Wirral Community Safety Partnership

Domestic Homicide Review Overview Report
Adult C

13th February 2013.

REPORT INTO THE DEATH OF ADULT C

REPORT PRODUCED BY
Gavin Butler

DATE 13th February 2013

INTRODUCTION

This report of a domestic homicide review examines agency responses and support given to Adult C prior to the point of her death in the early part of 2012.

The review will consider agencies contact/involvement with Adult C and Adult D.

The key purpose for undertaking DHRs is to enable lessons to be learned 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.

TIMESCALES

This review began on 21 May 2012 and was concluded on 18 October 2012. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

CONFIDENTIALITY

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

DISSEMINATION

No agency has yet received copies of this report which will be distributed amongst Panel Members agencies on the reports return from quality assurance at the Home Office.

Terms of Reference and Scope

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

Purpose of the review

The purpose of the review is to:

- Establish the events that led to the death of (Adult C) in the early part of 2012 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

Scope of the review

The review will

- Seek to establish whether the events in the early part of 2012 could have been predicted or prevented.

- Consider the period of two calendar years prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant. (period under consideration will be determined on the basis of agency involvement start dates)

- 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.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Take account of the coroners 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 October 2012, subject to 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.

The agencies responsible for providing details of their involvement, through chronologies of contact and Individual Management Review's (IMR's) 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 (MARAC)
Wirral MBC Children and Young Peoples Department.
Wirral MBC Department for Adult Social Services
Wirral University Teaching Hospital NHS Foundation Trust

Each of the above contributing agencies will be required to:

- Provide a chronology of their involvement with Adult C and Adult D plus their two children 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)

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 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.

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 Coroners 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.

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.

Expert witnesses and advisors

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

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 Partnerships websites, 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.

IMR table

Agency	IMR requested	IMR received
Cheshire and Wirral Partnership NHS Trust	May 2012	yes
Merseyside Police	May 2012	yes
Merseyside Probation Trust	May 2012	yes
Voluntary Community Action Wirral	May 2012	yes
Wirral Community NHS Trust	May 2012	yes
Wirral Community Safety Team (includes the Family Safety Unit)	May 2012	yes
Wirral MBC Children and Young People's Department	May 2012	no
Wirral MBC Department of Adult Social Services	May 2012	yes
Wirral University Teaching Hospital trust	May 2012	yes

DHR panel members

Gavin Butler, Senior Manager, Cheshire West and Chester Council (Chair)
Steve McGilvray, Community safety Co-ordinator, Wirral Borough Council
Tracey Coffey, Strategic Service Manager, Children and Families, Wirral MBC
Jo Wood, RASA/Voluntary Sector in Wirral
Dave Grisenthwaite, Safeguarding Officer, Directorate of Adult Social Services, Wirral MBC
DI Steve Cox, FCIU, Merseyside Police
Sue Brown, Assistant Chief Probation Officer, Merseyside Probation Trust
Ann-Marie Nobes, Wirral Community NHS Trust
Satwinder Lotay, Cheshire and Wirral Partnership Trust
Jill Barr, Wirral Family Safety Unit
Amanda McDonagh, Wirral University Teaching Hospital NHS Foundation Trust
Sue Hess, Wirral University Teaching Hospital NHS Foundation Trust

Author of overview report

Gavin Butler, Senior Manager Adult Safeguarding, Cheshire West and Chester

- Meeting with Merseyside Police Family Liaison Officer 30 May 2012.

- Letter sent to sister of Adult C on 30 May 2012 with relevant Home Office leaflet.
- Letter requesting a meeting with employer sent 22 August 2012

- Meeting with Adult C's sister, Child C and Child D on 24 August

- Letter requesting information to Adult C's Solicitor sent 17 September 2012

- Letter sent to Adult D via Merseyside Probation sent on 17 September 2012

- Meeting with Merseyside Police on 26 September 2012

- Telephone contact with Adult C's sister on 15 October 2012.

1. Background

Adult C and D lived in Leicester until 2010.

Adult C moved to Leasowe, Wirral in 2010 with her husband Adult D and their children Child E (born 1995) and Child F (born 1998), from another part of the UK. In 2010 the family moved to Moreton, Wirral. Adult C's sister had been resident in the Wirral area for several years and there was a strong bond between Adult C and her sister.

Child E and Child F attended Wirral schools from 2010 There were no recorded health concerns about either child, apart from a Child F having had a heart murmur when younger. Both children were up to date with immunisations.

On 19 July 2011 Adult C attended the Accident and Emergency Department at Wirral University Teaching Hospital (WUTH) with a wrist injury which resulted in three further appointments for treatment and physiotherapy. WUTH report that there were no disclosures of domestic abuse in relation to this injury.

Adult C worked for a national high street bank, transferring from an area branch near to her home to a Wirral branch in 2010. Her sister's adult daughter worked in the same branch.

Adult D worked for twenty-two hours per week as a bus driver for a company providing school transport.

Adult C's sister reports that Adult C and D had effectively separated, but were living in the same house. Adult C's sister reports that Adult C had received advice from a solicitor to establish a 'separate household within the house'. Adult C's sister and Child C and Child D describe Adult C as 'the

breadwinner'. They describe Adult D as having 'problems making friends', and making increased use of alcohol during this period. The children describe Adult D as losing his temper a lot, and being verbally abusive to them and their mother. An incident pre-dating the family's move to the WIrral had involved Adult D losing his temper and throwing a box which cut Child C's head. No police or social work referral was made.

As part of Adult C's establishment of a separate household she closed off access for Adult D to the television. Child C and Child D describe an 'awful' atmosphere at home. The family are not aware if Adult D sought any legal advice. They understand that members of Adult D's family in the home counties had given him some money on the 17th February in order to move back to live with them.

Merseyside Police report 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.

On 22 February 2012 Divorce papers were served on Adult D.

Adult D's employer advises that there had been no previous issues with Adult D's conduct at work. On the 23rd February Adult D arrived at work for his morning shift. He advised his manager that he had been having 'problems' in his relationship with Adult C and that he was upset at losing access to a joint bank account and access to a bicycle. His manager described Adult D as 'very upset' that morning.

Later that same day at 12 38 a call was received by Merseyside Police from Adult D stating that he had hit Adult C over the head with a hammer and that she was bleeding and that the wound was quite bad. He then went on to state that he had put a screwdriver in her throat.

It appears from Adult D's subsequent account of the offence to Merseyside Police that he had struck her more than four times with the hammer, then attempted to strangle her and then stabbed her in the neck or throat in order to inflict a fatal injury.

Adult C was admitted to hospital and died a day later when her life support was turned off. The Home Office pathologist gave the cause of death as 'severe blunt force head injuries the result of multiple hammer blows to the head'.

Adult D was arrested at the family home on and was charged with the murder of Adult C on 27 February 2012 He was tested on arrest and no intoxicants were detected. On 6 June 2012 Adult D pleaded guilty to the murder of Adult C and was sentenced to life. He is currently in HMP Liverpool. His Offender Manager reports that, in initial interview, Adult D has not reported that he sought any opportunities for emotional or psychological help during this period.

Adult D had no previous convictions for any offences.

There is no record of any other domestic abuse incidents against Adult C in the area the family lived in prior to the move to Wirral or Wirral.

A chronology of Panel Agency involvement with the family of Adult C and D is attached to this report.

2. ANALYSIS

As noted above, on 15 February 2012 Adult C and her sister attended Wallasey Police Station and spoke to a Police Constable in the open reception area about the incident where Adult D had grabbed Adult C's wrist. Adult C reported that she had been subject to an assault that sought to stop her leaving a bedroom with papers relevant to a divorce, and that her son had witnessed this and been upset. Adult C's sister states that they attended the Police Station following the advice of Adult C's solicitor. 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].'

Merseyside Police domestic abuse policy February 2012 states that:
'2.1.1 All staff taking an initial report of Domestic Abuse should seek the following information:

a) Location and identity of the person making the report
b) Location and identity of the suspect and victim
c) Whether any parties are injured
d) Severity of any injury and whether medical assistance is required

e) Whether any children are present and if they are safe
f) Location of any other parties (children and witnesses)'

and

'n) Record details of the demeanour of the victim, suspect and witnesses
o) A first account of what the caller says has occurred (recording it verbatim)'

The note recorded in the memo book does not appear compliant with information gathering requirements set out in the force policy. Further to that, a more specific set of instructions is given to Enquiry Office staff as follows:

'2.2.1 In addition to gathering the above information, where a victim of Domestic Abuse reports in person to a Police Station, Enquiry Office Staff should:

a) Where possible offer the victim the opportunity to speak in confidence

And

i) Be aware of the risk factors in Domestic Abuse cases, and be prepared to complete MeRIT, or inform the risk assessment process. See Para 11 'Risk Assessment'
j) Ensure that the Vulnerable Person Referral Form (VPRF1) is completed and scanned and e-mailed to the Area Family Crime Investigation Unit (FCIU)

And

l) If there is any evidence that a crime may have been committed, it must be recorded in line with NCRS [National Crime Recording Standard]

The Domestic Abuse Policy was not followed by the officer who dealt with Adult C. Adult C was not offered an opportunity to speak to a police officer in a private room. As stated above, a Vulnerable Persons Referral Form (VPRF1) was not completed. This means that an opportunity to gather more substantial information, and to interact for a longer period with Adult C, was lost. Consequently the Merseyside Police Family Crime Investigation Unit were unaware that there had been an incident, no risk assessment was undertaken, and no further information on domestic abuse and how to address it was provided to Adult C or her sister.

Based on the minimal information available from the Merseyside Police memo book, it is not possible to estimate what MeRIT score would have been given to Adult C on the Merit Risk Assessment (the risk assessment tool used by Merseyside Police).

Again, the entry in the memo book states that the incident occurred *'...in front of son [name and date of birth redacted]'*. Wirral Multi-Agency Safeguarding Children Policy and Procedures state that '*Where the victim is assessed as high risk through MERIT (Merseyside Risk Assessment Tool) assessment and there is a child in the household'*[1] a referral or notification should be made to Children's Social Care. As the VPRF1 was not completed, we cannot know what the MERIT score might have been and cannot speculate on what action would have resulted. However, it is clear that the presence of Adult C's son was not considered appropriately as a safeguarding issue.

A letter was sent on 17 September 2012 by the author of this report to the solicitor that Adult C consulted seeking information for this report. No response has been received.

Apart from this 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).

The scope of this review included at point 7 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."

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 C and Adult D 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

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[1] **11.3 Joint Protocol for the Management of Domestic Abuse Notification from Merseyside Police and Other Agencies, http://wirrallscb.proceduresonline.com/chapters/pr_man_dom_ab_notif.html**

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.

3. CONCLUSIONS AND RECOMMENDATIONS

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.

Merseyside Police advise that the enquiry officer who dealt with Adult C on 15th February has been brought in for management advice in relation to their failure to follow force policy. This will be followed by an action plan to raise their standard of work, with support from a mentor. The Area has recently doubled the size of its Family Crime Investigation Unit , and every officer and public facing member f police staff has been trained in the minimum standards for responding to domestic abuse.

On 5 March 2012 all Police staff were reminded of the Force 'Minimum Standards for Violent Crime', including domestic abuse. This reinforces the need to compete a VPRF1 form for every incident.

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.

A new process of Inspector level reviews of memo books has been initiated to try and ensure that a similar breach of policy and procedure does not happen again.

The author of this report attended Wallasey Police station on 26 September 2012. There was some minimal information on domestic abuse available in poster form. The civilian enquiry officer on duty did know the force policy and would have ensured that a complainant was seen in private, and that a VPRF1 was completed.

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'.

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. Adult D did not respond to a written offer to meet with the author of this report.

4. **Recommendations**

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.

Action Plan

	Recommendation	Scope of recommendation ie local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
1	Advise all relevant agencies that separation should be regarded as a risk factor, not a safety plan, and that no-one should be advised to establish a 'separate household within the home' during separation and divorce	Wirral	• Liverpool Law Society • Multi-agency training • CAFCASS • Merseyside Police Training for recruits • Increase police attendance at multi-agency training	Community Safety Family safety unit Family safety unit Merseyside Police Family Safety Unit/Merseyside Police	Obtain LSCB support		
2	All police reception areas to be checked to ensure that they have very clear, visible and up-to-	Wirral	• Merseyside Police • Community Safety Partnership and	Public Protection Unit			1 Dec 2012 28 February 2013

	date information on domestic abuse services displayed prominently		Merseyside Police to produce new materials that include advice on bullying in relationships and verbal abuse				
3	Audit the compliance by front-line staff with force policy on domestic abuse	Wirral	• Establish process for checking station memo books • Review staff awareness of the force policy and procedure on domestic abuse and evaluate whether number and quality of completion of VPRF1s has increased/improved as a result	Merseyside police			Jan 2013
4	Increase children and young people's awareness that	Wirral	Identify or commission resources that	Schools Domestic abuse co-ordinator,			April 2013

	Domestic Abuse can involve more than just overt violence		would inform children and young people that all forms of domestic abuse should not be tolerated, and that services exist to help address them.	with Family Safety Unit/LCSB			