Wirral Community Safety Partnership

Domestic Homicide Review
Executive Summary

REPORT INTO THE DEATH OF ADULT B ON 13 AUGUST 2011

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Executive Summary

1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Adult B on Wirral. Merseyside Police were called to a domestic incident on 13th August 2011 at the adress that Adults A and B shared with their two children, as a result of which Adult B died.

2. The review process

A Domestic Homicide Review (DHR) was recommended and commissioned by Wirral Community Safety Partnership in line with expectations of Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011.

The Home Office was informed of the intention to conduct a DHR on 9th September 2011. The process has been completed and the report submitted outside of the recommended 6 months reporting period. The report was delayed pending the conclusion of the criminal proceedings.

This summary outlines the process undertaken by the Wirral Domestic Homicide Review Panel (DHRP) in reviewing the murder of Adult B. Criminal proceedings ended in January 2012 when Adult A pleaded guilty to the murder of Adult B and was sentenced to 15 years imprisonment.

An initial meeting of all agencies that potentially had contact with Adult B and forming the DHRP was held on 14th September 2011, and a further meetings were held throughout 2011 and the early months of 2012.

Agencies participating in this Domestic Homicide Review were:

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
ARCH Initiatives

The purpose of the Review Panels work was to:

- Establish the events that led to the death of (Adult B) on 13th August 2011 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked individually and together to safeguard the family

- Identify what those lessons are, how, within what timescales they will be acted upon, and what is expected to change as a result

- Establish whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend any changes as a result of the review process

The Review specifically analysed the following issues;

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. Organisations access to specialist domestic abuse agencies

5. The training available to the agencies involved on domestic abuse issues

6. Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.

7. The Panel also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

The review also considered any other information found to be relevant.

Agencies were asked to give chronological accounts of their contact with the victim and immediate family prior to her death and for 2 years prior to this date. Nine agencies advised that they had had no or insignificant involvement with either adults or children forming Adult B's family unit and following agreement with the Home Office they completed an abridged version of the Independent Management Review (IMR).

In the case of agencies completing a full IMR 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

Only two agencies had records of contact with Adult A or Adult B or Child A or Child B prior to Adult B's death:

- ARCH
- Wirral Children and Young Peoples Department

No record could be found of Adult B making contact with any agency prior to her death in connection with a referral or subsequent assessment and case management associated with domestic violence. Adult B was not known to the agencies forming Wirral's domestic abuse Multi Agency Risk Assessment Committee (MARAC) and does not appear to be known to other domestic and sexual abuse support services on Wirral. There is no evidence from the review process of the adults or children in this case having had any contact with Merseyside Police.

3. Key issues arising from the review

Adult B worked as [redacted – sensitive information] Adult B's manager advised that he had no suspicions that Adult B was being subjected to any violence by Adult A. Adult B had no significant periods of absence, no recorded unexplained cuts or bruises and had monthly one-to-one sessions with her line manager in a private and confidential setting. Adult B's manager reports that Adult B had a range of positive friendships with work colleagues, and was a valued colleague.

Adult B's children both attended a local authority Primary School. The children's school was not aware of any safeguarding and domestic abuse issues in the family, and had observed a supportive family environment with well-presented, apparently happy, children with good attendance. They had been given no grounds to suspect problems within the family based on the children's attendance, behaviour and demeanour, and the involvement of both parents in school drop-offs, pick-ups and parent's evenings. The school was able to evidence that its policies and procedures had enabled one of the children to make a disclosure about bullying being experienced by a peer to a senior teacher.

In October 2010 Adult A self-referred to ARCH (Advice, Rehabilitation, Counselling, Health) Initiatives. ARCH Initiatives delivered an established programme to Adult A and gave him opportunities to discuss and address problematic behaviours. The risk assessment shows that Adult A had indicated there had been no violence or thought of violence towards others. They were able to corroborate some of the information provided in his self-assessment in their meeting with both Adult B and Adult A.

ARCH Initiatives provided information on domestic abuse in the form of leaflets/posters in rooms that Adult B and Adult A accessed.

It can be inferred from Adult B's recommendation of the [redacted – sensitive information] programme to an acquaintance that she viewed the programme's impact on Adult A as positive.

It appears from Police interviews after the homicide that Adult B moved out of the family home in June or July 2012. Some days later Adult B and her children returned, with Adult A agreeing to leave the family home and reside with his father. Police interviews after the murder indicate that this may have been an interim arrangement to allow the children to continue to attend their school until the end of term.

A Police interview with [redacted – sensitive information] indicates that Adult B moving out may have been prompted by an incident where one child attempted to intervene when Adult A was assaulting Adult B, and was subsequently knocked out of the way. This incident was not reported to any known agency.

There is some indication that Adult B's mother had concerns about potential violence from Adult A towards Adult B and had possibly seen some unexplained injuries. It does not appear that Adult B disclosed any violence to her mother during this period.

4. Lessons to be learnt

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 Adult B.

In the absence of any clear lessons learned about domestic abuse practice or policy, the review is left to reflect that a professional, resourceful and caring woman was experiencing violence and felt unable to seek help from the agencies charged with addressing it.

The need to continually raise public awareness of domestic violence and creating a network of informed professionals and organisations that have the knowledge and ability to recognise domestic abuse and work together to reduce the risk faced by victims of abuse is an ongoing issue recognised by Wirral Community Safety Partnership.

5. Conclusions

The first and most important conclusion from the review is that there is no indication from the evidence provided in the Individual Management Reviews that any agency had any knowledge of any domestic violence between Adult A and Adult B. Nor has this review identified any obvious failure by any agency to address domestic abuse or any other issue that may have contributed to the murder of Adult B. It appears that the apparently escalating domestic abuse remained hidden within the family.

It appears based on Police interviews that between March and August 2011 Adult A was violent towards Adult B. It is not possible to identify why Adult B was unable to disclose these problems to other people such as colleagues, or to public agencies. It is not known what immediately preceded the fatal assault on Adult B by Adult A.

The review has examined domestic abuse services on Wirral and concluded that the developments in services have resulted in the level of structural integration required to be effective. The Domestic Abuse MARAC provides a mechanism to enable a broad range of statutory and voluntary partners to work together to improve services to victims of abuse.

6. Recommendations from the review

1. Ensuring that information on addressing domestic abuse and accessing services is prominently displayed in all public buildings as well as spaces likely to be accessed by women alone ie toilet cubicles etc.
2. Consulting local family law networks to identify all opportunities to brief women who are seeking legal advice on separation and divorce about the resources available to address domestic abuse.
3. Auditing, reviewing and sharing effective practice on employee policies on domestic abuse to ensure that managers feel confident that they could support a colleague who is a victim of domestic abuse.
4. Partners should develop a training programme (based on the Wirral LSCB Multi-Agency Safeguarding Children training programme) for all front-line staff in recognising domestic abuse, to include Safeguarding, Domestic Abuse, Parental Mental Health and Substance Misuse.
5. Schools should be supported in making safeguarding advice available to parents, carers and young people on their websites.
6. Develop accredited voluntary perpetrator programmes for access via self referral and agency referral.
7. Review policy (and compliance with policy) on drug testing on arrest and admission to hospital for people arrested for domestic abuse.

In addition the following areas were explored during the Panels work and the Overview Report:

- Adult B had no known contact with any specialist domestic abuse agencies or services. The review explored whether more could be done on Wirral to raise awareness of services available to victims of domestic violence.

- Whether there were opportunities for professionals to ‘routinely enquire’ as to any domestic abuse experienced by the victim that were missed.

- Whether Adult A had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

- The Panels work also reviewed training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services on Wirral.