DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of Claire

in October 2023

Independent Chair and Author
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Report Completed: 27 August 2024

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POEM WRITTEN BY CLAIRE'S MUM AND DAD

To our darling daughter, on the day you arrived
the love and joy you brought to our lives.
Our sweet little girl we love you so much
now we both break as we long for your touch.

We remember your first word and first step
the pride on our faces as we watched as you slept.
You grew into a toddler, so cheeky and fun
oh, how we loved watching you run.

Before we were ready and to your delight
your first day at school, your smile so bright.
We encouraged your hobby, you danced so well
so proud of you daughter, all who'd listen we'd tell.

You were soon a woman with kids of your own
me and dad so proud remembering before you were grown.
Now all we have is the memories we keep
lying in bed as we try to sleep.

Our hearts now weigh heavy without you here
we would have done or given anything to keep you near.
The pain it gets harder day after day
not knowing how to live since you went away.

It wasn't your time, you should still be here
taken by evil of that we are clear.
We would give all to see you and hold your hand
one last day on the beach, see your footprints in the sand.

We will never forget you as united we stand
me and your dad hand in hand.
Our beautiful daughter your voice we will be
we will always love you.

Claire, we love and miss you more than anything, until we meet again.

Mum and Dad

POEM WRITTEN BY CLAIRE'S CHILDREN

Now that you are dead, it's time to move on
but how do we do it with our Mum gone.
She wanted some fun with a friend
but instead, she met a monster and her life he did end.

Many people who met him thought he was nice
now they all wonder, why did they not look twice.
They saw an old man not the evil within
a tall, ugly monster hidden in human skin.

We're sure even his parents could never have known
the evil person in which he had grown.
The hurt, pain and death he left in his wake
he abused many people and took what was not his to take.

Even in death he poisons our heads
thoughts of his evil whilst we lay in our beds.
We should be thinking of Mum and what he took
but instead, we see him everywhere we look.

All we have left is to look at the sky
talking to you Mum as we try not to cry.
You brought us up well, loved us and for that we are glad
it's hard here without you, we miss what we had.

We will miss you forever and think of you each day
memories of laughter in our hearts they will stay.
Such a kind loving person, a bright shining star
we wish heaven was not quite so far.

Mum, how do we rebuild now we don't have you
the light, love and laughter have all gone too.
We want you to know, we will fight in your name
for justice though life will never be the same.

They say life goes on and whilst that is true
the people we were, died that day with you.
We will keep moving on and for you we will fight
your name, memory and legacy will keep shining bright.

Always in our hearts and thoughts Mum.

Sam, Robin, Jordon and Drew

PREFACE

The Review Chair and Panel Members of this Domestic Homicide Review wish to express their deepest sympathy to Claire's[1] family and friends for the loss of a much-loved daughter, mother and friend.

The Review Chair thanks the Panel and all who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review. In particular, the Review Chair is grateful for the contributions which has been provided by family members and friends.

1. INTRODUCTION

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13 April 2011, established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act States that a Domestic Homicide Review must be held following the death of a person aged 16 or over which has, or appears to have, resulted from violence or neglect by a person to whom he or she was related, or with whom he or she has or had been in an intimate personal relationship.

1.2 Domestic Homicide Reviews (DHRs) are not disciplinary inquiries nor are they inquiries into how a person died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

1.3 This Review was held in compliance with Legislation and followed Statutory Guidance. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Claire and James[2] entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Claire's death in a meaningful way and address with candour the issues that it has raised.

1.4 The term domestic abuse will be used throughout this Review as it reflects the range of behaviours and avoids the inclination to view domestic abuse in terms of physical assault only.

1.5 This Domestic Homicide Review (DHR) examines agency responses and support given to Claire and James, to the point of Claire's death in October 2023.

1.6 In addition to agency involvement, the Review also examined the past, to identify any relevant background or possible abuse before Claire's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the Review seeks to identify appropriate solutions to make the future safer.[3]

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[1] Pseudonym for the deceased.
[2] Pseudonym for the perpetrator.
[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.7 The key purpose for undertaking this Review is to enable lessons to be learned where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. In order for lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change to reduce the risk of such tragedies occurring in the future.

1.8 **The Domestic Abuse Act 2021 defines Domestic Abuse as**:

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

(a) A and B are each 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 (see sub-section (4))
(e) psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct. https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

1.9 **The Home Office defines Controlling and Coercive behaviour as:**

- **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 assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

1.10 A summary of the circumstances that led to the Review being undertaken in this case:

1.11 On an evening in October 2023, Claire and James went out to a pub to watch a rugby match, they had some drinks and then returned to James' flat. In the early hours of the next morning, James got out of bed, Claire was asleep on the living room floor and could be heard snoring loudly. Some 3 hours later, James got out of bed again to go to the bathroom, this time, Claire had stopped snoring which prompted James to rouse her but was unable to get a response from her. James called 999 at 03:17 for the Ambulance Service to attend. (See section 13 for further details).

2. TIMESCALES

2.1 On 28 November 2023, a referral was made by Avon and Somerset Police to the Safer Somerset Partnership for a Domestic Homicide Review to be considered.

2.2 On 29 January 2024, North Somerset Council were notified of a potential domestic homicide from Avon and Somerset Police via Somerset County Council. The initial Police notification had gone to Somerset as this was the location of death. However, on further investigation, it became apparent that the deceased was actually a North Somerset resident. Consequently, and following an initial Panel meeting, the Chair of the North Somerset Community Safety Partnership made the decision on the 02 April 2024, that the homicide would be the subject of a Domestic Homicide Review held jointly between North Somerset and Somerset Councils due to the cross-border element of this case. The Coroner was notified of the decision the same day.

2.3 The Independent Domestic Homicide Review Chair was appointed on 03 April 2024 and a pre-meeting of the DHR was held on 15 April 2024 to agree process, timescales and Terms of Reference. A further update was provided to the Home Office by the Review Chair regarding timescales. The first Panel meeting was held at the earliest opportunity on 04 June 2024, during which the Panel members were instructed to secure their records relating to any contact had with either Claire or James and to appoint an IMR Author.

2.4 Normally such Reviews, in accordance with National Guidance, would be completed within six months of the commencement of the Review. However, due to the complexity of the case and ongoing criminal investigation, this was not possible and the Home Office authorised additional time.

2.5 The Review considered the contact and involvement that agencies had with Claire and James from September 2022 to the date of Claire's death in October 2023. These dates were selected, as it was at this time that Claire met James on an online dating site.

2.6 After an initial pre-meeting on 15 April 2024, the DHR Panel met formally four times via 'Teams'.

- 04 June 2024
- 16 July 2024
- 30 July 2024
- 27 August 2024

2.7 The Review was concluded on 27 August 2024.

3. CONFIDENTIALITY

3.1 In accordance with Statutory Guidance, the Review has been conducted in a respectful, confidential manner by Panel members and IMR Authors. The findings of this Review are restricted to only participating Officers / Professionals and their Line Managers until after this report has been approved for publication by the Home Office Quality Assurance Panel.

3.2 As recommended within the Guidance, to protect the identity of the deceased, the perpetrator, her family and friends, pseudonyms have been used throughout this report.

- Claire - (Deceased)
- James - (Perpetrator)
- Sam - (Claire's first child)
- Robin - (Claire's second child)
- Jordan - (Claire's third child)
- Drew - (Claire's fourth child)
- Pat - (Claire's best friend and work colleague)
- Alex - (Claire and James' friend)
- Dale - (Claire and James' friend)
- Riley - (Claire's Manager)

3.3 Pseudonyms for family members and friends were chosen; James was selected by the Review Chair and agreed to by the Panel Members.

3.4 Claire was aged 61 at the time of her death. James (now deceased) was aged 70 at the time. Both were white British nationals.

4. TERMS OF REFERENCE (As set out at commencement of the Review)

4.1 This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant statutory guidance for the conduct of Domestic Homicide Reviews.

4.2 **Statutory Guidance states the purpose of the Review is to:**

- Establish what lessons are to be learned from the Domestic Homicide Review regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- 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.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

4.3 **Specific Terms of Reference for this Review:**

- Consider the period from September 2022 and the date of Claire's death in October 2023, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events relating to domestic abuse, violence, substance abuse or mental health.

- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events, taking account of the criminal justice proceedings in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the Domestic Homicide Review being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Claire or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Identify how interventions designed to manage perpetrators were implemented (including registered sex offenders), and the impact this had on Claire.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the COVID pandemic).

5. METHODOLOGY

5.1 The method for conducting this Domestic Homicide Review is prescribed by Legislation and Home Office Guidance.

5.2 Agencies in the North Somerset/Somerset area were instructed to search for any contact they may have had with Claire and /or James and asked to secure their records. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Claire's circumstances in the future.

5.3 The Domestic Homicide Review Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies and multi-agency forums
- Discussions with members of Claire's family
- Information from Claire's friends and work colleagues
- Discussions during Review Panel meetings
- Pathologist Report / Post-Mortem

6. INVOLVEMENT OF FAMILY AND FRIENDS

6.1 At the commencement of the Review, the Review Chair contacted Claire's family by formal letter on the 24 April 2024. They were provided with a copy of the draft Terms of Reference which had been agreed by the Panel, together with the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA)

leaflets explaining DHRs and available support. During the first of the telephone conversations, the Review Chair explained the purpose of the Review and why it was being held. It was agreed during this conversation that Sam, Claire's older child would be the family liaison with the Review and where appropriate, communication should be done through Sam.

6.2 The Review Chair arranged advocacy support from Advocacy After Fatal Domestic Abuse (AAFDA) for Sam and regular updates were given to both Sam and her Advocate regarding the progress of the Review. Robin, Jordan and Drew declined support from AAFDA. At a later date, Jordan requested support from AAFDA which was arranged by the Review Chair.

6.3 Victim Support Homicide Service who are working with the family were given regular updates by the Review Chair as to the progress of the Review.

6.4 The family provided additional contact details of friends/colleagues to be contacted by the Review which has been included in this Report.

6.5 The Review Chair contacted the organisation that Claire worked for to enquire whether they had a Domestic Abuse Policy in place. It was confirmed that a Domestic Abuse Policy is in place.

6.6 It was requested by the family that no contact be made with Claire's ex-husband (from her first relationship). The Review Chair respected their wishes.

6.7 Claire's children, and her friend Pat were invited to the final Panel meeting on 27 August 2024 which they accepted. Sam had requested that Claire's mother not be invited to the meeting as it would be too distressing for her.

7. CONTRIBUTORS TO THE REVIEW

7.1 Whilst there is a statutory duty on bodies including the Police, Local Authority, Probation, and health bodies to engage in a Domestic Homicide Review, other organisations can voluntarily participate; in this case the following agencies were contacted by the Review:

- **Avon and Somerset Police:** This Police Force had relevant contact with James, and an Individual Management Review (IMR) was completed. A Senior Member of this Force is a Panel Member.

- **Next Link Domestic Abuse Support Service (North Somerset):** This domestic abuse support service had no relevant contacts relating to Claire or James. However, a recommendation has been put forward by a Senior Member of this Charity who is a Panel Member.

- **NHS Bristol (North Somerset & South Gloucestershire ICB on behalf of GPs):** This organisation had minimal contact with Claire. A Senior Member of this organisation is a Panel Member and an IMR was completed.

- **NHS Somerset Integrated Care Board (ICB) on behalf of GPs:** This organisation had minimal contact with James. A report has been provided to the Review.

- **North Somerset Public Health:** Although this organisation had no contact with Claire or James, a recommendation has been made by the Panel Member.

- **Probation Service (Taunton):** This Service had relevant contact with James, no contact was had with Claire. A Senior Member of this Service is a Panel Member and an IMR was completed.

- **South Western Ambulance Service NHS Foundation Trust (SWAST):** This service had contact with Claire on one occasion, this was on the day of Claire's death. A summary of their attendance was provided for the Review.

- **University Hospitals Bristol & Weston NHS Foundation Trust (UHBW):** This organisation had no contact with Claire or James. A Senior Member of organisation is a Panel Member.

- **With You:** This service had no previous involvement with Claire or James. A Senior Member of the Trust is a Panel Member.

7.2 The following agencies were contacted and reported having no contact with Claire or James:

- Alliance Homes
- AWP Mental Health
- Curo Housing
- Mankind
- Somerset and Avon Rape and Sexual Abuse Support

8. REVIEW PANEL

8.1 The Domestic Homicide Review Panel consists of Senior Officers from statutory and non-statutory agencies who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons. All Panel Members were independent of any direct involvement with or supervision of services involved in this case. Membership of the Panel:

Michelle Baird	Independent Chair & Author
Hannah Gray	Domestic Abuse & VAWG Lead - North Somerset Council
Suzanne Harris	Senior Commissioning Officer Interpersonal Violence - Somerset Council
Kate Blakley	Sexual Health Commissioning Manager /Mental Wellbeing and Community Development Manager - North Somerset Public Health

Louise Catlin	Detective Chief Inspector - Avon and Somerset Police
Leena Analyse	Safeguarding Adults Operational Lead Nurse - University Hospitals Bristol and Weston NHS Foundation Trust.
Lally Mergler	North Somerset Service Manager - Next Link Domestic Abuse Support Service (North Somerset)
Gill Flanaghan	Head of Service - With You North Somerset
Lucy Austin	Deputy Designated Nurse for all Age Safeguarding - NHS Bristol, North Somerset & South Gloucestershire ICB
Ashley Fussell	Head of Somerset Probation Delivery Unit (PDU)

9. CHAIR AND AUTHOR OF THE REVIEW

9.1 The Independent Chair and Author of this Domestic Homicide Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Safer Stronger North Somerset/Safer Somerset Partnerships and is independent of all the agencies involved in the Review. She has had no previous dealings with Claire or James.

9.2 Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Emotional Freedom Techniques (EFT).

9.3 She has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.

9.4 In June 2022, she attended a 2 day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention. She has also attended a number of online courses provided by the Institute for Addressing Strangulation (IFAS).

10. PARALLEL REVIEWS

10.1 Due to the nature of Claire's unexplained sudden death, a detailed investigation is being undertaken. The investigation remains open.

10.2 A complaint was received by Claire's family concerning the Police response to Claire's sudden death which has been referred to the Independent Office for Police Conduct. The IOPC are conducting an independent investigation.

10.3 At the time of concluding this Review, Claire's inquest had not taken place. The Coroner has listed Claire's death for a pre-inquest review on 24 September 2024.

11. EQUALITY AND DIVERSITY

11.1 The Panel and agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered.

11.2 Section 4 of the Quality Act 2020 defined 'protective characteristics' as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.3 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if -
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on a P's ability to carry out normal day-to-day activities[4]

11.4 Claire was 61 years of age at the time of her death, James was aged 70. Both, Claire and James were of white British origin and had been in a relationship for six months.

11.5 It was noted that James' lack of activity on his mobile phone was believed to be generational.

11.6 It was noted that both Claire and James had depression, which had not been registered as a disability.

11.7 Gender reassignment was identified as not relevant for the Review.

11.8 There was no reason to believe that any party had a religious belief.

11.9 Evidence has shown that domestic abuse is a gendered crime. There is evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2023, an estimated 1.4 million women 751,000 men aged 16 years and over experienced domestic abuse, a prevalence rate of approximately 5.7% of women and 3.2% of men.[5]

[4] Addiction/dependency to alcohol or illegal drugs are excluded from the definition of disability.
[5] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023

12. DISSEMINATION

12.1 Each of the Panel Members, the Chair and Members of the Safer Stronger North Somerset Partnership and the Safer Somerset Partnership have received copies of this report. A copy will also be sent to the Avon and Somerset Police and Crime Commissioner, the Coroner and the Domestic Abuse Commissioner for England and Wales.

12.2 Claire's family and Sam's AAFDA Advocate have been given draft electronic copies of this Overview Report to enable them to have the opportunity to read the report at length and in private, and to respond to the report if they wish to do so.

13. BACKGROUND INFORMATION (THE FACTS)[6]

13.1 Claire lived in an area in North Somerset with Jordan, her adult child and died at James' home address in an area in Somerset.

13.2 Claire and James met on a dating site. They had chatted online a few times before meeting each other in person on 02 September 2022. Initially friends, their relationship began in April 2023. They were in a relationship for 6 months prior to Claire's death.

13.3 James a Registered Sex Offender (RSO) had a history with Police and Probation Service. He was known to three Police Forces outside of Avon and Somerset.

13.4 James had previously administered substances to his victims in order to make them unaware of what he was subjecting them to. He used chloroform initially and when concerned over the potential to cause death to his victims, he used a mixture of antihistamines and alcohol. Once his victims were incapacitated, he would pose his victims in sexual positions, sexually assault, rape them and video his offences. In 2000, James was sentenced to life imprisonment. It was recorded by Probation that James had stated that he did not review the footage for sexual gratification on future occasions but kept the footage as it gave him the feeling of control over his victims.

13.5 On an evening in October 2023, Claire and James went out to a pub to watch the rugby, they had some drinks and then returned to James' flat. In the early hours of the next morning, James got out of bed, Claire was asleep on the living room floor and could be heard snoring loudly. Some 3 hours later, James got out of bed again to go to the bathroom, this time, Claire had stopped snoring which prompted James to rouse her but was unable to get a response from her. James called 999 at 03:17 for the Ambulance Service to attend. During the call, James was instructed by the call handler to perform CPR on Claire.

[6] This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

The Ambulance Service arrived at James' address at 03:27, Paramedics continued CPR with drug therapy. Police were called as they were attending to Claire who was unresponsive. Upon Police Officers arriving at the scene, Claire was laying on the floor in the living room and James was sat on a chair. On Police Officers speaking to the Paramedics, there was indication that Claire had taken 10 NYTOL sleeping tablets and had been drinking, there were also Viagra tablets at the scene. Claire was pronounced deceased at the scene at 04:05 hours.

Officers spoke to James to get his account of what had taken place, (recorded in para.13.5).

Officers observed James' behaviour to be very anxious and he seemed on edge, pacing the lounge floor. James explained they had popped the blister pack of the NYTOL tablets and placed them in a container prior to going out for the rugby, and when they got home Claire took them. An Officer asked James if he had taken any and he said, *"No but it's something we do because I like watching Claire sleep".*

An Officer ran a Police National Computer (PNC) check and found that it was of particular concern that James has a conviction history for administering drugs to obtain intercourse with females.

Rationale for Arrest

13.6 James now a suspect, is believed to have administered an illicit substance to Claire to allow him to carry out voyeuristic acts on her whilst she was stupefied. He had a history of this type of behaviour and the circumstances surrounding the discovery, appeared upon further investigative review to be suspicious.

13.7 James had also breached his licence requirements, by not informing Probation and his MOSOVO (Management of Sexual or Violent Offenders) Officer about his new relationship with Claire as he is a registered sex offender (RSO).

13.8 The following day, when an attempt to arrest James on suspicion of murder was made, it was discovered that he had fled to a location yet to be identified and had left his mobile phone behind at his address. A prison recall was issued for the breach and a manhunt was underway for the arrest of James on suspicion of Claire's murder. In April 2024, six months after Claire's death, James was found deceased by a member of the public who informed Avon and Somerset Police.

13.9 Claire's cause of death - Combined alcohol and diphenhydramine[7] use.

[7] Diphenhydramine is an antihistamine and sedative mainly used to treat allergies, insomnia, and symptoms of the common cold.

14. CHRONOLOGY

14.1 The events described in this section explain the background history of Claire and James, prior to the key timelines under Review as stated in the Terms of Reference. They have been collated from information provided by family and friends and the chronologies of agencies that had contact with Claire and James.

14.2 Claire was born and grew up in an area in Somerset. She was described by her mother as a loving, caring daughter who had a happy childhood. According to Claire's mother, Claire loved dancing which was evident at a very early age and at the age of 4, Claire attended dance classes three times a week until the age of 15. She competed in dance competitions and performed in pantomimes, receiving many accolades. Many friendships were made during Claire's time dancing, and everyone who came into contact with Claire loved her and thought the world of her.

14.3 Claire's mother informed the Review, that they enjoyed many summer holidays with Claire and her children at their holiday home abroad. This was something they always looked forward to, which enabled them to spend quality time together as a family.

14.4 Sam informed the Review, that Claire had been in two previous relationships and has four children, two from each relationship.

14.5 Claire was described by her children as a kind, loving mother who always greeted people with a huge smile. According to Sam, growing up, Claire always provided for her family and showered them with so much love.

14.6 According to Sam, Claire had worked extremely hard within many industries. She spent a number of years working in the care industry and had a good rapport with her clients, providing them with the best of care.

14.7 In 1982 Claire married her first husband, they were married for 13 years. Sam and Robin, (children from the marriage), described Claire's relationship as volatile, with Claire experiencing domestic abuse and coercive and controlling behaviour perpetrated against her by her husband throughout the relationship. There were times that their father would beat Claire so severely that people hardly recognised her. According to Sam, Claire was alcohol dependent which caused problems in the household. Claire did however seek support (agency unknown) over the years but unfortunately, her alcohol dependency continued.

14.8 In 1983, James was convicted of Criminal Damage against the property of a woman he had a one-night stand with. He found it difficult to accept that she did not want to see him again and caused damage to her property.

14.9 In 1986, James was convicted of a Section 20 assault[8], attempted kidnap and administering poison and using chloroform with the intent to commit an indictable offence[9]. These offences were committed against his wife at the time and occurred during and after they had separated. He was unable to accept the separation, he followed her, attempted to run her over and then hit her in the face to try and stop her from screaming. He was sentenced to 5 years imprisonment.

14.10 In 1991, James was convicted of attempting to alter a prescription for sleeping tablets to facilitate his offending.

14.11 Sam informed the Review, that Claire's relationship with her first husband broke down in 1995. Claire left the family home with Sam and Robin, taking only their clothing and due to financial constraints, they went to live with Claire's parents. They stayed with them for about 2 years.

14.12 In September 1998, Claire married her second husband. Two children were born from the marriage, Jordan and Drew. Jordan informed the Review that it was a good relationship, there were however, arguments/disagreements regarding Claire's alcohol dependency but never any domestic abuse perpetrated against Claire. Towards the latter part of Claire's 23 year relationship, the marriage broke down due to Claire's alcohol dependency. Although separated, Claire and her husband remained in the family home and lived separate lives.

14.13 Between 1998 - 2014, the following was recorded in Claire's medical history:

- Postnatal depression (1998),
- Alcohol dependence syndrome (2000)
- Alcohol detoxification (2001)
- Recurrent depression (2007)
- Alcohol problem drinking (2011)
- Essential hypertension (2014)

14.14 In 2000, James was convicted of offences that took place between 1986 and 1999. He drugged and sexually assaulted 4 victims over this period, all of them being adult females who he was in a relationship with. His relationships seemed to overlap, whereby he had already met the next victim as his current relationship was ending. James received a life sentence, during which time he completed a number of offending behaviour programmes.

14.15 Following his arrest in 2000, James had a GP consultation for symptoms of depression. He was referred to an Assessment Centre, offered counselling and prescribed antidepressants. Shortly after, he overdosed and spent 10 days in hospital.

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[8] A section 20 offence requires either an intent to do **some** kind of bodily harm to another person or recklessness as to whether any such harm might be caused. So, even if minor harm was intended but serious injury resulted, someone could be charged with this offence.
[9] Indictable offences are those that must be tried in the Crown Court.

14.16 James was released from prison in April 2013 on life licence and moved to approved premises in an area in Cheshire. He was managed by Probation as posing a medium risk of harm to intimate female partners. James moved to his first private rental accommodation in November 2013.

14.17 On 11 September 2014, James disclosed to Probation that he had become friendly with a female who was of a similar age to him. James was aware that should he proceed with this relationship, he would have to inform his MOSOVO Officer and disclosure of his offences would have to be made. James did not want to lose her as a friend but also felt that a progression in their relationship was imminent. He was also aware that if disclosure was made, she could end all contact with him and possibly share information with people in the area.

14.18 On 25 September 2014, James informed his MOSOVO Officer that he had made full disclosure of his offences to the female. A Sexual Offences Liaison Officer (SOLO) conducted an interview with her at her home on 06 October 2014. According to the SOLO, the female was fully aware of the risks that James posed, and stated that James had addressed his offending behaviour and she still wanted to be in a relationship with him.

14.19 At the beginning of the relationship, given the risk James posed, monthly phone calls were made by the SOLO to James' partner. After a few months, James' partner requested that these phone calls stop and should she require assistance, she would contact Probation or the Police. Contact numbers were provided for her to call should she require assistance.

14.20 During the summer of 2015, James and his partner separated. The SOLO communicated with James' ex-partner and she reported that there were no concerns with his behaviour. It was recorded that she still valued her independence and felt that James was investing too much in the relationship and spending too much time with her.

14.21 In September 2020, James moved to an area in Somerset and his management (and ViSOR record)[10] was transferred to Avon and Somerset Police and the local Probation Service. Management was joint, with Probation being the lead agency in managing James, to ensure compliance with his licence and conditions.

14.22 Upon being transferred to Taunton Probation in 2020, James' risk level was low, with no specific additional conditions on his licence. As low risk, James' MOSOVO visit frequency was annual.

14.23 On 08 September 2020 during a Probation Offender Manager visit, James reported meeting Alex and Dale and was invited to Christmas dinner. A

[10] Violent and Sex Offender Register - between the Police and Probation Service to register, risk assess and manage high-risk offenders.

decision was made by Probation and Police not to complete disclosure to those friends as his risks were towards intimate female partners.

14.24 Alex and Dale (James' friends) informed the Review that they had met James in September 2020 at their local pub.

14.25 On 06 October 2020, an in-person first MOSOVO Officer visit was conducted. James was described as initially difficult and was keen to assert that he knew the rules and did not need any supervision. He did not wish to discuss devices, mobile phones etc. (and was not compelled to do so). It was noted that he had no Sexual Harm Prevention Order (SHPO), so managing his risk would include ANPR work (track and monitor his vehicle) and having proactive conversations with him about new relationships.

14.26 In October 2020, James registered with this GP surgery. His past medical history recorded some minor illnesses. It was noted that James was a non-smoker, and his alcohol intake was 30 units per week.

14.27 In December 2020, Alex and Dale invited James to a Christmas dinner. According to Alex and Dale, James was very open and discussed his relationships with women who he had met on dating sites. He had told them that he would have sex with women even though he was not attracted to them. Alex further stated that James' behaviour at the dinner table was extremely rude and disrespectful, he sat trawling through his two mobile phones that he used for dating sites.

14.28 In February 2021, Avon and Somerset Police were contacted by a female who had been contacted by James via a dating website. They had engaged in conversation and James invited the female for a date (a walk). The female conducted her own due diligence by searching his address online before agreeing to the walk and discovered James' offending history.

14.29 In March 2021, Police advised Probation that James had met a female via a dating site. As a result, a Senior Probation Officer final warning was issued to James for not disclosing this relationship. An additional licence condition was applied for and was approved by Parole: *'Not to delete the usage history on any internet enabled device or computer used and to allow such items to be inspected as required by the Police or your Supervising Officer. Such inspection may include removal of the device for inspection and the installation of monitoring software'.*

14.30 On 06 May 2021 James was reassessed by Taunton Probation as posing a medium risk of harm towards intimate female partners and due to COVID measures, it was decided locally to increase him to monthly reporting. During this time, new COVID national standards were implemented, therefore complete home visits and office reporting were suspended, and more telephone appointments and doorstep visits were conducted.

14.31 Sam informed the Review, that when Claire separated from her second husband on 17 September 2021, she moved to a place of her own in an area

in North Somerset which she loved. Once settled, Claire found the evenings very lonely and it was at this time that she joined a dating site.

14.32 During a home visit on 26 September 2021, a further Senior Probation Officer final warning was issued. James' phone was searched, and he was found to have deleted some internet history. Despite James claiming that he was unaware that he was not permitted to do this, Probation proceeded with the final warning.

14.33 In November 2021, further phone checks were completed on James' phone by his Probation Offender Manager and there were no further issues regarding his phone. James started making requests for overnight stays at camping sites (he had his own camper van) and following the dates and addresses being provided and checked by Police and Probation, the overnight stays were granted. James continued to request campsite trips and checks continued to occur before permission was granted.

14.34 In February 2022, James requested permission to go abroad which was denied. The reason for this was due to him being on life licence, receiving the final warnings as well as being argumentative and challenging towards professionals. It was therefore assessed that his risks could not be managed towards female intimate partners whilst abroad.

14.35 On 14 April 2022, a MOSOVO Officer visited James' home address, this was made by appointment due to several earlier unsuccessful attempts to visit. James' phone was checked and ESAFE[11] was installed on a Samsung mobile phone. The Officer explained that the software monitors pornography use and highlights sexualised text messages. James informed the Officer that he had no further devices and advised he was not using any dating apps.

15. OVERVIEW

15.1 This section documents the key contacts agencies and professionals had with Claire and James together with information received from family and friends within the timeframe of the Review.

15.2 Claire's contact with agencies was found to be minimal with the only chronologies of contact arising from her GP practice. No reports of domestic abuse were recorded, therefore the Review had to rely on information provided by Claire's family, friends and work colleagues. James however, had contact with Police and Probation Service on a number of occasions.

15.3 Sam and Jordan informed the Review that Claire had met James on a dating site. They chatted online and met up in person on 02 September 2022 at a pub. After Claire and James had met up in person, James messaged Claire constantly inviting her to visit him at his home. Claire had told her children that

[11] ESAFE - monitoring software that tracks internet searches.

her and James were just friends, and that he was not the type of person she would get involved with.

15.4 Pat who had known Claire for many years, met Claire at their place of work and became the best of friends. Claire was described by Pat as an amazing friend, full of fun and a wonderful, loving person who was respected by all her work colleagues. Pat confirmed that Claire had met James on a dating site in September 2022, initially friends, their relationship began in April 2023.

15.5 On 23 September 2022, a doorstep visit was conducted by James' Probation Offender Manager. James presented well and no concerns or issues were raised. Discussions were held around his alcohol use and James reported only drinking alcohol when socialising. He reported not being on any dating websites or developing relationships. James remained medium risk of harm.

15.6 On 03 October 2022, an in-person MOSOVO visit was made to James' home address. James was initially quite difficult and refused the Officers entry without face masks. The Officers had to return to the Police station to collect face masks and returned to James' flat. The Officers reported that James never had anyone else in the property during this visit and added that the property was kept clean and tidy with no obvious signs of female belongings inside the property. James generally spoke about his walking group and cycling. Discussions were had with James about relationships, and James denied being in any relationships. James' phone was checked and there were no signs of deleting history or accessing pornography. The Officers stated that it appeared that James' phone was often dormant, and this lack of phone use was considered to be possibly generational. James emhasised that he was lonely and wanting a relationship but never disclosed anything further.

15.7 On 21 October 2022, a home visit conducted by James' Probation Offender Manager. James presented well and in good spirit and reported no changes to his routine. He informed his Offender Manager that MOSOVO Officers had recently visited him and James commented on them not wearing face masks. He said that the MOSOVO Officers checked his phone and there were no issues or concerns. James continued to state that he was not on any online dating sites and has no intention of doing so.

15.8 Alex and Dale informed the Review that towards the end of October 2022, James had taken a female away on a weekend break in his camper van. James had introduced Alex and Dale to this female and had met her on two occasions.

15.9 In January 2023, James informed his Probation Offender Manager that he was the Chairperson of the shared block in which he resides, and that he knew all the residents well. He further stated that he was in possession of two keys for two separate flats within the block. One for a female resident who had given James her key in order for him to look after her property for 3 months whilst she was travelling abroad, the other for a flat which was rented out by the owner as an Airbnb/holiday let where James would attend to any maintenance that needed to be done. James informed his MOSOVO Officer

that he would not be present when the property was being occupied. Upon Probation being made aware of this, it was agreed that disclosure of James' previous offending would be made to both parties. James did not want disclosure to be made and returned the keys and gave the excuse that he did not want the responsibility. Probation took the decision not to make disclosure as James had returned the keys. There was no proof provided to confirm that James had given the keys back.

15.10 On 05 January 2023, during a nurse appointment for blood pressure and lifestyle review, Claire reported problems sleeping linked to shift work. Her alcohol consumption was reported to be 32 units/week (national guidance is no more than 14 units per week maximum). Claire's compliance with blood pressure medication was suboptimal. The following was documented: *'Working long shifts. Eating pattern all over the place. Also, drinking Vodka to help sleep when coming off night shifts. We discussed needing to change jobs as not sustainable. Feels tired all the time, eating junk food, drinking alcohol to help sleeping pattern".*

15.11 On 28 March 2023, a Multi-Agency Public Protection Arrangement (MAPPA)[12] level 1 review was completed given James' challenging behaviour and Senior Probation Officer final warnings, however despite his behaviour, it was considered that he presented as stable and remained on monthly reporting.

15.12 An unannounced home visit was made to James by his MOSOVO Officer on 20 April 2023. James advised that he had recently been away in his camper van (which was authorised by Probation). He spoke about his neighbour/friend who had recently returned from a holiday abroad, who he goes walking with and stated that he was not in a relationship with her as he did not find her attractive. The Officers checked James' phone, there were no concerns and ESAFE was working well.

15.13 Towards the end of April 2023, James introduced Claire to Alex and Dale. Alex and Dale confirmed to the Review, that the female James took on a weekend away in October 2022 was not Claire (see para.15.6).

15.14 On 15 May 2023, Claire requested a medical review for a leg injury, as she was concerned about the excessive bruising. She was seen the same day by a GP who diagnosed cellulitis (skin infection) and prescribed antibiotics. The mechanism of injury was reported by Claire and documented by the GP: *Fell off a kerb forward and her left knee bumped the ground, has a graze on her knee. Bruising developed over left anterior lower leg. Moving knee okay, taking over the counter co-codamol as needed for bruising but feels bruising has increased rather than improving".*

15.15 A Lifer Panel[13] was held on 26 May 2023, and it was discussed that given the length of time on licence in the community, James could be considered for his supervision period to be lifted. Although James was assessed as a medium

[12] MAPPA - A system to ensure the successful management of violent and sexual offenders.
[13] Lifer Panels are an essential process through which the management and progress of lifers in the community can be monitored and reviewed at significant points.

risk, given his risks, nature of the offending and the risks he posed, the decision was made that he needed to remain on licence for the foreseeable future.

15.16 On 19 June 2023, during a nurse appointment for a new diagnosis of diabetes, Claire's alcohol consumption was reported to be 1-2 units/day. She was referred to a diabetes support programme and weight management clinic for obesity support (BMI 41). Claire was started on medication for cardiovascular protection/cholesterol reduction and given information about diabetes treatment options. Her kidney function was subsequently reviewed via blood tests and found to be reduced (chronic kidney disease stage 3)[14] in August 2023.

15.17 During a home visit on 28 August 2023, James' Probation Offender Manager could see no evidence of any intimate relationships. James engaged in conversation regarding the emotional impact of a family member who had been diagnosed with cancer which he was struggling with, alongside his feelings of loneliness as his family did not want to have anything to do with him. James was offered support and was signposted to agencies/services who could support him, however, he refused support.

15.18 On 12 September 2023, during a nurse appointment for a diabetes review, Claire requested a supporting letter to assist in changing her shift patterns to reduce cycling between days and nights. It was felt her current shift pattern was detrimental to her health, her diet and sleep. A supporting letter was written by the nurse which Claire collected from reception the following day.

15.19 In October 2023 (5 days prior to Claire's death), Claire disclosed to Pat that she was going to end her relationship with James as she had met someone else. Pat had advised Claire to do this via text message, but Claire insisted breaking it off in person. Claire went further to say that her and Pat had a lot of catching up to do, but sadly this did not happen.

16. INFORMATION PROVIDED BY FAMILY, FRIENDS & WORK COLLEAGUES

Claire's family - Sam and Jordan

16.1 Claire had never discussed her relationship with James, or the abuse she endured. Information known to the family came to their attention post Claire's death from friends, work colleagues and information found on Claire's mobile phone. However, the following was reported to the Review by the family.

[14] Chronic kidney disease (stage 3,) is really very rare to go on to develop kidney failure so that people need dialysis or a kidney transplant. It is very important to take care of the conditions that may contribute to kidney damage (e.g. diabetes, high blood pressure), as well as any risk factors for cardiovascular disease (for example high cholesterol, smoking).

16.2 The only member of the family who had met James, was Drew. This meeting took place when Drew (and partner) were spending a weekend at Claire's home and James arrived unexpectedly. James was very outspoken and extremely rude towards them, openly showing his disapproval of them being there. Arguments ensued and Drew took an instant disliking to James. It was evident to Drew that James was a bully with a controlling nature. Subsequently, Drew never saw James again.

16.3 Claire was always mindful when inviting James to visit her at her home and always ensured that Jordan was not home when James visited.

16.4 Claire had visited and stayed over at James' flat on a number of occasions. Claire would always arrive home very early the next morning which Jordan found very strange.

16.5 Jordan had witnessing bruising around Claire's eye and when Jordan questioned Claire as to what happened, she told Jordan that she had hit her eye on a filing cabinet drawer at work. Jordan can recall seeing the bruising after Claire had come back from visiting James.

16.6 Claire had never disclosed James' physical address to the family, and on one occasion (a few months prior to Claire's death), Claire had asked Jordan to drive her passed James' property so that she could show Jordan where James lived. After driving passed the property, Claire said *"Now at least you know where James lives, and if anything goes wrong, you know where to find me".*

16.7 On receiving Claire's mobile phone back from the Police in May 2024, Sam and Jordan went through the phone and the following internet searches were found:

- 08 April 2023 at 14:18, search on James' home address.
- 08 April 2023 at 14:25, search on James' real identity (Claire had spelt his surname incorrectly).
- 08 April 2023 at 16:48, *'How many is the most NYTOL tablets you can take'*.
- 01 August 2023 at 20:20, a further address search check on James' address.

16.8 The family were unsure as to how James' real identity became known to Claire and can only assume that Claire had found no information on James due to Claire spelling his surname incorrectly.

16.9 A topless photograph was found on Claire's phone, sent to her by James via WhatsApp on 13 June 2023. Claire appeared to look drowsy in the photograph.

16.10 Messages found from Claire to James asking him not to be angry with her when she was running 5 minutes late in seeing him.

16.11 It was evident on information found/provided by friends and work colleagues that Claire had tried to end the relationship with James on a few occasions.

She kept cancelling on James when he made arrangements to see her, using the excuse that she had COVID.

16.12 Sam and Jordan described Claire as an intelligent person but not very streetwise and very trusting of people. On the information provided to them from Claire's friends and colleagues, it is now clear to them that Claire was in an abusive, controlling relationship with James. This would explain why Claire had changed her appearance.

16.13 James had introduced himself to Claire under a false name. Claire and the family were unaware of James being a Registered Sex Offender and the danger he posed to women.

16.14 The family expressed their anger and dissatisfaction in the way Avon and Somerset Police conducted themselves on the day of Claire's death and during the investigation into her death. What was deeply concerning for them, was the fact that the Police were aware of James being a Registered Sex Offender and the modus operandi of his crimes, yet he was not taken into custody on the day of Claire's death. Police attended James' property the following day to arrest him on suspicion of Claire's murder only to find that he had disappeared.

Pat - Claire's best friend / work colleague

16.15 Pat had witnessed bruising on Claire's wrists, her cheekbone and Claire arriving at work wearing sunglasses to cover a bruised eye. Claire's explanation to Pat was that she had walked into a wardrobe, yet she told other work colleagues that she had fallen.

16.16 Claire confided to Pat about her relationship with James and the abuse she endured. She told Pat that James was very controlling, always telling her what she could wear. James wanted Claire to look feminine, she was a "t-shirt and joggers girl" which he did not like. He wanted Claire to wear skirts, blouses and to show a bit of cleavage. James also insisted that Claire change her hair colour as he preferred blondes. He constantly knocked Claire's confidence by telling her she was fat and that she had to lose weight.

16.17 Claire spoke to Pat about James' interest into bondage, discipline/dominance and sadomasochism (BDSM). He liked to tie Claire up, handcuff her and would perform sex with Claire which she was always extremely uncomfortable with. James would make Claire stay awake all night by slapping her in the face as he liked having sex with her whilst she was drowsy. James would also have sex with Claire whilst she was asleep. Claire had told Pat that she could not understand why she was always tired, not able to remember things and was always unwell after drinking with James.

16.18 Claire disclosed to Pat that she suspected that James was involved with other women whilst in a relationship with her. Claire had confronted James, only to be told by James that the women he was speaking to were just friends. Claire had tried to break off the relationship with James on two occasions

which James found hard to accept, apologising for any wrong doings and promising he would be nicer to Claire.

Alex and Dale - Claire & James' friends

16.19 Alex and Dale had known Claire for six months prior to her death. They had met James and Claire on four occasions at their local pub. They met Claire for the first time in April 2023.

16.20 On meeting Claire with James for the second time, Alex and Dale did not recognise Claire, she had changed the colour of her hair, the way she dressed and had dental work to repair a gap between her two front teeth. James told them that he insisted on Claire make these changes as he preferred blondes and wanted her to look more feminine. It was evident that Claire was being controlled by James.

16.21 James was constantly putting Claire down in front of people, telling her she was stupid, fat and had to lose weight. He would also made advances on women at the pub, and openly discussed and showed Alex and Dale a bag containing Viagra and condoms that he carried around with him, telling them that this was "in case of emergencies". This was all done in Claire's presence which made Claire feel extremely uncomfortable.

16.22 James was seeing a number of women whilst in a relationship with Claire, two of whom he introduced to Alex and Dale at the pub. Alex had disclosed this to Claire (in James' presence) as they were not going to cover up for James. James' response to the disclosure was that he only saw them when he and Claire had an argument, and they were just friends. Claire confirmed to Alex and Dale that James had already made her aware of this which they found hard to believe. Alex asked Claire why she put up with James' behaviour and Claire never responded, she just shrugged her shoulders. Alex and Dale described James as controlling, a narcissist and sexual predator.

16.23 Claire confided to Alex that one Saturday evening, James had been drinking heavily, he had sex with Claire and then watched a rugby match on TV. When Claire decided to leave, he started arguing with Claire, tied her up and would not let her go. Alex expressed her concern and told Claire that she had to end the relationship. Alex gave Claire her mobile number to call if she was scared and needed help.

16.24 According to Alex, James would often complement Alex on always being so well-groomed, and on more than one occasion James tried to get Alex on her own at the pub which made Alex extremely uncomfortable. James was aware that Alex and Dale were happily married, but this didn't seem to bother him. James had also made inappropriate advances towards Alex in Dale's presence. James had also mentioned to Alex that if anything had to happen to Dale (who was poorly), he would be there for Alex. This angered Alex which resulted in Alex and Dale having a fall out with James.

16.25 At the time of James' death, Alex contacted the female who James had taken away on a weekend break in October 2022, to inform her of his death and true identity. The female advised that she was aware of his death and had found out his true identity whilst on the weekend away. According to the female, James' credit card had fallen out of his wallet, and she noticed that the name on the credit card was different to the name he was known by on the dating site. She did an internet search and found out about James' offending history. The female did not disclose this information to anyone, and never saw James again.

16.26 Alex and Dale said that when they first met James, he introduced himself under a false name and were unaware of James being a Registered Sex Offender.

Riley - Claire's Manager

16.27 Riley had a good relationship with Claire and described her as an absolute star. Claire worked shifts and Riley can recall a weekend when Claire had called in sick. On returning to work, Claire was seen to have bruising around her left eye. She told Riley that she had too much to drink and had fallen over a table, hitting her eye on the corner of the table. Riley asked Claire if James had hit her and her response was *'he wouldn't dare do that to me'.* James had also witnessed extensive bruising on Claire's leg on a further occasion.

16.28 It came to Riley's attention via staff members that Claire was in a coercive and controlling relationship. On speaking to Claire, she disclosed some of the abuse that James had perpetrated against her. She mentioned that James had wanted her to take drugs, (none specified) so that he could have his way with her - he enjoyed having sex with Claire whilst she was asleep/drowsy. James was constantly telling Claire that she was fat and had to lose weight and made her wear clothing that was inappropriate for her. James had also asked Claire what flowers she would like placed on her coffin when she dies.

16.29 Riley had begged Claire to leave the relationship. Claire disclosed to Riley that she had previously met someone on a dating site who she was back in contact with, who has given her encouragement to end the relationship with James.

16.30 During Claire's last nightshift before her death, she told Riley that she was going to end the relationship with James. Riley had suggested to Claire that she do this over the phone, but Claire insisted on doing it face-to-face. Two days later, Riley received a call from Jordan with the devastating news that Claire had passed away. Riley then contacted the Police and gave an account of what was disclosed about Claire's relationship with James.

17. ANALYSIS

17.1 The Review Panel has checked that the key agencies taking part in this Review have Safeguarding and Domestic Abuse Policies (either stand alone

or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

17.2 Four organisations have provided Individual Management Reports (IMRs) / reports detailing relevant contacts with Claire and James. The Review Panel has considered each carefully to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Good practice has been acknowledged where appropriate.

17.3 The lessons learned and recommendations / action plans to address them, are listed in Section 19 and 20 in this report.

17.4 The following is the Review Panel's analysis of the agencies' interventions:

Avon and Somerset Police

17.5 Avon and Somerset Police had no contact with Claire during or prior to the timeframe of the Review. They had contact with James on nine occasions, when James reported at a Police station, or a Police Offender Management visit took place.

17.6 It was acknowledged by the IMR Author that there were no specific actions for Avon and Somerset Police within James' Risk Management Plan. The general ongoing actions were to carry out unannounced visits in line with the risk profile, checking of his devices (once licence conditions were amended) and investigate any new relationships. MOSOVO visits were conducted in line with policy and College of Policing APP.

17.7 Good information sharing, and communication was evidenced between Police and Probation Service. When concerns were raised about James' use of dating websites, action was taken to amend the conditions of his licence. The additional conditions to James' licence provided Police with the power to check his mobile phone.

17.8 There was a period of time where James was subject to Police Offender Manager visits during the COVID pandemic, the frequency of these visits was not impacted by this.

17.9 With the knowledge of James' past modus operandi and disclosure from the local female about James accessing a dating website, the IMR Author acknowledged that there may have been an opportunity to consider this further.

17.10 It was acknowledged by the IMR Author that James displayed disguised compliance. On notification of James' death and Police searching his property, it was discovered that James had successfully hidden a second mobile phone from his MOSOVO Officer. At the time of Police working with James, it was not possible for them to have known this as they were subject to s.17 powers and had no general powers to search his property.

17.11 The IMR Author acknowledged that on review of Police involvement with James and from information provided by his MOSOVO Officer, it was clear that James was adept at outwardly appropriately complying with the restrictions and conditions that he was subject to. The information known by Police did not raise concerns or suspicions at the time that would have met the requirements to take further action such as a referral to the Police Offender Management Internet Team or meet the legal threshold of suspicion to undertake financial checks to check for dating or mobile phone subscriptions.

17.12 Recommendations have been made by the IMR Author.

NHS Bristol, North Somerset & South Gloucestershire ICB

17.13 Claire registered with her GP surgery in October 2022. At the time of registration, her medical history included postnatal depression (1998), alcohol dependence syndrome (2000), alcohol detoxification (2001), recurrent depression (2007), alcohol problem drinking (2011) and essential hypertension (2014).

17.14 During the timeframe of the Review, Claire had contact with her GP surgery on seven occasions, six of which were routine reviews for blood pressure and diabetes, and on one occasion for an infection in her leg (cellulitis).

17.15 There was no documented evidence in Claire's medical records of any disclosure of domestic abuse, relationship issues, difficulties at home, or direct questioning being undertaken relating to domestic abuse as routine enquiries.

17.16 Good practice was evidenced during appointments regarding chronic disease management pathways (blood pressure and diabetes) by nurses throughout.

17.17 There was no evidence of Claire's mental health ever discussed, despite a previous history of depression and alcohol dependence being known from her records.

17.18 There were missed opportunities to explore history and alcohol intake further, and no referral or support services offered when Claire reported using excessive alcohol to assist with her sleep pattern in January 2023, and in May 2023 when Claire reported falling from a curb and injuring her leg. Drug misuse was also never discussed or reported.

17.19 It was acknowledged by the IMR Author that professional curiosity might have been appropriate, given Claire's mental health and alcohol dependency. This has resulted in recommendations being made by the IMR Author.

NHS Somerset Integrated Care Board (ICB) on behalf of GPs

17.20 James registered with his GP surgery in October 2020. His past medical history was recorded as unremarkable with the exception of some minor illnesses. It was recorded that James' alcohol intake was 30 units per week.

17.21 During the timeframe of the Review, James attended five appointments at his GP surgery for influenza and COVID vaccinations, and on one occasion for a pain in his left knee.

17.22 James' most active medical problems were Osteoarthritis of the knee, Lymphocyctic Colitis[15] which was well controlled and other minor illness not needing any active medications or interventions. James was not on any regular medication and was not under any specialist team.

17.23 No recommendations have been made by the IMR Author.

Probation Service - Taunton

17.24 James, a Registered Sex Offender was released on Life Licence in 2013 and had been jointly managed by various Police Forces and Probation Services.

17.25 Whilst on Life Licence, James had been offered 182 appointments, attended 169 with 11 acceptable and 2 unacceptable absences for which warnings were issued for failing to attend.

17.26 Good practice was evidenced by James' Offender Manager in September 2014, when James disclosed that he had met a female, and indicated that a relationship was likely to develop. Full disclosure of James' previous offences was made to this female by a Sexual Offences Liaison Officer, and monthly welfare telephone calls were made to her during the relationship.

17.27 Good practice was evidenced in March 2021 and September 2021, whereby Senior Probation Officer final warnings were issued to James for being dishonest regarding his use of a dating website and for deleting his internet history.

17.28 The IMR Author acknowledged that the management of this case would have benefitted from more formal conversations/reflections about James' disguised compliance (in conjunction with Police) which may have opened up additional actions being taken to explore James' circumstances/behaviour during the period leading up to Claire's death.

17.29 A recommendation has been made by the IMR Author.

South Western Ambulance Service NHS Trust (SWAST)

[15] Chronic inflammation in your colon, with a high density of inflammatory white blood cells called lymphocytes that leads to chronic diarrhea.

17.30 SWAST had contact with Claire on one occasion, this was on the day of her death. No contact was had with James during the timeframe of the Review.

18. KEY ISSUES AND CONCLUSIONS

18.1 The Review Panel has formed the following key issues and conclusions after considering all of the evidence presented in the reports from those agencies that had contact with Claire and James.

18.2 A key issue in this DHR is that Claire's contact with agencies was found to be minimal. There was no contact with any agencies relating to domestic abuse prior to her death, and as a result the Review Panel has not been able to look at the specific issue of how local professionals and organisation worked individually and together to safeguard Claire in this case. It has focused instead on identifying the lessons to be learned more broadly, and has applied these lessons to service responses, including considering any changes to policies and procedures where that may be appropriate. This is in keeping with the purposes of DHRs, which include: preventing domestic violence and homicide and improving service responses by developing a coordinated multi-agency approach to ensure earlier identification and improved response, as well as contributing to a better understanding of the nature of this issue. Where relevant, the Review Panel has also sought to identify good practice.

18.3 Conversations with family, friends and colleagues revealed a pattern of behaviour by James towards Claire of coercion and control. This was characterised by his interest in bondage, discipline/dominance and sadomasochism (BDSM), the monitoring of her movements, the changes made to Claire's appearance and James drugging and physically/sexually assaulting her.

18.4 It was acknowledged by the Review Panel that this Review highlights the importance of professional curiosity. Enquiries should have been conducted relating to Claire's mental health, alcohol and drug use given her history of depression and alcohol dependency.

18.5 The Review acknowledged that James displayed disguised compliance. James was in possession of a second mobile phone which he had hidden from Police and Probation Service. This would explain the mobile phone known to Police and Probation being dormant at times when checked by his MOSOVO Officer. It has however, been noted by the Review, that Police working with a managed offender remain subject to s.17 powers of entry and had no general powers to search their property.

18.6 Whilst there are lessons to be learnt and recommendations regarding the management of this case, the Police and Probation managed James' licence conditions in line with policy and agency guidelines. It was not possible for a coordinated response to be made by agencies regarding Claire, as it was not

known that she was in a relationship with James who purposely concealed it. Had the relationship been known, this would have led to enforcement action being taken, which might have included recall.

18.7 It was acknowledged by the Review, the vital role that friends and associates can play in providing information and insights about relationships being reviewed. This is especially so in circumstances when agency involvement is limited, as it was in this case.

18.8 Claire's death was tragic, and James' death has meant that the criminal justice process was unable to run its course, and those affected by Claire's death have been denied the opportunity to obtain justice.

19. LESSONS LEARNED

The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Annexure A of this report.

Avon and Somerset Police

19.1 When MOSOVO Officers checked James' mobile phone, it was often found to be dormant, and the lack of phone use was considered by the Officers to be possibly generational. Unconscious bias was displayed due to James' age.

19.2 Disguised compliance was displayed by James by not disclosing to MOSOVO Officers that he was in possession of a second mobile phone which he used to access dating website.

19.3 There were no specific actions for Police within James' Risk Management Plan. MOSOVO and Probation to review the viability of joint training in risk assessment.

NHS Bristol, North Somerset & South Gloucestershire ICB

19.4 There was no record of domestic abuse at the time Claire registered with the GP practice, or directed questioning relating to domestic abuse ever undertaken.

19.5 There were missed opportunities to explore Claire's alcohol intake further when she reported excessive alcohol intake and stress/sleep disturbance in January 2023, and in May 2023 when she reported falling from a curb and injuring her leg.

19.6 There was no evidence of Claire's mental health or drug use/misuse being discussed, despite a previous history of depression and alcohol dependence.

North Somerset Community Safety Partnership / Safer Somerset Community Safety Partnership

19.7 Information and advice on domestic abuse should be widely available and easily accessed online for all residents in the area.

19.8 Local awareness-raising re online dating in later life/internet safety.

19.9 DBS checks should be carried out on individuals who are voted, elected or volunteer as representatives on housing association and property management board limited companies within privately owned/rented accommodation.

North Somerset Public Health

19.10 Domestic Abuse toolkit for workplaces to be included in the North Somerset Healthy Workplaces Accreditation Scheme.

Probation Services - Taunton

19.11 Whilst Probation had an awareness that James' visible compliance may have been false, management of the case would have benefitted from more formal conversations/reflections about James' compliance (in conjunction with Police). This may have led to the relationship with Claire being discovered.

20. RECOMMENDATIONS

20.1 The Domestic Homicide Review Panel's up to date action plan, at the time of concluding the Review is set out in Appendix A of this report.

Avon and Somerset Police

20.2 MOSOVO to review requirement for regular refresher training in the MOSOVO National Policing Curriculum, in particular training focused on disguised compliance and manipulation by offenders.

20.3 Avon and Somerset to review the provision for regular training in unconscious bias for MOSOVO.

20.4 MOSOVO and Probation to review the viability of joint training in risk assessment.

National Recommendation

20.5 Home Office to put forward a recommendation to the Ministry of Housing Communities and Local Government for owner/tenant boards within private/rented accommodation to conduct appropriate checks on members who are voted, elected or volunteer as representatives on housing boards.

Next Link Domestic Abuse Service

20.6 All partner agencies who are made aware of domestic abuse should have the information to offer to Next Link

NHS Bristol, North Somerset & South Gloucestershire ICB

20.7 Review of new registration process/forms to consider inclusion of safeguarding screening questions.

20.8 Further training of primary care staff on risk factors for victims of domestic abuse, and indicators of abuse.

North Somerset Community Safety Partnership / Safer Somerset Community Safety Partnership

20.9 Information and advice on domestic abuse should be made widely available and easily accessed online for all residents in their area.

20.10 Local awareness-raising re online dating in later life/internet safety.

North Somerset Public Health

20.11 Domestic Abuse toolkit for workplaces to be included in the North Somerset Healthy Workplaces Accreditation Scheme.

Probation Services - Taunton

20.12 Head of Services for Somerset Probation to ensure that Probation Practitioners within Somerset undertake relevant training/briefings relating to 'disguised compliance'.

ANNEXURE A - ACTION PLAN

North Somerset Council

DHR9 ACTION PLAN – Updated as of 17/09/2025

Avon and Somerset Police

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
MOSOVO to review requirement for regular refresher training in the MOSOVO National Policing Curriculum, in particular training focused on disguised compliance and manipulation by offenders.	Force Wide	MOSOVO National Policing Curriculum Refresher training requirement to be reviewed and frequency of refresher training to be determined Review refresher training materials/modules to ensure a focus on disguised compliance and manipulation by managed offenders Deliver refresher trained delivered according to agreed schedule	ASP		December 2024 December 2024 In line with training cycle	ACTION CLOSED DEC 2024: training has been delivered - MOSOVO qualification now for 5 years and renew - full course but maybe shorten. Now part of business as usual in training package.
Force to review the provision for regular training in unconscious bias for MOSOVO.	Force Wide	Offender Manager training plans to be reviewed for inclusion of cyclical intentional training in unconscious bias.	ASP		December 2024 In line with training cycle	ACTION CLOSED DEC 2024: not much training around unconscious bias – it has been explored. Funding

		Training content to be developed if required. Frequency of training within training plan to be agreed. Deliver training as required by training schedule.				in 2025 for voice analytics will solve bias and disguised compliance and will properly address issue.
MOSOVO and Probation to review the viability of joint training in risk assessment.	Force Wide	MOSOVO and Probation to review viability of initiating joint training. Training plan and materials to be agreed if appropriate Training to be delivered	ASP / Probation		End October 2024 In line with training plan	March 24 Update - REMAINS OPEN: joint training being designed with probation. Roll out in Somerset initially Feb/March 2025 then wider after feedback. Chased for update 14/09/25

National Recommendation

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Home Office to put forward a recommendation to the Ministry of Housing Communities and Local Government for owner/tenant boards within private/rented accommodation to conduct	National	DBS checks should be carried out on individuals who are voted, elected or volunteer as representatives on housing association and property management board limited	NSCSP	National recommendations included in DHR Report and sent to HO for consideration.	TBC	July update – HO QA Panel provided 2 email addresses for MHCLG and LG and national recommendations

appropriate checks on members who are voted, elected or volunteer as representatives on housing boards.		companies within privately owned/rented accommodation.				sent 31/07/25. Response rec'd 01/08/25 to say they are dealing and will send a response when complete.

Next Link Domestic Abuse Support Service (North Somerset)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
All partner agencies who are made aware of domestic abuse should have the information to offer to Next Link.	Across BNSSG	Consider reaching out to agencies with referral pathways.	Next Link	Safer Stronger NS website being refreshed to include a section for professionals to access further resources and support to include Marac forms and contact details for Nextlink services. DA training for all frontline staff in North Somerset has been rewritten and delivered by Nextlink to raise awareness of the local	December 2024	Complete – new training offer commenced Oct 2024. New SSNS website scheduled to go live end of Nov 2024.

				commissioned DA support services and ensure robust referral pathways are in place.		

NHS Bristol, North Somerset & South Gloucestershire ICB

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
ICB to work with One Care to develop a supplementary registration information form for use across BNSSG, which includes safeguarding questions and risk assessment.	Across BNSSG	Consider meeting with GPCB about this, to influence rewriting of registration forms	BNSSG ICB/ GPCB	Including safeguarding screening question in GP registration form.	01/11/2025	Confirmation from NHSE and NNNGP that there is no plans to change national GP registration form. Email exchange with Named GPs on 07/02/2025 that a local, non-mandatory supplimentary registration form could be developed but that this would require additional resources. To be

						added to priority list for 2025-26
Further training of primary care staff on risk factors for victims of domestic abuse, and indicators of abuse.	Across BNSSG	Training session delivery via Lunch+Learn session, Level 3 training session, Link GP meetings.	BNSSG ICB	Promoting use of 'routine inquiry' so all staff (incl. nurses) feel able to ask direct question about domestic abuse during medical appointments where relevant.	25/03/2025	DA webinar will be completed on 25th March 2025, this will include signs and symptoms of domestic abuse. Training on DA is part of a rolling cycle of training offered by the ICB to primary care.

North Somerset Community Safety Partnership / Safer Somerset Community Safety Partnership

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Information and advice on domestic abuse should be widely available and easily accessed online for all residents in the area.	Local	Refresh of the NS Friends & Family DA Guide for the Safer Stronger North Somerset website. Updated area on Safer Stronger North Somerset and Somerset Domestic Abuse websites to include section for friends and family and information on Clare's Law disclosure scheme.	North Somerset & Safer Somerset CSPs	SSNS and Somerset Domestic Abuse websites has been updated to include the new content, currently being finalised by the web development team for re-launch end of Nov 2024. Toolkit containing online safety info, raising	October 2024	Complete

				awareness of safer online dating, Clares Law being rolled out as part of 16 Days of Action campaign running late Nov 24.		
Local awareness-raising re online dating in later life/internet safety.	Local l	Comms & social media campaign highlighting online dating safety targeting those aged 40+.	North Somerset & Safer Somerset CSPs	SSNS and Safer Somerset Partnership to plan joint awareness raising plan Both CSPs to launch awareness raising campaign across both North Somerset and Somerset areas.	TBC	November 2024 – toolkit and comms launched as part of 16 Days of Activism 2024. Toolkit available on SSNS website - 32609 Stay safe with onne dating branding toolkit.indd

North Somerset Public Health

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Domestic Abuse toolkit for workplaces to be included in the North Somerset Healthy Workplaces Accreditation Scheme.	Local	Inclusion of the toolkit to the co-ordinator of the healthy workplaces scheme.	NSC Public Health	Suggestion has been made to the lead on this programme of work and agreement been made to look at including during the review of criteria in July 2024.	Octobert 2024	Complete. February 2025 – uploaded to SSNS website.

				Toolkit to be included in new SSNS webpages.		

Probation Service - Taunton

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Head of Services for Somerset Probation to ensure that Probation Practitioners within Somerset undertake relevant training/briefings relating to 'disguised compliance'.	Local	Set up training days to ensure Practitioners have sufficient knowledge and awareness of disguised compliance.	Probation		December 2024	The current training packages run by the Probation Service include briefings regarding 'Professional Curiosity' which cover the area of 'disguised compliance'. These were delivered to many Somerset staff in 2023/2024; but continue to be available to all new and existing staff. The area of Professional Curiosity has also been revisited with staff as part of ongoing protected learning days and is covered as part of

						the induction for new practitioners.

APPENDIX B - LICENCE CONDITIONS

LICENCE

Crime (Sentence) Act 1997

The Secretary of State hereby authorises the release on licence within fifteen days of the date hereof of **JAMES** who shall on release and during this period of this licence comply with the following conditions or any other condition, which may be substituted or added from time to time.

1. He shall place himself under the supervision of whichever supervising officer is nominated for this purpose from time to time.

2. He shall on release report to the supervising officer so nominated and shall keep in touch with that office in accordance with that officer's instructions.

3. He shall, if his supervising officer so requires, receive visits from that officer where the licence holder is living.

4. He shall reside only at approved premises (name and address of premises redacted), and not leave to reside elsewhere; even for one night, without obtaining the approval of his supervising officer. Thereafter, he must reside as directed by his supervising officer.

5. He shall undertake work, including voluntary work, only when approved by his supervising officer and shall inform that officer of any change in or loss of such employment.

6. He shall not travel outside the United Kingdom without the prior permission of his supervising officer.

7. He shall be well behaved and not do anything which could undermine the purposes of supervision on licence which are to protect the public, by ensuring that their safety would not be placed at risk, and to secure his successful reintegration into the community.

8. He shall abide by the Rules and Regulations of his approved premises including the curfew from11pm to 6am.

9. He shall make himself available for alcohol testing.

10. He shall complete the Better Lives Booster programme.

11. He shall disclose to his supervising officer any emerging intimate relationships.

12. He must sign the Sex Offender Register within 48 hours of his release.

13. He shall not seek to approach (names redacted) or any of their immediate families.

14. He shall not enter the area of (redacted) as defined by the map attached hereto without the prior approval of his supervising officer.

15. He shall not enter the area of (redacted) as defined by the map attached hereto without the prior approval of his supervising officer.

16. He shall not enter the area or (redacted) as defined by the map attached hereto without the prior approval from his supervising officer.

Unless revoked this licence remains in force indefinitely

Licence signed by (name redacted)
On behalf of the Secretary of State
24 April 2013

Information for the Supervising Officer has not been included to protect the identity of the officer.

Maps not included - this would identify the areas where James' victims resided.

Notes

Subject to the provisions of section 31 and 32 of the Crime (Sentences) Act 1997.

(1) the conditions of this licence may be varied or cancelled, or further conditions may be added by the Secretary of State in accordance with the recommendations of the Parole Board.

(2) the Secretary of State may revoke the licence at any time.

For the purpose of this licence "United Kingdom" includes the Channel Islands and the Isle of Man.

APPENDIX C – Letter from Home Office Quality Assurance Panel

North Somerset QA Feedback Letter - June 2025.pdf