SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

RUTH

OVERVIEW REPORT

[Post Home Office Quality Assurance]

Author and Domestic Homicide Review Chair

David Hunter April 2017

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1. INTRODUCTION

1.1 This report is about the homicide of Ruth. In September 2015 the North West Ambulance Service attended a flat in Southport having been called to the sudden death of a woman. The paramedics confirmed death, established the woman was Ruth and requested the attendance of Merseyside Police.

1.2 The police arrived and Harry, her partner of about eight weeks, told the officers he found Ruth collapsed on the floor near the shower and alerted a neighbour who called the ambulance.

1.3 A little later that the same day the police became wary of Harry's account and arrested him on suspicion of murder. A post mortem found Ruth died of head injuries and chest wall trauma. She also had a large number of variable aged injuries. Two days later Harry was charged with Ruth's murder.

1.4 Her Majesty's Coroner was notified of Ruth's death and opened and adjourned an Inquest the day after Harry was charged, pending the outcome of the criminal proceedings.

1.5 The trial started in March 2016 and Harry pleaded not guilty to murder, having had his first day offer to plead guilty to manslaughter rejected by the Crown Prosecution Service. Part way through the trial Harry changed his plea to Guilty and was sentenced to life imprisonment with a minimum tariff of twenty years.

1.6 The Judge's sentencing remarks appear in full at Appendix A and make very difficult reading as they reveal the detail of Harry's brutality towards Ruth. The following is an extract.

"*Having heard that evidence and having considered all the medical and scientific evidence, I am quite satisfied that over a period of a month prior to her death, you caused her untold physical and mental suffering as a result of your ever increasing violence, culminating in a ferocious and sustained attack upon her on the night she died.*"

1.7 The police investigation showed that Ruth was a victim of domestic abuse from more than one partner and that Harry perpetrated domestic abuse on more than one partner. He also had a conviction for raping a female child. Their forensic history is detailed later.

1.8 The domestic homicide review Panel expresses its condolences to Ruth's family and friends for her tragic death.

1.9 The main people referred to in the report are:

Name/Identifier	Role/Relationship	Ethnicity
Ruth About 50 years	Victim and partner of Harry	White British
Harry About 55 years	Offender and partner of Ruth	White British
Tony	Son of Ruth [1]	White British
Adele	Daughter of Ruth [2]	White British
Georgia	Daughter of Ruth [2]	White British
Emily	Daughter of Ruth [2]	White British
Former Husband 1	Ruth's first husband and father of the three daughters	White British
Former Husband 2	Ruth's second husband	White British

1.10 All the names are pseudonyms chosen by the victim's family. The name of the perpetrator was agreed with his brother and was acceptable to the victim's family.

[1] All are adults

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1 Decision Making

2.1.1 Sefton Safer Communities Partnership [the Partnership] agreed that the death of Ruth met the criteria for a domestic homicide review as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013.

2.1.2 The Guidance states that a decision to hold a review should be taken within one month of the homicide coming to the attention of a community safety partnership and says it should be completed within a further six months. The target date for completing Ruth's review was 24th April 2016.

2.1.3 The DHR Panel needed to engage with Ruth's family and staff from Southport and Ormskirk Hospital for reasons set out later. The police advised that approaches should not be made to either group until after the trial as individuals within them may be required to give evidence in the week beginning 7th March 2016

2.1.4 The Chair of the Partnership approved a new completion date of 12th June 2016 and informed the Home Office. This was later amended by the Chair of the Partnership to 30th September 2016 to allow Southport and Ormskirk Hospital NHS Trust to finalise its Serious Untoward Incident Root Cause Analysis. The justification for this will be seen later in the report when the NHS Trust's role unfolds. The domestic homicide reviews was presented to, and approved by the Partnership on 8th September 2016.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author. Paul Cheeseman provided support to the review. Both are independent practitioners who between them have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews and Multi Agency Public Protection Arrangement Serious Case Reviews. Neither has been employed by any of the agencies involved with this DHR and both were judged to have the experience and skills for the task.

2.2.2 The first of five panel meetings was held on 5th November 2015. The independence of Paul and David was fortified by Gill WARD from Sefton Women and Children Aid who brought knowledge of domestic abuse. Andrew Rawlins from Lifeline, joined the Panel from the second meeting, and brought additional independence and knowledge of substance misuse.

2.2.3 Attendance was good and all members contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. All agencies demonstrated a willingness to learn from the

review, thereby demonstrating their commitment to helping victims of domestic violence.

The Panel comprised:

➢ Sam Atkinson	Designated Nurse Safeguarding Adults Sefton Clinical Commissioning Group
➢ Paul Cheeseman	Independent Support for Chair
➢ John Griffith	Detective Chief Inspector Merseyside Police[2]
➢ Tracey Lloyd	District Manager National Probation Service
➢ Dave Rooney	Detective Chief Inspector Merseyside Police
➢ Andrew Rawlins	Clinical Governance Lead Lifeline
➢ Collette Rice	Senior Independent Domestic Violence Adviser Sefton Council
➢ Gill Ward	Chief Executive Sefton Women's and Children's Aid
➢ David Hunter	Independent Chair and Author

2.3 Agencies Submitting Individual Management Reviews

2.3.1 The following agencies submitted Individual Management Reviews:

- Merseyside Police
- National Probation Service
- Southport and Ormskirk NHS Trust
- Lifeline

2.3.2 The Independent Domestic Violence Service from Sefton Council and the general practitioners provided shorter reports.

2.4 Notifications and Involvement of Families

2.4.1 Ruth's son Tony, and former Husband 2 live in the same house. On the 19th November 2015, the police Family Liaison Officer delivered: letters from the

[2] DCI Griffith took over from DCI Rooney on 12.02.2016

Chair expressing condolences and informing them of the review, together with an invitation to contribute at an appropriate time; the Home Office domestic homicide review leaflet for families and a leaflet from Advocacy After Fatal Domestic Abuse.[3] Harry has been estranged from his family for many years.[4] However, telephone and e-mail contact was made with a brother who emigrated several years ago and was willing to provide background information. This appears at paragraph 4.2.

2.4.2 The DHR Chair and his colleague, Paul Cheeseman, saw Ruth's four children on 7th April 2016. They provided a picture of their Mother and described with great dignity the suffering caused to her by Harry, and what they did to help her. The family feels badly let down by Merseyside Police and Southport and Ormskirk Hospital. The family's views appear in the report.

2.4.3 The DHR Panel took the view in the light of the Judge's sentencing remarks that there was little to be gained or learned by visiting Harry. He had a long history of violent and bullying behaviour with significant substance addictions. Nevertheless, the family felt it important that he should be given an opportunity to say why he had killed their Mother, something he never did during the criminal proceedings. The Domestic Homicide Review Chair wrote to him via his Offender Manager and received feedback that Harry would think about it. He later rejected the approach and was not seen

2.5 Parallel Processes

2.5.1 Merseyside Police held a criminal investigation; HM Coroner Sefton, Knowsley and St. Helens opened and adjourned an inquest and finally filed the case after the criminal verdict.

2.5.2 Southport and Ormskirk NHS Trust planned to do a root cause analysis. The police advised that the work be held in abeyance until the trial was over. The Root Cause Analysis was sent to the Domestic Homicide Review Chair on 24th August 2016 and was used to finalise the overview report and executive summary.

2.6 Terms of Reference

2.6.1 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims

[3] Advocacy After Fatal Domestic Abuse is a registered charity [1125973] that helps families with domestic homicide reviews.

[4] Harry's brother said a decision had been made by their sister not to tell their Mother about Harry's arrest/conviction for murder. Their Father does not live in England and it is not known if he knows about Harry's arrest/conviction.

- 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

- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working [5]

Timeframe under Review

The DHR examines the period 23rd January 2015 when Harry was released from prison on licence to September 2015.

Subjects of the DHR

Victim	Ruth
Offender	Harry

Specific Terms

1. What if any indicators of domestic abuse did you agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?

2. How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

3. Were single and multi-agency policies and procedures, including the Multi-Agency Risk Assessment Conference protocols, followed; are the procedures embedded in practice and were any gaps identified?

4. What knowledge of domestic abuse did the victim's and offender's families, friends and employers have of the relationship that could help the review Panel understand what was happening in their lives.

5. Did the families and friends know what to do with any such knowledge and if they brought their concerns to the attention of an agency, how did they view the response?

[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7

6. How effective were agencies responses to the concerns raised by the victim's family and friends that she was subject of domestic abuse?

7. How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?

8. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects?

9. How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

10. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

2.7 Meeting with Southport and Ormskirk NHS Trust [The Hospital]

2.7.1 The Domestic Homicide Review Chair proposed that a meeting should take place with key staff from the Hospital so their actions could be fully understood. The Panel supported this. On 4th April 2016 the Domestic Homicide Review Independent Chair accompanied by Paul Cheeseman met the following group of hospital staff to explore in more detail the background to how and why they made the decisions relevant to domestic abuse during Ruth's admission.

- Accident and Emergency consultant
- Deputy Director of Nursing
- Lead Alcohol Nurse
- Matron Medicine
- Matron Urgent Care
- Secretary Hospital Alcohol Liaison Team
- Ward Manager

2.7.2 The meeting proved very useful in determining the finer detail of Ruth's stay in hospital and what was done with the disclosures of domestic abuse she

made to staff. The attendees were open and demonstrated a willingness to learn. What emerged at that meeting is accurately reflected in the August 2016 Root Cause Analysis.

3. DEFINITIONS

3.1 The experiences of Ruth fell within the Government definition of domestic violence [6] which can be found at Appendix A.

4. BACKGROUND RUTH AND HARRY[7]

[6] In this report the term domestic abuse is used but it is synonymous with the Government definition of domestic violence

4.1 Ruth

4.1.1 Ruth was born and educated in the North West and spent all her life in the area. For most of her childhood she lived with her father. Ruth had Tony when she was relatively young but the relationship did not endure. Soon afterwards she met and married Husband 1. They had three daughters and divorced when the children were quite young. Ruth had different jobs [e.g. cleaning in licenced premises] and latterly qualified as a carer at which she excelled, achieving NVQ's and becoming a senior carer.

4.1.2 Ruth met Husband 2 and they married late in their nineteen year relationship after bringing up the four children together. They later separated and divorced. Ruth had close relationships with her four children, always telephoning them and dropping in for chats.

4.1.3 The family would like Ruth remembered as an unbelievably kind and very loving person. They felt they could not have had a better mother. She adored and loved her grandchildren and loved life. She was passionate about cross stitching and loved the 'Mod Scene' and scooters. In tribute to Ruth, eight scooters followed the funeral hearse.

4.1.4 The family were candid about their mother's use of alcohol and when asked what term they thought best fitted her pattern of drinking said she was, 'a problem drinker'. They also described Ruth as a 'functioning drinker'. They said her drinking seemed to get worse after her sister died and her marriage failed. There were lots of call outs by the police. They said their mother moved from being a 'functioning drinker' to what they described as being on 'the wrong pathway' when she met 'these characters' meaning people of Harry's ilk. When this happened the family were careful not to leave their children in the sole care of Ruth. Her family misses her each day and have dealt with her homicide in a dignified way.

4.1.5 In June 2013 Ruth entered a relationship which ended in March 2015. During this period she lost her job as a carer for the elderly because of alcohol misuse. Ruth then met another person and the relationship with him continued until the summer of 2015, at which time she became involved with Harry. Ruth moved in with Harry in July 2015 and lived with him until her death a few months later.

4.1.4 Merseyside Police has records of domestic incidents between Ruth and Husband 1. These were described as mainly verbal disputes. He is recorded as the victim fourteen times and Ruth once when she reported being assaulted by him.

[7] The information in this section is derived from the families and agency records.

4.1.5 However, on 31st October 2013 Husband 1's case went to a Multi-Agency Risk Assessment Conference because he had been assessed as facing a Gold[8] risk of serious harm from Ruth.

4.1.6 In November 2013 Ruth pleaded guilty to harassing Husband 1 and was conditionally discharged for twelve months. The court made a Restraining Order prohibiting her from contacting him.

4.1.7 Ruth breached the Restraining Order by contacting Husband 1 through social media and mobile telephony. She was sentenced to a 12 month Community Order which had two requirements; 12 months supervision and a specified activity to attend the Women's Turnaround project.[9]

4.1.8 On 7th July 2014, Merseyside Police made a referral to Sefton Women's and Children's Aid following a report by Ruth on 21st June 2014 that her partner had assaulted her. On 13th August 2014 a court sentenced the partner to eight weeks imprisonment for the assault and imposed a Restraining Order prohibiting him approaching Ruth.

4.1.9 Merseyside Police recorded that two of Ruth's daughters were victims of domestic abuse at the hands of their mother; one on three occasions, and the other on one occasion. None of the mother/daughter incidents resulted in formal complaints to police and happened in the context of the daughters trying to support their Mother and keep her from harm.

4.1.10 Ruth's victimisation by Harry is dealt with later in the report.

4.1.11 Merseyside Police noted that Ruth's use of alcohol featured heavily in their dealings with her.

4.1.12 In summary the family believe that Harry identified Ruth as a vulnerable person who he could exploit, dominate and abused. The Panel felt that was an accurate assessment.

4.2 Harry

4.2.1 Harry, the eldest of three children, was born and brought up in Oldham. Harry's brother describes how they were left to roam the streets after school until their parents returned from work. He described Harry as always being a violent person and recounted many stories of his cruelty to animals and

[8] Gold is the highest of the three risk levels {Gold, Silver and Bronze} used by Merseyside Police

[9] A service providing support to adult women offenders at risk of offending in Liverpool, Knowsley, St Helens and Sefton. They offer a "one stop" style of service that provides comprehensive support and advice to the women. www.womensbreakout.org.uk

serious assaults on their sister. Harry's bother also spoke of the domestic violence Harry perpetrated on his partners, on occasions viciously assaulting them. Harry has been estranged from his family for many years because of his violence. His brother summed Harry up by saying, "He was a brute and a bully who had the gift of the gab". He has long term dependency on alcohol and used his physical size to intimidate vulnerable people in furtherance of his criminal activities. He has twenty eight convictions beginning in 1981, including:

> In 1998 he was convicted of offences of violence against his wife and his daughter. He was also convicted of the rape and indecent assault of a female under 16 years of age. He received a seven year prison sentence.

4.2.2 In 2005 Harry was released from prison and moved to the Preston area where he remained for several years before relocating to Southport. At that time he was assessed as presenting a high risk of harm to children and his former partner. He was a Registered Sex Offender for life.

4.2.3 On 25th November 2010 he was sentenced to thirty six months custody for robbery. He was released on licence in April 2012 but was remanded in custody in June that year for an allegation of assault with intent to rob.[10] At the same time his licence was revoked. The offence was allegedly against a female who he hit with a hammer. The charges were later dropped and on 18th October 2013 he was released from his original robbery sentence having been denied parole. Following release he received support for his drug and alcohol misuse.

4.2.4 On 8th April 2014 Harry was sentenced at The Liverpool Community Justice Court to a Drug Rehabilitation Order; Medium intensity 9 months with 12 months supervision for an offence of theft.

4.2.5 Harry attended for his appointments but was often drunk and tested positive for prescribed methadone, cocaine, heroin and benzodiazepines.[11] On 27th May 2014 he was remanded in custody on another robbery charge.

4.2.6 The events following his release on 21st January 2015 are described later.

Ruth and Harry's Relationship

[10] Section 8(2) Theft Act 1968

[11] Often prescribed for alcohol withdrawal/anxiety

4.3.1 It is thought Ruth and Harry began their relationship after his release from prison on 26th May 2015 at his sentence end date. This meant he was not on licence and, subject to the law, could do what he wanted. However, he had to register where he lived with the Police because he was a Registered Sex Offender. In July 2015 they moved into separate rooms within the same multi-occupancy house. However, it appears Ruth spent the majority of the time living in Harry's room. Around this time Ruth's friends and family noticed a decline in her appearance and health. What the family knew and did with the information appears later in the report. In the first week of September 2015 Ruth and Harry were evicted and moved to the address where she met her death.

4.3.2 It is now known that Harry was violent towards Ruth and committed despicable acts of domestic abuse, including sexual violence. He also threatened to kill her and her family. The details appear later.

5. KEY EVENTS BEFORE JUNE 2015

5.1 Introduction

5.1.1 This section of the report is a chronological account of the contacts each agency had with Ruth and Harry that are judged relevant to the terms of reference. It also contains what Ruth's family knew and did about the domestic abuse she suffered.

5.1.2 The analysis of agencies' responses to Ruth's victimisation is dealt with at Section 7 of the report.

5.2 Harry's two Releases from Prison in 2015

Release one

5.2.1 On 23rd January 2015 Harry received 12 months imprisonment for robbery, but because of the time spent on remand, he was released the same day. A parole licence from previous offending was still in force until 26th May 2015, meaning he was under the supervision of a probation officer. He failed to report to his probation officer on 23rd January 2016 or 26th January 2015 and was given a formal written warning.

5.2.2 On 28th January 2015 Harry renewed his involvement with Lifeline from where he made contact with his probation officer. Harry's purpose in attending Lifeline was to receive support for his continuing need for methadone.[12] Lifeline completed an initial assessment and prescribed methadone to assist with his heroin addiction.

5.2.3 In May 2014 Harry's case was submitted for registration by his probation officer as a Multi-Agency Public Protection Arrangements case. He was a category 2 offender[13] who was to be managed at Level 1 with the National Probation Service as the lead agency.[14] However, it is now known that the registration did not happen in 2014 nor any time thereafter.

5.2.4 On 3rd February 2015 Harry received a final written warning for not keeping another appointment with his probation officer. Harry eventually attended the probation appointment on 6th February 2015.

5.2.5 On 10th February 2015 Harry was arrested and charged with theft of two bottles of spirits from a shop. He was kept in custody and the next morning received a non-custodial sentence at Sefton Magistrates' Court, following which he was immediately recalled to prison having breached the terms of his parole licence.

[12] Opioid substitution therapy

[13] Harry met the criteria for a category 1 and 2 offender and should have been nominated as category 1 [sex offender] because it takes precedence.

[14] See Appendix C for details of the Multi-Agency Public Protection Arrangements, the categories of offenders and management levels.

5.2.6 Between 10th February 2015 and 26th May2015 there is evidence of good interagency working by the National Probation Service, the details appear in Section 6.

Release Two

5.2.7 On 20th May 2015 Harry's Offender Assessment System[15] prepared by the National Probation Service showed he presented the following risks.

Who is at Risk	Level of Risk	Note
Children	Medium	
Known Adult	Medium	A previous victim [not Ruth]
The Public	High	

5.2.8 On the 26th May 2015 Harry was released at his sentence end date which meant that he was not under probation's supervision and could live and mix with who he wanted; neither was he being managed under the Multi-Agency Public Protection Arrangements. However, as a registered sex offender he was required to notify the police within three days of being released of where he was living. Harry complied.

5.2.9 Harry attended Lifeline on 28th May 2015 and underwent a brief initial assessment which included a risk assessment. Harry was assessed as being a medium risk of aggression to members of the public. The risk management plan was for Harry not to attend premises when intoxicated and to work on his anger and alcohol misuse.

5.3 Ruth

5.3.1 In March 2015 Ruth ended a relationship with a male. Later the same month she approached two of her daughters asking for money. They refused as they felt she would spend it on drink. Ruth, who they described as drunk, became troublesome and the police were called. The daughters were recorded as the victims of domestic abuse and assessed as facing a Bronze risk of harm from Ruth.[16]

5.3.2 On 6th April 2015 Ruth told Merseyside Police that her then partner [not Harry] had assaulted her and damaged her bicycle. He was arrested. The Crown Prosecution Service advised no further action as Ruth had no injuries; there was no damage to the bike and the incident was not witnessed. The alleged offender denied being with Ruth. The police completed a risk

[15] The standard risk assessment model used by the National Probation Service

[16] Bronze is derived from Merseyside Police's domestic abuse policy and its MeRIT risk assessment. Bronze if the lowest of the three risk levels which are: Gold, Silver and Bronze.

assessment which showed that Ruth faced a Gold risk of harm from her partner.

5.3.3 A court had granted a Restraining Order on 13th August 2014 prohibiting the partner from approaching Ruth. This arose from a previous assault by him on her.

5.3.4 On 30th April 2015 Ruth's case was presented to a Multi-Agency Risk Assessment Conference.[17] An action was raised and a letter was sent to the perpetrator offering engagement with the InPact Programme.[18]

[17] Multi Agency Risk Assessment Conferences aim to remove or control the risks faced by victims of domestic abuse. See Appendix B for more details.

[18] InPACT is a programme for men who want to stop being violent or abusive to their partners, or look at changing their past behaviour. www.thefirststep.org.uk

6. KEY EVENTS AFTER JUNE 2015

6.1 Introduction

6.1.1 Ruth probably met Harry soon after his release on 26th May 2015. There is no evidence they knew each other before or while he was in prison.

6.1.2 They moved in together in private rented accommodation in July 2015.

6.1.3 The next trace of them in agency records is on 15th July 2015.

6.2 July 2015

1st Report of Abuse

Wednesday 15th July 2015

6.2.1 On the 15th July 2015 Adele, on behalf of the family, telephoned Merseyside Police and said their mother had left home about a week ago taking all her belongings and had moved in with a "lad" who was known to be violent. Adele named Harry and provided the name of the street he lived in. She also said that Harry had recently been arrested for robbery at a Southport shop;[19] the details of which were in the local paper. Adele said her mother was vulnerable because of her drinking. Adele was concerned she may be taking drugs and needed an operation. The family did not know what to do. The police call taker made checks of some police databases and told Adele she could not locate Harry's address. Adele was advised to make her own enquiries and get back to the police when she had more information. The call taker took no further action.

6.2.2 While comment is made later on in the report on the way Adele's plea for help was dealt with, the family said this was the first of many calls where they believe Merseyside Police 'fobbed them off" and wondered whether Merseyside Police's lack of interest stemmed from their belief that because of Ruth's drinking, she was viewed as a nuisance.

Friday 31st July 2015

6.2.3 The next trace of them in agency records is on 31st July 2015 when it appears Harry persuaded Ruth to attend Lifeline Sefton Treatment and Recovery Service. They attended together and were seen separately. Ruth fully participated in an assessment and made plans to engage with the service, with the intention of achieving abstinence from alcohol. Ruth told Lifeline that she had been a victim of domestic abuse from a previous partner. Harry had previously told Lifeline he had verbally abused a previous partner. That is now known to be a significant minimisation. Ruth was due to attend a group session on 5th August 2015, but Harry telephoned to

[19] This incident was the theft of alcohol.

inform the service that Ruth was unwell and could not attend the appointment.

Thursday 13th August 2015

6.2.4 At 4:43 pm, Adele, telephoned Merseyside Police to say that her mother was the victim of domestic violence perpetrated by Harry.[20] Adele provided an address where she thought the couple were living, adding she had been unable to contact her mother for the last month and that Harry had previously flushed her Mother's mobile telephone down the lavatory. A Storm log[21] was created and given Grade 2 priority. Adele said her concerns had increased when a friend told her that earlier that day she had seen Harry in the Town Centre in company with Ruth who had a bruised face. At 4.51 pm Adele told the police operator she would find her mother, check on her welfare and recall the police if she still had concerns. At this time the response on the Storm incident was downgraded to 'scheduled.' [22]

6.2.5 At 6.21 pm Adele re-contacted Merseyside Police saying that she had seen Harry and her mother in the Town centre. Her face and legs were swollen and bruised. Adele spoke to her mother who said the injuries were the result of a fall following medication. Harry was apparently present throughout and urged Ruth to end the conversation with Adele.

6.2.6 At 6.23 pm the Storm incident log was upgraded to 'Priority' and at 8:35 pm the police operator contacted Adele to apologise for the lack of police attendance. At 10.33 pm Adele recalled the police requesting an update and was told no patrol had been deployed. At 10.37 pm a patrol was deployed but diverted to another incident. Adele continued to call the police for updates.

6.2.7 Due to higher priority commitments it was not possible to deploy any further patrols for the rest of that night.

Friday 14th August 2015

6.2.8 At 08.47 am a patrol attended at Ruth's address but no one replied. At 12.08 pm Adele again recalled the police for an update and was told that her mother had not been contacted.

6.2.9 At 1.58 pm a patrol attended at Ruth's address but no one answered.

6.2.10 At 4.19 pm a Merseyside Police Risk Manager reviewed the incident, and deemed further enquiries were necessary. At 5.04 pm a further visit to Ruth's address resulted in no reply.

[20] There were also seven further calls from Adele requesting feedback on her report.

[21] Merseyside Police command and control system;

[22] An agreed appointment with an officer to meet the person at an agreed location.

Saturday 15th August 2015

6.2.11 At 1.14 am a patrol called at the address but did not get a reply. It was noted on the log that Ruth and Harry were known to that officer.

6.2.12 At 2.08 pm [about 45.5 hours after the initial call] an officer saw Ruth at her address. The officer was only able to speak to her briefly before Harry returned. Ruth told the officer her injury was due to a fall after she had been drinking and taking medication. The officer observed a small bruise below her right eye, but considered her to be safe and well otherwise. She denied any domestic dispute or assault had taken place.

6.2.13 Ruth and Harry stated they were unhappy that such allegations had been made to the police without any basis. Harry said he was aware that officers had called at the flat throughout the night. It is not known how Harry knew this, but it is likely he was at home and just did not answer the door.

6.2.14 Checks on police databases revealed that Harry was a registered sex offender and Ruth was a victim and perpetrator of domestic abuse. Despite this, the matter was not recorded as a 'domestic incident' and a Vulnerable Persons Referral Form[23] was not completed. On 20th August 2015 a police supervisor in the Sex Offender Unit saw the log as part of their responsibility for monitoring registered sex offenders and directed the original attending officer to complete a Vulnerable Person Referral Form. The officer completed this document using information from the log and his memory, but did not revisit Ruth. The form was submitted via the officer's Sergeant and the risk assessment revealed Ruth as a Bronze victim, the lowest of the three risk levels. A referral or notification to another agency was not made. The family believes the Bronze rating did not reflect the risk their mother faced. As will be seen the Panel also felt the risk was underrated.

6.3 Harry's Arrest for Theft

6.3.1 On 20th August 2015 Harry was arrested and charged with theft of a mobile telephone from a shop. While in police custody he was seen by the Mersey Care NHS Trust Criminal Justice Liaison Team and declined a mental health assessment. He was released on conditional bail to appear at Court in the first week of September 2015.

6.4 2nd Report of Domestic Abuse

Saturday 22nd August 2015

[23] This form is completed by the officer to determine the level of risk faced by a victim of domestic abuse

6.4.1 At 0.26 am the landlady of the flat occupied by Ruth and Harry reported a domestic incident there to Merseyside Police. She said that twenty minutes previously she heard an argument between them, followed by Harry shouting at another male who did not live there. Harry was accusing the male of having an affair with Ruth. The landlady ejected the male, who was outside shouting for Harry to come downstairs and settle the issue.

6.4.2 At 0.47 am, after the landlady had recalled police twice to say the male was still outside behaving aggressively, a patrol was deployed and a male [not Harry] was arrested for being drunk and disorderly. This event was not classified as a 'domestic incident' and a risk assessment was not done.

6.4.3 There is no indication on the police log that a welfare check was made on Ruth that night, even though the original information showed she was involved in an argument with Harry.

6.5 Involvement of Tony in moving Ruth's Property

First week September 2015

6.5.1 Tony says his mother contacted him and asked for assistance to remove her property from the flat she shared with Harry. Tony went with a van believing his mother had decided to leave Harry. When he arrived he saw his mother had two healing black eyes and some healing scratches around her nose. He described the flat as dirty and the scene of obvious violence. Holes had been punched in doors and walls with evidence of drug abuse and blood stains on the settee. He became very concerned.

6.5.2 Ruth became panicky, insisting Tony should also move Harry's property, saying that she feared serious consequences for herself and others[24] if her son did not move both sets of property. Tony enlisted the help of his sister Georgia, and together they persuaded Ruth to go to Georgia's home. They wanted to protect their mother from further violence.

6.6 The Eviction of Harry

6.6.1 In the first week of September 2015 Harry barricaded himself inside his flat and threatened to stab his landlady and her dog. He behaved in a threatening manner towards Ruth who was with him in the room. Harry was evicted from his flat by the landlady and Harry and Ruth moved into the multi occupancy house where she later met her tragic death. He secured a larger room than the one allocated to him by "evicting" the occupant using threats of violence

6.7 Involvement of General Practitioner

[24] The family told the domestic homicide review chair that Ruth said, Harry has threatened to harm her father if she did not do as she told him or ever went to the police.

6.7.1 In the first week of September 2015 Georgia telephoned her mother's General Practitioner saying she has been missing for the last two nights and was using drugs and alcohol. Georgia said her mother was in a new relationship and he was also using drugs. Georgia felt the new partner was violent and her mother had bruises all over her but denied to police that she had been beaten or abused, adding that she lies to the doctors and does not accept that she is unwell. Georgia finished by saying her mother is suicidal and the police are looking for her. Georgia told the independent Chair that the doctor advised her to bring her mother to the surgery or take her to Accident and Emergency.

6.8 The Family Confront Harry

6.8.1 In the first week of September 2015 Tony contacted Georgia regarding the situation with their mother. Tony had been driving past an address and noticed two bikes outside. He found his mother and Harry hiding in the garage. He confronted Harry about the injuries to his mother but Harry denied causing them and ran away. Adele and Georgia visited Ruth and persuaded their mother to go with them to Southport and Ormskirk Hospital where, on entering Accident and Emergency, she immediately disclosed her victimisation to staff. Ruth told her friend who spent the night in the hospital with her, that she was terrified of Harry adding that people did not know what he was capable of. This friend did not respond to invitation to be seen by the Panel Chair.

6.9 Ruth's Stay in Southport and Ormskirk Hospital

First week September 2015

6.9.1 At 8.22 pm Ruth attended Southport and Ormskirk Hospital Accident and Emergency Department and told staff that she had been a victim of domestic violence over the past month and that this had led to her drinking more than usual and she suspected she was jaundiced. Ruth said she was alcohol dependent and wanted help to stop. Ruth was noted to have bruising of varying ages. Ruth was already flagged on the Accident and Emergency Department database as having been to a Multi-Agency Risk Assessment Conference in May 2015. There is nothing recorded in her notes that this flag was seen and acted on. Georgia said she urged staff to complete a body-map of her mother's injuries but this was not done. A narrative description of the injuries was recorded in her medical notes. A mental capacity assessment was commenced but not completed though it was noted she was not confused or suffering from dementia.

6.9.2 On examination in Accident and Emergency it is noted that she had a laceration to her hand following an assault with a knife. Bruising was noted on her left rib cage. At this point the care plan was:

- Admit to Ward

- Transfuse blood
- Gastroscopy[25]
- Refer to Hospital Alcohol Liaison Team

First week September 2015

6.9.3 At 0.10 am Ruth was admitted to a ward at Southport and Ormskirk Hospital and made comfortable. About mid-morning on Sunday a member of the Hospital Alcohol Liaison Team saw Ruth who said she was the victim of domestic abuse from her new partner, whose name was not asked for. Ruth described being punched all over her body, head and private parts and that she feared for her life. Ruth said to the staff member that he would kill her if she told the police and had used a knife on her once. She wanted to move out and live with her father. Ruth had drunk about 10-15 cans of lager on the day of admission.

6.9.4 Immediately after the disclosure, the staff member completed a vulnerable adult referral and left it in a tray on the ward for collection in the first week of September by the social workers from the Hospital Safeguarding Team. That Team would then consider making a referral to Sefton Adult Social Care. It is now known the form was not collected and a referral to Adult Social Care was not made. Ruth's disclosures, including the threat to kill, was not shared with the Police or any of the partner agencies until after her death. It is apparent that during her stay in hospital Ruth left the ward on several occasion. Some of these were short duration 'smoke breaks', but others involved Ruth spending periods with Harry around the Town Centre. However, there is no record of when Ruth left the ward or how long the absences were.

6.9.5 Ruth reported being abstinent from alcohol for a few weeks but since meeting her new partner had started drinking about 40 units daily.[26]

6.9.6 At 8.15 pm Ruth complained to a nurse of pain in her foot, stating it resulted from domestic violence.

First week September 2015

6.9.7 At 2.30 pm Ruth was seen again by the Hospital Alcohol Liaison Team who noted she was optimistic and informed them she was moving in with her father on discharge, which he confirmed to staff was correct. She also

[25] A gastroscopy is a procedure where a thin, flexible tube called an endoscope is used to look inside the gullet, stomach and first part of the small intestine.

[26] There are about nine units of alcohol in a standard [75 centilitre] bottle of wine.

stated that Harry was gone from her life. She refused to be referred to the police and social services. However, it is not known if she was signed posted to other agencies such as Sefton Women and Children's Aid. However since the homicide such referrals/signposting are made.

6.9.8 Ruth was visited by Georgia during the afternoon who observed a general improvement in her mother's condition. Ruth said she had decided to make a formal complaint to police about her abuse, and wanted to arrange it so one of her family could be with her while she did so.

First week September 2015

6.9.9 On Monday morning, during a consultant's ward round, a nurse mentioned to the consultant that Ruth was a victim of domestic abuse. The consultant asked if this should be referred to police. Ruth refused stating her daughter had already done so and no further action was required as the relationship was over. It appears an offer to refer Ruth to other domestic abuse services was not considered. Ruth stated that her foot was sore as the abuser had stamped on it. The consultant examined her foot but no further action was taken as she stated it was not uncomfortable.

6.9.10 Adele telephoned Merseyside Police at 7.58 am using the '101' number. The Police report author has listened to the recording and provide the following summary.

"Adele informs the operator that she had rung up a few times about her mum went missing suspecting that her partner was beating her up. She told the operator that her mum was now in hospital and had admitted everything to her family. She now realises and wants to make a report to the police. Adele informs the operator that her mum is an alcoholic and is in hospital having treatment for her addiction.

The operator tells her that he can take some details but ideally the police would need to speak to her mum if she is prepared to, as it would make more sense coming from her. If she wants to she should give the police a call herself. Adele informs the operator that her mum could be in hospital for some time.

The operator tells her they can get someone out to see her but to have a chat with her first.

Adele expresses her relief and states that she will get the family to speak to her mother with a view to her contacting the police in person".

Adele's overwhelming memory of this call is that she was once again being 'fobbed off'.

6.9.11 At 12.20 pm the Hospital Alcohol Liaison Team wanted to review Ruth but she was asleep. Nursing staff told the Hospital Alcohol Liaison Team that

Ruth had been upset that morning and removed her cannula.[27] She then left the ward for a short period.

6.9.12 About 2.30 pm Adele contacted the ward as she had been informed by a friend that Ruth was in Southport Town centre. Adele asked if her mother had been discharged. A Staff nurse told her no, but that she had left the ward for a cigarette and was expected to return. The daughter stated she would ask Tony to go and look for their mother.

6.9.13 On the afternoon of the same day [the first week of September 2015] Tony was driving his work van near the hospital when he saw his mother. She was being dragged along by Harry who had a knife and a can of lager in his hand. Tony tried to persuade her to leave Harry at the roadside and go with him. However, his mother told him to leave her alone. Tony did not call the police. It appears this incident happened during one of Ruth's absences from hospital.

6.9.14 About 8.50 pm the same day Ruth returned to the ward in company with Harry who was allowed in and spent a short time at her bedside.

6.9.15 The Ward Manager said that soon after Ruth's return to the ward, a young man, [not Harry] between 20 and 30 years accessed the ward and asked could he visit Ruth. The Ward Manager asked Ruth and she refused, stating that there was an injunction out against the man and he was not allowed to be near her.

First week September 2015

6.9.16 A neighbour described seeing Harry with two females of similar description in the vicinity of his flat. One, believed to be Ruth, was propelled out onto the step with considerable force by Harry. He witnessed further assaults on the same female when she was kicked on her posterior to encourage her back into the flat. The other female stood by. This incident was not reported to the Police. The second female was not identified by the murder investigation team. This incident took place during one of Ruth's absences from the ward.

Second week September 2015

Ruth's Self-Discharge from Hospital

[27] A *cannula* - from Latin "little reed" - is a tube that can be inserted into the body, often for the delivery or removal of fluid or for the gathering of data.

6.9.17 At 12.30 am Ruth left the hospital against medical advice and refused to sign the discharge documents, however it was noted she had full mental capacity. Ruth told staff she needed sleep but was prevented from doing so by the general level of noise on the ward. It is now thought she returned to her flat and spent the night with Harry.

Harry's Appearance at Court and Electronic Monitoring

6.9.18 Harry appeared at South Sefton Magistrates Court regarding theft of the mobile phone on 19th August 2015. It is not known whether Ruth accompanied him. He was granted bail to his flat with curfew conditions and ordered to have an electronic monitor device fitted.

6.9.19 At 9.26 pm Harry was visited at his address by a lone female from Electronic Monitoring Services who fitted the monitor. The female recalled that Ruth was present and apart from what appeared to be a small cut or cold sore on her lip she was fine; sitting on a mattress with a cover over her legs. Ruth was talking throughout the process and the interaction between Ruth and Harry appeared normal.

6.9.20 The Panel wondered what the process was for ensuring the safety of staff, in this case a lone female, allocated "fitting" jobs. Harry was a violent sex offender against females and given his history of alcohol misuse he was likely to be under the influence of alcohol at that time of night. Electronic Monitoring Services helpfully provided the following information to the DHR.

6.9.21 "When an Electronic Monitoring order is issued by a court or prison, the curfew order is sent to us. The order is then processed onto the system and a visit is scheduled for during the subject's curfew hours. If an order states that the offence is sexual, murder, firearms, racial or section 18 then the job is risk assessed as a double crew job. Also when inputting the order on the system staff check whether there are any other previous orders that indicate the job should be risk assessed".

6.9.22 "We do not query all orders received from the court or prisons, however if there is something on the paperwork that seems incorrect, our order entry team will contact the courts via telephone or email to confirm details. The order which we received from the courts for Harry did not have any information in regards to being a sex offender and being on the sex offender register for life; nor did previous orders on our system for Harry. If this information was given to us a lone female officer would not have been sent on the job. Additionally, all staff can contact their office immediately via secure electronic means".

Second week September 2015

6.9.23 At 5.15 am Merseyside Police received a call from the North West Ambulance Service following the report Sudden Death at Ruth and Harry's flat. A neighbour had called them from a nearby shop after being summoned to the premises by Harry who told him he had found Ruth collapsed near to the shower and could not detect any breath from her. Police officers attended the flat and Harry made a statement outlining how he had found Ruth and could not account for her death. The incident was originally dealt with as a sudden death with the paramedics informing the officers that Ruth had only recently discharged herself from hospital. A Merseyside Police Critical Incident Manager and the Force Night Cover Detective Inspector treated the incident as a potential murder investigation and secured the flat as a crime scene.

7. ANALYSIS USING THE SPECIFIC TERMS OF REFERENCE

7.1 Introduction

7.1.1 Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and other reports; the meeting with the Hospital staff and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

7.2 Term 1

What if any indicators of domestic abuse did you agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?

7.2.1 The following agencies were told that Ruth was the victim of domestic abuse and that Harry or her partner was the abuser:

Agency	Date first Knew
Merseyside Police	15.07.2015
General Practitioner	03.09.2015
Southport and Ormskirk Hospital	04.09.2015

7.2.2 Sefton Multi-Agency Risk Assessment Conference knew that Ruth was a victim of someone other than Harry.

7.2.3 Harry disclosed to Lifeline he had verbally abused a previous partner; not Ruth. It is now known he significantly understated the degree of abuse he perpetrated.

Merseyside Police

7.2.4 Merseyside Police's first contact came on 15th July 2015 when Adele reported the family's concerns for their mother's safety. These were explicit but were overlooked by the police. The DHR Panel obtained supplementary information about that call, including an explanation from the call taker who spoke with Adele and an overview from the Force Contact Centre Manager.

7.2.5 The call taker told Adele that Harry's address was not on the police system and to conduct her own enquiries. Firstly the Panel felt that was an inappropriate response for what should have been recorded as a "cause for concern" or possibly a "missing person". The family say they called the

Police because they knew their Mother's behaviour, in not having contact, was so out of character. It is easy to understand how the family felt the police did not care. More information about how the police responded to the family's many contacts appears under term of reference six.

7.2.6 Adele provided sufficient information about Harry that should have allowed for his easy identification and current address. For example his recent arrest for shop theft was recorded on Niche, [Merseyside Police's main information and crime recording database].

7.2.7 When spoken to the call taker could not recall which systems they checked. The Police report author notes that Harry is recorded on Niche in plain sight and concluded the call taker could not have looked. The call taker explained that they had only recently completed the training on Niche and they were still learning how to navigate the system.

7.2.8 While that may explain why Adele was told Harry's address could not be found, it does not explain why the call taker did not record the call as a "Concern for Safety" and have it investigated. The call taker now recognises that such a log should have been created and has learned a lesson. The family say that is too late to help their mother. The DHR Panel agrees.

7.2.9 The Police report author acknowledges this "…was a missed opportunity to safeguard the victim and if dealt with and recorded properly may have had an impact on how future calls were dealt with and how the victim was risk assessed".

7.2.10 The DHR Panel strongly agree with that conclusion and is particularly disappointed given that a recurring theme/learning point in domestic homicide reviews is that family and friends with knowledge or suspicions often do not tell the police of their suspicions. This is an example of where such suspicions were raised, but were not acted on correctly by the police. The Panel found no evidence that Merseyside Police mishandled this call because of Ruth's lifestyle. The issue was they did not recognise the risks.

7.2.11 When Adele told Merseyside Police [13th August 2015] that her mother was the victim of domestic abuse it took almost two days before they saw Ruth.

There were several reasons for the delay; these are:

- The priority given to the call was lowered and then raised
- There were higher priority demands
- Harry chose not to answer the door on several occasions

7.2.12 The officer who dealt with the incident knew that Harry was known for sexual offending but does not recall noting or remembering any other offences. When he saw Ruth and Harry they told the officer that an assault had not taken place and that her injury resulted from a fall caused by a

combination of medication and alcohol. The officer reported that for most of the visit Harry was present thereby making is very difficult for her to disclose abuse. The officer did not check any police databases until after he had left the incident and therefore did not discover facts that would have enabled him to probe her persistent and understandable denials that she had not been assaulted. The officer did not recognise the event as domestic abuse and therefore did not complete a Vulnerable Persons Referral Form, meaning that a risk assessment was not done. The supervisor who closed the Storm Log did not identify it should have been a domestic incident.

7.2.13 Five days later - 20th August 2015 - a supervisor in Merseyside Police Sex Offender Unit viewed the Storm log as part of his role to monitor registered sex offenders. He immediately recognised the event as a domestic incident and instructed the officer who dealt with the original call to complete a Vulnerable Person Referral Form. The officer did not re-visit Ruth but relied on the incident log and memory to complete the task which determined that Ruth faced a "Bronze" risk of harm from Harry.

7.2.14 The Panel believed the officer should have revisited Ruth before the risk assessment was done. A week had passed since the original call by Adele and a visit would have afforded Ruth another opportunity to disclose that she was the victim in, what is now known to have been, a very violent relationship. A day later, the risk assessment was looked at by a specialist domestic abuse officer in the Family Crime Investigation Unit who concurred with the Bronze outcome. There is no evidence that the specialist re-contacted Ruth or her daughter, or that wider checks were made of police systems. Had these lines of enquiry been pursued a different picture of Harry and Ruth would have emerged. He would have been identified as a very violent person, and she as vulnerable, both of which would have had a direct impact on the risk he posed to Ruth. The family strongly believe the assessed risk to Ruth was far too low, given Harry's background and their knowledge of the changes in their mother. This view is supported by the Panel, who believe on the evidence that was available, the risk faced by Ruth should have been assessed higher. This higher risk assessment would allow additional intervention measures[28] and maybe acted as an encouragement for Ruth to disclose further information, which in turn might have led to a referral to MARAC.

7.2.15 The fact that Ruth had been to a Multi-Agency Risk Assessment Conference in May 2015, albeit with a different perpetrator, does not appear to have been considered when formulating the risk she faced from Harry. There may

[28] Contact from police Domestic Aabuse investigator; signposting to services e.g. drug-alcohol-victims' programmes [Freedom Programme]; identifying where Harry could seek help.

have been information from that Multi-Agency Risk Assessment Conference that could have influenced the current level of risk facing her.

7.2.16 The Panel noted that no consideration seems to have been given on whether to use the Domestic Violence Disclosure Scheme[29] to furnish Ruth with information about Harry's violent past including his sexual offences. While Ruth knew he was violent towards her she may not have known he was violent to a former wife and was also a sex offender. The Panel felt that consideration should have been given by Merseyside Police to disclosing Harry's violent past to Ruth under "the right to know" leg of the Scheme so that she could make informed decisions about the future of the relationship. This point was also identified by the family.

7.2.17 The officer's explanation for not completing a Vulnerable Person Referral is summarised below and taken from Merseyside Police's report to the Panel.

7.2.18 "The officer had read the Storm log when initially allocated the incident and recalled that Harry had previous convictions for sexual offending. He did not recall noting or remembering any other offences. [He conducted checks on the Police National Computer and NICHE[30] whilst completing the Vulnerable Person Referral Form after the attendance.] On arrival he initially spoke with Ruth on her own and the only visible injury he could see was a small bruise on her left cheek, which she told him was caused by a fall when she was under the influence of medication and alcohol. He did not know that Harry was present in the building and the officer had only spoken with Ruth for two minutes before Harry entered, and then remained in the room. He noticed no change in Ruth's demeanour and she maintained her version of events. The officer said that he would not have asked Ruth about the domestic issues while Harry was present and would have informed her he would like to speak in private." The Panel understands there is danger in speaking directly about domestic abuse in the presence of a potential abuser. However, it only reinforces its view that Ruth should have been revisited when the officer was directed to undertake a risk assessment. Had that visit taken place the officer might have unearthed the coercive and controlling behaviour that is now known was present in the relationship. The supervision aspects of this incident are examined later.

7.2.19 The next opportunity for Merseyside Police to identify that Ruth was the victim of domestic violence came on 22nd August 2015, just a few days after their last engagement with her. Their landlady telephoned the police

[29] "The principal aim of the Domestic Violence Disclosure Scheme is to introduce recognised and consistent procedures for disclosing information which will enable a partner (A) of a previously violent individual (B) make informed choices about whether and how A takes forward that relationship with B." Section 2 [7] Domestic Violence Disclosure Scheme, Home Office March 2013

[30] Merseyside Police record management system for crime, custody and intelligence records

reporting a disturbance at their flat. The landlady's information had two elements:

1. That Ruth and Harry were arguing
2. That Harry and an unnamed male were shouting at each other.

7.2.20 The officer attending dealt with the second element of the complaint by arresting the unnamed male for being drunk and disorderly. However, the first element of the landlady's information was not followed up. The event log was not categorised as a domestic incident and no risk assessment or referrals were made.

7.2.21 While the disturbance between the two males is not a domestic incident the argument between Ruth and Harry might well have been. However it was not investigated and was probably lost when the male was arrested for being drunk and disorderly. Ruth was not seen, meaning that even a basic welfare check was not done.

7.2.22 The attending officer should have seen the landlady to clarify what had transpired between her tenants and by not doing so missed an opportunity to gather information about Ruth and Harry's relationship. This would have been useful and added context to the domestic incident of the 13th August 2015. It was discovered during the homicide investigation that towards the end of August 2015, Ruth had told a male friend, who lived in a flat in the same building as her and Harry, that she could not stand another beating from Harry who had discovered she had been smoking with her neighbour. The Panel noted this as controlling behaviour and Ruth's remarks illustrate the depth of her fear.[31]

7.2.23 Ruth's disclosure to her friend was not known to the attending officer and in any event could have been made after the 22nd August 2015 and before the 31st August 2015. However, by not making enquiries with the landlady and/or other people living in the multi-occupancy dwelling, the opportunity for discovering this or other relevant information was missed.

7.2.24 Again, as with the incident on the 13th August 2015, the Panel recognised the resource implications of doing such wider enquiries. Nevertheless the experience of domestic violence professionals is that victims very often disclose domestic violence to family and friends and not to agencies. Therefore armed with this knowledge, officers investigating domestic abuse have a ready-made line of enquiry which may prove fruitful.

[31] *Controlling behaviour is:* a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Home Office Circular 003/2013.

7.2.25 When Ruth was in the Hospital Adele telephoned Merseyside Police on 101 to make a third party report that her mother was the victim of domestic abuse and wanted to make a formal complaint. She was told if effect that her mother would have to make the complaint herself. The DHR Panel heard from its Merseyside Police representative that such advice was wholly inappropriate. The Panel felt that as Ruth was in a safe place, surrounded by family, the conditions to receive a disclosure from her were excellent and not to have done so was a major missed opportunity. Term six covers this point in more detail.

General Practitioner

7.2.26 Georgia told her General Practitioner that Ruth was the victim of domestic violence from a new partner who was misusing alcohol and drugs. Importantly Georgia said Ruth lies to her doctor, is suicidal and that the police are looking for her. Georgia said the doctor told her to bring Ruth to the surgery or take her to Accident and Emergency.

7.2.27 The Panel discussed at length what the doctor should have done with that information other than record it and offer the advice outlined above. Views ranged from making an adult safeguarding alert to nothing. The Panel concluded that immediate action was unnecessary as part of the information from Georgia said the police were looking for her mother and felt the advice given was an appropriate action that would have allowed the doctor opportunities to support Ruth. Georgia said the family took Ruth to hospital because the surgery was closed, thereby following the doctor's advice.

Southport and Ormskirk Hospital NHS Trust

7.2.28 Ruth was in hospital for six days in September 2015. There is no record of how many times or for how long she left the ward. The hospital does not have a policy for such events and say it would be impractical to log patients in/out when they leave the ward for 'smoke breaks'. However, the Hospital recognises that Ruth's longer absences were not picked up and that no consideration was given to what they meant.

7.2.29 Ruth was taken to Accident and Emergency by her family following an assault by Harry. She had an existing flag on the Accident and Emergency Medway database saying she had been the subject of a Multi-Agency Risk Assessment Conference. This flag was put onto Medway by the Safeguarding Nurse who attends the Multi Agency Risk Assessment Conference. However, at the time there was no policy or procedure advising staff what the flag meant or what they should consider doing if they were dealing/treating a 'flagged' patient.

7.2.30 The Hospital report to the Panel states: "The flag is merely an alert, there is no information or detail that states why the person was referred to Multi Agency Risk Assessment Conference or what was discussed. This is currently

under review as it is clear the flag is not giving enough information or direction for staff. The flag was introduced as an early warning system for staff so that they could tailor their questions depending on what the flag was for. Following on from this case a review of the process will be undertaken with the plan being a protocol will be developed to give clear instruction as to what staff should do with this information. The protocol will be added to the domestic violence policy which discusses Multi Agency Risk Assessment Conferences but does not give direction as to what staff need to do if a patient or their partner has been discussed". Almost immediately on entering the Hospital Ruth disclosed her victimisation to staff. The Panel thought that had a system of directing staff what to do in the event of treating a 'flagged' patient existed at the time, it would have made it more likely that her disclosures would have been acted on.

7.2.31 Accident and Emergency staff did not make a safeguarding referral to the Hospital's Safeguarding Team[32]. The staff acknowledged they should have discussed doing so with Ruth but in a busy environment their priority was dealing with Ruth's and other patients' medical needs. Additionally, they assumed a referral would be made by ward staff once she was transferred there. The staff explained there was no requirement in Ruth's circumstances to complete a body map or take photographs of her injuries. Instead a comprehensive narrative description of her injuries was recorded in her medical notes. The focus of the staff was on Ruth's suspected jaundice and detoxification. Ruth was judged to have mental capacity.

7.2.32 A nurse from the Hospital Alcohol Liaison Team saw Ruth on the ward about 10.00 am in the first week of September 2015 and received a disclosure of domestic abuse. The nurse complete a referral document destined for the Hospital Safeguarding Team. The process of getting such referrals to the Safeguarding Team is to leave the document in a tray on the ward for collection. Collections are not made on Saturdays and Sundays. There are procedures in place for making referrals direct to Adult Social Care when it is judged the case merits a fairly immediate response. The Panel felt the level of violence disclosed, including sexual violence, warranted an active response such as telephoning Sefton Adult Social Care, as opposed to the passivity of leaving the referral document in a tray. The member of staff involved did not have full knowledge of the Hospital's safeguarding procedures and felt an urgent referral to Adult Social Care was not needed, because Ruth was in a safe place. The Hospital recognises it should have made an urgent referral. Ruth was reported as refusing police intervention, although her view was not documented. The DHR Panel noted that an urgent referral could be made to a support service such as Sefton Women's

[32] The Hospital Safeguarding Team consists of two people; one who deals with child protection, the other with adult safeguarding. They provide mutual cover.

and Children's Aid or an Independent Domestic Violence Adviser. However in this case those services would not have been available at the weekend.

7.2.33 Part of Ruth's disclosure included an account that Harry had attacked her with a knife. There is no evidence that consideration was given to informing Merseyside Police of the knife wound in accordance with the General Medical Council's advice on reporting knife and gunshot injuries to the police.[33] The Hospital staff who attended the meeting with the chair readily acknowledged that this advice was not widely known within Accident and Emergency and practically unknown outside of it.

7.2.34 The Hospital did not ask Ruth the name of the perpetrator and now recognises it would have been good practice to do so and to record the answer in her medical notes. On an evening in the first week of September 2015 ward staff acted appropriately by stopping a previous abuser of Ruth's from seeing her when he turned up for a visit. They checked with Ruth and gave her a description of the male. Ruth said he was prohibited from contacting her. The Panel felt that was good practice. That evening Harry appeared on the ward with Ruth and remained at her bedside for a short while. The Ward Manager revealed at the meeting with the chair that Harry seemed affectionate towards Ruth and kissed her goodbye. The Panel felt Harry's behaviour in appearing to care for Ruth was a guise aimed at reassuring Hospital staff while exercising control over Ruth.

7.2.35 Ruth complained to a ward nurse of pain in her foot, attributing the injury to domestic abuse. There is no evidence that the nurse considered a referral to Hospital Safeguarding or checked on whether such a referral had been made.

7.2.36 Part of Ruth's disclosure to the Hospital Alcohol Liaison Team was that Harry had threatened to kill her should she tell the police about him abusing her. There is no record of that information being shared with the Hospital Safeguarding Team or Merseyside Police. Staff who attended the meeting with the chair confirmed that the Hospital does not have a discrete policy for 'threats to kill'.

Next 7.2.37

7.2.37 Set out below are the opportunities presented to the hospital staff.

[33] www.gmc-uk.org/guidance/ethical_guidance/28437.asp

Details of Disclosures to Hospital Staff

Time Date	Details of Disclosure	Who made it?	Who received it?	What did they do with it?	What should they have done?
8.22 pm A Friday in September 2015	Victim of domestic abuse: various amounts of bruising of varying ages seen on her body	Ruth	Accident and Emergency staff	Nothing	Discuss the disclosure with Ruth to determine her wishes and make a referral to the Hospital Safeguarding Team or direct to Adult Social Care
10.00 am A Saturday in September 2015	Punched all over body, head and private parts. Fears for her life. Stated he has said he will kill her, if she informs the police and he cut her with a knife on one occasion.	Ruth	Hospital Alcohol Liaison Team	Completed a paper referral and left it in a tray on the ward for collection on Monday	Given the severity of the abuse disclosed, consideration should have been given to immediately referring the case to Adult Social Care. Consider sharing the knife wound with the police Report the threats to kill to the police
Time Date	Details of Disclosure	Who made it?	Who receive it?	What did they do with it?	What should they have done?

8.15 pm A Saturday in September 2015	Complaining to a nurse of pain in her foot that she stated was related to domestic violence and abdominal pain.	Ruth	An unnamed nurse on the Ward	No detail	Should have made or checked that a referral had been made to the Hospital Safeguarding Team
Time unspecified A Sunday in September 2015	Discussed her victimisation.	Ruth	Members of the Hospital Alcohol Liaison Team	No further action as Ruth did not want referring as she had support; no longer with Harry. A hospital social worker stated they did not have any cause for concern about Ruth at this point	A wider discussion should have taken place and greater cognisance given to Ruth's disclosures.
AM A Monday in September 2015	During Consultant's ward round – a Nurse mentioned to Consultant that Ruth was a victim of domestic abuse. Harry stamped on her foot Consultant examined her foot but no further action was taken as she stated it wasn't uncomfortable.	Unnamed Nurse on Ward	Consultant	Consultant asked if this should be referred to police. Ruth refused stating her daughters had already done this and no further action was required as the relationship was over.	Ideally a check should have been made with the Police that they were dealing with this case. The degree of abuse was significant.

7.2.38 There is no record within the hospital that Ruth was risk assessed for domestic abuse. The Hospital did not undertake routine domestic abuse risk assessments. There is some evidence that these are now being undertaken.

The Hospital established that Ruth did not have formal child care responsibilities and if she had then a referral would have been made to Children's Services with or without her consent.

7.2.39 Ruth discharged herself from hospital during the second week of September 2015 against medical advice. Her family said she was desperate for sleep and found the ward environment too noisy. At that point the Panel judged that the level of risk she faced from Harry was high and she returned to live with him without any risk management plan. Despite many hospital professionals knowing the extent of her victimisation, none made a referral to Adult Social Care. The Panel concurred with The Root Cause Analysis findings:

'Throughout this incident there was a failing to follow or understand adult safeguarding procedures which resulted in the patient not being protected from domestic violence and allowed the perpetrator to continue offending. The Trust did not safeguard the patient from harm and did not have a plan in place to address the risks'.

Multi-Agency Risk Assessment Conference

7.2.40 Ruth was subject [victim] of a Multi-Agency Risk Assessment conference in July 2011 and May 2015 to two different perpetrators neither of whom was Harry. However, the fact that she had been abused by previous partners meant that she was a multiple victim. There is no evidence that this fact was taken into consideration when Merseyside Police completed the one risk assessment they did for Ruth.

Lifeline

7.2.41 Lifeline knew that Harry was subject to Multi-Agency Public Protection Risk Arrangements in January 2014 for violence and rape. Lifeline asked him whether he had ever been violent to a partner and when he answered 'yes' and was asked to elaborate, he said this was 'verbal, years ago'. The Panel felt this follow up question was sound practice, albeit Harry withheld the truth.

7.2.42 In February 2015 Harry was assessed by Lifeline as posing a medium risk of being aggressive to members of the public. It was known that Harry used his substantial size to intimidate people into giving him cash and goods. He was known to be dependent on alcohol and drugs.

7.2.43 On 31st July 2015 Harry accompanied Ruth to Lifeline. She wanted help to tackle her alcohol dependency; aiming for abstinence. Lifeline noted, "…she gave no information to indicate that she was at risk of violence or abuse and made positive plans to support her goal of achieving abstinence from alcohol." Lifeline routinely ask clients if they are victims of domestic abuse

and did so in this case. Ruth's denial reinforces the very difficult position she was in and probably illustrates her level of fear.

7.2.44 The Panel felt that Ruth's dependency on alcohol together with Harry's own dependency, drug misuse and his convictions for violence, including rape, meant that she was vulnerable to abuse at the hands of Harry. However the Panel recognised that Lifeline only knew part of Ruth's history and that it was reasonable to believe her account.

7.2.45 In the first week of September 2015 Harry telephoned Lifeline cancelling Ruth's appointment for that day saying she was sick. Lifeline note that, "…under the 'did not attend' policy that was in place at the time, Ruth's non-attendance at the group session should have been followed-up directly with her". Lifeline recognised its policy was unclear about whose responsibility it was to follow up on non-attenders and have since clarified the position in a new written policy.

7.2.46 The Panel felt this critical and open self-analysis demonstrated Lifeline's willingness to learn. They act swiftly when the policy gap was identified.

7.3 Term 2

How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

7.3.1 Lifeline provided an environment for Ruth where sensitive information could be shared. It is clear that Ruth felt confident speaking about her alcohol addiction but was not yet ready to disclose domestic abuse. It is now known that Harry played down his involvement in domestic abuse, thereby misleading Lifeline about the risk he posed.

7.3.2 Merseyside Police's interaction with the family is examined in more detail under Terms 5 and 6. Merseyside Police had two good opportunities to listen to Ruth. The first came on 13th August 2015 when Adele reported that her mother was the victim of domestic abuse. After nearly two days of trying, an officer saw Ruth who was adamant she was not a victim of domestic abuse. Unfortunately, the officer had only limited time alone with her before Harry appeared and reinforced her claim that nothing had happened. There is a substantial body of empirical evidence saying why victims feel unable to report domestic violence to the police, including fear of retribution which, as in now known, featured in this case. There are potential additional hurdles for victims who are dependent on alcohol. [34]

[34] Grasping the nettle: alcohol and domestic violence Revised edition, 2010 Sarah Galvani, University of Bedfordshire

7.3.3 The officer should have revisited Ruth when he was directed to complete a risk assessment. He did not, thereby denying Ruth another opportunity to express her wishes and feelings.

7.3.4 The second opportunity came on 20th August 2015 when Ruth's landlady reported a disturbance involving Ruth and Harry. The attending officer seems to have been distracted from speaking with Ruth when it became necessary to arrest another male. It can never be known what she might have said, but the chance for Ruth to say something was missed.

7.3.5 Staff in Southport and Ormskirk Hospital listened to Ruth and noted her disclosures. Ruth made them to about five members of staff, thereby demonstrating she had found the courage to seek help and had confidence in those she told. We now know that during her stay in hospital Harry regained power and control over her which is probably explains why, after a few days, she did not want her disclosures passing onto other agencies. It is not known if Harry knew she had disclosed his offending. Staff listened to Ruth when she declined a visit from a former partner because he had a Restraining Order not to approach or communicate with her. However, listening and taking action are different things and in Ruth's case, that action should as a minimum have been an immediate referral to Adult Social Care.

7.4 Term 3

Were single and multi-agency policies and procedures, including the Multi-Agency Risk Assessment Conference protocols, followed; are the procedures embedded in practice and were any gaps identified?

7.4.1 Merseyside Police did not always follow policies and procedures. The response from the call taker on 15th July 2015 when Adele reported concerns for her mother was outside of the policy in that a "cause for concern" log was not raised, thereby denying Ruth the opportunity to receive help. After attending the domestic incident on 13th August 2015 the officer did not classify the incident as domestic abuse nor did he undertake a risk assessment. That was rectified five days later on the intervention of a supervisor, albeit the assessment was inferior.

7.4.2 The second call to the police came from the couple's landlady but was not recognised as a domestic incident and therefore the attending officer did not comply with Merseyside Police's policy. The explanation for this is that the detail in the original call was overshadowed by the arrest of a male for drunkenness.

7.4.3 The advice given to Georgia by Merseyside Police that her mother had to report her own victimisation, was not supported by the Force's domestic abuse and response policies. The call was handled by a person whose

competence was later judged to be below an acceptable standard. That person no longer works for Merseyside Police.

7.4.4 Lifeline's "did not attend" policy was unclear on whose responsibility it was to follow up clients who did not keep appointments. That gap was identified prior to this incident and immediately rectified.

7.4.5 Southport and Ormskirk Hospital NHS Trust, Accident and Emergency Department has a procedure for placing flags on the Department's records to say that a person has been previously referred to a Multi-Agency Risk Assessment Conference. Such a flag was on Ruth's record. In preparing a report for the Panel the Hospital identified there is no written policy or practical procedures advising staff of what to do when a "flagged" patient entered the Department. This is a clear gap in policy which neither supports victims of domestic violence or multi-agency working. The Hospital took immediate action to rectify the lack of policy and procedure and will further amend its safeguarding policy so that specific advice is given to staff who receive disclosures of 'Threats to Kill.'

7.4.6 The Trust's website has the following statements about safeguarding.

"Trust Safeguarding Declaration [35]

This declaration represents assurance that Southport and Ormskirk Hospital NHS Trust (the Trust) Board has arrangements in place to ensure that Children and Adults at Risk of harm, who come into contact with the Trust either directly, or as a family member of one of our patients, are safeguarded from harm.

In the past year the Trust has met all its statutory requirements in relation to safeguarding children, young people and adults and is fully compliant with the CQC [Care Quality Commission] fundamental standards relating to safeguarding.

The Safeguarding Team is in place to ensure that all staff within the Trust receive the required advice, support, supervision and training in order to safeguard and promote the welfare of children and adults at risk."

7.4.7 After Ruth's disclosure of domestic abuse to the Hospital Alcohol Liaison Team Nurse a safeguarding referral was raised and left it in a tray on the ward for collection by the Safeguarding Team. In turn they would have decided on what action to take; e.g. referral to Sefton Adult Social Care or

[35] www.southportandormskirk.nhs.uk/Safeguarding.asp

Merseyside Police. It is now known that the referral was not collected from the tray because it was a Saturday.

7.4.8 The Safeguarding Team [two people] work Monday to Friday but there is advice on their answerphone on what to do in their absence. That advice includes making direct referrals to Adult Social Care. In this case no member of staff thought to make a direct referral.

7.4.9 The Hospital does not have a policy for patients who temporarily leave the ward. Staff told the chair that patients leave wards primarily to smoke and that this is accepted in recognition of their addictions and the smooth running of the ward. There is however, a policy for patients who go missing from a ward. In this case Ruth's absences fell into two categories; short smoke breaks and longer periods when she went into the Town. The significance of the longer absence was overlooked by staff whose focus was on 'treating' Ruth's addiction and not domestic abuse.

7.4.10 The Care Quality Commission Routine Inspection carried out on 12th-14th Nov 2014 noted that the compliance levels for mandatory safeguarding adults training needed improvement. The Hospital say that since then work has been done and compliance levels improved.

7.4.11 The Hospital did not comply with the General Medical Council's policy on gun and knife crime in that they did not consider referring Ruth's injury to the Police. The reason for the non-compliance is that the policy is generally not known about.

7.4.12 The National Probation Service identified that Harry should have been registered for active risk management under the Multi Agency Public Protection Arrangements and made a registration referral. However, because Harry returned to prison soon after the registration referral it was not progressed. The position could have been rectified had Harry's Offender Manager revisited the issue prior to Harry's release without licence on 26th May 2015. A simple oversight by the Offender Manager meant that the Multi-Agency Public Protection Arrangements were not followed and there was no active management of his risk. The failure to follow the registration policy meant that Harry's high risk of causing serious harm to members of the public was unmanaged from 26th May 2015.

7.4.13 Harry was a Registered Sex Offender and complied with his requirement to tell the police where he was living. That provided an element of supervision through the police, but was no substitute for developing a formal risk management plan within the Multi Agency Public Protection Arrangements. However, the Panel did not attribute Ruth's victimisation and death to the failure to manage him through the Multi-Agency Public Protection

Arrangements. Merseyside Police and the Hospital had ample opportunities to help Ruth.

7.5 Term 4

What knowledge of domestic abuse did the victim's and offender's families, friends and employers have of the relationship that could help the review Panel understand what was happening in their lives.

7.5.1 Neither Ruth nor Harry worked and the police investigation identified that Ruth disclosed her victimisation to a few friends. There is no information on whether Harry had friends. He appears to have been a 'loner.'

7.5.2 Ruth's Father, three daughters and son knew she was a victim of domestic abuse and that the perpetrator was Harry. From the information in the agency reports it is clear that Ruth was very frightened of Harry who is now known to have subjected her to violent, degrading and controlling behaviour, reinforced with a threat to kill her and members of her family should she disclose her victimisation to the police.

7.5.3 The family had limited success in trying to convince Ruth to end the relationship and report Harry to the police. In early September 2015 they convinced her to go to hospital where on admission she disclosed her victimisation and told her family she was ready to report Harry's abusiveness to the police. Ruth left hospital several times and was seen with Harry in the Town. He also was seen with her on the ward. Ruth told her family that she loved Harry and would not after all report him to the police. It is also known, and was at the time Ruth was in hospital, that Harry had threatened to kill her should she report him to the police.[36] It is also known that Ruth knew the level of violence Harry was capable of inflicting on her as evidenced by her remark that she could not take another beating.

7.5.4 Ruth's son witnessed Harry's abuse of his mother and worked with his sisters to support her, and with them was instrumental in her admission to hospital. It appears that Ruth's fear of Harry overcame her children's combined efforts to help her.

7.5.5 Ruth's family saw a deterioration in their mother's health, including weight loss and observed cuts and bruising. At one time the family felt she isolated herself from them. The truth is starker. It is now known that Harry exerted so much control over Ruth that she was virtually his prisoner and on one occasion he locked her in a shed and deprived her of food. He wore her down through sustained violence.

[36] It is well established through research that one of the reasons victims do not report abusers is the emotional attachment they have; another is the fear of retribution.

7.6 Term 5

Did the families and friends know what to do with any such knowledge and if they brought their concerns to the attention of an agency, how did they view the response?

7.6.1 The family reported its knowledge of Ruth's victimisation to the police and her general practitioner. As will be seen in the next term of reference the family believe it was let down by Merseyside Police. There is no report of a friend informing an agency of Ruth's victimisation prior to her death.

7.6.2 An internet search asking the question, "I know someone who is the victim of domestic abuse in Sefton, what should I do" produces several helpful links including one to the National Domestic Abuse Helpline[37] which provides practical advice that will not endanger the victim.

7.6.3 Ruth's family knew what to do to support her but their approaches to the police and hospital did not result in the help and support she wanted and needed. Ruth was let down as was her family.

7.7 Term 6

How effective were agencies responses to the concerns raised by the victim's family and friends that she was subject of domestic abuse?

7.7.1 Agencies do not have any records of Ruth's friends reporting her victimisation.

7.7.2 Merseyside Police's had three opportunities to respond to the concerns of Ruth's family and two opportunities to respond to a non-family report of a domestic incident. The family believe the police response failed to protect Ruth. The Panel's views appear later.

7.7.3 Merseyside Police handle calls from members of the public in the Force Contact Centre[38] which has a hierarchical structure, on top of which sits the Force Contact Centre Manager who has provided helpful commentary on the way two calls were dealt with. These appear below.

[37] 24-hour National Domestic Violence Freephone Helpline 0808 2000 247 Run in partnership between Women's Aid and Refuge www.nationaldomesticviolencehelpline.org.uk

[38] This encompasses the functions of Switchboard, Call Centres and Control Rooms

15th July 2015

7.7.4 Adele's call to Merseyside Police expressing concerns for her mother's safety was reviewed by the Force Contact Centre Manager who wrote:

"The call hasn't been dealt with in the manner in which the Department would expect. There are a number of issues.

1 A log should have been created for further checks to be completed in relation to the male.

3. The caller stated that the male had been in trouble with the Police previously, it would suggest that a search on Police National Computer persons would have possibly directed us to an address for the male.

4. Due to the caller stating that she believed that her mother had been subject to Domestic Violence this should have prompted further investigation from the call taker, this would have included checking previous calls and previous history on the address, also if there were any markers on the address. To access this information they needed to have completed a log.

4. Throughout the call there are a number of issues raised that would have shown that there are vulnerability factors that needed addressing.

As I listened to the call, it was clear that they had checked some systems to try and assist the caller, but I cannot confirm what they were because I don't have any log for me to reference this too. I have reviewed their previous quality assurance and there have been no previous issues identified."

7.7.5 The DHR Panel believed this was a significant opportunity to intervene in the abusive relationship and support Ruth. The Panel felt the call taker should have taken firmer control of the situation and accepted the responsibility on behalf of Merseyside Police to begin an investigation into the family's concerns. The response was unhelpful and placed the onus on the family to make further enquires. That "rejection" made the family feel the Police did not want to help them with their mother's victimisation.

7.7.6 The Panel noted that one of Merseyside Police's four priorities set in January 2016 is to: "Support victims, protect the Vulnerable and Maintain Public Safety". However, a similar priority existed in 2015 and in Ruth's case these written statements were not backed up with positive action.

13th August 2015

7.7.7 It took Merseyside Police nearly 48 hours to see Ruth after Adele reported her mother was being abused. The officer who saw Ruth took her denials of

victimisation at face value and decided that nothing had happened. This can be evidenced by the fact that the officer did not complete a domestic violence risk assessment at the time.

7.7.8 The situation was partly rescued when five days later a supervisor in the Sex Offender Management Unit noted that a risk assessment had not been done and instructed the officer to complete one. That was done by the officer without seeing Ruth and then passed to a specialist officer. The specialist did not undertake enquiries with her family who provided the original information or search all the available police databases for information on Harry and Ruth. The Panel felt both of these things should have been done. Had the family been seen they would have given the specialist officer a different perspective and may have persuaded them that the risk faced by Ruth was substantial.

7.7.9 The Panel understood the difficulties encountered by officers when faced with conflicting information; the family said one thing and Ruth another. It is well established through research that victims very often deny their victimisation and this places a greater responsibility on officers to seek out independent evidence. The family knew their mother and knew what was happening in her life. The police should have placed more cognisance on the family's account.

7.7.10 In the judgement of the Panel the handling of the August call was poor and the subsequent risk assessment which showed Ruth to face a "Bronze" risk was incorrect and should have been higher. This would have allowed her case to be considered at a Multi-Agency Risk Assessment Conference. Merseyside's Police's response did not support Ruth as a victim of domestic abuse; moreover it left the family with a feeling of despair and believing that Merseyside Police was not interested in helping their mother because she was addicted to alcohol. The Panel did not identify any information which suggested that Merseyside Police treated Ruth differently because of her addictions. Their errors stemmed from the substandard advice they were given on several occasions.

20th August 2015

7.7.11 Ruth's landlady reported a disturbance at the address where Ruth and Harry lived. The police attended and arrested a male [not Harry] for drunkenness, but did not recognise that the disturbance also included a report of arguing between Ruth and Harry. That element was not acknowledged or pursued and therefore Merseyside Police's response to Ruth's situation was wholly ineffective and did not support her. The Panel recognised that the attending officer's priority was to deal with the drunkenness and can understand how the potential risks faced by Ruth were overlooked. However, the Panel would have expected a supervisor to identify that Ruth needed seeing.

First week September 2015

7.7.12 While in hospital, Ruth asked Adele to report the domestic violence to the police. At this time Ruth was in a place of safety, surrounded by her family and with a firm plan to live with her Father. The expectation was that an officer would come to the ward and take a complaint from Ruth.[39]

7.7.13 Georgia telephoned the police on "101" to report the domestic violence and reported the call taker told her that her mother would have to report it herself when she was available to speak.

7.7.14 The Force Contact Centre Manager reviewed the call and made the following observations. 'The call is poor on several fronts, it lacks: questioning in relation to her mother, her vulnerability factors and assessment of harm and risk'.

7.7.15 The Police report author says of the same call that the call taker omitted to:

- Ask for her mother's details
- Ask for the identity of the offender
- Ask about the extent of the violence and any injuries
- Ask what hospital she was in
- Failed to check systems for history and background
- Did not create a log for a DV incident and dispatch a patrol.

7.7.16 The call taker no longer works for Merseyside Police.

7.7.17 The Panel, noted that Merseyside Police accepted the response to the "101" call was wholly inappropriate and against its policy and that an officer should have been sent to the hospital to progress Ruth's complaint. The Panel felt this was a significant missed opportunity to support Ruth. She had found the strength to involve the police and was in a place of safety which were very favourable conditions to escape from her victimisation by Harry. She was badly let down by the police which on this occasion was caused by the incompetence of an individual.

First week September 2015

7.7.18 Tony witnessed his mother being dragged along by Harry but did not call the police fearing Harry would stab her with the knife he was holding. He also states that the family were given the impression by the Police to, "stop calling as they were wasting police time because there was nothing that they could do about what they were telling them".

[39] The Hospital told the chair that it is not unusual for police officers to see patients and that staff always provide a private room where the police can see victims.

7.7.19 When the chair saw the family they felt that Merseyside Police simply did not care about their mother and formed a view that it was pointless in asking them for help on her behalf. The Panel concluded on the evidence it saw that the family's view was justified.

General Practitioner

7.7.20 The Panel concluded that Ruth's doctor who received the family disclosure acted appropriately and provided the right advice which the family followed when they took their mother to Accident and Emergency.

Southport and Ormskirk Hospital

7.7.21 While family or friends did not make any discrete disclosures to hospital staff they visited Ruth on the ward and spoke in general terms about her victimisation. The Hospital's response to Ruth's disclosures is dealt with elsewhere in the report.

7.8 Term 7

How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?

7.8.1 Merseyside Police did not share information with any agency. Ruth's risk assessment of Bronze did not require it. However, the Panel believes the risk was understated and that the opportunity for a referral to a Multi-Agency Risk Assessment Conference was missed as was consideration to register Harry under the Multi Agency Public Protection Arrangements. Had a referral been made to a Multi-Agency Risk Assessment conference, an Independent Domestic Violence Adviser would have approach Ruth thereby providing another opportunity for her to disclosure her victimisation.

7.8.2 The Panel also believes that Merseyside Police could have made a Safeguarding Alert to Sefton Adult Social Care.[40]

7.8.3 Southport and Ormskirk Hospital received notification that Ruth had been to a Multi-Agency Risk Assessment conference in May 2015 and flagged its Accident and Emergency database. That is an example of effective multi-agency working. However, as previously mention there was no policy behind such flagging, thereby making it ineffective.

7.8.4 The Hospital procedures for sharing/referring cases to Sefton Adult Social Care was ineffective. There are three main reasons.

[40] Care Act 2014 Section 42

i. The referral document from the ward was left in a tray on the ward for collection by the Hospital Safeguarding Team. It was not collected because outside of the Team's working hours there is no procedure for doing so. It is expected by the Team that urgent matters would be referred direct to the appropriate agency.

ii. The Nurse who received the disclosure did not judge it to require urgent action and was not aware of the Trust's full safeguarding procedures or of the Multi Agency Risk Assessment Conference.

iii. Staff did not recognise that Ruth, who had broken free of Harry on admission to hospital, was, through her absences from the ward, increasingly falling back under his coercive control, probably resulting in her being too frightened to allow her disclosures to be share with external agencies.

7.8.5 Ruth, through fear of retribution to herself and family, bowed to Harry's demands not to report him to the Police. However, at several points during her admission she gave the Hospital permission to share information on her victimisation. On an afternoon in the first week of September 2015, Ruth gave permission for Adele to formally report the domestic abuse to Merseyside Police, but the call to 101 was met with the inappropriate advice that Ruth had to report it herself.

7.8.6 Ruth told a member of the Hospital Alcohol Liaison Team that Harry had threatened to kill her if she told the police about him abusing her. The Panel considered whether this information should have been passed directly to Merseyside Police and concluded it should have been. The meeting with the Hospital revealed it does not have a specific policy to deal with such disclosures.

7.8.7 The Hospital did not consider sharing information about Ruth's knife wound with Merseyside Police because the General Medical Council's protocol on gun and knife crime was largely unknown to staff.

7.8.8 The National Probation Services representative on the Panel stated that it is their policy not to ask for offenders to be electronically tagged to an address where it is known there is domestic violence. In this case Harry was "tagged"[41] to the address he shared with Ruth when he was granted bail for theft.

7.8.9 There does not appear to be any system in place to establish whether a "tagged" person is a domestic abuser and whether a victim of domestic abuse lives at the 'curfew' address. The Panel thought this was a very

[41] This means he has a curfew to observe tying him to the house

difficult problem which had national implications and made a recommendation for the issue to be considered.

7.8.10 A Panel member raised a concern that the lone female worker from Electronic Monitoring Services who met Harry to fit his "tag" did not know he had convictions for violence and rape, thereby exposing her to unregulated risk. The company's response explained how it formulates risk using information provided by the courts when the Electronic Monitoring Order is generated, together with any history they have of "tagging" the same person. The staff are trained to deal with conflict and have "panic" buttons to alert their office should they need to. The Company recognises the issue and believes the onus is on the courts and police to inform them of significant risk factors.

7.8.11 Lifeline staff faced a similar issue in that they knew some of his history but not the detail. The Panel debated whether Lifeline should have access to its clients' Offender Assessment System risk assessment held by the National Probation Service which contains a full history of risk formulation. The Panel concluded that the current arrangements for sharing information between Lifeline and the National Probation Service were satisfactory.

7.8.12 It is impractical and unnecessary to vet all hospital visitors. If a patient is known to be a victim of domestic violence, as in the case of Ruth, perhaps it is possible to develop a process whereby the hospital could ban the abuser or potential abusers from visiting. However, without a statutory order such as a Restraining Order, Domestic Violence Protection Notice/Order[42] or a parole licence condition it seems an impractical proposition. This is an area where it is reasonable to reply on the professional judgement of hospital staff.

7.9 Term 8

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects?

7.9.1 The Equality Act 2010 Section 4 lists the following as Protected Characteristics:

- age;
- disability;
- gender reassignment;

[42] Domestic violence protection notices/orders are a new power [March 2014] that fill a gap in providing protection to victims by enabling the police and magistrates to put in place protection in the immediate aftermath of a domestic violence incident. A perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation

7.9.2 Section 6 of the same Act defines Disability as: A person has a disability if he has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities.

7.9.3 The Equality Act Guidance 2010 [Her Majesty's Government] has the following exclusions on disability.

"Certain conditions are not to be regarded as impairments for the purposes of the Act. These are:

- addiction to, or dependency on, alcohol, nicotine, or any other substance (other than in consequence of the substance being medically prescribed)
- the condition known as seasonal allergic rhinitis (e.g. hayfever), except where it aggravates the effect of another condition;
- tendency to set fires;
- tendency to steal;
- tendency to physical or sexual abuse of other persons;
- exhibitionism;
- voyeurism

7.9.4 It is not known what faith Ruth or Harry may have had.

7.9.5 The Panel believed from the material it saw and the ensuing discussions that the risk assessments completed and the services provided to Ruth and Harry were done without bias or prejudice; which is very different to saying they were undertaken satisfactorily.

7.10 Term 9

How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

7.10.1 At 4.19 pm on 14th August 2015 a Merseyside Police Risk Manager[43] viewed the Storm log generated almost twenty four hours earlier when Adele expressed concerns about her mother's welfare, and determined that further enquiries were necessary. The Storm log was classified as Grade 2.[44] "Priority". That demonstrated some oversight of an outstanding enquiry.

7.10.2 The officer who eventually saw Ruth finalised the Storm log without undertaking a risk assessment. This deficiency was not challenged.

7.10.3 However, because Harry was a registered sex offender, a supervisor in the Sex Offender Management Unit viewed the log and instructed the officer to complete a Vulnerable Person Referral Form.

7.10.4 The officer complied with the instruction and submitted the form through a sergeant who did not challenge the deficiencies in the form noted by the police report writer. When asked by the police report writer for an explanation the sergeant replied:

> "This was an incident which police constable … was sent to whilst covering patrol for the shift and he was not under my supervision on the day. I was on duty, but I am not his direct line manager and would have been on a different shift. I was unaware of the incident until the officer gave me the Vulnerable Person Referral Form to sign. The knowledge I had was what was recorded on the form". She believed from what the officer told her that he had enough time to establish what had happened when alone with Ruth and to risk assess the situation.

7.10.5 The sergeant did tell the officer that she would have completed the form at the time. The sergeant did not however conduct any research into the background of the couple or the incident. The police report writer opines, "Although there is an element of quality assurance and challenge, this is minimal and considered as poor supervision". The Panel supported that view.

7.10.6 The call by the landlady on the 22nd August 2015 was not recognised by the attending officer as a domestic incident and there was no challenge by the supervisor. The supervisor explained to the police report writer that she relied on what the attending officer reported. The Panel felt the supervision was below a reasonable standard but understood that the volume of calls

[43] Risk managers work in a contact centre control room environment in conjunction with team leaders, control room supervisors, police officers and police staff, to ensure a professional response to requests for assistance.

[44] Police National Call Handling Standards categorise incidents requiring action as: An Emergency Contact (Grade 1) A Non-Emergency Contact: Priority Response (Grade 2) Scheduled Response (Grade 3): National Call Handling Standards categorise enquiries requiring action as: Resolution without Deployment (Grade 4)

dealt with by supervisors probably prohibit all but the most serious from closer scrutiny.

7.10.7 This is the response in the Hospital report.

"This is an area where lessons can be learnt for the organisation. The referral procedures and the management of referrals were not clear to the staff in either A&E or the wards. The role of the Trust Adults at Risk Team also needs further work to raise their profile to ensure support is offered to both the victims and the staff in situations such as this. Staff appear unclear about mental capacity and referring if the victim does not agree with the referral."

7.10.8 The DHR Panel felt the management oversight by Southport and Ormskirk Hospital could have been better. When Ruth's vulnerabilities as described to the Hospital staff are listed, then it is clear that she had suffered significant violence, including sexual violence, and had her life threatened. Her vulnerability to further domestic abuse was never recognised or considered by management. The reasons for this is that the focus of the Hospital's work was dealing with Ruth's medical needs, the belief that she was leaving the abusive relationship and going to live with her Father and that she had the support of her family.

7.10.9 The National Probation Service offered the following critique:

"There is evidence in the record of management oversight on three occasions during the four months [of the review period] when Harry was managed by us. The first of the contacts is in relation to an enforcement decision, the second in respect of professional judgement and the third is recorded as a supervision session, all of which appear in line with the service's guidance.

7.10.10 It is Probation policy for managers to have structured supervision sessions four times per year with staff members, with the expectation that cases will be raised for discussion between these periods as and when required.

7.10.11 The implementation of the Multi Agency Public Protection Arrangements review will commence in January 2016. Until this in place there is no current system to formally discuss and record actions in respect cases outside of the structured supervision process."

7.10.12 The Merseyside Police Contact Centre Manager reported the following quality assurance process.

"…each shift the Call Handling Team Leader and/or a trained Quality Assurance Assessor completes at least one quality assurance for a member

of their team. This Quality Assurance process includes listening to the call and reading the associated log. All aspects of a call including, reassurance, active listening, establishing caller's needs, questioning, relevant information gathering , opening code, checking force systems…call handlers are given feedback as soon as practicable after the Quality Assurance has been completed".

7.10.13 No other agency noted weakness with supervision nor did the Panel identify any.

7.11 Term 10

Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

7.11.1 Lifeline accommodated Ruth when she turned up without an appointment which show their flexibility to respond immediately to people who have decided to seek help at short notice.

7.11.2 Merseyside Police reported that it took two days to contact Ruth following the initial call regarding concerns for her safety, but felt it was because of poor use of available resources and the wrong prioritisation of calls.

8. LESSONS IDENTIFIED

8.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix 'D'.

8.2 The DHR Lessons identified are listed below. Each lesson is followed by a narrative.

Lesson One
Lesson 1 Not considering all pathways for assessing and controlling risk can leave potential victims of domestic abuse exposed to unknown risks. National Probation Service Recommendation 3 applies
Narrative In May 2015 the National Probation Service did not submit Harry's case for consideration of Multi Agency Public Protection Arrangements registration.
Lesson 2 Not taking the family's concerns seriously meant that Ruth continued to be exposed to domestic abuse. Merseyside Police Recommendation 3 applies
Narrative Ruth's family reported their concerns about Harry's perpetration of domestic abuse to Merseyside Police many times but did not receive an effective response. In particular the advice that Ruth should report the abuse in person was inappropriate.
Lesson 3 Not following all reasonable lines of enquiry to discover the truth can leave victims of domestic abuse vulnerable and perpetrators with a sense of invincibility. Merseyside Police Recommendations 3 and 5 apply
Narrative The police were faced with conflicting evidence when Ruth said she had not been assaulted by Harry and the family said she had. No attempt was made to seek further and/or independent evidence.

Lesson 4 Not recognising when an incident is domestic abuse denies the victim access to justice and support. Merseyside Police Recommendation's 1 and 2 apply
Narrative apply. On one occasion it took Merseyside Police about five days before it recognised an incident involving Ruth was domestic abuse and on a second occasion, the domestic abuse element of a call was overlooked.
Lesson 5 Failing to formulate risk accurately exposes victims to further domestic abuse. Merseyside Police Recommendation's 1, 2, 3, 4 and 5 apply.
Narrative In arriving at the Bronze risk Ruth faced from Harry, not all of the risk factors were taken into account; specifically his violent history and her vulnerabilities.
Lesson 6 Failing to follow or understand adult safeguarding procedures does not protect victims of domestic violence and allows perpetrators to continue offending. Southport and Ormskirk Hospital NHS Trust Recommendation 2 applies.
Narrative Southport and Ormskirk Hospital had some gaps in its safeguarding adult procedures [for example: what to do when a 'threat to kill' is disclosed; the processes behind Multi-Agency Risk Assessment Conference flags and the General Medical Council's protocols on gun and knife crime]. On some occasions staff did not follow procedures or were not fully aware of them.

Lesson 7 Not recognising that Ruth's absences from the ward were more than 'smoke breaks' denied her the opportunity for assessment and support.
Narrative There was no investigation into why Ruth absented herself from the ward on several occasions, nor was there a complete record of those absences. The meeting with the Hospital staff discussed the practicalities of trying to log patients in/out who leave the ward for 'smoke' breaks or other short terms needs and conclude it was not practical or feasible and therefore there is no direct recommendation.
Lesson 8 Do not impose curfews on domestic abusers that ties them to an address where a victim also lives. The DHR Panel Recommendation 1 applies.
Narrative Harry was fitted with an electronic monitor as part of his bail curfew conditions for theft. No one seems to have considered that doing so tied him to an address where a victim of domestic abuse lived.
Lesson 9 Supervisors cannot always be relied on to identify oversights and errors. Merseyside Police Recommendation 6 and 7 apply.
Narrative There are several examples in the report of deficient supervision.

Lesson 10
Not knowing the full criminal history of offenders can potentially expose workers to unregulated risk.

DHR Panel Recommendation 2 applies.

Narrative
Electronic Monitoring Services and Lifeline did not know the full criminal history of Harry before they provided services to him. Electronic Monitoring Services feel the current way they assess risk is fit for purpose and place the responsibility on their commissioners to reveal risk factors. Therefore they do not believe it is necessary to have a recommendation.

Lifeline believes the current information sharing between them and the National Probation Service is satisfactory and do not need a recommendation.

9. CONCLUSIONS

9.1 Ruth and Harry met in May 2015 after he was released from prison and almost immediately they formed a relationship. A human error in the Multi-Agency Public Protection Arrangements within the National Probation Service meant no agency was managing his high risk. The police knew where he lived because he had to tell them as part of his sex offender registration. Ruth and Harry moved into together in July 2015. Harry came to the relationship as a registered sex offender with convictions for rape against a child and violence against a former female partner. He also brought with him dependency on alcohol, use of illegal drugs and a disregard for authority as evidenced by the many breaches of his parole licences and arrests for theft and violence, including robbery. He used his large physique to bully vulnerable people so that he could obtain goods or money to support his addictions.

9.2 Ruth was a vulnerable person who was also dependent on alcohol. She was known to Merseyside Police as a victim of domestic abuse. As recently as May 2015 her case as a victim of domestic violence was presented to a Multi-Agency Risk Assessment Conference. The offender was not Harry which meant she was a multiple victim. She had strong support from her four adult children and Father.

9.3 Ruth and Harry attended Lifeline together on 31st July 2015. Ruth's aspiration was to become abstinent. It is thought her attendance was encouraged by Harry who the Panel felt was exercising control over her.

9.4 It is believed that Harry first began abusing Ruth soon after they started their relationship. The first opportunity for an agency to intervene came on 15th July 2015 when the family report their concerns to Merseyside Police. That call for help was effectively ignored and the family told to make their own enquiries. On 13th August 2015 Adele reported to Merseyside Police that her mother was the victim of domestic abuse and had not been seen by the family for a few months.

9.5 The police took almost 48 hours to trace her and observed she had a facial injury, but were told by Ruth and Harry that there was no domestic abuse; the injury having occurred when she fell over. The attending officer did not recognise the incident as domestic abuse but several days later a supervisor did and directed the officer to complete a risk assessment. This was done without Ruth or her family being seen, or without a thorough check on their backgrounds. Unsurprisingly, but disappointingly, Ruth was assessed at the lowest risk level. This low level was confirmed by a specialist officer the following day. There is no doubt in the minds of the family, and the Panel, that Ruth faced a high risk of serious harm from Harry and should have been referred to a Multi-Agency Risk Assessment Conference.

9.6 Within a week there was another opportunity to assess the risk to Ruth but again the officer who attended [a different one to the previous call] did not believe he was dealing with a domestic incident. A thorough investigation by him would have provided information to the contrary.

9.7 Thereafter events gathered momentum. At the end of August 2015, Ruth told a friend that she could not take another beating. During the first week in September 2015 she asked her son Tony to help her move and insisted he also move Harry's belongings or she would face serious consequences. Tony saw she had two healing black eyes and some healing scratches around her nose. He described the flat as dirty and the scene of obvious violence as evidenced by holes punched in doors and walls, with indications of drug abuse and blood stains on the settee. He became very concerned and with the help of his sisters persuaded their mother to stay with a family member which she did for a few hours.

9.8 During the first week in September 2015 Harry was evicted from his flat and moved with Ruth to the property where she died. He bullied another resident in the multi occupancy house and moved into a larger room than the one he had been allocated.

9.9 The following day a member of Ruth's family expressed their concerns about her to her general practitioner who noted it in her records and advised them to bring Ruth to the surgery or take her to Accident and Emergency.

9.10 Ruth was persuaded to go to hospital by her family and disclosed to staff a catalogue of abuse, including that she feared for her life because Harry had threatened to kill her. The Hospital's response was poor and an opportunity was missed to refer her case to the police, for the threats to kill and to Adult Social Care for domestic abuse. Internal safeguarding procedures were poor and some staff's safeguarding knowledge was limited. The Hospital did not consider the General Medical Council's protocol of informing the police of gun and knife wounds.

9.11 Later that week Ruth's resolve to break free from Harry waned. In the morning and early afternoon she was still saying to staff that the relationship with Harry was over. Adele telephoned Merseyside Police on 101 to report her Mother's victimisation but was given inappropriate advice by the call taker. That advice was patently wrong and an officer should have been sent to the hospital to take her complaint of domestic abuse. This was a significant missed opportunity to help Ruth.

9.12 Later that afternoon she was seen in the Town being dragged along by Harry who had a knife and was threatening her. That evening Ruth returned to the ward with Harry and told one of her daughters that she loved him. Harry had reverted to type. He used violence and intimidation to regain his control over Ruth.

9.13 The following day Ruth was seen with Harry near their flat. He was physically abusing her by kicking her posterior to reinforce his desire to get her indoors. She later returned to the ward but in the early hours of the second week September 2015 discharged herself, against medical advice. She was killed by Harry about twenty four hours later.

9.14 The Panel felt there were many opportunities missed to support Ruth with her duel aim of leaving Harry and reporting his violence. The failings are shared between the Merseyside Police and Southport and Ormskirk Hospitals NHS Trust. Both organisations let down Ruth and her family; a point they acknowledge.

9.15 The need to arrest Harry and ask him to account formally for the catalogue of injuries he caused Ruth should have been identified. With Harry under arrest, Ruth may have re-found the will to make a complete disclosure which would have included her reasons why she felt it necessary to have previously underplayed her victimisation. It was a serious error not to have arrested Harry.

9.16 Ruth's family are devastated by the homicide and believe they received a very poor service from the police and the Hospital, who between them squandered excellent opportunities to support Ruth and end her victimisation.

10. PREDICTABILITY/PREVENTABILITY

10.1 Family's View

10.1.1 The family has no doubt that it was predictable that Harry would kill Ruth and that her death was preventable.

10.2 Predictability

10.2.1 Harry was a violent man who had previously assaulted an intimate partner and raped a child. His, dependency on alcohol, misuse of drugs, propensity to rob, coupled with his imposing physique, made him a danger to the public, children and intimate partners. When he was released in May 2015 he was assessed as posing high risk to members of the public but errors in the Multi Agency Public Protection Arrangements meant his risk was unmanaged. During the short relationship with Ruth he was assessed as posing a Bronze risk of causing her serious harm. That was clearly wrong, he posed a very real risk of causing her serious harm.

10.2.2 The Panel felt that had the evidence available to agencies been properly collated the almost certain outcome would have showed Harry posed a very real risk of causing serious harm to Ruth. In that context it was possible to predict that he would cause her serious harm. In the end he carried out his threat to kill her.

10.3 Preventability

10.3.1 Ruth's evidence was supportable by eye witness testimony from several people which together with her noted injuries provided opportunities for Ruth's complaints against Harry to have resulted in his arrest. He was not arrested because the police procedure and assessment was not undertaken correctly. Had it been the evidence would be scrutinised to determine if it met the criteria for a prosecution.

10.3.2 The reasons why he was not arrested for domestic abuse appear in the report. Had staff in Merseyside Police and Southport and Ormskirk Hospital NHS Trust who had contact with Ruth and/or her family, done their jobs effectively, the opportunity to intervene and reduce the risk of serious harm to Ruth was very real, as was the likelihood of preventing Ruth's death.

11. RECOMMENDATIONS

11.1 Agency Recommendations

11.1.1 The Agencies recommendations appear below and in the Action Plan at Appendix D and deal with the failings in this case.

11.2 Merseyside Police

1. Ensure that Patrols attending at the scene of 'domestic abuse' incidents are fully aware of the dangers of speaking with a potential victim in the presence of the alleged perpetrator.

2. Ensure that Patrols attending at the scene of 'domestic abuse' incidents are aware of the content of the Storm log, in particular the comments of the informant. There should be evidence that such comments have been considered during the closure of a log.

3. When family members report concerns for the safety of a close relative that involve alleged 'domestic abuse', then positive action must be taken. This should include a full de brief of the evidence / information held by the relative and effective evidence gathering while at the scene, including house to house enquiries.

4. When a 'domestic abuse' incident is reported, control room supervision must ensure that the communication officer handling the call has made all necessary checks of the relevant IT systems, not just the PROtect history, and informed the attending patrol of the full history of all parties concerned.

5. When a 'domestic abuse' incident is reported which is the first recorded between particular parties, this alone should not be judged as a factor to consider the incident as low risk. Cognisance must be taken of the 'domestic abuse' history of the parties with previous partners, particularly when they may have been risk assessed as 'Gold' or been a perpetrator of a 'Gold' victim and subject of the MARAC process.

6. All calls for service that initiate as domestic incidents, should be monitored and subject to scrutiny by control room supervision. The relevant Storm log must be endorsed by the supervisor to ensure compliance.

7. A patrol supervisor should be informed when a 'domestic abuse' incident is reported and his or her details recorded on the Storm log. The supervisor should ensure that a VPRF 1 is submitted prior to the

end of the tour of duty, having quality assured it and having appended his or her name and signature.

11.3 National Probation Service

1. A more investigative approach to be taken (by offender managers) in terms of Offenders with Domestic violence backgrounds. Regular FCIU checks to be undertaken regardless of whether an offender reports to being in a current relationship.

2. Checks to be made to Prison establishment regarding visits/contact with unknown females when those with a DV history are in custody.

3. Increased Management oversight and discussion of Level 1 MAPPA cases with a view to increasing the level of MAPPA management if required.

11.4 Lifeline

1. Lifeline Sefton workers should always use the same file when an individual starts a new treatment episode, rather than closing one file and re-opening another, to ensure continuity and a full treatment history within a single file.

2. The service should lead a reflective practice session with the team, focussing on working with couples when both are known to the service. Key questions for practitioners to consider should include:

   In what circumstances is it appropriate to follow-up independently something that one partner has told the service about the other?

   How should we best record risks relating to the clients in each other's files when both are known to us? – How do we manage this for newly established couples?

11.5 Originally Southport and Ormskirk Hospitals NHS Trust

11.5.1 Originally Southport and Ormskirk Hospitals NHS Trust included four recommendations in its Individual Management Report. The Root Cause Analysis produced an action plan with fifteen recommendations. While the format of the Root Cause Analysis action plan is slightly different to the other agencies format, it is comprehensive and therefore copied verbatim into Appendix D. The Hospital's action plan uses the following code.

12 RED	Little or No Progress Made
AMBER	Moderate Progress Made
YELLOW	Actions Almost Completed
GREEN	Completed

1. Immediate domestic abuse awareness and training for the following areas: A&E department: EAU and HALT team.

2. Staff do not understand the significance of MARAC; Safeguarding Adults Policy was and is not clear on processes / expectations.

   Staff do not recognise the significant risk when a patient reports a threat to kill/ know what the process are when a knife crime is

   The guidance regarding reporting of gun and knife crime will be circulated to key areas and will be included in the relevant safeguarding policies.

3. MARAC alerts on Medway to be amended so staff realise the significance of these alerts.

4. Staff must implement the Domestic Violence and Abuse Policy Clin Corp 18. Staff must receive education and training. Staff need to know who puts the flag on Medway and when to do so – Who has the access to do this and whose responsibility it is.

5. Safeguarding Adults Policy CORP 77- referrals must be made in accordance with Policy – staff must check the referral has been received. On admission staff should have contacted the Trusts Safeguarding Hotline (01704) 5248 and complete an incident report via DATIX. They should have contacted the Trust Safeguarding Adults Nurse Soh-tr.VulnerableAdultsTeam@nhs.net or via telephone (01704) 705248.

6. Safeguarding Adults Policy CORP 77 staff awareness and education – responsibilities/safeguarding and Mental Capacity Training (MCA), All Trust staff to realise that anyone who has contact with an adult at risk and hears disclosures or allegation has a duty to pass them on appropriately. When a crime has been committed capacity – consent is not relevant and the incident must be reported to the Police. Injuries must be body mapped as per Policy.

7. The Safeguarding Adults Flow Chart contained with the Safeguarding Adults Policy CORP 77; not clear that when a crime has been committed capacity/ consent is not relevant. The Safeguarding Adults Flow Chart does not stipulate how Section 2 Papers are to be sent to the team/ staff must check they are received. There are no

examples of these papers within the Policy. Safeguarding Adults Policy CORP 77 Flow Chart to be amended to state Consider – Has Crime been Reported? from Has Crime Been Committed?

8. Staff did not implement the Smoke Free Policy Corp 06 to be implemented. Health Promotion occurs.

9. Staff must follow the Protocol for the Missing Patient (CLIN CORP 76) patients go missing. Risk Assessments must be completed highlighting the risks of leaving the Ward and the actions taken to mitigate the risks. A "contract" needs to be considered and reinforced on the wards to protect the patient and other patient's when someone chooses to leave the ward. There should be more robust monitoring regarding patients who leave the ward area with absences documented and discussion with the patient regarding expectations on leaving the ward / return to the ward / length of absence.

10. There must be greater staff awareness of the Domestic Violence lead throughout the Trust Greater awareness of the role of the Adults at Risk Team.

11. To include capacity and consent in Domestic Violence and Abuse Policy Clin Corp 18.

12. Clinical Record Keeping must be adhered too – clinical records must record the dates and the times patients leave the Wards. Record why the patient has left the ward and how they were clinically on their return. When nurses are concerned that patients are drinking alcohol this must be reported to the Doctor so the patient can be assessed and the issues addressed.

13. Correspondence to GP: The Trust must highlight the risks to GPs so they can take actions to safeguard their patients.

14. Staff must complete incident forms and inform the Police when visitors attend the Ward and they are subject to an injunction. The incident must be recorded in the patient's clinical records and a Risk Assessment completed.

15. NICE Pathway/ Alcohol Use Disorders Pathway required. Alcohol-use disorders: diagnosis and management quality standard. The quality standard defines clinical best practice in the care of people (aged 10 and above) drinking in a harmful way and those with alcohol dependence and should be read in full.

11.6 Domestic Homicide Panel Recommendations

1. That the Ministry of Justice considers how the courts can avoid issuing electronic surveillance orders in support of bail curfews for known domestic abuse offenders, to addresses where victims of domestic abuse live.

Next Appendixes

Appendix A

The Judge's Sentencing Remarks

You are … years of age have pleaded guilty to murdering your … partner … on 10.9.15; you entered that plea half way through your trial, having on the first day, pleaded guilty to manslaughter, thereby admitting at a very late stage in the face of overwhelming evidence that you had unlawfully killed her, but continuing to deny until almost all the evidence of the history of your relationship had been given by her children and friends, that you had the requisite intent for murder.

Having heard that evidence and having considered all the medical and scientific evidence, I am quite satisfied that over a period of a month prior to her death, you caused her untold physical and mental suffering as a result of your ever increasing violence, culminating in a ferocious and sustained attack upon her on the night she died.

During the month of august and into early September, your violent conduct to her built up, starting as it did with punches which caused her black eyes, a bite to her ear, a head butt which split her lip and loosened her teeth, numerous punches to her pelvic and pubic region, and culminating in an attack upon her with a knife, on which she cut her hand in an attempt to prevent you cutting her throat and a fork with which you stabbed her in the arm and in the thigh, leaving her to remove it herself. Your campaign of violence towards her was compounded by threats of further violence – you threatened to kill her which was bad enough, but, displaying an element of warped sadism and sheer cruelty, you threatened also to cut off her clitoris with a pair of nail clippers if she ever left you or reported you to the police. Small wonder it is that for some considerable time she sought to attribute her injuries to her own clumsiness in drink; I reject any suggestion that, apart possibly from the odd scrape, any of the injuries identified in this case were sustained in that way – as her son said, if that were right, she had sustained more bruising from so-called falls and clumsiness in the last month of her life than in the previous 20 years.

I am also satisfied that far from protecting her at a time when you knew, because you shared that vulnerability that she was vulnerable because of a dependency or near-dependency on alcohol, you preyed on that vulnerability and exercised ever-more control over her life and actions, thereby effectively depriving her of a free choice whether to stay with you or to leave you. You smashed her phone and flushed it down the toilet to restrict her means of contacting her family and even resorted to locking her in to your flat [even though I cannot be sure that you purchased a padlock for the flat for that sole purpose] to prevent her from going out and being seen with all the hallmarks of domestic abuse.

At the beginning of September 2015, 'Ruth' was admitted to Southport General Hospital and discharged herself 4 days later. Whilst there she was vacillating between saying that she was ready to complain to the police and that she loved you

and wanted to return to you. As I have already stated, I am quite satisfied that she had been deprived of any real choice in the matter as a result of your controlling behaviour and threats. In those latter days, whatever the position may have been in the early weeks of your relationship, you had no regard or affection for her. In so far as you may have appeared protective towards her, I have no doubt that you were in truth seeking to protect yourself from the consequences of your behaviour towards her.

When she left hospital, Ruth was weak and had been told that if she didn't stop drinking, she was not long for this world. Within 36 hours she was dead, the victim of yet more, and on this occasion, prolonged as well as severe violence. It has been submitted on your behalf that this prolonged outburst was caused by a regurgitation of old arguments about drugs and alcohol [to which you were no less partial than Ruth] and because you had – and I accept you were – beaten up – been attacked the previous Friday evening. I reject that explanation; it took something of massive significance in the context of your relationship to cause you to embark on the final prolonged and vicious attack upon Ruth which killed her. I have reflected carefully upon what that might have been and I am satisfied that in the early hours of that morning, Ruth at last summoned up the courage to tell you that it was over and that she was going to the police. It was that realisation that led you to behave as you did, inflicting upon her the savage beating from which she died. Whilst I have already indicated that the prosecution cannot satisfy me on the evidence to the criminal standard that you intended to kill her, I am quite sure that you intended at least to cause her really serious injury and, in truth, cared not one iota whether she lived or died. I don't suppose after what she had been through at your hands, she cared much either.

When you had killed her – when she was dead, and not before – you called the emergency services and, ironically enough, tried to persuade them that she had taken no drugs or alcohol, prior to complaining of feeling unwell and collapsing in the shower; you also tried to persuade a neighbour to back up your lying account. And lie, you continued to do to a greater or lesser extent, until yesterday, when finally you pleaded guilty to murder, but not before her children had to give evidence and be crossed examined about their mother's last days. Whilst it must be acknowledged that your late plea is better than no plea, and is a belated acknowledgment of what you did, the credit to which you are entitled is very limited indeed. I do however accept that you stopped short of giving a lying account in evidence, although I have of course rejected some of the basis of your mitigation

The effect and manner of their mother's death on Ruth's children and her father has been traumatic and life changing. Small wonder it is that they feel hatred towards you. They will understand that I cannot allow their understandable feelings towards you to influence my approach to sentence.

The sentence for murder is life imprisonment. It remains for me to determine the minimum term which you must serve before you can be considered for release on licence; the starting point is 15 years; I must however weigh up such aggravating

and mitigating features as exist in this case and thereafter decide the extent to which that starting point should be adjusted, whether up or down.

In mitigation, I have accepted that there is no proven intent to kill. In the context of this case it counts for very little; not because of any premeditation, which I agree cannot be equated with a campaign of sustained violence, but because of the sheer brutality and duration of this attack – itself an aggravating feature – which, had you wished to, you could have brought to an end long before Ruth's death.

I agree that whilst drunkenness at the time of your attack upon Ruth affords no mitigation, your personality had become 'degraded' through a lifetime of drugs and alcohol.

There are a number of aggravating features, to which I must have regard, whilst being careful to avoid any double-counting, in other words not taking into account an aggravating feature more than once.

First, Ruth's vulnerability; you were not responsible for it in the sense that she was clearly vulnerable when you met, and had been drinking on and off heavily for some time, and there may have been a few weeks in the early days of your relationship in which she felt better for knowing and being with you and even thought she loved you – but you compounded that vulnerability and preyed on it.

Second, the prolonged campaign of violence in the 4 weeks prior to her death; it was a campaign of physical and mental cruelty, punctuated by the threats to which I have referred, the like of which, violence and threats combined, this court has rarely if ever heard before.

Third, it is inevitable that the duration and severity of the final attack will have caused acute mental and physical suffering to Ruth before, perhaps mercifully, she succumbed to the weight of your blows. Sadly for her, her suffering was not on that occasion numbed by the effect of drink or drugs.

Fourth, this was an attack which took place in her home, albeit one to which she had no opportunity to become attached.

And finally, you are, sadly, no stranger to violence generally, and in a domestic context, in particular. I am not going to prolong my sentencing remarks by rehearsing the details of your previous convictions. But they cannot be overlooked, despite the length of time since your last offence of domestic violence. You have in truth, by this crime, forfeited your right to live in society. Whether you ever regain that right will be for others to determine. Also, in the context of this case, although it pales into insignificance, at the time you killed Ruth you were on licence following your early release from a sentence of imp imposed for an offence of robbery, and you committed this offence within hours of the imposition of a condition order for an offence of theft.

The aggravating features in my judgement aggravate by far the limited mitigation available to you.

Had you been convicted following a trial, the minimum term would have been one of 21 years; I will reduce it to 20 years to take account of your belated plea.

The sentence of the court therefore is that you go to prison for life; the minimum term which I specify is one of 20 years, less 184 days which you have served on remand; you the press and the public would do well to remember that this is not a sentence of 20yrs imprisonment; it is a sentence of life imprisonment from which you will not be considered for release by the parole board until you have served a further 19 and a half years in custody – you may care to reflect that by then, you, a man of just 52, will be well into your 70's – but you will be released then, or at any time thereafter, only if the parole board consider that you are no longer a danger to society; I have no doubt that currently you represent a very significant danger, particularly to any woman who is unfortunate enough to become a part of your life.

If and when you are released, you will remain on licence for the remainder of your life, liable to recall at any time should the home office deem it expedient so to order.

Appendix 'B'

DEFINITIONS

Domestic Violence

The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

- This can encompass but is not limited to the following types of abuse:
- psychological
- physical
- sexual

financial

emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

Therefore, the experiences of Joan fell within the various descriptions of domestic violence and abuse.

Appendix C

Multi Agency Public Protection Arrangements

This is a process through which the Police, Probation and Prison Services work together with other agencies to help reduce the re-offending behaviour of violent and sexual offenders living in the community in order to protect the public. The purpose of the arrangements is to ensure that comprehensive risk assessments are undertaken and robust risk management plans put in place. It takes advantage of co-ordinated information sharing across the agencies on each offender and ensures that appropriate resources are directed in a way that enhances public protection. There are three categories under which offenders are managed.

Registered sexual offenders	Category 1
Violent offenders	Category 2
Other Dangerous Offenders	Category 3

There are three levels of management:

Level 1 cases

Ordinary agency management level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPP meeting.

It is essential that information-sharing takes place, disclosure is considered, and there are discussions between agencies as necessary.

The Responsible Authority agencies must have arrangements in place to review cases managed at level 1 in line with their own policies and procedures. Please see the guidance document MAPPA Level 1 Ordinary Agency Management Best Practice, issued by the Offender Management and Public Protection Group in March 2011 and available on EPIC at

Level 2 cases

Cases should be managed at level 2 where the offender:

Is assessed as posing a high or very high risk of serious harm
or
The risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm,
or

The case has been previously managed at level 3 but no longer meets the criteria for level 3
or
Multi-agency management adds value to the lead agency's management of the risk of serious harm posed.

Level 3 cases

Level 3 management should be used for cases that meet the criteria for level 2 but where it is determined that the management issues require senior representation from the Responsible Authority and Duty-to-Co-operate agencies. This may be when there is a perceived need to commit significant resources at short notice or where, although not assessed as high or very high risk of serious harm, there is a high likelihood of media scrutiny or public interest in the management of the case and there is a need to ensure that public confidence in the criminal justice system is maintained.

Appendix D

Action Plans

Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	That the Ministry of Justice considers how the courts can avoid issuing electronic surveillance orders in support of bail curfews for known domestic abuse offenders, to addresses where victims of domestic abuse live.	Prepare a letter for the Ministry of Justice	The letter	Victims of domestic abuse will not have perpetrators tied to their address and this will lessen the opportunities for them to be assaulted or controlled	Jannette Maxwell Sefton Council	30.09.2016

Agency Recommendations **Merseyside Police**						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Ensure that Patrols attending at the scene of 'domestic abuse' incidents are fully aware of the dangers of speaking with a potential victim in the presence of the alleged perpetrator.	Delivery of Training through the CIC Module 1 to all first responders highlighting the requirement to speak to individuals independently Ensure Force	Merseyside Police Training Academy provides training entitled 'Coercion, Intimidation and Control'. This has been delivered to all first responders and staff involved in domestic abuse. This resulted in 1424 officers being trained through 97 sessions which included guidance to officer's in dealing with domestic abuse. All training plans have been uploaded onto PAM which is the central database which measures Merseyside Police's activity against the National Domestic Violence Action plan and the PEEL report 'Everyone's Business'. Section 4.9.1 in force DA	The increased awareness of first responders and the reinforcement of speaking to the victim and perpetrator independently should ensure that honest and truthful accounts are obtained from the victim without fear of reprisal and intimidation. This should enable Merseyside Police to increase victim satisfaction and trust in the services provided for Domestic Abuse victims.	DCI Griffith	Completed Completed

		Policy reflects the requirement for first responders to communicate with both the victim and offender separately to ensure independent accounts are obtained and allow the victim to provide an honest account without intimidation. The introduction of the automated Vulnerability form will provide a tip point when completing the form to ensure that officers	policy stipulates that both parties involved in a DA incident must be spoken to separately. Further excerpts of Force Policy Item 4.5.1e and 4.9.1 reinforce this message. The automated vulnerability form has incorporated the 'tip point' to ensure officers are reminded to speak to victims and perpetrators separately. This form is currently being piloted within the Merseyside area.			Completed

		have spoken to the parties involved independently during any report of domestic abuse.				
2	Ensure that Patrols attending at the scene of 'domestic abuse' incidents are aware of the content of the Storm log, in particular the comments of the informant. There should be evidence that such comments have been considered during the closure of a log.	The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated vulnerability form. Issue of personal	The 'Bluestar' Vulnerability Person Index is currently being trialled which allows the calls and response call taker and dispatcher to view all relevant information surrounding the caller via the telephone contact number provided. This application will provide safeguarding information and allow informed decision making regarding deployment and actions to be taken at the scene. This index will also be provided upon the automated vulnerability form currently being piloted.	The VPI will allow informed decision making and appropriate interpretation of the Storm log set against the recorded vulnerability information held by Merseyside Police on all force systems of persons involved in the incident. The personal issue laptops will allow first responders to	DCI Griffith	Completed Completed

		laptops to all first responders deployed to incidents of Domestic Abuse which will allow access to Storm. CCRD Governance Process.	Personal issue laptops have now been provided to all first responders. This laptop provides remote access to the Storm databases and provides the officer with current information and an accurate reflection of the contents of the Storm log rather than a third hand precis via a dispatcher, therefore reducing the likelihood of miscommunication CCRD staff are consistently reminded of NSIR and NCRS requirements for the updates and closure of logs. CCRD has its own 'incidents to crime' governance meeting which examines this issue and there are daily reports via the CCRD DMM which looks at all logs which include risk logs incidents,	access the actual content of a Storm log and therefore the correct interpretation and application of the contents to the situation presented. The CCRD NCRS compliance DMM will ensure regular dip sampling of Storm logs to ensure the first account provided by reporting persons and victims has been actioned correctly in line with NCRS and Force policy.		Completed Completed

		FCC QA Process	this process ensure that where allegation of a crime has been made on a log it is appropriately recorded or if not a full explanation and rationale is provided. Before closure of a log all information on the log is addressed and any allegations made should be NCRS compliant. There is a separate QA process recently been developed for dispatch whereby the supervisors will listen in to the dispatcher when they perform their role			
3	When family members report concerns for the safety of a close relative that involve alleged 'domestic abuse', then positive action must be taken. This should include a full de brief of the evidence / information held by the relative and	Ensure Force Policy reflects the requirement for third party reporting process	Force policy clearly outlines the responsibility of officers when a report is received from a third party at section 16.3. Policy instructs that this type of incident is processed in the same manner as if the report was made by the victim in	The activity undertaken and planned briefings will increase the awareness of officers and reaffirm the policy and procedure of Merseyside Police when they receive a third party report of	DCI Griffith	Completed Completed

	effective evidence gathering while at the scene, including house to house enquiries.	Increased awareness of the responsibility to be undertaken when relatives contact police to report concerns and the procedure to be followed.	person. An 'In Touch' has been created and circulated to all first responders and call handling staff to remind them with regard their responsibilities and the procedures that should be followed. A 7@7 briefing aimed at first responders and call handling staff will be prepared and circulated by the PPU and an intranet screensaver will be designed aimed at increasing awareness and reaffirming policy and procedure with regard third part reporting.	domestic abuse, including when provided through the MARAC. The circulated material will be aimed at first responders, detectives and staff employed within the FCC and provide the community with a better response to Domestic Abuse when reported through a third party.		
4	When a 'domestic abuse' incident is reported, control room supervision must ensure that the communication officer handling the call has made all necessary	The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated	The 'Bluestar' Vulnerability Person Index is currently being trialled which allows the calls and response call taker and dispatcher to view all relevant information surrounding	The VPI will allow informed decision making and appropriate interpretation of the Storm log set against the recorded	DCI Griffith (Tony Jackson JCC)	Completed

	checks of the relevant IT systems, not just the PROtect history, and informed the attending patrol of the full history of all parties concerned.	vulnerability form. CCRD Governance Process.	the caller via the telephone contact number provided. This application will provide safeguarding information and allow informed decision making regarding deployment and actions to be taken at the scene. This index will also be provided upon the automated vulnerability form currently being piloted. CCRD staff are consistently reminded of NSIR and NCRS requirements for the updates and closure of logs. CCRD has its own 'incidents to crime' governance meeting which examines this issue and there are daily reports via the CCRD DMM which looks at all logs which include risk logs incidents, this process ensure that where allegation of a crime has been made on a log it	vulnerability information held by Merseyside Police on all force systems of persons involved in the incident. The CCRD NCRS compliance DMM will ensure regular dip sampling of Storm logs to ensure the first account provided by reporting persons and victims has been actioned correctly in line with NCRS and Force policy.		Completed

			is appropriately recorded or if not a full explanation and rationale is provided. Before closure of a log all information on the log is addressed and any allegations made should be NCRS compliant. FCC supervisors have been made aware of the IMR action for progression. The Blue Star vulnerability project is due to be piloted in April 2016. this will make the necessary checks of all relevant force IT systems without the requirement for a manual check by FCC staff			
5	When a 'domestic abuse' incident is reported which is the first recorded between particular parties, this alone should not be judged as a factor to consider the incident	The application of professional judgement by first responders though the use of the Merit risk assessment.	The College of Policing are currently reviewing risk assessment processes with a conclusion in 2018. At this time Merseyside Police utilise the Merit risk assessment which provides	A more holistic view of vulnerability will be available to first responders when deployed to incidents which can appropriately inform	DCI Griffith	Completed

	as low risk. Cognisance must be taken of the 'domestic abuse' history of the parties with previous partners, particularly when they may have been risk assessed as 'Gold' or been a perpetrator of a 'Gold' victim and subject of the MARAC process .	The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated vulnerability form.	a 40 question risk assessment which promotes the use of professional judgement based upon the circumstances presented to the first responder. These circumstances allow for an elevation in score and an increase in identified risk level. In addition this can be amended through the DARAS procedure where the office manager reviewing the case can use professional judgement regarding the risk level. The new automated form will answer some of the 40 questions through the use of known data in Merseyside Police systems. The VPI will allow previous safeguarding and risk assessment levels to be relied upon when officers use their professional judgement in applying risk assessment levels and intervention	risk intervention levels. The ability to view and draw through previous safeguarding information will allow a more detailed, appropriate and informed risk assessment which can allow first responders to take cognisance of previous Gold risk assessments.		Completed

			options. The system will take data from Niche which highlights previous Gold relationship which will assist in RA process.			
6	All calls for service that initiate as domestic incidents, should be monitored and subject to scrutiny by control room supervision. The relevant Storm log must be endorsed by the supervisor to ensure compliance.	Control Room Staff Audit CCRD Governance process	There is a separate QA process recently been developed for dispatch whereby the supervisors will listen in to the dispatcher when they perform their role. CCRD staff are consistently reminded of NSIR and NCRS requirements for the updates and closure of logs. CCRD has its own 'incidents to crime' governance meeting which examines this issue and there are daily reports via the CCRD DMM which looks at all logs which include risk logs incidents, this process ensure that where allegation of a crime has been made on a log it	The process will quality assure the actions of the dispatcher to ensure the pertinent information is passed to the first responder to allow them to take informed and accurate assessment and actions at the scene of a Domestic Violence incident. The CCRD NCRS compliance DMM will ensure regular dip sampling of Storm logs to ensure the first account provided by reporting persons	DCI Griffith (Tiny Jackson FCC)	Completed Completed

			is appropriately recorded or if not a full explanation and rationale is provided. Before closure of a log all information on the log is addressed and any allegations made should be NCRS compliant	and victims has been actioned correctly in line with NCRS and Force policy.		
7	A patrol supervisor should be informed when a 'domestic abuse' incident is reported and his or her details recorded on the Storm log. The supervisor should ensure that a VPRF 1 is submitted prior to the end of the tour of duty, having quality assured it and having appended his or her name and signature.	The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated vulnerability form will negate the requirement for this recommendation.	Due to the volume of vulnerability forms being completed and processed Merseyside Police initiated an IT solution which improves data quality and risk assessment process through the use of an intuitive application that can utilise known information on all Merseyside Police systems. Any incomplete forms will be subject to auditing through the creation of a daily report in Corvus. The automated system will make	The automated form will improve data quality and risk assessment process through the integration of police information systems.	DCI Griffith	Completed

			fields mandatory and provide legislative and procedural tip points negating the requirement for quality assurance as information previously cleansed will be relied upon and therefore direct the officer accordingly. When a GOLD victim of DA reports a new allegation the CIM is notified. The Blue Star vulnerability project will ensure that any initiated form is completed prior to the end of duty or become subject to a daily report generated through Corvus and then discussed for compliance at the area DMM. Currently the VPRF1 is to be signed by the officer's supervisor before they go off duty.			

National Probation Service						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	A more investigative approach to be taken (by offender managers) in terms of Offenders with Domestic violence backgrounds. Regular FCIU checks to be undertaken regardless of whether an offender reports to being in a current relationship	The Development of practice guidance regarding the management of Domestic Violence Cases The development of an audit tool to enable monitoring and feedback on such cases	A copy of the Practice guidance and audit tool to be shared with the board Sample feedback from monthly audits (which will be undertaken by the area MAPPA coordinator and Risk Lead)	Increased awareness in respect of any potential relationships developing Greater management oversight in respect of audit completions and feedback	Tracey Lloyd (District Manager) Risk Lead. Area safeguarding lead to provide feedback to board	Completed
2	Checks to be made to Prison establishment regarding visits/contact with unknown females when those with a DV history are in custody	This practice to be embedded via the implementation of the above practice guidance	As Above	As above	Tracey Lloyd (District Manager) Risk Lead	Completed

	..				Area safeguarding lead to provide feedback to the board	
3	Increased Management oversight and discussion of Level 1 MAPPA cases with a view to increasing the level of MAPPA management if required	The implementation of the MAPPA 1 review process as previously outlined The process to be shared with Offender Managers and Team Managers at team and Cluster meetings	Copies of new processes to be shared and explained to board members	More Effective management of MAPPA level 1 cases with timely referral into active MAPPA management if required Increased management oversight	Tracey Lloyd (District Manager) Risk Lead Jayne Phillips MAPPA coordinator	Completed

	Lifeline					
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Lifeline Sefton workers should always use the same file when an individual starts a new treatment episode, rather than closing one file and re-opening another, to ensure continuity and a full treatment history within a single file.	All staff to be informed of the requirement at a team meeting. Line managers to monitor on a monthly basis that all newly opened case files are for clients who have not previously accessed Lifeline STARS Safeguarding and governance lead to receive reports from line managers to confirm this	Minutes of briefing session at which the requirement was introduced Summaries of monitoring activity	Case files for individuals who have had several 'treatment episodes' should be more complete, and picture of an individual's progress, needs and risks over time	Safeguarding and Governance Lead	Completed
2	The service should lead a reflective practice session with the	Session to be organized	Email sent to staff team	Better understanding of	Safeguarding and	Completed

	team, focussing on working with couples when both are known to the service. Key questions for practitioners to consider should include: In what circumstances is it appropriate to follow-up independently something that one partner has told the service about the other? How should we best record risks relating to the clients in each other's files when both are known to us? – How do we manage this for newly established couples?	and facilitated Outcomes and learning from session to be typed up and circulated to the team	containing outcomes and learning from the reflective practice session	assessing and managing risk when working with couples who are both known to the service. Increased awareness of possible risk 'flags' requiring follow-up from staff	Governance Lead	

Southport and Ormskirk Hospitals NHS Trust

No	Issue	Recommended Action	Lead	Measure of Success	Date for Completion	Progress	Current Red Amber Green	Date Completed
1	Immediate domestic abuse awareness and training for the following areas: A&E department EAU 11B HALT team	The adults at risk team will provide concise training to all areas on the subject of domestic abuse. The E Reader will be given to all staff and followed up with face to face training Training Log will be provided Training materials will also be provided Incidents will be monitored to ensure that staff	Director of Nursing and Quality Safeguarding Adults Nurse	Staff awareness will be improved in this area. Increased referrals to the AAR team for this issue More referrals through MARAC for this issue Improved patient safety and experience Upload the training onto DATIX	Feb 16			

		are aware and not missing opportunities for reporting						
2	Staff do not understand the significance of MARAC; Safeguarding Adults Policy was and is not clear on processes / expectations Staff do not recognise the significant risk when a patient reports a threat to kill/ know what the process are when a knife crime is The guidance regarding reporting of gun and knife crime will be circulated to key areas and will be included in the relevant safeguarding policies	Policy will be fit for purpose – to include MARAC processes/ staffs duties/ Threats to kill/ knife crime –MARAC to be included within Safeguarding Training A protocol will be devised for the AAR team and A&E as to what steps should be taken following a patient being discussed at MARAC. This will include actions by the AAR team and the	Safeguarding Team	Policy reviewed Training includes MARAC Protocol devised Clear and detailed actions will be in place for any patient who is flagged on the A&E patient records system. Staff fully aware of their responsibilities No ambiguity in this area Improved	Dec 2016	The guidance regarding reporting of gun and knife crime circulated to key areas To be included in the relevant safeguarding policies (I have circulated this to training lead A&E, Consultant and Matron)- completed	Amber	Amber

		emergency care staff, both medics and nurses		patient safety Upload the training and policy onto DATIX				
3	MARAC alerts on Medway to be amended so staff realise the significance of these alerts	MARAC alerts amended so they are clear to staff Safeguarding Team	Safeguarding Team	MARAC alerts are meaningful to staff Screenshot to be uploaded	August 2016			
4	Staff must implement the Domestic Violence and Abuse Policy Clin Corp 18 Staff must receive education and training Staff need to know who puts the flag on Medway and when to do so – Who has the access to do this and whose responsibility it is.	Domestic Violence training to be delivered via the Safeguarding Training; When Domestic Violence is reported Staff must always believe what the woman is telling them patient most risk when they	Safeguarding Team	Training is deliveredd Upload the training onto DATIX	Dec 2016			

		leaving their partners Staff must interview the woman on her own in a quite private and safe area Inform the Domestic Violence lead The adults at risk team will provide concise training to all areas on the subject of domestic abuse. The E Reader will be given to all staff and followed up with face to face training						
5.	Safeguarding Adults	Safeguarding	Safeguardin	Referrals are	Dec			

	Policy CORP 77- referrals must be made in accordance with Policy – staff must check the referral has been received On admission staff should have contacted the Trusts Safeguarding Hotline (01704) 5248 and complete an incident report via DATIX. They should have contacted the Trust Safeguarding Adults Nurse Soh-tr.VulnerableAdultsTeam@nhs.net or via telephone (01704) 705248.	Adults Policy CORP 77 staff awareness and education Safeguarding Training to include referrals process	g Team	made in accordance with Policy	2016			
6	Safeguarding Adults Policy CORP 77 staff awareness and education – responsibilities/ Safeguarding and Mental Capacity Training (MCA)	Safeguarding Training to include responsibilities / capacity/ consent / body mapping of injuries	Safeguarding Team Head of Nursing The	Safeguarding Adults Policy CORP 77 is implemented and followed Staff awareness will	Dec 2016			

	All Trust staff to realise that anyone who has contact with an adult at risk and hears disclosures or allegation has a duty to pass them on appropriately When a crime has been committed capacity – consent is not relevant and the incident must be reported to the Police Injuries must be body mapped as per Policy		Associate Medical Director Urgent Care	be improved in this area. Increased referrals to the AAR team for this issue Improved patient safety and experience Upload the training onto DATIX				
7	Staff did not implement the Smoke Free Policy Corp 06 to be implemented Health Promotion occurs	Trust supports patients; we try and reduce the need for patients to go off the Ward for Cigarettes.	Head of Nursing	Smoke Free Policy Corp 06 is implemented and followed To be discussed in meetings/ huddles – upload actions	Dec 2016			

				onto DATIX				
8	The Safeguarding Adults Flow Chart contained with the Safeguarding Adults Policy CORP 77; not clear that when a crime has been committed capacity/ consent is not relevant. The Safeguarding Adults Flow Chart does not stipulate how Section 2 Papers are to be sent to the team/ staff must check they are received. There are no examples of these papers within the Policy Safeguarding Adults Policy CORP 77 Flow Chart to be amended to state Consider – Has Crime been Reported? from Has Crime Been Committed?	Flow Chart to be reviewed so it is fit for purpose – include capacity / consent when a crime had been committed / how to send: check receipt of referrals/ referral document to be included within the Policy. Safeguarding Training to include the appropriateness of capacity / consent when a crime has been committed / hoe to make a referral and the audit trail	Safeguarding Team	Flow Chart and Policy is fit for purpose Upload the Policy onto DATIX	Dec 2016			

9	Staff must follow the Protocol for the Missing Patient (CLIN CORP 76) patients go missing Risk Assessments must be completed highlighting the risks of leaving the Ward and the actions taken to mitigate the risks A "contract" needs to be considered and reinforced on the wards to protect the patient and other patient's when someone chooses to leave the ward. There should be more robust monitoring regarding patients who leave the ward area with absences documented and discussion with the patient regarding expectations on leaving	Staff must follow and implement the Protocol for the Missing Patient (CLIN CORP 76) Risk Assessments must be completed The Protocol for the Missing Patient (CLIN CORP 76) is implemented and followed / reviewed and includes the suggested Contract and Risk Assessments	Head of Nursing	The Protocol for the Missing Patient (CLIN CORP 76) is implemented and followed / reviewed and includes the suggested Contract and Risk Assessments Upload contract onto DATIX Upload the staff discussions regarding adherence to the protocol	Dec 2016			

	the ward / return to the ward / length of absence							
10	There must be greater staff awareness of the Domestic Violence lead throughout the Trust Greater awareness of the role of the Adults at Risk Team	Lead to be highlighted during Safeguarding Training Electronic Communication to staff The profile of the AAR team will be raised through a media campaign across the trust	Safeguarding Team	Awareness is raised Increased referrals to the team for all matters concerning adults at risk and their safety Upload the training onto DATIX	August 2016			
11	Domestic Violence and Abuse Policy Clin Corp 18	To include when capacity and consent is not relevant on the Flow Chart – e.g.	Domestic Violence lead	Policy is fit for purpose Upload the training onto	Dec 2016			

		when a crime has been committed Policy due for review August 2016- this incident to inform the review		DATIX				
12	Clinical Record Keeping must be adhered too – clinical records must Record the dates and the times patients leave the Wards Record why the patient has left the ward and how they were clinically on their return When nurses are concerned that patients are drinking alcohol this must be reported to the Doctor so the patient can be assessed and the issues addressed	Clinical Record Keeping must be adhered too – clinical records must reflect the episode of care	Head of Nursing	The Clinical Record Keeping is implemented and followed Upload the discussions with staff onto DATIX	August 2016			

13	Correspondence to GP The Trust must highlight the risks to GPs so they can take actions to safeguard their patients	Letters must reflect the risks and the actions taken to mitigate the risk/ highlight further actions needed	Deputy Medical Director The Associate Medical Director Urgent Care	Communication improves – patient safety maintained Upload the discussions with staff onto DATIX	August 2016			
14	Staff must complete incident forms and inform the Police when visitors attend the Ward and they are subject to an injunction. The incident must be recorded in the patients clinical records and a Risk Assessment completed	Clinical Record Keeping must be adhered too – clinical records must reflect the episode of care- RM 06 Policy for the Reporting and Management of Incidents-	Head of Nursing	Communication improves – patient safety maintained Upload the discussions with staff onto DATIX	August 2016			
15	NICE Pathway/ Alcohol Use Disorders Pathway required Alcohol-use disorders:	The Trust has no Policy hway for Alcohol Use Disorders – Quality standards	HALT Team	Quality Care is delivered Patient Safety Maintained	Jan 2017			

	diagnosis and management quality standard. The quality standard defines clinical best practice in the care of people (aged 10 and above) drinking in a harmful way and those with alcohol dependence and should be read in full	need to be adopted		Upload the pathway				

End of Final Overview Report