SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Victim FEMALE A

June 2014

CONTENTS

1. INTRODUCTION

1.1 On 05.01.2012 Merseyside Police [MSP] officers were called to Address 1 where they found the body of Female A. The call was made by Male A, the estranged husband of Female A, saying he was responsible for her death. A post mortem later established she died from multiple stab wounds.

1.2 Male A was present at the house and arrested on suspicion of causing Female A's death. He was later charged with her murder. On 13.07.2012 Male A was found guilty of murdering Female A and sentenced to life imprisonment with a minimum term of 18 years.

1.3 The sentencing Judge said, "I am satisfied you were abusive throughout the relationship and on occasions used physical violence...The victim personal statements in this case describe movingly how Female A's murder has devastated her family. She was a vulnerable and much loved individual who had much to contribute and whose absence has left the family numb".

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

Decision Making

2.1 On 13.01.2012 Sefton Safer Communities Partnership [SSCP] Domestic Homicide Screening Panel decided the criteria for a Domestic homicide Review [DHR] were met and agreed to postpone the DHR until the completion of the criminal investigation.

DHR Panel

2.2 David Hunter was appointed as the independent chair and author of the DHR on 20.02.2012 and began preparatory work. The DHR Panel met six times.

The Panel comprised of:

Peter CURRIE	Senior Investigating Officer Serious Crime Review Unit Merseyside Police - MSP-
Paul HOLT	Assistant Chief Officer Merseyside Probation Trust (MSPT)
Lesley PATERSON	Chief Executive Sefton Women and Children's Aid (SWACA)
Steph PREWETT	Head of Corporate Commissioning and Neighbourhood Co-ordination Sefton Metropolitan Borough Council
Linda WARD	Deputy Director of Nursing, NHS Halton and St. Helens and Head of Adult Safeguarding NHS Merseyside
David HUNTER	Independent Chair and Author

Agencies Submitting Individual Management Reviews (IMRs)

2.3 The following agencies submitted IMRs.

- Merseyside Police
- Merseyside Probation Trust
- Mersey Care NHS Trust – mental health
- Sefton Primary Care Trust – General Practitioners
- Sefton Metropolitan Borough Council – Vulnerable Persons Advocacy Team
- Local Solutions - Addressing Barriers for Change Project – ABC
- Local Solutions - Independent Domestic Violence Advocacy Service –IDVA
- City Safe Liverpool - Multi Agency Risk Assessment Conference – MARAC

2.4 The following agencies submitted written or verbal information.

- Merseyside Fire and Rescue Service
- Crown Prosecution Service
- Independent Police Complaints Commission
- Merseycare [Mental Health]
- One Vision Housing
- Venus
- Fairfield Housing
- Stonham Services
- The Water Adventure Centre
- Citizens Advice Bureau

Terms of Reference

Purpose of a DHR

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

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

  Source: Paragraph 3.3 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 [The Guidance].

Specific Terms of Reference

2.6

1. How did your agency respond to reports or knowledge of domestic abuse involving Male A and Female A; and did it comply with its policies and/or multi-agency ones?
2. What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?
3. Did the services your agency provided focus sufficiently on reducing the impact of domestic abuse by Male A on Female A and in identifying and dealing with the causative factors?
4. Were your agency's policies, procedures and training, that were relevant to this case, fit for purpose, including those relevant to assessing risk?
5. Were there issues in relation to capacity or resources in your agency or wider partnerships that impacted the ability to provide services to Female A and/or Male A, and to work effectively with other agencies?
6. Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?
7. Did professionals working with the victim have appropriate levels of supervision?
8. Was information sharing and communication with other agencies regarding Female A and Male A and the other subjects of the review, effective and did it enable joint understanding and working between agencies?
9. The DHR Panel will identify which local reviews are relevant to this DHR and take account of any findings or emerging findings in its final report.

The Target date for completing the review will be decided once the criminal trial had concluded.

Subject of Review

2.7 Female A White British 45 + years victim; died on 05.01.2012

People of Specific Interest

Male A White British 50 + years perpetrator

Other People

Female B	White British	Female A's sister
Male B	White British	Male A's brother

Time Period

2.8 The time period under review is from 31.01.2008 to 05.01.2012. Agencies were asked to exercise their professional judgement and include any information relevant to the terms of reference that pre-dates 31.01.2008.

2.9 The target date for completing the review was after the criminal trial and the completion of the Independent Police Complaints Commission.

Notification to Family of DHR

2.10 Selected members of Female A and Male A's families were written to informing them that a DHR was taking place and inviting them to contribute after the trial.

People Contributing to the DHR

2.11 The following people were seen or spoken to by telephone by the independent author during the DHR and their views are reflected in the report.

Female B and her husband by telephone conferencing on 21.09.2012; Male A was interviewed in prison on 26.09.2012. Male A asked that his adult daughter was not seen. Female A's mother and a brother of Male A did not want to take part in the DHR.

3. DEFINITIONS

Domestic Violence

3.1 The Government definition of domestic violence against both men and women (agreed in 2004) is:

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

3.2 An adult is any person aged 18 years and over and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

3.3 The definition and advice on Sefton Safer and Stronger Communities Partnership web site is:

"Domestic violence is a pattern of physically and emotionally violent and coercive behaviours that one person uses over another to exercise power and control. Domestic violence is physical, sexual, psychological, sexual or financial violence that takes place within an intimate, or previously intimate, relationship and forms a pattern of repeated, coercive and controlling behaviour.

... if you are experiencing any kind of violence and abuse it's very important to seek help and you can find services to help you by accessing our directory of services...".

3.4 MSP definition of domestic violence taken from its web site is:

"Domestic abuse is when one person harms another person who may be:

- a current partner
- a previous partner
- a close family member

They do not need to be heterosexual partners or live in the same property. Women, men and children can suffer domestic abuse".

3.5 MSP advice to victims is:

"If you are being abused by someone close to you:

Tell someone you trust what is happening. Have a pre-arranged key word or signal to let them know if you are in danger and need help.

Get help either from the police or one of the support groups below.

Tell your children that if the abuse starts not to get involved, to hide in the house or run and get help from a neighbour.

If you are attacked make as much noise as you can to raise the alarm".

3.6 Female A's death fell within the various descriptions of domestic violence/abuse. The DHR Panel felt that a common definition of domestic violence applicable to agencies would be helpful and noted that in December 2011 the Home Office began a consultation titled, "Cross- Government Definition of Domestic Violence". The consultation closed on 30.03.2012 and the new definition appears below

3.7 The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

Risk Assessment

Introduction

3.8 The terms: Risk of Serious Harm (ROSH); low, medium, high risk and very high risk, are explained below.

ROSH

3.9 Serious harm can be defined as an event which is life threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible. ROSH is the likelihood of this event happening. ROSH is a dynamic concept and should be kept under regular review.

Source:
Section 7.3 Multi Agency Public Protection Arrangements - MAPPA- Guidance 2009

Low, Medium, High and Very High Risk of Serious Harm

3.10 ***Low risk of Serious Harm:***

Current evidence does not indicate likelihood of serious harm.

Medium risk of Serious Harm:

There are identifiable indicators of ROSH. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.

High risk of Serious Harm:

There are identifiable indicators of ROSH. The potential event could happen at any time and the impact would be serious.

Very high of serious harm:

There is an imminent risk of serious harm. The event is more likely than not to happen imminently and the impact would be serious.

Source: Section 7.3 MAPPA Guidance 2009

MARAC Multi-Agency Risk Assessment Conference

3.11 MARAC: Multi-Agency Risk Assessment Conferences are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim

Source: www.caada.org.uk

Vulnerable Persons Referral Form (VPRF 1)

3.12 MSP officers responding to domestic violence incidents use the Merseyside Risk Identification Tool – MeRIT – to establish the level of risk faced by the victim. This information, together with any additional comments by the officer, is used to populate the VPRF 1.

3.13 The officer submits the VPRF 1 to the local Family Crimes Investigation Unit - FCIU- where a trained assessor reviews and categorises the risk, and takes appropriate actions which may include a referral to MARAC.

PROtect Database

3.14 MSP FCIUs use this database to record all incidents of domestic abuse, child protection and vulnerable adult abuse. The VPRF 1 is the input document.

Gold, Silver, Bronze categories

3.15 MSP FCIUs risk assess domestic abuse victims and categorise them as Gold, Silver or Bronze. Gold victims are the highest risk ones.

Vulnerable Victims Advocacy Team [VVAT] Sefton

3.16 This team is part of Adult Social Services and also contains the Independent Domestic Violence Advocates [IDVA]

4. BACKGROUND TO CASE

4.1 The following detail is a combination of information drawn from agency records and interviews with the family.

4.2 Female A's early family life was difficult and she entered public care whilst very young, leaving after 30 months to live with her grandmother. Her siblings remained with their father. Female A reported being bullied at school which she left aged 16 years. She obtained employment in an office and moved into a flat. Her father and grandmother died in 1999. Female A is known to have been in at least one previous abusive long term relationship where her partner misused alcohol.

4.3 Female A disclosed she had a high intake of alcohol in 1999 escalating to three to four bottles of wine a day from about 2006. [190 to 250 units a week against a Government recommended limit of 14 units a week for women]. Female A acknowledged that she concealed from professionals the true amount she drank.

4.4 In September 2007 Female A meet Male B [Male A's brother] at a party and spent the entire evening in his company, later saying it was love at first sight. Male B died in an arson attack in Portsmouth the same night. He was believed to be the innocent victim of a drug dispute. Female A attempted to take her own life as a reaction to Male B's death. Her sister, Female B supported her in the aftermath. [Female A reported three attempts to take her own life]. It is thought that Female A briefly met Male A following the death of his brother.

Note: In June 2010 a person was charged with Male B's manslaughter and arson. These charges were withdrawn at court following the person's conviction on drugs charges for which he received 16 years imprisonment.

4.5 In October 2008 Female A came to the attention of the police in Portsmouth when she was involved in a dispute with a neighbour over his cat who she believed was being neglected. The neighbour claimed Female A got drunk every day to cope with the death of Male B. Female B felt that her sister's continuing struggle with alcohol dependency was not directly linked to Male B's death. The police took no action against Female A.

4.6 In June of the same year the Police in Portsmouth dealt with an allegation that Female A had been assaulted by another woman in a dispute over an unknown man. Female A withdrew her complaint and no action was taken. This was not a domestic violence incident.

4.7 In early 2009, following her conviction for drink/driving; Female A lost her job as a driver. This caused her financial pressures resulting in Female A selling her house and moving in with her sister. Her sister recalls that in the seven months Female A lived there she stopped drinking and remembers that Male A telephoned almost daily.

4.8 Female B recalls her sister as an intelligent and creative woman who was very personable and easily engaged people in conversation. She worked hard [e.g. personal assistant and an event organiser] and always had two jobs to support her financial commitments. Her artistic skills were reflected in her immaculate garden and home. Female B acknowledged that her sister was dependent on alcohol but this

did not stop her functioning. Female B thought her sister's self isolation was a defensive mechanism and accepted Female A made her own choices.

4.9 A psychiatric assessment in 2009 produced an initial primary diagnosis of Alcohol abuse/misuse with low mood and low self esteem. This was revised in early 2010 as, Borderline Personality Traits with "mild personality traits".

4.10 Male A is a native of the North West. His education was limited by his persistent truancy for which he received statutory intervention. He reports suffering significant childhood trauma. He was employed in a wide range of jobs and spent many years working for a property maintenance and development company, undertaking general building work. He has not worked for several years. Male A suffered from depression and anxiety; using alcohol to self medicate. He denies being dependent on alcohol and says how he reduced his drinking from 22 pints a session to just 8; noting this volume would be over several hours. He says he rarely drank in the house. He acknowledges attempting suicide on at least three occasions. There is a history of domestic abuse with a previous partner. He was convicted of criminal damage after he smashed the windows of their home some 10/12 years ago. He minimised these events.

4.11 On 31.01.2008 Male A threatened a man in a Liverpool public house with a knife and what he described as a pellet gun which he had disposed of. On 09.05.2008 he pleaded guilty at Liverpool Crown Court to possessing an imitation firearm with intent. (Section 16 Firearms Act 1968) He received 15 months imprisonment. It appears that Female A kept in touch with Male A during his sentence. He was released on licence on 23.12.2008 which he successfully completed on 06.08.2009. MSPT recorded that Male A was in an on/off relationship but did not record with whom.

4.12 In 2009 Female A re-established contact with Male A and they fell in love. Female A left her home in Portsmouth to be with Male A in Liverpool. They moved into Address 3, on 19.11.2009 a property leased by Male A. Female A reported that domestic abuse - physical and financial - began shortly afterwards. They married in February 2010 and thereafter domestic abuse was ever present in the relationship, only ending when Male A killed Female A. During interview Male A denied strangling Female A, saying that the rows between them resulted in "mutual pushing and shoving". He does not accept the sentencing Judge's comments that he was violent towards Female A. Male A felt they were kindred spirits and given their similar needs, it was them against the world. The evidence established that Male A was violent towards Female A.

5. SIGNIFICANT EVENTS ANALYSIS

5.1 Introduction

5.1.1 The combined chronology contains dozens of entries. The DHR Panel decided to focus on those events it thought significant to the terms of reference. They are listed below and given a shorthand description. Thereafter each significant event is expanded upon in a narrative and where appropriate immediately followed by a critical analysis which draws on the IMRs and the deliberations of Panel members. A synopsis of significant events preceding 31.01.2008 appears first.

5.2 Synopsis

5.2.1 In November 2004 MSP attended Male A's home following a report by his then girlfriend that he intended to self harmed. They forced an entry and discovered that Male A had stabbed himself in the stomach and cut his wrists. The injuries were minor and Male A declined to co-operate or receive medical assistance. The officers took no further action.

5.3 List of Significant Events

Date	Event
31.01.2008	Male A firearm in public house
09.05.2008	Male A received 15 months imprisonment
26.10.2008	Female A cat incident
23.12.2008	Male A released on licence from prison
18.02.2009	Female A convicted of drink/driving
15.06.2009	Female A assaulted by woman in Hampshire
19.11.2009	Female A moved to Liverpool
12.01.2010	1st Domestic Abuse Report
29.01.2010	2nd Domestic Abuse Report
08.02.2010	Female A marries Male A
09.04.2010	3rd Domestic Abuse Report
10.05.2010	4th Domestic Abuse Report
17.05.2010	5th Domestic Abuse Report
28.06.2010	Male A failed to provide blood sample-drink/driving
04.07.2010	6th Domestic Abuse Report
12.07.2010	7th Domestic Abuse Report
13.07.2010	Contact with IDVA ABC
17.07.2010	Breach of bail/Female A retraction - 8th Domestic Abuse Report
20.07.2010	MSPT Pre-Sentence Report
21.07.2010	Male A convicted failing to provide blood drink/driving
23.07.2010	Female A told MSP she wanted to withdraw assault complaint
24.07.2010	Female A told MSP Male A damaged television
27.07.2010	Male A inducted MSPT
02.08.2010	Female A told MSP she wanted to withdraw assault complaint
03.08.2010	Liverpool MARAC
11.08.2010	MSPT OASys Risk Assessment
30.09.2010	Female A and Male A moved to Sefton
18.11.2010	9th Domestic Abuse Report

18.11.2010	Involvement of Support Services
16.12.2010	1st Sefton MARAC
01.02.2011	10th Domestic Abuse Report
01.02.2011	VVAT/ Stonham /VENUS: Assessment/action
03.03.2011	2nd Sefton MARAC
14.03.2011	11th Domestic Abuse Report
04.04.2011	Male A's Avoidance of ASRO
21.04.2011	3rd Sefton MARAC
27.04.2011	VENUS/VVAT/Stonham/MSPT contact 21.04.'11 to 26.09.'11
26.09.2011	12th Domestic Abuse Report
07.12.2011	13th Domestic Abuse Report
22.12.2011	14th Domestic Abuse Report
Dec - 2011	Male A's Breach of Bail Contacts with Female A
Dec - 2011	Contacts with Female A and Male A Dec 2011 to Jan 2012
05.01.2012	CPS Decision not to Prosecute Male A for 07.12.2011 assault
05.01.2012	Events of 05.01.2012 leading up to Female A's Death

5.4 Significant Event: *Male A Firearm in Public House*

5.4.1 On 31.01.2008 Male A used a gun and knife to threaten a man in a public house in Liverpool. He was arrested on 12.02.2008 after "giving himself up". He explained at the time of the incident he was drunk and had taken medication. He was charged and appeared before Liverpool Crown Court on 09.05.2010 where he pleaded guilty to possessing an imitation firearm with intent to cause fear or violence and received a 15 month custodial sentence.

Analysis:

5.4.2 The incident was appropriately dealt with by MSP. There was a 12 day period before Male A was arrested and it is not known if any consideration was given to the risks he might have presented during that time. He said he was drunk. It not known whether the combination of alcohol and medication impacted on his offending. This could be important for future management of his risks. However, as a minimum the incident documents him committing an offence whilst drunk.

5.5 Significant Event: *Female A Cat Incident*

5.5.1 On 26.10.2008 Female A's Hampshire neighbour reported to the police that she kept forcing her way into his house and removing his cat asserting it was a reincarnation of Male B. The neighbour said she threatened him and was drunk every day. She counter claimed, saying he was not taking proper care of his three cats. That matter was referred to the Royal Society for the Protection of Animals [RSPCA] and the police took no further action over the initial complaint.

Analysis:

5.5.2 Some faiths and people believe in reincarnation. The value of this incident is the information about Female A's being drunk every day. If that is accurate it reveals an individual who is probably dependent on alcohol.

5.6 Significant Event: *Male A released on Licence from Prison*

5.6.1 Male A was released on licence on 23.12.2008 and managed by OM 0 [Offender Manager 0]. It was noted in the file that Male A had been abusive to his former wife and that he had committed criminal damage to their home some 17 years previously. Male A had a conviction for assaulting his former wife's father but no further details appear to have been known about this offence.

5.6.2 OM 0 recorded that there could be risks of domestic violence if he formed a relationship. In January 2009, Male A told OM 0 that he had got engaged. OM 0 planned to manage that risk by maintaining contact with MSP, and addressing alcohol and victim issues with Male A.

5.6.3 The licence expired on 06.08.2009 without Male A being convicted of an offence with the eight month supervision period; this is classified as a successful completion.

Analysis:

5.6.4 MSPT IMR records:

"The case record of work carried out during the licence does not evidence work in relation to domestic violence directly but does address issues linked to his offending behaviour in general e.g. addressing his misuse of alcohol. The risk assessment does recognise that Male A could pose a risk in the context of relationships".

5.6.5 The firearms offence for which Male A was convicted was not related to domestic violence. At the termination of his licence Male A was assessed, as posing a medium risk of causing serious harm to the public and probably should have reflected a medium risk of harm to a known adult [Female A]. It appears that OM 0 who recognised the potential danger did not formally build it into the risk assessment.

5.7 Significant Event: *Female A Convicted Drink/Driving*

5.7.1 In February 2009 Female A was convicted at a Sussex Magistrates' Court of drink/ driving and disqualified for two years.

Analysis:

5.7.2 Female A was living in Hampshire at the time and the conviction provided independent evidence that she acted inappropriately whilst drinking. When viewed with her neighbour's earlier comments about her being drunk every day, it perhaps suggests a continuing problem with alcohol consumption.

5.8 Significant Event: *Female Assaulted by woman in Hampshire*

5.8.1 In June 2009 Female A reported to the Hampshire Constabulary that she had been assaulted in her home by a female. It seems an argument developed over a man and Female A was punched in the face resulting in bruised eyes. There are no further details and the identities of the assailant or man are unknown. Female A did not continue with her complaint and no further action was taken.

Analysis:

5.8.2 None needed.

5.9 Significant Event: *Female A moved to Liverpool*

5.9.1 It is believed that Female A moved to Liverpool on 19.11.2009 to live with Male A in leased accommodation.

Analysis:

5.9.2 None needed, other than to note that the move began a pattern of behaviour between Female A and Male A that brought them into regular contact with MSP.

5.10 Significant Event: *1st Domestic Abuse Report*

5.10.1 On 12.01.2010 Male A told MSP that following an argument with Female A the previous day she sent him a text message threatening to kill herself, adding that she had tried to take her life in 2009 whilst living in Hampshire. There is no police record of that event. MSP went to Female A's address and found her safe. She voluntarily accompanied them to a local hospital where she was seen by the mental health crisis team.

5.10.2 MSP later saw Female A and Male A at their home. Neither made any complaint but conceded they had argued. A VPRF 1 was submitted to FCIU and the incident was recorded on PROtect and risk assessed as Bronze. FCIU made a referral to Adult Social Services [IDVA] and a domestic violence letter send to Female A offering help from FCIU. The VPRF 1 could not be found.

Analysis:

5.10.3 This incident was mentioned by Male A when he called MSP on an unrelated matter. The response was appropriate and the officers used good judgement in persuading and accompanying Female A to hospital where they left her with mental health professionals. They did not leave the matter rest but later returned to the house to establish what lay behind Female A's threat to self harm and on discovering the domestic issues completed and submitted the VPRF 1 to FCIU who conclude the incident by making the required entry onto to PROtect, referring it to IDVA and raising a letter.

5.10.4 The VPRF 1 cannot be found and in its absence there is no rationale for Female A being designated the victim and receiving the "bronze" letter. However, the incident was dealt with professionally, appropriately in line with MSP procedures.

5.11 Significant Event: *2nd Domestic Abuse Report*

5.11.1 On 29.01.2010 Male A reported to MSP that Female A had assaulted him. On arrival he told officers that during an argument Female A pushed him downstairs. He did not want to make a complaint and declined to have his injuries photographed. Ambulance staff attended took Male A to hospital with a suspected fracture to his collar bone.

5.11.2 Female A was arrested and denied assaulting Male A counterclaiming that he had assaulted her. Female A said the couple had been out together and each drank about eight pints of lager. An argument ensued which continued when they arrived home. Female A said Male A grabbed her by the throat and hair and punched her. Male A

went upstairs but had evidently fallen down them as she heard a loud thud. Female A declined to make a statement of complaint.

5.11.3 Male A was arrested and admitted he had fallen downstairs and could not recall saying he had been pushed. He confirmed the volume of alcohol they had consumed and recalled the argument saying that Female A attacked him and he may have punched her.

5.11.4 The Crown Prosecution Service [CPS] was consulted and judged the case did not met the threshold test [Section 5 Code for Crown Prosecutors February 2010] and without independent evidence or co-operation from either party they were released without charge.

5.11.5 A VPRF 1 was completed for Male A and an entry made on PROtect 25 days later and risk assessed as "bronze" adding that a letter had been sent to Male A and the matter should be referred to Adult Social Services. A VPRF was not submitted for Female A. MSP IMR also notes:

"In addition, and whilst the outcome may have been obvious to them, it is unclear if, or when, both parties were informed as to the outcome of the investigation into their individual allegations.

The 'Code of Practice for Victims of Crime', issued by the Home Secretary, states that if a suspect is released with no further action being taken, the police must notify the victim of this event and the relevant reasons within one working day for vulnerable or intimidated victims and no later than five working days for all other victims.

In addition, in accordance with Merseyside Police 'Domestic Abuse (Policy and Procedure)', before a suspect is released from custody the police should ensure that the victim is informed of the impending release and should record such notification on the custody record".

Analysis:

5.11.6 MSP took positive action by arresting Female A and Male A, and appropriately consulted CPS when the contradictory picture of events unfolded. There is no evidence to say that once CPS decided the threshold test was not met and the couple were released, that any subsequent investigations into the allegations were made, albeit the scope for doing so was limited. However, enquiries could have been made with hospitals and neighbours.

5.11.7 IDVA does not have a record of a referral from MSP in respect of Male A or Female A relating to this incident and therefore it seems likely that one was not made. This oversight is consistent with the other procedural oversights for this incident: no VPRF 1 for Female A and not complying with the Code of Practice for Victims of Crime and MSP Domestic Abuse Policy. The reason for the oversights are not known and given that there are many examples in this DHR of VPRF 1's being submitted, the Panel concluded it was an oversight by the officer concerned rather than a systemic problem. The issue of officers not complying with the Victim's Code is repeated in several of MSP contacts in this case and may require more awareness training to address.

5.12 Significant Event:

5.12.1 On 08.02.2010 Female A and Male A married.

Analysis:

5.12.2 None required beyond the observation that the marriage took place after domestic abuse and alcohol consumption were present in the relationship.

5.13 Significant Event: *3rd Domestic Abuse Report*

5.13.1 On 09.04.2010 Male A reported to MSP that his estranged partner, Female A, [by this time she was his wife] was attempting to enter his house by kicking the front door. The attending officers found her inside the house, in drink. Male A wanted her to leave as it was his property. Female A began to argue and was arrested for breach of the police when she ignored the officer's request to stop. She was released the next morning without charge and it appears that Male A was not told. A VPRF 1 was completed and an entry made on PROtect. The resulting risk assessment showed Male A to be a "bronze" victim and he was sent a letter of advice. There was no referral to IDVA.

Analysis:

5.13.2 The incident was appropriately dealt with albeit a referral was not made to IDVA. This is the third report of domestic abuse between the couple in three months and the DHR Panel felt that FCIU could have been thinking about a problem solving approach to the emerging issues.

5.14 Significant Event: *4th Domestic Abuse Report*

5.14.1 On 10.05.2010 a member of the public reported that a man was kicking down the front door of a house. This turned out to be Male A, who in a drunken state, was trying to enter his property having been locked out by Female A. The attending officers found Female A "cowering in bed" saying her husband had returned home drunk and she was fearful of him.

5.14.2 Male A was asked to leave and when he refused was arrested to prevent a breach of the peace. He said he only kicked the door in because his wife had threatened to commit suicide. Female A denied this.

5.14.3 Male A was charged with breach of the peace and kept in custody and appeared before the court the following morning where he was bound over to in the sum of £100 to keep the peace for twelve months and released. During his time in custody he became violent and issued threats against his wife and punched the cell walls causing his fists to bleed.

5.14.4 A VPRF 1 was submitted to FCIU and recorded on PROtect. The incident was risk assessed as medium [Silver] and Female A sent a letter of advice. MSP does not have a record of referring the incident to IDVA, nor does IDVA have a record of receiving one.

Analysis:

5.14.5 MSP took firm action in support of Female A, although a referral to VVAT was not made. There is no explanation for this oversight. The DHR Panel felt that as this was the 4th incident in as many months, a firm plan should have been made by MSP to deal with the problems between the couple. MSP should have used professional judgement and referred the case to MARAC.

5.15 Significant Event: *5th Domestic Abuse Report*

5.15.1 On 17.05.2010 a distressed Female A called at a neighbour's home saying that Male A had grabbed her face and thrown her dog across the room. The attending officers noted that Female A and Male A were drunk. Female A did not make any complaints. MSP arranged for Female A to spend the night in a women's hostel and cared for the dog in police kennels.

5.15.2 A VPRF 1 was completed and a PROtect entry made. The incident was risk assessed as "silver" but not referred to IDVA. It is not known whether an advice letter was sent to Female A.

Analysis:

5.15.3 It is not known why MSP did not arrest Male A for assault or beach of the peace. Female A "played down" the incident but nevertheless the DHR Panel thought MSP could have arrested Male A despite the lack of a complaint from Female A. MSP had previously arrested Female A [29.01.2010 and 09.04.2010] by exercising their discretion in broadly similar circumstances.

5.15.4 The response officers took action in finding her hostel accommodation and caring for her dog. Whilst that action appears supportive the DHR Panel felt a better option was to have removed Male A from the home by arrest or persuasion. Despite risk assessing Female A as "silver" FCIU did not make a referral to IDVA, or adopt a wider review of the issues between the couple. Male A's exhibited two high risk traits; threats to a pet and on one previous occasion [29.01.2010] restricting Female A's airway. It is apparent that the significance of his cumulative behaviour was not recognised when the risk assessments were completed. The case should have been referred to MARAC.

5.16 Significant Event: *Male A Fails to provide blood for Analysis Drink/Driving*

5.16.1 Male A was arrested on 28.06.2010 having given a positive breath test for drink/driving. He later failed to provide a specimen for analysis and the following day appeared before the Magistrates' Court, entered a guilty plea and the case was adjourned for sentencing until 21.07.2010.

Analysis:

5.16.2 None needed except to observe that Male A made an inappropriate choice whilst under the influence of alcohol.

5.17 Significant Event: *6th Domestic Abuse Report*

5.17.1 On 04.07.2010 Female A was assaulted by Male A and prompted her neighbour to report it to MSP. The response officers found Female A crying in the street, saying Male A had tried to strangle her; bruising was apparent. Male A was arrested for assault. Female A declined to go to hospital but allowed her injuries to be photographed and made a written statement of complaint.

5.17.2 Female A said they had been out drinking and she had consumed six pints of lager and some wine. On arriving home they argued and Male A tried to strangle her and threatened to kill her. He then threw Female A's crying dog across the room. She recorded in her statement:

"I genuinely believed he would kill me and I think it is only a matter of time before he does kill me".

5.17.3 Female A was firm in her desire to press charges notwithstanding that Male A had told her she would end up in a land fill if she ever did. She gave MSP a letter written some eight weeks earlier in which he apologised for his behaviour, admitted hitting her and telling lies to get her arrested [29.01.2010 and 09.04.2010]. He specifically mentioned that he had lied about falling downstairs in order to have Female A arrested. A few days after disclosing Male A's letter, Female A made an additional statement to MSP saying she was "absolutely petrified" of Male A and never wanted him back because of his unpredictability. Female A also said she was suffering anxiety, scared of being alone and taking anti-depressants.

5.17.4 The officer in the case liaised with CPS and agreed that additional enquiries were needed. Male A was given conditional police bail which prohibited him from approaching or contacting Female A and to reside at a different address to Female A. MSP did not tell Female A that Male A had been released on bail until three days later. A VPRF 1 was submitted and a PROtect entry created.

5.17.5 On 07.07.2010 Female A told MSP she wished to withdraw her complaint. She made a written statement in which she denied speaking to Male A, saying she wanted her marriage to work and she was prepared for them to seek counselling for their alcohol problems. On 09.07.2010 the CPS re-examined the case and given Female A's withdrawal decided not to prosecute. Female A was informed and Male A's bail was cancelled. PROtect was updated and the risk assessment determined that Female A was a Gold (high risk) victim. A referral was made to IDVA and a domestic abuse advice letter sent to Female A. A location of interest [LOI] marker for Female A's address was created on STORM [MSP Command and Control database] identifying the occupant as a gold victim thereby ensuring a prompt response and positive action. PROtect records that a referral to MARAC was needed but does not say when it was made. It is known from Citysafe [Liverpool's Community Safety Partnership] that MSP made the referral to MARAC on 12.07.2010. PROtect also notes that no further action was taken and the incident was described as a "malicious allegation".

Analysis:

5.17.6 Operationally MSP dealt with this incident positively. Male A was arrested which supported the victim and complied with Force policy. The depth of Female A's fears was recorded in her written statement and further evidence was sought following liaison with CPS. Male A's conditional bail, including the requirement to live elsewhere provided a protective factor from the high risk he presented to Female A, as did the LOI marker. When Female A told MSP she wished to withdraw the complaint the officer suspected she had been influenced by Male A in breach of his bail conditions. However, Female A denied this saying she was motivated to save her marriage and engage in alcohol counselling with her husband. It would have been prudent for MSP to seek Male A's view on this point [which might have revealed contact between them] and to have referred them to appropriate services.

5.17.7 The letter was part of the case paper presented to CPS but the officer did not highlight its significance or seek advice on it and it seems CPS did not pick it up. Therefore MSP appears to have ignored the "false allegations" admission contained in Male A's letter and ironically, inaccurately recorded on PROtect that the current case was a "malicious allegation". The DHR Panel felt both of these mistakes were significant. The former was a missed opportunity to hold Male A to account for a criminal offence and correct erroneous and misleading information, whilst the latter exposes a lack of understanding on what constitutes a false allegation and in its own right is equally misleading and potentially damaging to the future credibility of Female A as a victim and witness.

5.18 Significant Event: *7th Domestic Abuse Report*

5.18.1 Om 12.07.2010 Female A reported to MSP that Male A had strangled her again. The LOI marker identified the address as requiring an emergency response. Female A was found in the crying in street with reddening to her neck. She was too drunk to provide a written statement but verbally complained that her husband had assaulted her.

5.18.2 The response officers spoke with Male A who said he had been drinking and arguing with his wife. It was noted he had a minor self inflicted wound on his arm. Male A was violent when arrested and verbally abused Female A telling her to go away as he was not prepared to talk with any women, ending, "I'll just get bail again and see what happens". A VPRF 1 was submitted to FCIU, a PROtect record opened and the case was assessed as Gold.

5.18.3 Female A made a written statement the following day [13.07.2010] saying the couple had been out drinking and arguing. The argument continued at home and Male A grabbed her by the throat. Later that day Female A made another statement saying she was scared of being assaulted again by her husband and did not want him to return home as he would bully her, physically and verbally, particularly if he had been drinking. Female A added that he had previously destroyed a television.

5.18.4 Male A denied strangling his wife but conceded that during an argument over money he pushed her away. He was charged with Common Assault. Male A was kept in custody [Female A was told] and appeared at court on 14.07.2010 where he was granted bail with residency, curfew and contact conditions. It is not clear if Female A was told of his release.

5.18.5 At 2010 hours on 13.07.2010 MSP attended Female A's house after a neighbour told them that Female A had consumes two bottles of wine and taken an overdose of tablets. They forced an entry and found pills scattered around along with two empty wine bottles. There was no evidence that Female A had taken any pills and her demeanour was attributed to alcohol consumption. She said she had written a suicide note. Female A was taken by ambulance to hospital. A response to an LOI marked address requires the submission of a VPRF 1. In this case one was not submitted and therefore the incident not recorded on PROtect.

Note:

MSP does not count the number of VPRF 1's submitted. It does count the number of STORM Logs closed with a domestic incident code. Each STORM log with a domestic incident code should result in a VPRF 1 being submitted and a PROtect record created. It is known from another DHR that Sefton basic command unit [BCU] has very high rates of compliance for submitting VPRF 1's.

Analysis:

5.18.6 MSP responded promptly and efficiently and took positive action which supported the victim, including arresting Male A photographing her injuries. Female A was sign posted to Victim Support by MSP and stated her willingness to engage with them. Victim Support reports that its involvement was not relevant to the terms of reference. Female A was resolved to support the prosecution notwithstanding her previous retractions. The incident was later referred to MARAC by MSP. Female A again said how frightened she was of Male A and did not want him back. The episode with the pills and wine reinforces the turmoil she was in. The fact that MSP thought she had not taken any pills should not have obscured what was likely to have been the actions of a frightened and vulnerable woman.

5.18.7 The DHR Panel felt that MSP should have shown more urgency and organised an immediate multi-agency meeting to support Female A. She was reaching out for help and describing an almost intolerable position.

5.19 Significant Event: *Contact with IDVA ABC*

5.19.1 On 09.07.2010 IDVA received a referral from MSP for the 04.07.2010 assault [6th domestic abuse report] and first spoke with Female A on 12.07.2012. This was during the day and before she was strangled late that evening. On 13.07.2010 Female A called IDVA and reported there had been a further incident the previous evening [7th domestic abuse report].

5.19.2 Female A reported feeling isolated as all her family were in Hampshire and therefore not readily available to support her. She was also worried about losing housing benefit because she had a joint tenancy with Male A. She felt financially controlled by her husband. She reported low mood and disclosed an attempt to take her life a year ago but said was under the care of a psychiatrist.

5.19.3 IDVA offered Female A refuge accommodation but she would not leave her dog as she felt it was the only thing left to her. An urgent appointment with a psychiatrist was made for 15.07.2010 and a referral made to Addressing Barriers for Change

[ABC]. IDVA checked with MSP that a LOI marker was active for her address and offered to assist with priority housing status.

5.19.4 On 15.07.2010 IDVA told Female A that Male A had been bailed and agreed to provide a letter to support her priority housing application. Female A told IDVA that she wanted to retract her statement against Male A and was advised against it. The following day [16.07.2010] IDVA and ABC made a joint visit to Female A to discuss the support available. Female A again said she wanted to retract her statement of complaint. On 20.07.2010 Female A told IDVA that she missed her husband and was not sure she wanted to end the relationship. On 02.08.2010 Female A told IDVA that she had seen her husband and that the police were aware. IDVA strongly advised Female A of the additional risks this posed.

Analysis:

5.19.5 IDVA response was positive and supportive of Female A and was aimed at making her feel safe and in control. There appeared to be an obstacle to Female A entering refuge because she could not take her dog; the DHR Panel judged that in the circumstances it was not reasonable for Female A to take her dog to a refuge. Pet minding services including fostering are available in the area. The DHR Panel wondered if Female A had been offered any option other than refuge and queried whether professionals think about issues from the victims perspective often enough. Female A's position in wanting to retract her complaint against Male A followed a familiar pattern of reaching out for help when in crisis and later changing her mind.

5.19.6 The DHR Panel felt that several of the following reasons why a woman may not be ready to leave were relevant to Female A. Source: www.womensaid.org.uk

- She may still **care for her partner** and hope that they will change (many women don't necessarily want to leave the relationship; they just want the violence to stop).
- She may **feel ashamed** about what has happened or believe that it is her fault.
- She may be **scared of the future** (where she will go, what she will do for money, whether she will have to hide forever and what will happen to the children).
- She may **worry about money**, and supporting herself and her children.
- She may feel **too exhausted** or unsure to make any decisions.
- She may be **isolated from family** or friends or be prevented from leaving the home or reaching out for help.
- She may not know **where to go**.
- She may have **low self-esteem** as a result of the abuse.
- She may believe that it is better to stay for the **sake of the children** (eg wanting a father for her children and/or wishing to prevent the stigma associated with being a single parent).

5.19.7 Neither IDVA or ABC mention the referral to MARAC and how that fitted into the package of support needed by Female A. The DHR Panel thought IDVA and/or ABC should have considered organising a more immediate multi-agency conference to deal with the difficulties facing Female A, rather than wait for MARAC.

5.20 Significant Event: *8th Domestic Abuse Report - Breach of bail/Female A retraction*

5.20.1 MSP investigation log for the 12.07.2010 assault [7th domestic abuse report] records on 17.07.2010 that Female A wanted to retract her complaint, although it is not clear when she said it. The investigating officer thought that Male A had breached his bail and intended to contact FCIU. A supervisor noted on the log that Male A was to be arrested if he breached his bail. On 23.07.2010 Female A again contacted MSP to say she wanted to retract her complaint and had been in contact with Male A. There was a one off contact authorised by the court so Male A, accompanied by a police officer, could retrieve some belongings from the house.

5.20.2 On 24.07.2010 Female A reported to MSP that Male A had been to her house and damaged the television. After several failed attempts to see Female A, including an appointment broken by them, MSP eventually saw her on 29.07.2010. She reported making up the story about Male A damaging the television and that she wanted him back. Female A admitted that Male A had been to the house but only after she called him and threatened suicide if he did visit. A VPRF 1 was sent to FCIU. Whilst an initial entry was made on PROtect there is no evidence that a risk assessment was undertaken or that an investigation into the breaches of bail was mounted.

5.20.3 Female A contacted MSP on 02.08.2010 and repeated her wish to retract her complaint. Despite the officer's suspicion that she had been intimidated and drawing the matter to the attention of a supervisor there is no evidence that anything was done about either issue.

Analysis:

5.20.4 The DHR Panel thought it very likely that Male A was exerting pressure on Female A to withdraw her complaint and successfully undermined her resolve to continue with the prosecution. Male A was certainly acting without fear of repercussions. Female A's feelings were mixed as evidenced by her remarks that she wanted him back and her threat to commit suicide if he did not visit the house.

5.20.5 The response by MSP to Female A's desire to withdraw and the alleged breaches of bail by Male A was poor. Whilst it is true MSP encouraged Female A to continue the prosecution they did nothing practical to support her. An investigation into the alleged breaches of bail was the starting point for that support but for an unknown reason [probably poor practice] that never happened even though supervisory officers were involved. A referral to IDVA saying Female A wanted to retract might also have helped her. The lack of action was a failure to support a victim of domestic abuse and a missed opportunity to adopt a problem solving approach, notwithstanding the case had been referred to MARAC. Female A made a written statement of retraction on 16.08.2010 saying the both wanted to give their relationship "another go".

5.21 Significant Event: *MSPT Pre-sentence Report [PSR]*

5.21.1 On 20.07.2010 MSPT completed a PSR in respect of Male A's offence of failing to provide a specimen of breath for a breath test [28.06.2010]. The PSR mentioned historic domestic abuse and that Male A was on bail for assaulting Female A. He was assessed as posing a medium risk of causing serious harm to a known adult [Female A] and the public. MSPT's IMR author notes that by the time the PSR was finalised the assault case against Male A had been dropped; adding that the risk management plan was a little limited in that it did not include looking at victim empathy, relationships or domestic abuse. It did however identify alcohol and emotional wellbeing as linked to harm and reoffending.

Analysis:

5.21.2 An analysis is unnecessary.

5.22 Significant Event: *Male A convicted failing to provide blood-drink/driving offence*

5.22.1 On 21.07.2010 Male A pleaded guilty to a drink/driving offence and was sentenced to:

- Disqualified from driving for 60 months
- 16 weeks imprisonment
- A Suspended Sentence Order for 24 months with requirements to:
  - Attend an Addressing Substance Related Offending Programme [ASRO]
  - be supervised by a probation officer

Analysis:

5.22.2 None needed other that the sentencing was consistent with the PSR conclusions and he attended MSPT for induction on 27.07.2010.

5.23 Significant Event: *Liverpool MARAC*

5.23.1 The MARAC of 03.08.2010 was originally called for following the 6th domestic abuse report [04.07.2010] but also heard of the 7th domestic abuse report [12.07.2012]. The meeting learned that:

- Female A had withdrawn her statement
- Male A had breached his bail conditions
- Female A was engaged with ABC
- Female A had disclosed mental health needs, including taking an overdose
- Female A was known to Mersey Care *

*****Mersey Care NHS Trust provides specialist mental health, learning disability and substance misuse services in Merseyside.

5.23.2 The only actions from the meeting were recorded as Mersey Care and FCIU to provide updates at the next MARAC meeting.

Analysis:

5.23.3 The MARAC IMR author is critical of the lack of actions arising from the MARAC and in the absence of any evidence the DHR Panel felt that the MARAC meeting was significantly deficient in its handling of Female A's case. By the time of the MARAC, MSP has recorded eight incidents of domestic abuse over six months [12.01.2010 to 12.07.2010]; and other agencies held information which would have exposed the depth of domestic abuse within the relationship and in turn Female A's considerable difficulties in coping with it. MARAC failed to produce even a basic action plan to support Female A. This lack of action compounded the previous missed opportunities when MSP and IDVA/ABC waited for the MARAC date when they should have arranged an urgent multi-agency response.

5.23.4 Outside of MARAC, ABC saw Female A and completed a support plan for her. This included registering her with Property Pool and sharing information with MSP and Mersey Care. Female A was referred to a counsellor for help with her depression and anxiety. This service was not provided because Female A transferred to Sefton's area where ABC is not funded to provide counselling. ABC filled a gap left by MARAC. The DHR Panel felt that geographical boundaries should not necessarily prevent services from being delivered to victims, particularly where the service providers are in neighbouring areas. In this case Female a moved from Liverpool to Sefton. The latter could have commissioned ABC to provide continuing help for Female A as she appeared to have valued their support.

5.24 Significant Event: *MSPT OASys Risk Assessment*

5.24.1 MSPT completed an Initial Sentence Plan [ISP] OASys on 11.08.2010 and judged Male A to present a medium risk to a known adult [female A] and the public. MSPT IMR comments: "Medium risk means there are identifiable indicators of the risk of harm; that the offender had the potential to cause serious harm but was unlikely to do so unless there was a change in circumstances. Risk was thought to be greatest when the offender was failing to cope with emotional problems and whilst under the influence of alcohol". MSPT established a risk management plan [RMP] which the IMR author critiqued saying," There was a deficiency in the plan ... in that she [the Offender Manager] identified his wife [Female A] as a support in relation to his mental health needs, but she was also identified as the person to whom he presented most risk".

5.24.2 Having reviewed the OASys the MSPT IMR author believed that Male A posed a high risk of causing serious harm to Female A given the three domestic violence incidents in a month.

Analysis:

5.24.3 The MSPT IMR openly acknowledges the inappropriate risk assessment and adds that a further opportunity to review it was missed on 08.09.2010 when the case against Male A was withdrawn and he returned to live with Female A. However, this oversight was partly neutralised when MSPT undertook a home visit and did not identify any immediate concerns. As will be seen later Male A was a difficult person

to manage. Nevertheless, the risk was understated and the risk management plan was not reviewed.

5.25 Significant Event: *Female A and Male A move from Liverpool to Sefton*

5.25.1 On 30.09.2010 MSP recorded that Female A and Male A moved from Liverpool 4 to Liverpool 21 meaning their local authority changed from Liverpool to Sefton and their MSP BCU changed from Liverpool North to Sefton. This should have resulted in the LOI marker being transferred to the new address.

Analysis:

5.25.2 There is no evidence of liaison between the two FCIUs and it is known that the LOI marker was not transferred at the time. Whilst all MSP FCIUs share the PROtect database it would have been prudent for Liverpool North FCIU to identify to Sefton FCIU that a very vulnerable "gold" victim was now living in their area. Sefton could then make sure the same level of support she was receiving at the Liverpool address was available to her at the Sefton one. There is no system that automatically transfers LOI markers. It requires liaison between the agency who knows of the new address and MSP.

5.26 Significant Event: *9th Domestic Abuse Report*

5.26.1 At 2017 hours on 18.11.2010 Female A reported to MSP that she had been assaulted by Male A at their home in Sefton. MSP provided a non-emergency but priority response to the call. It transpired that the LOI had not been transferred from her previous address to the current one and after interrogation of MSP systems; the call taker identified Female A as a Gold Victim. Female A said he had punched her about the head, threatened to smash up the house and kill her dog. Female A said she had consumed about five pints of lager but was coherent and wanted to make a complaint saying, "I've had enough this time". She made a written statement the next day.

5.26.2 Male A was arrested on 18.11.2010 and when interviewed the next day said they had been out drinking and each consumed about eight to twelve pints of lager. They argued and this continued during the journey home. He arrived first and when Female A came in they did not speak. She took the dog for a walk; he went to bed and was awoken by the officers and arrested. He denied assaulting Female A.

5.26.3 The officer in the case thought Male A should be charged with common assault and put forward what is described as a strong case, including the details of some previous incidents between the couple. The CPS decided they was insufficient evidence to provide a realistic prospect of a conviction and advised no further action. The CPS lawyer cited the following in arriving at the advice: no independent witnesses, no visible injury, Male A's denials and the amount of alcohol consumed.

5.26.4 MSP issued Male A with a "warning" under the Protection from Harassment Act 1997. This meant that if he continued a course of conduct likely to cause Female A harassment, alarm or distress he was liable to arrest and charge under the Act. He signed the custody recorded acknowledging the warning. Female A expressed her dissatisfaction when told Male A was not being charged and said she did not want her husband back.

5.26.5 A VPRF 1 was submitted on 18.11.2010 and an initial [skeleton] PROtect recorded created on 19.11.2010. The case was referred to the Sefton Vulnerable Victims Advocacy Team [VVAT] on 21.11.2010. The associated risk assessment was not completed until 01.12.2010 and deemed Female A was a "High Risk - Gold Victim" and again referred to VVAT the same day.

Analysis:

5.26.6 The call should have received an emergency response in line with the policy on Gold Victims but because the LOI marker had not been transferred to Female A's new address, it was not. Nevertheless the response was swift and positive action taken as evidenced by Male A's arrest. The CPS judged that Male A should not be charged on the evidence it was presented with. The DHR Panel felt that additional evidence should have been sought by MSP. For example any injury to Female A's head may have been hidden by her hair and therefore not immediately obvious. A medical examination may have revealed something even if it was only tenderness. Enquiries could have been made of neighbours to determine if they saw or heard anything. It is not known whether these lines were pursued but should have been, particularly as the officer in the case felt strongly that Male A should be held accountable for the allegations.

5.26.7 The DHR Panel thought the issuing of a Harassment Warning was an example of lateral thinking and good practice. It supported Female A and provided an element of control over Male A.

5.26.8 This was the ninth report of domestic abuse within eleven months and required more that the apparent piecemeal approach. Several Agencies knew of the history or parts of it and one of them should have recognised a deteriorating situation and insisted on an immediate co-ordinated approach to protecting Female A and solving the problem. MSP were in the prime position to do this. MSPT and the CPS could also have prompted action, albeit CPS say this is not part of their function. The established pathway for a problem solving approach is MARAC and it is known from the ABC risk assessment completed on 19.11.2010 that Male A scored 176 with 60 being the threshold for high risk. The case was referred to MARAC by as it is the role of the MARAC to respond to such complex cases and went to Sefton MARAC on 16.12.2010. However MARAC is a formula driven process operating in slow time. The situation between Female A and Male A was difficult and their needs complex, warranting immediate consideration and a clear action plan. This appears not to have been recognised by any agency.

5.27 Significant Event: *Involvement of Support Services*

5.27.1 Following the three domestic abuse incidents in July 2010 [6th, 7th and 8th domestic abuse reports] Female A received support from ABC after a referral from IDVA who closed their case in about September 2010. Following the 9th domestic abuse report [18.11.2010] Female A contacted ABC who on discovering she had moved to Sefton liaised with VVAT [VVAT], shared information and provided some joint support until the case could be transferred to them. ABC arranged for an LOI marker and target hardening on the Sefton address. These are important and necessary measures; a pre-requisite to dealing with the couple's complex underlying issues of alcohol misuse, mental health problems, unemployment and the future of the marriage.

5.27.2 An example of the liaison between ABC and VVAT came when on 22.11.2010; ABC contacted Female A to tell her about the handover arrangements. Female A wanted an injunction against Male A and the ABC worker passed this information to VVAT. On 23.11.2010 VVAT spoke to Female A on the telephone and she agreed to an assessment. Thereafter, it took until 02.02.2011 and another domestic abuse incident before VVAT spoke to Female A.

5.27.3 The handover encountered some problems when ABC found it difficult to contact VVAT. On 01.12.2010 ABC asked Female A if VVAT had been in contact and was told they had not. VVAT telephoned Female A on 01.12.2010 but the call was rejected and a letter could not be sent as the couple were living together. By 10.12.2010 ABC had still not managed to contact VVAT to complete the handover. The formal handover was achieved on 20.12.2010 and ABC closed its file. By then VVAT had only spoken to Female A once to arrange an assessment. However, it is not clear if that assessment was ever undertaken or if the request for an injunction made by Female A to ABC and passed by them to VVAT was ever actioned. It is known that Female A turned to ABC for help after Male A assaulted her on 01.02.2011.

Analysis:

5.27.4 It is not known why it took so long to arrange the handover from ABC to VVAT. It appears VVAT was difficult to contact in terms of receiving and responding to messages. However, the DHR Panel learned from a senior manager that at this time VVAT was not functioning too well and was poorly led. Female A consistently turned to ABC for support even after it closed her case, suggesting her confidence lay with them. VVAT had not started an assessment of Female A by the time of the 16.12.2010 MARAC.

5.27.5 The DHR Panel thought the move to a new address may not have been in the best long term interests of Female A. She was socially isolated and far from any type of family/friends support. It might have been more effective to provide her with additional support where she lived.

5.28 Significant Event: 1st *Sefton MARAC 16.12.2010*

5.28.1 MSP made a referral to Sefton MARAC following the 18.11.2010 assault [9th Domestic abuse report]. The DHR Panel has seen a summary of the case as presented to Sefton MARAC and whilst it contains some of the background it is not expansive or wholly accurate. For example it records that Male A served a prison sentence in 2008 for a non-domestic malicious wounding. The 2008 offence as specified in MSP and MSPT IMRs was: "possessing an imitation firearm with intent".

5.28.2 The actions arising from the meeting were VVAT:

- to contact Liverpool IDVA)
) to see if victim was engaged with their service
- to contact Victim Support)

Analysis:

5.28.3 It is not possible from the minutes to determine what actions were taken to protect Female A. The two actions recorded did not offer any protection. The DHR Panel felt that the risks should have been specified and the actions to minimise the risks, listed with owners. The DHR Panel was told that the lack of actions, limited records and referrals to agencies not ideally suited or commissioned to provide domestic abuse services, were a manifestation of the poor leadership mentioned above. This has been addressed and MSP now chair MARAC. A wider review of domestic abuse services in Sefton, including VVAT/MARAC arrangements has been established. See paragraph 6.10.2

5.29 Significant Event: *10th domestic Abuse Report*

5.29.1 At 2030 hours on 01.02.2011 Female A reported to MSP that Male A had punched in the face, threatened to kill her dog, smash the contents of the house and set fire to it. Male A had taken her mobile telephone and she was calling from a neighbour's house. The MSP call taker noted the LOI marker, the Gold response requirement and the harassment warning. The attending officers found Female A "clearly drunk" but steadfast in her complaint of assault. She had no visible injuries but complained of soreness to her head.

5.29.2 The officers saw Male A in the marital home and noted he had been drinking. He recounted an argument with Female A over clipping the dog's toenails and leaving them in the house. He was arrested.

5.29.3 Female A made a written statement the following day saying they had been out drinking and began arguing when they arrived home. She specified her domestic abuse victimisation and how she always felt sorry for him, leading to reconciliations. Female A was adamant that enough was enough saying:

- she did not want him back
- she was the named tenant
- he always got away with it because she had no visible injuries
- she had lost faith in the criminal justice system
- she did not wish to attend court

5.29.4 Male A declined to answer questions when interviewed and was released without charge or consultation with the CPS. The protection from harassment warning was not explored. A VPRF 1 was completed and a PROtect record created the next day. Female A was assessed as High Risk and FCIU made a referral to VVAT who contacted Female A on 02.02.2010 and arranged an assessment appointment for 07.02.2010. Female A had also telephoned ABC.

Analysis:

5.29.5 The initial operational response was good resulting in the arrest of Male A; a supportive action for the victim. Thereafter not much positive action happened. Female A could have been examined by a doctor to establish what her injuries were and enquiries made of neighbours [the neighbour to whom Female A fled to would provide evidence of early complaint].

5.29.6 No one in MSP seems to have considered the potential Protection from Harassment Act offences [which may have encompassed Male A's action in taking Female A's mobile telephone] or thought to seek advice from the CPS. Both of these actions were fairly obvious and the fact that the officers did not pursue them reflects badly on their professional judgements and that of the supervisor who had oversight of the incident. The threat to burn the house down appears to have gone unnoticed and certainly unactioned. This treat could amount to an offence under the Criminal Damage Act 1971 and present a danger to adjoining properties.

5.29.7 The DHR Panel was empathetic towards Female A's position. She was exposed to significant danger from Male A and was confused about how to deal with it and no one seemed to offer her any real hope. She was let down badly by those who should have protected her.

5.30 Significant Event: *VVAT/ Stonham /VENUS: Assessment/action*

5.30.1 VVAT completed a needs assessment on Female A and produced an Individual Support Plan [ISP]. The assessment identified the following issues.

- involved with mental health services
- victim of violence including strangulation/choking, bruises on face, soreness without bruising, loss of hair and black eye
- experienced stalking/harassment
- has no access to money
- depression, anxiety suicidal thoughts
- isolated from family and friends
- alcohol misuse in 2009, not drunk since
- wants to end relationship
- victim of emotional psychological and financial abuse
- Male A binge drinks and has mental health needs
- Male A believed violent in previous relationship

5.30.2 The ISP included:

- LOI marker
- new locks fitted to house
- fire safety check
- Female A to report all incidents to MSP
- housing application support - waiting for bidding number One Vision Housing
- refer to VENUS* for floating support [benefits advice, additional support for mental health issues and counselling for abuse and childhood issues]
- referral to Sefton MARAC
- referral to Citizens Advice Bureau for debt counselling [£5,000]
- referred for "Sanctuary" scheme in current property

- unsafe areas identified
- referral to Stonham

* Venus is an organisation providing support for women, young women, families and children.

Analysis:

5.30.3 The VVAT assessment noted, "Female A stated problem with alcohol misuse in 2009 drinking daily, stayed with sister – not drunk since". The DHR Panel was unsure whether "not drunk since" referred to abstinence or tolerance. In either event it was misleading given that Female A acknowledged on many occasions that "they had been out drinking" and MSP noted she was drunk on more than one occasion. It is also known that Male A misused alcohol.

5.30.4 The ISP did not have an action to address Female A's drinking or for that matter Male A's, and given that many of the domestic abuse reports followed episodes of drinking, this meant that an important area of vulnerability was unaddressed. Nevertheless, substantial support was put in place for Female A aimed at tackling her side of a complex problem.

5.30.5 Male A was being supervised by MSPT and the DHR Panel thought that VVAT could have established a direct line of communication with MSPT to share and gather information about how his problems associated with domestic abuse were being managed.

5.30.6 It is not known if any discussions took place with Female A to seek her views on relocating to Hampshire to be nearer her family, or whether she was sufficiently motivated to do it.

5.31 Significant Event: *2nd Sefton MARAC*

5.31.1 Sefton MARAC met on 03.03.2011 and discussed Female A's case. The meeting concluded that VVAT has completed a full needs assessment and a safety plan was in place.

Analysis:

5.31.2 Ideally, the minutes should have provided details of VVAT's risk assessment and risk management plan to show they were appropriately scrutinised and agreed by MARAC. It might also have occurred to agencies to wonder whether after ten domestic abuse incidents and three MARACs, a change of approach was needed.

5.32 Significant Event: *11th Domestic Abuse Report*

5.32.1 During a meeting with MSPT on 10.03.2011, Male A said he was moving to his new address but was staying a few nights with Female A.

5.32.2 On 14.03.2011 Female A reported to MSP that Male A had head butted her and hurt the dog. The LOI marker produced an emergency response and the attending officers found Male A drunk, claiming he did not know why she called the police. Female A was found drunk, distressed and crying in the downstairs lavatory saying Male A had been away drinking for two days and on his return they argued. He head

butted her but no injury was visible. Female A reported locking herself in the lavatory but Male A kicked the door open. There was evidence that the door was damaged. Female A made a complaint saying, "I've had enough". Male A was arrested and during the journey to the police station he began crying saying he loved his wife and could not understand why she kept doing this. Female A was seen later that evening [14th] but was too drunk to make a statement. A VPRF 1 was submitted to FCIU and an initial entry made on 16.03.2011.

5.33.3 Female A was seen by MSP on 15.03.2011. She was sober and declined to make a written statement or to repeat the allegation. Male A was released and no further action taken. A referral was made to VVAT on 17.03.2012 and on 05.04.2011 Sefton FCIU updated the PROtect record and risk assessed Female A as High, noting that Female A and Male A were "very heavy drinkers" and she had been advised not to allow him into the house.

5.33.4 Female A contacted VVAT on 15.03.2011 and disclosed the assault saying she had let Male A into the house to collect some belongings; he left, came back drunk and head butted her. She had reported the incident to MSP but would not make a statement. Female A also disclosed that two days earlier Male A held a knife to her. The Safety plan was reviewed and a referral was made to Sefton MARAC. Female A additionally disclosed that Male A's daughter had begged her during an unsolicited telephone call not to make a statement against her father. Female A now wanted a divorce and VVAT made a referral to a solicitor. The appointment was arranged for 23.03.2011.

5.33.5 MSPT requested information on Male A from FCIU and learned of the 9th, 10th and 11th domestic abuse reports [18.11.2010, 01.02.2011 and 14.03.2011].

5.33.6 Stonham received a referral from VVAT on 21.01.2011 and offered services to Female A on 25.03.2011. These services were:

- Support with re-housing because Female A had suffered domestic abuse involving violence from her ex husband and he had knowledge of her current address
- Support around domestic abuse
- Mental health support
- Debt advice and management

Note: Stonham Home Group provides supported housing offer services to help adults take control of their lives.

Analysis:

5.33.7 MSP responded promptly and took positive and supportive action by arresting Male A and the officer were met by Female A's refusal to provide a written statement. The CPS has a Policy for Prosecuting Cases of Domestic Violence that has been agreed with the Association of Chief Police Officers [ACPO]. It sets out that if the police have a reasonable suspicion that a suspect has committed an offence of domestic violence, they must refer that case to a prosecutor, who will make a decision whether to charge. That did not happen on this and six other occasions. The DHR Panel felt that given the totality of the assaults on Female A, MSP should have liaised

immediately with the CPS to determine what was needed to secure a charging decision and in the absence of Female A's cooperation, built an independent case against Male A.

5.33.8 MSPT should have reviewed the RMP once it knew of the three domestic abuse reports and the independent evidence of Male A's drinking, both of which were risk factors. The MSPT IMR author is critical of this oversight by both the Offender Manager and the Team Manager who reviewed the case at the time. VVAT had information that Male A had recently held a knife to Female A and it appears this was not immediately shared with MSP. The knife information was also of value to MSPT and because VVAT had not involved the agency in the needs assessment/support plan for Female A, they did not think to share it. Another piece of significant information held by MSPT was their knowledge that on 10.3.2011 Male A indicated he was going to spend a few days at Female A' s house. Had lines of communication between VVAT and MSPT been established there is a reasonable prospect this information would have been shared and Female A warned of the dangers of allowing the visit.

5.33.9 The DHR Panel thought that the 11th domestic abuse report and associated events as described above were poorly handled overall and that MSP, MSPT and VVAT all missed opportunities to share information with each other and assess risk. MSP failed to comply with the CPS/ACPO domestic violence policy and missed an opportunity to explore a prosecution without the support of Female A. Had Female A seen that MSP were determined to "charge" Male A she might have gained sufficient confidence to provide a written statement. The referral from VVAT to Stonham and the latter's response illustrates two agencies working together to support a victim of domestic abuse. Stonham will work with VVAT to increase the level of detail in referrals. There was some concern that Female A's perception of her risk as formed by contact with VVAT was not explored with her by the support worker.

5.34 Significant Event: *Male A's Avoidance of Addressing Substance Related Offending [ARSO]*

5.34.1 Male A was convicted on 21.07.2010 for failing to provide a specimen of blood for analysis [drink/driving]. Part of the sentence was a requirement to complete the ASRO accredited programme under the supervision of MSPT. On 04.04.2011 Male A told his Offender Manager that, "he would do whatever he could to get out of it". Male A did not complete the ASRO programme.

5.34.2 MSPT IMR is critical of this and notes:

"In total Male A was enrolled to commence on the ASRO programme on four occasions: 7.9.10; 26.4.11; 26.7.11 and 29.11.11. Each time he failed to engage. Sometimes re-enrolment was prompt, but not always e.g. OM 1 had indicated in her transfer of the case at the beginning of October 2010 that he should be enrolled to commence on a programme in January 2011. It was an oversight on OM 2's behalf that he did not do this until February for a programme which was scheduled to start in April".

"Consideration was given to revoking the order due to his failure to commence ASRO. OM 2 sought medical evidence to support such an application but this was rather late in the day i.e. after the offender had failed to attend the third programme

he had been enrolled onto. When it arrived, the GP letter seemed to indicate that the offender was sufficiently fit to complete ASRO with certain caveats e.g. explanation re how his illnesses could impact on attendance/ concentration. It is recorded in OASys that he suffered from depression; anxiety and emphysema".

"OM 2 should have requested immediate re enrolment on ASRO, but two months passed before this activity took place. He was re enrolled to start on 29.11.11. His failure to attend on this occasion should have been swiftly enforced".

Analysis:

5.34.3 MSPT recognised that Male A's misuse of alcohol was not only associated with his July 2010 conviction for failing to provide a specimen of blood for analysis, but also impacted on his domestic abuse propensities. By avoiding the ARSO Male A's risk associated with domestic abuse was largely uncontrolled albeit the OM did do some one to one work on the matter. No other agency tried to engage Male A with addressing his misuse of alcohol.

5.35 Significant Event: *3rd Sefton MARAC 21.04.2011*

5.35.1 Female A's case was presented to Sefton MARAC for the third time in four months [16.12.2010, 03.03.2011 and 21.04.2011]. The majority of the minute is descriptive of the 14.03.2011 assault and summarises the actions in place to support Female A, including the VVAT safety plan. It mentions that both parties have alcohol issues. The misinformation about Male A's conviction in 2008 for malicious wounding is repeated.

5.35.2 The minute notes that VVAT spoke to Female A on 20.04.2011 and everything was alright and there had been no contact with Male A. There were no minuted actions arising from the meeting. There is no evidence that the risk and the plan to manage it were scrutinised by agencies.

Analysis:

5.35.3 It is difficult to understand what value this MARAC meeting played in protecting Female A, particularly as no actions were required. It is not known if the VVAT needs assessment and safety plan were shared in full with the meeting and subjected to interagency scrutiny. MSP did not challenge the accuracy of the 2008 conviction, suggesting it had not been checked. Female A was one of 21 cases listed for the meeting and the DHR Panel wondered whether the pressure of referrals to MARAC meant that insufficient time was available for a more in depth review of Female A's case. If so, the same is probably true of the other twenty cases.

5.35.4 MSPT IMR records that on 18.04.2011 OM 2 made a home visit to see Male A where he met Female A and noted the physical state of the home; commenting there were no obvious signs of current domestic violence and that Male A was waiting for a liver biopsy. The DHR Panel felt that the "no obvious signs of current DV" was potentially misleading. This visit and note are important for two reasons. Firstly, they indicate a potential serious health problem associated with alcohol and more crucially it provides independent evidence that Female A had contact with Male A just two days before she denied doing so during a telephone call to VVAT. Had MARAC known this it should have prompted a review of the safety plan.

5.35.5 MSPT was represented at the three MARACs by the same person. The DHR Panel thought it was reasonable that the information about the contact between Female A and Male A should have been discovered by the MSPT representative as part of preparing for MARAC, and then shared with the meeting.

5.35.6 The DHR Panel was conscious that its work should not be over influenced by hindsight and felt that effective probing by MARAC might have produced the following additional actions to support Female A.

- the formation of a core group with a named lead professional to adopt a problem solving approach
- the production of an interagency risk assessment and control plan that applied to Male A and Female A
- the involvement of CPS to scrutinise future reports of domestic violence with a view to maximising the opportunities for a charge and conviction, including the Protection from Harassment legislation
- exploring a move for Female A to take her nearer the support of her family
- ensuring that all agencies attending MARAC came with the latest information
- a greater role for VVAT

5.36 Significant Event: *VENUS/VVAT/Stonham/MSPT contact 21.04.2011 to 26.09.2011*

5.36.1 VENUS spoke with Female A on 27.04.2011 to arrange the next [second] home visit. Female A, who was shopping, said she would call back because she did not have her diary. That call never came. Thereafter VENUS made another twelve unsuccessful attempts to contact/engage with Female A and closed the case on 10.08.2011.

5.36.2 The first recorded information by VVAT after the April MARAC came on 04.07.2011 when it was noted that Female A had moved and that Male A did not know the address. VVAT closed the case. On 11.07.2011 VVAT completed its outcome form. The DHR Panel felt it would be useful to include the full entry in the overview report:

a. *VVAT confirmed it worked in partnership with other agencies to deliver support- Housing Services, Benefits, Police/Probation and other (not specified).*

b. *11/07/11 confirmed as end date of support.*

c. *Female A to occupy general needs tenancy- Local Authority after departing the service. Confirmed that this was a planned move from the support service in accordance with Female A's Support Plan. Confirmed that the move and or end to support service resulted in greater independence for Female A.*

d. *Section on outcomes achieved; Achieve Economic Wellbeing – no outcomes, Enjoy and Achieve – no outcomes. Be Healthy – Female A needed support to*

manage mental health confirmed. Actual outcome for Female A – confirmed that she is managing her mental health better.

e. *Be Safe – confirmed that Female A needed support to secure/obtain settled accommodation. Actual outcome Female A confirmed that she had secured/obtained settled accommodation. Confirmed that Female A needed support to minimise harm/risk of harm from others. Actual outcome – confirmed that Female A is minimising the harm/risk of harm from others*

f. *Make a Positive Contribution – Confirmed that Female A needed support in developing confidence and ability to have greater choice and/or control and/or involvement. Actual outcome – confirmed that Female A had more choice and/or involvement and/or control at service level.*

g. *Letter from VVAT to Female A closing the case as there have been no recent incidents since her move to her new address [Address 1]. Letter states that it would appear that the risk from Male A has been reduced. Office number for VVAT is within the letter with the offer for support at any time. Client feedback form enclosed. This was not returned.*

5.36.3 MSPT continued its contact with Male A. He was proving troublesome to manage and missed some appointments. On 27.05.2011 OM 2 reviewed his OASys risk assessment which concluded he presented a medium risk of causing serious harm to a known female [Female A] and the public. The MSPT IMR author is critical of the OASys saying:

"Some sections of RMP updated, but still makes reference to completing Initial Sentence Plan and enrolling on ASRO within 15 days of sentence and Female A still inappropriately listed as his support despite the police intelligence to the contrary. Review sentence plan indicates that Victim work has been started but there is little if any evidence of this in the contact log/file. Actions highlighted in previous plans which are no longer appropriate because the resource is not available e.g. alcohol advocacy has not been deleted and replaced with something else".

5.36.4 At a supervision meeting on 16.06.2011 Male A told OM 2 that he was living apart from Female A but knew she lived in the area where Address 1 was located. On 23.08.2011 Male A told OM 2 that he stayed with Female A over the weekend.

5.36.5 On 13.07.2011, Stonham reviewed Female A's Support and Risk Management Plan. She reported feeling safe in her new home. Stonham continued to support Female A with: re-settlement, financial issues including debt advice, benefit applications and physical and mental health issues. Stonham was aware that Male A visited his wife, but unaware of the incident of the 26.09.2011 [12th domestic abuse report]

Analysis:

5.36.6 This appears a quiet period for Female A with no reported incidents involving Male A. VENUS and VVAT had both closed their cases; the former because Female A would not engage, the latter because they judged the risk from Male A appeared to have been reduced, a point they included in the 11.07.2011 closing letter to Female A. VVAT invited Female A to contact them if she needed support.

5.36.7 The DHR Panel felt that VVAT's outcome report was a little over optimistic with several of the outcomes based on Female A's judgement of the position. Whilst Female A's view of her own situation is valuable, it was somewhat contradicted by the uncontrolled risk factors present. It was known to VVAT that Female A had substantial difficulty in breaking free from Male A who consistently exercise control over her. Their abuse of alcohol was a significant risk factor, yet there is no evidence that it was being tackled. VVAT did not share its Supporting People Outcome form with Stonham, despite knowing that Stonham continued to provide support to Female A beyond VVAT's disengagement. VVAT does not appear to have put a contingency plan in place whereby they could discover if Male A was in contact with Female A. VVAT could not rely on Female A telling them because she had previous withheld exactly that type of information. The obvious source of independent information was MSPT.

5.36.8 MSPT acknowledges it had not effectively addressed his alcohol related offending and that its OASys assessment of risk was flawed. It is particularly concerning that MSPT did not review Male A's risk when it knew he had spent the weekend at Female A's house. The lessons from this period [summer 2011] is that effective lines of communication need establishing between agencies who have or might discover knowledge about victims and perpetrators that impact on risk assessments and that when new information surfaces it should be used to review the level of risk. Neither was done in this case because of individual oversights.

5.36.9 Stonham told VVAT that Male A was visiting his wife, but it appears did not have a discussion with Female A about the potential dangers that posed or had a discussion with VVAT about the risk. The DHR Panel felt that VVAT should have passed this information to MSP and MSP.

5.37 Significant Event: *12th Domestic Abuse Report*

5.37.1 On the evening of 26.09.2011 Female A reported to MSP that Male A was at her house [Address 1] smashing the property and threatening to kill her and the dog. She was not identified as a Gold victim but did receive an emergency response. The attending officers found no damage nor received any allegations of assault. It appeared to be a verbal argument. Officers noted that Female A and Male A were drunk.

5.37.2 Male A reluctantly agreed to leave the house and driven to the railway station. No further action was taken. A VPRF 1 was completed and an entry made on PROtect. The incident was risk assessed as Bronze and later as Gold. MSP made a referral to VVAT and moved the LOI marker to Address 1.

5.37.3 Male A telephoned OM 2 on 28.09.2011 saying he had been ordered to leave Address 1 the previous night. VVAT spoke to Female A on 06.10.2011 and noted she did not wish to engage saying she had VVATs telephone number should she need it.

Analysis:

5.37.4 MSP responded promptly and recorded that no damage or assault had taken place and pragmatically persuaded Male A to leave. No thought seems to have been given about the threats to kill allegation or of using the Protection from Harassment Act, both of which would have supported the victim. A referral was made to VVAT

thereby opening the door to further help for Female A. The LOI marker had not been transferred to Female A's new address and this is a failure which fortunately did not have any adverse consequences.

5.37.5 This incident provided an opportunity for agencies to reassess the risks faced by Female A and make a referral to MARAC. It appears that MSPT, MSP and VVAT did not appreciate the importance of the latest incident which was the twelfth in twenty one months.

5.38 Significant Event: *13th Domestic Abuse Report*

5.38.1 At 1928 hours on 07.12.2011 Female A reported to MSP that Male A had tried to choke her and threatened to kill her if she called the police. MSP noted the LOI marker and responded as an emergency. On arrival officers found Female A drunk and confused. She incorrectly told them that Male A had already been taken away by the police. Male A was not present and after the officers satisfied themselves that Female A was safe went to look for him.

5.38.2 Female A telephoned MSP at 2004 hours reporting Male A was back in the house. Officers responded but again Male A was not there. Female A was advised to stay inside and lock the doors whilst they looked for Male A. Officers did not see any injuries on Female A or signs of disturbance in the house, although there was evidence that two people had been drinking. The incident log remained open. A VPRF 1 was submitted to FCIU and an initial entry created on PROtect the next day. PROtect was not updated or the incident risk assessed until 05.01.2012. There is no evidence to say this incident was referred by MSP to VVAT; neither organisation has a note of sending or receiving one.

5.38.3 Female A was seen at her home the following morning and made a written statement of complaint. She was visibly distressed and crying throughout the officer's visit. Female A reported that she and Male A had been drinking and arguing. He grabbed her by the throat. In a Victim Personal Statement made later that day, Female A said Male A would physically assault her when he had been drinking, commenting, " I am a nervous wreck. I am in fear of [Male A] and feel he is capable of anything". Female A also said that she was subjected to emotional abuse. She described how Male A would watch her through the window when she was in the garden and would question her if anyone spoke to her. He dictated who she could see, who she could speak to, and who she could be friends with.

5.38.4 A crime of assault was recorded and the investigation allocated to a detective [Officer in the Case] from FCIU. A supervisor instructed, "Ensure that victim contact plan is recorded on this log and attempt to trace/arrest suspect ASAP". On 09.12.2011 Female A was examined by her General Practitioner who noted bruising to her neck consistent with assault and strangulation. The OIC took photographs later that day. The GP's written statement was dated 30.12.2011 and received by the OIC on 04.01.2012.

5.38.5 On 08.12.2011 VVAT recorded they received a telephone call from Stonham to say that Female A had been assaulted by Male A who had a key to Address 1. VVAT made contact with Female A who confirmed that Male A had a key and refused to give it back. Thereafter liaison took place between Stonham, VVAT and OVH resulting in the locks at Address 1 being changed.

5.38.6 On 10.12.2012 Female A told MSP that she believed Male A had returned to the area she lived in and had sent her text messages saying he loved her and they could sort things out. She provided them with Male A's new telephone number. Male A was arrested on 11.12.2011 [3 ½ days later] and following consultation with the CPS, Male A was released on conditional bail until 05.01.2012 [not to approach Female A or enter Address 1] whilst further investigations were undertaken. The CPS lawyer advised that Female A should be referred for agency support. Female A was told at some unknown point that Male A had been released on bail without charge.

Analysis:

5.38.7 The original report of assault on 07.12.2011 contained allegations of assault, threats to kill and potentially perverting the course of justice. Additionally offences under the Protection from Harassment Act should have been considered given the history and warning already given to Male A. MSP and CPS missed an opportunity to think more widely on how to protect and support Female A. Investigating the assault was the only facet pursued. A supervisor thought it necessary to arrest Male A as soon as possible and the DHR Panel wonder if he had been circulated on the Police National Computer as a wanted person. This would have allowed any officer in any part of the country who checked Male A to know he was wanted and arrest him.

5.38.8 The failure of FCIU to risk assess the 07.12.2011 assault and refer it to VVAT is probably explained by the backlog of work within FCIU caused in part by the inexperience and transitory nature of the staff undertaking the role.

5.38.9 There was good interagency work between Stonham, VVAT and OVH which offered practical and emotional support to Female A following the 13th report of domestic abuse. The DHR Panel felt this will have helped to strengthen her resolve to resist Male A's attempts at "reconciliation". Ironically, this resolve is likely to have increased the risk Female A faced from Male A.

Note: Lees S [2000] found that "Ending a relationship with a violent man places a woman at particular risk for her life - either at the point of separation or shortly afterwards".

5.39 Significant Event: *14th Domestic Abuse Report*

5.39.1 At 2003 hours on 22.12.2011 Female A reported to MSP via 999 that Male A was banging on her front door [Address 1]. She told the call taker she was very frightened and the incident log noted that she was crying and distressed. The response officers attended but Male A was not present. They saw that Female A was still visibly upset.

5.39.2 The officers began searching the area when Male A returned to the house. They were in the process of arresting him when Female A again telephoned MSP to say he was back. He was drunk and arrested for breaching his bail conditions and to prevent a further breach of the peace. Male A was detained overnight and the arresting officer completed a VPRF 1 and a Remand in Custody Application stating:

"The DP [detained person] has been granted police bail for domestic violence offences and has breached his bail by attempting to contact the aggrieved and by personally making to the location. Officers have attended and whilst in the area the

DP has returned and resumed his behaviour. If bailed this behaviour is likely to continue".

5.39.3 A VPRF 1 was submitted to FCIU and an initial PROtect record created the next day. The incident was risk assessed as Gold and a referral made to VVAT on 23.12.2011. The PROtect record was updated on 05.01.2012 and marked, "closed in favour of previous incident" with a cross reference to the 07.12.2012 assault. At 0719 hours the next morning [23.12.2011] the custody sergeant released Male A without charge and endorsed the custody record thus, "sober calm – no complaint – no evidence of bop [breach of peace]".

5.39.4 Female A was not told of his release and an officer contacted her mid-morning [23.12.2011] to arrange for a witness statement covering the precious evening's incident. Female A said she would be available on 24.12.2011 and MSP left a voice message on her telephone on that date. Female A contacted MSP on 27.12.2012 to say she had just picked up the message and was told a witness statement was not required as Male A had been released without charge and advised to contact MSP if there were any more incidents.

Analysis:

5.39.5 The initial response by MSP was timely and after a short while Male A was arrested. This action supported the victim, as opposed to his release without charge which did not. MSP IMR author helpfully notes "Had there been any likelihood that Male A would re-offend, in accordance with force policy, Male A should have been placed before the next available court." The DHR Panel judged it was very probable that Male A would re-offend given his history of consistently doing so.

5.39.6 MSP failed to consider the Protection from Harassment legislation or the breach of bail and released Male A without charge and against the wishes of the arresting officer who felt a remand in custody was needed. There is no evidence that the custody sergeant took the officer's views into account [or even knew them], or considered Force policy when making the decision. It is also known that the events of the 22.12.2011 were not brought to the attention of CPS and so could not be considered by a case lawyer.

5.39.7 It is quite clear that in the next two days at least two attempts were made to obtain a statement from Female A for an incident which had already been "no further actioned". This illustrates a lack of co-ordination between MSP officers and was not supportive of a vulnerable victim who was very frightened of Male A and had a long history of being abused by him.

5.40 Significant Event: *Male A's Breach of Bail Contacts with Female A*

5.40.1 On 19.12.2011 Female A received a Christmas card from Male A saying how much he loved her and did not want to lose her. She told MSP about the card who passed the detail to the OIC.

5.40.2 On 29.12.2011 Female A received a letter by post from Male A saying he was going to kill himself and asking that she inform the police. They went to his home and spoke to him for two hours. A VPRF 1 was submitted to FCIU but not recorded on PROtect until 04.01.2012 thereby missing an opportunity to assess the risk posed by

Male A. Female A received a second letter the following day [30.12.2012] begging her to take him back. She had not been threatened but was fed up with him breaking his bail conditions. She felt manipulated. Female A made a written statement and the letters were seized. A VPRF 1 was submitted but not processed until 06.01.2012, thereby missing another opportunity to assess Male A's risk.

Note:

The text message of 10.12.2011, the Christmas card of 19.12.2011 and the two letters [29/30.12.2011] from Male A could fall within the definition of emotional abuse but have not been "counted" within the 13 reports of domestic abuse. Sending the Christmas card and letters likely breached his bail.

Analysis:

5.40.3 The actions of Male A were recognised by Female A as being manipulative. She resisted the approaches and reported the contacts to MSP, thereby demonstrating her continuing resolve to support a prosecution and extricate herself from an abusive relationship. This should have been recognised by the OIC and was valuable information that should have been specifically brought to the attention of the CPS case lawyer. Consideration should also have been given by MSP to referring Male A to a mental health crisis team.

5.41 Significant Event: *Contacts with Female A Male A December 2011/January 2012*

5.41.1 On 12.12.2011 VVAT noted that One Vision Housing [OVH] had changed the locks and target hardened the house by installing alarms on the windows and entrance door, with a plan to provide a new door and additional external lighting at Address 1. This followed the 07.12.2011 incident and the knowledge that Male A had keys.

5.41.2 Also on 12.12.2011 Male A advised MSPT that he had been arrested on 11.12.2011 for assaulting Female A [07.12.2011] and was on police bail until 05.01.2012. The record wrongly states he had been charged, but that information came from Male A. On 13.12.2011 Male A told MSPT that he could not attend his appointment that day; he was depressed and need to see his doctor.

5.41.3 MSP referred the 22.12.2011 incident to VVAT the following day. VVAT spoke with Female A on 27.12.2011 and agreed that she would call the office if she needed anything.

5.41.4 Male A was next seen by MSPT on 03.12.2012 when he reported being arrested over the Christmas period [22.12.2012] and charged with assaulting Female A; he had not. He reported feeling very depressed and stated he had suicidal thoughts. He said Female A has refused to have anything to do with him and that he now wants nothing more to do with her but he does want an answer to why she has treated him like this. He was interviewed by the Police over a card and letter he sent to Female A. His GP referred him to an initiative called "Inclusion Matters".

Analysis:

5.41.5 The action by OVH was very supportive of Female A and likely to have reinforced her resolve to continue with the prosecution. Male A's disclosures to MSPT reveal a man portraying himself as a confused victim, wanting to know why Female A was treating

him "like this". Male A told the independent author that he felt Female A, having secured a move to a nice area, simply dumped him without any real justification. He felt she was being unreasonable and they could have sorted out their differences if only she would have talked to him. He did acknowledge there were faults on his side, but not to the extent Female A portrayed. This attitude perhaps provides an insight into the events of 05.01.2012 when he wanted to challenge Female A over why she wanted to end the relationship. Male A was clearly agitated by her stance and minimised his pat in the domestic abuse.

5.41.6 Male A's disclosures to MSPT were not checked out with MSP and did not prompt a review of his risk. MSPT IMR author is critical of these errors.

5.42 Significant Event: *CPS Decision not to Prosecute Male A for 07.12.2011 Assault*

5.42.1 On 11.12.2011 MSP contacted CPS Direct [out of hours service] to seek advice about charging Male A with assaulting Female A. The prosecutor felt further evidence was required and agreed an action plan with MSP, including police bail for Male A.

5.42.2 On 04.01.2012 the OIC received a faxed copy of the medical evidence and passed it to CPS. The reviewing lawyer knew of the pattern of domestic abuse, but the incident on the 22.12.2011 was not brought to the attention of the CPS lawyer. At 1108 hours on 05.01.2012, the OIC spoke with a CPS lawyer who having reviewed the evidence, concluded there was insufficient evidence to realistically secure a conviction. Therefore the decision not to charge Male A coincidently came on the day he killed Female A. The OIC telephoned Male A at 1137 hours on 05.01.2012 and informed him of the decision. Male A thought it was trick to find him.

Analysis:

5.42.3 The DHR Panel thought the investigation should have been progressed more quickly, particularly as Female A had maintained her resolve to continue with the prosecution, a position she had hitherto avoided. The allegation was made on 07.12.1011 and Female A was still insisting on a prosecution on 30.12.2011. Moreover Christmas and New Year are anecdotally known to place additional pressure on families and in this case probably explained the delay in securing the medical evidence.

5.42.4 The DHR Panel was surprised that the CPS decided not to prosecute and thought it dealt with the 07.12.2011 allegation in isolation and did not take into account the cumulative allegations when making the decision. Additionally, the DHR Panel felt that CPS had a wider role to play in either initiating or contributing to a problem solving approach to reducing domestic violence between the couple.

5.42.5 In response to the DHR Panel's views, the Deputy Chief Crown Prosecutor [DCCP] Mersey-Cheshire wrote two helpful letters; July and August 2012. The August letter set out how domestic violence cases are handled.

1. "The police refer Domestic Violence cases to the CPS for a charging decision, if they consider that there may be sufficient evidence to charge the suspect. As part of the referral process, the police send a pre-charge report, the key evidence, exhibits, CCTV, forensic reports, previous convictions, and any material which may undermine the prosecution case or assist the defence. It is the police who have the accurate and holistic picture of any previous

offending history. We have to rely on them to provide all the relevant available evidence as they have responsibility to investigate cases – our responsibility is to make decisions on that evidence and prosecute where appropriate.

2. The material is sent via an electronic interface and reviewed by a prosecutor. The police then make telephone contact with that prosecutor for the case to be discussed and a decision made. If contact is made out of regular working hours then the case is handled by a national out of hours service known as CPS Direct.

3. The prosecutor reviews the case in accordance with the CPS Full Code Test. This Test was set out in my letter dated 18 July. Firstly, there must be sufficient evidence to provide a realistic prospect of conviction. Secondly, if there is sufficient evidence, then it must be in the public interest to prosecute. If the Full Code Test is being applied, and the prosecutor decides that further relevant evidence can be gathered, then this is requested, an action plan agreed with the police, and the suspect granted police bail.

4. Sometimes, there are cases when not all the evidence is available at the time a charging decision has to be made and it is necessary to detain the suspect in custody. The CPS may then apply the "Threshold Test." The prosecutor must be satisfied that, although there is insufficient evidence available to apply the Full Code Test, there is a reasonable suspicion that the suspect has committed the offence, and there are reasonable grounds for believing that further evidence will become available. Also, the seriousness or the circumstances of the case must justify the making of an immediate charging decision, and there must be substantial grounds to object to bail.

5. When deciding if there is sufficient evidence, each case is considered in isolation. Sometimes, it is possible to use previous incidents of bad character to bolster a case, but there must already be a realistic prospect of conviction on the other available evidence before it can be used.

6. Only if there is sufficient evidence, can the prosecutor then consider whether the public interest requires a prosecution. The CPS Domestic Violence Policy makes it clear that the domestic element of the offence is seen as an aggravating factor; therefore, if there is sufficient evidence in a domestic violence case, a prosecution will usually take place. Any previous offending is taken in to account at this stage. If there is not sufficient evidence, then the case cannot go ahead however much risk is posed to a complainant".

5.42.6 The DCCP for CPS Mersey-Cheshire has reviewed the decision not to prosecute Male A for the assault on Female A on 07.12.2011 and concluded it was consistent with the available evidence and in line with the CPS Code and Domestic Violence Policy. The DHR Panel accepted this conclusion.

5.42.7 In the July 2012 letter the DCCP said:

"You asked a question about the CPS role in problem solving in Domestic Violence cases. Our role is set out in the Code and the Domestic Violence Policy. If there is insufficient evidence in a case it cannot be prosecuted despite the risk that a

complainant may face. If a case is being prosecuted then the prosecutor will be mindful of the need to safeguard the victim, by making robust decisions about bail, safeguarding the victims and witnesses during the court process, and assisting the court at the point of sentence".

5.42.8 The DHR Panel noted the reactive role of CPS and recognised that initiating a problem solving approach to domestic abuse was outside of its remit. Nevertheless, the DHR Panel thought that some agency [or MARAC] involved with Female A and Male A should have developed a plan to reduce the domestic abuse. Part of that plan might have been to secure a relevant conviction against Male A and inviting CPS to contribute its expertise to achieving it.

5.43 Significant Event: *Events of the 05.01.2012 leading up to Female A's death.*

Introduction

5.43.1 MSP made a voluntary referral to the Independent Police Complaints Commission [IPCC] following the murder of Female A. The IPCC has investigated the events of 05.01.2012 and has looked at the actions of individual officers to determine whether anyone in MSP subject to the investigation has committed a criminal offence, misconduct or gross misconduct. The IPCC completed its report in March 2014 under the reference IPCC 2012/000362. Its findings are compatible with the findings of the DHR when examining common ground.

5.43.2 Therefore, this DHR, while looking at the sequence of events in detail, does not critically examine them, but draws broad conclusions. It does not attribute failings to individual officers, that is for the IPCC investigation to determine.

Events on the Day Female A Died

5.43.3 The general sequence of events on 05.01.2012 is set out below and is taken from MSP IMR.

Time	Event
1115	A Project Worker from Stonham Housing was with Female A and telephoned the OIC who told her that CPS had not authorised charges against Male A for the assault on 07.12.2011.
1115	Female A told the OIC that earlier in the day she had found Male A's laptop computer containing an apparent suicide message on her doorstep with his keys and wallet. The officer told her that he would make arrangements for a welfare check on Male A.
1130	OIC requested patrol to visit Male A's address to check on his welfare.
1137	OIC called Male A's mobile, expressed concerns, asked for his location, told him of CPS no charge decision, Male A thought it was a ruse, OIC suggested he sees a doctor:
1137	OIC spoke to Inspector who was Critical Incident Manager [CIM] who agreed a patrol should visit Male A's address before authority was sought for

telephone enquiries to locate Male A's mobile. It was not clear what the purpose of visit to Male A was.

1151 Officers forced entry to Male A's address; no one in.

1155 Male A's neighbour called Fairfield Housing Society to say police had broken in; a Housing Officer established from the police they were checking on Male A's welfare

1155 The Housing Officer called Male A's mobile and spoke with him. He was aware that the police were at his flat but sounded very calm about it. He did not want to see anyone and did not want anyone to know where he was, saying, "I've just got to do what I've got to do". The Housing Support Officer asked him what he meant and he replied, "I've just got to end it all." He confirmed that he intended to commit suicide and asked the Housing Support Officer to telephone his wife to ask her to call him. Male A then terminated the call.

1155 The Housing Support Officer then tried to contact Male A's Probation Officer and left a message, asking the Probation Officer to call him back. He later called Male A again to ask how he was and Male A replied, "How the fuck do you think I am?" Male A then terminated the call again.

1155 The Housing Support Officer subsequently contacted the police to advise them about his conversations with Male A. He did not believe that Male A was a danger to anyone else.

1214 OIC called Male A's mobile and spoke with him. Male A said that he was 'on the path he wanted to be on'. He refused to go into a police station to show that he was safe and well and terminated the call. He did not sound drunk or under the influence of drugs.

1222 OIC telephoned Female A and asked her about the previous house that she and Male A shared. Female A said that both she and Male A had ceased to have any involvement with that address.

1250 The duty CIM for Sefton made an entry on the incident log to the effect that the OIC had been advised to bring the log to the attention of the duty CIM in Liverpool South. In addition, the OIC was to conduct all relevant intelligence enquires in respect of Male A.

1250 The CIM also recorded that he had liaised with the duty superintendent, Sefton, regarding enquiries that could be undertaken to try to locate Male A's mobile telephone. The CIM advised the Force Incident Manager [FIM] accordingly.

1251 The FIM contacted the duty telecommunications single point of contact (SPOC) in force, with a view to arranging appropriate enquiries to locate Male A's mobile telephone.

1251 The duty CIM for Sefton was designated the officer in charge for the purposes of telephone enquiries. To avoid confusion, that individual will continue to be referred to as the CIM [Sefton] in this report.

1253 The SPOC contacted the duty superintendent, Sefton who at 1254 gave urgent verbal authority for appropriate telephone enquiries to locate Male A's mobile telephone. The authorisation was on the basis that there was concern for a missing/suicidal person and that this action was deemed necessary and proportionate.

1255 Enquiries indicated that Male A's mobile telephone was in the vicinity of Lime Street, Liverpool 1, in the city centre. The SPOC passed this information to the duty CIM for Sefton and noted on the SPOC log sheet that a further update was to be provided at 1400.

1256 The PROtect record for Female A's allegation of assault on 7th December, 2011, was updated and risk assessed as gold.

1304 An entry was made on the incident log that the OIC had liaised with the duty CIM for Liverpool South, who had asked that the control room supervisors for Liverpool South and Sefton be made aware of the ongoing telephone enquiries, so that he could be kept abreast of developments.

1311 The OIC tried to contact Male A's daughter on a telephone number that was believed to be her mobile. She did not answer and the OIC left a voicemail message for her but did not receive a reply.

1315 The OIC spoke by telephone to Male A's brother and informed him of the situation. The brother suggested that Male A would probably be drinking and would then 'sleep it off'. At the officer's request, he telephoned Male A, who was unwilling to provide his exact location but said that he was in a café having something to eat.

1317 An entry was made on the incident log that the duty CIM for Sefton had liaised with the OIC and had asked him to populate the log with full descriptive details of Male A. Reference was also made to the fact that a recent photograph of Male A was available.

1317 The OIC had informed the CIM that Male A frequented Wetherspoons and The Blob Shop public houses in Liverpool city centre. The CIM asked that the duty CIM for Liverpool North, covering the city centre, be informed and that a patrol be deployed to check those locations.

1317 The CIM for Sefton also directed that CCTV operators should be informed and provided with descriptive details and a photograph so that they could monitor the locations where Male A was thought to be. It is unclear, though, what instructions, if any, officers were given in the event that they located Male A.

Note:
Consideration could have been given to contacting British Transport Police, who operate in the area, and travel companies, such as Merseyrail, as it appeared that Male A had been travelling to and from Southport. Police patrols in the vicinity of Female A's home could also have been alerted as to the situation and told to make regular checks on her address.

1319 The Housing Officer from Fairfield Housing Society telephoned the police again and asked if he could be kept updated. It would seem that during this call he told the police about his telephone conversations with Male A.

1322 Female A telephoned the OIC and suggested that she call Male A. The OIC advised her against doing so, as he was unsure as to the effect that it would have on Male A.

1324 The OIC arranged for a further incident log to be created to check for Male A at Wetherspoons and The Blob Shop. The log included Male A's descriptive details and requested that the checks be made as soon as possible.

1330 The OIC contacted Male A's probation officer and informed him of the ongoing incident. The probation officer said that he would telephone Male A to check on his welfare and establish his whereabouts.

1330 The probation officer called the OIC a few minutes later and said that he had spoken with Male A, who had said that he was in Southport. Male A had indicated that he was going to Female A's home and was not far from the address. Once there, he intended to 'harm' himself, so that she could see his body. Arrangements were made for a police patrol to visit Female A.

1345 Two officers visited The Blob Shop, though it is unclear what their remit was in the event that they traced Male A. They found the premises to be busy and estimated that there were between thirty and fifty customers seated at tables, with several others standing around the bar area.

1345 One of the officers spoke with the bar staff and with a customer, who was standing nearby and overheard their conversation. Neither the members of staff nor the customer could assist. Before leaving, he asked the bar staff to call the police if they saw anyone whom they thought might be Male A. In the meantime, the other officer 'had a general look around the bar', which was followed by 'a quick look around the area' as they left the premises.

1345 Both officers speak of being hampered by a 'vague' description of the subject, when the incident log refers to an individual who was six feet tall, with blue eyes, a 'bald grey skin head hair cut', a Liverpool accent, a scar on the left side of his face and a mark on his left arm. In addition, there was a photograph available.

1400 Officers went to Female A's home address and found her to be 'in good spirits…smiling and quite chatty'. She showed the officers a case containing Male A's laptop computer, keys, a wallet and other miscellaneous items. She

tried to show them a suicide note that had been entered onto the laptop but was unable to do so because it appeared to be faulty. She said that the note was to the effect that Male A wanted to end his life as their relationship had come to an end.

Note: Victims of domestic abuse are at greater risk of serious harm and death when the perpetrator finally recognises the relationship has ended and the power and control they exercised will be no more.

1400 One of the officers spoke with the OIC by radio and confirmed that their remit was to check on Female A's welfare and take possession of the property. The officer made a notebook entry regarding taking the property, which Female A signed. The items were subsequently taken to Southport Police Station and booked into the property system.

1400 Before the officers left, Female A was asked whether she had any concerns for Male A. She said that she did not; as she felt he was trying to make her feel sorry for him so that she would contact him with a view to reconciliation. She was advised to telephone the police immediately if he arrived there

1400 A VPRF 1 was not completed for the visit and no further risk assessment was conducted, even though it appeared that Male A had been to the address. It would also appear that other patrols in the vicinity were not alerted as to the situation, so that they could watch out for Male A and make regular visits to the road where Female A lived.

1404 Male A's mobile telephone was still in the vicinity of Lime Street, Liverpool 1. The SPOC passed this information to the duty CIM for Sefton and noted on the SPOC log sheet that a further update was to be provided at 1500 to the second duty CIM for Sefton. At that point, CIM responsibility in Sefton was to pass from one inspector to another.

1428 The OIC made a further telephone call to Male A's brother, who said that he had not any further contact with Male A.

1434 Male A telephoned the police to say that two officers had just been into the The Blob Shop looking for him. He said that they stood next to him and asked him if he knew Male A, which he denied.

1441 Male A's brother telephoned the OIC to report that he had just spoken with Male A, who had said, "It's going to happen today". The brother said that Male A needed to be traced for his own benefit, which contrasts with his earlier thoughts at 1315 that Male A would probably be drinking and would then 'sleep it off'.

1458 Male A's mobile was switched off. The SPOC passed this information to the second duty CIM for Sefton but recorded on the SPOC log sheet that she was 'struggling to identify who … [was] … taking ownership' of the enquiry between Sefton, Liverpool North and Liverpool South. The CIM for Sefton was to call her once BCU ownership had been decided upon.

Note:

The SPOC was not re-contacted, no further telephone updates were requested and, from this point, the telephone authorisation became ineffectual. The duty CIM for Sefton had been designated the officer in charge for the purposes of telephone enquiries

1546 A patrol was deployed to revisit The Blob Shop to check for Male A. The deployment was designated Grade 2 (non-emergency but priority) and the patrol did not immediately attend. There is no indication that the officers took the opportunity to obtain a photograph of the subject in the meantime.

1627 The patrol deployed to The Blob Shop was diverted to another call.

1643 Officers arrived at The Blob Shop and were told by staff that Male A had identified himself to them after the earlier police visit. They said that he had left approximately an hour and a half earlier and was not drunk but upset, saying that his wife had hung herself the previous day. The police advised the staff members to call 999 if they saw him again.

1654 The officers made a further visit to Wetherspoons but Male A was not found. At 1654 an entry was made on the incident log to the effect that there was no trace of Male A at either pub (i.e. The Blob Shop and Wetherspoons).

1700 The OIC went off duty but does not appear to have passed the enquiry to another, appropriately briefed officer before doing so. It is also unclear whether he liaised with the duty CIM for Sefton.

1705 A police control room operator called Male A's mobile telephone, apparently of her own volition. It rang but was not answered.

The following events in *italics* were discovered during the murder investigation.

1720 A member of staff at The Fleetwood pub, Banks, near Southport, served a customer who is believed to have been Male A. The customer asked the barman where he was and how far it was from Southport and Ainsdale. He asked the barman to call him a taxi, which he did.

Note:

Male A later told the police that he had fallen asleep on a bus and had arrived in Banks, not knowing where he was.

1745 A taxi driver collected a fare, who was undoubtedly Male A, from The Fleetwood pub, Banks. He seemed calm and spoke in a confident manner, asked to be taken to Female A's address and said that he was going to his sister's address. He also said something to the effect of, "If she doesn't

answer the door, I will just grab a block of concrete and throw it through the window".

1745 Male A told the driver that he had been in Liverpool and Bootle earlier in the day and was not sure how he had ended up in Banks. He said something similar to, "My wife hung herself today", and although the driver did not believe him, he did not pass comment. Male A also told him that the police had been checking on his welfare.

1755 During the taxi journey, Male A received a call on his mobile telephone, which he answered. The driver cannot recall what was said but after the call Male A told him that it had been the police checking on him. He then said, "My wife's hung herself today; how do they think I'm going to feel?" This call is likely to have been a further call from a police control room operator.

1800 The taxi arrived at Female A's address; Male A apologised to the driver for the way he had been during the journey. He walked through the front gate and closed it behind him as the taxi driver drove away.

1800 A neighbour then heard glass breaking and saw a man in the front garden of Female A's house. Male A knocked the loose glass out before climbing onto the window frame. He got back down again and she saw him remove further glass before losing sight of him. At the same time, a milkman heard breaking glass and saw a person in the front garden of a house.

1810 The police were notified by ambulance control of a report of a stabbing at Female A's address. The informant was Male A, who was crying and had said that Female A had been stabbed several times and that he had been responsible. The LOI marker on the address identified that Female A was a gold victim and the Police provided a Grade 1 (emergency) response.

1820 Male A was arrested at the scene for the murder of Female A.

5.43.4 MSP set itself the task of ensuring that Male A and Female A were safe and well. This was prompted by the suicide note Male A left on his computer at Female A's address. That task was appropriate, but limited; because it did not take account of the history of domestic abuse between Male A and Female A and the risks he posed to her.

5.43.5 It was known to MSP that Male A presented a high risk of causing serious harm to Female A and there is no evidence that the risk was reviewed following the discovery of the suicide note. That was a significant error. The emphasis of MSP actions appears to have been around ensuring that both Male A and Female A were safe and well; laudable as that was, it missed the point that Female A was likely to be in significant danger. Male A's stated intention [to MSPT 1306 hours] of going to Address 1 to kill himself on Female A's lawn was an extreme reaction to his separation from Female A. MSP should have thought through the consequences of such a grand gesture, including the impact it might have on neighbours. No account seems to have been taken of the substantial history of domestic abuse suffered by Female A and the dangers she faced from Male A. Equally MSPT did not reassess the risk Male A presented to Female A when it knew of his stated intention to commit suicide on her lawn. Had they done so it is likely he would have been assessed as

posing a very high risk of causing serious harm to Female A, which if shared with MSP should have prompted them into considering the dangers she faced.

5.43.6 Notwithstanding that MSP failed to identify the danger to Female A, it did not perform very well in the search for Male A. The command and control of the events on 05.01.2012 was confused; no one person was in overall charge and therefore the search for Male A was somewhat piecemeal. The responsibility for recognising that Female A was in danger rested with junior and senior officers; however, the responsibility for establishing a single coordinated plan sat with supervisors and managers. The failure to initiate a clear command and control structure has its origins in the failure to appreciate that Male A presented a very high risk of harming Female A. Had that been recognised a different outcome was very probable.

5.43.7 The telephone SPOC's entry on her log at 1458 precisely illustrates the point that there was no leadership: "...struggling to identify who … [was] … taking ownership of the enquiry between Sefton, Liverpool North and Liverpool South".

5.43.8 It is not clear what actions the officers looking for Male A were required to take beyond establishing that he was safe and well. For example, if Male A had been located in a city centre public house what would have happened? Unless he was arrested or detained, the risk to Female A remained.

5.43.9 Therefore not recognising that risk in the first place, set the pace and tone for the events of 05.01.2012 which ended with the death of Female A.

6. ANALYSIS AGAINST TERMS OF REFERENCE

6.1 Introduction

6.1.1 Each term of reference is commented on from material in the IMRs, the debates of the DHR Panel and the views of family members. Some commentary could fit into more than one term and the decision on where it appears was made on a best fit basis.

6.1.2 The terms appear in ***bold italics*** followed by an analysis.

6.2 *How did your agency respond to reports or knowledge of domestic abuse involving Male A and Female A; and did it comply with its policies and/or multi-agency ones?*

6.2.1 All the agencies contributing to this DHR knew there was domestic abuse between Male A, as the perpetrator, and Female A as the victim. MSP recorded fourteen incidents of domestic abuse between the couple and arrested Male A on ten occasions. MSP front line operational response was good and in general supported by the back offices processes of risk assessment and referral, albeit there were some lapses. Female A was recognised as a repeat victim and graduated from Bronze to Silver and Gold, ending in referrals to MARAC.

6.2.2 However, MSP, in common with other agencies did not stop and adopted a problem solving approach to the complex issues involved, they tended to deal with the reports in isolation. There were breaches in policies in two specific areas. The first was failing to consult with the CPS following Male A's arrested for domestic violence as required by the ACPO/CPS agreement. Of Male A's ten arrests, CPS was consulted on five occasions. The second was not always informing Female A that Male A had been released from custody as required by MSP policy. This policy is aimed at providing victims with timely information on perpetrators.

6.2.3 MSPT supervised Male A for two periods, neither of which was related to domestic abuse offending. The first period was from 23.12.2008 to 14.08.2009 when MSPT supervised his licence following his release from prison for a firearms offence. OM 0 knew that Male A's domestically abused a previous partner and recognised the dangers to future ones. OM 0 also knew Male A was engaged but did not formally translate that into a specific risk assessment due to an oversight. However, during this first period OM 0 worked with Male A on reducing his domestic abuse risk factors by looking at alcohol and victim issues.

6.2.4 The second period of supervision was for 24 months and began on 21.07.2010 when he was convicted of failing to provide a specimen of blood for drink/driving analysis. Part of the sentence required Male A to undergo an ASRO programme. Staff felt that Male A would attend the ASRO programme and gave him too many chances and in some ways were manipulated by him. He successfully and deliberately avoided attending that programme and MSPT acknowledges it should have taken a firmer line with him and referred him back to court for resentencing.

6.2.5 The greatest issue with MSPT's supervision of Male A from a DHR perspective was the flawed risk assessments and risk management plans. These consistently showed that he presented a medium risk of causing serious harm to Female A despite the

frequency and nature of the domestic abuse. The work done with Male A did not substantially or effectively reduce or manage his risk. MSPT recognise that from August 2010 onwards, Male A should have been assessed as posing a high risk of causing serious harm to Female A, thereby making his case eligible for management through MAPPA. The mistakes in assessment were made by two OMs and are attributed to their failure to recognise that new information should have been used to re-assess Male A's risk. They showed a lack of awareness and judgement which they now acknowledge. An example of this is; neither OM thought the domestic abuse was serious because Male A's many arrests had not led to charges. [One did but it was withdrawn]. However, The DHR Panel judged that by themselves there was no direct connection between their mistakes and the death of Female A.

6.2.6 In August 2010 the Liverpool MARAC missed an opportunity to scrutinise the domestic abuse suffered by Female A. Citysafe said in its IMR:

"Looking at the information recorded in the MARAC meeting and the dearth of actions there appears to have been a lack of scrutiny on the information presented to the meeting. There is no clear evidence of consideration of causative factors this is reflected within the notes of the meeting and the actions agreed. It is worth noting that some of the systems for MARAC have changed since 2010 following the CAADA Audit and also a recent Serious Case Review".

6.2.7 Liverpool IDVA referred Female A to ABC who between them supported Female A before closing the case when she moved to Sefton. The services provided were appropriate and appeared well received by Female A.

6.2.8 Sefton VVAT and Stonham along with some other organisations provided support and services following referrals from MSP or each other. Female A regularly wavered between supporting a prosecution and permanently ending her relationship with Male A, to one where he persuaded her to have him back. It took until the 14th report of domestic abuse [07.12.2012] before she was strong enough to withstand Male A's persistent and threatening attempts at reconciliation. Female A accepted some offers of help and declined others. A house move was arranged and soon after Female A took up the accommodation Male A was visiting her and reverted to his abusive behaviour.

6.2.9 Following the 14th report of domestic abuse, Stonham and other support agencies worked hard to support Female A through a very difficult period. Stonham noted a minor breach of it recording procedures.

6.3 *What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?*

6.3.1 Nearly all agencies established that Female A and Male A did not have children as evidenced by the entries in the combined chronology and IMR's. ABC noted Male A had a child in a previous relationship but overlooked establishing the age. Female A was a vulnerable adult because of her victimisation, alcohol misuse, mental health needs and social isolation. Male A was also vulnerable because of his alcohol misuse and mental health needs. However, there is no excuse for his violence towards Female A.

6.3.2 VVAT completed an ISP on 07.02.2011 and noted that Female A had an alcohol problem in 2009 but - not drunk since. There was evidence [available from MSP and Male A] that she was abusing alcohol but no action to deal with that appears to have been taken by any agency. Female A's other vulnerabilities were recognised and being addressed by health and other support services. For example, Stonham arranged for her to visit a solicitor. It is testament to the support services that they persevered with their support for Female A, who was bullied, harassed and emotionally blackmailed into allowing Male A back into her life. There is evidence that during periods of reconciliation Female A was less inclined to fully engage with services probably because she was fatigued by the abuse and took the line of least resistance.

6.3.3 The CPS recognised Female A as being vulnerable on one occasion [07.12.2011] and advised MSP to refer her to support services. Like all other agencies reporting to this DHR, they did not stop and take stock of the situation.

6.3.4 Appropriate referrals were made to agencies for Female A apart from some oversights by MSP.

6.3.5 Male A was receiving services from the NHS to deal with his mental health needs and from MSPT to deal with his alcohol related offending, albeit the latter was largely ineffective as evidenced by his avoidance of the ASRO without effective substitution.

6.3.6 There does not appear to have been a co-ordinated approach to addressing Male A's problems. MSPT seemed to have worked in isolation from health.

6.3.7 In general terms marriage guidance would not be appropriate in domestic violence cases as the control element of the perpetrator's behaviour would preclude it.

6.4 *Did the services your agency provided focus sufficiently on reducing the impact of domestic abuse by Male A on Female A and in identifying and dealing with the causative factors?*

6.4.1 MARAC is the vehicle which should bring focus in dealing with the impact of domestic abuse. In this case, the MARAC process brought no focus on the causative factors and appeared to concentrate on limited short terms actions. A more fundamental problem solving approach was needed.

6.4.2 MSPT worked with Male A on two of his domestic violence risk factors; alcohol misuse and victim empathy. There is evidence that MSPT identified mental health as an issue for Male A but not whether it was linked to his domestic abuse offending. There is no evidence that MSPT sought information from health on his mental health needs and how those needs might have impacted on his risk assessment.

6.4.3 The practical steps taken by support services were focussed on reducing the impact of domestic abuse and in many cases were effective; target hardening, ISP, arranging appointments and acting as intercessors. Male A undermined these measures when he cajoled and intimidate Female A into having him back.

6.4.4 The DHR Panel thought that MSP and CPS could have worked more effectively by agreeing a plan on how to secure a successful conviction against Male A. For example each report of domestic abuse could have been allocated to the same

officer to investigate [recognising that response officers would be different] and referred to the same CPS Lawyer [recognising the role of CPS Direct- out of hours service] for continuity and familiarisation of the issues, thereby bringing focus on the problem.

6.5 *Were your agency's policies, procedures and training, that were relevant to this case, fit for purpose, including those relevant to assessing risk?*

6.5.1 All agencies submitting reports to the DHR have comprehensive written domestic abuse and risk policies. There were no gaps identified in those policies and the breaches which occurred resulted from individual failings rather than systemic ones.

6.5.2 The risk assessment tools vary between agencies and are designed for different purposes. Therefore in order to fully understand the risks posed by Male A each organisation should know what tools the others used and what the results mean. For example MSPT uses OASys to assess risk of serious harm which includes domestic violence but also uses SARA [Spousal Assault Risk Assessment] a domestic violence specific tool. Therefore agencies need to consider risk as an amalgamation of the various risk assessment models and use the information at MARAC to inform the actions needed to reduce the risk.

6.5.3 Sefton MARAC uses the CAADA DASH risk assessment model. However, this is not universally used by all organisations that are part of MARAC. MERIT is also a tool commonly used to assess risk. Some organisations have been using MERIT and then transferring the information onto DASH before going to MARAC. This led to confusion around systems and an increase in bureaucracy in getting cases to MARAC which could have contributed to the ability to deal with the number of cases at each MARAC. Since the review of Sefton MARAC in February 2012, a new common MARAC referral form has been put into place which all organisations have agreed and signed up to. MERIT or DASH referrals are now accepted.

6.5.4 A database for Sefton MARAC and domestic violence had been in development for some time, but has never been signed up to by partners. Sefton MARAC and the VVAT Team have no electronic systems in place to track clients and information. However, this is now being addressed and organisations are being consulted about the best approach to share and store information.

6.6 *Were there issues in relation to capacity or resources in your agency or wider partnerships that impacted the ability to provide services to Female A and/or Male A, and to work effectively with other agencies?*

6.6.1 MSPT IMR notes:

"OM 2 qualified in October 2010 and so was newly qualified when he assumed responsibility for the case. TM 2 [Team Manager] advised that at that time i.e. October 2010 her team had been carrying two long term sickness absences at Probation Services Officer (PSO) grade. OM 2 inherited a caseload of mostly lower risk cases belonging to one of the absent PSOs as well as a few higher risk cases. He recalls he was not afforded any caseload protection which a newly qualified officer would usually expect to receive (50 % reduction during the first 6 months). The purpose of this protection is to assist newly qualified staff by providing time to reflect upon their work; develop confidence skills and experience in managing the demands

of a broad range of cases whilst at the same time not being responsible for a full caseload. The reason why this did not take place in OM2's case was due to the fact that his arrival was seen as alleviating pressure from other staff who had been carrying the workload of absent colleagues combined with the fact that the majority of the cases were assessed as being of lower risk and therefore less demanding in terms of time and input".

6.6.2 The DHR Panel thought this candid explanation reflected the type of pressures facing many agencies.

6.6.3 MSP report two issues with capacity. On 24.07.2010 Female A reported to MSP that Male A had been to her house and damaged a television. She was recognised as a Gold victim but no patrols were available to attend and an agreement was made to see her the next day. That did not happen and an appointment was made for her to attend a police station two days later. When Female A arrived she was told no one was available to see her. She was eventually seen on 29.07.2010 and withdrew her complaint. Gold victims of domestic violence receive a grade 1 response for any call emanating from the marked address. This domestic violence incident warranted a prompter response and because of the resourcing issues MSP missed an opportunity to support Female A when she first reached out for help.

6.6.4 It appears that Sefton FCIU is meeting its performance targets for creating PROtect records by generating a "skeleton" record using minimum datasets. Whilst there are benefits in creating timely records, MSP IMR notes: "Thereafter, there are delays within FCIU on updating PROtect records and completing risk assessments which may have been due to workload and resilience levels. The IMR author understands that steps are being taken to address this but the situation will need to be closely monitored. Part of the problem would seem to be that Sefton FCIU does not have a dedicated risk assessor and, as a result, the role is performed by different staff, working restricted duties, as they become available". The issue is subject of a recommendation.

6.7 *Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?*

6.7.1 Female A and Male A are white British with English as their first language. Both had mental health needs that were known to agencies. All of the agencies reporting to this DHR have diversity policies. None of the agencies, apart from MSPT, reported any difficulties in delivering services because of diversity.

6.7.2 MSPT IMR records:

"Male A had numerous serious health problems which both OM 1 and 2 endeavoured to cater for in terms of rearranging appointments to facilitate hospital appointments. However the attention upon his health needs appears to have had a detrimental impact on the management of the case in two important respects. Firstly the fact that Female A was inappropriately included in the risk management plan was in relation to the support she gave to Male A with his emotional problems. Secondly discussion about health related issues dominated most contacts Male A had with OM 2 at the expense of other issues. OM 2 should have considered seeking medical opinion sooner than he did e.g. after the second failure to commence ASRO. Had he

done so he would then have not felt quite so wrong-footed when the GP's letter arrived indicating he was fit to complete the ASRO group, albeit with certain caveats.

6.8 *Did professionals working with the victim have appropriate levels of supervision?*

6.8.1 MSP identified a few areas where supervision could have been better. For example, the VPRF 1 should be checked and signed by a supervisor before submission to FCIU; that did not always happen. The IMR author comments: "This would tend to suggest that forms are frequently submitted without any real degree of quality assurance, which could also mean that supervisors may be unaware of domestic violence within their own particular geographical sphere of responsibility.

6.8.2 Importantly the IMR observes: "There are also occasions where a supervisor's details do not appear on a PROtect record. Whilst this may be due to workload, it may have contributed to delays in updating records, conducting risk assessments and making referrals. There is also little evidence that any supervisor intervened to address the underlying causes or Male A's continual harassment of Female A and his repeated breaches of bail conditions.

6.8.3 The DHR Panel felt the last point about supervisory intervention was significant, given that MSP attended fourteen reports of domestic abuse and whilst escalating Female A to Gold victim status, did not, in common with some other agencies, think to adopt a problem solving approach.

6.8.4 The VVAT Team had a turnover of staff dealing with Female A and a VVAT member with no experience was assigned to Female A's case with supervision. The level of supervision is unclear, but the VVAT Team have not been offered any clinical supervision or been through any professional IDVA training. This issue will be picked up by Sefton's review of its domestic violence services and is not subject of a recommendation within this report. See paragraph 6.10.2.

6.9 *Was information sharing and communication with other agencies regarding Female A and Male A and the other subjects of the review, effective and did it enable joint understanding and working between agencies?*

6.9.1 Of the fourteen reports domestic abuse reports recorded by MSP, referrals were made to domestic violence support services in less than half. Additionally, MSP did not always communicate with CPS on each occasion Male A was arrested. This will partly have obscured CPS's full knowledge of his involvement. MSP could have informed CPS of the missed arrests on the next occasion they referred a case. Both agencies were in a good position to support Female A and better information sharing would have increased the opportunity to do so. The LOI markers were not always transferred to Female A new addresses making it less likely that Female A would be identified as a Gold Victim requiring an immediate response.

6.9.2 MSPT was largely content with the information sharing between itself and the MSP, but noted that there was no policy for them to be routinely notified of the arrest of offenders subject to MSPT supervision. MSPT note they did not always respond appropriately to information that was shared as illustrated by not updating Male A's risk assessment.

6.9.3 It is not possible from the minutes of the MARAC meetings to know whether all the relevant information was shared and this restricts commentary on whether communication was effective. There is evidence that Female A abused alcohol but denied this to one service. MARAC is ideally placed to identify such anomalies and given that alcohol was a significant feature of the domestic abuse, an opportunity was missed to help Female A. It is believed that not all the agencies knew that Male A had attempted to strangle/choke Female A and was cruel to her dog. There is some confusion around Male A's background insofar as the details of his domestic violence offending/alleged offending against previous partner[s] appear vague. MARAC was well placed to identify the confusion and seek clarity. The volume of cases dealt with in a day by MARAC, probably precludes recording everything that was shared.

6.9.4 There is evidence of some communication difficulties between Liverpool IDVA and Sefton VVAT when transferring the case; it appears VVAT struggled to respond to the IDVA calls. There are also some issues around the fullness of the information on the referral from Sefton VVAT to Stonham. However, these have to be balance against the evidence contained in the combined chronology which shows good information sharing between services in support of Female A. This is evidenced by the response she received when it became known that Male A had a set of keys to her house. VVAT, Stonham and OVH worked closely and swiftly to change the locks and deploy additional security measures. MSP did not refer the 07.12.2011 assault to Sefton VVAT [until 05.01.2012]. However, Female A told Stonham of the incident and they shared that information with Sefton VVAT, resulting in the above action.

6.9.5 There were substantial MSP internal communication issues on the day of Female A's murder [05.01.2012] which will be scrutinised and reported on by the IPCC.

6.10 *The DHR Panel will identify which local reviews are relevant to this DHR and take account of any findings or emerging findings in its final report.*

6.10.1 MSPT completed a Serious Further Offences review which was shared with the independent DHR author who confirms that the findings of the SFO review are consistent with the findings of the IMR.

6.10.2 Sefton Council on behalf of the Safer Communities Partnership instigated a review of the MARAC in February 2012. This was due to the death of Female A and also concerns already expressed by partners about the volume and treatment of cases. An immediate action was for the MARAC to be chaired by MPS and not the Council.

The key findings of the MARAC Review have been implemented and are:

- Develop more effective systems and processes that focus on the person and actions – ongoing
- Produce a directory of agencies attending/offering support to MARAC
- Review Risk management plan actions case by case at MARAC – implemented
- Ensure adequate support is built in for facilitation of MARAC - Chair to attend MARAC chair training – implemented

- Review of current membership and identify gaps – implemented
- Look at available training provision for organisations/representatives attending MARAC – implemented
- Develop means of sharing good practice on prepping for MARAC – good practice/ document template – implemented
- Review of timescales for info going our pre-MARAC to allow adequate preparation (within CAADA guidelines) or necessary action – implemented
- Define a criteria for multi-repeats and consider a special approach for dealing with such cases – ongoing
- Visit other LA's MARAC to observe – implemented
- Look at how we better encourage partnership working outside of meetings – implemented/ongoing

6.10.3 There is also a wider review of domestic violence services which has been instigated following two domestic homicides, increasing numbers of reported domestic violence incidents and community intelligence saying that levels of under-reporting are high. This has been compounded by concerns around fragmented service delivery, no systematic approach to sharing information and the budgetary restrictions that the Council and partners are facing.

6.10.4 The proposed commissioning strategy for domestic violence which will come out of the review will deliver a more informed understanding of the current and future needs of victims of domestic violence and their families, what measures can be put into place for perpetrators, the demand for the service, what works and what needs to change. The outcomes of the review contained within the commissioning strategy specify the new shared outcomes that we need to achieve to develop a more co-ordinated community response to preventing and reducing domestic violence.

The Terms of Reference for the Domestic Violence Review are:

- Do we have the right governance and partnership relationships in place to effectively tackle domestic and sexual violence?
- How are we responding to the increased budgetary pressures placed on organisations who deliver domestic and sexual violence services in Sefton? Have we got the necessary resilience in place to deal with these pressures?
- How are we effectively commissioning domestic and sexual violence services in order to improve outcomes?
- Have we placed sufficient emphasis on working with perpetrators and if not how may we develop this further?
- Are current domestic and sexual violence services targeted at adults and children effectively co-ordinated to meet the needs of children and vulnerable adults?

- What learning and development is provided for both domestic and sexual violence services and those agencies that may come into contact with victims of domestic violence?

7. LESSONS LEARNED

7.1 Merseyside Police

7.1.1 Creating skeleton PROtect records can result in focus being lost on the important task of risk assessment and referral.

7.1.2 Supervisors breached MSP policy by not consistently checking and signing VPRF 1's, thereby denying themselves the opportunity to quality assure officers work and provide them with feedback.

7.1.3 The process for updating LOI markers did not work in this case, meaning that a call might not receive the appropriate priority because command and control staff would not automatically know that it came from a Gold Victim's address.

7.1.4 MSP domestic violence policies and procedures are there to support victims and in this case there were several breaches of them as evidenced by: not referring each arrest of Male A to CPS; not completing risk assessments or completing them too slowly; not always keeping Female A informed of developments.

7.1.5 The substantive lesson for MSP was its failure to recognise the persistence of Male A's victimisation of Female A, and that the complex issues resulting in multiple calls [fourteen] needed tackling through a problem solving model, rather than the discrete approach that was actually used. For example, the thoughtful issuing of Male A with a warning under the Protection from Harassment Act was not subsequently built on when he continued to victimise Female A in a way that evidentially fell short of a prosecution. Each incident could have been allocated to the same OIC, thereby established a common link between MSP and Female A, whilst enabling the OIC to build a body of evidence in conjunction with a named CPR lawyer.

7.2 Merseyside Probation Trust

7.2.1 MSPT IMR summarises its key learning points as:

1. There was an insufficient focus on public protection.

2. How offender manager thinking in domestic abuse cases can be influenced by a range of factors e.g.

   the index offence not being domestic abuse related

   the impact of arrests being made which do not result in prosecutions

   not receiving intelligence re Police call outs as and when they happen

   not seeking information from Police in a timely way when there is a re-emergence of risk factors

3. Lack of objectivity which led to poor management of the case e.g. The offender was complying with parts but not all of his order and this should have been addressed sooner.

4. There is a need to provide guidance to staff re how to respond effectively to volatile relationships and in particular ones where the victim wishes to maintain the relationship.

5. How to ensure effective management oversight.

7.3 **Liverpool MARAC** [August 2010]

7.3.1 Cases require more careful scrutiny the salient details of which should be recorded in the minutes along with SMART actions allocated to appropriate agencies. Failure to scrutinise does not support the victims of domestic abuse. [Specific, Measurable, Achievable, Relevant and Time defined]

7.4 **ABC Liverpool**

7.4.1 When children from previous relationships are mention their age should be established and where they are under 18 years, safeguarding procedures followed.

Note: The "child" in this case was in fact an adult.

7.4.2 When experiencing difficulties in transferring cases to another agency [in this case to Sefton VVAT] workers should seek the support of their managers.

7.5 **Sefton MARACs** [16.12.2010, 03.03.2011 and 21.04.2011]

7.4.1 The documented actions arsing from the three MARACs [two from the first, one from the second and none from the third] did little to support the victim despite the presence of over 15 agencies at each meeting. The DHR Panel felt the focus of the three MARACs was on processing the cases [86 over the three meetings] rather than detailed scrutiny of the issues. Sefton recognises this and is reviewing its domestic abuse services.

7.6 **DHR Panel Observations**

7.6.1 **Risk:**

1. Risk factors not always recognised
2. Risk assessments not updated to reflect new or changing risk factors
3. Risk was generally understated

7.6.2 **MARAC**

1. MARAC was ineffective in protecting Female A
2. MARAC agencies did not have clear risk management plans

7.6.3 **Leadership**

1. No agency identified that MARAC was not protecting Female A and that a different approach was needed to support her.
2. Leadership was absent from the search for Male A on 05.01.2012.

3. MARAC in Sefton was lead poorly, leading to a review

7.6.4 Domestic Abuse Sefton

1. Domestic abuse services in Sefton were fragmented resulting in Borough wide review.

7.6.5 Victim Focus

1. Some good work was done to support Female A but the power and control exercised by Male A over her was not fully appreciated and countered.

2. Alcohol misuse was a central element in domestic abuse but was never effectively tackled.

3. Female A's geographical isolation from her family made it harder for her to keep her resolve to leave Male A.

8. CONCLUSIONS

8.1 When Female A and Male A began their relationship each brought to it a history alcohol misuse, mental health needs and domestic violence; Female A as a victim and Male A as a perpetrator. The blending of these ingredients resulted in Male A's dominance and bullying of Female A and she soon faced a familiar pattern of victimisation.

8.2 Between 12.01.2010 and Female A's death on 05.01.2012, MSP recorded fourteen incidents of domestic abuse of which thirteen identified Female A as the victim and Male A as the perpetrator. Overall the initial response to the fourteen incidents was swift and dealt with the immediate issues.

8.3 MSP dealt with each incident in isolation and missed some opportunities to arrest Male A. When they did arrest him [on nine occasions] they only referred the case to the CPS on five occasions. This denied independent scrutiny of the circumstances.

8.4 Female A's pattern of reporting violence and retracting or minimising them is a recognised phenomenon in domestic abuse and illustrates the complex nature of the relationships between victims and perpetrators and adds to the victims' vulnerability. Professionals should have looked beyond each incident and taken account of the cumulative impact of the abuse when assessing risk.

8.5 Alcohol abuse was a considerable facet of the domestic violence, yet no agency addressed this effectively. MSPT tried when Male A was required to undergo an ASRO programme, following his drink/driving related conviction. MSPT recognised that Male A was a perpetrator of domestic violence and that his alcohol misuse was a risk factor which the ASRO would have addressed. Male A openly out-manoeuvred MSPT and avoided the ASRO programme.

8.6 MSPT deemed Male A posed a medium risk of causing serious harm to the public and a known female [Female A] but did not respond to factors which would have increase his risk to high, nor was sufficient effort put into seeking them out. This meant that the risk management plan was based on a lower level of risk than it should have been. Significantly, two OM's felt that as Male A had not been to court for domestic violence against Female A, the matters may not be serious.

8.7 MSP followed their domestic abuse escalation pathway and Female A was identified as a Gold victim requiring a priority response. However, this case required more than response; a proactive problem solving approach was called for. MARAC provided a framework for that.

8.8 Female A was referred to four MARAC meetings because she was assessed as facing a high risk of serious harm from Male A. MSPT was represented at the MARAC meetings but did not identify that their "Medium" risk assessment of Male A was different to the "High" presented by other agencies.

8.9 MARACs' focus, as determined from the minutes, appears to have been on process issues rather than problem solving Some actions were agreed that supported Female A, but nothing was done to address Male A's offending. The support services worked well together and provided Female A with practical and emotional help, including moving home and being non-judgemental when Male A forced his way back into her life.

8.10 Sefton MARAC was not operating effectively and consequently victims of domestic abuse were not receiving an appropriate level of support. The death of Female A [and an earlier DHR] prompted a Council lead review into MARAC, with an immediate action to move the chairing of MARACs from VVAT to MSP.

8.11 The DHR Panel thought that no agency recognised the complexities of the relationship between Male A and Female A or the depth of their dependency on alcohol. Their mental health needs and Female A's geographical isolation from her family added to the problem. The situation required leadership; firstly to recognise that the traditional approach was failing and secondly to identify the alternative. The DHR Panel understands that MSP deal with large volumes of domestic abuse. Nevertheless, Female A's case demanded an approach that was going to halt her exposure to domestic violence from Male A. The fourteen recorded incidents, along with the high risk indicators should have prompted a more effective response. Clear leadership should have produced this.

8.12 Female A was a woman in need of significant support to break away from Male A and when she mustered sufficient courage and strength to do so [07.12.2012] the help was in place and sustained her resolve. It is known that the risk to victims increases at the point of or soon after separation.

8.13 The CPS contribution to the DHR was useful and explained its reactive role in domestic violence and how it has to examine each case against its merits and only then arrive at a prosecution decision. The CPS reviewed its decision not to prosecute Male A for the 07.12.2011 assault and conclude it was properly made against the code.

8.14 The DHR Panel thought that more could and should have been done by MSP, working in collaboration with the CPS, to secure a charge and conviction against Male A for domestic abuse on Female A. A competent multi-agency problem solving approach should have included CPS to advise on evidential matters and the range of legislative options open to investigators and support workers.

8.15 All agencies submitting information to the DHR review were open and appropriately self critical, thereby demonstrating a willingness to learn from their oversights and mistakes.

9. PREDICTABILITY –PREVENTABILITY

9.1 Female B believes that her sister's death could and should have been prevented.

9.2 The DHR Panel felt it was possible to predict that Female A was likely to suffer really serious harm on 05.01.2012. This is predicated on: MSP's existing assessment that Male A posed a high risk of causing serious harm to Female A and MSPT's acknowledgment that Male A should have been assessed as posing a high risk of causing serious harm to Female A.

9.3 Male A had previously restricted Female A's airway and harmed her dog. He had convictions for using an imitation firearm and a knife. On several occasions Female A had expressed her fear that Male A was capable of killing her. She prophetically said in July 2010, "I genuinely believed he would kill me and I think it is only a matter of time before he does kill me". Additionally, Female A is recorded as saying to MSP on 08.12.2011; "I am a nervous wreck. I am in fear of [Male A] and feel he is capable of anything".

9.4 All that information was available to MSP on 05.01.2012 when they were looking for Male A.

9.5 MSPT learned on 05.01.2012 that Male A had stated his intention to kill himself on the lawn at Female A's home. Whilst the OM spoke with Male A there was no reassessment of the risk he posed. It is clear that he visited the house during the night of 04/05.01.2012, as evidenced by Female A finding the laptop computer and "suicide" note.

9.6 MSP began a search for Male A to establish if he was safe and well. That was appropriate, but only looked at the problem from one perspective. The substantive task of ensuring that Female A was protected was not identified because no one considered what Male A's actions meant for her safety. That was a serious error and misjudgement and MSP should have recognised that Male A's threat to take his life on Female A's lawn had wider implications and spotted the danger he presented to Female A.

9.7 Notwithstanding that the substantive task was not identified, MSP's command and control of the search for Male A was uncoordinated and poorly led. Had MSP taken tighter control over the search for Male A they would have given themselves a far better chance of finding him, thereby preventing Females A's death.

10. RECOMMENDATIONS

10.1 Introduction

10.1.1 There was a considerable gap between the recommendations being written and the conclusion of the criminal proceedings and the completion of IPCC investigation. In that time all the agencies report having completed their actions. However, the recommendations are shown below to demonstrate what has been done.

10.1.2 Therefore the Action Plan at Appendix A does not contain the single agency recommendations; it does include the recommendations of the DHR Panel and Sefton MARAC/VVAT.

10.1 Single Agency

10.1.1 Merseyside Police

1. Introduce time parameters for creating a full and meaningful entry on PROtect for gold victims, with risk assessment and appropriate referrals. To meet such deadlines, all FCIU would need dedicated risk assessors.

2. Review procedures force-wide for the storage of completed VPRF 1 forms, which should be retrievable for evidential or audit purposes. It may be feasible to scan the original forms onto a system such as Niche.

3. A supervisor should be informed when a domestic abuse incident is reported and his or her details recorded on the Storm log. The supervisor should ensure that a VPRF 1 is submitted prior to the end of the tour of duty, having quality assured it and having appended his or her name and signature.

4. Agencies must work together to address underlying causative factors, such as alcohol dependency, and must ensure that vulnerable victims are not left in an isolated situation. Perpetrator programmes should also be available.

5. Once gold risk assessment status is reached, a single FCIU investigator should be identified and assigned to the individual or family concerned as a point of contact and, as far as practicable, should deal with all cases. That individual would then be responsible for case-building and should liaise with the CPS at an early stage to discuss the options available, rather than considering each incident in isolation.

6. 'Location of interest' (LOI) markers must be regularly reviewed, with an updated risk assessment, to ensure they are still appropriate and sitting on the right address. They should contain details such as bail conditions and any harassment notices, which should be acted upon.

7. Incidents of concern such as critical incidents and high risk missing persons should be clearly defined and classified and an officer at inspector level (usually a CIM) or above should be identified as the person in charge of it. That individual's details should be recorded on Storm and if responsibility is passed to another officer, that person must be fully briefed and must ensure that his or her details are recorded on the Storm log.

8. Regular audit and inspection should ensure that policy and procedure is adhered to. Particular attention should be paid to the reporting and recording of domestic abuse incidents, with risk assessment and referrals, and the requirements of both force 'Domestic Abuse (Policy and Procedure)' and the 'Code of Practice for Victims of Crime' issued by the Home Secretary to inform victims of a suspect's release and any bail conditions.

9. Appropriate supervisors, particularly critical incident managers (CIM), should be provided with regular training updates regarding any effective practice and lessons learned from relevant reviews.

10.1.2 **Merseyside Probation Trust**

1. The Trust will prepare advice for staff in the use of restrictive requirements with particular reference to Domestic abuse scenarios. The Trust will also take legal advice to consider the impact that article 8 of the Human Rights Act i.e. the right to have a family life, may have upon any guidance to be issued.

2. The Trust will develop staff to ensure that triggers for escalating risk, including arrests that do not result in prosecution are properly assessed and the risk assessment and risk management plan reviewed and updated. In cases characterised by volatile relationship OMs should ensure an investigative approach is applied by actively seeking information on a regular and frequent basis.

3. The Trust should review its strategy for managing cases in which domestic abuse features either as the index offence or as a known factor in cases where it is not the index offence.

4. The Trust should satisfy itself that all operational staff including managers, have a sound understanding of when and how they should make referrals to the MARAC.

5. Trust should remind its MARAC Representatives that information from the MARAC relevant to the case should be recorded in the non disclosure section of OASys and an email sent to the Offender Manager to alert them.

6. The Trust should satisfy itself that OM 1 and 2 are sufficiently responsive to issues of increased risk in cases where there is known domestic abuse; there is evidence that assessments which have been reviewed are accurate and that sentence plans are fully implemented.

7. Improve the ability of all TMs to provide appropriate advise and guidance in the management of domestic abuse including how domestic abuse registers should be reviewed for best effect.

8. The Trust should satisfy itself that all operational staff and managers can articulate how information gained by a SARA assessment can enhance risk assessment and management.

9. The Trust should review its Domestic Abuse Policy and in doing so ensure OM responsibilities are clear re how and when to refer to MARACs and IDVAs . The

review should also consider how the policy may be re formatted to make it more accessible.

10. The Trust should ensure that newly qualified staff are afforded the correct level of caseload protection .

11. The Trust should require LDU leaders to reinforce with their staff the guidance in the Acceptable Absence policy in relation to managing ongoing health issues.

12. The Trust should work with Merseyside Police to try and identify a mechanism whereby any domestic abuse calls which involve an offender currently managed by the Probation Trust results in an immediate notification of the circumstances to the Offender Manager.

10.1.3 **Liverpool MARAC**

1. Ensure that actions offered/assigned in the MARAC process are SMART

2. Introduction of a tracker for actions outstanding.

10.1.4 **Stonham**

Stonham report having completed all their actions.

10.1.5 **Sefton MARAC/VVAT**

1. That the actions from MARAC Review are reviewed by Sefton Safer Community Safety Partnership to ensure that they take place.

2. The VVAT Team should:

- receive appropriate supervision which includes clinical supervision
- put into place effective systems and processes should be put into place to hold and share information which all organisations are able to access
- have appropriate professional training to enable them to undertake their role successfully

3. That VVAT and MARAC look at all of the evidence from the victim, perpetrator and agencies and develop more imaginative and collaborative solutions. Initial contact methods with victims and ongoing methods need to be improved and reduce the reliance on phone contact based on the needs of the victim.

10.2 DHR Panel

10.2.1 That Sefton Safer Communities Partnership satisfies itself that:

1. The Council led review of domestic abuse services has been completed and the recommendations implemented.

2. MARAC is working and protecting victims.

3. Domestic abuse training includes the complex nature of the issues facing victims, particularly the pressures they face when reporting abuse and leaving relationships.

4. Alcohol services are available for victims and perpetrators of domestic abuse.

5. Its constituent agencies understand how to identify and assess domestic abuse risk factors, alter risk levels when factors change and produce appropriate risk management plans.

END OF REPORT

Appendix A below

APPENDIX A

ACTION PLAN Sefton Safer Communities Partnership DHR Female A

Recommendation	
What was the over-arching recommendation?	What we have achieved to date
SEFTON MARAC/VVAT	
1. That the actions from MARAC Review are reviewed by Sefton Safer Community Safety Partnership to ensure that they take place. 2. The VVAT Team should: • receive appropriate supervision which includes clinical supervision • effective systems and processes should be put into place to hold and share information which all organisations are able to access • have appropriate professional training to enable them to undertake their role successfully 3. That VVAT and MARAC look at all of the evidence from the victim, perpetrator and agencies and develop more imaginative and collaborative solutions. Initial contact methods with victims and ongoing methods need to be improved and reduce the reliance on phone contact based on the needs of the victim.	This has been done and CAADA observations have also been reported to SSCP Supervision is in place and VVATs have regular case management sessions. We have looked into clinical supervision but have been unable to find anyone to deliver at this stage This is still an outstanding action. We need to identify a suitable system that we can use to hold and share info. We are looking at the Hub system currently used by ASBU to see if that has capability for Domestic Abuse info Some of the team have undertaken IDVA training (due to capacity and resources not all have been able to do training).VVATs have (and continue) to access relevant training for example, through LSCB This is still an ongoing piece of work. MARAC workshop being planned and can be picked up in this

DHR PANEL	
That Sefton Safer Communities Partnership satisfies itself that: 1. The Council led review of domestic abuse services has been completed and the recommendations implemented.	Overview has been done and Health Needs Assessment commissioned. This will inform strategy and make recommendations on service needs
That Sefton Safer Communities Partnership satisfies itself that: 2. MARAC is working effectively and protecting victims.	MARAC self assessment to be completed. CAADA observation has bee carried out with a series of actions. A MARAC workshop is being planned within next couple of months to review practice and consider effective ways of working
That Sefton Safer Communities Partnership satisfies itself that: 3. Domestic abuse training includes the complex nature of the issues facing victims, particularly the pressures they face when reporting abuse and leaving relationships.	Working in partnership with LSCB around Toxic Trio Training which looks at Parental Mental Health, Domestic Abuse and Parental Drug and Alcohol.
That Sefton Safer Communities Partnership satisfies itself that: 4. Alcohol services are available for victims and perpetrators of domestic abuse.	Lifeline have drug and alcohol contract and are members of MARAC.
That Sefton Safer Communities Partnership satisfies itself that: 5. Its constituent agencies understand how to identify and assess domestic abuse risk factors, alter risk levels when factors change and produce appropriate risk management plans.	This can be picked up at MARAC workshop