RoSH) analysis within a completed Offender Assessment System (OASys) assessment, which is consistent with the guidance in place at the time. A comprehensive assessment was subsequently undertaken post-allocation, when the Probation Practitioner completed an Offender Assessment System (OASys) assessment on 7 March 2023. A further court appearance on 25 February 2023 resulted in an 'all options' PSR being requested, at which point a more detailed and structured assessment process was engaged.

2.3.33 Noel's Offender Group Reconviction Scale (OGRS), likelihood of reoffending, score of 62% indicated a medium risk of re-conviction. It was the conclusion of the Court Officer that given the offences had occurred in such a short period of time and that Rachel was the victim on both occasions that the risk of re-offending was correct.

2.3.34 In relation to the risk of serious harm, Noel's Risk of Serious Recidivism (RSR) score was 1.33%, indicating a low statistical likelihood of serious reoffending. However, the RSR score does not, in itself, determine the level of Risk of Serious Harm (RoSH). RoSH assessments are informed by a structured, holistic process, underpinned by professional judgement and not derived from actuarial predictors alone.

2.3.35 In line with His Majesty's Prison and Probation Service (HMPPS) RoSH Guidance, assessments should be completed using the Four Step Process: (1) consideration of actuarial indicators, including the RSR; (2) structured assessment of dynamic risk and protective factors; (3) assessment of imminence, including potential triggers and escalation; and (4) the application of professional judgement to determine the overall RoSH level.

2.3.36 This assessment tool generates a score, based on static factors about the person and the likelihood of a seriously harmful offence within two years. However, the conclusion of the Court Officer was that this underestimated that risk. Using their professional judgment,

the pre-sentence report writer concluded that the risk of serious harm was in the medium range. He also concluded that that risk was likely to increase should Rachel withdraw completely from the relationship or not engaging in the way that he would expect.

2.3.35 Noel had an offending history that dated back to 2002, and records indicate that in total he had 14 previous convictions consisting of 78 offences. However, there was a considerable time between Noel's last conviction (2012) and the conviction in November 2022.

2.3.36 Noel was managed for a relatively brief period of time by the Probation Service in the community. Once Noel was sentenced for the Assault by Beating, he was supervised from the 06/02/2023 until his arrest for the murder of Rachel on the 26/04/2023. In total, Noel was seen by his Probation Practitioner on six occasions and rehabilitative work was to commence as part of his sentence plan.

2.3.37 Internal learning from this review has highlighted the following:

The frequency of Noel's appointments was not in line with expected probation practice, particularly at this early stage in his sentence. All staff will be reminded of the guidance and expectations regarding the frequency of contact. There will be a discussion with line managers to ensure that Home Visits take place and that there is management oversight recorded to explain why a home visit has not been completed.

2.3.38 With regards to Noel's OASys assessment (Offender Assessment System) a SARA (Spousal Assault Risk Assessment) was not completed. The omission occurred for two reasons. The allocated Probation Practitioner was not SARA-trained at the time, reflecting wider organisational challenges linked to staff turnover and recruitment in 2023. Additionally, the Court Duty Officer did not complete a SARA within the Short Format Report due to a time-pressured oversight, with evidence indicating this was an isolated instance of human error rather than a lack of competence. This has highlighted a training need for Probation practitioners. An action has already been assigned to North Essex line managers to ensure the staff who require SARA training are identified and scheduled to undertake it over a 6-month period.

2.3.39 Noel's compliance was of an acceptable standard during community sentence. However, his compliance with one of the Commissioned Rehabilitative Service (CRS) appears to be superficial and Noel did not attend one session. As a learning point, probation practitioners will make contact with the supervised person and bring forward their probation appointment so that frequent contact is maintained.

Essex Partnership University Foundation Trust (EPUT)

2.3.40 Between 2003 and 2011, Noel had contact with EPUT on eight separate occasions either through a referral from the GP or through the Criminal Justice process.

2.3.41 In 2004, a brief assessment reported that there were no signs or symptoms of any mental health illness. In 2010, Noel received an assessment from a psychologist who stated

that he should be referred to a specialist service for personality disorders on his release from HMP. He was also seen in relation to an eating disorder and drug abuse.

2.3.42 In November 2022, Noel was seen whilst in police custody and reported no suicidal or self-harm ideations and there was no reason to doubt capacity. EPUT continued to assess Noel throughout the criminal justice process and provided reports to the Court accordingly.

Clare's Law

2.3.43 The Domestic Violence Disclosure Scheme (DVDS), also known as Clare's law, enables the Police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. This was implemented across all police forces in England and Wales in March 2014.

2.3.44 It is to provide a victim or potential victim with enough information to make an informed decision on their relationship and highlight any potential risk they may be facing if they continue in that relationship. The scheme has two elements: "Right to Ask" and "Right to Know." This allows an individual or relevant third party to ask the police to check if their partner of ex-partner has a violent or abusive past. The police will consider whether to disclose any information due to its relevancy. It also allows the police to make disclosure on their own initiative if they feel a person's violent or abusive behaviour may impact on the safety of their current partner.

2.3.45 In 2022, the last full year before Essex Police's new Domestic Abuse Review Team (DART) went live and adopted changes to how they manage DVDS, there were 1182 applications of which only 37 resulted in a disclosure (3.1%). In 2024 the first full year under DART the applications increased to 2067, with 1371 of these having a disclosure made (66.3%), which shows a substantial increase. The year 2025 looks set to continue this rise with projections set to exceed 3000 applications in the year with disclosures thought to be near the 2000 mark. This has been significantly supported by the DVDS Campaign delivered in collaboration with SETDAB to raise public and partner awareness, and additionally by internal communications and process changes to remind personnel of the duty to consider Right to Know (R2K) disclosures when relevant information around risk is known.

Compass

2.3.46 Compass is a central point of contact funded by Southend City Council, Essex County Council and Essex Police, Fire and Police Crime Commissioner to support victims of domestic abuse across Southend, Essex and Thurrock. Compass is delivered by a partnership of established domestic abuse support agencies; Safe Steps, Changing Pathways and The Next Chapter.

2.3.47 Part of the support they offer is assisting victims with housing and refuge placements.

Section 3 - Analysis

3.1 Family and friends' involvement and perspective

The below is an extract from an email sent on behalf of the family from Rachel's auntie early on in the review and prior to Noel's conviction.

I just don't know where to start to be honest, as Rachel was totally let down from start to finish.

When Noel (her partner that killed her) the first time on bail, he broke his bail condition by going to the house early one morning after he had disconnected the ring doorbell, this was reported to the police, so he was re-arrested.

When he was let out again, the court said he had to go back to his home address where Rachel and her 2 children were living. She asked for help from the court and Essex County Council, but no one would help. All the court gave her was the weekend to leave the house, so she fled to her mums.

There are many women and men going through this abuse and there isn't anything being done for them, so as you can understand why we as a family are very angry with the system.

There is nothing you can do for my niece now. I am hoping the Jury, when he is at court sends him down for life, but maybe you can help and save others.

3.2 Terms of reference areas

Were there adequate risk assessments and support for safeguarding measures for both Rachel and her children?

3.2.1 When trying to find alternative accommodation for Noel whilst on bail, there did not appear to be a clear understanding from the case workers within ASC, of the roles and responsibilities of agencies, including police and housing and over time when there was involvement of bail officers and probation service. The impact of not clearly understanding each other's roles had the potential of limiting good collaborative work. In considering how Rachel and her children were supported during this time by ASC, there was not a consideration of the risk Rachel was exposed to and how this was managed and if there was a safety plan being in place There was potential to demonstrate better professional curiosity.

3.2.2 The initial contact that ASC had from the police on the 8 November 2022, when ASC were first informed that Noel had been arrested and in custody for assaulting Rachel, is recorded that the police were enquiring about how they can protect her'. This can be interpreted as either how the police can protect her or how ASC can protect her and there is no record of how this conversation was conducted and the Social Workers state that they were of the understanding that the police and the legal process were supporting Rachel and her children. There is a gap here in the response to how Rachel could be

protected, which was either not agreed upon, or shared. ASC made the assumption that Rachel was protected and did not clarify or show professional curiosity to understand the position. Initiating the completion of a DASH assessment or checking if one was completed, had the potential of returning the conversation to how Rachel was protected and consideration for MARAC. It is noted that Rachel did directly contact ASC and inform them of her fears for herself and her children and request a Social Worker of her own, but this was not acted upon.

3.2.3 There was no consideration for a referral for the children to Children and Families Service, to determine support for the children, given that it was reported that Rachel's daughter heard the domestic abuse that resulted in the police being called. Rachel had also commented on her concerns or her safety and that of her children and was concerned that Noel would arrive back without warning and this concern was not explored further by ASC or a referral made to relevant services. Again, there was an understanding that if there were risks, it would be picked up by police and considered as part of bail arrangements, and this may very well be the case, however the questions were not asked. Given that the Domestic Abuse Act (2021) set outs the duties in relation to consideration of children as victims, irrespective of whether they were present when abuse occurred there was a missed opportunity in understanding the support that they may require.

3.2.4 The police process is that following an initial DASH being completed by an attending officer, a supervisor will complete a secondary assessment to ensure it has been risk assessed appropriately. There were two occasions that this process was not followed and a secondary risk assessment not completed. These risk assessments should be made with the holistic knowledge of the surrounding background and may have therefore, been identified as high risk with the correlation of threats made by Noel's mum as similar to that of Noel's threats and the influence this may have on his behaviour. The filing of the investigation into the threats she had made to Rachel may be construed as dismissive and the potential risk elevated due to Noel's recent release from HMP ignored.
The conviction history and known offending behaviour of Noel between 2002 and 2022, his management within MAPPA and his referral to MARAC were available and accessible to officers and staff within Essex Police via there computer systems but not always accessed which may have a correlation with their relationship not being considered as high risk for domestic abuse as the wider risks were not recognised.

3.2.5 The Police and the Crown Prosecution Service correctly applied for a Remand in Custody to the courts on each occasion that Noel was charged with offences, utilising this to safeguard Rachel during that period and had contacted Adult Social Care and Compass to provide opportunity to explore alternative accommodation for Noel when he was released. It was unfortunate that Rachel felt that it was the police who had let her down in relation to accommodation as she had to move back in with her mother.

3.2.6 Although the acceptance of Noel as a MAPPA nominal would have had to have been assessed, there was failure to recognise that he had previously been a MAPPA nominal and a missed opportunity to make the referral which would have provided an opportunity for multi-agency discussion and approach.

3.2.7 The request for support submitted to CFSC in 2022 described the allegation as an attempt to strangle Rachel which is an act of violence in which the perpetrator may be moments away from killing the victim, yet the response did not reflect this concern, and no MARAC referral was made.

3.2.8 Clarion Housing could have offered Rachel additional security equipment earlier as this was not until Jan 2023. Additional security equipment could have been offered at a much earlier point, November 22, rather than waiting.

3.2.9 A DASH risk assessment was not completed with Rachel when the incidents were first reported and there is no consideration given to the children within the household.

Is the correlation between domestic abuse and carers recognised amongst agencies within Chelmsford?

3.2.10 Essex County Council, Adult Social Care and Children and Families produced an All-age carers strategy in 2022 in which it does not include domestic abuse as a risk factor or highlight the correlation of increased risk of domestic abuse where a carer is present, either to the carer or the person being cared for. (Recommendation refers)

3.2.11 Rachel initially had a Carers Assessment and a direct payment, and this direct payment was transferred to Noel's support plan. Following this, she declined a Carers Assessment. It is not clear if she fully understood the purpose of a Carers Assessment, meaning that it was not just about receiving a direct payment, but also recognising the advice and support that could be available to her as there is reference to her providing 24hr support and Noels' reliance on her, in particular around his anxieties.

3.2.12 Following the assaults, Rachel requested a social worker for her and her children and initially she was asked her reasons for wanting a social worker and was advised to contact Children and family service. This was an opportunity for ASC to consider other support for Rachel and as a carer in transition (she ended her caring role but was a carer at the time of the incident), consideration for a social worker for advice and support in understanding the support available for her, was reasonable. Within adult social care, there is a recognised cohort of carers who are transitioning from their carer role, either through the cared for person going into residential carer or the death of the cared for person and whilst neither of these scenarios related to Rachel's circumstances, she was in transition which included losing her home, financial benefits and having to consider the safety of her and her children.

3.2.13 Therefore, having a discussion with her in relation to services to support Domestic Abuse including Compass and The Next Chapter, would have enabled her to consider the available support. There was also no liaison between ASC and CSC for collaborated safeguarding.

3.2.14 The loss of her home and financial implications could have been barriers to Rachel leaving the relationship and should be considered and recognised by professionals when a carer is looking to leave an abusive relationship.

The recognition of Children as victims of domestic abuse

3.2.15 Within ASC records, there is no reference to the impact of Noel's needs on the children within the household. Case workers understood that they were not providing any care for him and the indication that Noel spent most of his time in his bedroom and lived separate from them. However, this conflicts with the level of care and support that Noel indicates that he was receiving and based on that account, it is difficult to understand why it would not impact on the children. Having a clearly documented conversation with Rachel around the impact on her children, would have given an opportunity to consider if they met the criteria as Young Carers and consideration for the support available for Young Carers.

3.2.16 Having made the initial 999 call in the middle of the night in November 2022, neither Kerry nor Jody were spoken to by the initial police officers who attended which was not complying with Force procedure as it states,
'It is mandatory that the voice of an involved child in any investigation, including their appearance, demeanour and environment will always be captured[14]
The Officers stated that they had not thought to speak with the children and were not aware of the requirement to do so.

3.2.17 Having not spoken with the children, opportunities to obtain wider evidence/information relating to domestic abuse or offending (over a protracted period) in the relationship between Rachel and Noel were not explored and as such not considered as part of the investigation and assessment of risk at the initial point of police contact.

3.2.18 This was a missed opportunity to fully understand the family dynamics as this was the first interaction with the family by the police and also, to understand the immediate needs of the children and the potential to make referrals to partners for support. This was also the case for the attending officers responding to the breach of bail in January 2024.

3.2.19 CFSC showed good practice in accessing historic records but did not explore Noel's propensity for violence in more detail and dealt with the November incident as an isolated occurrence without considering any propensity for violence.

3.2.20 When the request for support was submitted by the police in 2023, there was no information provided at the time which indicated that Noel had a history of domestic abuse with a former partner or any grading of risk levels then. The Request for support identified that the need was for Rachel and Kerry to receive emotional support regarding their experiences arising from the domestic abuse and ongoing risk management was not a feature of the request. This did not prompt Children's Social Care to explore other records and connect any risk information. Also. It does not appear that Jody was considered for support but was in the house at the time of the assault.

[14] Essex Police Procedure B0602 – Investigation of Crime

3.2.21 Noel's disabilities were noted on ASC and CFSC records and it cannot be ascertained whether this affected professional's understanding of the risk as they may have felt his ability to cause harm was diminished due to this. The steps that Rachel was taking to safeguard herself and her children were seen as adequate whereas involvement by CFSC could have enhanced this and also provided assistance to Rachel at a traumatic time. It is of note that at that time, Rachel declined service and the threshold for s47 was not made to force their presence. The service would have had to have consent which is often a barrier to them.

3.2.22 Although processes have undoubtedly changed through the years with the awareness of the importance of listening to children, the voice of the child was not listened to in the three referrals made to Children Social Care between 2011 and 2013 when comment was directly made from Kerry and this can correlate to recent times when the voice of the child is either not asked or disregarded.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 The involvement of ASC with the family was limited to activities around assessment, a review or in situations where Noel had a problem that he needed support with. There were opportunities to have done somethings differently, including having a better understanding of why Noel needed so much paid support and the level of support both he and Rachel had reported that he also required from her. It is possible that professional curiosity may have given case workers some of the views that have now been voiced to include how Noel controlled meetings and other interaction with ASC. By opening up conversations and offering challenge in relation to an understanding of a persons need, which is due process, can lead to other conversations. This includes potential limitations in ASC's understanding of Noel, his family, and his social network. Due process and in line with Care Act (2014) around consideration for Carer's Assessments, for Rachel and for his grandmother may have assisted in triangulating information and provide a better understanding. Similarly, ASC had limited details of persons who Noel identified as cousins and/or Personal Assistants, who he was employing through a Local Authority Direct Payment and only had a first name which prevents informed assessments in risk and also what care is being provided.

4.1.2 Agencies were aware of Noel's previous domestic abuse history yet no consideration to advice or application for Clare's Law was given at any time.

4.1.3 Although a statement was eventually obtained from Kerry later in the first investigation, the voice of the child was neither considered or undertaken and no referrals were made throughout the investigation for support or safeguarding yet Rachel had stated to officers that she could no longer cope as Noel's carer and she feared for her children and the environment they were being brought up in. This was another missed opportunity for a MARAC referral or multiagency meeting.

4.1.4 Investigative decisions impacted on both the welfare and the safeguarding of Rachel and her children. Kerry's evidential account should have been obtained via an ABE interview. This was not considered by the officer and seen as a failure to provide support to a child witness in the provision of their evidence although Kerry was considered for special measures[15]. This was also the case with the decision to obtain a written statement from Rachel on both occasions and as a consequence, the officers did not discuss the alternative ways in which Rachel's evidence could be obtained and the wider Enhanced Rights under the Victims Code to which Rachel may be entitled.

4.1.5 The effects of the Prosecution not being case ready to present at court are self-evident and can have a significant impact upon witnesses and victims. In this case the delay in taking the statement, which was clearly needed to be obtained from the commencement of the investigation, was avoidable. Throughout all investigations, there was a lack of application of the Victims Code of practice.

4.1.6 The absence of any attending or investigating police officers accessing previous history of Noel prevented a holistic risk assessment which may have led to the risk assessment being high and the opportunity for a referral to MARAC providing a multi-agency approach and information sharing platform so that the risk was known to all agencies and appropriate support services could have engaged with Rachel.

4.1.7 Good practice should be recognised in the positive action of taken by the police in obtaining a Harassment Order and then the response to the breach of the Harassment Order of Noel's arrest and incarceration. Also, the acknowledgement of the swift response by Essex Police in attending the address of Noel once contacted by the MPS, although sadly, this was too late to have been able to save Rachel. The panel noted the initial decision not to deem her a missing person which is disappointing based on the recorded information they could refer to which immediately identifies risk, but accept that this was rectified three hours later, showing the checks and balances were efficient.

4.1.8 Neither the Council nor Rachel were able to obtain quick action to seek to determine whether there was an option for the social housing joint tenancy at which she had resided to be moved to her sole name alongside an occupation order etc. This may or may not have been possible, but there was no swift response or suggestion that it might be viable from the landlord, Clarion Housing. Both Rachel and Noel separately were seeking legal remedies for an occupation order.

[15] A request was made for the witnesses statement to be given behind a screen should she have to provide evidence at court.

4.2 Lessons to be learnt

Professionals understanding and recognising domestic abuse

4.2.1 There was a view held by Adult Social Care case workers that Noel should be going back to the home that he shared with Rachel and her children, and instead, that they move out. This was on the basis that he had initially had the tenancy, and the home was adapted to meet his needs. This did not consider Rachel or the children as victims of domestic abuse and their need for stability with the children's schooling and prioritised one perpetrator over three victims.

4.2.2 ASC were very focussed on the fact that Noel had care and support needs that met the criteria under the Care Act which appeared to overshadow Rachel's needs as a domestic abuse victim and a carer. They offered him advice and assisted him with an Occupancy Order and whilst Rachel had discussed her concerns about Noel returning and was advised to seek support from CAB and housing, this approach was not mindful of the wider issue around Domestic Abuse and how victims and families should be supported and protected. As a carer, Rachel had equal rights under the Care Act 2014.

4.2.3 The S42 Enquiry that was open, following allegations that Noel made against Rachel in November 2022, did not progress due to concerns of interfering with the criminal justice investigation. Whilst the social worker had informed the police that Noel had made these allegations, it was not reported to the police as a crime until the February 2023. Reporting it earlier to the police as a crime, which is due process, and following through as a s42 strategy meeting, would have given opportunity for MDT consideration and understand the wider context. (Recommendations refer)

Housing issues/barriers faced

4.2.4 The circumstances within this review highlight and accentuate the barriers that victims of domestic abuse, and in particular with children face at a time when they need protecting the most. Noel and Rachel's home was a joint tenancy.

4.2.5 ASC case workers explicitly supported Noel returning to his home was he was the individual under there care and they disregarded the risk towards or feelings of Rachel and her children. ASC actively cited reasons why Noel should return home and Rachel and her two children who were all victims of domestic abuse, should be moved elsewhere.

4.2.6 Rachel fled the home in which she had joint tenancy as she was fearful of Noel returning and harming her and her children and although she was offered a place in refuge, this was out of the area and she declined as she would not practically be able to keep the children in their schools or travel to work. Essex only has one refuge available near to Chelmsford which is twenty miles away.

4.2.7 Rachel made a homeless application following her fleeing her home but although she was offered two temporary accommodations whilst her homelessness application was considered, they were declined for the same barriers she faced with the refuge.

4.2.8 The properties that she was being offered were not 'safe accommodation' in which Essex have identified they have very few. (Recommendation refers)

4.2.9 This review highlights the issues and difficulties for social landlords in dealing with decisions around tenancy matters when there are joint tenants and one is subject to domestic abuse. Landlords should be able to end the joint tenancy earlier and allow a sole tenancy for the DA survivor if it would be safe for them to remain or return to the property especially as, in this case, the perpetrator had been charged and gone to court. Even if not safe for the victim to remain in the home, but enabling a sole tenancy, it then opens up the option to grant a management move in the survivor's sole name elsewhere.

4.2.10 Consideration of a recommendation in regard to additional Safer Accommodation was considered by the panel but was not deemed necessary at this time. Clarion Housing has not progressed to DHA accreditation

Absence of a multi-agency approach

4.2.11 On reviewing the referrals made within this review, there are identified occasions when they were either not made or the information provided was insufficient and they were made on the basis of one agency to another with no consideration of multi-agency meetings.

4.2.12 There were missed opportunities to provide this platform as there was no referral to MAPPA which should have been considered owing to Noel previously being a MAPPA subject, his criminal history and his current offending.

4.2.13 Also, due to the absence of secondary risk assessments and police officers not accessing previous records for a holistic risk assessment, Rachel was not deemed to be at high risk and therefore, a MARAC referral was not made.

4.2.14 There was a lack of referrals to support services which may have then negated the lack of application of the Victim's Code of Practice as they would have been able to provide advocacy and identify these gaps.

4.2.15 There was no holistic working between Adult Social Care and Children's Services to provide support for Rachel and her children and see them as a family who were victim's to domestic abuse rather than separate entities. (Recommendations refer)

4.2.16 Essex has a Wider Eastern Information Stakeholder Forum which has an Information Sharing Protocol which overarches safeguarding across geographic Essex. All agencies involved in safeguarding activities across geographical Essex are partners to this protocol. This outlines and provides guidance on the sharing of information for the purpose of safeguarding both adults and children. Panel members voiced their reticence to sharing information due to a lack of knowledge as to what could be shared in what circumstance.

4.3 Recommendations

4.3.1 Due to the length of time this review has taken whilst awaiting the judicial process to be completed, agencies have managed internal action plans to expeditiously address internal learning and individual staff learning. These individual actions have not been replicated within this report unless not addressed or not deemed necessary for this review.

National

There are no National recommendations identified from this review

Local

1. **ASC to include domestic abuse and the heightened risk of this as part of the carer's strategy.**
   Domestic abuse is not included in the carer's strategy at this time and as carer's do not generally meet the adult safeguarding threshold, this leaves them with little means of support or recognition of the heightened risk within the household. Inclusion will provide a framework to address the specific correlation between carers and domestic abuse.

2. **ASC to provide an awareness event of the correlation between carers, disabilities and the heightened risk of domestic abuse in these circumstances.**
   This will provide awareness of the issues amongst professionals and front-line responders and increase the identification of risk and submission of relevant referrals.

3. **Essex Police are to educate and communicate the MAPPA process and referral mechanism to all staff and officers, providing accessible guidance.**
   This is to provide a clear understanding of the process and an increased identification of individuals that meet the criteria for referral and how to complete this.

4. **Essex Police to refresh training and communication to provide awareness around policy and procedure within domestic abuse investigations and Victims Code of Practice for vulnerable and/or intimidated witnesses.**
   This will provide compliance with procedures including secondary supervisory risk assessments and ensure the most appropriate means of capturing evidential accounts is obtained to provide the witness with the options for special measures as outlined in the Domestic Abuse Act 2021.

5. **The following statutory agencies within Essex are to be reminded of the opportunities/existence for multi-agency meetings/forums in order to share information and make holistic risk assessments based on all information.**
   A – Essex Police
   B – ASC
   C – CSC
   D – Probation Service
   This will improve relevant referrals/requests for multi-agency meetings in cases where it has been identified that multiple agencies may have or should have involvement and input. It will promote conversation at the 'point of need' for issues that may 'sit outside' of the formalised multi-agency meetings.

6. **Children's Social Care to work with the Children and Adults Safeguarding Boards in Essex and their SET partners to continue developing the Whole Family Approach.**
   This will assist all agencies with identifying their responsibilities and roles within a holistic approach when responding to domestic abuse and alleviate assumptions from agencies that others may be conducting an action when they are not.

7. **The following statutory agencies within Essex to ensure that they include any relevant historic information they hold on record when submitting referrals to other agencies.**
   A – Essex Police
   B – ASC
   C – CSC
   D – Probation Service
   This will provide additional context to the referral to make an informed risk assessment and safeguarding response.

Appendices

Appendix A

Terms of Reference

- The date parameters under consideration are from January 2020 up to the date of death of Rachel.
- This is to be reviewed as a homicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Rachel.
- Was adequate support in safeguarding measures put into place to assist in the protection of Rachel and her children and not reliant on existing constraints such as the Restraining Order, Remand in Custody and Rachel's own actions?
- Are agencies within Chelmsford considering Clare's Law and providing guidance and advice when it is identified that this may be relevant?
- Is the correlation between domestic abuse and carers recognised amongst agencies within Chelmsford for
  a) Identifying the vulnerability and impact of carers to being either the abuser or subject to domestic abuse due to their role within the relationship and are adequate safeguarding measures and recording processes implemented in these situations.
  b) Information sharing between services with regard to the safeguarding of adults and their careers.
  c) Are referral mechanisms adequate and were they sufficiently made to support and safeguard
- Where we know children are victims of domestic abuse, what protections and support are provided to those children?
- How do agencies take account of the voice of the child?
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process, including voice of the child.
- Do support provisions work collaboratively and communicate sufficiently to provide a collective approach when assisting victims?
- Were procedures sensitive to the vulnerabilities, disabilities, and sex of the deceased and the family as a whole? Were any of the other protected characteristics relevant in this case?