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A Domestic Homicide Review

'Domestic Homicide Review 2 '

The Overview Report

March 2015

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1 Introduction

1.1 Summary of the circumstances leading to the review

1. This Domestic Homicide Review concerns the murder of 30 year old the victim by 58 year old the perpetrator in March 2011. The perpetrator was convicted of murder in October 2012 and sentenced to 15 years imprisonment.

2. The victim had met the perpetrator about eight weeks before she died. The victim had moved in with the perpetrator soon afterwards. About two weeks before she died, the victim's sibling had first noticed bruising on her legs and ribs. Although her sibling tried to encourage the victim to leave the perpetrator she was frightened of him and he had threatened her if she left him. Further information about the relationship and about the domestic abuse is provided in later sections of this report.

3. The perpetrator has a history of domestic abuse and violence from previous relationships although had only been arrested on one occasion for domestic abuse. He had been arrested for assaults on a previous partner. He punched her in the face in the street. On another occasion he verbally abused and assaulted another woman and knocked her unconscious. He had also cut up a previous partner's clothes after they had an argument.

4. The perpetrator has also assaulted police officers including those who responded to the emergency call made by a neighbour during the fatal attack on the Victim.

1.2 Reason for conducting a Domestic Homicide Review in this case

5. The circumstances under which a Domestic Homicide Review must be carried out are described in legislation and national guidance. The relevant legal requirement is the Domestic Violence, Crime & Victims Act (2004) Section 9 that came into force on the 13th April 2011. The national guidance is described in *Multi-agency statutory guidance for the conduct of domestic homicide reviews* that was revised in 2013.

6. A domestic homicide review has to analyse the circumstances in which the death of person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or a member of the same household as themselves.

7. The circumstances of The Victim's death were referred to the Domestic Homicide Review Standing Group and discussed on the 18th April 2012. That

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meeting made the decision that the circumstances met the criteria for a Domestic Homicide Review.

1.3 The purpose of the Domestic Homicide Review

8. The purpose of a Domestic Homicide Review as stated in the statutory guidance is to:

    a) 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;

    b) 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;

    c) Apply these lessons to service responses including changes to policies and procedures as appropriate; and

    d) Prevent domestic violence homicide and improve service responses for all domestic violence victims through improved intra and inter-agency working.

9. Domestic Homicide Reviews are not inquiries into how the victim died or into who is culpable; that is a matter for the coroner and the criminal court respectively, to determine as appropriate. Domestic Homicide Reviews are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a Domestic Homicide Review indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the Domestic Homicide Review process. Alternatively, some Domestic Homicide Reviews may be conducted concurrently with (but separate to) disciplinary action. The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions.

1.4 The terms of reference and key lines of enquiry

10. The national guidance describes generic terms of reference that provide a context for the development of more case specific key lines of enquiry and learning that are described.

<u>Recognition</u>

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i. What knowledge/information did your agency have that indicated the victim might be subjected to domestic violence and how did your agency respond to information including that provided by other agencies.

Services provided

ii. What services did your agency offered to the victim were they accessible, appropriate and sympathetic to her needs?

Using and Sharing Information

iii. What information and/or concerns did the victim's family and friends have about victimisation and what did they do?

Knowledge about the perpetrator as a violent perpetrator

iv. What knowledge did your agency have that indicated the perpetrator might be a perpetrator of domestic violence?

The capacity and resources of services

v. Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim, the alleged perpetrator or any other members of the family and also impacted on the agency's ability to work effectively with other agencies?

Learning from Domestic Homicide Reviews and other review processes

vi. Consider relevant research or evidence from previous reviews conducted locally, regionally or nationally; consideration may also be given to evidence from other Community Safety Partnerships, LSCBs or evaluations of reviews. Take into account any common themes and actions arising from that research and those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case.

vii. Consider any previous reviews of single agency practice. Take into account any common themes and actions arising from those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case.

11. Each of the key lines of enquiry was accompanied by additional prompts for the agencies and their authors to consider when undertaking their agency review. For example, authors were asked to consider whether any information known to their services should have led to a different response and to consider the significant contributory factors that influenced how people made their decisions at the time.

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1.5 The methodology of the review including evidence from documents and interviews

12. The Domestic Homicide Review was completed using the methodology and requirements set out in government national guidance that applied at the time of the review being commissioned and completed.

13. A review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel was chaired by an appropriately senior and experienced person. An experienced and independent person has provided this overview report.

14. The panel established the identity of services in contact with the family during the time frame agreed for the review.

15. Reviews of all records and materials that were considered included;

    a) Electronic records
    b) Paper records and files
    c) Patient or family held records.

16. Agencies that identified significant background histories on family members pre-dating the scope of the review provided a brief summary account of that significant history.

17. The services that had significant involvement were required to provide an individual management review (IMR) that were completed by senior people who had no direct involvement or responsibility for the services provided. Individual management reviews were completed using the community safety partnership template and were quality assured and approved by the most senior officer of the reviewing agency.

18. The following agencies have provided an individual management review that was completed in accordance with *Multi-agency statutory guidance for the conduct of domestic homicide reviews* and any associated local guidance and relevant procedures including those of the Community Safety Partnership or Liverpool Safeguarding Children Board where appropriate:

    a) Merseyside Police
    b) Merseyside Probation
    c) St Helens and Knowsley Teaching Hospitals NHS Trust
    d) North West Ambulance Service

e) South Liverpool Homes[1]

19. Information was contributed to the chronology from other services that had less substantial contact with the victim or the perpetrator during the time frame for the Domestic Homicide Review. This included Liverpool Community Health (GP and walk in health treatment services), Liverpool Women's Hospital, Mersey Care NHS Trust (alcohol and drug treatment services) and the North West Ambulance Service (NWAS).

1.6 The scope of the review

20. The period of the review is from the beginning of January 2004 when the perpetrator received a warning from the police in regard to harassment until the murder of the victim in March 2012. All information known to a service providing an IMR was reviewed. Any information regarding involvement prior to the period of the detailed chronology and analysis had to be summarised in the IMR and is included where relevant in the overview report.

1.7 Membership of the review panel and access to expert advice

21. The case review panel that oversaw this review comprised the following people and organisations.

Position	Organisation
Quality Assurance Manager for Safeguarding	Liverpool Adult Services (safeguarding)
Assistant Director Children's Social Care	Liverpool Children Services (social care services)
Domestic Violence & Sexual Violence Reduction Officer and professional advisor to the panel	Liverpool City Safe (the community safety partnership)(until December 2013)
Team Leader – Supporting Victims and Vulnerable People	Liverpool City Council (from December 2013)
Head of Safeguarding	NHS Merseyside Liverpool PCT until April 2013 and for the remainder of the Domestic Homicide Review Liverpool Clinical Commissioning Group (CCG)

[1] South Liverpool Homes (SLH) is a housing association and charitable industrial and provident society. It provides social housing at sub-market rents to charitable beneficiaries in housing need. SLH also has a dedicated community safety team that provides support to witnesses and victims of crime and ASB including domestic violence.

Group Manager	Merseyside Fire & Rescue Service (chair of the panel until summer 2013)
Detective Chief Inspector	Merseyside Police
Assistant Chief Officer (ACO)	Merseyside Probation Trust
Area Service Manager	NSPCC
Community Safety Manager	South Liverpool Homes

22. The independent author of the overview report attended every meeting of the panel from the 18th June 2012 and assumed responsibility for chairing the panel from summer 2013.

23. The panel had access to legal advice from a solicitor in the council's legal service.

24. Written minutes of the panel meeting discussions and decisions were recorded by a member of the Community Safety Partnership staff team.

1.8 Independent author of the overview report and the chair of the review panel

25. Peter Maddocks was commissioned in June 2012 as the independent author for this overview report. He has over thirty-five years' experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the General Social Care Council. He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several Local Safeguarding Children Boards in England and Wales. He has undertaken training in relation to the application of system based learning in serious case reviews.

1.9 Family contribution to the Domestic Homicide Review

26. The victim's family were advised of the review through the police family liaison officer following the first meeting of the panel. The Domestic Homicide Review had been postponed until the completion of the perpetrator's criminal trial and conviction in October 2012.

27. The panel maintained contact with the family through the family liaison officer and by correspondence hoping that it might it might be possible to meet with them at some stage during the review. In the event, additional to the very high level of distress amongst family and friends of the victim and the circumstances of her death, some family members were under other sources of stress from

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unrelated events and felt unable to deal with contact from the panel or to participate in the Domestic Homicide Review in any way.

28. A final approach in the latter half of 2013 was made with close family relatives. In the event none of the family has felt able to have any further contact or to contribute to the Domestic Homicide Review.

29. Contact with the perpetrator was postponed until the process of appeals had been finalised. In view of the victim's family not wishing to have contact with the Domestic Homicide Review the panel have agreed not to pursue any further contact with the perpetrator.

1.10 Time scale for completing the Domestic Homicide Review

30. The Domestic Homicide Review panel met on five occasions between September 2012 and January 2014. The initial chronology of services involvement was completed by February 2013. The first drafts of some of the narrative agency reviews were also completed in February 2013 although final drafts including agency analysis were not finalised until January 2014. The final report was presented to an extraordinary meeting of the Community Safety Partnership in June 2014.

1.11 Status and ownership of the overview report

31. This report is the property of the Liverpool Citysafe (the Community Safety Partnership as the commissioning body for the review. All Domestic Homicide Review overview reports provided to Community Safety Partnerships in England are expected to be published. This report provides the detailed account of the key events and the analysis of professional involvement and decision making. It concludes with findings and recommendations to address the learning identified during the review.

32. The report is primarily written with the intention of addressing professionals involved with the design, oversight or delivery of multi-agency services although it should also provide accountability and information to other interested parties. The executive summary provides a more accessible and shorter account of the key findings from the review.

33. Both of the reports have to balance maintaining the confidentiality of the family and other parties who are involved whilst providing sufficient information to support the best possible level of learning.

34. In reading this overview report, it is important to remain clear about the purpose of the review and of this overview report in particular. The Domestic Homicide Review examines with the benefit of hindsight and other analysis, if it is possible to identify whether alternative judgments and decisions could or

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should have been taken, and whether different outcomes might have been achieved. The review does not investigate the circumstances of the death. This was dealt with through the criminal investigation and prosecution. The coroner's inquest and trial of the perpetrator were completed in the autumn of 2012.

35. The Community Safety Partnership will determine how and what further information is provided to the family at the conclusion of the review and the assessment by the Home Office Quality Assurance Group.

1.12 Synopsis and summary of the review panel's findings

36. None of the services had known about the relationship between the victim and the perpetrator prior to her murder. Although a close relative had become aware of the perpetrator's violence towards the victim and his coercive and controlling behaviour, this was not reported to the police or to any other service.

37. The panel wanted to find out more why the friends and relatives who knew about the violence felt unable to provide information to any service.

38. This is not to blame or criticise the people who clearly have been devastated by the victim's awful death and understand their reasons for feeling they cannot engage with a further process. However it is by listening to the views and experiences of the family and friends of a victim that provide a better prospect of understanding the factors and reasons that prevent contact with services.

39. It is now known that the victim had become afraid of the perpetrator and had resisted efforts by her sister to leave the relationship and was also anxious about repercussions when her sister had confronted the perpetrator about his abuse and violence towards the victim shortly before her death.

40. The victim was emotionally vulnerable. She had experienced the bereavement of a sibling and had lost a baby. She had increasingly used alcohol to help deal with her emotional and mental distress.

41. The Domestic Homicide Review has confirmed that there was no opportunity for an individual professional from any service to have identified the risk that the perpetrator could pose to the victim. The review has been an opportunity for the relevant health trusts to examine the arrangements for example when dealing with vulnerable women when they attend for emergency medical treatment which have been the subject of change and investment in recent months.

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42. Important primary health professionals such as the GP were not kept informed about the victim's presentations at the hospital emergency service. There were five attendances that the victim made at the hospital emergency services that were not reported to the GP who could have been in a position to at least offer further follow up on the alcohol issues. It also meant that routine primary health care for example when the victim became pregnant was provided without information and knowledge about the significance of alcohol. Routine notification has now been in place since December 2012.

43. The IMR from the St Helen's and Knowsley Health Trust has made recommendations to address the implementation of the domestic abuse training programme, improvements to the routine communication between hospital and GP practices and to the recording of decisions and transfers.

44. Alcohol is a significant factor in this case and was in the previous Domestic Homicide Review undertaken by the Community Safety Partnership. The victim was increasingly using alcohol and the perpetrator's consumption was also very high and had persisted over very many years. The relationship between alcohol and domestic abuse is complex; this does not mean that alcohol causes domestic abuse. Further analysis is provided in the final chapter dealing with findings and recommendations from the review.

45. A lifestyle service has been in place for several years within health but has relied on people referring themselves after being given information. Acknowledging a difficulty with alcohol is notoriously difficult for adults with difficult lifestyles and circumstances. Information had been provided to the victim on several occasions.

46. The perpetrator has a longstanding alcohol dependency and has been abusive and violent to previous partners as well as to police officers on more than one occasion. Although he participated in a court directed drink driving course following one of his convictions relating to drink driving he had shown an inability and unwillingness to address his alcohol problems (or violence).

47. The way in which domestic violence is dealt with has become a national priority and services in Liverpool have already been making changes to the way in which they respond to both victims and perpetrators. For example, the police operate an assertive policy in regard to domestic abuse that puts a far clearer onus on the police to investigate and secure evidence of crime rather than relying on a victim being prepared to make a complaint. This type of practice recognises the barriers that face victims in disclosing information about violence and their fear of repercussions if they are seen to be instigating action to prosecute a perpetrator.

48. There are programmes being developed to help perpetrators to acknowledge and take responsibility for their behaviour and there are also services that aim to help victims and their families.

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49. The IMRs also comment on the changes that have taken place in recent years. For example, the police have been given new powers such as domestic violence prevention notices (DVPN) and have adopted a more assertive policy of arresting all perpetrators of domestic violence regardless of a victim's wishes not to support a prosecution and for advice to be sought from the Crown Prosecution Service (CPS) regarding every allegation of domestic violence.

50. Although these initiatives would not have applied in respect of contact with the victim it would have been relevant in regard to the incidents that involved the perpetrator's violence towards a previous partner.

51. Mental health services that were available during the timeline for the review had long waiting times. This has improved since October 2012 although funding was under review in March 2014 when the review was concluding its work.

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2 The Facts

2.1 Synopsis of the death

52. At 1845 hours on 17th March 2012 the police were contacted by a female neighbour of the victim, who stated that her friend (the victim) was being assaulted by the perpetrator. The neighbour reported that the perpetrator was in possession of a knife and that the victim was lying on her back in the ground floor communal entrance to the complex of flats where the victim lived with the perpetrator.

53. At 1852 hours the police arrived at the scene of the crime and it was established that a male (later identified as the perpetrator) was at the address and was in possession of a knife. He was disarmed and arrested by police officers. He was so violent towards the police officers that he had to be handcuffed and also placed in leg restraints. He was extremely drunk and out of control. He was arrested on suspicion of assault with intent to commit grievous bodily harm and was taken to a police station where he was interviewed and initially charged with wounding with intent and remanded into custody for a future court hearing.

54. Once the area had been made safe the ambulance crew was able to enter the building to provide assistance to the victim who had extensive facial and head injuries. The victim was transported to hospital by ambulance. The victim remained in hospital where her condition steadily deteriorated and she died four days later.

55. The fatal assault had followed an escalation of violence that begun earlier in the evening when the perpetrator had accused the victim of seeing another man. A friend of the victim's had called at the flat at 18.40 on her way to see another friend. This friend saw both the victim and the perpetrator in their living room. There was broken glass on the floor. The victim indicated that there had been a violent argument. The perpetrator became very angry and threatening and told the victim's friend to leave the flat which they did being chased from the flat by the perpetrator who was in possession of a knife.

56. It appears that the victim also managed to leave the flat soon afterwards and went to a neighbouring property at about 18.30 where a friend of the perpetrator lived. The victim was crying and had a large bump to the centre of her forehead. Within minutes the perpetrator came to the flat and asked to speak to the victim. He was drunk but at that time was described by the perpetrator's friend as being calm. The perpetrator spoke with the victim and they left the flat together.

57. The girlfriend of the perpetrator's friend went to check that the victim was safe. She returned very quickly having found the perpetrator assaulting the

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victim in the adjacent flats. The perpetrator chased her and forced entry to their flat with a hammer. Inside the flat he destroyed a table and clock and left the property making further verbal threats that he intended to 'leather' the victim and to 'kill her'. The perpetrator's friend who had left the block of flats had returned within minutes because of concern for the victim. On entering the block the perpetrator's friend could see the victim lying on the floor of the entrance and was the point at which the emergency call was made to summon the police.

58. On 31st March 2012 the victim died of her injuries.

59. On 10th April 2012 the perpetrator was charged with murder of the victim and was subsequently convicted at his trial in October 2012.

Members of the victim's family

60. The victim was the youngest of six siblings and she had lived with her mother until she was about 28 years old. A brother who had been closer in age to the victim was killed in a road traffic accident in 2003. The death of her brother had a profound impact on the victim who began to rely on alcohol to manage the trauma. She managed to overcome her difficulties and was employed as an assistant manager at a local retailer.

61. During a brief relationship in 2008 the victim became pregnant with her first child who was born prematurely at six months and died shortly afterwards. The relationship with the father ended after which the victim had a relationship with another man. During this relationship, the victim suffered domestic abuse and this involved the police arresting this partner on two occasions.

62. The IMR from the St Helen's & Knowsley Teaching Hospitals Trust refers to the victim being brought to the hospital emergency department on the 27th October 2009 by ambulance. Although the victim referred to having a boyfriend no details were recorded about who the boyfriend was.

63. In 2010 the victim became pregnant for the second time but lost her baby before the birth. The victim became depressed. Following an incident in late 2011 when the victim had threatened her mother with a knife she was admitted for in-patient hospital treatment. The threatening behaviour was not reported to the police.

64. After the victim left the hospital she moved into a flat which she shared with a sister for a while. According to her sister the victim had begun to get 'her life back on track'.

65. The flat was burgled and both sisters moved back to their home area. It appears that the victim had begun drinking again. About eight weeks before

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she died, the victim had met the perpetrator at the flat of a friend. Very soon after their first meeting and to the surprise of her sister because of the significant difference in their ages, the victim decided to move in with the perpetrator.

66. The cumulative impact on the victim of the trauma of successive bereavements and depression resulted in her resuming her reliance on alcohol and being very vulnerable emotionally. It was within these circumstances that she met the perpetrator. The victim's sister thought that the perpetrator initially provided her with a sense of safety and security. He initially had been seen as being 'a quiet man'.

2.2 Relationship between the victim and perpetrator

67. According to all the other information collated by the Domestic Homicide Review, the victim had only known the perpetrator for about eight weeks before she was killed. The victim's elder sister feels that she was never intending to have a long term relationship with the perpetrator and that she had only become involved with him because of the extent to which she had become emotionally vulnerable as a result of the traumatic events in her life. It is also known that the victim and the perpetrator were both drinking significant amounts of alcohol and the respective histories of the victim and the perpetrator created the latent conditions for co-dependency.

68. The victim's sister visited the victim daily after she moved in with the perpetrator to make sure that she was OK. Initially everything seemed so although the sister had the feeling that the victim was not happy although never said anything specific.

69. About two weeks before she died, the victim had visited her sister at her home. Whilst there she had tried on a dress of the victim's sister's as they were planning to go out on the victim's birthday. It was then that the victim's sister noticed that the victim had bruises on her legs and ribs. The victim was reluctant to discuss the injuries; the perpetrator was downstairs. The victim told her the victim's sister not to ask questions 'because he'll kill me'.

70. The victim's sister went downstairs and confronted the perpetrator. The perpetrator and the victim left the flat. A short time afterwards the victim's sister went to their flat because she was worried about the victim. When she got to the property she found the front door to the flat hanging off its hinges. A neighbour had heard them arguing and had informed their friend who lived in the adjacent block and he had forced entry to the flat. The victim was on the floor with facial injuries. The perpetrator was accusing the victim of sleeping with other men.

71. Although the victim stayed overnight with her sister and had tried to persuade her to not to go back to the perpetrator she went back the following day. Whilst she was with her sister, the victim described the perpetrator as being jealous and obsessed with her and being very controlling. He controlled her movements, putting time limits on how long she could be out and even watched her from the window of the flat if she went to the shops. He had threatened to kill her if she tried to leave him. None of this information was reported to any professional including the police until after the victim's death.

2.3 Details of criminal proceedings

72. The perpetrator was convicted of murder at a trial that was completed in October 2012. He was sentenced to 15 years imprisonment.

2.4 The narrative overview and summary of information about the contact and involvement of services.

73. This section of the report summarises the information known to agencies and professionals in contact with the victim and the perpetrator's families. It provides the narrative summary of professional contact with the victim and the perpetrator between January 2004 and the end of March 2012.

74. It provides an account of the most significant events and decisions from the different services involved but not every contact; for example the ambulance service had nine contacts between 2007 and 2011. The analysis of agency involvement is provided in the next chapter.

75. The first recorded contact during the time frame for the Domestic Homicide Review was when the police were asked for urgent help from a sister of the perpetrator in the late afternoon of the 31st January 2004. They had just had a verbal argument about the care of their mother. The perpetrator had left the property before the police arrived.

76. The perpetrator's sister had told the police officers that she wanted her brother to stop harassing her and the police officers decided that the perpetrator should be warned about his behaviour. He was located the following day and was formally warned under the Harassment Act 1997.

77. Two months later in April 2004 the perpetrator's then wife (now ex-wife) contacted the police at 08.48 who said that the perpetrator was attempting to kick the property's external door in having been out all night. He had been drinking. Police officers who attended were told by the perpetrator's wife that she did not wish to make a formal complaint.

78. Almost five months later in September 2004 the perpetrator's wife contacted the police to say that she had been assaulted by the perpetrator. The police

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attended to be met by the perpetrator who was drunk and abusive; he was arrested to prevent a further breach of the peace. A statement taken from the perpetrator's wife described how the perpetrator had drunkenly knocked a table full of drinks over the perpetrator's wife and several other people. No physical assault had taken place and no further action was required by the police.

79. Almost a year later the police responded to a drunken argument between the victim and one of her sisters regarding a male that both siblings knew. A domestic violence referral was completed as a routine procedure and no further action was required.

80. Almost three months later in late November 2005 the perpetrator's wife contacted the police asking for help to deal with the perpetrator who was drunk and causing damage to her property. Neither of them was prepared to make statements to the police officers who attended; a domestic violence referral was completed but no further action was required.

81. Less than 24 hours later a police traffic patrol officer made a routine stop of a vehicle to speak to the driver (the perpetrator) who admitted to having drunk alcohol. He was breathalysed and was confirmed to be over the legal limit for driving a motor vehicle. He was subsequently prosecuted and disqualified from driving and was made subject of a 12 months supervised community order.

82. As a consequence, in January 2006 the probation service became involved with the perpetrator to manage the 12 month community order that required the perpetrator to attend a drink impaired driver's programme. He was routinely assessed using the OASys (offender assessment system) framework although this was late in being administered. The perpetrator was assessed as being a low risk of harm; this was based on his previous convictions as well as exploring issues such as his use of alcohol. He was managed as a tier two case; there are four tiers with one being the lowest risk of harm and reoffending and four being the highest. The perpetrator had been assessed as being a medium risk for re-offending.

83. The drink impaired driver's course started in mid-April 2006 and was completed in late July 2006. Although there should have been a meeting involving the offender manager (OM1) and programme staff with the perpetrator to discuss the learning from participating in the course, the meeting did not take place and no reason is recorded.

84. OM1 was aware that the perpetrator's relationship with his wife was breaking down and about his use of alcohol although it is less clear what the extent of detail that was known. OM1 did try to explore the potential for domestic violence with the perpetrator who denied that he had any intention of harming his wife. No checks were made with the police or with the perpetrator's wife.

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The probation IMR explains that changes to procedures in 2012 now include the sharing of information about domestic violence at the start of a sentence.

85. The perpetrator demonstrated good compliance with the conditions of the community order and he was regarded as having successfully completed the drink impaired driver's course; the probation IMR acknowledges that there could have been a referral to alcohol services although it is not clear that OM1 ever regarded the perpetrator's use of alcohol as problematic. The community order was completed in January 2007.

86. In September 2006 the police and regional ambulance service were called to assist the perpetrator's wife following an assault on the street by the perpetrator. She had bruising to her face and ribs and the perpetrator had damaged her mobile phone. The perpetrator's wife was visited by police officers with the intention of taking a statement. The perpetrator's wife was unsure that she wanted to make a formal complaint and was advised to contact the police in the near future if she wanted to take the matter further. This would not be current police practice which would be more encouraging of securing a statement if at all possible. A domestic violence referral was completed and the perpetrator's wife's address was tagged as TAU (treat as urgent) to ensure that any further calls were prioritised.

87. A fortnight later the perpetrator's wife went to her local police station with the intention of making a formal statement of complaint. However once at the police station she felt unable to complete a statement and left the police station.

88. In October 2006 the perpetrator's wife told an employee of the landlord that she was suffering domestic abuse that went back to November 2005. The employee contacted the police to report the information on the 10th October 2006; there is not a corresponding record of the telephone call to the police officer on the police information for the Domestic Homicide Review. The landlord employee 1 arranged for the perpetrator to attend an interview to discuss the allegations of domestic abuse and for the property to be checked for security in respect of front and rear doors.

89. At the interview on the 18th October 2006 the perpetrator made counter allegations against the perpetrator's wife. A week later a telephone call was made to the perpetrator's wife to check that she was safe and well and a written tenancy warning letter was sent to the perpetrator regarding the domestic abuse. The perpetrator informed the landlord that he and the perpetrator's wife 'had sorted out their differences'.

90. A second safety check by telephone on the 2nd November 2006 by the landlord resulted in the perpetrator's wife stating that she had not resumed a relationship with the perpetrator; she declined pursuing an anti-social behaviour injunction or any other court sanction against the perpetrator.

91. In early December 2006 the perpetrator was warned under the harassment legislation having been verbally abusive to his wife.

92. Several attempts were made by the police to secure a statement from the perpetrator's wife and in January 2007 told Officer 11 that because there had been only occasion when the perpetrator had spoken to her since the assault she did not want to make a formal complaint feeling that it would only make matters worse.

93. In early May 2007 the victim was brought to a hospital emergency service by ambulance just after midnight having sustained a head injury. The victim was with a friend. She had told the ambulance crew that it was the anniversary of her brother's death three years previously. She had been out drinking. Earlier in the evening she had been involved in a fight and had been punched; she had fallen later in the evening and had struck her head. The victim had no assessment or recording of observations at that point. The victim left the department without waiting for an assessment of her injuries. No follow up letter was sent to her GP.

94. In June 2007 the perpetrator was assaulted by another male. The male was subsequently convicted of grievous bodily harm. In early July 2007 the perpetrator reported having his bank card stolen. There is a record of the perpetrator attending a local NHS walk in centre stating he had been attacked by someone with a machete two days previously after opening his front door; he had also stated that he had been bitten by a dog and had been kicked in face and head. He had attended a local hospital but had left before being seen due to waiting time. He had been advised to seek medical attention by the police. He had multiple bruises to his chest and back, superficial bites, and loose front teeth. He was advised to attend hospital for an X-ray but he was very reluctant; advice was given regarding fracture clinics, and a need to see a dentist.

95. In early August 2007 the landlord had received complaints about anti-social behaviour involving the perpetrator that included noise and arguments. He was interviewed by the landlord and during which he blamed the problems on Adult 4 although admitted arguing and fighting with her. He was issued with a second breach of tenancy letter.

96. Later in August 2007 the perpetrator went to the local police station to request help from the police to remove his then partner from his home. They had both been drinking. Whilst he was at the police station the partner arrived at which point the perpetrator had decided he no longer needed police involvement now that the partner had left his home. A domestic violence referral was completed.

97. In the late afternoon the following day the perpetrator contacted the police to report that his partner, who was now referred to as an ex-partner, had made threats from outside his property; the perpetrator reported that she was drunk and was threatening to return with her brother to assault him.

98. A police patrol attended and spoke with both adults who appeared calm and willing to sort their differences out. A domestic violence referral was completed.

99. In late September 2007 the victim was brought by ambulance to a hospital emergency department having injured her ankle the previous evening while out drinking.

100. In mid-October 2007 the perpetrator was brought to the hospital emergency department in the early hours having been assaulted by two men with golf clubs.

101. In February 2008 the landlord received anonymous complaints about the perpetrator and his ex-partner fighting and shouting.

102. In March 2008 the victim's sister contacted the police asking for help to have the victim removed from her property. The victim was drunk and was being verbally abusive and causing damage. When a police patrol arrived the victim had to be restrained and placed in handcuffs. The victim was arrested and removed from the property into police custody. She was released without charge and a domestic violence referral was completed.

103. In late June 2008 the perpetrator's son contacted the police to report that his father had been assaulted by the 'ex-partner' who was very drunk; in statements to the police she is referred to as partner suggesting that this was an on off relationship. She left the property before the police arrived. A domestic violence referral was completed.

104. The perpetrator's ex-partner went to the property the following day demanding to have her bank card which the perpetrator denied having. The police were called to deal with the argument but she had left before they had arrived. Four days later the police were called to the perpetrator's property after a member of the public reported a violent argument and screaming that was taking place at the perpetrator's property. The police found both the perpetrator and ex-partner to be very drunk. She was removed to a friend's home. A domestic violence referral was completed.

105. In mid-July 2008 the police dealt with a further violent argument between the perpetrator and the same partner. A domestic violence referral was completed.

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106. In early August 2008 the perpetrator reported that his car had been stolen. When the police located the vehicle outside the perpetrator's property they identified that the vehicle had no valid insurance and therefore confiscated the vehicle. The perpetrator threatened and abused the police officer; he was arrested and was subsequently fined for a public order offence.

107. At the end of August 2008 the police dealt with a domestic argument between the victim and her mother. The victim agreed to leave the property and a domestic violence referral was completed. The landlord had also received complaints about and incident on the 29th August 2008.

108. The landlord was also told of an incident on the 4th September 2008 when the perpetrator had stabbed another male with a kitchen knife during an argument. There is no information about a stabbing recorded by the police and no evidence that that the landlord passed this information on. The landlord began a formal procedure that was concluded in early November 2008 when an anti-social behaviour injunction and possession proceedings were taken against the perpetrator because of his drunken and violent behaviour.

109. At the end of October 2008 the victim attended the hospital antenatal service for her first pregnancy. The GP referral letter included information about the victim's consumption of more than 100 units of alcohol per week although the victim had declined a referral to local alcohol services. The victim disclosed to the antenatal service that she was consuming 18-20 units of alcohol per week[2]. A referral was made to a consultant obstetrician because of the alcohol usage. The victim stated that she had separated from the father and declined to give any information including a name.

110. On the 4th November 2008 the victim contacted the police via the 999 emergency telephone services in a very drunk and upset condition and asking for her mother and stating that she had nowhere to stay. The police contacted members of the victim's family.

111. The police checked that the victim was safe and well the following day and confirmed that she was at her mother's home. Two days later the police were called to deal with an argument between the victim and her mother. The victim was five months pregnant and was drinking alcohol.

112. The police were met by the victim being abusive and unable to calm down. She was arrested and a domestic abuse referral was completed and sent through to CSC and the women's hospital. The fact that the victim was so drunk and

[2] UK guidance on safe limits for alcohol consumption is 14 units per week for women and recommendation that pregnant women or trying to conceive should consume no alcohol and in any event not more than 1-2 units per week to avoid damage to the baby.

five months pregnant clearly had implications for her unborn baby. The victim was bound over to keep the peace.

113. The victim did not keep a scheduled appointment with the community midwife on the 12th November 2008. The community midwife recorded that they received a telephone call from a social worker who reported that there had been reports of a domestic abuse incident between the victim and her mother. The victim had been reported to be under the influence of alcohol. The social worker reported that they were not going to take any further action. The community midwife has recorded that the plan would be to send a further appointment for the victim to attend for an appointment in one week.

114. A 'health professional's letter' was generated by MW1. The letter stated that the Trust had received a police notification that an incident of domestic abuse had occurred on 8th November 2008 between the victim and her mother. The incident report detailed that the victim's mother had contacted the police to report that she was having problems with the victim and she was becoming abusive. The police attended and arrested the victim for breach of the peace. The victim was noted to be drunk at the time of the incident.

115. MW1 contacted children's social care services to ensure that they were aware of the information given that the victim was pregnant at the time of the incident. MW1 was advised that the information would be passed to the alcohol specialist team who would follow up on this information.

116. MW1 made a request that the dangers of drinking alcohol during pregnancy were explained to the victim. The letter was sent to the victim's GP, to the health visitor liaison service, to the victim's community midwife and to MW2 the named midwife for safeguarding children.

117. At a routine antenatal appointment on the 3rd December 2008 she disclosed to MW3 that she was still consuming 1-2 cans of lager a day (no indication of the ABV of the lager)[3]. MW3 recorded that the victim was receiving job seekers allowance. MW3 made a request for the victim to attend a growth scan appointment. There was no contact or referral to other services about the use of alcohol.

118. On the 11th December 2008 the victim was admitted to hospital via ambulance. The victim had given birth at home prior to the arrival of the ambulance. The victim was accompanied by her sister. The baby was immediately transferred to the neonatal intensive care unit and the victim was admitted to a post natal ward. She was diagnosed with tonsillitis three days later but was otherwise described as well. The baby's condition deteriorated and died on the 15th

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[3] A low alcohol lager of two per cent will have about 0.7 unit of alcohol compared to the four units to be found in a nine per cent super strength can of lager (well over four times as much).

December 2008. According to hospital records the victim was on the unit with her partner when the baby died. The victim was very distressed, declined to have support from the bereavement team and requested a discharge from hospital.

119. In early December 2008 the perpetrator was made the subject of an anti-social behaviour injunction prohibiting him from being close to the home of his ex-partner.

120. On the 26th December 2008 the police were alerted to the victim making verbal intention to kill herself. The phone call was made by a brother of the victim who explained that the victim's baby had recently died. A further phone call reported that the victim was running around with a knife and had locked herself into a bedroom. The police and mental health practitioner and doctor attended and a Mental Health Act Assessment was carried out at her home address.

121. The victim had been distressed following the loss of her baby who had been born 14 weeks premature. He had survived for five days and died in hospital on 15th December 2008. On assessment she was crying, disturbed and smelled of alcohol and had threatened to kill her mother with a knife. The victim had also stated that she had wanted to kill her family and her sister's children. She also still displayed suicidal ideation but had no specific plans or intent in relation to herself. She had been prescribed anti-depressant medication by her GP. The victim was admitted under the direction of a mental health practitioner to hospital under section 2 of the Mental Health Act 1983 for assessment and treatment.

122. The victim stayed on the ward until the 29th December 2008 when she was reviewed by the senior house officer who is a qualified doctor undergoing training in a specialism and a consultant psychiatrist. There was no evidence to indicate that the victim had any mental illness and she was discharged back home under the care of her GP. No medication was needed or prescribed. Information was given to her regarding bereavement services. A discharge letter and summary was completed and sent to the victim's GP.

123. Less than two weeks later on the 6th January 2009 at 0137 the victim's sister contacted the police to report that the victim was outside her home drunk and was shouting through her letter box. The police attended and a domestic violence referral was completed.

124. On the evening of the same day the police were called to the home of the victim's mother. The victim was in a drunk and distressed condition and she was transported voluntarily by ambulance to a local hospital emergency service for an assessment of her mental and physical health.

125. A mental health practitioner went to see the victim and the victim reported that she had been drinking wine, but had not consumed any for two hours. She did not want a full assessment under the Mental Health Act but gave permission for the practitioner to complete a current mental state examination. During the assessment the victim displayed no signs of mental illness. The victim talked about her grief and sadness regarding her premature baby dying and the practitioner provided the victim with the telephone number for the Liverpool Women's Hospital (for the PALS service[4]). She also gave the victim the telephone number for the bereavement counselling service.

126. The mental health practitioner faxed the above information to the victim's GP with a copy of her Mental Health Act report and discharge report. The victim had an appointment with her GP on 7th January 2009.

127. On the 16th January there was a further argument between the victim and her mother. The police removed the victim from the house; alcohol had been consumed by both adults.

128. On the 27th February 2009 the perpetrator was arrested at his home when he assaulted a police officer; he was described as 'extremely drunk'. He was convicted and was made subject of a community order.

129. In a separate incident on the same day, the victim's sister asked for police assistance to deal with the victim who was very drunk and was causing a disturbance and had locked herself in the bathroom and was confused about why she was at the property.

130. The victim was unable to calm down and was arrested and removed from the property and after spending the night in police custody she was released without charge.

131. On the 10th March 2009 the police were asked to attend at the victim's sister's home to deal with an argument between the victim and her mother. The victim had been drinking. The victim had left the property by the time the police arrived; her mother expressed her concern about the victim's mental health and emotional state. The police completed a domestic referral form and made a referral to adult services. The Domestic Homicide Review did not have any information about what happened as a result of that referral.

132. On the 18th March 2009 the victim was attempting to break in to her sister's home. Against police advice the victim's sister let the victim into the property but immediately removed herself and her baby and was effectively locked out

[4] Patient and advice liaison service that provides confidential advice, support and information on health related issues as a point of contact for patients, families and carers.

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of her own home. The victim left the property when the police arrived and had spoken with her. A domestic violence referral from was completed.

133. On the 18th March 2009 the perpetrator was convicted of assaulting a police officer and was made subject of a second community order that involved supervision and attendance on a specified activity (Alcohol Choices and Change). This was an acknowledgement that alcohol had been a significant factor in the offence that he had been convicted for and contributed to his anti-social and abusive behaviour. The OASys identified that he posed a medium risk of harm. The probation IMR describes the basis of the assessment and is analysed in further detail later in the report.

134. At 0200 on the 19th March 2009 a member of the public asked the police to remove the victim from her property. The victim was refusing to leave and was very drunk and was upsetting the children at the address. The victim declined to leave when the police arrived and became abusive; she was arrested and kept in police custody overnight and then released without charge.

135. In early July 2009 the perpetrator was the subject of a OASys review that updated information that had been missing about his relationships. The perpetrator stated that he was not in relationship.

136. On the 21st July 2009 at 2241 a brother of the victim asked for police assistance to deal with the victim who was arguing with their mother. The victim and her mother had both been drinking for most of the evening. The argument had subsided by the time the police arrived and the adults had calmed down. A domestic violence referral was completed.

137. The perpetrator had been the subject of regular contact with OM2 up until mid-September 2009 when there was a gap until mid-November 2009. He had failed to keep an appointment in September due to ill health; this information was not checked. There was similar gap in February 2010. In the later stages of his community order, ill health became an increasing factor that was also accompanied by an increase in alcohol consumption. Although he was encouraged to keep a drinks diary (of daily consumption of alcohol) the probation IMR acknowledges that there was little other work done to involve specialist services and there is no information about what if anything was recorded about the perpetrator's consumption of alcohol.

138. At the end of October 2009 the victim was brought by ambulance to a hospital emergency department. She was unsure if she was pregnant. She left the department before a full history and assessment had been completed. The victim had provided a partial history that included the loss of her baby in December 2008 and had also reported drinking three litres of cider a day and was taking anti-depressants. No information was recorded about the strength

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of cider which could have ranged from six units of alcohol per litre to more than 27 units for a super strength cider of nine per cent per litre.

139. In late March 2010 the victim received treatment at the hospital emergency department; she thought that she had miscarried having not had a period for three months; she was not pregnant. A routine letter to the GP confirmed the attendance at hospital.

140. On the 25th July 2010 the police were called to a domestic disturbance on the street between the victim and her then partner. Neither wanted to make a statement to the police and the argument had subsided. They were both advised to go to their respective mother's homes and a domestic violence referral was completed.

141. In early August 2010 the victim attended the emergency service with a one day history of hematemesis (vomiting of blood) and associated abdominal pain. The victim gave a history to the nursing and medical staff of heavy drinking for one year since losing a baby. The victim stated that she was drinking 3 – 4 bottles of wine per day; again no information was recorded about alcohol by volume (ABV) or units which represented a potential variation of between 30 units per day up to 42 units.

142. The victim also stated she had been diagnosed with depression but she was not complying with the medication. It is unclear if this meant that she was not taking the medication at all or whether it was a case of irregular or chaotic use of the medication.

143. The victim was diagnosed with possible alcohol related gastritis. She had bloods taken; she also had a pregnancy test which was positive. The victim informed staff that she had been to the GP two weeks before with abdominal pain, and was referred to the gynaecology department (although there is no further information about this). The victim requested and was supplied with information relating to the Lifestyle Drug & Alcohol Team. The victim was admitted for 24hours for review. There was no safeguarding referral in regard to the pregnancy.

144. The victim was prescribed medication for alcohol withdrawal and advised to contact the Lifestyle Team. The victim was also advised to contact her GP regarding ante natal care and referral. The victim was discharged home; information regarding her attendance and positive pregnancy test were documented on the hospital's discharge letter which was sent to her GP.

145. On the 24th August 2010 the victim attended an antenatal booking; she was with her new partner although no details were recorded of who this was.

146. MW3 has recorded that there was a smell of alcohol on the breath of both the victim and her partner. The victim reported that she was drinking two bottles

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of wine a day prior to becoming pregnant. Again there is no information about ABV or units. The victim reported that she was now drinking 6 – 8 glasses a week and again no indication of units which in any event were far in excess of recommended guidance.

147. MW3 recorded that the victim's partner was of no fixed abode. The victim requested smoking cessation support. The victim reported that her GP had already referred her for support regarding her alcohol misuse. There is no confirmation that this was correct or of contact being made with the GP or a safeguarding referral being considered or made in respect of the baby. The victim reported that she had been admitted to an inpatient psychiatric facility as the result of postnatal depression. MW3 completed referrals to a consultant obstetrician for perinatal mental health and to the enhanced midwifery team and MW2.

148. On the 2nd September 2010 the victim attended the local hospital emergency service via ambulance. The victim reported that she was experiencing abdominal pain and had 'the sensation that she needed to push'. The victim reported that she had drunk two glasses of wine. The victim was diagnosed with abdominal pain with a query about the cause. The victim was asked to attend for a follow up scan appointment on 5th September 2010 which she did not attend. The community midwife or the GP does not seem to have been informed about either event.

149. On the 21st September 2010 the victim was admitted to the hospital emergency service by ambulance. She had drunk a bottle of wine that day and was very anxious about having lost a previous baby.

150. The victim was diagnosed with a possible viral illness and was advised to take regular fluids and an anti-emetic (anti-sickness). The victim was advised to attend the emergency service if there were any further concerns. The community midwife or the GP does not appear to have been informed about the attendance.

151. A week later the victim attended a routine ante natal appointment; no concerns were noted. The victim missed the following appointment on the 12th October 2010 and did not attend a scheduled appointment with the perinatal service on the 14th October 2010.

152. On the 15th October 2010 the victim had a miscarriage; she had arrived at the hospital emergency department via the ambulance service with her partner and stayed overnight.

153. On the 18th October 2010 the victim was reviewed by the registrar due to her history of postnatal depression. The victim reported that she had previously had an inpatient admission at a psychiatric unit. The victim reported that she had been prescribed anti-depressants but she had stopped taking these six

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months previously. The victim reported that she was upset at the loss of her baby but she was not experiencing any feelings of self-harm. The victim reported that she had been drinking three bottles of wine a day but she had reduced this to three glasses a day when she had discovered that she was pregnant. The victim reported that she had no fixed address to return to on discharge. A review was requested by the perinatal mental health team and a referral was made to social care services. The perinatal mental health team were unable to review the victim that day.

154. On the 19th October 2010 the perinatal service reviewed the victim who was diagnosed with a high risk of recurrence of post natal depression and it was planned to recommence antidepressants; the GP was to refer the victim to counselling services. A nurse also contacted the homeless team to make a referral for the victim.

155. On the 20th October 2010 the victim informed maternity staff that she could be discharged to her sister's address on a temporary basis and that she could then apply for housing with her partner. She was discharged and a follow up appointment was arranged for 11th January 2011. The victim did not keep that appointment.

156. At 0358 on the 22nd March 2011 the police were asked by the victim to help remove her partner from her property. He was causing a disturbance and both adults had been drinking.

157. He refused to leave the property when the police arrived and had become abusive. He was arrested and remained in police custody for the evening. He was released without charge the following morning 23rd March 2011 and a domestic violence referral was completed.

158. The police were asked by the victim to remove her then partner from the property at 0040 after he had become abusive; they had both been drinking. He had left the property when police visited and a domestic violence referral was completed.

159. At 0218 the police were contacted again by the victim who stated that her partner had just run out of the property with her baby's ashes. He had left the property by the time the police arrived. A domestic violence referral was completed.

160. On the 21st April 2011 the victim cut her wrists which required a response from the police and ambulance service. The injury was superficial and not life threatening. The victim expressed a wish to go to hospital. The police took the victim and her partner to hospital when it became apparent that there would be a delay in sending an ambulance. An initial Mental Health Act assessment was carried out by a mental health practitioner. A Care Programme Approach

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risk assessment and Care Programme Approach care plan was completed along with a mental health cluster tool[5].

161. Following this assessment the victim was seen by the senior house officer. The assessments showed no evidence of mental illness and she did not meet Care Programme Approach criteria to be referred to any of the secondary mental health services. The victim regretted cutting her arm and following the medical assessment she did not meet the threshold for an assessment under The Mental Health Act 1983. the victim discussed openly that she at times felt depressed due to losing two premature babies, also the loss of her father and her brother too, and that she used alcohol as a coping mechanism.

162. During the assessment she agreed to seek help regarding her alcohol dependency. Actions from the assessment included a referral to the lifestyles clinic and also Inclusion Matters (for bereavement counselling). A letter was sent to GP. The victim was discharged from hospital less than two hours after the arrival. The victim did not make contact with any of the services.

163. On the 19th May 2011 the victim told the police that her front door keys and mobile phone had been stolen. The suspects were two men that the victim had allowed into her home but had asked to leave when one of them had propositioned her.

164. In the late afternoon of the 13th July 2011 the victim's brother reported that the victim was at their mother's home having an argument. The victim was drunk and refusing to leave. The victim was removed from the property and transported to her home. A domestic violence referral was completed.

165. According to the NWAS, on the 12th August 2011 the ambulance and police service were called to a property where there was a 'domestic fight' in progress. The caller was the victim. When the ambulance arrived the victim had left the property to go to an off licence. The injured party was the victim's then partner who had been drinking and had been fighting with other males. He was not in any pain. He had a nose bleed and swelling to the right side of his face. He had a Glasgow Coma Scale (GCS) score 15[6]. This is the highest and best score possible and is a measure of consciousness and pain and reacting pupils. He was aggressive and could not recall events. He was taken to hospital. There was no evidence of domestic abuse. The police made follow up calls to

[5] The Care Programme Approach (CPA) is the system that is used to organise the delivery of care from 'secondary mental health services' such as outreach teams. The mental health cluster tool is the needs assessment tool.

[6] The GCS is a 15 point scale which is used to determine level of consciousness based on responses to various stimuli with the purpose of an initial assessment in regard to internal head or brain injury.

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ascertain whether he wished to make any complaint against the other males; no complaint was made and no further action was taken.

166. In late August 2011 the victim left her property for five days. During her absence a neighbour gained access to her property in order to look after a cat. Upon the victim's return to her home she reported the cat had been stolen. She was very drunk.

167. On the 12th November 2011 the victim was locked out of her home by her then partner. The victim gained entry eventually and the police made a visit to check that both adults were safe and well. A domestic violence referral was completed.

168. On the 7th December 2011 the victim reported an assault by her sister's boyfriend although a police interview established that no assault had taken place.

169. At 2203 on the 8th December 2011 the victim's brother asked the police to attend at his mother's address to assist with the removal of the victim who was drunk and arguing with her mother. The victim was taken to her home. A domestic violence referral was completed.

170. At 1845 on the 17th March 2011 the police were called by a neighbour of the victim who stated that her friend and neighbour had been injured by her partner the perpetrator. This is the fatal assault that has been described in previous sections of the report.

171. The victim was admitted to the hospital emergency service at 20.20. The victim had refused to be taken to hospital initially. She had lost consciousness for a while and had also vomited. At 21.40 she had a CAT scan. Her GCS (Glasgow coma scale) had declined to 7/15 by 22.01 and she required intubation (assistance to breath). The victim was transferred to a specialist neurological unit where she died.

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3 Analysis of information against the key lines of enquiry

3.1 Significant themes for learning that emerge from examining the IMRs

172. In the summary of the review's finding provided in chapter one there is acknowledgement that some of the issues to come out of this review are reflected in the finding of national evaluation and research. Important messages for learning from this review include:

a) The speed and extent of the escalation in the perpetrator's violence was very swift and occurred when it became clear to the perpetrator that disclosures had been made and the victim had tried to resist his control;
b) Neither the victim nor her sibling or close friends felt able to contact the police or any other service about their concerns when the extent of danger from the perpetrator towards the victim became clear;
c) As with the first Domestic Homicide Review completed in Liverpool, alcohol was a significant factor and aggravated the vulnerability of the victim and the escalation and severity of the fatal assault;
d) Emotional trauma associated with bereavement and depression were exacerbated by substance misuse;
e) The excessive and persistent use of alcohol represented a considerable demand on the resources of the primary and specialist or secondary health services, the police and wider criminal justice services;
f) The frequency of contact with the police and health services was characterised by routine processing of information and referrals that did not initiate any escalation in the help or intervention; the domestic violence referrals by the police resulted in an assessment that there was low risk to the victim;
g) The GP was not informed of all contacts or presentations by the victim in regard to alcohol and assaults;
h) History taking did not establish clearly enough the identity and background of partners or relationships or an accurate enough description about the volume of alcohol being used;
i) There was a high reliance on the victim and the perpetrator having the motivation and capacity to seek further help to address their problems in regard to chronic alcohol consumption;
j) Reliance on self-disclosure without additional checks including with other services contributed to narrow risk assessment and management; this included contact with the victim on both occasions that she was pregnant and was disclosing a high risk lifestyle as well as in respect of mental health intervention;
k) The evidence of impact from participation in programmes designed to address issues such as alcohol use were inadequately evaluated against individual plans and assessment.

173. Examples of good practice identified by the review include;

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a) The landlord invoked breach of tenancy proceedings and ensured that the perpetrator's wife received support when she disclosed domestic abuse;

b) The police arranged on two occasions for mental health assessments to be undertaken with the co-operation of the victim; this predates the recent initiative nationally to co-locate mental health practitioners with police in pilot areas to co-ordinate assessment and support to vulnerable people.

What knowledge/information did the agency have that indicated the victim might be a victim of domestic violence and how did the agency respond to information including that provided by other services.

174. None of the services were aware of the relationship between the victim and the perpetrator. During their brief relationship there were no reports of domestic violence until the fatal assault.

175. The victim was known to the police who had been called on nineteen occasions to help diffuse domestic arguments. On only one of those occasions was the victim identified as a potential victim; in December 2011 the victim had reported being assaulted by the boyfriend of a sibling although the subsequent police interview established that no physical assault had taken place. There were several occasions, for example in March 2011, when the victim had asked for help to have a former partner removed from the home after an argument although no domestic violence was disclosed.

176. Officers were sent to see the victim in person every time and records of these contacts were made. At no time was it ever alleged that the victim had been the victim of any physical form of domestic violence relating to her relationship with this male the calls to police consisted of the victim asking for the police to attend and request that her partner leave the premises.

177. All of the total of nineteen incidents that the police dealt with followed significant consumption of alcohol by the victim and was often in the company of somebody else who had also been drinking.

178. Although the victim was not identified as a victim of domestic violence, almost without exception a domestic violence referral was completed by the police officers dealing with the incidents. Many of the incidents involved a relative of the victim.

179. The extent to which the victim used alcohol was an indication of her vulnerability. In March 2008 she was homeless for a period of time and this coincided with the victim being pregnant. On two occasions the police were sufficiently concerned about the victim's mental health that they transported the victim to a local hospital to enable a mental health assessment to be completed.

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180. In August 2012 the ambulance and police service were called to a domestic incident involving the victim and her then partner. On that occasion it was the partner who was taken to hospital for treatment; the victim was not seen.

181. The presentations at hospital emergency services were following drink related episodes none of which were as a result of domestic abuse. When the victim became pregnant on two occasions there was little information recorded about whom the victim's partner was or details about their relationship.

What services did your agency offered to the victim were they accessible, appropriate and sympathetic to her needs?

182. The most extensive contact with the victim was by the police service responding to requests for assistance. The majority of the calls were requests to have the victim removed from property and several of those involved family members.

183. On one occasion the subject of the victim's fragile state of mind was disclosed to attending officers. The officers acted appropriately and with the victim's needs in mind, they requested that mental health professionals attend the address and speak to the victim in person. This resulted in the victim leaving the address in the care of the mental health professionals to attend a hospital for a Mental Health Act assessment.

184. On a second occasion the police were called to the victim's mother's address to remove the victim. The attending officers formed the opinion that the victim might be suffering from mental health problems and instead of forcibly removing the victim from the address, they instead called for an ambulance on behalf of the victim. The victim agreed, in that case, to attend hospital voluntarily and was taken to hospital for assessment. The actions of the officers showed a clear commitment to address the victim's needs when called by one of her relatives to remove her from an address as result of a domestic disturbance.

185. All the incidents of a domestic nature were recorded on domestic violence referral form and these were inputted onto the PROtect computer system that is used by Merseyside Police to record all incidents of a domestic nature.

186. The police focus was upon restoring calm and order. On some occasions this required the victim being arrested in order to restore that calm. The victim sought police help on several occasions and for example when she had become very distressed in late 2008 and felt she had nowhere to go she made contact with the police who arranged for the victim's mother to care for her.

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187. Although the victim was subject of mental health assessments on at least two occasions there was no longer term involvement from mental health services. Similarly, it is not apparent that the victim received any counselling or treatment in regard to her chronic use of alcohol. Information was provided about bereavement and lifestyle services although the victim did not make contact with any of these.

188. In November 2008 the police were contacted by the victim when she was drunk and upset and had nowhere to stay implying that she was homeless. The victim told the police that she was five months pregnant. A referral was made to CSC and to the women's hospital.

189. There were two incidents in March 2009. The first involved the police being called to the victim's sister's address and a domestic abuse form was completed in compliance with policy. No further referral was required as no children were involved. The following day a member of the public asked the police to help remove the victim from their property as the victim was very drunk and was upsetting children at the address. No referrals were made because the incident involved the victim and a friend.

What information and/or concerns did the victim's family and friends have about victimisation and what did they do?

190. None of the services in contact with the victim received any information from friends or family regarding victimisation. The panel would have welcomed discussion with family and friends who had only just become concerned about the controlling relationship between the perpetrator and the victim. Regrettably that has not been possible although there will be further attempts to speak with them when the review has been completed and the family are notified about the findings.

191. It was about two weeks before the victim died that the victim's sister had observed injuries to the victim in respect of bruising. Although the victim's sister confronted the perpetrator about the injuries no contact was made with the police or any other services. It is not clear if the very controlling behaviour that was described earlier in the report became more acute after this disclosure. It is known from research and other Domestic Homicide Reviews that this is a moment of heightened risk for a victim when a controlling and abusive partner fears losing control over the abused partner.

What knowledge did your agency have that indicated the perpetrator might be a perpetrator of domestic violence?

192. The perpetrator had violent relationships with his birth family as well as with domestic partners. He assaulted the perpetrator's wife in their home and elsewhere. His sister complained of harassment. He was involved in other incidents of violence that on at least one occasion saw him being assaulted by

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another male. Complaints made to his landlord resulted in warning being given and in November 2008 he was made subject of the anti-social behaviour injunction and he was evicted from his property.

193. The perpetrator's history of domestic abuse incidents were known to differing extent by the police, probation and housing services over several years and he displayed violence, often when he was under the influence of drink. However, the perpetrator had never been arrested for or convicted of any offence of domestic violence although the police IMR highlights that an incident in September 2006 should have been processed as such.

194. The police have had numerous dealings with the perpetrator some of which were calls to reports of domestic incidents in progress. As far back as April 2004 the police were contacted to issue a harassment warning to the perpetrator in relation to his behaviour towards his sister.

195. There were two further domestic incidents in April and September 2004 where the perpetrator had become abusive towards his wife but no allegations of violence were made and no injuries observed by officers at that time.

196. In November 2005 the police were called by the perpetrator's wife, to a report of criminal damage by the perpetrator at the marital home. Although no violence was used against the perpetrator's wife, the perpetrator was arrested on suspicion of criminal damage. He was released without charge as the perpetrator's wife refused to support a prosecution.

197. The only report received by the police alleging domestic violence used by the perpetrator was in September 2006. The perpetrator's wife had contacted the police to state that the perpetrator, who she was estranged from, had physically attacked her.

198. The incident which occurred on 22nd September 2006 involved the perpetrator's wife describing a violent assault by the perpetrator. This included the perpetrator's wife being punched to the face and ribs by the perpetrator and damage being caused to the perpetrator's wife's mobile phone. This resulted in bruising and swelling to the right side of the perpetrator's wife's forehead.

199. The attending officers did not take the necessary positive action against the perpetrator. Despite injuries being recorded, on the wishes of the perpetrator's wife, the perpetrator was not arrested or interviewed and the investigation was closed and filed as undetected.

200. The incident predated the current system of risk assessment and management and coincided with a local study that had highlighted disappointing compliance with the previous risk framework.

201. The police IMR made clear that the perpetrator should have been arrested in relation to the allegation of assault. It appears that after several attempts to obtain a formal complaint of assault from the victim, she provided a statement detailing that she was unwilling to support a prosecution against the perpetrator, and specifically asked the police not to make any form of contact with the perpetrator.

202. From August 2007 until July 2008 the police received five further calls for service in relation to domestic incidents involving the perpetrator. Four of these calls were made by the perpetrator requesting police assistance in removing his partner from his address. There were no allegations of any violence used by either party in relation to these calls for service. The remaining call was made by the partner of the perpetrator regarding a heated family argument that was taking place. Again no allegation of any violence was made by any party.

203. In December 2008 the perpetrator was made the subject of the antisocial behaviour injunction described in previous sections.

204. In February 2009 the perpetrator was arrested in connection to an offence of violence but this was against a police officer and was not in a domestic setting. This was the last contact the police had with the perpetrator until the incident in March 2012.

205. The information provided to the land lord by the perpetrator's wife (a former partner) was not shared with the police or any other service. The IMR from the landlord refers to an incident in September 2008 when the perpetrator stabbed another man with a kitchen knife. There is no information about this incident in the police IMR and it appears that the landlord service did not share this information.

206. The assessment work by the probation service explored whether the perpetrator was a perpetrator of domestic violence and in the face of his denials was not aware of the degree of violence that had affected his partners' lives.

Were there issues in relation to capacity or resources in the agency that impacted on the ability to provide services to the victim, the alleged perpetrator or any other members of the family and also impacted on the agency's ability to work effectively with other agencies?

207. None of the IMRs have identified any issues in regard to capacity or resources as having an impact on how their contact with the victim was managed.

208. Comment has already been made about the apparent absence of any counselling or treatment for the victim in regard to her significant use of alcohol.

209. The land lord service comments on the multi-agency liaison in regard to the perpetrator. Although there was a concerted response to challenging the perpetrator's violence that ultimately led to enforcement procedures being used, there was no apparent sharing of information with the police and other services.

210. Inter-agency working has developed and improved since 2006, this has led to a proactive approach when training front line officers within service. Officers within South Liverpool Homes attend training in relation to children's safeguarding from Liverpool Safeguarding Children Board and are aware of the organisations accountability and responsibility in relation to safeguarding. The organisation has a children's safeguarding policy which clearly identifies a lead and deputy lead officer for the organisation. A user defined characteristic (UDC) has been introduced on the housing management system to highlight safeguarding issues that are known about in a family home. This UDC is to alert staff to capture information when visiting homes where there may be signs of domestic abuse that includes property damage or financial abuse.

211. The perpetrator's conviction for driving offences that resulted in a community supervision order that required his participation in a drink impaired driver's course and when he was convicted of assaulting a police officer in 2009 he was again subject of a community supervision order that required his participation in a specified activity that aimed to address his use of alcohol and it contribution to his pattern of offending.

212. The probation IMR does not provide any information on how the impact on the perpetrator's behaviour of the specified activities was evaluated over and above confirming that the perpetrator attended as required. The IMR from probation acknowledges that there was limited work done to involve other specialist services in regard to the perpetrator's drinking.

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4 Findings from the review and recommendations

213. Any meaningful analysis of the complex human interactions and processes for decision making that characterise multiagency work with adults vulnerable to domestic abuse has to understand why things happen and the extent to which local systems help or hinder effective work.

214. There is a risk when undertaking a review that has examined the involvement of several different services for it to then result in a range of recommendations that overwhelm rather than promote the further positive development of services and practice. The IMRs have generated 14 recommendations single agency learning and improvement.

215. In this final chapter of the report, the focus is on the key points of learning to come out of this particular review. The process of undertaking the review has already generated learning across several services and therefore it is of doubtful quality to take an unduly forensic approach of dealing with every detailed aspect; such an approach leads to over complicated and ultimately less effective action plans and strategies. The fact that this overview report is a public document also means that the full content is available for relevant training and development to promote continued learning across all services.

216. In framing the findings and recommendations the panel are conscious that the tragic circumstances of the victim's death were not an event that could have been predicted. The relationship with the perpetrator had only lasted a few weeks and had only been known to a handful of friends and relatives.

217. The key points of learning relate to

a) Public awareness and confidence in reporting concerns about coercive and abusive relationships;
b) Risk assessment and protecting unborn children;
c) Substance misuse and the implications for policy and practice;
d) Organisations capacity to undertake statutory reviews.

Public awareness and confidence in reporting concerns

218. Earlier sections of the report have referred to the evident concerns that the victim's sister had when she saw injuries on the victim's legs and arms shortly before the victim's death. She quite correctly talked to the victim about the injuries and ascertained that it was caused by the perpetrator's abuse. She provided immediate advice and support which the victim was unable to accept; she also confronted the perpetrator. This was an understandable reaction although it also represented a direct threat and challenge to the perpetrator's coercion and control of the victim. The victim expressed her fear of reprisals.

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219. It is a fact that domestic abuse is a very under reported crime by the victims of the abuse across the UK. Reluctance to report domestic abuse is attributed to a range of different factors; a fear of reprisals (as expressed by the victim), psychological and economic dependence and feeling that services will not take it seriously. For example, some of the difficulties that the victim had with her lifestyle may or may not have been an additional factor in any reluctance to take action to escape the relationship.

220. The concerns that victims can have about being responsible for making statements and supporting a prosecution has been recognised as a powerful disincentive to victims reporting and cooperating with the police in regard to domestic abuse.

221. The police IMR summarised in earlier sections of this report have described work already underway in regard to an assertive policing policy that does not rely on victims to process an investigation and prosecution.

222. The speed and scale of the escalation in the violence was very quick; the trigger appears to have been the victim having already disclosed abuse and evidence about the coercion being exerted by the perpetrator and having removed herself from the flat.

223. Promoting a general awareness of domestic abuse and providing information about sources of help are routinely promoted at local and national levels.

224. A message from this review is ensuring that such information is also targeted at friends and family of people who are living with an abusive partner or spouse and encouraging them to make contact with services if they have reason to be concerned. Stressing the importance of not ignoring physical injuries or evidence of coercion. Domestic abuse is not about loss of control but rather the need to exert and maintain control by the abuser over their partner, spouse or other family member.

Recommendation 1

That the Community Safety Partnership review current information strategies to ensure that information about the type of behaviours that constitute domestic abuse is explicitly described and includes ensuring that friends and family of victims (and of perpetrators) are encouraged to report concerns.

Risk assessment and unborn children

225. The report has included information about gaps in information being provided to the GP about all of the emergency presentations in regard to alcohol and the action already taken since 2012 to address this within the health community.

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226. On several occasions during the pregnancies the victim disclosed very excessive levels of drinking that represented a serious health risk to her as well as to her unborn child.

227. None of the services apparently considered the risk to the unborn children under the LSCB protocols. This would have provided an opportunity for a statutory assessment of the victim's circumstances as well as considering how risk to an unborn child should be addressed.

Recommendation two

The Community Safety Partnership should ensure that a copy of the overview report is provided to the chair of the Liverpool Safeguarding Children Board and Liverpool Safeguarding Adults Board drawing particular attention to the issues in relation to risk assessment arising from lifestyle during pregnancy.

Substance misuse and implications for practice

228. Alcohol does not cause domestic violence, but there is evidence that where the domestic violence exists, alcohol is often also a factor. This is the second Domestic Homicide Review in Liverpool and in both reviews the use of alcohol was a significant factor. The consumption of alcohol represents difficult cultural and ethical problems and especially within the context of domestic abuse.

229. There is evidence that a victim's increasing alcohol consumption heightens their risk of becoming a victim of crime or violence. In relation to domestic violence in particular, a British study found that victims of domestic "assault" had higher levels of alcohol consumption than non-victims and that the risk of violence increased with increasing levels of drinking[7]. Some studies have found that once women began using substances they became more vulnerable to victimisation from both domestic violence and sexual assault. Other research evidence is more equivocal. However, a number of researchers point out that there is evidence to suggest that women's drinking is a way of coping with abuse (as well as other difficulties such as trauma).

230. Research from the UK and the USA consistently shows a high rate of prevalence of domestic violence victimisation among women presenting to alcohol and drug services.

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[7] Mirrlees - Black, C. (1999) Domestic violence: findings from a new British Crime Survey self-completion questionnaire, London, HMSO and cited by Alcohol Concern's information and statistical digest Grasping the nettle: alcohol and domestic violence June 2010 which also provides references for the other studies cited.

231. There is also research evidence that identifies a high use of alcohol by men who abuse partners and children and that injuries tend to be more severe when the perpetrator is under the influence of alcohol at the time of the abuse; alcohol was an aggravating factor in the severity of the assault on the victim by the perpetrator.

232. The links between alcohol use and the suffering and perpetration of domestic violence are clear. However, an important issue for practice is the extent to which the perpetrator or victim blames alcohol for the domestic violence. This may be done in several ways:

a) The perpetrator blames the alcohol for his violent or abusive behaviour rather than take responsibility himself;

b) The victim blames the alcohol rather than assign responsibility to her partner for his violent behaviour;

c) The victim blames her own drinking for her partner's violence to her.

233. Studies seeking the views of victims and perpetrators on the role of alcohol in domestic or sexual violence show varying degrees of blame being placed on alcohol.

234. In alcohol treatment settings the belief a person holds about their alcohol use are at the core of any intervention. It is therefore essential that alcohol treatment services reinforce the message that alcohol is not responsible for the perpetration or suffering of domestic violence.

235. For service users the problems associated with using alcohol and living with domestic abuse is;

a) The challenge of seeking some kind of change or improvement in their lives;

b) Often have a history of emotional, sexual and physical violence or abuse as a child and/or adult;

c) Are isolated in terms of self and family;

d) History of denying or minimising the problems/suffering they face;

e) Live with a sense of shame, stigma and covering up;
f) 'Relapse'; returning to alcohol use or to an abusive partner;

g) Live with insecurity about their housing or home environment;

h) Contact with legal, medical, and criminal justice systems;

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i) Live with the potential for serious harm or death without intervention.

236. The implications for professionals are that they are frequently working with people in crisis; this was a characteristic in this case. They will often face ambivalence from the person they are trying to help and they will also know that change is hard to achieve. They will also understand the need to establish trust and confidence for victims to feel they can disclose information.

237. It may well be that dealing with the range of complexity summarised here (and in relation to the victim's circumstances) leads to some professionals becoming more passive in how they approach the collation of information. An example highlighted at several points in the report is the lack of information sought to help understand the extent of alcohol use or the context for it.

238. Although there was no evidence about the victim being a victim of domestic abuse until just before her death (and were not reported to any service), there were risk factors associated with her lifestyle and history that invited a more proactive approach to seeking information about vulnerability and risk.

Recommendation 3

The Community Safety Partnership should consider whether sufficient data and information is collated in regard to the extent of alcohol related domestic abuse.

Recommendation 4

The Community Safety Partnership should consider whether practitioners working in substance misuse services have sufficient information and professional support to identify and respond to evidence of domestic abuse.

The capacity of organisations to undertake statutory reviews.

239. This Domestic Homicide Review has been severely delayed. The main contributory factor was the national reorganisation of health trusts as part of the Health and Social Care Act 2012 that was implemented from April 2013. This led to changes in personnel participating in the review and contributing information. Some of the information in the form of reports was effectively lost in the transfer of systems and people.

240. All of this had implications for being able to meet the timescales for the review and to identify learning in a more timely and effective manner. A delay in finishing a review also has implications for the family and friends of victims.

Recommendation 5

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The Community Safety Partnership should consider whether any further action is required to improve the capacity of future statutory reviews.

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Appendix 1 Agency recommendations in individual management reviews (IMR)

St Helens & Knowsley Teaching Hospitals NHS Trust

Continue to implement Trust Domestic Abuse Training Plan;

Emergency Department to review process for communicating with GPs particularly around patients who leave the department before their treatment has been concluded.

The Trust to work towards extending the funding of the Mental Health Liaison Service ideally on a recurring basis;

The Trust to work towards extending the funding of the Alcohol Liaison Service ideally on a recurring basis;

The links between alcohol, mental health, domestic abuse (the toxic trio) and safeguarding to be further emphasised within the Emergency Department;

South Liverpool Homes

Start identifying cases of domestic abuse where the victim doesn't make a complaint specifically about domestic abuse but is known through other complaints and where appropriate signpost to relevant support agencies or refer to MARAC without consent on professional judgement should the incident meet MARAC's threshold.

Produce a training matrix to ensure annual awareness sessions are being completed and incorporate domestic abuse procedures into induction for new employees.

Approach local Mental Health Services and commissioning bodies to identify a process of joint working to support both South Liverpool Homes officers and Mental Health Services with clients in the Speke and Garston housing estates.

Establish more effective working relationships with Liverpool Probation Service to support South Liverpool Homes approach to perpetrators of domestic abuse.

Merseyside Police

The Merseyside Police Domestic Abuse Policy is reinforced to officers across the force, and that supervisors responsible for quality assuring domestic abuse crime investigations (Investigation Managers and D/Sgts within FCIUs) are asked particularly to check that these elements of Domestic Abuse Policy are adhered to when authorising the closure of domestic abuse files.

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'Where there is sufficient evidence, the alleged offender should normally be arrested. This is particularly the case where there is clear evidence of injury and/or physical damage. Similar action should be taken where anyone (adult or child) within the household is displaying signs of alarm, fear or distress, or if there is evidence of repeat victimisation. (Merseyside Police Domestic Abuse policy and procedure section 4.10.1).

Merseyside Police policy stipulates '*It is the decision of the police officer whether or not to arrest: therefore the victim should not be asked whether they require an arrest to be made. Efforts should be focused on gathering alternative evidence in order to charge and build a prosecution case, rather than rely entirely on the victim's willingness*

Merseyside Police supervisors responsible for quality assuring domestic abuse crime investigations (Investigation Managers and D/Sgts within FCIUs) are to particularly check that these elements of domestic abuse policy are adhered to when authorising the closure of domestic abuse files.

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Appendix 2 – Circulation list for the report

Addaction (specialist drug and alcohol charity)
Adullam Homes Housing Association Limited
Alder Hey Children's Hospital
Arena Housing Association Ltd
Cobalt Housing Limited
Crown Prosecution Service Merseyside and Cheshire
HM Courts and Tribunal Service
HM Prison Service
Liverpool Direct Limited (public and private partnership for providing revenue and benefits services, Information, Communications and Technology (ICT), human resources and payroll and a small call centre operation.
Liverpool City Council
Liverpool Clinical Commissioning Group
Liverpool Community Health NHS Trust
Liverpool Domestic Abuse Service
Liverpool Housing Trust
Liverpool Mutual Homes
Liverpool Safeguarding Adults Board
Liverpool Safeguarding Children Board
Liverpool Victim Support
Liverpool Women's NHS Foundation Trust
Local Solutions (umbrella group for voluntary organisations in Merseyside)
Mersey Care NHS Trust (Mersey Care provides specialist inpatient and community mental health, learning disability and substance misuse services for adults in Liverpool, Sefton and Kirkby)
Merseyside Fire and Rescue Service
Merseyside Police
Merseyside Probation
Merseyside Rape and Sexual Abuse Centre
NHS England
North West Ambulance Service
Plus Dane Group (neighbourhood investor)
Riverside Group Limited (provider of social housing)
SHAP Ltd (advocacy and advice service)
South Liverpool Domestic Abuse Services
South Liverpool Homes
St Helens and Knowsley Teaching Hospitals NHS Trust
The Crossing Point (counselling service)
The Whitechapel Centre (a homeless and housing charity working with people who are sleeping rough, living in hostels or struggling to manage their own accommodation)
Victim Support

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Appendix 3 - Procedures and guidance relevant to this serious case review

Date	Policy or legislation	Prime agency
1990	**Home Office Circular 60/1990 Domestic Violence:** issued to all police forces in England and Wales advising police to ensure that all police officers involved in the investigation of cases of domestic violence regard as their overriding priority the protection of the victim and the apprehension of the offender. The circular emphasised the importance of multi-agency working, establishment of domestic violence units, reviewing of recording policy and ensuring that officers were aware of the power of arrest and providing support to the victim.	Police
October 1991	**Children Act 1989 implemented;** major legislation in regard to investigation and protection for children at risk of harm. Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need. Section 25 describes the circumstances under which a local authority can seek to restrict the liberty of a child by placing them in secure accommodation. Section 46 provides the police with powers of removal and accommodation of children in cases of emergency to take children into police protection where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm. Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a child has contravened a ban imposed by a Curfew Notice	Social care and police have specific duties and powers described in the Act but implications and duty to cooperate for other services.

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	within the meaning of chapter I of Part I of the Crime and Disorder Act 1998. Section 31 (9) defines harm which was extended via section 120 Adoption and Children Act 2002 implemented in January 2005 that now includes 'impairment suffered from seeing or hearing the ill-treatment of another' recognising that children who witness or hear abuse suffer, or are likely to suffer, significant harm as a result.	
1995	**Home Office and Welsh Office (1995)** inter agency circular/inter agency coordination to tackle domestic violence: issued to all agencies involved in tackling domestic violence including the police.	All services
1996	**Family Law Act 1996**: changed the legal framework relating to civil injunctions in the context of family law. Part IV of the Family Law Act 1996 provides single and unified domestic violence remedies in the county courts and magistrates' courts. Two types of order can be granted: • A non-molestation order, which can either prohibit particular behaviour or general molestation; • An occupation order, which can define or regulate rights of occupation of the home.	
1997	**Protection from Harassment Act 1997**: (PHA) introduced the offence of harassment and power of the court to issue restraining orders on conviction. PHA makes it a criminal offence to pursue a course of conduct which amounts to harassment of a person. A court may issue a restraining order against someone found guilty of such an offence. Amendments to the PHA introduced by the Domestic Violence, Crimes and Victims Act 2004 will gives courts the power to issue a restraining order in certain circumstances against a defendant acquitted of a charge of harassment. In addition to the criminal offence, the PHA also creates a civil statutory tort of harassment, which enables a person to obtain a civil court injunction to stop harassment occurring and to claim damages where appropriate.	Police and courts

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	This legislation can provide protection in neighbourhood disputes, cases of racial harassment and can also potentially apply in cases of domestic abuse.	
1998	**Crime and Disorder Act 1998**: established the framework of multiagency Crime and Disorder Reduction Partnerships tasked with conducting audits of local crime and disorder and agreeing a local strategy. Section 17 of the Act requires the police (in partnership with local authorities) to exercise all their functions —*with regard to the effect on the need to prevent crime and disorder in their areas*. Domestic violence falls clearly within these duties.	
1998	**Human Rights Act 1998**: introduced positive obligations to protect life and protect victims against inhuman and degrading treatment.	All services and courts
1999	**Youth Justice & Criminal Evidence Act 1999**: introduced special measures within a court setting, for vulnerable and intimidated witnesses.	Police and courts
2000	**Home Office (2000) Domestic Violence Break the Chain multiagency guidance for addressing domestic violence**: the guidance includes advice for the police that *"there must be no suggestion that dealing with domestic violence is in any sense second class police work*" and that specialist officers should maintain close links with other units dealing with issues such as child protection.	Police as well as other agencies
2000	**Home Office Circular 19/2000; Domestic Violence revised circular to the police**: this circular provided more specific and detailed information to the police and reflected changes in legislation since 1990 and the findings of recent research.	Police
2004	**HMCPSI/HMIC (2004)** ***Violence at home, a joint thematic inspection of the investigation and prosecution of cases involving domestic violence***: includes a number of recommendations relating to policing and prosecuting domestic violence cases.	Police and courts
2004	**Domestic Violence Crime and Victims Act 2004;** Civil injunctions (under Part IV of the Family Law Act 1996) offer temporary protection through non-molestation orders or occupation orders. However, breach of injunction by the perpetrator was often not effectively enforced. New provision under section 1 of the DVCVA 2004 is intended to address this issue. Until now a	

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	breach has only been punishable as a civil contempt of court. When a non-molestation order either made after July 1st 2007, or an earlier order which has been varied is breached it will be treated like any other criminal offence, meaning that the perpetrator can be arrested, charged and brought before the magistrates' court. The victim, who was the applicant in the original civil process, becomes the key witness in a criminal case. As in other criminal cases, the decision whether or not to prosecute will be made by the Crown Prosecution Service (CPS) in conjunction with the police, where there is sufficient evidence and it is in the public interest to do so. The maximum custodial sentence for breaches dealt with as a criminal offence is five years.	
2004	**ACPO (2004) guidance on investigating domestic violence**: guidance includes a clear focus on the investigation of criminal offences relating to domestic violence.	
2004	**Home Office Violent Crime Unit (2004) Developing Domestic Violence Strategies – A Guide for Partnerships.**	
2005	**ACPO (2005) guidance on identifying, assessing and managing risk in the context of policing domestic violence**: includes a list of risk 313 factors and general information about the basic principles of identifying, assessing and managing risk in domestic violence cases.	Police
January 2005	**Adoption and Children Act 2002**, section 120 implemented: amends section 31 of the Children Act 1989 to include the following in the definition of harm: impairment suffered from seeing or hearing the ill treatment of another‖ e.g. witnessing domestic violence.	Police, social care and courts
February 2005	**ACPO (2005) policy on police officers who commit domestic violence related criminal offences**: clearly establishes the principle that evidence that a police officer has committed criminal offences relating to domestic violence is not compatible with a police service that has public confidence.	Police
March 2005	**ACPO (2005) guidance on investigating child abuse and safeguarding children**: guidance includes a clear focus on the investigation of allegations of criminal offences relating to child abuse and the need to identify concerns	Police

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	for children which are managed in the multi-agency structure for safeguarding children.	
June 2005	**ACPO (2005) Practice Advice on Investigating Harassment**: this provides information on harassment including that related to domestic abuse.	Police
September 2005	**ACPO (2005) Guidance on Investigating Serious Sexual Offences:** includes specific investigative guidance on investigating domestic or intimate partner sexual offences.	Police
2005	**Home Office (2005) Domestic Violence**: **A National Report**: this developed a national delivery plan for services relating to domestic violence.	All services and courts
December 2005	**Responding to domestic abuse:** a handbook for health professionals and superseded an earlier handbook issued in 2000.	Health
2006	**H M Government (2006) Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children** that includes guidance on children exposed to domestic violence (superseded in 2010)	All services
2007	**ACPO (2007) Police Officers and Police Staff that are Victims of Domestic Abuse**	
2007	**Home Office (2007) National Domestic Violence Delivery Plan: Annual Progress Report 2006-2007.**	
April 2008	**ACPO (2008) Guidance on Investigating Domestic Abuse**: this revised and updated the ACPO (2004) Guidance on Investigating Domestic Violence.	
April 2009	**National MAPPA guidance v3**	
September 2009	**Improving safety, reducing harm. Children and Young People and domestic violence**; A practical toolkit for front-line practitioners	Health
March 2010	Working Together revised and reissued	All services
8th April 2010	The Crime and Security Act (CSA 2010) gained royal assent of which Sections 24-33 of the Act relate to Domestic Violence Protection Notices/Orders. (DVPN/O) These are legislated for under Sections 24 - 33 of the Crime and Security Act 2010 which (when fully implemented after being piloted in Greater Manchester, West Mercia and Wiltshire) will grant powers to the police in England and Wales to issues notices which immediately prevent allegedly violent partners from returning to a family home pending a	Police

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	formal order being issued by a magistrate. Section 33 came into effect when the Act came into force; sections 24-30 were commenced from 30th June 2011 for one year. Sections 31 and 32 have not been commenced.	
November 2010	**Call to End Violence against Women and Girls;** national action plan, vision and guiding principles for reducing violence against women and children	
April 2011	Domestic Homicide Reviews (Domestic Homicide Reviews) were established on a statutory basis under **section 9 of the Domestic Violence, Crime and Victims Act (2004)**	
April 2012	***Striking the Balance*; Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences**); Guidance intended to assist those involved in information sharing between agencies about Domestic Violence to make decisions. It identifies the underlying ethical considerations so that tensions between confidentiality and information sharing may be resolved.	Health
May 2012	**Responding to domestic abuse: Guidance for general practices;** a general guide to GP practices issued by the Royal College of General Practitioners and CAADA to help them provide effective help to patients experiencing domestic violence.	
2012	**CAADA Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence** (this is not government guidance or legislation but is included as an important contribution to local and national arrangements	
June 2012	Government issues consultation on revised guidance for working together	
July 2012	Pilot of the Domestic Violence Disclosure Scheme begins for 12 months in Greater Manchester, Nottinghamshire and Wiltshire in England and in Gwent in Wales. The scheme is commonly referred to as Clare's law; this is a reference to Clare Wood who was murdered by her ex-boyfriend in Salford in 2009. The boyfriend had a history of domestic violence that was not known to Clare Wood. The pilot scheme allows a check with police on whether a partner has a history of domestic violence.	

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