SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW 1

EXECUTIVE SUMMARY

Victim FEMALE 1

July 2012

CONTENTS

SSCP DHR Female 1 Executive Summary

1. INTRODUCTION

1.1 On 03.12.2011 Merseyside Police – MSP - officers were called to Female 1's home where they found her body and that of her mother, Female 2. Female 1 had last been seen alive on 26.11.2011 and Female 2 on 02.12.2011. Both women had been strangled and Male 1 became an immediate suspect because of his relationship with Female 1.

1.2 On 08.12.2011 Male 1 was arrested and later charged with murdering the two women and remanded in custody. On 09.02.2012 Male 1 was found hanged in his cell at Manchester Prison. Greater Manchester Police are preparing a file on his death for HM Coroner for Manchester City District. A date for his Inquest had not been set by 31.05.2013.

1.3 At an inquest on 24.04.2012 HM Coroner for Sefton declared that Female 1 and Female 2 had been unlawfully killed. MSP are satisfied that Male 1 killed the two women and that no one else was involved.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

Decision Making

2.1 Sefton Safer Communities Partnership (SSCP) Domestic Homicide Review Screening Panel decided that the death of Female 1 met the criteria for a domestic homicide review (DHR) as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews April 2011 (the Guidance).

DHR Panel

2.2 David Hunter was appointed as the independent chair and author of the DHR on 20.02.2012 and the DHR Panel met four times.

The Panel comprised of:

Paul HOLT	Assistant Chief Officer Merseyside Probation Trust (MPT)
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
Rachel WILSON	Detective Inspector Merseyside Police (MSP)
David HUNTER	Independent Chair and Author

Agencies Submitting Individual Management Reviews (IMRs)

2.3 The following agencies submitted IMRs.

Merseyside Probation Trust

Merseyside Police

2.4 Health submitted a letter because it had very little relevant information. Sefton Metropolitan Borough Council (Children's Services) had one relevant contact.

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 The Guidance.

Specific Terms of Reference

2.6

1. How did your agency respond to reports or knowledge of domestic abuse involving Male 1 and Female 1?
2. What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?
3. What impact did the services provided by your agency have on reducing the impact of domestic abuse by Male 1 on Female 1 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 1 and/or Male 1 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 Male 1 and Female 1 and the other subjects of the review, effective and did it enable joint understanding and working between agencies?'

Subject of Review

2.7 Female 1 White British 50 + years victim; died on or about 28.11.2011

People of Specific Interest

Male 1	White British 50 + years believed perpetrator (now deceased)
Female 3	White British 40 + former partner Male 1

Other People

Male 2	Son of Male 1 and Female 6
Female 2	70 + Mother of Female 1; also believed killed by Male 1 on or about 02.12.2011
Female 4	Daughter of Female 1
Female 5	Daughter of Female 1
Female 6	Former wife of Male 1
Female 7	Victim of Male 1 in 2001
Female 8	Daughter of Female 3
Female 9	Former Fiancé of Male 1
Female 10	Best Friend of Female 1

Note: Female 2's death is outside the definition of a domestic homicide review.

Time Period

2.8 The time period under review is from 25.02.2010 to 03.12.2011. Agencies were asked to exercise their professional judgement and include any information relevant to the terms of reference that pre-dates 25.02.2010.

Notification to Family of DHR

2.9 Selected members of Female 1 and Male 1's family were written to informing them that a DHR was taking place and inviting them to contribute after the trial.

Family and Friends Contributing to the DHR

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

- Female 4: Telephone - Daughter of Female 1 (victim)
- Female 3: Seen - Former partner of Male 1 (perpetrator)
- Female 8: Seen - Female 3's daughter
- Female 10: Seen - Female 1's best friend

2.11 Females 5 and 6 and Male 2 did not want to take part in the review.

3. DEFINITION OF DOMESTIC VIOLENCE

3.1 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.

4. BACKGROUND TO CASE

4.1 The following detail is an amalgamation of information drawn from agency records and interviews with family and friends. It was noted in MPT records that much of what Male 1 told them was unverified and considerable doubt exists as to its veracity. This view is supported by Female 1's family and friends.

4.2 Female 1 spent her entire life living and working in and around Sefton. She joined the Civil Service when she left school and returned after the birth of her first daughter. Female 1 spent ten years as a dinner lady in a special school and combined that with an evening and weekend job as a representative for a cosmetics firm selling to people in their homes. Thereafter she worked as a sales assistant for a national supermarket chain. Female 1 was described as being very successful at selling and was a well liked and respected person; in short thoroughly decent. She had a close relationship with her family and enjoyed socialising with her friends. Her relationship with her husband ended in 2005.

4.3 Male 1 was born and educated in Burnley. It is believed his parents died by the time he was 22 years of age. He married Female 6 a few years later and divorced in 1995. His son Male 2 remained with Female 6. All of his addresses were in the North West, save for a period in London and a reported year abroad. He described himself as a skilled engineer but his field of expertise was unknown. Male 1 claimed to have spent about a year in Saudi Arabia, returning to England in 2000 when he moved to London. In 2002 he was convicted of False Imprisonment and Indecent Assault and sentenced to four years imprisonment. He was released in September 2004 and

moved to the Widnes area, then Blackpool and latterly Southport. Male 1 does not appear to have been in regular employment and it is evident from his actions in borrowing money that he struggled financially. After his divorce he formed relationships with several women. In 2007 and 2008 Male 1's general practitioner referred him to services to deal with his anger management but he did not attend.

4.4 In 2008 Female 1 was given a gift of a flying experience at the Flight Academy in Blackpool where Male 1 worked as a coordinator. Soon afterwards they began seeing each other and formed a relationship, albeit they lived at separate addresses. The relationship ended on good terms in February 2009. In April 2009 Male 1 went to live at Female 1's address as a lodger after he obtained work in the area. Female 4 who was living at home at the time described how she had a difficult relationship with Male 1, in that he tried to drive a wedge between them.

4.5 Male 1 began a relationship with Female 3 in July 2009 whilst lodging with Female 1. In November 2009 Male 1 took a twelve month tenancy on a house which was in the same street as Female 3's home. In February 2010 Male 1 assaulted Female 3 and she ended the relationship. He remained at Address 4 until the tenancy expired in November 2010 and then moved back in with Female 1 where he remained until the deaths in December 2011.

4.6 Sometime between the February 2010 assault and July 2010, Female 1 sought out Female 3 and they exchanged telephone numbers and remained in touch. Female 3 warned Female 1 of the danger Male 1 posed but could not persuade her she was at risk. It appears that Female 1 was strongly influenced by Male 1's account of the assault on Female 3, a supposition supported MPT's IMR which records that Male 1 minimised the incident, questioning the accuracy of Female 3's account and even queering whether it happened at all, albeit he pleaded guilty.

4.7 On the weekend of Friday 25.11.2011 Female 1 and Male 1 left for a weekend in the Lake District. It appears something happened between them as it is known they left the hotel early claiming a family emergency. Female 1 was last seen alive by a neighbour on Saturday 26.11.2011.

5. ANALYSIS

5.1 Introduction

5.1.1 The analysis focuses on the DHR period, 25.02.2010 to 03.12.2011 and is preceded by a synopsis.

5.2 Synopsis 1998 to 25.02.2010

5.2.1 The following incidents are recorded on Lancashire Constabulary's SLEUTH database and are all that remain on record.

Note: SLEUTH is used for crime recording; intelligence management, missing persons; officer tasking and briefing and public protection.

5.2.2 In 1998 Male 1 and Female 6 (his then current partner) were on a holiday abroad. She described how without warning he assaulted her in the presence of her children by attempting to strangle her. The police were called but Female 6 did not wish to pursue the matter.

5.2.3 They returned to England together where Female 6 tried to end the relationship. Male 1 refused to accept this but moved out of Female 6's home shortly afterwards. He began bothering her and was arrested by Police and charged with harassment, which was later discontinued by the Crown Prosecution Service (CPS).

5.2.4 In 2002 Male 1 was convicted at a London Crown Court of False Imprisonment and Indecent Assault on Female 7 arising from an incident on 18.11.2001 when they were in a brief relationship. He received four years imprisonment for the first offence and 1 year imprisonment for the indecent assault to be served concurrently. He did not qualify to be registered as a sex offender. Part of the assault involved Male 1 placing a pillow over Female 7's mouth.

5.2.5 This was the second known incident where Male 1 restricted the airway of a female within a relationship.

5.2.6 In 2004 Male 1 was released on licence which ended on 30.01.2005. At the time he was assessed as posing a medium risk of causing serious harm to a known adult (Female 7)and a low risk to all other women.

5.2.7 On 31.08.2007 Male 1 was arrested on suspicion of assaulting Female 9 (his future fiancé) in her home. In October 2007 the CPS decided there was insufficient evidence to prosecute Male 1 and he was released from bail. In 2008 he used deceit to obtain cash from Female 9 and her mother. There was no prosecution. His dishonest behaviour ended the relationship.

5.2.8 Male 1 formed a relationship with Female 1 in 2008 which ended on good terms in February 2009. He commenced a relationship with Female 3 in July 2009.

5.3 DHR Review Period 22.02.2010 to 03.12.2011

Merseyside Police Missed Opportunities

First

5.3.1 MSP failed on three occasions to complete a risk assessment on Male 1. All the opportunities arose from the same domestic violence incident.

5.3.2 On 25.02.2010 Male 1 attempted to strangle Female 3 who tried to leave the house with her young grandchild. She did not report the attack to the police. A week later Female 3 and her daughter Female 8 sought advice from an off duty MSP officer who told them to report the incident to the police. Female 3 was reluctant to do so because she did not want social services involved because of the Special Guardianship Order she held for her grandchild. She now understands the role of children's services in domestic violence.

5.3.3 Female 3 and Female 8 accompanied the officer to see Male 1. Female 3 disclosed that Male 1 had assaulted and strangled her. Male 1 apologised and officer advised Female 3 how to make a formal complaint of assault but she declined. He made an entry in his official note book and took no further action.

5.3.4 Female 3 felt confident enough to disclose domestic abuse to a police officer in the presence of the perpetrator. The officer's actions fell well short of those required by force policy. It made no difference that he was off duty or a friend of Female 8. He should have followed Force policy for domestic abuse procedures and formally reported the matter himself.

5.3.5 The officer might have found himself in a difficult position given the "informal" approach, but he failed to recognise the wider issues of child protection and the need to formally assess the risks posed by Male 1. His action in attempting reconciliation as evidenced by Male 1's apology and his failure to arrest or arrange for the arrest of Male 1 did not support the victim of domestic abuse. He failed to complete a Vulnerable Persons Referral Form 1 or refer the incident to Family Crime Investigation Unit (FCIU). A VPRF 1 is an essential source document and officers are required to submit them to FCIU who complete a formal risk assessment. Not referring the matter served to leave Female 3 and her granddaughter in a vulnerable position. The officer's actions in keeping the information to himself meant that any subsequent checks by agencies for information on Male 1 or Female 3 would not have identified the "admitted" allegation. He also made his decisions without the benefit of undertaking the usual police checks to determine Male 1's background. MSP are examining the officer's actions.

Second

5.3.6 On 10.03.2010 MSP officers attended Male 1's home in response to concerns for his safety expressed by Female 8. On arrival they found Male 1 and Female 3. She repeated her allegation that Male 1 had assaulted her on 25.02.2010. The officer took a statement in which Female 3 describes how during an argument Male 1 strangled her and she blacked out. She regained consciousness and attempted to leave with her young grandchild. Male 1 refused and shouted at the child to return to bed. Male 1 was arrested and denied the allegation when interviewed. He was

conditionally bailed to return to the police station on 14.04.2010. He was not to approach or communicate by self, servant or agent Female 3 or to pass her address.

5.3.7 The arresting officer said he completed a VPRF 1. The VPRF did not reach FCIU who learned of the incident through the domestic violence closing code on the incident log which they endorsed saying they were waiting for the VPRF 1. On 13.03.2010 FCIU send an e-mail reminder to the officer to submit the VPRF 1 and again endorsed the incident log. There the matter ceased and no further action was taken by FCIU. This meant that a risk assessment was not undertaken nor was a referral made to children's services or MARAC, ** leaving Female 3 and her grandchild potentially vulnerable.

** 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. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55,000 cases a year.

Source: www.caada.org.uk

5.3.8 On the 11.03.2010, just one day after his release, the Crown Prosecution Service authorised MSP to charge Male 1 with a Section 39 Common Assault when he answered his bail.

5.3.9 The response of MSP was mixed. The officer took positive action by arresting Male 1, thereby complying with Force policy and supporting the victim of domestic violence. There is no record of the VPRF 1 being received in FCIU who after one attempt to obtain it took no further action. FCIU staff spoken to during the DHR recall that in 2010 there was a backlog of work in the unit and resilience was an issue. The problems of VPRF 1 and backlogs in FCIU have since been successfully addressed and therefore MSP does not make a recommendation.

5.3.10 VPRF 1 submission is now an item on the daily Basic Command Unit (BCU) Command Team meetings, with lapses being dealt with by way of the Performance and Development Review system. Members of the Force Protection of Vulnerable Persons Senior Command Team meet monthly with the Detective Chief Inspectors from each BCU to discuss staffing and resilience issues in FCIUs and where necessary take supportive remedial action.

5.3.11 The current MSP compliance rate for submitting VPRF 1's is 96.4% and for Sefton BCU it is 96.5%.

5.3.12 The failure of FCIU to obtain a VPRF 1 for the incident had the same negative consequences as when the "off duty" officer did not report Female 3's disclosure. The opportunity to undertake a risk assessment on Male 1 and provide services to Female 3 was missed and the child protection implications of her grandchild witnessing domestic abuse were left un-assessed. Additionally, the absence of a risk assessment meant that a referral to MARAC was not considered. The incident was not recorded on the PROTECT** database. However, it was easily retrievable from other databases and would have been found during a routine, "what do you know about Male 1/Female 3" check. ** A specialist database of vulnerable people.

5.3.13 In the absence of a VPRF 1 the DHR Panel retrospectively completed the Merseyside Risk Identification Tool (MeRIT) using the 40 question screening form. The Panel members put themselves in the position of what the officer could have reasonable found out from the victim and a check of the Police National Computer.

5.3.14 The DHR Panel MeRIT risk assessed score was 144. The numerical threshold for categorising a case as High Risk is 60+. Therefore a score of 144 would have resulted in referral to MARAC with immediate consideration being given to the safety of Female 3 and her grandchild. Therefore MSP's second failure to complete a risk assessment was a significant error and meant that Female 3 was not referred to MARAC and Male 1's level of risk to others was not assessed. The DHR Panel debated whether the fate of Female 1 might have been different had a referral been made to MARAC, but concluded that the separation in time between the spring of 2010 and the death of Female 1 in December 2011 prevented any reliable view.

5.3.15 When CPS made the charging decision on Male 1 they discounted the 2002 convictions and opted for Common Assault as being appropriate. MSP did not tell CPS of the 1998 and 2007 assault allegations. The reason appears to be that the officer in the case had not sought out the information.

Third

5.3.16 On 12.07.2010 Female 3 telephoned MSP saying that Male 1 had sent her a birthday card and present (using Female 1 as the courier) in direct contravention of his bail conditions. Male 1 was arrested and charged with breaching his bail and kept in custody until he appeared before the court following morning when he was re-bailed to appear at court on 23.07.2010. There is no record that a VPRF 1 was completed and the incident does not appear on the PROTECT. Therefore a third opportunity to complete a risk assessment on Male 1 was missed. Female 1 was seen as a witness during the "breaching bail" investigation and did not make any allegations against Male 1.

Merseyside Probation Trust Involvement

Pre Sentence Phase

5.3.17 MPT's involvement with Male 1 began when it prepared a Pre-Sentence Report to inform the Magistrates' sentencing decision. MPT noted that, "Verifiable information about Male 1's history was difficult to acquire as he was evasive and well defended in terms of allowing access to information about his circumstances".

5.3.18 MPT knew the details of Male 1's 2002 conviction, including the suffocation aspect and acquired an OASys assessment from his licence supervision file following his release in 2004. Given that Male 1 was evasive about his past, MSP could have done more research into his background. For example where had he qualified as an engineer and what was his expertise in. MPT was unaware of the 2007 alleged assault on Female 9 and the 2008 allegations of dishonesty.

5.8.19 MPT knew Female 3's grandchild had witnessed an element of domestic abuse and enquired if children's services had any contact with Female 3. Children's services had not and agreed to refer the case to the Family Support Team who carried out an Initial Assessment and were reassured by Female 3 that she had ended the relationship for good. This referral by the probation officer is an example of a

professional not making an assumption that the police had referred the case to children's service; they had not.

Male 1's Conviction

5.3.20 On 23.07.2010 Male 1 pleaded guilty at Magistrates' Court to assaulting Female 3 on the 25.02.2010. His 2002 conviction was known to the court. Male 1 was sentenced to:

- Suspended sentence order: four months imprisonment suspended for twelve months
- A twelve month Supervision requirement
- A requirement to attend a Community Domestic Violence Programme
- A twelve month Restraining Order: Protection from Harassment Act
- £500 compensation to the Victim
- £150 costs to CPS

5.3.21 MPT policy requires a Spousal Attack Risk Assessment - SARA – to be completed in cases of domestic violence and reviewed each time OASys (Offender Assessment System) is reviewed. Male 1's SARA judged him to be a medium risk of causing serious harm to a known adult (Female 3) and a known child (Female 3's grandchild) and a low risk to other females.

5.3.22 A major concern of Female 3's is that after Male 1 was convicted of assaulting her, she was not told of his 2002 conviction. Had Female 3 known of it she would have used the information to try and persuade Female 1 that Male 1 posed a real risk. Female 3 is fixed in her view that she was entitled to know about his offending history given that she was a victim.

5.3.23 The DHR Panel considered the disclosure issues from a broader perspective. The purpose of disclosing information about Male 1 would be to enable Female 3 to make decisions about protecting herself and her grandchild and not about protecting other females. Protecting other females through disclosure falls to the appropriate agencies where it is deemed necessary and in accordance with policies and procedures. Any disclosure to Female 3 would need to be commensurate with her degree of resistance to ending the relationship. Female 3 had successfully severed her links with Male 1 making disclosure less justifiable.

5.3.24 On balance the DHR Panel felt that following the July 2010 conviction, Female 3 could have been told of Male 1's 2002 convictions. These were a matter of public record, albeit not easily accessible. The justification for telling Female 3 lay with her status as a victim and to reinforce her decision not to reform a relationship with Male 1, rather than enabling her to pass the information on to Female 1. However, once Female 3 knew of the conviction, she was in control of who she told and would probably have passed the information to Female 3.

5.3.25 MSP does not have a specific policy on disclosing perpetrators' previous convictions to victims following convictions and the DHR Panel did not feel it necessary to make a recommendation on the matter, believing the existing disclosure rules were

sufficient. Disclosures or partial disclosure is usually made within the MARAC/MAPPA - Multi Agency Public Protection Procedures - and/or child protection procedures.

5.3.26 The DHR Panel noted that children witnessed domestic abuse in 1998 (incident abroad) and the 2010 assault on Female 3. This meant that Male 1 posed a risk to children of female partners. The significance of that appears not to have been recognised by any agency.

Post Conviction Supervision

5.3.27 Male 1 never effectively engaged with MPT despite the conscientiousness of his probation officer. Male 1's trait of concealing his past and making what are believed to be exaggerated claims about his work and lifestyle, coupled with a reluctance to take responsibility for his actions made it difficult for his probation officer to, "get any genuine sense of the true motivation behind some of the acts surrounding the (2010) offence". At this stage Male 1's was assessed using OASys as posing a medium risk of causing serious harm to Female 3 and a low risk to other females.

5.3.28 It is not known how many female partners Male 1 had and therefore it is not possible to quantify the proportion which resulted in violence. Male 1 was convicted of assaulting two women, one in 2002 and another in 2010. There is recorded police intelligence saying he assaulted two other women, one in 1998 and another in 2007. That intelligence was readily available had the probation officer sought it and given the "slippery" nature of Male 1 the DHR Panel felt it should have been discovered.

5.3.29 MPT did not consider Male 1 to be above a low risk of harm to unknown females. The risk he presented to women was directly linked to those he was in a partnership with, and then not all of them. For example it is known that his former wife reported that he was not violent to her. At the time of his 2010 conviction, MPT believed that Male 1 was not in a relationship and therefore his risk to unknown females was low. This belief came from questioning Male 1 and observing him during a home visit. Perhaps MPT could have recognised that being in a relationship was a key indicator of risk and put a contingency plan in place to discover when that happened and reassess Male 1's risk when it did. That plan might have included asking the police/children's services/health to let MPT know should they discover Male 1 was in a relationship with an adult female.

5.3.30 Male 1's successfully resisted attending the Community Domestic Violence Programme and minimised the assault on Female 3 to such an extent that he queried if it actually happened; this was in the face of his guilty plea.

5.3.31 The DHR Panel felt the analysis by the MPT IMR author accurately set out most the issues.

"The problems encountered in this case reflect an increasingly common issue with domestic abuse perpetrators, whereby initial acceptance of some responsibility is replaced (usually after sentence) with more resistant and entrenched views. This means that a sentence proposal which may have seemed appropriate when a Pre Sentence Report (PSR) was being prepared becomes unworkable once the Order has commenced. In circumstances where offenders simply refuse to comply with all or part of their Order, this can be dealt with by returning them to Court for Breach of the Order and a complete resentence on the original offence, with added punishment for the breach. However, where – as in this case – there is not an actual refusal to

comply, the Probation Service is in a more difficult position. It is an area that the Ministry of Justice and the National Offender Management Service (NOMS) are currently considering, as present arrangements are not felt to be adequate...".

5.3.32 MPT interventions with Male 1 did not achieve any fundamental change in his attitude towards his offending. At one point they recorded that Male 1 was "prone to exaggerate his achievements to the point of outright fantasy".

5.3.33 Male 1 complied with his reporting schedule and national standards were met, save for one period in the spring/summer of 2011. He completed his twelve month supervision requirement on 22.07.2011 without offending.

Police Discover the Bodies of Female 1 and Female 2

5.3.34 Female 1 and Females 2's bodies were discovered on 03.12.2012.

5.3.35 No agency held information about Female 1 other than her involvement as a witness to Male 1's breach of his bail. There was no reported history of domestic abuse between them and Female 1's death came as a shock to her family and friends. Whilst many of them did not like Male 1, none felt he presented a physical danger.

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. Term 1

How did your agency respond to reports or knowledge of domestic abuse involving Male 1 and Female 1?

6.2.1 When this term was drawn up is was thought that there was a history of recorded domestic abuse between Male 1 and Female 1. However, it turned out that Female 1 was not known to agencies as victim of domestic abuse. Nonetheless, many of the terms are relevant to Female 3 and are commented on from her perspective. Effectively only two agencies - MSP and MPT - had relevant dealings with Female 3 and Male 1. The health family did not have relevant material for the period under review and the older information was no longer pertinent.

6.2.2 Male 1 had a conviction from 2002 the circumstances of which included domestic abuse and whilst that was known to MSP and MPT in March 2010 following Male 1's assault on Female 3, neither agency was aware that he had formed a relationship with Female 1. The response of agencies to Female 3's victimisation appears in term 2.

6.3 Term 2

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

6.3.1 MSP failed to take any effective action to safeguard Female 3 and her grandchild following Female 3's disclosure of domestic abuse to an "off duty" police officer on 05.03.2010. The officer did not follow Force procedures and overlooked the child protection issues stemming from the Grandchild witnessing the latter stages of an abusive incident. His lack of action has been referred to MSP Professional Standards Department and therefore an explanation of his actions is not yet available.

6.3.2 Five days later on 10.03.2010 MSP took positive action when Female 3 repeated the allegation against Male 1. He was arrested and bailed with conditions not to approach Female 1 directly or through a third party and not to walk past her house. That action was protective of Female 3. The VPRF 1 did not arrive at FCIU and after one attempt to have it "re-sent" the matter received no further action. This meant that:

- a MeRIT risk assessment was not carried out
- a referral was not made to children's services
- a referral was not made to MARAC

6.3.3 The DHR Panel reconstructed the MeRIT risk assessment and concluded that Female 3 met the Gold Standard criteria for domestic violence and should have been referred to MARAC and children's services. The failure of FCIU in these matters meant that Female 3 and her grandchild very denied additional protective services.

6.3.4 The attack on Female 3 was the third known incidence of Male 1 "strangling" females within an intimate relationship. Neither MSP nor MPT had this information which should have lead them to consider a referral to MARAC. DHR Panel judged that is was reasonable to expect MSP and MPT to have gathered this very relevant historical data. Not doing so was not supportive of Female 3 or any female with whom Male 1 formed an intimate relationship.

6.3.5 MSP could have liaised with CPS whilst Male 1 was in custody on the 10.03.2010 and sought the authority to charge him. There is no explanation for why that did not happen or whether the officer in the case knew of the 1998, 2007 and 2008 incidents. It is known they were not on the advice file presented to CPS. The authority to charge Male 1 came the following day by which time he had been bailed to re-appear at the police station on 14.04.2010 and because of the restrictions of PACE 1984 he could not brought back earlier.

6.3.6 On one occasion MSP acted swiftly when Female 3 reported that he breached his bail conditions. He was arrested, kept in custody and placed before the court the next day. That is supportive of Female 3 and in stark contrast to the two previous occasions when she went to a police station counter to report Male 1 for breaching his bail conditions. It has not been possible to trace those two events.

6.3.7 Following Male 1's arrest for breaching his bail a VPRF 1 should have been submitted and a MeRIT risk assessment undertaken. Neither of those things happened and for the third time MSP failed to follow Force policy in this respect. As stated earlier those weakness have been recognised and effective remedial action taken before this DHR was commissioned.

6.3.8 Children's Services acted promptly following the referral from MPT that Female 3's granddaughter had witnessed part of the domestic violence between her grandmother and Male 1. An Initial Assessment was undertaken and professionals were satisfied that Female 3 could properly protect the child. This illustrates sound practice against expected standards.

6.4 Term 3

What impact did the services provided by your agency have on reducing the impact of domestic abuse by Male 1 on Female 1 and in identifying and dealing with the causative factors?

6.4.1 It is now known that agencies did not have any information that Male 1 was abusive towards Female 1. However, the following actions were taken following his attack on Female 3 aimed at reducing the impact on Female 3 and indentifying causative factors.

- CDVP
- Bail condition,
- Risk Assessments,
- Twelve month Supervision Order
- Restraining Order, Protection from Harassment Act.
- Referral to children's services by MPT

6.4.2 Male 1 would not engage with services when referred to them for anger management by his general practitioner or MPT in their attempts to deliver the Community Domestic Violence Programme. His non-engagement meant that the causative factors for his violence towards intimate female partners were never established. The bail conditions were effective in that when he breached them he was arrested and dealt with. Male 1 was not convicted of an offence during his supervision period; July 2010 to July 2011.

6.5 Term 4

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 The DHR Panel did not detect any gaps in agencies policies, procedures or training. MSP had difficulties with some staff complying with some policies.

6.5.2 The risk assessment policies of the agencies involved are fit for purpose; it was their application which was not always so. Not all of Male 1's historical date was gathered and used to inform his risk assessment, nor was sufficient emphasis placed on discovering whether he had formed any new relationships with females.

6.6 Term 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 1 and/or Male 1 and to work effectively with other agencies?

6.6.1 MSP was the only agency reporting capacity and resourcing issues and these impacted adversely on the services provided to Female 3. The MSP IMR readily acknowledges that in 2010 the relevant FCIU had difficulty in dealing promptly with relevant cases, resulting in some domestic violence cases not being assessed and services not being provided to victims as a direct consequence. In this case MSP was not required to provide or facilitate services to Female 3 and her grandchild.

6.7 Term 6

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

6.7.1 The three people looked at in this DHR are white British with English as their first language. They had no known diversity issues and they were culturally well equipped to deal with MSP and/or MPT.

6.7.2 MSP and MPT have well defined diversity policies and practices and no breaches of them were detected in the DHR.

6.8 Term 7

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

6.8.1 PrO 1 sought managerial advice when he recognised Male 1's manipulative behaviour. PrO 2's minor breach of national reporting standards was not picked up by his supervisor.

6.8.2 MSP supervisory processes did not identify that Female 3's case had not been risk assessed within FCIU and the IMR author believes this was associated with the inadequate resourcing in 2010.

6.9 Term 8

Was information sharing and communication with other agencies regarding Male 1 and Female 1 and the other subjects of the review, effective and did it enable joint understanding and working between agencies?'

6.9.1 MSP did not share information with children's services or MARAC following Female 3's complaint of assault, because they failed on three occasions to complete a MeRIT risk assessment which would have triggered the action.

6.9.2 MPT was effective in sharing information with children's services about the potential child protection issues arising from Female 3's grandchild witnessing domestic violence, albeit they could have told children's services about the breach of bail conditions by Male 1.

6.9.3 MSP and MPT should have been more proactive in seeking out information about Male 1, particularly given his reluctance to share his history and the doubts about the truth of those bits he did.

7. LESSONS LEARNED

7.1 Professionals working with resistant and manipulative clients should make every effort to verify what they are told and look at all possible sources of information to enable them to robustly challenge difficult people and inform risk assessments.

7.2 The pattern of Male 1's violent behaviour when ending relationships with some female partners was not recognised.

7.3 Where offenders are known to present a risk to intimate female partners, agencies should put processes in place that provide the very best opportunity of detecting when such relationships are forming or have formed.

7.4 Inadequate staffing in FCIU meant that routine procedures were not followed, the consequences of which did not fully support a victim or allow for appropriate information sharing including a referral to MARAC. This issue has been addressed and police practice is reported as being improved.

7.5 PrO 1 did not assume that MSP had referred Female 1's grandchild to children's services following the 2010 assault and showed good judgement by making the referral.

8. SEFTON'S DOMESTIC VIOLENCE PROGRAMME

8.1 Sefton Safer Communities Partnership (SSCP), Local Safeguarding Children's Board (LSCB) and Health and Wellbeing Board have identified Domestic Violence as a core priority; recognising the significant impact upon Communities. The strategic governance arrangements for DV were reviewed 12 months ago to allow an effective governance structure.

8.2 A review of MARAC was conducted as part of this DHR review and highlighted a number of areas of development. An action plan was formulated and implemented with a number of positive outcomes.

8.3 A specific action related to the focus upon high level repeat victims/perpetrators looking at specific issues and actions that could be put in place to provide tailored support/action.

8.4 Current training offered:

- LSCB Level 1 DV multi agency training
- LSCB Advanced DV multi-agency training. Delivered by SWACA, FCIU, RASA, Health and Children's Social Care

8.5 A range of statutory and voluntary sector agencies offer crisis and early intervention and prevention services. Good working relationships between services remain of

prime importance and Sefton partner agencies continue to build and strengthen links to ensure appropriate referral mechanisms are in place to ensure the best possible outcome for the individual.

8.6 Sefton's Voluntary Perpetrator's programme (NoXcuses) is currently running as a pilot. The 30 week programme is offered on a group work basis in order address abusive behaviours by male perpetrators.

9. CONCLUSIONS

9.1 Male 1 killed Female 1 by strangulation without any previous recorded history of domestic violence between them. However, by the time he did so, it was known that he had attempted to strangle intimate female partners on two previous occasions 1998 and 2010 and to smother one in 2001. There was another allegation of assault from 2007 and some suspected dishonest in 2008.

9.2 Therefore, when Male 1 was arrested and charged with assaulting Female 3 by strangulation, MSP and MPT should have made a greater effort to piece together his history and to consider what impact it made on his assessed risk. The intelligence was there to be had. MSP failed to complete a risk assessment thereby preventing a referral to MARAC and children's services and the opportunity to look more closely at Male 1. Part of MARAC's role could have been to consider making a partial or full disclosure of Male 1's 2002 conviction to Female 3

9.3 MPT recognised Male 1's manipulative nature as evidenced by his refusal to engage with the CDVP which was not substituted with an alternative. Male 1 was able to complete his twelve month Supervision Order without effectively acknowledging or addressing the causative factors of his offending, thereby leaving an important element of risk management uncontrolled.

9.4 Male 1 was correctly assessed as posing a medium risk of causing serious harm to a known adult (Female 3) and low risk to all other women. His pattern of being violent to some females during the ending of relationships was not recognised and therefore no plans were made to discover when he formed a new relationship.

9.5 It appears no agency knew that Male 1 had been in and re-formed an intimate relationship with Female 1. However, in July 2010 he used Female 1 as a go-between to contact Female 3 in direct contravention of his bail conditions and neither MSP nor MPT used that opportunity to explore what the relationship between Male 1 and Female 1 was.

9.6 The best predictor of criminal behaviour is a history of criminal behaviour, and past violence will suggest a probability of future violence. A history of criminal behaviour is the best predictor of criminal recidivism regardless of whether the offender is mentally disordered or normal – Bronta, Law and Hanson, 1998.

9.7 The DHR Panel concluded that based on his past history it was likely that Male 1 might cause harm to a female when a relationship was ended against his wishes. His full criminal behaviour was not known to or sought by MSP or MPT. This meant that Male 1's assessed risk was based on incomplete information. Female 1 and Male 1 ended a relationship in February 2009 on good terms. The relationship was re-

formed and it is not known why Male 1 took Female 1's life. However, the deficiencies of MSP and MPT did not directly or indirectly lead to Female 1's unpredictable death. The opportunity to discover what happened and why, ended when he was found dead in his cell at Manchester Prison and may emerge at his inquest.

10. RECOMMENDATIONS

10.1 Single Agency

Merseyside Probation Trust

1. That MPT ensures the key lessons from this review are made available to staff and used to support and improve practice.

2. That MPT develop a structured programme pack to assist Offender Managers to work with perpetrators of domestic abuse who are unable or unwilling to accept responsibility for their actions.

3. That MPT implements whatever guidance is received from NOMS/Ministry of Justice, regarding the amendment of Orders

4. That MPT reviews guidance to staff decision making in respect of frequency of reporting, as part of the development of professional judgement in Offender Managers.

Merseyside Police

5 That Merseyside Police renew and reinvigorate Domestic Abuse training for frontline uniform/Sergeants and Inspectors.

6. That Merseyside Police ensures that a dedicated Risk Assessor role is utilised in Domestic Violence Unit Administration.

10.2 DHR Panel

7. That Sefton Safer Communities Partnership satisfies itself that MSP and MPT have systems and practices in place for gathering background information on domestic violence offenders, including knowing when new partnerships have formed, and use all such information in risk assessments.

END OF EXECUTIVE SUMMARY

NEXT APPENDIX 1 Action Plan

APPENDIX 1

Sefton Safer Communities Partnership FEMALE 1 DHR ACTION PLAN

Ref No.	Recommendation	Action	Responsible Agency/ Lead Person	By When (date)	Outcome
	MERSEYSIDE PROBATION TRUST				
9.1	**1.** That MPT ensures the key lessons from this review are made available to staff and used to support and improve practice.	That the lessons from the DHR are disseminated to staff via the Senior Management Team.	IMR Author Steve Chambers MPT ACO	31/8/12	Improved understanding and delivery
	2. That MPT develop a structured programme pack to assist Offender Managers to work with perpetrators of domestic abuse who are unable or unwilling to accept responsibility for their actions.	That a programme pack be developed and distributed to Offender Managers.	Sonia Turner MPT ACO	31/10/12	More effective intervention with those denying responsibility

	3. That MPT implements whatever guidance is received from NOMS/Ministry of Justice, regarding the amendment of Orders following non-Compliance	Guidance/Instruction will be implemented.	Anne Pakula Head of Operations	As required	More effective management of cases
	4. That MPT reviews guidance to staff regarding decision making in respect of frequency of reporting, as part of the development of professional judgement in Offender Managers.	MPT to review expectations in respect of frequency of reporting as part of an urgent revision of practice with Domestic Abuse perpetrators	Anne Pakula Head of Operations	31/10/12	Increase in contact levels with DV perpetrators
SEFTON SAFER COMMUNITIES PARTNERSHIP					
9.2	**5.** That MSP and MPT satisfy themselves that their systems and practice for gathering background information on domestic violence offenders are documented, robust and fit for purpose.	SSCP to request reports from MSP and MPT on the criteria each agency uses when conducting background checks on people suspected of domestic violence in the discharge of their responsibilities. The reports should include which databases are check and which agencies are	Steph Prewett Head of Corporate Commissioning and Neighbourhood Co-ordination	31/10/2012	Thorough Risk Assessments resulting in robust risk management plans in

	consulted.	Sefton Metropolitan Borough Council		support of victims
MERSEYSIDE POLICE					
9.3	**6.** That Merseyside Police renew and reinvigorate Domestic Abuse training for frontline uniform/Sergeants and Inspectors.	Training.	Public Protection Unit.	31/03/2013	Positive Police response by frontline officers. VPRF1 completed at scene.
	7. That Merseyside Police ensure that a dedicated Risk Assessor role is utilised in Domestic Violence Unit Administration.	Full time Risk Assessor post to be created and filled within each Basic Command Unit.	Public Protection Unit.	31/12/12	Swift input and exchange of information internally and to partner agencies.