EXECUTIVE SUMMARY

WIRRAL COMMUNITY SAFETY PARTNERSHIP

OVERVIEW REPORT

of

DOMESTIC HOMICIDE REVIEW

Independent Author: Audrey Williamson
December 2012

1. Introduction

1.1 This report has been undertaken following the murder of E by her partner F on 16th April 2012 at her home address in Wirral.

1.2 A decision was made to undertake a review on 31 may 2012 and the first meeting of the Panel took place on 27th June 2013. The Panel met on two further occasions during this period; 20th September 2012 and 10th December 2012. The report was completed on 11th January 2013**.** The report was referred for consideration at the next scheduled Community Safety Partnership Meeting on 13th February 2013. This meant that the Review was submitted to the Home Office 7 weeks after completion. It is intended that in future, extra-ordinary Community Safety Partnership Meetings will be convened to consider completed Domestic Homicide Reviews so as to avoid any delay in submission to the Home Office.

1.3 There was one parallel processes occurring during this period; a criminal investigation and conviction took place within the timeframe of this review. On 10th September 2013, F was sentenced to a minimum of 10 years and 10 months years imprisonment for the murder of E.

1.4 In accordance with the Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews(DHR), the purpose of this DHR to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professional 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.

1.3 A Review Panel was established which comprised of representatives from the following agencies:

- Steve Mc.Gilvray Head of Community Safety Wirral Community Safety Partnership
- Jonathon Smith, Family Crime Investigation Unit, Merseyside Police
- Wirral MARAC
- Satwinder Lotay, Safeguarding Officer, Cheshire and Wirral Partnership NHS Foundation Trust
- Sue Brown, Assistant Chief Probation Officer, Merseyside Probation Trust

- Jill Barr, Family Safety Unit Manager, Wirral Metropolitan Borough Council
- David Grisenthwaite, Safeguarding Officer, Directorate for Adult Social Services
- Tracey Coffey, Strategic Service Manager, Directorate for Children and Young People Services (CYPD)
- Jo Wood, Chief Executive Officer, RASA ;Voluntary Sector Wirral
- Amanda McDonough, Operational Lead for Safeguarding, Wirral University Teaching Hospital Foundation Trust
- Ann Marie Nobes, Head of Safeguarding, Wirral Community NHS Trust
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1.4 An Independent Person Ms Colleen Murphy was appointed to chair the review. Ms Murphy works as an Independent Social Worker undertaking a range of work specialising in reviews and quality assurance. Ms Murphy has been a qualified Social worker for twenty-four years, and has previously worked in Social work and Social work management posts in the Local Authority and voluntary sector. Ms Murphy has undertaken many previous Independent Chair and Authorship roles in Serious Case Reviews and domestic Homicide Review.

1.5 An Independent Author Ms Audrey Williamson was appointed to write this overview report. Ms Williamson is an experienced social care manager with 28 years of experience in Local Authorities. She has held senior management roles for 11 years and currently chairs three Safeguarding Children boards in the North West. Prior to becoming an independent consultant in 2011 she was Operational Director for Adult Services in Halton Council. This role included responsibility for the coordination and commissioning of Domestic Abuse services to meet the needs of domestic abuse victims and their children.

Neither Ms Murphy nor Ms Williamson have had any involvement with the individuals subject of this review, nor are they attached or employed to any participating agency.

1.6 The specific methodology of the review included the following to:

- Consider the period of two calendar years prior to the incident, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant. Any information outside this timescale relating to domestic abuse within the relevant family history should be included;
- Request Individual Management Reviews by each of the agencies with a connection to the victim or perpetrator , and invite responses from any other relevant agencies or individuals identified through the process of the review;
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events;

- Take account of the Coroner's inquest in terms of timing and contact with the family
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature
- Reach a conclusion which establishes whether the events could have been predicted or prevented.

1.7 The following agencies were approached to provide details of their involvement, through chronologies of contact and Individual Management Review's (IMR's):

Cheshire and Wirral Partnership NHS Trust
Merseyside Police
Merseyside Probation Trust
VCA Wirral
Wirral Community NHS Trust
Wirral Community Safety Team
Wirral MBC Children and Young Peoples Department.
Wirral MBC Department for Adult Social Services
Wirral Partnership Homes
Wirral University Teaching Hospital NHS Foundation Trust

1.6 The DHR was particularly focused on the following key lines of enquiry:

1. Communication and co-operation between different agencies involved with the couple;
2. Opportunity for agencies to identify and assess domestic abuse risk;
3. Agency responses to any identification of domestic abuse issues;
4. The victim and organizations' access to specialist domestic abuse agencies;
5. The training available to the agencies involved on domestic abuse issues;
6. Review of the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care;
7. Any equality and diversity issues at all times, as language, culture, family ties and kinship, sexual orientation and disability will all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

1.7 Expert advice was provided by the Panel member from Wirral MARAC service.

1.8 It was agreed that the management of any media matters would take place through a joint team drawn from participating panel agency representation.

1.9 The review was mindful of a parallel criminal process, and whilst informing family members and the then alleged perpetrator of the review taking place, consultations with both family and the perpetrator took place after the criminal justice process was concluded.

1.10 The author of this report is grateful for the valuable contribution to this report made by the brother of E. The family had been approached through the police liaison officer to contribute to this review and had decided that the brother should provide information and views on the family's behalf; he had a close relationship with his sister and was in a strong position to make a contribution to this review. E's brother talked to the independent chair of the Domestic Homicide Review Panel and the information he provided and his views have been included in this report. While E and F had regular contact with E's family they did not appear to belong to a strong and close social network.

1.11 The author and independent chair visited F in prison and received information about his perception of the relationship which has also been included in this report.

The Panel was made aware through the criminal investigation that F had an ex-wife and that violence had been a feature of that relationship.

2. The Facts

2.1 There was very little involvement by any of the agencies with either the victim, E or her partner F. As a result there is little known about them either as individuals or their relationship together although as noted above information was provided by the brother of E.

2.2 E was a forty one year old female who had a close family living in the Wirral. The family is affluent and E was in a position where she did not need to find employment. E had never been married and had no children. E is described as vivacious, friendly and with a gift for forming good relationships with people across the social spectrum. It is significant that the family received three hundred letters of condolence from individuals who had known her following her death.

2.3 F is a forty one year old male who was born in Dublin and lived in Ireland until 2003 when he moved to England. F worked in the building industry and stated that he had moved around Ireland as a young adult because of work opportunities. He married in Ireland but following the breakdown of his marriage he decided to move to England in 2003. He has no contact with his birth family following the breakdown of his marriage. He stated that the breakdown of the marriage was acrimonious and police and social services had been involved. Through court proceedings, and he was banned from the

family home for four months. Information received from his wife as part of the criminal investigation indicated that he had been violent towards her. There are no criminal charges against him in respect of violence against his wife.

2.4 F found employment in the south of England in the building industry. Little is known about his life during this period although Probation Service records state that F was convicted in May 2004 of an offence of theft by employee. Bromley Magistrates court imposed a sentence of Community Punishment order for 200 hours of unpaid work. This order was supervised by Kent Probation service. F breached this order and was sentenced to a further twenty hours unpaid works on 18 4 2007.The orders were subsequently transferred to Merseyside Probation Trust in June 2007. Again F was returned to court having failed to complete the 220 hours unpaid work ordered by the court On 21 2 2008 at Wirral Magistrates Court F's order was revoked and he was ordered to pay a £200 fine. The Probation Trust has had no contact since that date.

2.5 F came to the Wirral in 2006 to work having gained short term employment in the area. He stated that he liked the area, finding the community friendlier than in London and so decided to stay. F met E and stated that she had been "on the rebound" following a failed relationship and was living with her mother at the time of their first meeting. E moved into F's rented flat very quickly and the couple subsequently bought a flat together in the Wirral. E and F established a business together and were the named Directors of a small local building company established in 2008. At the time of E's death in April 2012 the company business was failing, F stated he had found difficulty in competing in an increasingly difficult economic climate and in the face of a great deal of competition in the local area.

2.6 The relationship appears to have been volatile, and the use of alcohol was a feature. It has not been possible to establish the level of E's drinking; the family do not think it was significant or detrimental to her life. F has stated that he was not alcohol dependent although he liked to drink and he used cannabis. Neighbours reported that they heard arguments but no concerns were reported to any agency. By March 2012 the relationship appeared to be ending. E had informed F that she wanted the relationship to end and F stated that he then started to make enquiries with a recruitment agency that placed those who worked in the building trade in temporary employment in Qatar. E had informed her mother and brother that the relationship had ended and F was aware of this.

2.7 During the weekend of the 7th and 8th of April; E had not returned home following an evening out in Liverpool. F stated that on April 8th following Sunday lunch at E's mother's house E and F had discussed their relationship and decided to continue with the relationship. The following Saturday evening,14th April E went out and returned on the Sunday morning. F stated

that E had consumed alcohol that morning and that he left the home at lunchtime. F went to a local pub to drink. He then bought beer and vodka and returned to the flat. F stated E was asleep in bed in the spare room and that he continued to drink with a friend in the garden. The friend left at 11pm and subsequently in a witness statement described F as very drunk and erratic in his behaviour. F stated that he returned to the flat and continued to drink. E woke up and F stated that E was argumentative and belittling him. He stated that an argument ensued and that he pushed her to a kneeling position in the spare room and then strangled her.

2.8 F continued to drink and then fell asleep. The following morning on 16th Aril 2012 he telephoned a friend in Ireland and also tried to contact a business contact who lived in the Wirral and who was a solicitor. F then telephoned the Merseyside Police to inform them that he had killed E. The police attended the property and found E deceased; F was arrested. F later pleaded guilty to murder and was sentenced on 10th September 2012 to life imprisonment with a minimum tariff of 10 years and 10 months.

3. Agencies Involvement

3.1 Individual Management reviews were provided by:

- Merseyside Probation Trust
- Merseyside Police
- Cheshire and Wirral Partnership NHS Foundation Trust
- Wirral Metropolitan Borough Council
- Directorate for children and young peoples services
- Directorate for Adult Social Services
- Wirral University teaching Hospital Foundation Trust

3.2 This review examined the involvement of the relevant agencies in the two year period prior to Adult E's murder in April 2012. The two year period was identified to start at the point that a domestic abuse agency was altered to the possibility of violence within the relationship. This review concluded that there had not been any relevant contact with any of the agencies with the exception of the police.

3.2 On October 14th 2010 E abandoned a 999 call. The police followed up and a patrol requested subscriber details. E was identified as the caller and the patrol attended the couple's address. The police were informed that there had been a minor argument about a warrant in F's name. There had been no physical violence. F was arrested in respect of the outstanding warrant which related to non-payment of compensation to his previous employer in Kent. On October 16th 2010 E again made an emergency phone call reporting that F would not leave the address. On arrival the patrol found E safe and well and that F had already left the premises. Merseyside police had no further contact with E or F until F telephoned on 16th April 2012 to inform them he had murdered E.

3.3 As required for this review Merseyside Police undertook an analysis of their involvement. Merseyside Police have purpose designed Risk Assessment Tool (MERIT) which is used to identify key risk areas for domestic violence and alert officers to those identified through risk assessment those most at risk. This tool devised in collaboration with Liverpool University was adopted across Mersey Police Force at the end of January 2009. Victims are identified as being Bronze, Silver or Gold victims. Bronze being those deemed to be at least risk and Gold signifies those to be subject to high risk. All Gold victims are nominated to the local MARAC for further coordinated support. Those identified as Bronze or New Silver receive a letter signposting to support agencies while repeat Silver victims will be referred direct to support agencies. There were no critical or significant risk factors identified in the risk assessment which would have led to a direct referral to MARAC or partner agencies. On both occasions E appeared well and did not report any physical violence. The police identified that there was a delay in risk assessing a week after the event and the second was assessed on the day of the referral but was only sent to Wirral FCIU two weeks after the incident. There has not been an explanation for the cause of this delay.

3.4 From the criminal investigation, it became known that F had been married between 2000 and 2003. The investigation revealed that although never charged or convicted, F had been abusive to the ex-wife on at least three occasions, with medical records confirming resultant injuries 2003. The police force were called on two occasions. No intelligence was available which was suggestive of violence in the years between 2003 and 2010.

4. Analysis

4.1 Little is known about the couple's relationship prior to E's death in April 2012. Both were in business, E was supported by an affluent family and there was no significant contact with agencies with the exception of the police which has been detailed above. No agency, including the police, was aware of F's history of violence which may have alerted them to potential increased risk to E by F.

4.2 E did not appear to have disclosed any domestic abuse to any other individual. While F had previously been violent in the past it is not clear whether this was known to E. If E did know she does not appear to have shared this with her family as E's family were unaware of F's previous violence until the court case.

4.3 Following E's death her family informed the police that she never made any disclosures to them and they had no reason to think there were problems.

4.4 Research indicates that early intervention can reduce risk (Evaluation of early Intervention Models for change in Domestic Violence: Northern Rock

Foundation Domestic Abuse Intervention Project 2004-09) There are a number of agencies that victims of abuse can directly access and receive support from on Wirral at any stage. These include; a domestic abuse drop in service, a centre providing support & advice for Women in relation to benefits, housing, family, health and relationships, support, advice & guidance for ethnic minority groups, a range of services for disabled people and carers and a rape and sexual abuse centre.

4.5 There is no evidence that E approached any support agencies to seek help for any violence she may have experienced in her relationship. Following contact with the police E would have received a letter signposting her to services offering support and advice. Wirral services do not track or monitor outcomes for those who receive such letters and this is a significant gap in the evaluation of the delivery of coordinated services and the evaluation of the MERIT system. It is difficult to assess the numbers of victims who subsequently access services or to understand what may have prevented victims from making contact. The Partnership should consider the establishment of simple monitoring systems which will contribute to the evaluation of the current arrangements.

4.6 Given the lack of information it is not possible to assess the level and frequency of violence E may have experienced during the period of her relationship with F. A number of risk factors existed which are known to potentially increase the risk of violence to victims; these include a history of violence and the use of alcohol. The fact that E had ended the relationship may have been significant to the incident that led to her death. Studies have indicated that women who leave or attempt to leave the abusive partner are at increased risk of homicide *(City University, London "An Investigation into the antecedents of Domestic Homicide with a view to its prevention 2004, cite Campbell1992, Johnson and Hotton 2003, Richards 2003)* It is not possible to draw any firm conclusions about the impact of E's decision in this particular case given the lack of detailed information but it is likely to have increased the risk of violence. F spoke in some detail about E's decision to leave. It is a recommendation that that all agencies are made aware of increased risk of homicide when women attempt to leave abusive partners.

4.7 The incidence of domestic violence in Wirral is high, on average Mersey Police receive over 2500 notifications of incidents relating to domestic abuse per month Wirral notifications average 550 per month of this. In 2012-2013 Wirral recorded the second highest numbers of domestic abuse in Merseyside. As part of this review there was discussion about the triage system adopted by Merseyside police, at Bronze level this means signposting and letters to victims. Merseyside police state that given the demand on their services it is not possible to provide bespoke services for all victims of domestic abuse.

4.8 The two risk assessments undertaken by Merseyside Police following the two contacts in October2012 were undertaken in a professional and informed way. The current procedure and use of the MERIT risk assessment placed E in the Bronze category and therefore she would have received a letter signposting her to support services. This was seen to be in accordance with current procedures given the information available and the fact that E did not make any criminal allegations against F. The procedures followed were consistent with organisational policy .This takes into account ethnic, cultural, linguistic and religious identity of all parties. There were no known vulnerabilities or disabilities which would have impacted on either of the incidents reported. The MERIT risk assessment tool is currently being reviewed and it is recommended that this report contributes to the review.

4.9 Merseyside Police have noted the delay in forwarding the referral form to the FCIU and completing the risk assessment; however it would not appear that the delay was significant in this case. Merseyside Police have identified that there is a general requirement for patrol staff attending domestic violence incidents to ensure that the form VPRF1 is forward to the FCIU at the earliest opportunity. There is then the requirement that the appropriate risk assessment is completed within a short timescale thus enabling any appropriate support services to be put in place. Wirral FCIU is currently rolling out an in house training package to patrol staff to ensure that they are aware of these responsibilities.

4.10 The terms of reference for this review state "Consider the period of two calendar years prior to the incident, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant. Any information outside this timescale relating to domestic abuse within the relevant family history should be included" During the criminal investigation it emerged that F had been violent towards his wife. It is significant that F had been violent in the past and sought to minimise his behaviour when talking to the independent chair; past history of violence is a strong predictor of future violence. F was living in his home country, at the time of the breakdown of his marriage and importantly was not subject to any criminal charges of violence against his wife. In February 2013 the International Conviction Exchange was established whereby police officers can seek information about criminal convictions in other countries in the course of criminal investigations in the United Kingdom. It should be noted, however, that even if this arrangement had been in place at the time of E's murder this would not have provided any information as F had not been convicted of any previous domestic violence.

5. Conclusion and Recommendations

5.1 This review has not identified any obvious failure by any agency to address domestic abuse or any other issue that may have contributed to the murder of E. The brother of E has confirmed the family belief in this conclusion.

5.2 The existing policies and procedures in Wirral require review to assess the MERIT process and the subsequent multi agency response to "Bronze victims".

5.3 It is clear that domestic homicides cross cultural, gender, class and ethnic divides but this did not impact negatively on the response by agencies involved.

5.4 Information from foreign law enforcement is not readily available to UK police forces to assist in the risk assessment of individuals as perpetrators of domestic violence.

5.5 While this review recognised that the homicide investigation was not relevant to this review the brother of E was very clear that the work undertaken by Merseyside Police and their involvement with the bereaved family was of the highest standard and wished this to be noted in the report.

Recommendations

1. This review and its findings to contribute to the review of MERIT, particularly in reference to responses to Bronze victims.

2. The research on the potential of increased risk of violence and murder at the point of separation for the victim to be disseminated to all agencies.

3. The Safer Communities Partnership to give consideration to the establishment of simple monitoring systems which will contribute to the evaluation and future strategic planning of the current arrangements to respond to domestic abuse.

Merseyside Police has made one recommendation following the completion of the Individual Management review:

4. The submission of Risk assessments needs to be driven by Patrol. Supervision to ensure compliance within the appropriate timescale. The Mersey Force Public Protection Unit has addressed all Patrol Sections within Wirral BCU and stressed the importance of completing the VPRF1referral form at scene and ensuring that it is submitted to the FCIU before the end of the shift .The message to be driven by the BCU Command and the patrol supervision.