Wirral Community Safety Partnership

EXECUTIVE SUMMARY

Adult C

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1. THE REVIEW PROCESS

This summary outlines the process undertaken by Wirral domestic homicide review panel in reviewing the murder of Adult C by Adult D in February 2012.

Adult D pleaded guilty to murder on 6 June 2012 and was sentenced to life imprisonment.

The process began with an initial meeting on 21 May 2012 of all agencies that potentially had contact with Adult C between early 2010 (two years before her death) to the point of death. As the family had moved to the area from the Midlands in 2010, enquiries were made of the relevant authorities in that area. No incidents of domestic abuse were identified through those enquiries.

Agencies participating in this review are:

Cheshire and Wirral Partnership NHS Foundation Trust
Merseyside Police
Merseyside probation Trust
Rape and Sexual Abuse Centre
VCA Wirral
Wirral Community NHS Trust
Wirral Community Safety Team/Family Safety Unit
Wirral MBC Children and Young People Department
Wirral MBC Department for Adult Services
Wirral Partnership Homes
Wirral University Teaching Hospital NHS Foundation Trust

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family;
- What was done or agreed;
- Whether internal procedures were followed; and
- Conclusions and recommendations from the agency's point of view.

The accounts of involvement with this victim cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

All Panel agencies were asked to complete Individual Management Reviews (IMRs). In total, seven (7) agencies have responded as having no contact with either the victim or the suspect or with any children involved: Cheshire and Wirral Partnership NHS Trust; Merseyside Probation Trust; Rape and Sexual Abuse Centre; VCA Wirral; Wirral Community Safety Team/Family Safety Unit; Wirral MBC Dept of Adult Social Care.

The remaining agencies have responded with information indicating some level of involvement with the victim: Wirral Community NHS Trust; Merseyside Police; Wirral University Teaching Hospital Trust

Wirral University Teaching Hospital's IMR indicates that Adult C attended A&E on 19 July 2011with a wrist injury. There was no disclosure of domestic abuse and nothing in the medical notes to suggest that domestic abuse was a factor.

Merseyside Police report in their IMR that on Wednesday 15th February 2012 Adult C had returned from the part of the country where she previously lived where she and the children had been visiting friends. Adult C had an appointment with her Solicitor with regard to the divorce proceedings and she and the children went to the family home to get some paperwork. Adult D was at the home and as Adult C was leaving he reportedly grabbed her wrists to try and take the papers, and to try and stop her leaving the bedroom. Adult C was subsequently able to leave the house, but the Police account indicates that Child F witnessed the incident and was upset. The incident left a mark on Adult C's wrist. Adult C and her sister attended a Solicitor's appointment that day and adult C was advised to report the incident to Merseyside Police. Adult C and her sister attended Wallasey Police Station at 16 45 on the 15th February and reported the incident to a Merseyside Police Constable acting as Enquiry Officer. A short, hand-written entry was made in relation to a verbal dispute about divorce in the enquiry office book, but it was not recorded as a crime or incident and no further information was provided to Adult C. No referral was made on to the Family Crime Investigation Unit, or any other Police unit. No referral was made to Wirral's Family Safety Unit, Wirral Children's Services or any other agency.

Adult C's sister said that they attended expecting to be able to make a report of the incident. . She also stated that, with hindsight she would have expected them to have been seen 'in private'. Adult C's sister recalls that they advised the officer that both children had been in the house when the incident took place. The station memo book for that day states that 'Dispute in property over divorce paperwork'. [illegible] argument in front of son [name redacted].'

One agency contributed to the panel but did not provide an IMR. Wirral MBC's Children services had reported at the DHR panel that-apart from attendance by the children at Wirral schools- they had no involvement with the family prior to the death of Adult C, but did not formally confirm this in a written IMR.

2. KEY ISSUES ARISING FROM THE REVIEW

Merseyside Police's own policy on domestic abuse was not followed on 15 February, when Adult C attended Wallasey police station. Consequently a clear opportunity to elicit more information from Adult C in a structured manner and in a confidential setting was missed. An opportunity to provide more information to Adult C -and her sister as a supportive family member- was also missed, and she was not referred to any other agency for advice and assistance, for example the national helpline for accessing injunctions.

The 15th February incident reported to Merseyside Police should have been recorded as a Section 47 assault. This is a breach of the national crime recording standards.

Adult C's children are unusually articulate young people and seem secure in their family and school placements. They advised the author of this report that they feel that more consideration should be given to the consequences of emotional and verbal abuse in relationships, and what they describe as 'bullying'.

3. CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

Apart from the attendance at Wallasey Police Station on 15 February 2012, there is no evidence of any other points of engagement with Adult C or Adult D by relevant agencies in the period from August 2010-February 2012 (the period they were resident in Wirral).

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If a VPRF1 had been completed, the structure of the form (unlike the Domestic Abuse Stalking and Harassment Risk Indicator Checklist –DASH RIC-used elsewhere) does not require scoring by an officer, and therefore the tool does not immediately and obviously advise a front line officer of the level of risk: for example by providing a score out 24 as the CAADA DASH RIC does.

Minimal information on domestic abuse was available in the Wallasey Police Station on when the space was reviewed on 26 September 2012.

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Adult C's sister stated that the concept of establishing a 'separate household within the home' was flawed as it magnified tensions within the relationship. Adult D reported to his Probation Officer on 3 August 2012 that he had felt like 'a stranger in his own home' before the murder.

1. Separation should be seen as process which can magnify risk factors, not a safety plan in itself. All agencies, especially family law solicitors and the Children and Family Court Advisory and Support Service (CAFCASS) , should be advised that the period around separation- especially while a couple still share a home- should be seen as a period of enhanced risk of violence, and should advise service users accordingly.
2. All Police reception areas in Wirral should be checked to ensure that they have very clear, very visible and up-to-date information on domestic abuse services displayed prominently. Strong consideration of the use of keywords such as 'verbal abuse' and 'bullying in relationship' should be given in the development of new materials to prompt referrals by and about people who may not consider themselves victims of domestic abuse per se.
3. An audit of Merseyside Police's compliance with its own domestic abuse policy and procedures should be undertaken in the Wirral in January 2013 to ensure that front line staff are compliant and that VPRF1s are being completed. An audit should be undertaken of the new Inspector reviews of memo books, to ensure that domestic abuse incidents are not being retained on paper-based records.
4. Consider the revision of the VPRF1 to give an immediate and clearly visible score for risk, so that front line staff feel ownership of the risk level, rather than it being left to a specialist team for assessment.