# SEFTON SAFER COMMUNITIES PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# OVERVIEW REPORT-FINAL

# 'Nathaniel'

February 2016

## CONTENTS

## 1. INTRODUCTION

1.1 The principal people referred to in this report are:

| Person | Role | Relationship | Ethnicity |
|---|---|---|---|
| Nathaniel | Victim | Brother of Kristian | White British |
| Kristian | Offender | Brother of Nathaniel | White British |
| Male 1 (M1) | 1st Husband FB | Father Kristian and Nathaniel | |
| Male 2 (M2) | 2nd Husband FB | Step-father Kristian and Nathaniel | |
| Male 3 (M3) | 3rd Husband FB | 2nd Step-father Kristian and Nathaniel | |
| Female A (FA) | Spouse | Wife of Kristian | White British |
| Female B (FB) | Mother | Kristian & Nathaniel | |
| Female C (FC) | 1st Former partner & Mother of Child D | Nathaniel & Child D | |
| Female D (FD) | 2nd Former partner | Nathaniel | |
| Female E (FE) | 3rd Former partner | Nathaniel | |
| Female F (FF) | 4th Former partner | Nathaniel | |
| Female G (FG) | 5th Former partner | Nathaniel | |
| Child A,B and C | Offenders children | Children of Kristian and FA | White British |
| Victims Child | Child D | Child of Nathaniel | |

| | | | |
|---|---|---|---|
| | | and FC | |
| Victims Home | Address 1 | | |

1.2 On a Sunday in early autumn 2014 police and ambulance attended address 1. The body of Nathaniel was found in the house, he had been beaten by Kristian. Kristian was arrested and later charged with the murder of Nathaniel. He appeared before a Crown Court and pleaded guilty to the manslaughter of Nathaniel. This was accepted by the prosecution and he was sentenced to 7 years imprisonment.

## 2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

### 2.1 Decision Making

2.1.1 Sefton Safer Communities Partnership [SSCP] decided that the death of Nathaniel met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months.

2.1.3 The DHR was originally scheduled for completion on 31.05.2015. However due to a number of delays in obtaining information from agencies and further unexpected information that had to be sought, this deadline could not be met. The Chair of Sefton's Safer Communities Partnership agreed an extension until 31.08.2015. The Home Office Domestic Homicide Review Public Protection Unit was informed in writing on 21.04.2015.

### 2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair. Paul Cheeseman authored the report. Both are independent practitioner who between them have chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. Neither have been employed by any of the agencies involved with this DHR and were judged to have the experience and skills for the task. Five panel meetings were held and attendance was good with all members freely contributing 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. The Panel comprised of:

| Name | Job Title | Organisation |
|---|---|---|
| ➢ Paul Cheeseman | Author | Independent |
| ➢ David Hunter | Chair | Independent |
| ➢ Janette Maxwell | Strategic Area Manager | Sefton Metropolitan Borough Council |
| ➢ John Middleton | Detective Chief Inspector | Merseyside Police |
| ➢ Sandra Dean | Detective Inspector | Merseyside Police |
| ➢ Susan Norbury | Designated Nurse Safeguarding Adults CCG | NHS Halton Clinical Commissioning Group |
| ➢ Andrea Watts | Head of Communities | Sefton Safer |

| | | |
|---|---|---|
| | | Communities Partnership |
| ➢ Gill Ward | Chief Executive | Sefton Women's and Children's Aid |
| ➢ Bridgette Welch | Assistant Director of Nursing Safeguarding Adults | Lancashire Care NHS Foundation Trust |

## 2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- Liverpool Community Health Trust
- Lancashire Constabulary
- Merseyside Police
- GPs
- Lancashire Care NHS Foundation Trust
- Linaker Children's Centre
- Vulnerable Victims Advocacy Team Sefton Metropolitan Borough Council
- Merseycare
- Southport and Ormskirk NHS Trust
- Sefton Women's and Children's Aid
- Lancashire County Council
- NSPCC
- National Probation Service

2.3.2 Lifeline and Sefton Council Children's Services provided chronologies and relevant information when requested. When this material is used within the body of this report it is attributed accordingly.

## 2.4 Notifications and Involvement of Families

2.4.1 David Hunter wrote to the victim's mother FB and her husband and FA the wife of Kristian inviting them to contribute. He spoke to FB by telephone and met FA in person. Their views are contained within the report and attributed accordingly.

## 2.5 Terms of Reference

### 2.5.1 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;
- 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.

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

### 2.5.2 Timeframe under Review

The DHR covers the period 12.01.2006 to the homicide. The reason this date was selected was because an incident on 12.05.2006 was the first occasion on which there was a record of conflict between Nathaniel and Kristian (event 1 Appendix A).

### 2.5.3 Case Specific Terms

1. How did your agency identify and assess the domestic abuse risk indicators in this case; was the historical domestic abuse taken into account when setting the risk levels and were those levels appropriate?
2. How did you agency manage those risks and did they change in response to new information?
3. What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?
4. How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?
5. What did your agency do to safeguard any children exposed to domestic abuse?
6. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?
7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator?

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

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 and perpetrator or to work with other agencies?

## 3. DEFINITIONS

3.1 The Government definition of domestic violence which can be found at Appendix A. (Hereinafter referred to as domestic abuse). Nathaniel's experiences and his behaviour meant that he was both a victim and perpetrator of domestic abuse.

## 4. BACKGROUND NATHANIEL AND KRISTIAN

### 4.1 Nathaniel

4.1.1 Nathaniel was the eldest of two children Kristian being his younger brother. His mother FB and natural father M1 divorced not long after the birth of Kristian. This was due to the fact M1 was an alcoholic who subjected FB to domestic violence. The children had supervised access to M1 who died during 1994 at the age of 38 years, due to alcohol related problems.

4.1.2 FB married M2 in 1985. This relationship lasted for eleven years and also ended in divorce. This was also an abusive relationship with FB and both children suffering domestic violence at the hands of M2. Nathaniel received a local secondary education and had trained as a painter and decorator. However according to Kristian and FA he found it difficult to hold down work because of the problems he had with alcohol which made him unreliable. At the time of his death he was receiving disability benefits. His disability was caused when he jumped from a bridge into some shallow water and sustained a serious injury to his neck.

4.1.3 FB described Nathaniel as a "loving lad" whose personality changed after he was involved in a road traffic accident aged 11 years. He became aggressive and had a bad temper. FB recalls Nathaniel made several suicide attempts and felt that no one [health professionals] listened to her about Nathaniel's significant behavioural problems.

4.1.4 FB said that on occasions she begged professionals to "section" Nathaniel under the Mental Health Act because she felt that he was mentally ill. FB thought that the cycle of Nathaniel's offending followed by imprisonment should have been halted through "sectioning". She feels strongly that Nathaniel never received the mental health services to correct his behaviour.

4.1.5 He had several relationships with different female partners that were often tainted by domestic abuse. During one of these relationships, with FC, he fathered a son (Child D) who, at the time of Nathaniel's death, was nine years of age.

4.1.6 Nathaniel regularly abused alcohol and controlled drugs to such an extent that, according to FB he was waiting for a liver transplant. He frequently displayed aggressive and violent behaviour. He suffered from mental health issues and depression. He had also attempted to take his own life on a number of occasions.

4.1.7 Although Nathaniel was ultimately the victim of a domestic homicide, and his voice cannot be heard, it is well documented that he was a violent and disruptive individual. He inflicted assaults and injuries on many other people including members of his own family.

4.1.8 Nathaniel had been arrested or summonsed by the police on fifty two occasions for offences against the person, against property, public disorder, drugs and motoring offences. He had twenty five criminal convictions and had served several short terms of imprisonment. He had also been the subject of several supervision orders including an alcohol treatment order. At the time of his death he was on bail to the courts charged with an offence of criminal damage.

4.1.9 FB acknowledged that Nathaniel had problems with drink but also says he had periods of abstinence, always ending in relapses. In the weeks before his death

Nathaniel was drinking occasionally although during the last two weekends of his life he drank a lot; so much so that FB sometimes left the house to stay with a relative.

4.1.10 FB said that she loves both of her sons and cannot choose between them. She recognised that Nathaniel was an aggressive person and that Kristian was generally placid. She confirmed that her second husband was violent towards her and her sons.

## 4.2 Kristian

4.2.1 Kristian was seen in prison by Paul Cheeseman in the presence of his Offender Supervisor.[1]He was contrite and keen to contribute to the review. He described his childhood as difficult. His father (M1) died when he was very young. His mother married M2 and both he and Nathaniel suffered abuse at his hands as did FB. Kristian described how M2 used an old cast iron soup ladle that he used to regularly beat Nathaniel with. Kristian felt that Nathaniel's personality changed when he was about 10 years of age because of the abuse he received. As Nathaniel got older he became violent himself and turned his aggression towards Kristian. He said he didn't believe that anyone ever reported M2's behaviour towards them to an appropriate agency[2].

4.2.2 Kristian said that Nathaniel could be reasonable, although at the click of a finger he could turn violent towards other people. He said that people looked upon Nathaniel as an angry person. Later in life Kristian said there was a suggestion that Nathaniel suffered from mild schizophrenia. Kristian said that FB could not control Nathaniel's behaviour and she felt let down by services who dealt with him.

4.2.3 Although Nathaniel did not achieve academically, Kristian did and he gained seven GCSEs, two A levels and an HND. Kristian said he started to build a life for himself and moved away from his mother's house. He took employment as a support worker in mental health and between 2003 and 2006 studied for and gained a qualification as a registered mental health nurse. Laterally he worked on contracts providing nursing cover in a variety of locations. At the time of Nathaniel's death Kristian was about to set up his own business as a nursing agency.

4.2.4 Kristian said that because FB could not control Nathaniel she often rang Kristian and asked him to come round and sort Nathaniel out. When Kristian met his wife FA he said that these calls started to damage the relationship he had with her and with FB. Kristian said that Nathaniel was so violent he had assaulted all of Kristian's friends at one time or another.

4.2.5 When Nathaniel was 16 years old he moved in with his grandfather in an attempt to try and resolve his behavioural issues. Kristian said that when Nathaniel was about 17 years old he locked his grandfather out of the house. When their grandfather eventually got in he collapsed and died on the floor. Kristian was 15 and had just come home from school and both he and Nathaniel tried to revive him. Kristian felt

[1] No attempts have been made to verify Kristian's account

[2] The panel asked Merseyside Police if they could identify M2. They reported that M2 was recorded although he only had one conviction for an offence of assault occasioning bodily harm which was committed in 1984 and was now spent.

that his grandfather's death robbed Nathaniel of the only male role model he ever had.

4.2.6 Kristian also described another traumatic event in their childhood that affected him and Nathaniel. This was when M2 attempted to hang himself in front of the boys. They had to cut him down to save his life. Kristian felt that this and the behaviour of Nathaniel and FB had caused him health issues later in his life.

4.2.7 Kristian said that when Nathaniel met FC he hoped this would 'sort him out'. They had a child (D) however the relationship between Nathaniel and FC ended because of violence between them. Nathaniel was the aggressor. While Kristian thought that Nathaniel loved D he also thought Nathaniel thought alcohol was more important and he didn't appear to care about D. Following the break-up of his relationship with FC Nathaniel moved back into FB's house.

4.2.8 Kristian said that he suffered from anxiety although he only recognised this for what it was when he qualified as a nurse. He went to his GP who provided help and support and counselled Kristian personally. He did not want to attend the local mental health clinic as he was well known there professionally. Kristian said that he had abused alcohol and had used it as a coping mechanism although he was never reliant upon it. He had also used recreational drugs including cannabis, cocaine and ecstasy; he said had not used cannabis since he was 18.

4.2.9 Kristian said that Nathaniel was a very heavy drinker since he was about 13 years of age. However he did not feel Nathaniel was alcohol dependent as he would have five or six day's abstinence before returning to alcohol. Although he drank alcohol Kristian said Nathaniel did not use pubs and was not a social person and lived in his bedroom. Nathaniel smoked heroin, said Kristian, as well as using other drugs such as cocaine and ecstasy and that he funded his habit by selling cannabis to other people.

4.2.10 He said Nathaniel was in and out of trouble all the time. Kristian said that Nathaniel even smashed up FA's father's house. Kristian said he rang the police on many occasions to try and resolve issues with Nathaniel who, he felt, did not appreciate what Kristian did for him.

4.2.11 Kristian admitted he had been violent towards FA on one occasion and accepted this was domestic abuse. He said this happened when he suffered a severe episode of anxiety. He admitted striking her after she laughed at him. When FA later self-referred she told Sefton Women and Children's Aid violence had happened on more than one occasion.

4.2.12 Kristian gave an account of the events on the day he killed Nathaniel. He said he had been working in Buxton in Derbyshire. He had been staying there overnight as it was such a long way from the home he shared with FA in West Lancashire. He had argued with FA who he thought had taken cocaine. FA denied this when she was seen. He didn't want to stay at the marital home and therefore went to address 1. Here he found that Nathaniel was drunk from the night before. Kristian claimed Nathaniel had assaulted someone that night because that person had lost some cannabis belonging to him.

4.2.13 Kristian said Nathaniel demanded money from him for whisky. Kristian refused to give him anything and instead went with Nathaniel to a local pub where they

consumed 2-3 pints of beer. On the way back to address 1 Kristian said Nathaniel again demanded money for whisky. A fight then took place between them during which Kristian said he got the better of Nathaniel. This had never happened before. Kristian said Nathaniel then got a knife and came at him with it; he was petrified and Nathaniel slashed him twice with it.

4.2.14 At that point Kristian threw what money he had at Nathaniel who went to buy whisky. Kristian then went to a friend's house to get away as he hadn't slept for 16 or 17 hours. Nathaniel found him at the friend's house and told Kristian he had slashed the tyres on Kristian's car. They returned to address 1 together by taxi and Kristian went to bed as he was tired. Kristian said he was just 'nodding off' when Nathaniel came into the bedroom armed with a knife. They started fighting and Nathaniel slashed Kristian wounding him. Kristian said he fought with Nathaniel and tried to get the knife off him; it went too far and the next thing he knew the police had arrived.

4.2.15 Kristian said that when he was arrested FB was not told that Nathaniel had inflicted knife wounds on Kristian. This fact only became known to FB about six months later and Kristian said she would not accept what had actually happened. Kristian accepted he had broken the law.

4.2.16 Kristian was asked whether anything could have been done that might have prevented the homicide of Nathaniel. Kristian said he felt Nathaniel was 'as he was' and he needed some treatment such as cognitive behavioural therapy (CBT). Although Kristian was a mental health nurse he said he was never in a position to help his brother because Nathaniel would flare up if Kristian tried to offer advice.

4.2.17 Kristian said he felt Nathaniel would not engage with services; for example he had visited the Hesketh Centre[3] in connection with his mental health issues and had disengaged as soon as he received his disability living allowance. Kristian felt that Nathaniel simply would not comply and firmer action needed taking against him.

4.2.18 He felt that FB had been lenient towards Nathaniel. As an example Kristian said that Nathaniel had assaulted both FB and M3 after demanding money from them and they had both ended up at the hospital. However FB refused to support a prosecution. Kristian said the Crown Prosecution Service had proceeded with a prosecution and that FB had then written to the judge pleading for Nathaniel. He received a suspended sentence when Kristian felt he should have been imprisoned for longer. He said whenever Nathaniel did go to prison it was only for short periods.

4.2.19 FA described Kristian as someone with problems and suffering from anxiety which caused him to drink. She said when she first met Kristian he was terrified that she might meet Nathaniel. FA said that when they lived together Kristian would constantly receive calls from FB asking him to come and 'sort' Nathaniel out. According to FA she and Kristian started to argue, she knew about Kristian's background and exposure to abuse and felt she may become a victim. This eventually happened although FA said there was only one occasion she had been subjected to abuse.

[3] A mental health clinic close to address 1

4.2.20 Following this assault and after her release from hospital FA said she went to address 1 and confronted FB. She assaulted FB who called the police and told them that FA had drugs at her house. The police searched Kristian and FA's house and recovered amphetamines as a result of which she was convicted of assault and possession of drugs. These events then triggered care proceedings for her child (Child A) which FA said were triggered as a result of claims made by FB about the risks from FA and Kristian. FA said she lost custody of the child for two years.

4.2.21 FA said that following the assault on her, Kristian started to 'get a grip', started to turn his life round and stopped drinking. She said that Nathaniel had always bullied Kristian. She recalled an incident of bad behaviour when Nathaniel had threatened to 'kick off', FA told Kristian she felt he needed sorting out. According to FA, Kristian said 'If I hit him I'll end up killing him'.

4.2.22 FA said she felt Nathaniel had a classic case of personality disorder and suffered from psychosis. She didn't think Nathaniel could be helped except if he had received longer prison sentences. She said she felt that Children's Services should have done more to prevent Nathaniel having unsupervised access to Child D.

## THE FACTS BY AGENCY

### 5.1 Introduction

5.1.1 The agencies who submitted IMRs are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

### 5.2 Events Pre-12.01.2006

5.2.1 A relevant event before the start date of the DHR was on 03.01.2005 when Merseyside Police were called to the home address of Nathaniel and FC. Neighbours head a disturbance and FC shouting 'stop hitting me'. Police officers attending witnessed the argument and being unable to receive a response forced entry into the house. They spoke to Nathaniel and FC and established the argument had been verbal and no violence had been used or threatened. Child D, who was newly born, was in the house.

5.2.2 A referral was made to CS and the incident was correctly recorded as a domestic one and risk assessed as 'bronze' (see appendix B for a description of Merseyside Police domestic abuse processes and levels of risk).

5.2.3 Three further domestic incidents were recorded in May, July and August between Nathaniel and FC. On all these occasions he was the perpetrator and alcohol featured in all of them.

5.2.4 CS hold a significant amount of information concerning Nathaniel, Child D and Child D's mother and Nathaniel's former partner FC. CS records show a number of contacts with Nathaniel and FC in 2005 following domestic abuse incidents. In 2005 a decision was made to undertake a pre-birth core assessment for Child D, following which a S47[4] investigation was conducted. This resulted in a child in need plan being implemented. Because these events took place 10 years ago and files have since been migrated to a different system there is little detail in respect of these matters.

### 5.3 Merseyside Police

5.3.1 Because of the large number of occasions that Nathaniel came to the notice of Merseyside Police these events have been summarised in Appendix A. Only those incidents that are of significance are further analysed in this section.

5.3.2 Between 12.01.2006 and the date of his death there were 42 incidents involving Nathaniel that were reported to Merseyside Police. Almost without exception these occurred when Nathaniel was intoxicated. They all involved some element of violence, damage, weapons or threats of some description.

5.3.3 Thirty incidents involving Nathaniel were classified as meeting the Merseyside Police criteria of a domestic incident. On most occasions these were correctly recorded by Merseyside Police officers in accordance with their policy on domestic abuse and a risk assessment was completed. The victims of Nathaniel's abuse included his

[4] S47 of the Children Act 1989 requires the local authority, under specified circumstances, to make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote a child's welfare.

brother Kristian who is recorded as such on five occasions (Appendix A events 1, 3, 14 & 17). On one of these occasions (event 17) Nathaniel assaulted Kristian and was arrested. Although he admitted damage and assault Nathaniel was only bound over to keep the peace as the other allegations were retracted.

5.3.4 As well as Kristian, Nathaniel directed violence and threats towards his mother FB (events 2, 4, 17, 48 & 51). The most serious of these incidents (event 51) occurred on 06.05.2013 when FB and M3 returned home and found Nathaniel at address 1. He demanded money, caused damage to their property and then assaulted the couple. He was arrested and, while FB and M3 did not wish to cooperate, he was charged with offences of assault and damage. However it appears that he did not receive an immediate custodial sentence as the complainants (FB and M3) wrote to the court on Nathaniel's behalf.

5.3.5 Nathaniel also directed violence towards other females with whom he was in a relationship. The first of these was FC who bore his only known child (Child D). He damaged her property (event 7) and was involved in incidents in which he refused to let her in the house (event 9) and he punched her in the face (event 10). Neither of these resulted in any charges against Nathaniel as FC denied she had been assaulted. The relationship between FC and Nathaniel ended around 01.07.2007 and on this date she reported that Nathaniel, Kristian and another male had broken into her house and removed property. Despite them being arrested FC withdrew her complaint so no action was taken. The final incident involving the couple was event 21 when FC alleged Nathaniel might not return Child D.

5.3.6 Following his relationship with FC Nathaniel was involved in relationships with four other women (Females FD, FE, FF and FG). Again these relationships all featured events of intoxication, damage, assaults and threats. By far the most serious of these incidents occurred on 30.10.2009 (event 41) when Nathaniel lured FD back to his house where he assaulted her causing her to suffer a broken jaw for which he received a sentence of two years imprisonment.

5.3.7 He was released on 02.11.2010 and at some point between then and 03.2011 entered into a relationship with FE. Again this relationship featured arguments (event 42) and violence (event 44) although there were no complaints of assault by FE.

5.3.8 Nathaniel's final relationship was with FG with whom there was only one reported incident (event 52) in which, while travelling in a taxi, he argued with her and grabbed her. No action was taken as FG said it was only a verbal argument. However within one hour of the police attending Nathaniel had damaged the tyres of FG's daughter's boyfriend's bicycle with a knife.

5.3.9 As well as females with whom he was in a relationship Nathaniel also assaulted a female paramedic by kicking her (event 27). Nathaniel also directed violence towards male associates (events 6, 8, 13, 16 & 45). Two of these incidents involved significant levels of injury. In relation to event 13 Nathaniel was alleged to have broken the jaw of a male acquaintance. He was charged and stood trial before the Crown Court and was acquitted.

5.3.10 Potentially the most serious allegation against Nathaniel was in relation to event 16. This involved another male with whom Nathaniel had been engaged in an all-day drinking session. The male was taken to hospital and had serious head injuries.

Although he did not make a complaint at the time he later alleged that Nathaniel caused the injuries by kicking him about the head. He was not charged as the CPS believed there was insufficient evidence to convict him.

5.3.11 Kristian was involved in some incidents with Nathaniel either when he was a victim (event 17) or made reports to the police concerning Nathaniel's actions. However, although Nathaniel is the victim in this DHR, there are no records from Merseyside Police or information from third parties that Kristian assaulted or engaged in violence towards Nathaniel prior to his death.

5.3.12 Kristian and FA had a relationship that was also punctuated with violent behaviour albeit FA says he only assaulted her once. In 10.2008 the couple were involved in two events that involved the police. The first of these was event 19 when Kristian reported cause for the concern of FA. The second was event 20 when FA reported Kristian had wrecked her bedroom and she took an overdose.

5.3.13 On 29.03.2009 FA reported that Kristian had been out drinking and tried to kick the door down (event 26). This was followed on 11.04.2009 with event 28 when FA alleged Kristian assaulted her. Although Kristian was arrested and denied the matter this was the catalyst for a series of other events involving the couple and FB (event 29). This resulted in FA receiving a conviction for assault on FB and the possession of controlled drugs.

5.3.14 FA then made what appears to have been a suicide attempt following a dispute over the arrangements for the collection of Child A (event 30). This then led FA to make further reports of historic assaults on her by Kristian over the previous two years (event 31). FA agreed to give evidence against Kristian and he was interviewed and charged.

5.3.15 However on 12.06.2009 FA decided she wished to resume her relationship with Kristian and she withdrew her allegations of assault. Although the matters were discontinued at court Kristian failed to appear as he and FA had gone on holiday to Turkey (event 33).

5.3.16 A feature of this case is the involvement of children in a number of the events. Appendix A documents the occasions when this happened or was suspected. The children involved were principally child D (Nathaniel's son) and Child A (Kristian and FA's eldest daughter). There were no complaints or information that suggested either of these children had suffered assaults or neglect.

5.3.17 However there were concerns that children had been present when some of these events occurred and these events are analysed further in section 6.5.

### 5.4 Lancashire Constabulary

5.4.1 Lancashire Constabulary had one contact with Nathaniel as outlined at event 1 (Appendix A). They held no information that Kristian presented any threat to Nathaniel. There were a number of contacts between Lancashire Constabulary, Kristian and FA.

5.4.2 During the early hours of 20.01.2011 FA reported to Lancashire Constabulary that Kristian had not returned home after going into Liverpool to celebrate the end of a course. She just wanted the police to know and at 10.00hrs she reported he had returned home.

5.4.3 At 15.03 on 26.01.2011 a silent 999 call was received from the home of Kristian and FA. When re-contacted by Lancashire Constabulary, Kristian said he had rung for a taxi and must have called 999 accidentally.

5.4.4 An officer from Lancashire Constabulary Public Protection Unit attended a case conference into the unborn child (Child B) of Kristian and FA. The child was placed on a Child in Need Plan and a file retained by Public Protection Unit.

5.4.5 On 30.10.2012 a neighbour reported damage to a window at Kristian and FA's home, when officers attended the couple said it was accidental. On 26.05.2012 Kristian reported FA missing from home. She returned the following day and said she stayed with friends although refused to say who they were.

## 5.5 Sefton Multi-Agency Risk Assessment Conference

5.5.1 On 19.11.2009 Nathaniel was discussed at a Multi-Agency Risk Assessment Conference after Merseyside Police following referred the case. This related to FD (event 41 appendix A). This incident was risk assessed as Gold (High Risk) using the MERIT[5] risk tool. Details for FD, Nathaniel and Child D were circulated to partner agencies who were asked to identify from their records for any relevant information. At the meeting information was shared and actions were set for NHS Sefton and Children's Services to trace the details/location of Child D. No further incidents were reported and the case was closed on 22.11.2010.

5.5.2 Nathaniel was referred to a Multi-Agency Risk Assessment Conference by Sefton Vulnerable Victim Advocacy Team as a perpetrator of domestic abuse on FE and a Multi-Agency Risk Assessment Conference held on 04.08.2011. The risk to FE was assessed as Gold (High Risk)[6]. Agencies were again asked to search for, and provide, relevant information. At the meeting this information was shared and an action was set for Merseyside Probation (now National Probations Service) to confirm Nathaniel's Multi-Agency Public Protection Arrangements[7] status. No further incidents were reported and the case was closed on 29.08.12.

5.5.3 Merseyside Police referred Nathaniel to a Multi-Agency Risk Assessment Conference which was held on 06.12.2012 relating to FF. Again the risk to her was assessed as Gold (High Risk). Relevant information was shared at the meeting. Sefton Vulnerable Victims Advocacy Team were set an action to feedback the Multi-Agency Risk Assessment Conference concerns to FF and re-offer support. No further incidents were reported and the case was closed on 23.12.2013.

5.5.4 The final referral was by Merseyside Police and a Multi-Agency Risk Assessment Conference was on held on 30.05.2013. This related to event 51 (appendix A). This incident was risk assessed as Gold (High Risk). Information of relevance was shared at the meeting and actions set for Merseyside Probation (now National Probation Service) to feedback the result of Nathaniel's court appearance on 30.05.2013. No further incidents were reported and the case was closed by the Multi-Agency Risk Assessment Conference on 30.05.2014.

[5] MERIT is the risk assessment tool used by Merseyside Police and is described more fully at appendix B.
[6] See appendix B for a description of the way in which domestic abuse is categorised by Merseyside Police.
[7] MAPPA stands for Multi-Agency Public Protection Arrangements. It is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.

## 5.4 National Probation Service

5.4.1 National Probation Service (formerly Merseyside Probation Trust) held information in relation to Nathaniel, Kristian and FA. Nathaniel was recorded by National Probation Service as a Domestic Violence Perpetrator and assessed under their guidelines as presenting a High Risk of Harm to known persons and a medium risk to the public; he was considered a risk to children. He was managed at MAPPA Level 1 (single agency management {sometimes known as ordinary level management})[8] as a Category 2 (convicted of a violent offence) offender. Whilst under supervision he committed several offences additional to his index including violent offences.

5.4.2 Nathaniel was managed by Probation Officers, they consulted a senior probation officer at appropriate times regarding the case and in particular regarding his compliance with his order/licence. National Probation Service recognised that Nathaniel suffered from alcohol dependency and he was placed on an Alcohol Choices and Change Programme as part of his order in 2006 (event 5). He was also made subject of an Alcohol Treatment Requirement in 2013 (event 51). His dependence on alcohol was discussed throughout the period under supervision.

5.4.3 Following event 41 (Appendix A) Nathaniel was also enrolled on the Community Domestic Violence Programme as part of his sentence. He consistently refused to attend this course as he felt he had covered this work whilst in custody. The Probation Officer managing his case therefore determined that the work would be carried out on a one to one basis. Nathaniel co-operated with this approach although the programme was not completed.

5.4.4 Regular home visits were conducted as part of the supervision process and the supervising officers spoke with FB on many occasions. There was no evidence during these visits of recent domestic abuse and the relationship between Nathaniel and FB seemed stable throughout.

5.4.5 There were a number of victims of Nathaniel's domestic abuse and the focus of National Probation Service work was upon managing the risk he presented to them and on protecting those victims. National Probation Service held no information that related to Nathaniel expressing any concern for his own safety.

5.4.6 FA was supervised by National Probation Service between 28.07.2009 and 12.08.2010 following her conviction for assault on FB and possession of amphetamine (event 29 Appendix A). Her case was managed by a Probation Officer and a Probation Service Officer. National Probation Service records indicate CS were involved with the children of FA and Kristian.

5.4.7 FA told her supervising officers that she and Kristian were undertaking marriage guidance counselling and he was also seeking help for his alcohol abuse. FA was attending counselling at the Hesketh Centre, a Domestic Violence Awareness Course at Sefton Women's And Children's Aid and was also referred to Tomorrow's People, a national employment charity. Throughout the National Probation Service records there is mention of Nathaniel and FB harassing FA and Kristian.

[8] Multi Agency Public Protection Arrangements (MAPPA) Guidance 2012 V0.4: National MAPPA Team-National Offender Management Service

5.4.8 FA reported to National Probation Service that she was in fear of Nathaniel, that criminal damage had been committed at her home and that abusive text messages were being received from family members. She also reported to her supervisors that Nathaniel was on remand and further reported that he had received a custodial sentence. There is no record of the supervising officer checking whether he was known to National Probation Service. The National Probation Service author states this would have been a reasonable course of action to take given that Nathaniel was allegedly harassing FA and her family to the extent that they considered moving to another area to escape from him and FB.

5.4.9 At the time of FA's sentence the records show she was already under the care of the Hesketh Centre. She also appears to have received support in the form of signposting to several other agencies. FA took advantage of the Probation Bond scheme in order to secure a new property for the family. The National Probation Service author states there was a strong theme of FA wanting distance from Kristian's family and that she and Kristian were in fear to the extent that they both suffered from mental health difficulties.

5.4.10 The National Probation Service author has concerns about the fact that officers supervising Nathaniel and FA were unaware they were supervising members of the same family despite FA being very open about Nathaniel's criminality and the fact he was recorded on National Probation Service systems. There are also concerns about a failure to adopt an investigative approach and carry out checks with other agencies to share or verify information. These are discussed further in section 6.8. The panel have made separate comment at paragraph 6.5.11 about the measures put in place to protect Child D from the risks presented by Nathaniel.

## 5.5 GP Services-Nathaniel

5.5.1 Nathaniel's GP practice records contain a number of references to attendance by him with alcohol, overdose, liver and low mood issues. He is described as having a long history of impulsivity, aggression, self-harm, alcohol addiction, mood instability and poor judgment.

5.5.2 The records show that FB and M1 separated when Nathaniel was 3 year of age and that M1 was a violent alcoholic who died at 38 years of age. His stepfather (M2) was described as physically abusive towards Nathaniel who said that his childhood was 'horrendous'. On a number of occasions he told his GP he was 'embarrassed by his experiences' and that he had unresolved issues from childhood.

5.5.3 As a child he was under the care of the Child and Family Psychiatric Services. His GP records record that he drank alcohol from the age of 9 or 10 and by 2009 he was drinking 3 to 4 litres of vodka each day. He was also recorded as being a previous user of cannabis from the age of 15 and that he used cocaine and amphetamine. There are cross references to regular contact with criminal justice agencies.

5.5.4 Although there is no information to suggest that Kristian presented a risk to Nathaniel there is a comment in the GP notes, attributed to Nathaniel, that his brother was also a problem drinker and had assaulted FB. While Kristian's alcohol issues are documented the suggestion he assaulted FB is unsubstantiated.

5.5.5 Nathaniel made three presentations to his GP during the relevant period. These start with a visit on 07.03.2007 when he was stressed and depressed and was drinking eight pints each night. On 19.11.2007 he visited his GP and said he was drinking two bottles of vodka each night. He was referred for a gastrointestinal endoscopy. On 04.11.2008 his GP prescribed him medication for anger management and referred him to a psychologist. On 08.11.2009 FB wrote to Nathaniel's GP requesting he be 'sectioned[9]' before he killed himself and provided a diary of recent events of self-harm and overdoses.

5.5.6 Although Nathaniel does not appear to have attended his GP after 04.11.2008 the GP records contain numerous cross references to Nathaniel's attendance at both acute and chronic health services. These included one on 24.11.2009 from Merseycare requesting a psychologist's opinion regarding an assessment of mental capacity after he refused a liver transplant following an overdose of paracetamol.

5.5.7 On 25.06.2011 a letter was received from Southport and Ormskirk Hospital informing his GP that Nathaniel had been in an accident and suffered a significant injury to his neck and needed to wear a halo vest. The following day a further letter from North West Regional Spinal Injuries Centre stated Nathaniel was requesting removal of the halo vest. He was warned removal could be catastrophic leading to permanent paralysis to the spinal cord. However Nathaniel signed a letter accepting consequences of halo vest removal. There are then a number of cross references to him attending hospital with numbness in his fingers and pain in his spine and neck.

5.5.8 The events described at 5.5.6 & 7 were also recalled by Kristian when he was seen. As well as the alcohol and drug misuse that Nathaniel embarked upon these events support a picture of a person who seemed to have little regard for his own health and wellbeing.

## 5.6 Southport and Ormskirk NHS Trust Hospital

### *Involvement with Nathaniel*

5.6.1 During the period under review Nathaniel made eight attendances at Southport And Ormskirk NHS Trust Hospital Accident and Emergency Department (AED). On 20.09.2008 he attended with an alcohol related fit. He left without being seen and was described as being 'very aggressive'.

5.6.2 On 28.09.2008 Nathaniel attended AED with mental health problems. He was seen by the psychiatric team and discharged with a referral for alcohol and anger management services. On 09.09.2009 he attended AED after an alcoholic seizure and did not wait to be seen. The following day he returned with another seizure that was queried as a panic attack and he was discharged.

5.6.3 On 11.09.2009 Nathaniel visited AED with self-inflicted stab wounds to his chest. He had consumed alcohol and was referred to the psychiatric team. On 13.10.2009 he was admitted to hospital after having consumed 96 paracetamol tablets. He was referred to the Hesketh Centre on discharge from hospital. Later the same day Nathaniel attended AED having taken another overdose and this time was admitted to the intensive care unit.

[9] An abbreviation for compulsorily detaining a person in order to assess their mental health under S2(2) of the Mental Health Act 1983

5.6.4 His final attendance was on 31.10.2009 when he collapsed following his arrest by Merseyside Police (see event 41 appendix A). He was discharged. The Southport And Ormskirk NHS Trust Hospital IMR author highlights that the case notes of Nathaniel documented a discussion with mental health practitioners about family problems. These included the fact that he did not get on with Kristian. However there is no reference to any risk that Kristian may have posed to him.

***Involvement with Kristian***

5.6.5 Kristian had two attendances at AED for injuries to his hand (23.12.2009) and a knee (25.12.2012). These do not appear to be connected to the events considered in this report.

***Involvement with FA***

5.6.6 On 14.10.2008 FA attended AED at Southport and Ormskirk NHS Trust Hospital having taken an overdose of prescribed medicine. She left without treatment and was found to be safe and well at address 1 with FB. On 11.04.2009 FA was admitted to the observation ward following attendance at AED. She had consumed alcohol and had been assaulted by Kristian (event 28 appendix A). Referrals were made to social services.

5.6.7 With the exception of her confinement for the delivery of her three children, her last attendance at AED was on 24.04.2009 when she took an overdose. She was discharged home and a referral made to social services.

***Involvement with Children A, B, C and D***

5.6.8 Three of the children made attendances at AED for matters that were not connected to this review and there were no concerns about them. The notes of Child D contained reference to a child protection plan. The maternity booking references for the birth of Child A contained cross references to domestic abuse, drugs and alcohol issues and for Child B a cross reference to previous social care involvement due to the assault on FA by Kristian.

**Mersey Care NHS Trust**

5.6.9 Nathaniel was known to Merseycare from 06.01.2008, when he attended an arranged assessment at an Alcohol Treatment Unit. He was referred to Merseycare's Community Alcohol Team for support with a home detoxification plan. However he failed to engage and was therefore discharged from the service on 12.02.2008.

5.6.10 On 28.09.2008 Nathaniel's GP made a telephone referral requesting advice about access to a mental health assessment. This was at the request of Nathaniel who had concerns for his own mental well-being. NATHANIEL was intoxicated at that time so Merseycare was unable to conduct a mental health assessment. He was give advice given to attend accident & emergency (AED) for support.

5.6.11 Nathaniel attended AED at 03.44hrs the following morning and a mental health assessment was completed at this point. There was no evidence of a mental health diagnosis. During this assessment Nathaniel identified he had issues with anger management, anxiety and alcohol misuse. FB was present during this assessment and expressed concerns for Child D who she said was being taken to places where

Nathaniel was consuming alcohol with acquaintances. Following the assessment Nathaniel was discharged back to the care of his GP. A referral was made to CS in respect of Child D.

5.6.12 At 19.10 on 03.11.2008 Nathaniel contacted the CMT Gateway team under the influence of alcohol requesting advice. The nature of what he wanted was unclear and he was therefore advised to contact his GP.

5.6.13 Between 11.09.2009 and 13.10.2009 Nathaniel presented himself three times at AED with either deliberate self-harm injuries or overdoses with suicidal intent. These episodes were all whilst under the influence of alcohol. Nathaniel discharged himself against medical advice and did not engage in follow up mental health services.

5.6.14 In 10.2009 Nathaniel agreed to a voluntary admission to a mental health ward for full assessment, however during this period he also received a custodial sentence and was placed under the care of HMP Liverpool. Risk assessment and care plans were shared with the mental health practitioners within HMP Liverpool to ensure the mental well-being of Nathaniel. He agreed to an assessment on 17.11.2009 by an Merseycare Criminal Liaison Nurse. It was identified that he did not require an admission to an inpatient mental health ward. He was discharged from the service on 12.03.2010 and on this date received 2 years imprisonment.

5.6.15 A health care professional who is a member of the DHR panel reviewed the chronology provided by Merseycare. They are satisfied appropriate assessments appear to have taken place following the sharing of information. Nathaniel was not deemed to require prison hospital input for mental health following assessments. He was reviewed from a mental health perspective and also reviewed regarding court. The panel member concluded there was no gap in communication or assessments.

5.6.16 On 17.05.2013 Nathaniel was referred back to Merseycare by his GP regarding concerns for his mental health. His case was discussed within the Access to Care Team and a referral made to the Early Interventions Service. On 26.06.2013 Nathaniel was accepted into the EIS and commenced out-patient treatment with them.

5.6.17 There are a large number of recorded contacts personally and by telephone with Nathaniel and EIS between then and the time of his death. In summary it appeared that Nathaniel generally remained stable whilst engaged with EIS and compliant with his medication. On 20.01.2014 it was reported that Nathaniel had been abstinent from alcohol since 25.12.2013 although on 07.04.2014 he admitted to his family that he had consumed alcohol.

5.6.18 Information was shared by and between Merseycare and other agencies. Child protection issues were recorded in relation to Child D and on 06.08.2014 that Nathaniel had entered into a relationship with another service user who had children.

5.6.19 The last significant contact that Merseycare had with Nathaniel prior to his death was on 31.08.2014 at 21.00hrs. At this time their Street Car Triage attended address 1 after Nathaniel contacted the police to say that 'men were after him'. FB expressed concerns that he may not have been compliant with his medication while

she had been away on holiday. Advice was given to the family regarding who to contact if Nathaniel's condition deteriorated further.

5.6.20 Nathaniel was due to attend an appointment with EIS on 04.09.2014 but a message was received from FB to say he could not attend an appointment due to back problems. This was the last recorded contact with Nathaniel. Merseycare held no information that identified Nathaniel was at risk from Kristian or anyone else.

## 5.7 Greater Preston, Chorley and South Ribble and West Lancashire CCG

5.7.1 NATHANIEL and FA attended different surgeries in the Merseyside area before moving to the West Lancashire area. The author from Greater Preston, Chorley and South Ribble and West Lancashire CCG has included information from all relevant GPs in their IMR.

### *Involvement with Kristian*

5.7.2 Kristian attended his GP in Merseyside on 06.03.2009 complaining of stress at work. There was no suggestion from the records that he was a risk to others at this point and nothing in his past history to raise concerns. On 11.04.2009 (event 28 appendix A) he assaulted FA. After that event he attended his GP on 31.07.2009 again with stress. The GP notes indicate there were child protection issues ongoing due to Kristian's aggression and he was referred to the psychology team. Kristian did not then attend his GP for several months.

5.7.3 On 09.03.2010 in March 2010, Kristian's mental state was said to be such a concern to the family's social worker that she phoned the surgery. The GP responded by seeing Kristian the same day. Kristian described depressive symptoms and told his GP something of his own traumatic past. It was decided not to refer him urgently to the mental health team as Kristian was reluctant to attend the Hesketh Centre due to his own job in the mental health service. Instead the GP agreed to manage him at the surgery. Kristian continued to attend for follow up after this, appearing to improve with medication and time.

5.7.4 Kristian eventually attended two counselling sessions but then chose not to continue so was discharged. This was despite him telling his GP previously that the court psychiatrist had said he needed long term psychological support. The GP did not have access to this report. Presumably it had been prepared following the charges brought against him for assaulting FA that were subsequently withdrawn (event 32 appendix A).

5.7.5 The panel raised some concerns that a report prepared by a psychiatrist for the court was not subsequently made available to Kristian's GP. The panel recognise that expert reports are often produced on instructions from the defence. None the less they feel there would be value in such documents being made available to the subjects GP as they may contain new information about the condition of a patient that may be useful in treating them or assessing the risks they may pose to others. The panel has made a recommendation on this issue (Recommendation 1)

5.7.6 When he moved to West Lancashire Kristian attended his new GP practice for his patient check on 14.04.2011. He volunteered information about problems in the past including "anger issues" and previous alcohol abuse and suggested any issues were historical. After this he attended only sporadically to ask for mirtazapine and short periods off work with stress. There are no entries in the notes to suggest he

was considered a danger to others at any point. However the IMR author notes that, had the assault on FA been coded[10] on Kristian's records the issue of domestic abuse could have been scrutinised further with him. If the "perpetrator of domestic violence" code had been used this information would show on the front screen meaning that staff seeing Kristian would know that this had happened in the past and therefore be more vigilant to the possibility in the future.

***Involvement with FA***

5.7.7 On 10.01.2006 FA was referred by her GP for counselling, which she attended. She had suffered a number of traumatic events including the death of her mother and brother. She was an infrequent attender at the surgery. However her GP did receive notifications from AED and from the acute care team concerning an assault on her by Kristian (event 28 appendix A) and in relation to an overdose and mental health difficulties.

5.7.8 The GP IMR author suggests it would have been excellent practice if this information was pro-actively followed up by FA's GP. However the assault and subsequent overdose were coded as significant on her records, meaning that this information could have been easily seen by anyone accessing her notes in the future.

5.7.9 The GP surgery were invited to an initial child protection conference regarding Child A. They were not able to send anyone although they did provide a report with apologies. On moving to West Lancashire FA attended for a new patient assessment with the surgery's practice nurse on 14.04.2011. Domestic abuse was not discussed and the IMR author comments that this visit could have included specific questioning by the nurse of FA about that subject.

5.7.10 The author points out that NICE guidance recommends routine enquiry about domestic abuse in these situations. This relevant for FA as her records contained coding relating to a past history of "assault by husband". FA visited her GP on one occasion in 08.2012 when she attended with anxiety. Again domestic abuse was not considered as a contributory factor.

## 5.8 Sefton Children's Services

***Involvement with Child A***

5.8.1 Sefton Children's Services records contain comprehensive cross references relating to the allegations of assault made by FA against Kristian (event 28) and of the assault by FA on FB (event 29). The records show that information has been provided from a number of sources including Merseyside Police, a nursery and family members about the behaviour of Kristian and FA (event 30). Following these concerns Sefton Children's Services carried out an initial assessment of Child A on 17.06.2009 which led to the completion of a formal S47 investigation on 24.06.2009. Following this a child in need plan was put in place for Child A.

5.8.2 Child A eventually became a looked after child and was cared for by members of Kristian's family. Sefton Children's Services remained engaged and hosted child

[10] Coded refers to standardised codes (also used by the hospital) called READ codes which are used for the purpose of adding new diagnoses and data to a patients summary sheet. Every practice has a coding policy and specially trained staff to do this.

protection review conferences in respect of Child A until a final family court hearing on 17.03.2011 when a full care order was made and Lancashire Children's Social Care became the designated authority (see section 5.14). It appeared to the DHR panel that Sefton Children's Services took all appropriate steps in respect of Child A.

***Involvement with Child D***

5.8.3 As mentioned at paragraph 5.2.4 CS hold a significant amount of information concerning Nathaniel, Child D and Child D's mother and Nathaniel's former partner FC some of which predates the commencement date of this review. Following the implementation of a child in need plan for Child D Sefton Children's Services records show that referrals were made to them on 21.1.2006 and 02.08.2007 concerning domestic abuse between Nathaniel and FC. An initial assessment was carried out however because of system migration it is not possible to say what action was then taken.

5.8.4 On 30.09.2008 Sefton Children's Services records show that Nathaniel presented at A&E with suicidal thoughts and reported cannabis use and a long history of drunk and disorderly behaviour. It was recorded that Nathaniel had contact with Child D at weekend and this raised concerns about the possibility of neglect. Although an initial assessment was undertaken on 14.10.2008 because of system migration no further information is available about the action taken. There are then further cross entries in the records relating to Nathaniel's conviction for assault (event 36) and concerns about FC's relationship with a new partner that are not relevant to this review.

5.8.5 On 08.06.2011 the school Child D attended made a referral to Sefton Children's Services as Nathaniel collected the child while in drink. Following a strategy discussion a S47 investigation was conducted and Child D was made the subject of a child protection plan. A number of Child Protection Review Conferences were held although these centred upon FC relationship with another male and not Nathaniel. Although the information provided by Sefton Children's Services does not include the detail within the child protection plan there is a comment on 10.12.2012 that Nathaniel did not have unsupervised access to Child D. It therefore appears this was a protective measure put in place by Sefton Children's Services.

5.8.6 The child protection plan for Child D ended on 13.12.2012. On 07.05.2013 information was received by Sefton Children's Services concerning event 51 which occurred the previous day. The concern was that Child D had witnessed this incident in which Nathaniel assaulted FB and M3. An initial assessment, S47 investigation and child protection conference then followed and on 28.05.2013 Child D was again made the subject of a child protection plan due to the risk of physical harm. Although event 51 was the catalyst for these measures there were also other concerns regarding the behaviour of FC and her new partner that also heightened the risk that Child D was exposed to.

5.8.7 On 28.06.2013 a further core assessment was conducted and a decision was made to continue with child protection planning. The record notes that there were concerns that Nathaniel was chaotic and posed a risk of physical harm to Child D. However the risk was felt to be reduced by the fact that FB was responsible for supervising contact between Nathaniel and the child. On 25.06.2014 a Child Protection Review Conference took place. Child protection planning ended and a child in need plan was put in place. This decision was precipitated by the fact that

FC ceased her relationship with her then partner. However there is a note in the record that a risk assessment had been conducted in respect of Child D. This disclosed that his contact with Nathaniel was positive.

5.8.8 A further core assessment was conducted on 27.08.2014 again precipitated by an incident involving FC and her partner that is outside the scope of this DHR. A note in the records shows that Child D's contact with Nathaniel is reported to be positive and that Nathaniel was engaging well with the Hesketh Centre. This was the final entry before Nathaniel's death.

## 5.9 Lancashire Care NHS Foundation Trust

5.9.1 Lancashire Care NHS Foundation Trust had no involvement with either Nathaniel or Child D. They only provided services to Kristian, FA and their children.

5.9.2 Staff within Lancashire Care NHS Foundation Trust received information on 03.08.10 from a Health Visitor that the Looked After Child placement of Child A had broken down and the child was to be placed with their extended family within the locality. The issues relating to this family were reported to be parental alcohol and drug misuse and domestic violence. Both parents were mental health nurses and were subject to the scrutiny of their professional body, the Nursing and Midwifery Council. They were not employed by Lancashire Care NHS Foundation Trust.

5.9.3 Child A was identified as in greater need as they were in a foster placement and because of Children's Services involvement. While in the care of foster parents health assessments and care were provided by a Health visitor from Lancashire Care NHS Foundation Trust. There is no information relevant to this DHR from that period.

5.9.4 On 22.03.2011 the family court determined Child A should be returned to Kristian and FA. Lancashire Care NHS Foundation Trust offered the child the Healthy Child Programme which involved a series of visits and development checks. After transfer into Lancashire Care NHS Foundation Trust services visits were carried out in line with the Trust's policies and these reflected the needs of a LAC child. As well as visits and assessments Lancashire Care NHS Foundation Trust also attended meetings held in connection with Child A's welfare. There were no reported health concerns.

5.9.5 During the time Child A was in foster care FA gave birth to Child B. Child B was also identified as in greater need for the same reasons as Child A. Kristian and FA were reported to have been cooperative during the assessment process and addressed their issues with drug and alcohol use. An initial child protection conference held on 30.03.2011 determined Child B should be subject to a Child in Need Plan and remain in the care of Kristian and FA. They engaged with this process and cooperated fully with all professionals. The Child in Need Case for Child B was closed on 11.10.2011.

5.9.6 There were no concerns identified in respect of Child C and they were provided with the level one universal core programme. This is the standard service offered to all families within Lancashire Care NHS Foundation Trust. Lancashire Care NHS Foundation Trust had no further contact with the family after 17.03.2014. There is nothing in the records to indicate that KRISTIAN or FA were under the influence of alcohol or any other substances whilst caring for the children.

## 5.10 Liverpool Community Health

### *Involvement with Nathaniel*

5.10.1 Nathaniel was known to Liverpool Community Health for several episodes during the relevant period. On 28.09.2008 at 17.58 he made contact with the on call centre demanding to see a psychiatrist. The on call doctor discussed this request with a psychiatrist and Nathaniel was told he would be seen in AED when he had sobered up.

5.10.2 At 20.11 on 22.10.2009 Nathaniel again contacted Liverpool Community Health with upper abdominal pain and a vomiting history after an overdose paracetamol two weeks previously. He was advised he needed to be seen at the hospital however he refused to go. He was advised of the consequences and was contacted twice after the initial consultation. Each time the centre reiterated the need to attend AED. He refused and said he 'wanted morphine or something for pain". He appeared lucid and answered the telephone himself on each occasion. Liverpool Community Health were content that he had capacity and that his actions were against medical advice.

5.10.3 At 12.47 on 01.11.2009 FB contacted Liverpool Community Health and said she wanted Nathaniel 'sectioned' after he was transferred to hospital from a police station after attempting self-harm. FB was told that Liverpool Community Health could not help. FB was concerned that the doctor who had seen Nathaniel had assessed him and said he was fit to appear in court. Liverpool Community Health explained that they could not discuss the matter as they did not have Nathaniel's consent. The final contact with Nathaniel was on 14.01.2014 and was for dental pain for which an appointment was made the same day.

### *Involvement with Child D*

5.10.4 There were a significant number of Health Visiting contacts by staff from Liverpool Community Health in respect of Child D that related to their safeguarding. Only those most relevant to this DHR are discussed here.

5.10.5 On 28.10.2005 Liverpool Community Health were involved in an initial child protection conference due to previous incidents of domestic abuse between Nathaniel and FC. The named Health Visitor was to maintain regular visits and monitor the child's mental health. On 21.01.2008 a Health Visitor conducted a visit to see Child D and FC following an incident in which the child was admitted to hospital with a lacerated cornea. During that visit FC said that at the weekend Nathaniel had informed the police that 'she was a bad Mum and she beats Child D and he was covered in bruises. Her family are drug addicts'. She said she was seen by the police and Child D's clothes were removed and no evidence of bruising was found.

5.10.6 Liverpool Community Health records show that on 09.11.2009 Merseyside Police shared information with them regarding Nathaniel's assault on FD (event 4 appendix A) for which he had been remanded in custody. The next relevant information was when no response was received from Nathaniel or FC to repeated requests for pre-school health information about Child D during 08.2010 and 06.2011.

5.10.7 On 14.06.2011 a strategy meeting was held following a referral from CS. This followed an incident when Nathaniel collected Child D from school while intoxicated.

Liverpool Community Health records show that on 04.07.2011 Child D was made the subject of a child protection plan because of the likelihood of physical abuse. A School Nurse from Liverpool Community Health then attended a number of child protection case conferences and core group meetings in respect of Child D.

5.10.8 Much of the information in Liverpool Community Health records replicates information provided by other agencies that is discussed elsewhere in this report and is therefore not repeated here. However it is clear that all relevant information was shared by other agencies with Liverpool Community Health when critical events occurred that might present a risk to Child D. For example Nathaniel's assault on FA and M3 which Child D witnessed (event 51 appendix A) then triggered a strategy meeting which the School Nurse attended.

5.10.9 The main health concerns relating to Child D related to his vision. There is no evidence within their records that Child D was subjected to any physical abuse by Nathaniel with who he maintained supervised contact. Although not falling within the terms of reference for this DHR it is noteworthy that after she ended her relationship with Nathaniel, FC entered into a new relationship that involved domestic abuse. This information was fed into the child protection conferences for Child D which continued up until the point at which Nathaniel died.

### 5.11 Linaker Children's Centre

5.11.1 FC attended Linaker Children's Centre on seven occasions with Child D between 01.08.2007 and 01.12.2008. Child D was then provided with a free respite childcare placement between 01.04.2008 and 01.06.2008 while FC received support from the centre. The support she received is documented in information provided by Sefton Women's And Children's Aid.

5.11.2 In 02.2010 FA attended two sessions of a parenting course. Between 01.06.2010 and 01.20.2010 FA and Kristian attended five stay and play sessions as part of the Parenting 2000 programme. Linaker Children's Centre holds no information that indicates Kristian presented any threat to Nathaniel.

### 5.12 Lifeline

5.12.1 Lifeline is a Charity managing drug and alcohol services. Nathaniel accessed their services from 01.10.2013 having transferred from another drugs and alcohol charity (Addaction). He had been with Addaction since 09.2013 as part of an Alcohol Treatment Requirement imposed by the courts (event 51 appendix A).

5.12.2 Nathaniel attended for one to one appointments and at his last appointment on 29.11.2013 reported that he had finally achieved stability in his life by becoming abstinent but declined the offer of accessing groups. He did have times when he did not attend appointments due to poor mobility. This included the injury to his neck sustained when he jumped off a bridge.

### 5.13 Sefton Women's and Children's Aid

5.13.1 Sefton Women's And Children's Aid provides services to women, young people and children to enable families to overcome the impact of domestic abuse. Kristian, Nathaniel and Children A, B and C were not known to Sefton Women's And Children's Aid. However they did provide services to FA and Child D.

5.13.2 FA was referred to Sefton Women's And Children's Aid by Merseyside Police on 01.04.2009 and was assessed as at medium risk of harm (even 26 appendix A). A number of attempts were made to contact FA and when these failed the referral was closed.

5.13.3 On the next occasion FA self-referred to Sefton Women's And Children's Aid and on 05.05.2009 saw a member of staff from the agency. She described an incident of physical abuse by Kristian on 10.04.2009 when she says he kicked her and wrapped a wire round her neck (event 28 appendix A).

5.13.4 FA's case was referred to Multi-Agency Risk Assessment Conference because of the level of risk Kristian was believed to present to her. However the Sefton Women's And Children's Aid records do not indicate what the outcome of this referral was. On 12.06.2009 FA contacted Sefton Women's And Children's Aid and informed a member of staff that she and Kristian were resuming their relationship as he had stated he was willing to attend counselling. A check was carried out and no record was found that this case was discussed at a Multi-Agency Risk Assessment Conference meeting. As this was more than 5 years ago paper files for this case are no longer available and therefore it is not possible to confirm this with certainty. Systems have changed since this this event. A new paperless data hub system is being implemented which will allow for a more systematic approach to recording, storing and cross referencing of case information.

5.13.5 Although FA withdrew her complaints of assault against Kristian she continued to work with Sefton Women's And Children's Aid and attended a number of sessions of a Domestic Abuse Awareness Course arranged by them. Sefton Women's And Children's Aid continued to support FA until 16.06.2010 by which time she had completed that course and was attending sessions on parenting activities. Throughout the time FA was engaged with Sefton Women's And Children's Aid, members of staff from there were involved in attending care planning meetings in relation to Child A.

5.13.6 Child D was identified as a child living with domestic abuse as a result of FC's relationship with Nathaniel. A child protection review meeting was held on 11.11.2011. As a result of this Sefton Women's And Children's Aid provided support to Child D to help them identify, explore and address any worries or concerns they had. There was then significant engagement by staff from Sefton Women's And Children's Aid with Child D, his school and other agencies in relation to his protection.

5.13.7 On 15.05.2013 Sefton Women's And Children's Aid received a further referral in relation to concerns that Nathaniel had resumed his relationship with FC and in relation to the assault upon FA and M3 by Nathaniel (event 51 appendix A).

5.13.8 Sefton Women's And Children's Aid staff continued to engage with other agencies and with Child D in order to gain his wishes and feelings regarding contact with Nathaniel, FA and M3. This work continued until 08.01.2014 when Child D's file was closed. By this time he had completed a personal plan and had a support network. He talked positively about his relationship with Nathaniel, FA and M3 and outlined the people he would feel comfortable talking to about his worries and how to make contact with them.

## 5.14 NSPCC

5.14.1 NSPCC supplied information relating to the attendance of Kristian on a 'No-Excuses' domestic abuse perpetrators programme. He was referred by Sefton Social Care on 11.12.2009 due to a history of domestic abuse in his relationship with FA. During a number of meetings he and FA had with members of staff from the NSPCC, as well as discussing their own relationship, they disclosed the violent behaviour of Nathaniel. FA said in one meeting on 31.03.2010 that Nathaniel, who was at that time was in prison, had threatened to kill them on his release. Kristian also described an incident in which Nathaniel had tried to strangle a previous girlfriend Kristian lived with. Nathaniel had used an electrical cord and it appeared this matter had not resulted in any charges. There is no record of such an incident in any of the agency IMRs so it is not possible to verify if this assault took place.

5.14.2 NSPCC continued to have contact with Kristian and FA. Kristian successfully completed the 'No-Excuses' programme and his case was closed on 07.03.2011. The panel felt it was important to note that, at the time 'No-Excuses' represented one of few opportunities available for male perpetrators to attend a programme that sought to address their behaviour. However the panel were not able to come to a view as to whether attendance on the programme actually worked for Kristian as he was subsequently convicted of the manslaughter of Nathaniel in circumstance that amounted to domestic abuse.

## 5.15 Lancashire Children's Social Care

5.15.1 On 30.07.2010 Lancashire Children's Social Care was notified by Sefton Children's Social Care that Child A was subject to an Interim Care Order and was residing in Lancashire with extended maternal family members. This was in accordance with statutory requirements.

5.15.2 On 17.01.2011 Lancashire Children's Social Care received a referral from the Midwifery Service. FA was pregnant with Child B and services were aware of Child A's previous removal from their parent's care. A statutory assessment and Initial Child Protection Conference was arranged. This was held on 30.03.2011 and was attended by relevant agencies. It was agreed a Child Protection Plan was not required and that support would be provided to Child B under a Child In Need Plan.

5.15.3 From 18.03.2011 Lancashire County Council assumed case responsibility for Child A, who was a looked after child having been made subject to a Care Order by the court. Lancashire therefore shared parental responsibility for Child A with Kristian and FA. Lancashire Children's Social Care were aware of the alcohol, drug misuse and domestic violence that led to Child A's removal. During the period the case was open to Lancashire Children's Social Care there was no evidence of the original concerns.

5.15.4 However, there were two occasions when potential concerns were highlighted. On 02.03.2012 a Social Worker received information that an undesirable person was staying at the home of Kristian and that he appeared to be losing weight which had been a concern previously when he was using drugs. It was also reported that FA may be presenting as depressed. The second incident related to an unannounced statutory visit on the 27.04.2012 when an undesirable male with a history of offending and drug misuse was present in the home of Kristian and FA.

5.15.5 Child A was returned to the full-time care of FA and Kristian under home placement regulations on the 04.04.2011. FA and Kristian were cooperative with Lancashire Children's Social Care staff and engaged fully in making positive changes to their respective lifestyles and parenting skills.

5.15.6 A Looked After Child Review was held in respect of Child A on 19.04.2012. A recommendation was made that Lancashire Children's Social Care hold a multi-agency planning meeting to discuss and consider discharging the Care Order in respect of Child A. Kristian and FA had fully cooperated and adhered to the Care Plan. The Home Placement had been in place for over twelve months and there were no concerns in respect of Kristian or FA's care of the children.

5.15.7 When Child C was born Lancashire Children's Social Care did not conduct an assessment due to the positive progress made by Kristian and FA and there being no concerns in relation to Children A and B. On 25.06.2013 the court granted discharge of the Care Order and Child A ceased to be a looked after child. The Child In Need Plan was closed on the same day.

5.15.8 Neither Nathaniel nor Child D were known to Lancashire Children's Social Care. The only reference in Lancashire Children's Social Care records is within the Care Plan that Child A must not have contact with Nathaniel. However, given that stipulation, the Lancashire Children's Social Care IMR author believes the reasons for this stipulation and an assessment of the risk posed by Nathaniel should have been recorded on Child A's case file. Whilst there is a risk assessment, it does not clarify what the perceived risk was nor how this was to be managed. The views of the paternal grandmother (FB) should also have been recorded given that Nathaniel lived with her and she was having contact with Child A. This should have informed a judgement about her ability to protect Child A.

## 6. ANALYSIS AGAINST THE TERMS OF REFERENCE

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

### 6.1 How did your agency identify and assess the domestic abuse risk indicators in this case; was the historical domestic abuse taken into account when setting the risk levels and were those levels appropriate?

6.1.1 Nathaniel is the victim in this case. However he had a history of aggressive and violent behaviour almost always involving excessive consumption of alcohol. Consequently he was never considered to be at risk from anyone other than himself (with one exception due to a recording error). Warning signs were correctly recorded on the Police National Computer that identified him as presenting risks to police officers and others in respect of 'alcohol' and 'violence'

6.1.2 Merseyside Police recorded Nathaniel as the perpetrator of domestic abuse on thirty five occasions; his victims included females he was in a relationships with as well as his mother FB. During thirty of those incidents he was under the influence of alcohol and on thirteen of them he caused injury to victims or inflicted damage. The two exceptions when Nathaniel was considered to be a victim relate to events 9 and 10 (appendix A) when Nathaniel was involved in domestic abuse with FC. At that time she was his sixteen year old girlfriend and pregnant. It has been identified in respect of the event on 03.01.2005 that a recording error resulted in Nathaniel being shown as the victim.

6.1.3 Kristian was recorded by Merseyside Police as the perpetrator of domestic abuse on four occasions on each of which his wife FA was the victim. A record held on the Merseyside Police PROtect[11] system contained a warning sign for violence. Kristian was intoxicated during three of these incidents all of which were classified as low level. On one occasion (event 28 appendix A)) he physically assaulted FA although she later retracted the allegation. Sefton Women's And Children's Aid also identified the risk of domestic abuse posed by Kristian as a result of FA self-referring to them. They also identified Child D was a child living with domestic abuse as a result of a referral from CS.

6.1.4 Paradoxically Kristian was recorded by Merseyside Police as being the victim of domestic abuse on four occasions at the hands of his brother Nathaniel. These were all recorded as low level incidents and only one (event 17 appendix A) involved a physical assault by Nathaniel on Kristian. One two other occasions (events 30 appendix A) Kristian was recorded as the victim of domestic abuse with FA recorded as the perpetrator. There are no occasions on which any agency held any information that Kristian had perpetrated or presented a risk of domestic abuse to Nathaniel.

6.1.5 Although other agencies held information about domestic abuse between Nathaniel and FA this had either already been shared with them by Merseyside Police, or, that

[11] 'PROtect' – Merseyside Police Family Crime Investigation Unit (FCIU) system on which all incidents of 'domestic abuse' are recorded.

agency satisfied itself the information was shared. (i.e. FA's attendance at Southport And Ormskirk NHS Trust Hospital with injuries following event 28).

6.1.6 Lancashire Care NHS Foundation Trust identified that their records do not show routine enquiry was made into domestic abuse at every contact with FA. Current operating procedures now require this as expected practice. However when the IMR author interviewed the Health Visitors involved they said they did discuss and ask about domestic abuse. The issue is therefore one of inadequate record keeping.

6.1.7 The GP IMR author identified that in respect of Kristian and FA there was a general lack of inquisitiveness and no routine questioning about domestic abuse.

### 6.2 How did your agency manage those risks and did they change in response to new information?

6.2.1 No agencies held any information to indicate that Kristian presented a risk to Nathaniel. Therefore there were no opportunities for any agencies to manage any risk in respect of their relationship. In respect of Nathaniel as the perpetrator of domestic abuse on other persons the risks appear to have been correctly identified and managed by Merseyside Police. Where risk has changed there has been an appropriate increase in the assessment and categorisation.

6.2.2 In relation to Kristian as a perpetrator of domestic abuse it appears that the risks he presented were solely towards his wife FA. All of these risks were correctly identified and appropriately managed by Merseyside Police and other agencies. Both Kristian as the perpetrator and FA as the victim appear to have engaged with services. FA attended programmes designed for victims to help them identify and minimise the risks she faced. Kristian willingly attended programmes designed to ensure that perpetrators addressed their behaviour. Both Kristian and FA attended parenting classes and counselling the result of which was that they resumed their relationship and there were no further reports of domestic abuse.

6.2.3 Sefton Women's And Children's Aid did identify there were some gaps in the information they recorded in respect of their contact with FA. There are gaps relate to evidence of processes and lack of clarity of information. However there is no indication that these gaps impacted upon the level of risk that FA was exposed to or that the risk was not properly managed

### 6.3 What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

6.3.1 Both Nathaniel and Kristian were known to a large number of statutory and voluntary agencies including two police forces, National Probation Service, GPs, acute and chronic health agencies, domestic abuse advisory services and drugs and alcohol services. There were a significant number of contacts which are set out in section 5. Overall the services provided to them were proportion. Some IMR authors have identified areas where improvements could be made and these are highlighted below. However it should be stressed that none of these were of such significance that they would have altered the outcome of events.

6.3.2 Merseyside Police noted that a number of the internal domestic incident referral forms completed in respect of Nathaniel when he was a perpetrator, included a 'tick box' indication that he had mental health issues. Although these boxes had been ticked, it did not appear that Merseyside Police staff then made attempts to confirm these mental health issues with other agencies. Had they done so then a warning sign of 'mental health' could have made on his PROtect record held by Merseyside Police. This may have prompted risk assessors to consider a referral. At the time of writing this report Merseyside Police does not mandate a referral under these circumstances. However it is recognised that doing so is best practise and this requirement will shortly become part of a 'minimum standard' of intervention for Merseyside Police. In this case NATHANIEL was already well known to health agencies and at times was receiving treatment so the lack of referral by Merseyside Police did not alter the care he was receiving.

6.3.3 Sefton Women's And Children's Aid identified that the services they provided were proportionate and did alter as a result of a change in risk. For example Sefton Women's And Children's Aid completed a Merit risk assessment in respect of FA on 27.05.2009. As a result of this they made a referral to the vulnerable victims team. This was in order for FA to access further safety planning and security assessments on her property.

6.3.4 Southport And Ormskirk NHS Trust Hospital identified that the services they provided to Nathaniel in respect of mental health were appropriate, documented and that follow up was provided. Although there had been claims that Nathaniel should be 'sectioned' (for example by FB) Southport And Ormskirk NHS Trust Hospital identified that Nathaniel had mental capacity. Despite the levels of care provided to Nathaniel on some occasions he self-discharged from Southport And Ormskirk NHS Trust Hospital against medical advice.

6.3.5 Mersey Care Trust (Merseycare) contact with Nathaniel was in respect of his mental health condition and this included an assessment of risks to himself and others. They found that all relevant and appropriate assessments and an updated treatment, care plan and risk assessments were in place. A Mental Capacity Act assessment was completed on 15.10.2009 in relation to Nathaniel's refusal to accept medical intervention in relation to a liver transplant. This was conducted by a Merseycare consultant psychiatrist. They found that Nathaniel did have capacity to make this decision.

### 6.4 How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?

6.4.1 Although he was the victim in this case and his voice cannot be heard it is beyond any doubt that Nathaniel was a violent person who had a long record of offending towards others including female partners, friends and family members. There is an absence of any meaningful remorse for his actions, any moderation in his behaviour or any recognition that it was anti-social and unacceptable. Sadly Nathaniel showed little if any consideration towards his victims or those who cared for him, including the agencies that tried to work with him.

6.4.2 On the other hand his family appeared to care about him and seem to have been prepared to forgive his shortcomings in the belief that he might one day change.

For example when they had been the victims of violence or aggression they later retracted their complaints in order to avoid a prosecution against Nathaniel (for example events 17 and 51 appendix A).

6.4.3 In respect of the latter event, while FB and M3 provided statements, they refused to include the detail of what Nathaniel actually did to them. They also made it clear that they would not support any prosecution against him, stipulating that he needed treatment rather than punishment. The advice of the CPS was sought and a prosecution authorised without the assistance of FB and M3. That decision demonstrated that, while the wishes and feelings of the victims were important, ultimately Nathaniel's behaviour had to be addressed through the criminal justice system.

6.4.4 That decision resulted in Nathaniel pleading guilty. Despite that, FB and M3 then wrote and persuaded the court not to impose a custodial sentence. Instead he was offered treatment for alcohol abuse. While that was the victims wishes Kristian believed that what they did was wrong. He felt that Nathaniel had reached the point at which a custodial sentence was the only meaningful option.

6.4.5 No agencies, or the DHR Panel, identified any shortcomings in the manner in which they ascertained the feelings and wishes of Nathaniel, Kristian, FA or any other individuals involved in this case.

### 6.5 What did your agency do to safeguard any children exposed to domestic abuse?

6.5.1 When police officers attended domestic incidents as set out in Appendix A they recorded the details of the persons that were present. On ten of these occasions there is a record that children were present. It is unclear on three occasions whether a child was present. When a child was present the police officers that attended took steps to ensure they were safe.

6.5.2 Merseyside Police officers recognised that all of the children exposed to abusive behaviour by Nathaniel or Kristian were potentially at risk. Officers therefore took the appropriate steps of ensuring the child's details were recorded and referred to children's services. The Merseyside Police IMR author has identified this did not happen on a few occasions (events 10, 21, 26 appendix A). The author has established this was due to a misunderstanding, at the risk assessing stage, of when a child should be referred. However they are satisfied it did not give rise to missed opportunities to safeguard a child as the particular child in question was already being monitored by agencies due to previously referred incidents.

6.5.3 In an effort to provide direction and consistency to the referring process, Merseyside Police has introduced a pilot scheme in the Liverpool South Policing Area. The scheme is focused on conducting a risk assessment of any 'domestic incident' that involves children (and vulnerable people). It uses a traffic light approach to dealing with the perceived risk from such assessments.

6.5.4 National Probation Service identified that during their supervision of FA they became aware that Child A had been removed from her and Kristian's care because of their volatile relationship. They were also aware of concerns that were raised regarding Child A's care by their foster carer's family. There is no evidence that NSP

officers contacted children's services or Merseyside Police to confirm or follow up this information. The case has therefore identified concerns for National Probation Service around officers employing an investigative approach to the information they are given by service users. This is particularly relevant in this DHR as both Nathaniel and FA's cases contained domestic abuse markers.

6.5.5 The Lancashire Children's Social Care IMR author did not identify any issues or practice which had a negative impact on the safety and well-being of children A, B or C. However there were some areas of learning. One of these related to the decision of the pre-birth Initial Child Protection Conference that Child B did not require safeguarding under a Child Protection Plan. Whilst this did not impact on the outcomes for Child B it did highlight an inconsistency in the application of thresholds. Furthermore, regular Child in Need Reviews should have been held to review the Child in Need Plan in respect of Child B in accordance with Lancashire Children's Social Care procedures. The decision to close the records in respect of Child B was also considered as premature.

6.5.6 There were also some gaps in recording relating to risk assessment in respect of Nathaniel which were insufficiently detailed. Although the social worker involved followed up reports of an 'undesirable' adult at the home of Kristian and FA this was not recorded on the case file. Previous serious case reviews have highlighted the issue of 'absent parents' and in particular the issue of unassessed males as a risk factor. Whilst both parents in this case were assessed within the care proceedings the IMR author believes more regular observations should have been made of Kristian's care of the children. He was often absent when visits were carried out. In respect of Child C it is felt that an assessment should have been completed prior to the decision being made to close the case to Lancashire Children's Social CARE because of a third baby coming into the family and the potential impact on Kristian and FA's parenting.

6.5.7 Lancashire Care NHS Foundation Trust found that the Health Visitor for child C was unaware of the previous history of domestic abuse and FA did not disclose this when asked at the primary visit. Their IMR author believes that routine enquiry at every core contact was an opportunity missed in order to fully assess the risks posed to Child A, B and C.

6.5.8 Sefton CS records show extensive contact with Nathaniel, FC and Child D. Referrals were received on a number of occasions relating to Nathaniel's violent relationship with FC. As a result of this Child D was made the subject of a child in need plan before birth. While their relationship ceased in 2007 Nathaniel continued to have access to Child D. It appears that when CS received referrals in relation to concerns these were assessed and on most occasions led to core assessments, S47 reviews and Child Protection Review conferences.

6.5.9 Matters are complicated by the fact that, following the cessation of her relationship with Nathaniel, FC entered into another violent relationship. CS were therefore dealing with risks to Child D from both Nathaniel and from this new relationship. It is outside the scope of this panel to comment upon their effectiveness in respect of the risks that arose from the relationship between FC and her new partner.

6.5.10 In respect of the risk from Nathaniel, the protective measure in place for Child D appeared to be that he did not have unsupervised contact with his father. It seems

these measures were not effective as on 06.05.2013 Nathaniel assaulted FB while Child D was present (event 51). The panel felt that, following this event, FB was then vulnerable while in the presence of Nathaniel. This therefore significantly reduced FB's ability to continue to act as a protective measure for Child D.

### 6.6 How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?

6.6.1 Merseyside Police worked closely with other criminal justice agencies such as the courts, National Probation Service and CPS. Information was shared between those agencies that resulted in Nathaniel being subjected to a number of criminal justice sanctions aimed at addressing his behaviour when intoxicated. These included an alcohol choices and changes programme, fitting him with a security tag and sentences which required alcohol treatment as well as a rehabilitation course recommendation in respect of a drinking and driving offence (imposed on 29/04/2005 and outside the timescale of this DHR). Unfortunately inter-agency cooperation was let down by the fact that Nathaniel chose to reject these opportunities on most occasions (i.e. by removing the tag, and continuing to drink excessively).

6.6.2 The Merseyside Police author has considered whether information held by the force could have been shared with other agencies outside the criminal justice family. The IMR author notes that, while there was a considerable amount of information held by Merseyside Police concerning Nathaniel (particularly in respect of violence, mental health issues and misuse of alcohol) the force did not refer him to other agencies for these issues.

6.6.3 The reason for this is that Merseyside Police list interventions for each category of risk at 'gold', 'silver' and 'bronze' levels (See appendix B). These interventions are intended as a list of considerations designed to differentiate between the levels and reduce the amount of work being undertaken at 'bronze' level. The sheer volume of incidents reported at that level would otherwise be unmanageable without some form of filtration system.

6.6.4 In this case, most of the incidents involving Nathaniel were classed as low level and therefore required a 'bronze' approach. Consequently no mandatory referral to another agency was required. The menu of interventions is not exhaustive and Merseyside Police policy states that any appropriate action that could reduce the risk to the victim should be considered. However in this case, as Nathaniel was already known to health and drug and alcohol agencies, the fact Merseyside Police did not refer him is not a significant shortcoming and did no effect the treatment he was given or the opportunities he was provided to access help.

6.6.5 In respect of Kristian, the GP IMR author states that no care plans were shared with the GP with respect to domestic abuse or child protection. Having been invited to the case conference and sending a report the author would have expected the practice to follow up and ask for the decision sheet. None the less the IMR author believes the fact the GP was invited to the conference is commendable and believes this should become standard practice.

6.6.6 The GP IMR author also identified difficulties in the communication between the social worker dealing with Kristian's mental health and his GP. While considerable effort was made by both to communicate by phone they kept missing each other and this led to delays. The author suggest an alternative means of communication such as secure e-mail should be considered.

6.6.7 No other agency identified shortcomings in relation to sharing information and many commented upon the good practice in this case in respect of the continuous liaison between professionals at various levels.

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

6.7.1 As a minimum, services have a legal obligation to ensure they do not discriminate against people on the grounds of age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment (Equality Act 2010). Based upon what was known about Nathaniel, Kristian and FA the panel are satisfied that agencies took account of these criteria when assessing and delivering services.

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

6.8.1 Domestic abuse cases involving Nathaniel as the perpetrator were referred to a Multi-Agency Risk Assessment Conference on four occasions. On each occasion the protocols and practices in place appear to have been followed and no gaps have been identified. As there were no incidents of abusive behaviour by Kristian towards Nathaniel he was never the subject of a Multi-Agency Risk Assessment Conference. The risk Kristian presented to FA was recorded as low. Although Sefton Women's And Children's Aid made a referral there is uncertainty as to whether this was discussed at a Multi-Agency Risk Assessment Conference. (See comments at paragraph 5.13.4).

6.8.2 Nathaniel was recorded by National Probation Service as a Domestic Violence Perpetrator and assessed under their guidelines as presenting a High Risk of Harm and was considered a risk to children. He was MAPPA registered as a Level 1 (single agency management) Category 2 (convicted of a violent offence) offender. The only gap identified by National Probation Service was that they were not aware that FA was also being managed by them as part of a community order.

6.8.3 FA provided National Probation Service with information that Nathaniel and FB were harassing her and Kristian. It does not appear that the supervising officers from National Probation Service made enquiries to establish who Nathaniel was and, had they done so, they would have identified him as a MAPPA subject. In addition FA gave information to National Probation Service that Nathaniel had attempted to take his own life. Again no attempt was made to corroborate this information. Consequently an opportunity was lost to gather important information about Nathaniel and cross reference it to his records.

6.8.4 Merseyside Police identified a disparity in the classification of victims and perpetrators. This could potentially impact upon whether a referral is made to Multi-Agency Risk Assessment Conference, although in this case it did not. This is a recurring theme from a previous DHR. When a Merseyside Police patrol attends at the scene of a 'domestic incident' to find that only a verbal argument has taken place, with no clear aggressor, the officers are faced with a difficult decision in establishing exactly who the perpetrator was. This occurred on some occasions in this case. The IMR author states this is exacerbated by the current procedures that require one of the parties to be recorded as the victim.

6.8.5 The Merseyside Police author states this has already been recognised as a national problem. The current draft of Approved Professional Practice, circulated by the College of Policing, makes reference to this very issue. This states that when there is doubt around, "who is the victim?" and "who is the perpetrator?", then a risk assessment should be conducted on both parties. Consideration is now being given to incorporating this guidance within a revised Merseyside Police policy on domestic abuse.

6.8.6 Sefton Women's And Children's Aid identified that the information provided by Merseyside Police on 16.04.2009 in respect of event 28 (appendix A) included the words "FA was assaulted, found unconscious and hospitalised for 2 days". The Sefton Women's And Children's Aid IMR author believes that, based upon that information, professional judgment could have been exercised and a referral to Multi Agency Risk Assessment Conference made. They identify that a similar opportunity was available when FA self-presented on 05.05.2009. (See comments at paragraph 5.13.4). While these were missed opportunities in respect of FA they were of no relevance to any risk to the victim in this DHR.

### 6.9 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?

6.9.1 The supervision and management of police patrols that attended at incidents involving Nathaniel, Kristian and FA was assessed as compliant with contemporary Merseyside Police policies and procedures. Some issues were identified in respect of supervision and management at FCIU level. These related to the endorsement of logs as requiring 'no further action' and a failure to challenge the fact that referrals to children's services should have been considered (see paragraph 6.5.2). They were not critical and did not impact upon the outcome in this case. It is considered the introduction of the pilot scheme should bridge these gaps in the future (see paragraph6.5.3). There was also evidence that on occasions Merseyside Police managers challenged omissions and ensured compliance.

6.9.2 Sefton Women's And Children's Aid found that during FA's involvement with their agency, there was no information recorded within the case file relating to discussions between practitioners and managers. During FA's engagement with Sefton Women's And Children's Aid it was agency practice to maintain separate supervision notes. Since 2013, all case discussions and issues or actions raised during supervision, both with individuals and within a group are now recorded within a service-user's file.

6.9.3 No other agencies reported any issues in respect of supervision and management.

**6.10 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 and perpetrator or to work with other agencies?**

6.10.1 Although Merseyside Police did not identify any capacity or resource issues that impacted upon this case, the IMR author has highlighted process and policy improvements introduced since some of these events. For example officers attending the scene of 'domestic incidents' must now categorise the level of risk there and then. This avoids unnecessary delay and provides instant intervention to those deemed at high risk. The Force has introduced minimum standards of investigation in relation to 'domestic abuse' incidents. These are available on the 'Niche' crime recording system and over 1500 frontline staff and supervisors have received personal briefings about the standards and their importance. Merseyside Police are also introducing the wearing of 'Body Worn Video Cameras'. These assist in cases were a witness may be reluctant to attend court. The force has also provided training to staff around the option of utilising Domestic Violence Protection Notices.

6.10.2 Sefton Women's And Children's Aid identified a number of capacity issues in relation to the numbers of children's referrals. The agency has since increased service provision for children and young people.

## 7. LESSONS IDENTIFIED

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

7.2 The DHR Lessons Identified are listed below. Each lesson is preceded by a narrative.

**Lesson 1 (**Recommendation 2 and 4 applies)

**Unfamiliar patterns of abuse**

**Narrative**

Nathaniel was murdered by his brother Kristian. There was no evidence that Kristian had ever used violence or perpetrated any other form of domestic abuse upon Nathaniel. There was evidence that Nathaniel used violence towards Kristian. In fact on occasions Kristian was seen as a protective factor and someone to whom the family could turn for help in controlling Nathaniel's behaviour. This is the second recent homicide case in the SSCP area that has involved violence between family members that were not in an intimate relationship.

**Lesson**

This was not intimate partner abuse or violence and for this reason the normal channels of referral for domestic abuse did not apply in this case.

**Lesson 2** (Recommendations 1 and 3 applies)

**Embedded Behaviours**

**Narrative**

Nathaniel and Kristian were raised in a household in which they were exposed to domestic abuse. Both experienced violence as children and, according to Kristian, Nathaniel was the target of particularly brutal assaults which involved a weapon. Kristian felt that Nathaniel's personality changed when he was about 10 years of age because of the abuse he received. As Nathaniel got older he became violent himself and turned his aggression towards others. Nathaniel consumed alcohol from an early age and eventually abused both alcohol and drugs. Kristian also abused alcohol and drugs. Nathaniel perpetrated abuse and violence on partners on numerous occasions. Kristian used violence towards FA on one occasion.

**Lesson**

Examination of the family history of Nathaniel and Kristian show these behaviours were well embedded many years ago.

**Lesson 3** (Recommendation 3 applies)

**Presence of the Toxic Trio**

**Narrative**

Nathaniel abused alcohol and drugs from an early age. Apart from some short periods of abstinence his patterns of consumption continued until his death. All the occasions he committed assaults on other people or abused partners occurred when he was intoxicated and/or had misused drugs. Nathaniel suffered with mental health problems and that appears to have impacted upon the way he behaved to others. Kristian also abused alcohol, misused drugs although to a much lesser degree than Nathaniel. On one occasion Kristian abused his wife FA. Nathaniel and Kristian had both consumed alcohol when they were engaged in a fight that ultimately resulted in NATHANIEL's death. There were concerns amongst agencies about the risk of harm to Child A and Child D because of exposure to these behaviours.

**Lesson**

The term 'Toxic Trio' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

## 8. CONCLUSIONS

8.1 Nathaniel and Kristian experienced significant trauma in their childhoods. Although they had little contact with their father (M1) he misused alcohol and perpetrated domestic abuse to which they were both exposed. The arrival of M2 within the household perpetuated that exposure. While both Nathaniel and Kristian suffered, in the words of Kristian, his brother suffered and appeared to be the focus of M2's aggression. The description by Kristian of how Nathaniel was regularly beaten by M2 with a metal soup ladle was distressing to listen to.

8.2 They also experienced other traumas such as the sudden death of a grandfather; Nathaniel's only stable male role model. They also witnessed an attempt by M2 to kill himself by hanging. According to Kristian, by the age of thirteen Nathaniel was drinking alcohol and was a violent child. Although it can never be established with certainty, based upon comments Nathaniel himself made to professionals over the years and from what Kristian recalled, Nathaniel's behaviour was the product of his childhood experiences and according to his mother, head injuries following a road accident.

8.3 Kristian faired differently and achieved academic results that were in contrast to Nathaniel. He worked hard and qualified as a mental health nurse. In Kristian's words he was 'the rose that grew through the concrete'. However despite his achievements and the fact he left home as soon as he reached adolescence Kristian never seemed to be able to separate his path from that of his brother. Nathaniel's behaviour had a profound effect on the family. He assaulted Kristian and his friends and Kristian was regularly required to return home to try and 'sort' Nathaniel out when he was intoxicated or involved in some sort of disturbance.

8.4 Kristian's mental health also suffered and, while he did not misuse alcohol to the extent that Nathaniel did, it is clear that his childhood experiences and the pressures of trying to cope with Nathaniel's behaviour affected him. As a qualified mental health nurse he recognised what was happening and sought help and engaged with professionals. In contrast Nathaniel appeared unable to address his behaviours and the direction in which his abuse of alcohol and drugs was taking him. As appendix 'A' sets out he had an appalling record of involvement in assaults on a range of people including female partners, friends, professionals and his own brother and mother.

8.5 Nathaniel was known to many agencies and his misuse of alcohol and drugs and his violent was well documented. While there are some minor issues in respect of the way in which incidents were recorded these had no impact at all on the way agencies dealt with Nathaniel. The risks he presented towards others were well known and documented and he was correctly classified as a MAPPA nominal and had been the subject of four Multi-Agency Risk Assessment Conference. Nathaniel was given every chance possible by agencies to address and modify his behaviour and yet seemed either unwilling to engage, or having engaged, to remain so. While he is the victim in this case he seemed to care as little for his own wellbeing as he did for those he abused. He was reckless in the way he considered the risks to himself. For example his misuse of alcohol and drugs, jumping from a bridge, refusing to wear the neck brace 'halo' and to be considered for a liver transplant after taking an overdose.

8.6 Agencies recognised the risk to Child D and steps were taken protect him. These included child protection plans and case reviews. Issues were complicated as the risk to Child D was not just from Nathaniel and there were risks arising from FC's new relationship. Part of the plan to reduce the risk to Child D from Nathaniel was to ensure he did not have unsupervised contact with him. However the DHR panel are concerned that, after Nathaniel assaulted FB (event 51), she continued to be entrusted with supervising his contact with Child D when she was actually vulnerable and at risk from Nathaniel as he had assaulted her. The panel believe this meant that FB was not capable of protecting Child D while he was in Nathaniel's presence.

8.7 While Kristian recognised that he had mental health and alcohol issues this did not prevent him perpetrating domestic abuse on his own wife FA. This event then triggered a series of other events that further fractured the relationships between them as a couple and with FB. These events caused child A, their eldest, to be the subject of care proceedings. While some minor shortcomings have been identified in processes it is clear that agencies acted in a coordinated and appropriate way to protect that child.

8.8 Unlike Nathaniel, Kristian appeared to recognise the consequence of his actions. After he assaulted her information was shared about his behaviour and about FA's misuse of drugs. He engaged with agencies to address his behaviour and he and his wife were reconciled. Agencies took appropriate steps to ensure that child A continued to be protected while also ensuring that she could return to the couple when it was safe to do so. Because of the historic abuse and drugs and alcohol issues careful consideration was also given to the wellbeing of child B.

8.9 Despite moving out of the neighbourhood to distance themselves from Nathaniel he continued to cast a spectre over Kristian and FA's life with FB continuing to require Kristian to intervene in his brother's behaviour. While FB's actions in trying to minimise the consequences for her son are perhaps understandable, her efforts were eventually counter-productive. As Kristian recognised, having failed to take the chances he was given, Nathaniel's behaviour really needed to be addressed through the criminal justice system.

8.10 It is clear that agencies such as Merseyside Police and the CPS recognised this and took the correct step in initiating proceedings against Nathaniel. This was despite FB and M3 unwillingness to support prosecution after they were violently assaulted by Nathaniel. However he escaped a custodial sentence after FB pleaded for him. There are indications Nathaniel responded positively to the Alcohol Treatment Order he was given. He reported himself as abstinent in 12.2013 and the frequency of incidents he was involved in declined markedly.

8.11 However the description of his intoxicated state on the day he died revealed that his abstinence was only temporary. Nathaniel always seems to have been the aggressor in their relationship and no agency held information that he was at any risk from Kristian.

8.12 Finally, although it did not form part of the terms of reference, the panel took cognisance of the fact that both FA and Kristian were trained and registered as nurses. Consequently their conduct, and their fitness to practice, was subject to investigatory processes by the Nursing and Midwifery Council (the Council) who are the professional body responsible for the registration of nurses and midwives. The

panel are satisfied that FA's conduct in relation to event 29 and Kristian's conduct in relation to 31 were known to and scrutinised by the Council who took any action they considered appropriate.

8.13 Following his conviction for manslaughter Kristian is no longer registered with the Council and he is recorded as being subject to an interim suspension order.

## 9. PREDICTABILITY/PREVENTABILITY

9.1 Even though Nathaniel is the victim in this case it is clear he was a man who misused drugs and alcohol and perpetrated violence on many people, male and female, partners, friends and family and often without any apparent reason. Given his history of behaviour and reckless lifestyle it was always a possibility that his death would not occur from natural causes.

9.2 He was a violent offender as recognised by his MAPPA classification and he presented a high risk to others. It was more likely that he would continue to be a perpetrator of domestic abuse as opposed to becoming the victim of a domestic homicide. Given the lack of any information that Kristian presented a risk towards Nathaniel it could not be predicted that he would kill him and consequently Nathaniel's death could not have been prevented.

## 10. RECOMMENDATIONS

10.1 The Agencies recommendations appear in the Action Plan at Appendix 'B'.

10.2 The DHR panel recommendations appear below and also in the Action Plan;

i. That Sefton Safer Communities Partnership (SSCP) raise with Merseyside Local Criminal Justice Board (LCJB) the issue of the disclosure of expert health reports and request the LCJB consider whether, when such reports are commissioned by the court, the defence or the prosecution, steps can be taken to ensure they are also provided to the subjects GP;

ii. SSCP work with partner agencies, and request them to review their own services in respect of domestic abuse and ensure they meet the needs of persons with similar issues to Nathaniel. In particular as a child who had himself survived abuse and as someone who suffered with drugs, alcohol and mental health problems through his adolescent and adult years.

iii. SSCP to share the findings of this review as a case study with other agencies so as to ensure they recognise the long term impact of domestic abuse on children and understand the impact it can have upon them and their behaviours as they reach maturity.

iv. SSCP ask the Home Office whether they are able to identify the profile of offenders that have committed a domestic homicide (i.e. age, sex, relationship) and whether there are any emerging patterns such as an increase in the number of siblings who commit such offences.

**Appendix A**

## Table of Key Events

| Event | Date | Nature of Event | Outcome | Recorded as Domestic Incident | Children Present |
|---|---|---|---|---|---|
| 1 | 10.05.2006<br><br>22.46 | Kristian reports to Lancs Const that Nathaniel is at his home in drink and kicking off. Concern expressed for child D and FC staying there. | Police attend. No assaults and Nathaniel compliant. He is taken to mother's house by police. | Yes | Yes-Child D |
| 2 | 11.05.2006<br><br>10.37 | Kristian reports to Merseyside Police that FB says Nathaniel is at address 1 drunk and 'kicking off'. | Merseyside Police attend. Nathaniel has left prior to their attendance. FB says this was a verbal argument only. | Yes | No |
| 3 | 11.05.2006<br><br>10.49 | Kristian contacts Lancs Const. Reports threats by Nathaniel to kill Kristian and burn house down. | Kristian believes threats are idle and only wants to bring situation to the attention of the police. | No | No |
| 4 | 11.05.2006<br><br>23.59 | Nathaniel telephones Merseyside Police from address 1. Intoxicated and incoherent. Call cut off. | FB re-contacted by Merseyside Police. She says this is only her son and she did not need police assistance. | No | No |
| 5 | 12.05.2006<br><br>12.08 | Nathaniel rings Merseyside Police and reports male with knife. Nathaniel then climbs tree armed with knife and makes threats to stab people. | Nathaniel arrested and charged with S4 POA<br><br>**12 months supervised community Order** | No | No |
| 6 | 2.09.2006<br><br>13.46 | Male friend of Nathaniel reports he was assaulted by him and | Nathaniel arrested and interviewed. He denied offence and NFA as no | No | No |

| | | | | | |
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| | | suffered facial bruising and broken tooth. | independent evidence. | | |
| 7 | 18.11.2006<br><br>18.53 | FC reports Nathaniel smashing house up and forcing her outside. | Nathaniel arrested for Breach of the Peace. Released without charge when further breach considered unlikely. | Yes | Yes-Child D |
| 8 | 31.12.2006<br><br>00.47 | Male acquaintance of Nathaniel reports being assaulted by him and damage to his flat. | Nathaniel arrested and interviewed. Admits assault and damage and is charged.<br><br>**Fined** | | |
| 9 | 12.05.2007<br><br>23.28 | FC rings Merseyside Police reports Nathaniel refusing to let her in house. | Police attend no offences disclosed and Nathaniel had left the house. | Yes | Unclear |
| 10 | 30.06.2007<br><br>13.55 | FC reports to Merseyside Police Nathaniel is drunk and has punched her in face and is refusing to let her take Child D. | Police attend. Nathaniel and FC have minor injuries although they deny any assault. Nathaniel escorted to collect belongings. | Yes-RA for FC | Yes-but no referral to CS. |
| 11 | 01.07.2007<br><br>13.55 | FC reports to Merseyside Police that Nathaniel, Kristian and a third party have broken into her house and removed property. | Nathaniel and Kristian arrested. NFA taken as FC withdrew complaint. End of relationship between FC and Nathaniel. | No | No |
| 12 | 21.10.2007<br><br>18.15 | Nathaniel stopped for speeding and arrested for driving with excess alcohol. | Failed to surrender to court and arrested on warrant.<br><br>**12 Community order (unpaid work) & 120 hours supervision (Later varied to 28 days** | No | No |

| | | | | | |
|---|---|---|---|---|---|
| | | | **imprisonment)** | | |
| 13 | 23.10.2007<br><br>21.57 | Merseyside Police receive report that Nathaniel has broken jaw of a male acquaintance. | Arrested and charged. Found not guilty after Crown Court trial. | No | No |
| 14 | 22.01.2008 | Kristian reported Nathaniel had attended his house and was drunk and smashed window. | Nathaniel arrested, interviewed and charged with damage.<br><br>**18 months conditional discharge & costs.** | Yes-Bronze RA for Kristian | No |
| 15 | 26.01.2008 | FB reports Nathaniel has assaulted a female friend of his. | Merseyside Police attend address 1. Nathaniel arrested and charged. Complaint withdrawn and NFA taken. | Yes (on review did not fit criteria for DA) | No |
| 16 | 27.02.2008<br><br>11.52 | Nathaniel arrested for previously unreported serious assault 27.07.2007. Male claimed Nathaniel lured him into park and kicked him about head during all day drinking session. | NFA on advice of CPS. | No | No |
| 17 | 03.04.2008 | FB reports damage to door at address 1 during burglary. Nathaniel returns to house, confronts Kristian and assaults him. | Nathaniel arrested and interviewed. Admits assault and damage. Subsequently retracted by FB and Kristian.<br><br>**Bound over to keep the peace.** | Yes-Bronze RA for FB. No RA found for Kristian. | No |
| 18 | 13.09.2008<br><br>22.40 | Merseyside Police receive call of disturbance and concern for safety of a female. Nathaniel arrested for | Nathaniel charged with possession of controlled drug.<br><br>**Fined £75 with costs** | No | No |

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| | | possession of amphetamine. | | | |
| 19 | 13.10.2008<br><br>23.01 | Kristian rang Merseyside Police stating that FA had left following argument & was depressed. Police did not attend as it transpired both parties had gone to the pub. | Police patrol attended on 14.10.2008 and confirmed both parties safe and well and only a verbal disagreement. | Yes. Kristian recorded as victim and FA as perpetrator. | Unclear |
| 20 | 14.10.2008<br><br>21.59 | FA reported to Merseyside Police that Kristian was wrecking her bedroom. Ambulance called as FA suspected of taking overdose. | Police attended. FA refused treatment. Verbal argument only. | Yes | No |
| 21 | 21.10.2008<br><br>17.54 | FC reports to Merseyside Police that Nathaniel has taken child D and had indicated he would not return him. Concern that Nathaniel may be in drink. | Police officers locate Child D. No indication Nathaniel in drink. Child D returned to FC who says Nathaniel had permission to take him swimming. | Yes | Yes-no CS referral for Child D. |
| 22 | 30.01.2009<br><br>12.37 | Female reports to Merseyside Police that she had been assaulted by Nathaniel who is her mother (FD's) boyfriend. | Police attend. Nathaniel in drink and arrested to prevent a breach of the peace. Neither female wished to make a complaint. | Yes | No |
| 23 | 14.02.2009<br><br>23.40 | Neighbour reports disturbance to Merseyside Police at same address as incident 22. Involving Nathaniel & FD. | Nathaniel and FD intoxicated and evidence of damage. Nathaniel arrested and charged with breach of the peace. NFA by CPS because of lack of corroboration and denials by FD. | Yes | No |
| 24 | 6.03.2009 | Report from hospital that | Nathaniel arrested. FD refused to make | Yes-FD risk assessed as | No |

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| | 22.07 | Nathaniel causing disturbance. FD attended hospital and has cuts and bruising to face. States they had been drinking all day and Nathaniel had slapped her and pulled her hair. FD alleged her face was bruised by Nathaniel who assaulted her previous week. | statement and had retracted a previous complaint. NFA on advice of CPS. | silver and referred to Vulnerable Victim Advocacy Team. | |
| 25 | 20.03.2009 | FD contacted Merseyside Police and reported Nathaniel had smashed her house up. | Police attend and see damage and blood at scene. FD did not wish to make a complaint. Nathaniel and FD had been drinking all day. Nathaniel advised not to return to FD's address. | Yes | No |
| 26 | 29.03.2009 | FA contacted Merseyside Police to report Kristian had been out drinking and was trying to kick the door in. | Police attended and FA said KRISTIAN had left and gone to his mother's. She said this was a verbal argument with no violence. Child C present and safe and well. | Yes | Yes-no referral to CS. |
| 27 | 09.04.2009<br><br>12.21 | Ambulance control reports to Merseyside Police that paramedic has been assaulted while treating Nathaniel for suspected stroke at home of FD. | Police attend Nathaniel who had kicked paramedic in the thigh. He was arrested and charged with common assault. (see event 36) | No | No |
| 28 | 11.04.2009 | FA found drunk in street and bleeding from the mouth stating she had been assaulted by | Police trace Kristian and he is arrested. When interviewed he denies offence. Agreement reached that child A would | Yes-RA for FA (Bronze) | Yes-CS referral in respect Child A |

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| | | Kristian. | live with FB. | | |
| 29 | 13.04.2009 | FB reports to Merseyside Police that FA entered address 1 and punched and scratched her leaving with Child A. FB expressed concern that FA was using drugs. | Police attended address of FA and arrested her for assault. Recovered amphetamine & cocaine. FA was charged with possession of controlled drugs and assault.<br><br>**Community Order 80 hours unpaid work & costs.** | Yes-RA for FB (Bronze). | No |
| 30 | 23.04.2009<br><br>17.18<br><br><br><br>17.41 | FA reported to Merseyside Police that she had been assaulted by Kristian outside child A's nursery when trying to collect them. Kristian contacted Merseyside Police and said he anticipated problems problem from FA who might attempt to abscond with Child A. | Arrangements were made to speak to both parties. Kristian said it had been a verbal disagreement only. When a patrol called at 08.19 hours the following day to see FA they found her in a collapsed state in what appeared to be a suicide attempt. | Yes-RA records Kristian as victim (Bronze) and FA as perpetrator. | Yes-referral made to CS. |
| 31 | 06.05.2009 | FA made allegations of several assaults on her by Kristian over last two years including the incident on 11.04.2009 when she claims he struck her and used cord to try and strangle her. | FA agreed to give evidence in court and provided victim personal statement. | | |
| 32 | 13.05.2009 | Kristian surrendered to bail regarding allegations of assault made by FA. | Interviewed and denied assaults. Charged with assault occasioning actual bodily harm on FA and bailed to court 22.06.2009. | | |

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| 33 | 12.06.2009<br><br>08.10 | FA contacted Merseyside Police and said she wished to withdraw allegations against Kristian as they wished to resume their relationship. They planned to go on holiday with Child A. | Contact made with CS triggering child protection concerns for Child D. Child D's passport seized to prevent travel. Although the assault charge was discontinued Kristian failed to appear at court.<br><br>**Kristian fined for failing to appear.** | | Yes |
| 34 | 12.06.2009<br><br>22.06 | Report to Merseyside Police that FD has been assaulted by Nathaniel. | Police attend. FD found to be in drink with facial injury. Taken to hospital and said she had verbal argument with Nathaniel. She could not say how she came by her injury and refused to make a complaint. | Yes | No |
| 35 | 13.06.2009<br><br>21.11 | Report to Merseyside Police that Nathaniel at FD house in drunken state. | Police attend and FD denied and assault had taken place and the incident was recorded as a verbal one only. | Yes | No |
| 36 | 14.06.2009<br><br>02.34 | Report to Merseyside Police that Nathaniel at address of FD 'kicking off' and had removed pane of glass and gained entry to house. | Police attend. Nathaniel arrested for damage. FD then made allegation of assault (event 34). She detailed history of repeated assaults. Nathaniel charged with S47 assault. Appeared at court and pleaded guilty to this offence and common assault on paramedic (See event 27)<br><br>**10 weeks and 8 weeks imprisonment consecutively** | | |

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| | | | **imposed 29.06.2009** | | |
| 37 | 06.08.2009<br><br>04.30 | Merseyside Police received call reporting disturbance. | Police attend address of FA who is engaged in loud argument with Nathaniel. Both described as drunk. | Yes | No |
| 38 | 07.08.2009<br><br>15.20 | Neighbour contacts Merseyside Police and reports disturbance at address of FD involving Nathaniel, FB and FD. | Police attend. Nathaniel has resumed relationship with FD and were drinking together. FB went to house and Nathaniel asked her for money. FB refused. FD had cut to eye. Conflicting accounts given and Nathaniel charged with S47 assault. Discontinued by CPS as insufficient evidence. | Yes | No |
| 39 | 09.10.2009<br><br>17.25 | A daughter of FD reports that Nathaniel is at FD's house drunk. Daughter reports Nathaniel has previously assaulted FD. | Police attend and remove Nathaniel. No offences were disclosed. | Yes | No |
| 40 | 10.10.2009<br><br>19.15 | FA reports to Merseyside Police that Nathaniel banging on door for Kristian and has damaged glass in door. | Police attend and arrested Nathaniel. He was in drink and interviewed the following day and denied damage. He was bailed and failed to re-appear. NFA on advice of evidence review officer. | Yes | No |
| 41 | 30.10.2009<br><br>23.45 | FD contacted Merseyside Police and reports Nathaniel has attacked her after luring her to his house. FD taken to hospital with | Nathaniel was arrested and charged with S18 assault after initial mental health assessment he is kept in custody. | Yes | No |

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| | | suspected broken jaw. | **Sentence to two years imprisonment on 12.03.2010. Released 02.11.2010.** | | |
| 42 | 23.03.2011<br><br>20.52 | FE contacted Merseyside Police after she had argued with Nathaniel. | Police attended. Nathaniel in relationship with FE for one week. No allegations made. | Yes | No |
| 43 | 04.07.2011<br><br>19.29 | Nathaniel contacted Merseyside Police and reported FE was in charge of her children while under the influence of drink and drugs. | Police attended home of FE. FD and children safe and well and call established as malicious. | Yes | Yes-One child of FD already on child protection plan as a result of threats from Nathaniel. |
| 44 | 15.07.2011<br><br>19.01 | FE contacted Merseyside Police to report that Nathaniel was 'kicking off'. She left to stay with friends. | Police attended. NATHANIEL had left and FE taken to her mother's house. No allegation of assault. | Yes | No |
| 45 | 28.07.2011 | Nathaniel engaged in drunken confrontation with another male and he uproots and destroys a section fencing. | Arrested, interviewed and admitted the offence of damage. Charged and appeared at court 30.08.2011 and **sentenced to seven days imprisonment concurrent to other sentences.** | No | No |
| 46 | 06.08.2011 | Nathaniel recalled to prison in respect of poor behaviour and further charges. | **Recalled to prison** | No | No |

| | | | | | |
|---|---|---|---|---|---|
| 47 | 24.12.2011 | Nathaniel arrested for being drunk and disorderly. | While in custody suite kicked one police officer and head butted another. Charged with all three offences.<br><br>**21.03.2012 Sentenced to 24 weeks imprisonment (later varied to 20 weeks)** | No | No |
| 48 | 09.06.2012<br><br>22.08 | FB reported that Nathaniel had called at address 1 drunk and demanding money. He was aggressive and would not leave. | Police attended and Nathaniel had left. Verbal argument only and no offences disclose. | Yes | No |
| 49 | 21.11.2012<br><br>15.48 | FF reported to Merseyside Police that she had verbal argument with partner of two months (Nathaniel). She said he assaulted her and damaged her telephone. | Police attended. FF would not make a complaint. | Yes | No |
| 50 | 22.11.2012<br><br>16.42 | FF contacted Merseyside Police and reported Nathaniel had made threats earlier that day and believed he would return to carry them out. | Nathaniel did not return and FF stayed with a friend to avoid a confrontation. | Yes | |
| 51 | 06.05.2013<br><br>21.11 | FB called Merseyside Police. She said she and M3 had returned home and Nathaniel had demanded money, assaulted them and damaged the | Police attended and arrested Nathaniel. FB and M3 refused to cooperate or give evidence. On advice of CPS Nathaniel was charged with assault (x2) and damage. H was kept in custody until | Yes | Yes |

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| | | house. There was as a suggestion child D witnessed the assault. | 30.05.2013.<br><br>**Sentenced to two terms of 16 weeks imprisonment suspended for 12 months. Requirement for supervision and Alcohol Treatment**<br><br>Note: Court result contained the comments that `*Reason for custody; pre-sentence report and letter from complainants considered. Assault upon his parents in their home and child present, consumed alcohol, would justify immediate custodial sentence, but persuaded by letter from complainants."* | | |
| 52 | 20.08.2013 | Taxi driver contacts Merseyside Police stating that a passenger in cab had argued with a female (FG) and had grabbed her. | A patrol attended and spoke to FG. She confirmed verbal argument only. Within 1 hour boyfriend of FG daughter reported Nathaniel had taken a knife and slashed the tyres on his bicycle. Nathaniel was arrested for criminal damage. He admitted the offence and was charged and bailed to court. (Discontinued on his death) | Yes | Unclear |
| 53 | 23.08.2013 | Nathaniel arrested for breach of bail in relation to not entering address of FF. | He was further arrested for possession of drugs after being seen to discard a small bag of green vegetable matter. He appeared before the court the same day | No | No |

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| | | | and his bail conditions in relation to incident 52 were renewed. | | |
| 54 | 01.09.2014 | A member of staff from a local hospital reported Nathaniel had visited FF in hospital the previous day and believed he was in breach of a restraining order. | Police traced FF she confirmed the restraining order was in respect of her daughter and not her. She said she wanted to end the relationship with Nathaniel although she was fearful of his reaction. | Yes | No |
| 55 | Autumn 2014<br><br>19.47 | Merseyside Police alerted by ambulance control that FB had found the body of Nathaniel at address 1. | Police attended and arrested Kristian. | | |

**Appendix 'B'**

## Definitions

### Domestic Violence and Abuse

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

2. Therefore, the experiences of FA and FD fell within the various descriptions of domestic violence and abuse.

### Risk Assessment Terms

### Merseyside Risk Identification Toolkit (MeRIT)

3. MeRIT is the risk assessment model currently by Merseyside Police and partner agencies. MeRIT is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference.

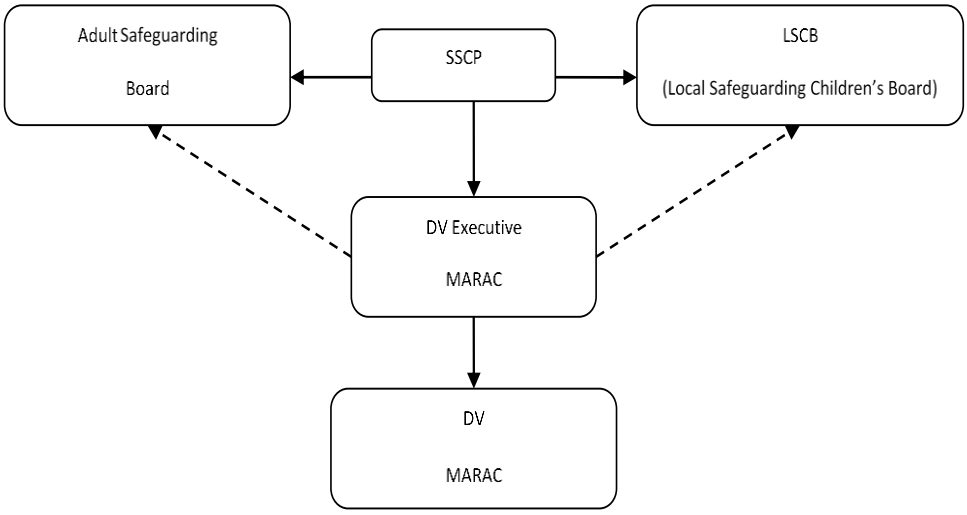
4. Police officers who attend domestic abuse incidents use the MeRIT tool to identify the level of risk faced by the victim. Information gathered, together with any additional comments by the officer are submitted to the Family Crime Investigation Unit (FCIU) using a Vulnerable Person Referral Form 1.

5. A trained assessor in the FCIU reviews and categorises the risk to the victim of abuse. The FCIU risk assesses victims of domestic abuse and categorise them as Gold, Silver or Bronze. Gold victims suffer the highest risk of further abuse which could amount to serious harm.

6. The FCIU use the information contained in the VPRF 1 document to populate a database entitled 'PROTECT' where all incidents of domestic abuse are held. During the risk assessment process the FCIU identify actions designed to reduce known risks to the victims and this can include referrals to other agencies or a multi-agency risk assessment conference.

7. Multi Agency Risk Assessment Conferences are meetings where information about high risk domestic abuse victims is shared between local agencies. By bringing all agencies together at a Multi-Agency Risk Assessment Conference, a risk focused, coordinated safety plan can be drawn up to support the victim.

**Governance arrangements in Sefton**




8. Sefton Safer Communities Partnership (SSCP) and Local Safeguarding Children's Board (LSCB) have identified Domestic Violence as a core priority recognising the significant impact upon Communities.

9. SSCP has responsibility for all crime and community safety issues in Sefton. The CSP is chaired by the Cabinet Member Safer Communities and Neighbourhoods.

10. DV Exec is a specific group to look in detail at the top level repeat cases and identify specific Multi Agency Risk Assessment Conference actions to address what is causing the repeats.

11. DV Multi Agency Risk Assessment Conferences are meetings where information about high risk domestic abuse victims is shared between local agencies and appropriate actions defined.

12. LSCB (Local Safeguarding Children's Board) is the key statutory mechanism for agreeing how organisations will cooperate to safeguard and promote the welfare of children and young people.

**Support to Victims**

13. Currently those individuals experiencing domestic violence have access to a range of support services provided through the Council and voluntary sector these include the following.

14. VVAT Support high risk domestic violence victims and all high risk sexual violence victims and all Multi Agency Risk Assessment Conference cases; provide crisis interventions, undertake full needs and risk assessment and sanctuary assessments; assist with safety and support plans and act as an advocate on behalf of the victim in dealing with other agencies. VVAT also provides support to victims of domestic abuse at any risk level.

15. Sefton Women's And Children's Aid Offer long term specialist support for women who experience domestic abuse, Refuge accommodation and children's service for children and young people who have experienced or lived with domestic violence.

16. Venus Women's organisation offering info & support (on issues such as housing, benefits, etc.), volunteering, day trips, residential.

17. Voice4Change. An Independent support and counselling service for male and female victims of Domestic Violence.

18. RASA Sefton provides essential crisis and therapeutic support to survivors of sexual violence by offering support and counselling. RASA works with all individuals who have been victims of sexual violence at any time in their lives.

19. Aspire (Sefton) Female offenders access supervision appointments within Sefton Women's And Children's Aid. Packages of support are developed by Offender managers and SWAN centre.

20. Probation perpetrator programmes. For offenders who are convicted of any offence related to violence against their partner or ex-partner.

21. NoXcuses: Approx 30 week Voluntary Perpetrator Programme facilitated by Sefton Family Support Workers. Referrals made by Social Workers. Partner support offered by Sefton Women's And Children's Aid. Currently a pilot programme. VVAT can also provide partner support for Noxcuses programme.

22. InPACT, a Knowsley based organisation, is also delivering a pilot programme in Sefton. Funded by the Police and Crime Commissioner via the Sefton Safer Communities Partnership they focus on targeting perpetrators not eligible for the Noxcuses programme. InPACT is a programme for men aged 18 or over who want to stop being violent or abusive, or look at changing their past behaviour. 26+ week group programme and individual assessments.

**Review of Domestic Abuse**

23. A sub group of the LSCB agreed a review of domestic violence should be carried out to provide an up to date picture of the key issues facing Sefton. From this a Domestic and Sexual Abuse Strategy for the next 3 years has been developed and has now been approved by Sefton Safer Communities Partnership. A Domestic Violence Executive Group is being established to take this forward, develop the action plan and to oversee the lessons learned from DHRs on an ongoing basis.

**Appendix C**

| **Panel Recommendations** | | | | | | |
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| **No.** | **Recommendation** | **Key Actions** | **Evidence** | **Key Outcomes** | **Lead Officer** | **Date** |
| 1 | Raise with Merseyside Local Criminal Justice Board (LCJB) the issue of the disclosure of expert health reports and request the LCJB consider whether, when such reports are commissioned by the court, the defence or the prosecution, steps can be taken to ensure they are also provided to the subjects GP; | Chair of the SSCP to write to the LCJB | Letter and response from LCJB | Relevant health information is shared with GPs | SSCP | March 2016 |
| 2 | Work with partner agencies, and request them to review their own services in respect of domestic abuse and ensure they meet the needs of persons with similar issues to Nathaniel. In particular as a child who had himself survived abuse and as someone who suffered with drugs, alcohol and mental health problems through his adolescent and adult years. | Mapping work with agencies to look at current domestic policies they have in place – this has already been started so review of what agencies have already done this<br><br>Support from IDVA and MARAC team around domestic abuse awareness and staff training if needed – ongoing piece of work | Mapping work completed –know what agencies have reviewed their policies<br><br>Agencies accessed training support | Agencies have appropriate policies in place which reflect the wider definition of domestic abuse and how they respond this as services.<br><br>Agencies have a clear understanding of support and referral processes in Sefton | SSCP | Mapping by March 2016<br><br>First round of training/briefings by April 2016 |

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| 3 | Share the findings of this review as a case study with other agencies so as to ensure they recognise the long term impact of domestic abuse on children and understand the impact it can have upon them and their behaviours as they reach maturity. | Work with Sefton's LSCB (Local Safeguarding Children's Board) Business Manager to share this learning across the partnership agencies | Briefing information shared<br><br>Case study built into training/awareness raising sessions | Increased awareness of the impact of domestic abuse on children | SSCP | March 2016 |
| 4 | Ask the Home Office whether they are able to identify the profile of offenders that have committed a domestic homicide (i.e. age, sex, relationship) and whether there are any emerging patterns such as an increase in the number of siblings who commit such offences. | Chair of the SSCP to write to the Home Office | Letter and response from Home Office | Shared learning around any trends nationally emerging DHRs | SSCP | March 2016 |

**Appendix D**

| **Agency Recommendations Merseyside Police** | | | | | | |
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| **No.** | **Recommendation** | **Key Actions** | **Evidence** | **Key Outcomes** | **Lead Officer** | **Date** |
| 1 | When it is identified that a person involved in a 'domestic incident', is suspected of suffering with mental health issues, then that person must be referred to Adult Social Services. | Merseyside Police Force policy will be amended to ensure that all persons suffering mental health issues are referred to Adult Social Care | Force DA policy | The number of referrals to Adult Social Care will increase | DCI Middleton | 01/05/15 |
| 2 | When dealing with repeated low key 'domestic incidents' that involve alcohol abuse as a continued factor, then interventions and referrals to other agencies must be considered. | A briefing document highlighting the need to make enquiries with DA perpetrators around voluntary attendance at alcohol programmes is to be circulated to front-line staff. This is to include instruction on Alcohol Treatment Orders should the perpetrator be convicted of an offence. | Briefing document and Force DA policy | Increase in referrals to alcohol programmes and requests for Alcohol Treatment Orders | DCI Middleton | 01/05/15 |
| 3 | Consider changes to the manner in which the Force records the part played by individual parties involved in 'domestic incidents' to encompass the situation when there is no clear victim or perpetrator. | The situation in relation to conducting a risk assessment on both parties (when it is not clear who is the perpetrator/victim) is to be discussed during the consultation process for the | Force Policy | Risk assessments conducted for both parties when it is not clear who is the perpetrator and who is victim. | DCI Middleton | 01/05/15 |

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| | | new DA policy. | | | | |
| **Agency Recommendations GPs** | | | | | | |
| **No.** | **Recommendation** | **Key Actions** | **Evidence** | **Key Outcomes** | **Lead Officer** | **Date** |
| 1 | (NEW) GPs and practice nurses to embed routine questioning about domestic abuse into consultations – particularly in ante natal and post-natal situations and in mental health presentations. | NICE guidance to be summarised and sent to practice safeguarding leads for implementation within their practices. | Training materials | Increased awareness of domestic abuse indicators and risk assessments. | LW | 1/5/15 |
| 2 | REVIEW<br>Practice to ensure that safeguarding concerns are routinely considered for the "child behind the adult", particularly when toxic trio risk factors are present in the adult they are seeing (or reading correspondence about) | Practice to consider in-house meeting to discuss – with facilitation from safeguarding team if the practice wish. | Assurance from practice that this has been done | Revision of safeguarding training. | Practice safeguarding lead | 1/7/15 |
| 3 | REVIEW<br>The practice to ensure that when coding child protection issues that the other family's records are also coded. | Practice to consider in-house meeting to discuss – with facilitation from safeguarding team if the practice wish. | Assurance from practice that this has been done | Improved accuracy of records will aid practitioners when dealing with family members. | Practice safeguarding lead | 1/7/15 |
| **Agency Recommendations Lancashire Care NHS Foundation Trust** | | | | | | |

| No. | Recommendation | Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
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| 1 | Increase awareness of routine enquiry into domestic abuse across the service and Network in line with NICE Guidance February 2014 | Support attendance at domestic abuse awareness training of identified staff in children and families.<br><br>Review standard operating procedure for core contacts to ensure that routine enquiry is recommended at each core contact and that this recorded and a rationale for noncompliance is recorded in records.<br><br>Provide briefings regarding routine enquiry and advice re review of historical records if available. | Monitor take up of training of domestic abuse awareness.<br><br>Standard operating procedure assured and ratified | Increased awareness of domestic abuse for key staff<br><br>Routine enquiry will be embedded in practice | Service Integration Managers and Domestic Abuse Lead | July 2015 |

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| | | LCT Dom Abuse action plan 2015.doc | Briefing re team information boards regarding routine enquiry of domestic abuse. | Briefing on team information boards | | |
| 2 | Share information from post incident review across Children and Family Network via governance arrangements. | Learning will be shared with teams in the Universal service line via the lessons learnt agenda item on the governance agendas from senior management to team level. The review will also be shared via the Quality and Safety meeting at which all the service lines are present and the lessons learnt shared in their governance meetings.<br><br>Dare to Share Events to be organised across the Trust to disseminate the information. Dare to share | Evidence will be available from minutes of meetings | Increased awareness of staff across the Network regarding domestic homicide review and lessons learnt | Debra Wilson<br><br>Clinical Leads | July 2015 |

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| | | is part of the Networks governance arrangements to ensure all lessons learnt from any reviews are shared with practitioners | Dates for Dare to Share available and staff invited to attend | Increased awareness of staff across the Network regarding lessons learnt | Debra Wilson Clinical Lead<br><br>Jo Counsell Named Nurse | September 2015 |
| **Agency Recommendations Southport and Ormskirk NHS Trust** | | | | | | |
| **No.** | **Recommendation** | **Key Actions** | **Evidence** | **Key Outcomes** | **Lead Officer** | **Date** |
| 1 | Alerts for domestic violence victims | Comparison of what was in place for domestic violence victims in 2009 and now. | Safeguarding referrals for domestic violence through DATIX<br><br>Training both Children and Adult safeguarding | Vulnerable adults flagged and appropriately referred to services | Adults at risk team | April 2015 |

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| | | | awareness | | | |
| **Agency Recommendations SEFTON WOMEN'S AND CHILDREN'S AID** | | | | | | |
| **No.** | **Recommendation** | **Key Actions** | **Evidence** | **Key Outcomes** | **Lead Officer** | **Date** |
| 1 | Ensure appropriate recording is in place.<br><br>A particular emphasis on accurate recording of professionals involved in the case, response to risk, sharing information in a timely manner, evidence of information shared, and achieved outcomes. | Review current system of recording information.<br><br>Delivery of case management training<br><br>To ensure consistent input of information. | Team meeting minutes.<br><br>monitoring reports produced by Case management system.<br><br>Case file audit records. | Increased awareness for staff and managers of expected standard of record keeping.<br><br>Installation of Case management system.<br><br>Review of Policy and procedure relating to case management system and recording of information. | CEO and Management team | December 2015. |

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| 2 | Effective recording of management oversight and case discussion | Review existing arrangements<br><br>Review current policy and procedure<br><br>Develop new policy and procedure if appropriate. | Case file audit notes.<br><br>Policy in place<br><br>Minutes of Meeting | Improved evidence in ways in which practitioners respond to change, risk, need etc. | CEO | Review by Dec 2015<br><br>Policy by March 2016. |
| 3 | Share learning from agency and Homicide Review. | Share findings and areas of concern. | Minutes of meetings.<br><br>Case file audit | Consistent and improved standard of record keeping.<br><br>Team report increased awareness of | CEO and Management team | Initial findings shared with team members within team meeting and group |

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| | | | records. | agency standard. | | supervision relating to case file recording.<br><br>Completed 04/02/15.<br><br>Wider learning by Dec 2015. |
| **Agency Recommendations Southport and Ormskirk NHS Trust** | | | | | | |
| **No.** | **Recommendation** | **Key Actions** | **Evidence** | **Key Outcomes** | **Lead Officer** | **Date** |
| 1 | That a briefing is completed in relation to the learning from this IMR which is shared with all Team and Practice Managers within Lancashire Children's Social Care for inclusion on team briefings with front-line practitioners. In particular this will highlight:<br><br>• The need for accurate and clear recording in relation to the action taken when following up any safeguarding concerns. | Briefing completed and sent to Head of CSC.<br><br>Briefing to be included on the agenda for IRO and CSC Cluster Meetings to consider the learning. | Team Brief document distributed to all managers within CSC.<br><br>Minutes of IRO and CSC Cluster Meetings. | Increased awareness of recording requirements.<br><br>Improved quality of risk assessments.<br><br>More robust assessments of home placements. | Sally Allen, Safeguarding Manager<br><br>Diane Booth Head of CSC | 31/05/15 |

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| | • That risk assessments must clearly identify the risk posed by an adult to a child and how this will be managed, in order to ensure children are appropriately safeguarded.<br>• The requirement that Social Workers regularly see both parents as part of their ongoing assessment of the safety and well-being of children subject to home placement arrangements.<br>• The need to undertake an assessment of siblings of the same household where a child is subject to home placement regulations.<br>• The requirement to hold Child in Need Reviews in accordance with procedural requirements and to hold a Child in Need Review where consideration is being given to stepping down the case to universal services. | | | Child in Need Reviews held in accordance with procedural requirements.<br><br>Appropriate decision making in Child Protection Conferences. | | |
| 2 | The learning from this IMR will be shared with IROs at a team learning and development event. Specific consideration to be given to decision making in child protection conferences and the criteria for making a child subject to a Child Protection Plan. | IRO Learning and Development Event to be arranged. IRO attendance to be mandatory. | Agenda and Record of IRO Learning & Development Event.<br><br>Learning from this DHR discussed at | Increased awareness of IRO responsibilities in relation to developing the Child in Need Plan when ceasing a Child | Sally Allen, Safeguarding Manager | 31/07/2015 |

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| | | | IRO Team Meeting. | Protection Plan at conference.<br><br>Improved quality of Child In Need Plans. | | |

End of Final