DDCNH/12

Domestic Homicide Review Overview Report in respect of:

Miss A - Born: June 1982 - Died: September 2012

Marion Wright

Independent Overview Author

Date: December 2014

1. Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances around the death of Miss A in Derbyshire in 2012. Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies; how and within what timescales they will be acted upon and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent further domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

1.3 DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004. The provision for undertaking the reviews came into effect on the 13th April 2011. The death of Miss A in this case met the criteria for a statutory DHR in that the victim died as a result of being assaulted by her boyfriend in the kitchen of her home.

Home Office criteria for a DHR is " A review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence abuse or neglect by a) a person to whom he or she was related or with whom he or she had been in an intimate relationship"

It is recognised that a domestic abuse (DA) incident which results in the death of a victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse and possibly other physical attacks.

1.4 This review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from the different agencies involved for their contribution to the review process; for their time, openness and commitment.

1.5 Domestic Homicide Review Panel Members

Name	Organisation
Sally Goodwin	Chair and Head of Community Safety, Derbyshire County Council
Marion Wright	Independent Overview Report Author
Superintendent Andy Stokes	Head of Public Protection Derbyshire Constabulary
Bill Nicol	Head of Safeguarding Adults Derbyshire County and City Clinical Commissioning Groups.
Simon Gladwin	Assistant Director, Amber Valley Borough Council
Jane Brooks	Deputy Asst. Director Derbyshire County Council Children & Younger Adults Dept.
Lisa Morris	DV Manager & Commissioner of DV Services Derbyshire County Council

1.6 To reinforce the impartiality of this report it is confirmed that the Independent Overview Report Author has not previously been employed in any other capacity than providing Independent Review Reports by any agency in Derbyshire, and has not previously had any direct involvement in the case. The Independent Author is a retired Assistant Chief Officer of Probation with 33 years of experience working in criminal justice. She has previously had responsibility for Public Protection issues, including domestic abuse, and has been involved in Chairing and writing Serious Case reviews for Multi Agency Public Protection Arrangement Boards and Domestic Violence Homicide Panels.

1.7 Both the agency review panel members and the Individual Management Review report authors who have provided the agency evidence considered by the review are independent from any direct involvement in the case or direct line management of those involved in providing the service.

1.8 The Chair of the review panel, whilst being employed by Derbyshire County Council and having relevant experience ,has not been involved with any of the agencies who have had contact with Miss A or Mr D either directly or in providing management oversight. As such she brings impartiality and objectivity to her role as Chair.

1.9 In line with the National Domestic Homicide Review Guidance the decision was taken to undertake a DHR within four weeks of the homicide. The Home Office were notified of the decision on the 12th October 2012, the homicide having taken place on the 22nd September 2012. As the perpetrator, Mr D, at that stage denied the charge of murder, following initial meetings; the review process was temporarily paused until after conclusion of the criminal proceedings. The Home Office was informed of the delay. The criminal court case was concluded on the 20th December 2013 and the outcome was that

Mr D was convicted of murder and sentenced to life imprisonment with a tariff of 20 years. As a result the review process was immediately resumed.

1.10 The view of the Review Panel was that to interview the perpetrator and the family members prior to the conclusion of the criminal proceedings was inappropriate. However any lessons to be learnt by any agency regarding practice were advised to be taken forward without delay.

1.11 Following the conclusion of the criminal proceedings contact was made with identified family members, friends and a work colleague who could provide useful information to the review and may wish to have their voices heard within the process. The perpetrator was also contacted.

1.12 Parallel processes include the criminal trial and Coroner's Inquest. Appropriate liaison has been undertaken to inform the different processes. As there has been a criminal investigation resulting in a conviction, there will be no Coroner's investigation.

1.13 Circumstances that led to the review being undertaken

On Saturday 22nd September 2012 just before 16.00 hours Police were called to the home of the victim Miss A. It was reported that she had been stabbed by her boyfriend with a kitchen knife. The couple had been in a relationship for approximately 8 months. Following the attack the perpetrator Mr D had telephoned his mother. His mother got a taxi to the address and it was when she arrived that the emergency services were called by the taxi driver. [Redacted] The Paramedics arrived at 16.10 and confirmed Miss A had received multiple stab wounds. Her injuries were so significant that they were described as incompatible with life. She died at the scene. Mr D took an overdose of paracetamol and prescribed drugs and was later transported to hospital.

1.14 Scope of the Review

The scope of the review will include information available on Miss A, the victim and Mr D the perpetrator. The time frame of the review was agreed to be between 1st January 2012 to the 23rd September 2012 when Mr D was charged with Miss A's murder. However, if any agency felt there was relevant information from outside the time period under review it was agreed the information should be included in their Individual Management Review (IMR). As well as the IMRs, each agency provided a chronology of contact with the identified individuals including what action was taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures were followed, whether they were adequate, and if appropriate, were charged with making recommendations from the agency perspective.

1.15 Terms of Reference (TOR) for the Review

The IMR authors were tasked with answering the questions set out below in the TOR and providing analysis of agency involvement. Issues to be addressed were:

1) Are there any specific considerations around equality and diversity issues such as ethnicity, age and disability that may require special consideration?

2) Was the victim subject to a MARAC?

3) Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)?

4) Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)?

5) Did the victim have any contact with a domestic violence organisation or Helpline?

6) Did anyone in contact with the victim know whether or not the victim was aware of domestic violence services available locally? If yes but not used were there any barriers to the victim accessing the services?

7) How should friends, family members and other support networks and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement?

8) How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for this?

9) Consideration should also be given to whether either the victim or the perpetrator was a 'vulnerable adult'

10) How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?

11) How should the review process take account of previous lessons learned i.e. from research and previous DHRs?

12) Were there any issues, in communication, information sharing or service delivery, between services?

13) Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?

14) What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator. What was the quality of any multi-agency assessments?

15) Was the impact of domestic violence on the victim recognised?

16) Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

17) Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

18) Could the homicide have been anticipated or prevented?

1.16 Methodology

The Review Panel was convened by the Head of Community Safety on behalf of the Derbyshire Safer Communities Board and included representatives from the relevant agencies and the Independent Overview Report Author. The Review Panel commissioned a chronology and IMR from each agency involved in the scope period. There were two other agencies that whilst not involved in the scoping period had had contact previously. The Youth Offending Team and the Probation Trust were contacted to provide information relating to offending history, risk assessments and any other relevant information they may have had. This was provided.

1.17 A total of three meetings were held with the Review Panel. Firstly to agree the Terms of Reference and commission the IMRs. Secondly to discuss the content of the IMRs, ask questions to clarify any points as necessary and seek further information as appropriate. The third meeting was to consider the draft Overview Report in order to ensure it accurately reflected the information provided by the agencies in a full and fair way.

1.18 In order for agencies to prepare their contribution, they were asked to consider contact and practice in providing a service measured against agency policies and procedures and to identify any shortfalls or indeed where current policies and procedures required improvement. Where relevant, staff were interviewed who were known to have had involvement with Miss A and Mr D. The Independent Report Author liaised with the Police Senior Investigation Officer in the case, the Police Family Liaison Officer and the Derbyshire County Council's Acting Domestic Violence Manager.

1.19 The agencies completing IMRs and the profile of their involvement are as follows:

- The Derbyshire Constabulary who responded to calls for assistance in September 2012 and had some previous information relating to both parties.

- The Head of Safeguarding Adults for Derbyshire County and City Clinical Commissioning Groups who represented all health providers in Derbyshire who had any contact with the victim or perpetrator including GPs during the period of time in scope.

- Derbyshire Children and Younger Adults Department of Derbyshire County Council who confirmed that they last had contact with the perpetrator and his mother in 2008 and there had been no further involvement.

- Amber Valley Borough Council who had contact with Miss A in relation to council tax and with Mr D in relation to benefit claims and council tax since August 2007.

1.20 In preparing the Overview Report the following documents were referenced:

a) CAADA Co-ordinated Action Against Domestic Abuse. Work on coercive control by Professor Evan Stark. CAADA 2012 report 'A Place of Greater Safety'.

b) The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews.

c) The Home Office Domestic Violence Homicide Review Toolkit Guide for Overview Report Authors.

d) Call an End to Violence Against Women and Girls –H.M. Government publication 25th November 2010.

e) A number of published Domestic Homicide Review Reports available on the internet to identify common areas of learning.

f) The Cross Government definition of Domestic Violence Consultation Summary of Responses 2012.

g) Michael Johnson Research. Intimate Terrorism V Situational Couple Violence.

1.21 Where confidential information has been detailed in relation to Miss A and Mr D it has been gathered and shared in the public interest and in line with National Guidance for the conduct of DHR.

1.22 The mother of Miss A and the mother of Mr D, the perpetrator and his maternal aunt, the victim's friend, a work colleague and the person who

rented a room in Miss A's house were all contacted offering them the opportunity to contribute to the review.

1.23 Once the draft Overview Report was completed, family friends and the perpetrator were contacted so that they had the opportunity to consider the report and comment on the content before publication.

1.24 Subjects included in the scope of the DHR were:

Miss A – the Victim	Girlfriend of the perpetrator
Mr D – the perpetrator	Boyfriend of the victim
Mr E	Friend of the victim

2 The Facts

2.1 At the time of the homicide Miss A was a single person and lived in her owner occupied home in Derbyshire. Miss A had a female lodger who rented a room from her. She had lived in this property since early 2009 some three and a half years. The house was up for sale. Miss A had been in a relationship with Mr D for approximately eight months. He had his own privately rented accommodation in the same area of Derbyshire where it appeared he had lived alone since January 2012. Both Miss A and Mr D were in regular contact with their relevant mothers and extended family members.

2.2 Miss A was in full time employment and Mr D was on sick leave from his place of work due to suffering from epileptic fits and seizures. He had suffered these episodes on a regular basis from December 2009. He was given alternative medication for his anti-epileptic treatment from December 2011. He was frustrated at not being able to work whilst undergoing this treatment and could not learn to drive until his epilepsy was under control. It is the view of the perpetrator's family that the side effects of the new anti-epileptic drug he was prescribed, which included agitation, some paranoia and suicidal thoughts may have played a part in the way Mr D was thinking and feeling in the weeks leading up to the homicide.

2.3 The circumstances of the homicide were that following an assault on a male friend at Miss A's home by Mr D in the early hours of Sunday 16th September 2012 it is alleged Miss A apparently recognised the relationship was not working out and wished to end her relationship with Mr D. Apparently Mr D stayed over at Miss A's home on Friday 21st September the night before the homicide. At approximately 3.15 in the afternoon of the 22nd September 2012 Miss A and Mr D had an argument. It has been established since that Mr D took knives out of the kitchen drawer and repeatedly stabbed Miss A. Miss A died at the scene in the kitchen of her home.

2.4 Mr D telephoned his mother after the attack. His mother got a taxi to the house and the emergency services were called by the taxi driver as the mother was too distressed. Mr D took an overdose of his anti-epileptic prescribed drugs and paracetamol. He was arrested and transported to hospital. He was charged with the murder of Miss A on the 23rd September

2012. A trial was due to take place however Mr D eventually pleaded guilty and was sentenced on the 20th December 2013 to life imprisonment for the murder of Miss A.

2.5 The Post Mortem revealed the cause of death was essentially exsanguination from loss of blood from the totality of the many incised wounds and stab wounds Miss A received. There was evidence that she had taken purposeful action to defend herself during at least some of the attack. There was no evidence of any injury to Mr D.

2.6 Whilst there was no recorded history of domestic violence in their 8 months relationship it has since come to light that Mr D had shown signs of aggression at the home of Miss A. It is alleged that he had on at least two occasions caused damage to her property by kicking or punching household fittings e.g. the wardrobe door and it is reported that he pushed her into the garden fence causing damage. This behaviour had not been reported to the Police or any other agency. With hindsight it is possible that this behaviour was designed to coerce and control Miss A, a key factor of domestic abuse.

2.7 The Police investigation into the murder identified that Miss A had confided in a work colleague that her relationship with Mr D was not working out and had shared information about his aggressive outbursts towards her property. Her father was also aware and was involved in making good the damage caused by Mr D. Her friend who was assaulted by Mr D on the 16th September 2012 was sufficiently concerned about her welfare to call the Police as she was with Mr D after the assault and he appeared to be agitated.

2.8 There is some evidence that Miss A may have been subject to an element of emotional/psychological domestic abuse from a previous relationship. She had contacted the Police on the 31st July 2011 when she reported that she was the victim of unwanted texts and attention at her home from her ex-boyfriend. She made no official complaint and no form 621 was completed by the Police. A form 621 was a Derbyshire Constabulary form designed to assess the risks in domestic and child abuse cases. It was replaced by the CAADA ACPO DASH risk assessment in October 2011. Research recognises that emotional abuse can cause lasting damage for victims of domestic abuse. The impact on their self-esteem and self-worth makes them vulnerable to enter into other abusive relationships in the future.(CAADA Report 2012 ‘A Place of Greater Safety’) This may have been a relevant factor in this case. Also it is recognised that people experiencing abusive behaviours that are not yet physical violence may not identify themselves as suffering domestic violence and so may not seek help. This may be relevant in the case of Miss A.

2.9 There was a history of domestic difficulties relating to Mr D’s behaviour within his family. Given the Police policy and guidance at the time, due to his young

age, only one event was classified as being of a domestic nature. [Redacted] The final event was on the 20th June 2008 when there was an argument reported to the Police between Mr D and his stepfather. As Mr D was then 18 years old this incident was correctly recorded as domestic and a form 621 was completed. The risk was classed as standard. For the offence of criminal damage in 2008 Mr D was made subject of an Absolute Discharge.

2.10 The reason that only the last event in June 2008 was considered to be domestic was that the cross government definition of a domestic incident which was applicable at that time excluded incidents involving those under the age of 18 years. It was defined as "any incident of threatening behaviour; violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality. Adults were considered to be aged 18 and over. Derbyshire Constabulary changed its local definition to include 16 and 17 year olds in 2010 and the national definition was also changed with effect from March 2013 to include 16 and 17 year olds and to include the issue of coercive control.

2.11 As well as the four incidents referred to above, Mr D had previously come to the attention of the Police, Youth Offending Service (YOS) and the Probation Trust. In 2001 aged 10 years he was reprimanded for assaulting a fellow pupil. In 2006 he was referred to YOS for a final warning assessment for criminal damage at a fast food establishment. In January 2007 he was charged with Section 18 wounding with intent. Records indicate he stabbed a boy in the face in an argument over a girlfriend. However, he was convicted of actual bodily harm a lesser charge. [Redacted] On 1st August 2009 he was convicted of assaulting a man where he allegedly used a glass and then with an associate kicked and punched him to the ground. He was convicted of a Section 39 assault but denied using a glass as part of the attack.

2.12 On the 16th September 2012 the Police received a 999 call from a male friend of Miss A, Mr E, reporting that Mr D had assaulted him; he had pushed his head into the tap injuring his nose. The trigger for the assault was said to be that Mr D had become very agitated as Mr D believed that Miss A was "cheating on him". Miss A was out socially with Mr E's fiancé and Mr D was also upset that she preferred to be "out drinking" with someone else not him. After the assault, Mr E had been very concerned for Miss A's welfare as she was missing. Miss A had apparently gone out with Mr D to try and resolve the issue. Miss A and Mr D were subsequently spoken to separately by the Police. Miss A was interviewed at home alone and not in the presence of Mr D and was safe and well. Mr E did not support a prosecution and the offence was dealt with by way of Restorative Justice in that Mr D apologised to Mr E.

2.13 In terms of intervention from agencies Mr D was made the subject of a Referral Order in September 2007 at Derby Youth Court for the offence of burglary and actual bodily harm. He had been on a programme of Bail Supervision and support and stayed in an English Churches Housing Hostel from the beginning of August 2007 until September 2007. He was described as a young person who sometimes experienced emotional and behavioural difficulties and he accepted that managing his anger appropriately could be a problem at times. A referral was considered to the Child and Adolescent Mental Health Service. However he was assessed by his GP in May 2008 and offered anger management. He did not wish to pursue this. The GP informed YOT there were no concerns of a mental health nature.

2.14 He attended all of the sessions of the referral order programme and completed the programme successfully. He was referred to the Derbyshire Healthcare Foundation Trust Breakout Service for drug advice. He was using cannabis on a day to day basis and reported use of other drugs experimentally. The focus of input was strategies to reduce cannabis use. He attended three appointments then failed to attend all others and was discharged from the service on the 11th August 2008. [Redacted].

2.15 For the assault of the man in 2009 he was subject of a Court Report prepared by the Derbyshire Probation Trust. On the 17th June 2009 he was sentenced to 150 hours unpaid work three month curfew between 7pm and 7am and an exclusion order. He completed all aspect of the sentence successfully. The Offender Assessment (OASyS) undertaken in June 2009 assessed Mr D as low risk of harm in the community with a slightly higher risk of re-offending.

2.16 Alcohol and drug misuse was identified as a factor related to his offending along with thinking and behaviour, education, training and employability. Although Mr D stated he had stopped using drugs, he admitted to having injected amphetamine. In October 2011 there is reference that Mr D was still smoking five spliffs of cannabis a day. In January 2011 Council Tax staff received an Appointee form from Mr D asking for his mother to be his appointee for Council Tax and benefits due to Mr D having difficulty dealing with his financial affairs due to the fact he had a history of substance abuse. It is not recorded whether Mr D was still using cannabis at the time of the murder. Information from the Police investigation indicates he had been drinking but was not drunk.

2.17 The Probation OASyS assessment indicated that Mr D could act impulsively on occasions and not think through the consequences of his actions. Throughout the assessment and court report there are recorded issues of family relationship difficulties.

2.18 There was no further contact between Mr D and the Youth Offending Team after 2008 or with the Probation Trust from December 2009 when he completed the unpaid work order. There is no relevant involvement with Police between September 2009 and the incident involving the assault to Miss A's friend Mr E in September 2012.

3. Chronology

3.1 There is a chronology charting contact of involvement with Miss A and Mr D [Redacted} for the period of the scope. Also included is information the Review Panel agencies felt appropriate prior to January 2012. All contacts significant to the DHR have been referred to elsewhere in this report. Therefore given the limited contact with agencies it is not proposed to repeat the information in this section. [Redacted].

3.2 There is reference to medical information relating to Mr D's epilepsy and the positive effect of new treatment which started in January 2012. [Redacted] However in August 2012 he told East Midlands Ambulance crews, who had been called to his home due to him suffering chest pains, that he had had five fits in the last three days. On 13th September 2012 GP records indicate no further seizures and that he feels well and would hope to return to work in six to eight weeks and was considering driving lessons for the New Year. There appears to be some discrepancies in Mr D's reporting of the frequency of his seizures. In my contact with Mr D's aunt she identified that with hindsight, the family considered Mr D had been suffering from depression since 2010. However he had not recognised this or shared the symptoms with his Doctor. The family consider that the new medication for his epilepsy whilst improving the regularity of the seizures, had significant side effects. These effects were worse during the immediate weeks before the homicide when the transition from the previous medication was complete and that medication was withdrawn.

3.3 Whilst his epilepsy was, I understand, linked to his possible defence in relation to the murder, the Senior Investigating Police Officer confirmed that this was in the final summing up of the criminal proceedings accepted as having no direct relevance to the events of the 22nd September 2012. I also understand from his aunt that it is the families' intention to continue to gather evidence about the effects of the anti-epileptic drug on Mr D's thinking and behaviour and how this may have impacted on the fateful events. Whilst all the family fully accept Mr D's culpability for the homicide they wish to try and understand how his devastating actions occurred.

4. Analysis relating to the Terms of Reference

4.1 Are there any specific considerations around equality and diversity issues such as ethnicity, age and disability that may require special consideration?

4.1.1 [Redacted]

4.1.2 Mr D suffered from epilepsy which according to records prevented him from undertaking his employment for several months in 2012. This was the same period as his relationship with Miss A. It is recorded that he found the impact of his epilepsy both debilitating and frustrating in that he considered the seizures and his prescribed medication may have had a negative impact on other aspects of his health and functioning. E.g. it prevented him from working and learning to drive. It is the author's view based on researching the subject that the stigma of such an illness may have affected Mr D's feelings of self-confidence and self- worth. The anti- seizure reduction medication does have side effects as referred to previously which may effect mood and feeling of well being. Whilst suffering epilepsy and its associated health issues may have affected Mr D's thinking and feeling, there is no reference in the agency IMRs that his epilepsy had a direct impact on the domestic violence that he perpetrated against Miss A. The lack of relevance was also highlighted by the Sentencing Judge and accepted by Defence Counsel at that time.

4.2 *Was the victim subject to MARAC? (Multi-Agency Risk Assessment Conference)*

4.2.1 There was no reported or recorded history of domestic violence between the couple. With the benefit of hindsight the damage to the property at Miss A's home and the assault of her friend may now be viewed as a pattern of escalating behaviour designed to coerce and control Miss A by Mr D. This information was not recorded and not recognised at the time either by the Police or the victim. Her friend Mr E was very concerned for her welfare due to Mr D's attitude and behaviour but when the Police investigated Miss A did not highlight any concerns and Mr D apologised which was accepted by the friend. In the circumstances it would appear appropriate that Miss A was not referred to MARAC as there were no risk indicators identified.

4.3 *Was the perpetrator subject to Multi Agency Public Protection Arrangements? (MAPPA)?*

4.3.1 The perpetrator was not subject to MAPPA. There had been three convictions against Mr D, two for violence and a burglary at his grandparent's home and one for criminal damage at his mother's home; the last one being in 2009. No agency had identified that he was a high risk of serious harm nor had he been sentenced to a period of imprisonment for 12 months or over for the offences committed. Both are the criteria for referral to MAPPA. He had

received community sentencing for the offences. In the circumstances not being referred to MAPPA would appear appropriate practice.

4.4 *Was the perpetrator subject to a Domestic Violence Perpetrator Programme? (DVPP)?*

4.4.1 The perpetrator was not subject to a DVPP nor given his history, would he have been eligible. The OASyS assessment undertaken by the Probation Trust in 2009 assessed Mr D as someone who was low risk of harm in the community. It identified "he could act impulsively on occasions and not think through the consequences of his actions". Throughout the assessment and court report there are recorded issues of family relationship difficulties. However his behaviour and the perceived difficulties did not warrant a referral to a DVPP.

4.5 *Did the victim have any contact with a domestic violence organisation or Helpline?*

4.5.1 There is no evidence that the victim Miss A had any contact with a domestic violence organisation or helpline. Whilst the Police investigation following the murder identified that Miss A had confided in a work colleague that her relationship with Mr D was not working out and highlighted Mr D's impulsive behaviour in causing damage to her property, it would not appear that Miss A or anyone close to her, saw her as a victim of the psychological/emotional domestic abuse that may with hindsight have been in existence. There is some evidence from family that Mr D had been aggressive towards Miss A previously having pushed her into the garden fence causing damage to the fence. However in recounting this to her mother at the time Miss A underplayed the significance of the incident. Following the assault on Mr E Miss A took steps to end the relationship recognising she no longer wanted to be with someone who could behave in such away. For her to leave a dangerous relationship was the safest choice but ending an abusive relationship is a very dangerous time when a safety plan for home and work is needed. This was not recognised at the time.

4.6 *Did anyone in contact with the victim know whether or not the victim was aware of domestic violence services available locally? If yes but not used were there any barriers to the victim accessing the services?*

4.6.1 There is no evidence to date that would suggest the victim was aware of domestic violence services locally. The Police investigation did highlight that Miss A may have been a victim of domestic abuse before from a previous partner in relation to unwanted texts however the incident was not recorded or classified as domestic therefore she would not have been provided with information on domestic violence services and there was no professional or other input recorded.

4.6.2. There is no evidence that when she was seen by the Police on the 16th September 2012 following the assault on her friend Mr E by Mr D and the friends subsequent reported concerns for Miss A's welfare that she was

given any information about domestic abuse services locally. Miss A did not identify that she was in anyway a victim of domestic abuse. In fact she told Police all was okay and despite her friend's anxieties, Police considered all was well. It was considered by the Police Officer investigating at that time whether to record the incident as domestic given Mr D's jealousy as the motivation for the assault, however when Police spoke to Miss A and Mr D both stated there had been no argument between them. With the benefit of hindsight, to have recorded the incident as domestic and to complete an CAADA ACPO DASH may have triggered a different response to Miss A including giving her information about local domestic abuse services should she need it or feel at risk in the future. In any event had a DASH form been completed, the incident would have been graded as 'standard' and would not have met the threshold for a referral to MARAC. However, as well as providing information to Miss A, to have completed a DASH would have recorded the incident as domestic and provided some history had there been further domestic abuse incidents.

4.7 *How should friends, family members and other support networks, and where appropriate the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?*

4.7.1 Friends, colleagues and immediate family members, together with the perpetrator, have been written to to be given the opportunity to contribute to the review. The Home Office leaflet was sent to the family and friends. Contact by way of interview, telephone or by writing was an option. The letters were sent by and contact offered with the Independent Report Author. A home interview was undertaken with Miss A`s mother. During the interview Miss A`s maternal grandparents, to whom she was very close, visited unexpectedly and also contributed to the review. Mr D requested that contact was made with his maternal aunt to discuss the review on his behalf. An extended interview was undertaken with his aunt.

4.8 *How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for this.*

4.8.1 Matters concerning family and friends, the public and media will be managed before, during and after the review in accordance with a Communication Plan drafted by the Deputy Director Communications for Derbyshire County Council.

4.9 *Consideration should also be given to whether the victim or the perpetrator was a 'vulnerable adult.'*

4.9.1 Based upon information received from the health providers, and the definition provided by the Law Commission neither the victim Miss A or Mr D were considered to be a 'vulnerable adult.'

4.10 *How will the review take account of the Coroner's Inquiry and any criminal investigations related to the homicide, including disclosure issues, to ensure*

that relevant information can be shared without incurring significant delay in the review process?

4.10.1 The review has been undertaken in close liaison with the Police Senior Investigating Officer to share information in relation to criminal investigations, disclosure issues and any Coroner's Inquiry. As Mr D was pleading not guilty to the charge of murder the DHR was paused until after the completion of the criminal proceedings to avoid DHR enquiries influencing the process. There is no evidence that there will be a Coroner's Inquiry.

4.11 *How should the review process take account of previous lessons learned from research and previous DHRs?*

4.11.1 The DHR author has accessed other published DHR reports to consider lessons learned and their relevance to this case. Given the limited contact with agencies there is limited relevant learning to be applied in this case. The Police identified a recent Serious Case Review which highlighted the fact that warning markers were not considered regarding a youth who displayed a tendency to self -harm and subsequently committed suicide. The links with issues around the warning markers in this case leads to a recommendation relating to the use of warning markers.

4.11.2 In relation to research, the author has found two pieces of research information that may be relevant. The first, included in a CAADA 2012 report 'A Place Of Greater Safety' referred to work undertaken by Professor Evan Stark on coercive control which may be relevant. He proposed that we need to reframe domestic abuse to place greater emphasis on the dynamics of power and control present in the majority of abusive relationships. Coercive control had been added to the cross government definition of domestic abuse in March 2013, after this homicide took place. High risk domestic abuse is often underpinned by coercive control. 79% of victims experienced jealous and controlling behaviour.

4.11.3 Jo Morrish, CAADA's Learning and Quality Service Manager, says: 'It is clear that extreme levels of coercion and control are also directly associated with the risk of homicide or serious harm. Indeed a number of homicide cases have been characterised mainly by the extent of coercion rather than previous physical violence.' ' We have always argued that practitioners should recognise the significance of coercion and control and welcome the changes in definition to include this.'

4.11.4 Colleagues working in the field of domestic abuse referred the author to the work of Michael P Johnson on Intimate Terrorism v Situational Couple Violence. This may be relevant in this case. He suggests there are three major types of intimate partner violence, only one of which (intimate terrorism) is the sort of violence that we all think about when we hear the term domestic violence. It is primarily male perpetrated and in the case of heterosexual relationships probably best understood through some versions of a feminist theory of domestic violence.

4.11.5 Johnson considers it is no longer scientifically or ethically acceptable to speak of domestic violence without specifying the type of violence to which one refers. The three types are distinguished from each other by the control context within which they are embedded e.g. a) violence enacted in the services of taking control over one's partner (intimate terrorism) b) violence utilised in response to intimate terrorism (violent resistance) and c) violence that is not embedded in a general pattern of power and control but is a function of the escalation of a specific conflict or series of conflicts (situational couple violence). The first would seem to resonate with this case. The damage of property at Miss A's home, the incident of pushing her into the fence and the jealous outburst that led to the assault of her friend would appear, with hindsight, to be a pattern of male dominated power and control behaviour.

4.12 *Were there any issues in communication, information sharing or service delivery between services?*

4.12.1 None of the agencies involved identified any issues or barriers to communication, information sharing or service delivery in relation to the care treatment and responses to Miss A or Mr D. Domestic abuse was not reported or recognised. The only opportunities for service delivery, within scope, related to the reporting of the assault by Miss A's friend on 16th September 2012 and his concerns for Miss A having left with Mr D. This was due to Mr D's agitation, aggression and unpredictability and the fact that he could not get a response from Miss A on her mobile phone which she had switched off. Miss A was interviewed by Police on her own without the perpetrator being present and said she was ok and that she had not had an argument with Mr D. The victim, Mr E, did not wish to support a prosecution and the assault was dealt with by way of restorative justice, in that Mr D apologised to the victim of the assault.

4.13 *Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults and with the wider professional standards?*

4.13.1 In January 2007 Mr D was charged with a section 18 wounding with intent when he stabbed a boy in the face in an argument over a girl. The offence was reclassified at Court and Mr D was convicted of the lesser charge of actual bodily harm. No marker was placed on the police national computer (PNC) relating to Mr D's propensity to use weapons. In addition, on 1st August 2009 Mr D was convicted of section 39 common assault having 'glassed' a man. He denied using a glass as part of the assault. No marker was put onto PNC.

4.13.2 The IMR author from the Police considers that the PNC record for Mr D should have been updated with a weapons marker in 2007 and that the assault in 2009 reinforced Mr D's propensity to use weapons. However, in considering the definition of the Derbyshire Constabulary policy and the PNC manual at the time, there appeared to be confusion between the two definitions. As a result, the policy has now been amended to make it clear

when markers should be used and that the definition includes 'used a weapon to commit an offence or intelligence suggests may carry a weapon.' The issue of warning markers was highlighted in a recent Serious Case Review. As a result the IMR author makes a recommendation that the use of warning markers are publicised across the Force. Miss A`s family feel strongly that Miss A should have been informed of Mr D`s history of violent offending when the police had contact with her following the 16th September incident. However, the Review Panel gave this issue careful consideration and concluded that even with hindsight this case would not have met the threshold for disclosure of such information as there was no evidence of a pressing need to prevent further offences at that time.

4.13.3 There were four incidents including Mr D and members of his family prior to 2012 which could be considered to be of a domestic nature. One led to conviction for criminal damage at his mother's home in 2008. However, only the last incident, an assault on his stepfather on 20th June 2008, was marked as domestic with a form 621 submitted with an entry on the critical register for the address in question. The practice was in line with the cross government definition of a domestic incident and Derbyshire Constabulary's definition and policy. The definitions at the time excluded incidents involving those under eighteen years of age. Mr D was under eighteen years for all incidents except the 20th June 2008 which was correctly marked. Derbyshire Constabulary changed its definition of domestic abuse in 2010 to include sixteen and seventeen year olds and the national definition changed in March 2013. Had all five incidents been marked as 'domestic' it may have given a different picture of the history of Mr D to the investigation of the 16th September incident. The issue of coercive control has been added to Derbyshire Constabulary's definition of domestic abuse in line with cross government development on definition.

4.13.4 The Police IMR author considered and reassessed against professional standards the incident reported on 31st July 2011 concerning the ex-boyfriend of Miss A sending unwanted texts. It was clear that Miss A did not want any Police action taking other than the call logging, however it is considered that the operator should have classified the incident as domestic related and submitted a form 621 risk assessment. This would have likely been classed as standard and warranted no further action but none the less it would have provided intelligence that Miss A may have been a victim of domestic abuse previously.

4.13.5 In the light of the response from the victim of the assault on 16th September 2012 saying he did not wish to support a prosecution but just wanted an apology from Mr D, together with Miss A saying she was ok and that there had been no altercation between her and Mr D, the police officer utilised the restorative justice (RJ) approach and an apology was made and accepted. As Mr D had previous convictions for assault to deal with the incident by way of Restorative Justice would be the exception rather than the rule and required agreement by Senior Police staff. The process was followed correctly and involved the Officer's Line Manager. The IMR author considered the approach pragmatic and satisfactory. With hindsight had Mr

D been prosecuted the process may have helped him to see that his controlling and jealous behaviour was unacceptable and it may have provided an opportunity for recognition by Miss A that she was a potential victim of domestic abuse and for intervention by outside agencies e.g. Police, Courts and Probation, who are aware of the implication of such behaviour and could have offered assistance. Miss A`s family consider that it was totally inappropriate to have dealt with such a nasty assault by way of RJ and that regardless of Mr E`s willingness to accept an apology that there was sufficient evidence to support a prosecution and that this course of action should have been pursued. Whilst there are current changes planned in relation to preventing the use of Restorative Justice for domestic abuse where the victim and perpetrator are intimate partners, the circumstances of the assault on the friend in this case would not have fallen into this category and therefore the RJ disposal may still have met the criteria for such an outcome.

4.13.6 Although the assault on the friend was not 'domestic' in itself, the motivation for the incident may be seen as such as the trigger for the assault was the jealousy and wish by Mr D to control the relationship between Miss A and himself. The Police Constable advised that at the time she considered defining the incident as domestic and submitting a DASH risk assessment. However, the separate conversations with Miss A and Mr D both stated that there had been no altercation between them and therefore the officer did not complete a DASH. Had a DASH been completed and had Miss A been asked the questions included in the DASH it may have uncovered potential indications of domestic abuse in the relationship. Certainly, had Miss A shared her experiences, we now know there would have been some 'yes' answers to the DASH questions posed. It is possible that the very process of asking the questions and giving information about domestic abuse services may have assisted Miss A in recognising that she was a victim of domestic abuse and may need professional help to manage her situation. Given that research would suggest on average that there are thirty five incidents of domestic abuse before a victim reports it, it is important where domestic abuse is considered likely that presenting issues are not accepted without further exploration and that professional probing questions are asked to assist victims to recognise and express their concerns in such sensitive situations.

4.14 *What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator? What was the quality of any multi- agency assessments?*

4.14.1 Given that there was very limited contact with Miss A and Mr D by agencies during the scope period, opportunities for assessment and decision making in this case were very limited.

4.14.2 Assessments were undertaken in the past relating to Mr D when he was supervised by the Youth Offending Service and the Probation Trust, the last being in 2009. The assessment identified Mr D as low risk of serious harm. Difficulties were identified in family relationships, his impulsive behaviour,

and his use of drugs (in the main cannabis). He was identified by the Youth Offending Team as requiring assessment for his mental health. He was seen by his GP in May 2008, aged eighteen years, and was offered anger management which he refused. This does not appear to have been an issue that was raised again.

4.14.3 The two opportunities for assessment in relation to Miss A were firstly when she contacted the Police on 31st July 2011 to report that she was receiving unwanted texts and attention from an ex- boyfriend. It is reported that she did not want the Police to take action but wanted the call logging, presumably for future reference should the texts continue. The matter was logged. On reflection by the IMR author, the view is that the operator receiving the call should have classed the incident as 'domestic related' and submitted a form 621 risk assessment. It is considered that the incident would have been classed as standard and would not have warranted any further intervention at that time.

4.14.4 The other opportunity for assessment in relation to both Miss A and Mr D was following the report of assault by Mr D on Miss A's friend on 16th September 2012. The assessment was that given it was a minor assault it could be dealt with by way of RJ and that Miss A did not require further input. It is recorded that the victim of the assault did not wish to pursue a prosecution despite the fact he had a broken nose. However, even with hindsight had there been a prosecution, it may have influenced a different outcome and at least given a clear message to Mr D that his behaviour was unacceptable and may have supported Miss A in her desire to end the relationship.

4.14.5 Although Miss A asserted that she was 'ok' had the Police Officer completed the DASH risk assessment at that time it may have identified all was not well in the relationship and provided an opportunity for input in relation to information about domestic abuse support services. It may also have assisted Miss A to recognise that she was a victim of domestic abuse and supported her resolve to end the relationship. It is recognised in domestic abuse cases that risk increases when the victim attempts to end the relationship. A victim safety plan is advised at such times.

4.14.6 There were no multi-agency assessments undertaken in this case because none were required or expected.

4.15 *Was the impact of domestic violence on the victim recognised?*

4.15.1 The issue of domestic violence was not clearly recognised by those agencies involved with Miss A. She herself did not identify that she was a victim and it is likely that she did not recognise that she was a victim and needed professional support. She did, however, indicate to her work colleague that she was concerned about her relationship and wished to end it. Miss A`s Mother was aware that she had ended the relationship following the assault on her friend. However Miss A`s kind nature meant that she hoped they could still be friends. Her mother had advised against this

recognising Mr D`s potential to be controlling and she recalled that Mr D was very possessive and monitored her daughters whereabouts and contacts by constantly checking on her via mobile telephone calls and texts. Even so neither could have foreseen what was to come in the next few days and the ferociousness of the attack that took Miss A`s life.

4.16 *Did the actions accord with assessments and decision made? Were appropriate services offered /practical or relevant enquiries made in the light of assessments?*

4.16.1 As covered above at 4.14.6 it was appropriate that no professional assessments were undertaken. Decisions were made to deal with the assault of the friend by way of RJ and not to class the incident as domestic. This was supported both by the Police Sergeant and Inspector and was considered satisfactory with all concerned. On reflection, the reviewing IMR author also considered the practice to be satisfactory.

4.16.2 In the light of Miss A asserting all was well no services were offered or further enquiries made. This would seem reasonable at the time. With hindsight to exercise greater professional curiosity with greater probing questions and exploration would have ensured a more robust input.

4.17 *Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?*

4.17.1 The main opportunity for decision making was the 16th September 2012 incident. The Police Officer involved their Sergeant and Inspector in the decision to deal with the case on a RJ basis. The IMR author concludes that all decisions made were at an appropriate level given the information that was available at the time and the Police Officer made appropriate judgements in the circumstances.

4.18 *Could the homicide have been anticipated or prevented?*

4.18.1 Given that the relationship between Miss A and Mr D was not recognised by or reported to any agency as being abusive, it is very unlikely that the homicide could have been anticipated or prevented. Even with the application of hindsight for the purposes of learning lessons, had the events of 16th September 2012 been dealt with differently as discussed above, no one could have foreseen that the risk was so high and that the homicide would take place six days later.

5. Lessons learned from the Review

5.1 There was a lack of clarity by Derbyshire Constabulary about using the weapons marker to flag specific concerns about the propensity to use a weapon.

5.2 There was limited knowledge about potential indicators of domestic abuse in relation to coercive control and the actions to be taken in such circumstances.

5.3 The importance of asking probing questions should be highlighted to avoid the acceptance of presenting issues and to help identify underlying concerns in order to arrive at a more in depth assessment in possible domestic abuse cases.

6. Conclusion

6.1 This review has identified that agencies were not aware of domestic abuse being a feature in the relationship between Miss A and Mr D. Indeed it would appear that Miss A had not considered herself a victim. No incidents of domestic abuse had been reported to the Police or other agencies.

6.2 With the benefit of hindsight from information gained during the homicide investigation, there is evidence that there had been incidents of damage to Miss A's property by Mr D. This had gone unreported to the Police and other professionals. Miss A had confided in a work colleague and members of her family that the relationship was not working and about the damage and the incident of pushing. This, together with the assault on Miss A's friend on 16th September 2012, could be considered potential indicators of coercive control. Since the homicide coercive control has been included in the cross government definition of domestic abuse and in Derbyshire Constabulary's definition.

6.3 There was only one event relating to Police contact that provided the opportunity for a DASH risk assessment involving Miss A and Mr D. Given the information that was available at the time, it is considered within the bounds of reasonableness that it was not completed. However, had it been completed the response from Miss A may have indicated to professionals that abuse in the form of coercive control was a feature. Even so, it is unlikely it would have changed the final outcome as no one could have predicted, with the information available that the situation would escalate and that the homicide would take place six days later.

7. **Changes made since the homicide took place**

7.1 <u>Derbyshire Constabulary</u>

7.1.1 Face to face refresher training in domestic abuse is in the process of being provided to all front line Police staff.

7.1.2 A laminated aide memoir in relation to when an CAADA ACPO DASH should be completed has been developed and circulated to staff.

7.1.3 New Police pocket books have been designed and are in the process of being provided to all officers with the CAADA ACPO DASH risk assessment questions printed in the back so that they are available at all times.

7.1.4 A domestic abuse pack has been developed for the use of frontline police officers dealing with domestic abuse cases. This incorporates information for victims of domestic abuse and provides details of support available to them.

7.2 Derbyshire Safer Communities Board

7.2.1 Domestic Violence Perpetrator Programme – Derbyshire Domestic Violence and Sexual Abuse Services (DDVSAS), formerly North Derbyshire Women's Aid has successfully obtained funding from the Big Lottery, match funded by Derbyshire County Council, to deliver a county wide voluntary perpetrator programme that assists men to stop their abusive behaviour towards their female partners. The programme requires men to attend a group session of two hours, once a week for approximately six months. The group is facilitated by professionals and delivers a structured programme which addresses different forms of abusive behaviour.

7.2.2 Children's Domestic Abuse services – Derbyshire County Council's Children and Younger Adults (CAYA) department commissioned children's domestic abuse services, (the new contracts for which began 1 April 2013) include work with young people who are at risk of becoming domestic abuse perpetrators. The services are conducting group work with young people looking at positive relationships.

8. Recommendations

8.1. Derbyshire Constabulary

8.1.1 The operational Police Officers and staff are made aware of PNC warning markers and reminded that they should be used whenever appropriate.

8.1.2 Front line Police Officers should receive awareness training in relation to potential indicators of coercive control in domestic abuse and what action to take.

8.1.3 Front line Police Officers should receive training on the importance of professional curiosity in asking probing and explorative questions to identify underlying concerns rather than accept the presenting issues in potential domestic abuse cases.

8.2 Derbyshire Safer Communities Board

8.2.1 The Derbyshire Safer Communities Board should take steps to raise public awareness of the importance of recognising the role of coercive control in domestic abuse cases.

8.2.2 Derbyshire Safer Communities Board to ensure multi agency domestic abuse training should include specific training on the role of coercive control in domestic abuse and potential indicators of such control.

8.2.3 Consideration to be given to sharing the newly developed police domestic abuse pack with other agencies. The purpose would be to estimate its usefulness by others in providing information and details of support to victims of domestic abuse.

8.2.4 The Derbyshire Safer Communities Board to seek assurance that the recommendations are addressed within 6 months of the date the report is accepted by the Derbyshire Safer Communities Board .

Marion Wright
Independent Overview Author

Glossary of Terms

ACPO - Association of Chief Police Officers
CAADA - Co-ordinated Action Against Domestic Abuse
DA - Domestic Abuse
DV - Domestic Violence
DAO - Domestic Abuse Officer (Police)
DASH - Domestic Abuse Stalking and Honour
DPT - Derbyshire Probation Trust
DHR - Domestic Violence Homicide Review
DVPP - Domestic Violence Perpetrator Programme
DYOS - Derbyshire Youth Offending Service
GP - General Practitioner
EMAS - East Midlands Ambulance Service
IDAP - Integrated Domestic Abuse Programme
IMR - Individual Management Review
MAPPA - Multi Agency Public Protection Arrangements
MARAC - Multi Agency Risk Assessment Conference
OASys - Offender Assessment System
YOS – Youth Offending Service
YOT – Youth Offending Team