Wirral Community Safety Partnership

Domestic Homicide Review
Overview Report

REPORT INTO THE DEATH OF ADULT B ON 13 AUGUST 2011

Report produced by Gavin Butler

Date: 18th May 2012.

OVERVIEW REPORT INTO THE DEATH OF
Adult B

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1.0 INTRODUCTION

1.1 This report of a Domestic Homicide Review (DHR), combines agency responses and support given to Adult B, a resident of Wirral prior to the point of her death on 13th August 2011.

1.2 The brief circumstances surrounding this death are that on 13 August 2011, at about 2pm, it appears that Adult A attacked Adult B inflicting nine serious stab wounds to her body, including one which pierced her heart. Adult B died later that day at a local Hospital.

1.3 The review considers agency contact/involvement with Adult B and Adult A from two calendar years prior to the event.

1.4 The key purpose for undertaking DHRs is to enable lessons to be learned by agencies from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.5 The report's conclusions represent the collective view of the Domestic Homicide Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

2.0 TIMESCALES

2.1 This review began on 14 September 2011 and was concluded on 14 May 2012. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. However, the criminal justice process meant that the report could not be completed within six months.

3.0 CONFIDENTIALITY

3.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

4.0 DISSEMINATION

4.1 Whilst key issues have been shared with organisations the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

4.2 In order to secure agreement, pre-publication drafts of the report were seen by the membership of the Review Panel (as listed at 1.3), IMR authors (as listed at 1.6), and the membership of the Community Safety Partnership. The IMRs will not be published

4.3 The following list of recipients will receive copies of this report once clearance has been received:-

- Wirral Community Safety Partnership
- All Members of DHR Panel
- Wirral Children Safeguarding Board
- Wirral Adult Safeguarding Board

5.0 INTRODUCTION

5.1 The circumstances that led to this report being undertaken follow the murder of Adult B on 13 August 2011 by Adult A. The terms of reference for the review from 14 Sept 2011 follow:

5.2 **'Terms of Reference and Scope (ADULT B)**

The Review Panel will be chaired by Gavin Butler of Cheshire West and Chester Borough Council.

5.3 **Purpose of the review**

The purpose of the review is 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.

5.4 **Scope of the review**

The review will

- Seek to establish whether the events of 13th August 2011 could have been predicted or prevented.

- Consider the period of 24 months prior to the events in August 2011, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Internal Management Reviews by each of the agencies defined in Section 9 of the Act*, and invite responses from any other relevant agencies or individuals identified through the process of the review.

  * Domestic Violence, Crime and Victims Act (2004)

- 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.

- Subject to the conclusion of the criminal justice process we aim to produce the report by the end of January 2012. Further critical issues impacting upon the time taken to conclude the report will include, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the internal management reviews being completed and the potential for identifying matters which may require further review.

- Merseyside Police will advise the Panel if there is any conflict between the work of this meeting and the criminal justice process. In which case the Review may be suspended to await the conclusion of the criminal justice process.

5.5 The agencies responsible for providing details of their involvement, through chronologies of contact and Individual Management Reviews (IMRs) will be as follows:

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

5.6 Each of the above contributing agencies will be required to:-

- Provide a chronology of their involvement with family members identified on the genogram during the relevant time period.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an Individual Management Review (IMR)

5.7 The Review will specifically analyse the following:-

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 will 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.

5.8 **Family involvement**

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people the family think relevant to the review process.

Agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

Identify the timescale and process of the Coroner's inquest and criminal trial and ensure that the family are able to respond to this review, the inquest and criminal trial avoiding duplication of effort and without undue pressure.

5.9 **Legal advice and costs**

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

There may be a requirement to access independent legal advice on the part of the review team, and the team will seek funding of this advice from the Safer Communities Partnership statutory partners and agree from which source this advice will be sought.

At this stage it is not anticipated that the review will require additional resources or funding for their time to undertake this review. Should the scope of the review extend beyond the anticipated internal review, the review team will raise this through the Safer Communities Partnership for further guidance.

5.10 **Expert witnesses and advisors**

It is not intended at this stage to consult with any expert witnesses or advisors.

5.11 **Media and communication**

The management of all media and communication matters will be through a joint team drawn from the panel members' organisations.

There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process.

An executive summary of the review will be published on the Community Safety Partnerships website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

All written communication from the review team will be sent under the Safer Communities Partnership logo, using business addresses for the review team members.'

6.0 Methodology

6.1 IMRs were requested from the agencies normally represented at Multi-Agency Risk Assessment Conference (MARAC). Ten agencies were asked to complete Individual Management Reviews (IMRs), with ten complying. Eight agencies responded indicating that they had no relevant contact with Adult B or Adult A. Two agencies completed IMRs that indicated some involvement. As it was clear that some agencies had no involvement in the case, a shortened IMR format was agreed with the DHR Panel. Table 1 below sets out the IMR requests and responses.

Table 1: IMRs

Agency	Shortened IMR requested and returned	Full IMR requested and returned
Wirral MBC Children's Services		Y
Cheshire and Wirral Partnership Trust	Y	
ARCH Initiatives		Y
Wirral MBC Adult Social Care and Health	Y	
Merseyside Police	Y	
Merseyside Probation Trust	Y	
Rape and Sexual Abuse Services (for VCA Wirral)	Y	
Wirral Community NHS Trust	Y	
Wirral Family Safety Unit (for Wirral Community Safety Team)	Y	
Wirral University Teaching Hospital NHS Foundation Trust	Y	

6.2 The Chair of the Review panel attended the following meetings and interviewed the following people. Interviews were carried out by the Chair with the following individuals. The Chair decided that an interview

with a representative of [redacted – sensitive information] was more appropriate than an IMR, as the representative had known Adult B directly.

Table 2: Meetings/Interviews

	Date	Individual(s)/Agency	Method
1	12 October 2011	Wirral MARAC	Visit
2	18 November 2011	Manager, [redacted – sensitive information]	Visit
3	15 February 2012	Local Authority Designated Officer, Wirral Children's Services	Telephone
4	17 Feb 2012	Safeguarding Manager/Service User Involvement Coordinator , ARCH initiatives	Telephone
5	16 March 2012	Service Manager, Open Access, Birkenhead, Stimulant Substance Misuse Worker, ARCH Initiatives	Visit to ARCH
6	26 March 2012	Police Inspector, Merseyside Police	Telephone
7	3 May 2012	Police Inspector, Merseyside Police	Visit

6.3 A key purpose of a domestic homicide review is to facilitate the views of friends and family in contributing to the prevention of further domestic homicides and to get a more complete view of the victim's life.

6.4 Two letters from the Chair of the Panel were personally delivered to the victim's mother by the Merseyside Police Family Liaison Officer, offering to meet with her to discuss any aspect of her daughter's life. This offer was not taken up and the Chair concluded that further offers would be intrusive. The relevant Home Office leaflet was attached to the first letter.

6.5 One letter was sent via the victim's employer to be distributed to close friends of the victim at work, offering them the opportunity to meet with the Chair of the Review Panel. The relevant Home Office leaflet was attached to the letter. There were no requests to meet the Chair from the victim's colleagues.

6.6 The Chair attended the Wirral Multi-Agency Risk Assessment Conference. This is a standing conference that oversees agency involvement in the highest risk domestic abuse cases in the Wirral MBC area, and is conducted in line with national effective practice. Adult B had not been referred to MARAC.

6.7 The members of the DHR panel were:-

- Steve McGilvray, Community Safety Coordinator, Wirral
- Gavin Butler, Adult Safeguarding Manager, Cheshire West and Chester (Chair)
- Tracey Coffey, Strategic Services Manager, Children's Social Care
- Amanda Kelly, Safeguarding Manager, Adult Social Care
- Ann-Marie Nobes, Head of Safeguarding for Wirral Community NHS Trust
- Phil Spilsted, Safeguarding for Wirral Partnership
- Mandy McDonough, Operational Lead for Safeguarding, Wirral University Teaching Hospital
- DI Dave Rich, Family Crime Investigation Unit, Sefton
- Jill Barr, Manager, Wirral Family Safety Unit
- Sue Brown, Assistant Chief Probation Officer, Merseyside Probation Trust
- Jo Wood MBE, Finance & Development Coordinator Rape & Sexual Abuse (RASA) Centre Wirral

6.8 The author of this overview report is the Chair of the DHR panel, Gavin Butler, Senior Manager, Adult Safeguarding in the neighbouring authority of Cheshire West and Chester.

Domestic Abuse Expertise on the Panel.

Membership of the Panel included two of the three chairs of Wirral domestic abuse MARAC.

The manager of Wirrals Family Safety Unit a multi agency co-located team of professionals, including IDVA's, who provide support and safety planning for victims of abuse and their families.

The Operational Lead for Safeguarding at Wirral University Teaching Hospital NHS Foundation Trust Safeguarding Team, who is a qualified Midwife and is based within the Maternity Unit at the hospital.

Additionally the panel included a senior member of a voluntary sector organisation which provides support to victims of rape and sexual abuse including when this takes place within a relationship.

With this level of expertise available to it the Chair did not feel it necessary to call upon the services of any other expert during this Review.

Equality and Diversity

An equality impact assessment has reviewed the process for conducting a domestic homicide review by Wirral Council.

Point 7 within the scope of this review states that

> The review panel will bear in mind 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."

At the first meeting of the Panel all members agreed to point 7 within the Scope and Terms of Reference for the Review.

During the work of the Panel no challenges had to be made by the Chair to agencies for a breach of equality.

No issues associated with disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation were identified in any of the IMR's.

Adult A and Adult B subject of this Review are both white British adults with English as their first language. It was the desire of the Panel and practice of the Chair that all people interviewed as part of the Review were treated with respect and dignity throughout.

Wirral domestic abuse MARAC addresses the needs of members of diverse communities (including victims from BME communities, LGBT people, people with disabilities, people from faith communities and heterosexual men). There is evidence from the CAADA review in 2012 – 2013 that Wirral MARAC has 6% of clients which are male, compared to a national average of male clients of 4%.

1% of clients were reported as being Lesbian, Gay or Bisexual; this is consistent with the national average which is also 1%

Statistics show that in the last 12 months the Wirral domestic abuse MARAC has received 2% of its referrals from the BME community, which represents 5% of the total local population.

7.0 THE FACTS

7.1 On August 13 2011 Adult B was 41 years old and lived in an owner occupied house in Wallasey. She had been married to Adult A (Aged 51) for nearly 25 years. They had two children: a daughter Child A (Aged 11) and a son Child B (Aged 9). Adult A had three adult children from a previous relationship.

7.2 Adult B worked as a [redacted – sensitive information] Adult B had previously worked for [redacted – sensitive information] from the age of 18, and had [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 was responsible for arranging for repairs to houses, and was not involved directly in lettings policy or decision-making about enforcement or other tenancy management issues that might have involved knowledge of domestic abuse. [redacted – sensitive information] had a domestic abuse policy in place in relation to service users, but no specific policy in relation to domestic abuse by or against staff.

7.3 Adult B's children both attended a local authority Primary School and their teacher was an experienced member of staff who supports a number of children subject to child safeguarding interventions. The teacher has also been instrumental in referring concerns regarding other children in her teaching group to the local authority because of safeguarding issues.. For the purposes of this Domestic Homicide Review (DHR), Wirral MBC's Local Authority Designated Officer (LADO) interviewed the Head teacher. No unusual physical, behavioural or emotional changes had been noted in either child by their school in the period before the homicide.

7.4 Child A had been at Primary School since Sept 2004. Child B attended from 1 September 2005. Attendance was high (there were no unauthorised absences for either child in the 09-10 School year, and one day of unauthorised absence for Child B in 2010-11). The School describes both children as '*immaculately dressed and presented'.*

7.5 Where a minor concern about Child B's behaviour had been identified and raised with parents, both parents attended the meeting. Both parents were involved in collecting children from School, attending parents evenings and *'appeared relaxed in each other's company'*. The School staff did not witness any controlling behaviour by either parent at any time.

7.6 The school had teachers acting as 'leads' for specific issues, including domestic abuse, and this was seen as progressive by the Council's

LADO. The School Safeguarding Co-ordinator (in this case the Head-teacher) undertook the Designated Safeguarding Co-ordinator's training in July 2010 and whole- school training was delivered to all staff in January 2010. There was evidence that Child B had responded to whole-school work on bullying and harassment by advocating on behalf of a classmate with additional needs directly with the Head teacher.

7.7 Checks were made to ascertain whether Adult A had been violent to known a previous partner which was outside the two year timescale agreed in the scope of the review but may have revealed important background information. There was no evidence of any incidents or agency involvement.

7.8 Between 22 February 2005 and 1 August 2005, Adults A and B cared for Adult A's nephew Child C [redacted – sensitive information] due to a change in family caring arrangements. Due to the arrangement being within the extended family, there was no requirement on Children's Services to make any formal assessment of Adult A and B, and none was undertaken. Professionals managing the case did not make a formal assessment of the suitability of Adults A and B to be carers, but it was recorded that both adults gave appropriate emotional warmth and suitable boundaries toward Child C: they *'...appear to be considerate of Child C's needs and are very caring' (Children's Services IMR)*. There were no reported concerns about the relationship between Adults A and B. Problems emerge over this period with the family arrangements around the management of Child C's behaviour, and there is a record of one occasion where Adult A was *'verbally abusive using inappropriate language, but eventually calms down' (ibid.)*. The family arrangement eventually failed, with Child C going into local authority foster care with the consent Adult A and B and of Child C's mother. It is not clear whether contact was maintained between Adults A and B and Child C.

7.9 On 23 June 2010 Adult A's adult son [redacted – sensitive information] was discussed at MARAC in relation to stalking and harassment allegations made by a former partner. There is no reference to Adults A or B in the management of that case.

7.10 On 26 October 2010 Adult A self-referred to ARCH (Advice, Rehabilitation, Counselling, Health) Initiatives for support with [redacted – sensitive information]. ARCH Initiatives is a local charitable organisation which provides a significant range of substance misuse services on the Wirral and in other areas. They are housed in a large, high profile building on Conway St Birkenhead, adjacent to major transport, retail and other services.

7.11 Adult A attended seven sessions at ARCH between 26 October 2010 and 4 March 2011. The Comprehensive assessment form for Arch (dated 26 November 2010) indicates that Adult A reported using [redacted – sensitive information] seven days per week, but had

stopped using some two weeks before completing the assessment. His [redacted – sensitive information] use started at forty-one years of age, and Adult A was fifty years old at the time of the assessment. In Section 18 of the form ('Motivation') the entry reads *'client is really motivated through the love of his wife and family'*.

7.12 The risk assessment states that *'wife has been upset by clients behaviour however this is changing'* (pg 5) and *'his wife is supportive'* (in ibid). Section 21 notes that the couple had spent five of the last thirty days *'in conflict'*. Against the question '*Any violence?'* the box marked *'no'* has been ticked, as has the question of *'Thought of violence to others'* ('*no*'). Adult A rated his overall quality of life as 17 out of a possible 20, where 20 is *'good'*.

7.13 Adult A completed Section 31 on satisfaction with social circumstances. He rated himself as *'fairly satisfied'* or *'satisfied'* (the highest score) with all the elements (accommodation, employment etc) and *'satisfied'* with *'closest relationship'* (e.g. spouse, partner, lover, best friend, and *'satisfied'* with *'relationship with family'* (pg 14).

7.14 ARCH undertook a detailed risk assessment. Based on the evidence available to them the risk posed by Adult A was graded as 'low'.

7.15 There were two sessions that he did not attend without giving notice, on 14 January 2011 and 4 February 2011. Adult A had given Adult B as a contact and, after the 4 Feb missed appointment and no further contact, ARCH rang Adult B on 24 February 2011 and made an appointment to see both Adult A and Adult B together on 4 March 2011. This was in line with ARCH policy and procedure.

7.16 Adult A and Adult B attended on the 4 March 2011. Self report from Adult A was that *'I feel strong and drug free for the first time in years'* (ARCH IMR). ARCH was not able to test Adult A for [redacted – sensitive information] as it is not resourced to do this for clients outside the criminal justice system. Workers at Arch report that Adult B was positive about Adult A's involvement in [redacted – sensitive information] counselling and was supportive in the session. Adult A presented as relaxed and in control of his emotions. He did acknowledge in sessions at ARCH that he knew that there were risks that the relationship with Adult B could end, and was reflective and remorseful about his drug use. Workers assessed Adult A as being able to talk about alternatives to hypothetical situations and consider alternative approaches. At this joint session it was determined that Adult A had now completed the [redacted – sensitive information] (evidence for programme) and the case was reviewed and closed.

ARCH regularly attend Wirral's MARAC and there is evidence of them referring domestic abuse and sexualised violence cases to appropriate local agencies. The Wirral Family Safety Unit has a seconded drugs worker, and report that referrals to the FSU and MARAC from ARCH are consistent and appropriate.

Wirral domestic abuse MARAC has a total of 20 agencies who are signatories to the MARAC Operating Protocol and data sharing agreement.

A secure internet based referral system exists which enables MARAC agencies to refer cases to the MARAC Co-ordinator for possible inclusion on the next MARAC. This referral process requires the completion and inclusion at the point of referral of a CAADA DASH risk assessment checklist in all cases by the referring agency.

7.18 ARCH report that Adults A and B left the session together. Subsequent to this session Adult B recommended the [redacted – sensitive information] to an acquaintance. ARCH currently have information on Domestic Abuse displayed prominently in the reception and duty rooms that they use with service users, and confirm that this information would have been displayed when Adults A and B visited.

7.19 It appears from Police interviews after the homicide that Adult B moved out of the family home in June or July 2011. Reports indicate that Adult B left the family home with the children temporarily, staying at a relative of Adult A. 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 this may all 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.

7.20 Contact between the children and Adult A continued through July and August. 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. There is no evidence that Adult B disclosed any violence to her mother during this period.

7.21 It is not known if Adult B consulted a solicitor during this period about separation.

7.22 Without interviewing [redacted – sensitive information] again it does not seem possible to explore these assertions further. [redacted – sensitive information] As this Review is about learning lessons from this case to apply to future policy and procedures-*and there are no safeguarding concerns about Child A and Child B*-in consultation with the Wirral LADO, the Chair has decided that it is clearly not appropriate to seek to interview two relatively young, bereaved children for this review.

7.23 On 13 August 2011, at about 2pm, it appears that Adult A attacked Adult B with up to three different knives, inflicting nine serious stab wounds to her body, including one which pierced her heart. Adult B also had deep cuts to her hands. Child B returned home with a friend at that point and saw Adult A assaulting Adult B. Merseyside Police report that Child B tried to intervene. Adult B died an hour later in Wirral University Teaching Hospital (Arrowe Park Hospital). The cause of death was cardiac arrest following the trauma to her heart.

7.24 Adult A was arrested on the night of the 13th August in a nearby park after cutting his wrists with a broken bottle. Merseyside Police did not test Adult A for drug use on arrest. Adult A was admitted to Wirral University Teaching Hospital NHS Foundation Trust with minor self-harm related injuries. Medical notes from that admission confirm that Adult A was not tested for drugs by the Hospital, following his arrest.

8.0 ANALYSIS

8.1 Because the Review was unable to find evidence that Adult B had disclosed domestic abuse to any friend, or family member or had sought the support of any agency statutory or voluntary for this issue much of the analysis will focus upon the two Independent Management Reviews which do provide some insight into the relationship between Adult A and Adult B.

The available evidence indicates that Adult B was a warm and effective parent, a valued colleague who was progressing at work and a supportive partner to Adult A.

8.2 The children's school was not aware of any safeguarding and domestic abuse issues in the family the school reports that even with the benefit of hindsight the children displayed no physical or emotional characteristics that may suggest that they were being subjected to or witnessing harm within their home. The school reported that they had observed a supportive family environment with well-presented, apparently happy, children with good attendance.

All staff at the school had undergone safeguarding training in January 2010 and updates to that course are delivered annually via the Area Team Social Worker. All the training includes recognising the signs an symptoms both physical and behavioural which may indicate that a child is being abused and also details how these concerns can be referred on to safeguarding agencies.

The school 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 reported that during these attendances both adults presented very well both physically and mentally and appeared relaxed in each others company. The staff concluded that there was nothing to suggest that Adult B felt threatened or intimidated

by Adult A. Neither did the school staff witness any controlling behaviours by either party at any time.

The school was able to evidence that it had policies and procedures in place together with a number of means of supporting children who have concerns. This includes a pastoral support programme consisting of sessions from Bullybusters and Child line and also sessions such as Thinking about others, people who can help me, Keeping myself safe, Friends and Families, Healthy relationships, Children's rights and Knowing my feelings. The school had a worry box that is actively used by pupils which can be used anonymously and circle time is also used to provide pupils with opportunities to discuss concerns as a group or on a one to one basis with staff.

These systems had enabled one of the children to make a disclosure about bullying being experienced by a peer to a senior teacher.

However, the school may wish to consider ensuring that information on domestic abuse and the support that is available is prominent in spaces that children and parents access, and on their website.

8.3 Wirral MBC and partners have a strong; evidence based set of arrangements for managing high-risk cases of domestic abuse, and recently underwent a national Quality Assurance process, obtaining Leading Lights status with Co-ordinated Action Against Domestic Abuse (CAADA). Safety planning is built around use of the CAADA DASH risk assessment checklist used by all MARAC agencies on Wirral.

8.4 Ten months before committing the homicide Adult A self referred himself to a local substance misuse treatment agency Arch Initiatives.

Staff at Arch Initiatives are trained in domestic abuse awareness and response and as an organisation are active members of the domestic abuse MARAC. Consulting and waiting rooms at Arch Initiatives display information regarding domestic abuse and how to access support.

As part of the established programme delivered to Adult A by Arch Initiatives a comprehensive assessment programme is undertaken which includes a self assessment completed by Adult A. It is acknowledged that the assessment process and self assessment is completed in respect of the person presenting for treatment only and formal assessments are not extended to other family members.

Adult A reported to staff at Arch that if nothing was done about his substance misuse he would "loose his family". He stated that his difficulties were his "secretive behaviour, being deceitful and emotional." This was underlined sometime later within the treatment programme when his key worker noted that the discovery of his

substance misuse by his partner after 12 years created a big change in the family.

Although Adult A reported that the couple had spent five of the last thirty days *'in conflict'* Adult A answered No to the question of having "thoughts of violence towards others" and No to the question "is there any violence within the relationship."

Adult A scored his quality of life as being 17 out of a maximum of 20. Throughout his time on the treatment programme there were no indicators of domestic abuse detected by and staff at Arch Initiatives.

Adult B accompanied her husband to the final session before discharge at Arch Initiatives and key workers noted that on leaving the programme Adult A was drug free that he and his wife left the building hand in hand. We also know that Adult B later recommended the programme to a colleague for the positive impact it had on Adult A.

Adult A was not tested for substance misuse on arrest nor on his admission to hospital.

8.5 Whilst all elements of the programme which Adult A attended were correctly followed and no member of staff detected any indication of domestic abuse being present within the relationship between Adult A and Adult B key workers have been emotionally affected by this homicide and ARCH Initiatives have reported that their staff have requested further training on domestic abuse and MARAC which is being undertaken.

8.6 Outside of the facts listed above, the nature, frequency and duration of Adult A's [redacted – sensitive information] is not known. It has not been possible to establish any causal relationship between Adult A's [redacted – sensitive information] and his violent behaviour towards Adult B during this review.

8.7 One obvious factor is the couple's apparent separation. The Office of National Statistics state that *'the number of divorces in 2010 was highest among men and women aged 40 to 44'* (ONS, 8 Dec 2011). Separation and divorce are known risk factors for domestic abuse (for example, it is flagged in the CAADA/DASH Risk Identification Checklist) which is in use by all MARAC agencies on Wirral. Research quoted by Women's Aid Federation of England states that women can be assaulted up to thirty-five times before disclosing abuse, and may leave up to seven times before successfully separating.

9.0 CONCLUSIONS AND RECOMMENDATIONS

9.1 It appears, based on Police interviews, that between March and August 2011 Adult A was violent towards Adult B. It has not been possible to

establish if Adult B discussed the exact nature and seriousness of problems in the relationship with her family.

Processes exist within many public and voluntary sector agencies on Wirral to facilitate the reporting of domestic abuse and beyond that, networks exist which can provide support and safety planning for victims and their families.

Additionally we know that one of the children in this family was confident enough to use school systems to disclose bullying being experienced by a peer. However none of the children disclosed domestic abuse taking place in their home whilst at school.

9.2 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. Further effort is required to educate more people of all ages on Wirral on what constitutes domestic abuse and the gateways which exist to support and safety plan within them.

Guidance from victims of abuse should be sought in getting these messages out to all sections of our society in order to maximise the effectiveness of the message and the likelihood that a victim will act upon the message.

9.2 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. It appears that the apparently escalating domestic abuse remained hidden within the family.

9.3 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.

9.4 The opportunity to gather any available evidence of drug use by Adult A was not taken up as he was not tested on arrest, or on admission to hospital. Although this made no difference to the criminal justice outcome, it may have been relevant to future policy and procedure.

10.0 ACTION PLAN

10.1 Partner agencies on the Wirral may wish to consider the following draft Action Plan to try and increase the chances of victims and children accessing appropriate services. These actions should be developed into a complete, time scaled plan, by 1 July 2011:

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 i.e. 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. Following Children's Services, Family Safety Unit and ARCH raising the issue, 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. It may be helpful to look at other areas that have developed Parental Challenges training and awareness programmes.

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.

A detailed Action Plan follows.

Wirral Community Safety Partnership
Report into the death of Adult B
Action Plan

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
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 i.e. toilet cubicles etc.	Local	CSP task and finish group to review all relevant promotional and publicity material, identify the most effective and request all partners to display in public areas of their buildings	Community Safety Partnership (CSP)	Review progress against action plan at 14 August 2012 CSP	New materials distributed by 1 October 2012	Report on effectiveness noting any change in the nature and volume of referrals and next steps to CSP Jan 2013
2	Consulting family law networks to	Local (national for links with	Identify relevant providers and any useful networks, e.g.: Resolution	CSP in liaison with	1. Produce map/data-base of family law solicitors and	1 October 2012	CSP to send evaluation

	identify all opportunities to brief women who are seeking legal advice on separation and divorce about the resources available in Wirral to address domestic abuse	national organisations	http://www.resolution.org.uk/domesticviolence/ 1. CAFCASS 2. Family Courts 3. CAB	Home Office	other resources 2. Provide advice on accessing domestic abuse services		letter out seeking views on effectiveness of material provided, and taking stock of any change in nature/volume of referrals in April 2013
3	Develop a model Employee Domestic Abuse Policy for consideration by partners and any Wirral employer	Local	Human Resources to gather a range of Employee Domestic Abuse policies and use a panel of Human Resources leads from MARAC, CSP and CVS partners to collate a model Policy and distribute	CSP	1. Collate at least 5 policies 2. Draw model policy from most effective examples 3. Disseminate and publicise	1 October 2012	Progress report to August CSP, all steps complete by 1 October
4	Develop a 'Level One' Domestic Abuse training	Local	Local Safeguarding Children Board(LSCB)/Local Safeguarding Adults Board (LSAB)/CSP	Family Safety Unit (FSU) via	1. Half day/One day Level One training programme developed and	1. Pilot Oct 2012 2. Programme advertised	All Boards to Check evaluation and

	programme, for access by any professional, to increase knowledge of the scale and impact of domestic abuse, to examine the links between domestic abuse and other safeguarding issues, to improve referrals, information sharing, risk assessment and safety planning			Safeguarding Training Board	agreed with partners 2. Pilot course held with maximum 25 participants 3. Evaluation and amendment 4. Full programme advertised via LSCB/LSAB Jan 2013	Jan 2013	programme roll-out in Jan 2013
5	All schools to be encouraged to ensure safeguarding policies and	Local	Presentation on relevant aspects of this DHR to Primary Teacher's Forum	Director of Children's Services	Presentation to Primary School Heads/Safeguarding leads	August 2012	CSP to request update from Primary Teacher's

	procedures are available to pupils and parents in public areas and websites						Forum in October 2012
6	Develop costed proposal for accredited, open access Voluntary Perpetrator Programme	Local/Regional (Merseyside)	Identify options for provision of an accredited Voluntary Perpetrator programme and recommend a course of action for support at CSP and any relevant boards	CSP via Merseyside Criminal Justice Board	1. Identifying programme 2. Identifying funding for pilot and evaluating outcomes 3. Mainstreaming in 2013	CSP to review proposal 14 August 2012	Jan 2013
7	Review policy (and compliance with policy) on drug testing on arrest and admission to hospital for people arrested for domestic abuse	Local/Regional	Check that policy and procedures on drug testing for alleged perpetrators (including homicide) are sufficient, and that staff are aware	Mersey-side Police/ Wirral University Teaching Hospital NHS Foundation Trust	Policy review by both agencies and report to CSP	August 2012	Assurance to CSP that policies are fit for purpose