LIVERPOOL'S COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Janice'

OVERVIEW REPORT

Chair and Author David Hunter

November 2017

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1. INTRODUCTION

1.1 The principal people referred to in this report are:

Janice	Victim Less than 55 years of age	White British
Lucas	Offender and former Partner of Janice Less than 55 years of age	White British

1.2 In March 2016 Lucas was an inpatient in a Liverpool hospital receiving care. He had terminal cancer. Janice his former partner was visiting him on the ward when a verbal argument developed. Lucas struck Janice on the head/neck with a crutch. Janice had an apparent seizure and was taken to the resuscitation ward with a suspected bleed on the brain. Lucas was arrested and taken into custody. He was later charged with causing grievous bodily harm with intent, an offence contrary to section 18 of the Offences Against the Person Act 1861 and remanded in custody to HMP Liverpool.

1.3 Janice died two days after the assault; the post mortem revealed the cause to be:

Traumatic Basal Subarachnoid haemorrhage[1] and vertebral artery trauma and a ruptured berry aneurism.[2] The pathologist concluded the assault was directly attributable to the cause of death.

1.4 Lucas was interviewed twice. In the first interview he denied the assault on Janice. The second interview was also in relation to the assault and he declined to comment. He was charged with wounding Janice and remanded in custody. He was never interviewed for her homicide, because he died before the arrangements were finalised. The evidence that he struck Janice with a crutch, 'suddenly and without warning'[3], was overwhelming, including eyewitness testimony. Merseyside Police recorded the homicide as a crime,[4] showing Janice as the victim and Lucas as the offender.

1.5 During the early hours of 26 March 2016, Lucas complained of suffering from breathing difficulties. As a consequence, he was taken from HMP Liverpool to University Hospital Aintree. His condition deteriorated and he

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[1] Bleeding on the brain

[2] A small aneurysm [an excessive swelling of the wall of an artery] that looks like a berry and classically occurs at the point at which a cerebral artery departs from the circular artery at the base of the brain. Berry aneurysms frequently rupture and bleed

[3] Words taken from Section 3 Record of Inquest.

[4] National Crime Recording Standards www.gov.uk/government/uploads/system/uploads/attachment_data/file/116269/ncrs.pdf

died the following day. A Home Office post mortem was conducted and the recorded cause of death was: Pulmonary emboli; Deep venous thrombosis; Broncho pneumonia, chronic obstructive pulmonary disease and metastatic synovial sarcoma [cancer]. But for his death he would almost certainly have faced a manslaughter or murder charge.

1.6 HM Coroner, Liverpool held an inquest into Lucas's death on 15 June 2016 and determined he died from natural causes.

1.7 On 28 June 2016 HM Coroner, Liverpool held an inquest into Janice's death and determined she had been unlawfully killed.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1 Decision Making

2.1.1 On 5 April 2016 Liverpool's Community Safety Partnership Standing Group Meeting noted:

'The case meets the definition of a DHR as set out in the Domestic Violence, Crime and Victims Act 2004.

The case did not meet any of the circumstances of particular concern.

The group considered the contra-indications for a DHR and agreed that it is not necessary for a DHR to be conducted as there was no agency involvement with the two parties'.

Additionally the minutes indicated that it would be useful to determine what, if anything, the family and friends knew about the domestic abuse in the relationship and whether they sought help or advice, or knew how to access it.

2.1.2 The decision not to hold a domestic homicide review was discussed with a representative of the Home Office during a Core Cities meeting in Liverpool on 15 April 2016. The official advised the Community Safety Partnership that it should conduct a domestic homicide review involving friends and family to look at whether they had any knowledge of abuse and if they did, why they did not try to seek help.

2.1.3 A second screening meeting was held on 24 June 2016 at which a DHR was approved. The initial completion date was 24 December 2016. Later the chair of Citysafe approved a new completion date of 20 February 2017 to enable additional contact with Janice's family and to make additional attempts to engage with Lucas's family.

2.2 Domestic Homicide Review Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on 12 May 2016. He was supported by Paul Cheeseman. Both are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. Neither has been employed by any of the agencies involved with this review and were judged to have the necessary experience and skills. The first of four panel meetings was held on 24 June 2016 at which the terms of reference were agreed.

The Panel members were:

Angela Clarke	Safer & Stronger Communities Liverpool City Council

Samantha Connolly[5]	Safer & Stronger Communities Liverpool City Council
John Griffith	Detective Chief Inspector Merseyside Police
Carmel Hale	Designated Nurse Adult Safeguarding Liverpool Clinical Commissioning Group
Nick Kayani	Senior Probation Officer National Probation Service[6]
Caroline Grant	Head of Domestic Abuse Services Local Solutions
Nick Suffield[7]	Detective Inspector Merseyside Police
Paul Cheeseman	Independent Support for chair
David Hunter	Independent chair and author

2.2.2 Agencies attendance was good and all members studiously contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings supplementary work was undertaken via e-mail and telephone. The level of cooperation was excellent.

2.3 Agencies Submitting Individual Management Reviews

2.3.1 The following agencies submitted information.

Agency	IMR	Chronology	Other report
Merseyside Police	√	√	Plus HM Coroner's report
National Probation Service	√	√	
Liverpool Clinical Commissioning Group		√	
Royal Liverpool Hospital		√	
Royal British Legion			E -mail

[5] Administrator
[6] He provided expert advice on temporary releases on licence.
[7] Attended for the initial meeting

2.4 Notifications and Involvement of Families

2.4.1 Janice's daughter Sarah was nominated by the family as the spokesperson. The DHR chair wrote to Sarah. The letter, the Home Office Leaflet on DHR's, together with a leaflet from AADFA[8] were given to Sarah by Detective Inspector N Suffield on 28 June 2016.

2.4.2 The DHR chair saw Sarah on 20 July 2106. A friend of Janice's joined them partway through the meeting. As the review progressed additional questions arose and further contact was made with Sarah, who with the help of another family friend, was able provide additional information. Their attributed views appear as appropriate. The family wanted their mother known as Janice and had no objection to the use of Lucas.

2.4.3 Detective Inspector N Suffield approached Lucas's step-brother who agreed to sharing his e-mail address with the DHR chair who sent two unanswered e-mails. The DHR chair obtained a postal address for Lucas's brother and wrote to him. He did not reply or make any contact.

2.4.4 The DHR chair shared the overview report with Sarah who agreed with the contents.

2.5 Terms of Reference

2.5.1 The purpose of a Domestic Homicide Review is to:

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

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7] The Guidance was update in December 2016.

[8] Advocacy After Fatal Domestic Abuse Registered Charity number 1125973

2.5.2 Timeframe under Review

From 1 January 2009, the year in which Janice formed a relationship with Lucas, to 14 March 2016 the day she was assaulted.

2.5.3 Specific Terms of reference

1. What knowledge/information did your agency have that indicated Janice might be a victim of domestic violence and how did your agency respond to it?

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

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

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

5. Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim or perpetrator, or, on your agency's ability to work effectively with other agencies?

6. Was abuse of alcohol or drugs a significant issue in relation to this homicide and domestic violence risks? If so, how did your agency respond to this issue?

7. Are there any examples of outstanding or innovative practice arising from this case?

8. Are there any other issues, not already covered in 1 to 7 above which the DHR Panel should consider as important learning from the circumstances leading up to this homicide?

3. BACKGROUND TO JANICE AND LUCAS

Note: The information in this section is drawn from the documents seen by the Panel and contributions from family members and friends.

3.1 Janice

3.1.1 Janice was one of six children from a Liverpool family. She was educated locally and took up hairdressing under a Youth Training Scheme. She did not like it and moved to shop work and then obtained employment as a carer. She never married and had three children.

3.1.2 Family and friends want Janice remembered as a very kind, loyal, empathetic, warm and calm person, who helped others and put their needs before her own; above all she was a gentle person. She had a contagious laugh and you would hear her in the street before you saw her. She was a good mum and grandmother and her grandchildren really miss her. Janice's daughter and friends are at a loss to know why Lucas assaulted her.

3.2 Lucas[9]

3.2.1 Lucas was born in Scotland; one of twelve children. He told a probation officer that he recalled a happy and settled childhood with close supportive relationships with his family. He left school aged sixteen years without gaining any formal qualifications. He enlisted in the Armed Forces and served for nine years in various countries. Upon completing his service he was employed as a labourer in building and construction.

3.2.2 He married in the late 1970s in Glasgow and had three children who are now adults. His relationship with his wife ended in 1995 and he remained good friends with her and saw his children regularly when they visited him or when he travelled to Scotland. His parents and one brother are dead. Lucas reported these bereavements upset him greatly and his consumption of alcohol increased dramatically

3.2.3 He moved to Liverpool in 2004/5 to seek employment and met Janice, but was not in a relationship with her at that time. He sustained a head injury at work and became unemployed in December 2005. He derived his income from benefits.

3.2.4 In spring 2008 while living in Liverpool he reported to the police that he was the victim of a theft. Lucas's convictions included dishonesty, drugs and violence. In late 2010 he was sentenced to a long term of imprisonment for wounding a person he knew. It is known from police records that he used weapons in two assaults. His convictions suggest that on occasions he used violence to resolve disputes.

[9] The source of the information on Lucas was taken from the National Probation Service and Merseyside Police IMRs and Janice's daughter.

3.3 Janice and Lucas's Relationship

3.3.1 It is believed they started a relationship in 2009 and they visited each other at their respective homes. The relationship ended in 2015. Sarah said that during those 6/7 years her mother and Lucas only lived together for a few months and that was not until several years into the relationship.

3.3.2 Sarah recalls her mum being badly beaten up by Lucas very early in the relationship. Sarah described Lucas as dependent on alcoholic and a nasty person who she did not like.

3.3.3 Sarah said Lucas would smash furniture and ornaments in Janice's house. She further described, along with Janice's friend, Lucas's controlling and coercive behaviour. In part this took the form of multiple text messages and telephone calls demanding to know where she was and what she was doing. Janice's friend witnessed Lucas pushing and shoving her and said Janice was frightened of Lucas who threatened her with his brothers, saying they would come and sort her out. Janice ended the relationship but Lucas kept appearing, overriding her feelings and disrespecting her choice. Sarah said that physical abuse and mental control continued after Lucas was released from prison. Sarah felt Lucas took advantage of Janice's kind nature and compassion and that Janice wanted to support him with his ill-health. Sarah believed that Janice would have severed all ties with Lucas had he not been so ill.

3.3.4 Sarah asked her mum if she loved Lucas and she replied that she just felt sorry for him.

3.3.5 After Lucas became ill, Janice told Sarah that no one should die alone. Sarah and Janice's friend remarked that by visiting him in hospital Janice thought she was going to a safe place.

4. WHAT AGENCIES KNEW

4.1 Introduction

4.1.1 This section of the report is a factual chronological account of what agencies knew about the relationship. The DHR Panel's views on the facts appear in Section 5 of the report.

4.2 2009 to 2010

4.2.1 On 5 July 2009 Janice's general practitioner [GP] received notification from hospital that she had attended Accident and Emergency following a fall earlier that day. The presenting injuries were consistent with Janice's account; she received appropriate treatment. The hospital recorded Janice's next-of-kin details but these did not relate to Lucas.

4.2.2 On 26 July 2009 Sarah reported to Merseyside Police that her mother had been assaulted by Lucas who then ran away. Officers attended and saw Janice who refuted Sarah's claims. The officers noted that both parties were under the influence of alcohol and there were issues around separation as they had recently broken up. A domestic abuse risk assessment was completed which showed that Janice faced a Bronze[10] risk of harm from Lucas. Merseyside Police sent Janice a letter explaining what support was available for victims of domestic abuse.

4.2.3 In a statement made following her mother's death, Sarah said the police officers who dealt with this incident stated they would call and speak to Lucas, however neither she nor her mother heard any more about it. The Occurrence Enquiry Log is silent on whether Lucas was approached by Merseyside Police regarding this incident.

4.2.4 On the following day, 27 July 2009, Janice's GP record notes, 'Punched by someone-unknown person-refuses to go to hospital'. The entry is timed as 00.00 hours, but is likely to be a day time appointment.

4.2.5 At 8.27 pm the same day, Sarah accompanied her mother to Accident and Emergency and was treated for a black eye and bruising to left side of her face. Janice indicated that the injury had occurred two days prior to attendance and that she had no recollection of the incident as she was

[10] Merseyside Police use MeRIT [Merseyside Risk Identification Toolkit] as its domestic abuse risk Assessment tool. A criminal psychologist developed MeRIT with the assistance of experienced officers, domestic abuse practitioners, input from operational officers, victims and from scientific analysis. MeRIT helps officers to assess incidents more reliably, target interventions and thus potentially reduce domestic abuse incidents. MeRIT consists of 40 risk factors, written as trigger questions, to assist in information gathering at the scene of an incident, or when a domestic incident is reported. The risk factors should be identified through conversation rather than using the trigger questions. Merseyside Police categorises risk to victims of 'domestic abuse' as 'gold', 'silver' or 'bronze'. Bronze is the lowest level of risk.

intoxicated. An attempt was made to take a history of how the injury occurred but no further information could be obtained. A partner named within the documentation is called Thomas who was noted to live at the same address. It was recorded that 'No concerns relating to the presenting injury; appropriate clinical review and actions undertaken'.

4.2.6 Lucas's landlord repeatedly visited Lucas at home regarding rent arrears. During these visits Lucas was abusive and threatening towards the landlord saying he would burn the property down. In late January 2010 Lucas handed the keys back to the landlord. This information came from Merseyside Police.

4.2.7 In March 2010 Janice made a witness statement to Merseyside Police which did not support Lucas's alibi for a wounding offence.

4.2.8 In October/November 2010 Janice's GP saw her for a panic attack, agoraphobia and depression. She was referred to Inclusion Matters Counselling. That agency has since merged and enquiries with its successor determined that no historic information is available.

4.2.9 In late 2010 Lucas was convicted of wounding and burglary [the incidents were not connected and neither of them involved Janice] and was sentenced to eight years imprisonment. Sarah remarked that, 'her mother's life was now peaceful'.

4.3 2012

4.3.1 Lucas's Probation record notes that in February 2012 Janice received financial support from the Royal British Legion [RBL] to help with festive expenses. The RBL confirmed they had a record of Sarah's contact and that she did not disclose any domestic abuse.[11] The same Probation entry says; 'It is clear Lucas values the strong support of his wife and family who all visit him regularly'.

4.3.2 In November 2012 Lucas was being considered for Release on Temporary Licence [ROTL] as part of his sentence planning. Probation noted that Janice had agreed to let Lucas stay with her during the few days of his ROTL. Probation approved the arrangement.

4.3.3 Lucas was granted ROTL for two days beginning 11 December 2012. His Probation Offender Manager [OM] visited him at Janice' house and noted, 'He is enjoying proper contact with his family and seeing his grandchildren growing up quickly has made him realise what he has lost by his offending'. Sarah believes the reference to grandchildren relate to her child and is sure that his own grandchildren never visited him.

4.4 2013

[11] RBL has a written policy to deal with any domestic abuse disclosures from clients.

4.4.1 On 8 January 2013 Lucas who was on ROTL for two days was visited by his Offender Manager [OM] at Janice's house. The OM noted, 'Lucas, Janice and his eldest son were present. No one seen by the review has knowledge of Lucas's eldest son visiting at this time. Sarah is certain he did not. The household seemed harmonious. Lucas intended to reside at the address upon his release.

4.4.2 In autumn 2013 Lucas was diagnosed with cancer and given compassionate leave from prison for treatment in hospital. Within a week his leg was amputated below the knee.

4.5 2014

4.5.1 In January 2014 Lucas was on ROTL and disclosed to his OM that the cancer had spread. The OM asked Lucas about his home situation and relationships. He reported all was well.

4.5.2 In early summer 2014 the OM telephoned Janice who agreed that Lucas could reside with her and the children when he was released on licence in September 2014. Sarah said her mother did not have any children living with her and that she had three grandchildren who visited.

4.5.3 On 11 July 2014 Lucas was granted ROTL until 15 July 2014.

4.5.4 On 14 July 2014 Janice was seen by her GP who noted, 'panic attack, started on Mirtazapine[12] which has helped a little. Refer for CBT[13] psychotherapy'.

4.5.5 On 22 July 2014 the prison noted that Janice had written to them saying she had ended her relationship with Lucas and that she did not want him at her address and requested that probation remove her details from their records and not to contact her in future. The Offender Supervisor in prison discussed the matter with Lucas who agreed the 'relationship was over and he was trying to secure accommodation via Shelter'.

4.5.6 Three days later the following is record on Probation's records. 'Following on from our conversation on Tues I have seen Lucas again today, he has seen Shelter to assist with securing accommodation after release, due to him having been in the Armed Forces it is hoped that accommodation can be secured via this avenue'.

4.5.7 Lucas was keen to point out that his partner (now ex-partner) Janice had "fallen out" with him a number of occasions and instructed the prison to prevent him from contacting her and on each previous occasion had later rescinded this. Lucas stated that prior to the prison receiving the letter from Janice he had already made up his mind that their relationship was over and that he had the opportunity to make a fresh start on release from custody

[12] An anti-depressant
[13] Cognitive Behavioural Therapy

and concentrate on reintegrating into the community. He said he had no intention to rekindle the relationship

4.5.8 A few days later the following entry appears in Probation records and was addressed to Merseyside Police. 'I am Lucas's supervising probation officer and have been made aware his relationship with Janice has ended acrimoniously. Lucas is a serving prisoner and subject to occasional home leave to Janice's address. Prior to the break-up the relationship was volatile. I would therefore, greatly appreciate any information relating to domestic violence incidents over the past 6 months in relation to Lucas. If he has a history of domestic violence this could cause him to seek recriminations when he is released on temporary licence, particularly if he does not accept Janice's decision to end their long-term relationship'. The entry does not say what the source of the information was. It is likely to have come from Janice when she told the Prison Service that she no longer wanted contact from Lucas.

4.5.9 On 8 August 2014 Merseyside Police told the OM in response to their query that it had no trace of Lucas on the Family Crime Investigation Unit [FCIU] database. Ordinarily the domestic abuse incident reported by Sarah in 2009 would have been recorded on FCIU database. This is achieved by the attending officer completing a Vulnerable Person Referral Form [VPRF/1]. The police IMR author could not find this form and therefore it seems likely one was not submitted as required. If that is the case the reason is an individual error rather than a gap in policy.

4.6 Lucas's Release on Licence

4.6.1 Lucas was released on licence on 3 September 2014. Two days later he kept an appointment at NACRO[14] for a housing assessment and was met there by Janice who wanted to support him to find accommodation. His licence did not contain any restrictions specifically aimed at Janice.

4.6.2 On 11 September 2014 he was registered under the Multi-Agency Public Protection Arrangements [MAPPA] as presenting a high risk of causing serious harm to a named person [the victim of the 2010 wounding] and the public. He was a category 2 offender subject of level 1 ordinary agency management. The lead agency was the National Probation Service, Liverpool.

4.7 Events following Lucas's Release on Licence

4.7.1 The following table is a summary of events that are relevant to the DHR Terms of Reference. The majority relate to entries on his Probation record by his OM.

[14] A Social Justice Charity: registration number 226171 which emerged in 1999 from the National Association for the Care and Resettlement of Offenders.

Table of Events following Lucas's Release on Licence	
Date	**Note**
24.09.2014	Lucas reported he is being supported by his ex-partner Janice who is also financially supporting him as he is still waiting to get his benefits sorted.
01.10.2014	Alcohol – Lucas reported to his OM he has not relapsed, he had 4 drinks on Saturday watching the match and nothing more since. He recognises the consequences if he was to relapse and what he would stand to lose.
Date	**Note**
06.11.2014	Alcohol - reported drinking in a social capacity once a week and told OM he is not interested in going back down that path and he acknowledged what he had to lose. He is trying to re-build his relationship with his ex-partner Janice.
04.12.2014	OM completed home visit to Lucas, he was feeling unwell due to his medical treatment. His ex-partner Janice was also there and she is supporting him through this as he is feeling really down.
09.12.2014	Lucas reported to his OM that the cancer was terminal.
15.01.2015	The OM undertook a home visit to Lucas. He seemed like he is learning to deal with his cancer and has a lot of family support around him including his partner Janice.
26.01.2015	He reports he is feeling tired but he is trying to live a "normal" life spending time with his partner and her family. He seemed upbeat.
30.01.2015	Janice attended the accident and emergency department after she had slipped on a step. She complained of lower back pain radiating into her left leg. There were no concerns relating to the presenting injury, appropriate clinical review and actions were undertaken. Lucas was not recorded as the next of kin.
12.02.2015	OM telephoned Lucas who said he is feeling ok in himself however is still in a lot of pain. His partner Janice's mum passed away yesterday so he needs to remains strong for her. He has still not told his grown up children about his terminal cancer as he does not feel ready.
06.03.2015	Lucas asked if he could return to Glasgow if his condition worsened as he felt he would like to be closer to his children

	and family despite having Janice his partner here in Liverpool. I informed him this would not be an issue.
28.05.2015	Lucas reported he has been spending a lot of time at home with his partner Janice and been doing little chores and shopping in order to get out. Reported he was in contact with all his family in Scotland, however has not decided whether he wants to go home or remain in Liverpool.
Date	**Note**
27.08.2015	Lucas's risk of causing serious harm reduced from high to medium.[15]
03.09.2015	Lucas reported spending time with his family going for meals and no alcohol. OM spoke about Lucas going to Scotland to spend time with his family.
02.10.2015	Lucas reports no illicit drug use or alcohol use. Sarah said that Janice told her Lucas used heroin and drank excessively daily.
08.12.2015	Lucas is in hospital receiving treatment.
08.01.2016	Lucas reported no alcohol issues or illicit drugs. No issues with benefits or accommodation Lucas reported he is still being supported by his partner Janice and reports no issues with his relationship.
04.02.2016	Home visit to Lucas by GP. Patient seen with ex-wife Janice who wants Lucas moved to a different location. She feels he is unable to cope in a flat on his own. He does not consent to a transfer. Janice not happy. GP advised Janice that as Lucas has capacity he can make decisions for himself.
08.03.2016	OM visited Lucas; looked very unwell. He reported his partner took his cash card a few weeks ago and spent his money, I advised he needed to contact the Police but he does not want to do this. He told me he is having nothing more to do with her. Sarah said that Lucas gave Janice his bank card and authorised the withdrawals she made for him. These were for his household expenses and drink.

[15] Medium: there are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. MAPPA Guidance 2012.

11.03.2016	Lucas was admitted to Hospital [GP records] after being found on the floor at home by his partner. Patient is unsure how he came to be on the floor.

4.9 The Homicide

4.9.1 On 14 March 2016 Lucas was told by a nurse that he would be discharged from hospital after the Occupational Therapist had assessed his needs. He was reviewed mid-morning and told a discharge letter would be written.

4.9.2 He was dissatisfied with the amount of time his discharge was taking and became abusive to staff. This was noticed by patients. His attempt to leave the hospital in a porter's wheelchair, aided by another patient, was halted when his exit was blocked by staff. He returned to the ward.

4.9.3 About 2.30 pm a nurse introduced herself to Janice and explained some requirements in respect of Lucas's care. In doing so, she also informed Janice that Lucas had been abusive and aggressive. Janice walked over to Lucas who was still sitting in the porter's chair with two crutches on his lap. The nurse heard Janice asking Lucas to stand with the aid of his crutches and prove to the staff that he could do it. He refused and Janice stated, "See you can't do it, accept their help."

4.9.4 Without warning, Lucas hit Janice on her head with one of his crutches causing her to fall over a few minutes later. First aid was administered and Janice was taken to Accident and Emergency where her care continued.

4.9.5 Janice died some days later without leaving hospital.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

5.1 Introduction

5.1.1 Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the Individual Management Reviews, other documents and the Domestic Homicide Review Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken to avoid unnecessary duplication.

5.2 Term 1

What knowledge/information did your agency have that indicated Janice might be a victim of domestic violence and how did your agency respond to it?

5.2.1 The first potential indicator any agency had that Janice might be a victim of domestic abuse came on 5 July 2009 when she attended Accident and Emergency having fallen earlier in the day. The Panel heard that the account of the fall was consistent with the injury and staff were not concerned that she could be a victim of domestic abuse. Staff in Accident and Emergency are trained to identify domestic abuse and what to do if they receive a disclosure of domestic abuse or suspect a patient is a victim. The Care Quality Commission published its inspection report into the Royal Liverpool Hospital on 29 July 2016 and noted:[16]

'Staff were aware of their roles and responsibilities and knew how to raise safeguarding concerns appropriately. There was a high compliance with both adult and child safeguarding training [all levels]'.

5.2.2 The Panel felt that the in the circumstances the Hospital staff had no cause to ask Janice directly whether she had been the victim of an assault because of the reasons outlined above. Staff who treated Janice judged she had capacity[17] and was not a vulnerable adult.

5.2.3 On 26 July 2009 there was a direct complaint by Sarah to Merseyside Police that Lucas had assaulted her mother. When Janice when seen by officers she declined to make a complaint and refuted her daughter's allegation that Lucas had assaulted her. Lucas was not present when the officers saw Janice and therefore one barrier to disclosure was removed; however as is known from research, there are many other barriers facing victims of domestic abuse. Term of Reference 2 looks at this aspect. It is possible, that Janice had an injury, but there is nothing recorded on the police log. The entry on the log said the service of an ambulance was declined, which could

[16] www.cqc.org.uk/provider/RQ6

[17] The Mental Capacity Act 2005 says: Everyone has the right to make his or her own decisions. Health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.

suggest that Janice was injured. The Merseyside Police Panel member said that if injuries were visible and thought to have been caused by Lucas that would be enough to warrant his arrest.

5.2.4 Because Janice declined to make a complaint and refuted the allegations made by her daughter there was no expectation from a police policy perspective that the officers should speak with Lucas. After Janice's death Sarah told the police investigators that the officers said they would speak to Lucas but neither she nor her mother heard anything more. Lucas could not fairly be described as a suspect and therefore the officers were not required to trace him and ask him for an explanation. It is unlikely that speaking to Lucas would have altered the assessment that Janice faced a Bronze level of risk. The Panel felt that if Lucas had been seen he would know he was likely to be challenged if there was a reoccurrence.

5.2.5 The next opportunity came the following day [27.07.2009] when Janice saw her GP complaining that she had been punched by an unknown person and declined the advice to go to hospital. The Panel felt that the GP must have been concerned about Janice to recommend she attended hospital.

5.2.6 The Panel noted that two injuries in July 2009 were about three weeks apart. The explanation of a fall for the first one was accepted without question. The second injury was inflicted. The Panel felt the GP, who held both pieces of information, should have asked Janice about the circumstance of the earlier fall once she disclosed that the second injury had been caused by a punch. Janice's GP record does not reveal whether that happened and the Panel did not have sufficient information to make a defensible judgement on whether the fall was linked to domestic abuse.

5.2.7 The GP noted that Janice 'declined' to go to hospital. However, at 8.27 pm the same day [27.07.2009][18] Janice attended hospital. There is no information why she went or what she was treated for. An attempt to take a history of how the injury occurred was made but no further information could be obtained. It was noted there were no concerns relating to the presenting injury. Her recorded partner's name was not Lucas. Sarah felt Janice gave a false name to protect him and herself.

5.2.8 The Panel felt the Hospital's judgement, that there were no concerns about Janice's injury, was potentially incompatible with staff being unable to obtain a history of how it happened.

5.2.9 Janice told the GP she was punched. It is reasonable to say the visit to the hospital later the same day was very likely to be for the same injury.

5.2.10 The Panel felt that when the following sequence of events is considered, it is reasonable to say that there was substance in Sarah's report to Merseyside Police that Janice's had been assaulted.

[18] The DHR Panel assumed the visit to the hospital came after the untimed visit to the GP.

Date	Event
26.07.2009	Sarah reported to Merseyside Police that her mother had been assaulted by Lucas.
27.07.2009	Janice saw her GP and reported she had been punched and was advised to go to hospital which she declined.
27.07.2009	Janice attend accident and emergency and did not give staff an explanation of her injuries.

5.2.11 Janice attended Accident and Emergency in January 2015 saying she slipped on a step resulting in back pain. Falls can be a euphemism for domestic assault. In this case staff judged the injury was compatible with the explanation and there is nothing recorded to say whether domestic abuse was discussed or considered. Sarah had no knowledge of this incident.

5.2.12 It appears that Janice and Lucas maintained their relationship for some of his custodial sentence as evidenced by Janice allowing him to stay with her on his temporary releases on licence. One such release came on 14 July 2014 and this coincided with Janice visiting her GP after a panic attack.

5.2.13 Six days later on 22 July 2014 after Lucas returned to prison Janice told the prison they had ended their relationship and she did not want him at her address. She requested that probation remove her details from their records and not to contact her in future. Lucas also told prison staff he had finished with Janice.

5.2.14 The Panel carefully considered if there was any cause and effect between, the panic attack, the temporary release on licence and the ending of the relationship. There were two other documented occasions when Janice suffered a panic attack. One happened in late 2010 before Lucas was sent to prison. However, she had a second after his incarceration and was also treated for anxiety and depression. Therefore, beyond a suspicion, the Panel was not able to safely conclude that the panic attack Janice experienced on 14 July 2014 and the ending of the relationship so soon thereafter, were indicators of domestic abuse.

5.2.15 In December 2016 the Home Office published key findings from domestic homicide reviews. Here is a relevant extract that shows the frequency of mental health in DHRs.[19] Janice's depression was a risk factor in her earlier victimisation but did not appear to be an active element at the time of her death.

[19] Domestic Homicide Reviews Key Findings From Analysis of Domestic Homicide Reviews December 2016

'Mental health issues were present in 25 of the 33 intimate partner homicide DHRs. Twenty-one cases involved perpetrators with mental health issues: 15 cases where only the perpetrator had mental health issues and six cases where both the perpetrator and the victim had mental health issues. The remaining four cases involved victims with mental health issues but not perpetrators.

Of the 21 DHRs involving perpetrators with mental health issues, the majority (16) were known to health professionals. Of the 10 DHRs involving victims with mental health issues, all were known to health services'.

Depression was by far the most common type of mental health problems experienced by victims'.

5.2.16 Given there was information shared that the relationship had been volatile and had ended acrimoniously it was appropriate that checks were undertaken by the Probation Officer with Merseyside Police. Whilst the results of the check indicated there had been no information of concern it would have been good practice to explore with Lucas in more depth how the relationship ended and clarify what was meant by 'volatile and acrimonious'. This would have been particularly relevant given the index offence was one of significant violence albeit not linked to domestic violence. It is possible the outcome of discussions may have unearthed concerns regarding Janice's safety, or that of her grandchildren, which would have required further action to ensure their safety. This would need to be balanced with the fact that the Probation Officer who was allocated the case had various contacts with Janice throughout the period Lucas was supervised on licence and was not alerted to, nor observed, any issues of concern in relation to her safety.

5.2.17 Between Lucas's release on licence on 03.09.2014 and the assault on Janice on 14 March 2016 he had substantial contact with her. During this period agencies did not have any indicators of domestic abuse.

5.2.18 In summary, there were indicators of domestic abuse between Janice and Lucas, and apart from the allegation made by Sarah, the others were more tenuous and oblique. An opportunity was lost to explore why the relationship was volatile and ended acrimoniously. With the benefit of hindsight had one agency/person seen all the information a different picture of Lucas may have emerged.

5.3 Term 2

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

5.3.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment

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

5.3.2 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

5.3.3 Janice had mental health problems and agoraphobia but there was nothing to suggest these conditions impaired her ability to carry out normal day-to-day functions.

5.3.4 The position with Lucas was different. In September 2013 he was diagnosed with cancer and from then until his death his health deteriorated to a point which effected his ability to carry out normal daily tasks. He was treated with appropriate compassion by the Prison and Probation Services who made reasonable adjustments to their regimes in recognition of his disabilities. He was also supported by Janice despite his poor attitude towards her. The panel considered that his treatment of Janice was consistent with his now recognised history of coercive and controlling behaviour towards her.

5.3.5 Janice dealt with one incident [the assault by an unnamed person] in three different ways. She told her GP she had been assaulted but not by who; she did not give the hospital an explanation and denied being assaulted when asked by Merseyside Police.

5.3.6 Set out below is one research finding which illustrates the barriers victims of domestic abuse face when considering disclosure.

'Many victims do not report their abuse. It is vitally important that police officers understand why this might be the case. Of those that responded to HMIC's open on-line survey, 46 percent had never reported domestic abuse to the police. The Crime Survey for England and Wales reported that while the majority of victims [79 percent] told someone about the abuse, for both women and men this was most likely to be someone they know personally [76 percent for women and 61 percent for men]. Only 27 percent of women and 10 percent of men said they would tell the police.

The reasons the victims we surveyed gave for not reporting the domestic abuse to the police were: fear of retaliation [45 percent]; embarrassment or

shame [40 percent]; lack of trust or confidence in the police [30 percent]; and the effect on children [30 percent]'.[20]

5.3.7 The prison listened and acted on Janice's request to remove her from Lucas's approved contacts list following the ending of their relationship. This information was shared by the prison with probation. However, it appears that prison and probation knew the relationship ended acrimoniously and had been volatile. It is not clear how that emerged or what support was offered or provided to Janice as a result of her disclosure.

5.3.8 Probation visited Janice and Lucas on several occasions when he was on temporary and full licence and provided the opportunity for Janice to talk.

5.3.9 Janice's GP signposted her to counselling services. The absorption of the counselling service by another organisation has meant that any record of Janice's attendance and service provision are unknown. The Royal British Legion [RBL] provided practical support to Janice. She did not disclose domestic abuse to them. Has she done they would have acted in accordance with their written policy. The Liverpool area office of the RBL has experience of dealing with disclosures of domestic abuse from clients. This DHR has prompted the RBL to access additional local domestic abuse training. The Panel saw that as a positive outcome given the welfare role of the RBL.

5.3.10 In summary Janice and Lucas were white British with English as their first language; they were literate and numerate. The Panel did not detect any positive or negative bias from agencies who provided services. Any deficiencies in the services provided to Janice had other causes.

5.4 Term 3

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

5.4.1 Sarah knew her mother had been assaulted by Lucas. Janice's friends knew she was pushed and shoved by Lucas. They also knew he was controlling and coercive. Sarah reported the assault to Merseyside Police and thought that asking the police for help was an appropriate way of supporting her mother. The outcome was not what Sarah wanted for her mother when she denied being a victim. Sarah's recollection that Merseyside Police would speak with Lucas was not met. Had Lucas been seen it is very likely Sarah would have known, thereby reinforcing her decision that it was appropriate to protect her mother through engagement with the police.

5.4.2 Neither Sarah nor the friends of Janice who were seen during the review knew what to do about the controlling and coercive behaviour in the face of Janice's wishes not to report Lucas's violent conduct to the police.

[20] Everyone's business: Improving the police response to domestic abuse 27 March 2014 ISBN: 978-1-78246-381-8 www.hmic.gov.uk

5.4.3 Other than contacting the police Sarah did not know where else to go for help and believed the best approach was to support Janice by being there if she needed help. Sarah felt she should respect Janice's wishes while simultaneously watching out for her. Sarah does not recall her mother being a member of any particular group who might have helped her. The Panel noted that Janice reached out to the Royal British Legion when she needed practical help but did not disclose any domestic abuse to them.

5.4.4 It is known from collaborative work done across Merseyside Community Safety Partnership that in eight of their eleven domestic homicide reviews, family and/or friends had knowledge of domestic abuse in the relationship. In another case the victim's mother suspected her daughter was being abused. In some cases family and/or friends were the only people to know that domestic abuse was happening.

5.4.5 On 25 November 2016 Liverpool Citysafe took an active part in the International Day for the Elimination of Violence against Women.[21] Additionally Liverpool Citysafe ran a fourteen day campaign to raise the awareness of domestic abuse, including what advice to give family and friends who receive disclosures of domestic abuse. This was partly in response to findings from another DHR.

5.5 Term 4

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

5.5.1 Merseyside Police received a report from Sarah that Lucas had assaulted her mother. Janice was seen she refuted the allegation she had been assault by Lucas, therefore there was no requirement for officers to see Lucas. The prison and probation services knew the relationship had been volatile and ended acrimoniously but did not explore the reasons or offer any support. However, Lucas's Offender Manager did not see any signs of domestic abuse and had no concerns about the relationship between Janice and Lucas.

5.5.2 When Janice attended hospital on 27 July 2009 the name of her partner was recorded. It was not Lucas. Sarah thinks Janice will have done that so as to protect Lucas and to protect herself should he ever be traced and asked about the injury.

5.5.3 Lucas had several risk factors associated with abusers. He used weapons to attack people, misused drugs and alcohol, and had a criminal history. All these were known to Merseyside Police but something else needed to happen before they could seriously be considered as part of his risk profile. What was not known to agencies was his threat to Janice to 'get his brothers to sort her out'. The Panel discussed what that 'something else' might be and concluded that fuller background checks would only be made in cases where the risk to the victim was assessed as high, or when professional

[21] http://www.un.org/en/events/endviolenceday/

judgement raised particular concerns. In this case the risk he posed to Janice was assessed as Bronze [standard] and no one felt it necessary to make further enquiries using the professional judgement route.

5.5.4 After Janice was assaulted in the hospital two members of staff asked her separately whether Lucas had assaulted her before. Janice said no. The Panel believe on the balance of probabilities that Lucas assaulted her in 2009 as identified by Sarah and 'corroborated' Janice's visits to her GP and hospital.

5.6 Term 5

Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim or perpetrator, or on your agency's ability to work effectively with other agencies?

5.6.1 All the agencies involved with Janice and Lucas have policies and processes to identify and respond to domestic abuse and Janice was afforded the opportunity to share her victimisation with them. The agencies have supervision policies in place. No agency reported any capacity or resource issues that impacted on this term. The Panel identified that Merseyside Police supervision could have picked up the fact that Lucas had not been seen following Sarah's report to them in 2009. The benefits of seeing him were discussed earlier. The Panel would also have expected supervision within the prison and probation services to have recognised that the volatile and acrimonious description of the relationship had not been explored. That had the potential for under-assessing risk. GPs in Liverpool offer the standard ten minute appointment. This could suggest that, within the consultation, domestic violence, unless overtly disclosed, may be more difficult to identify. The IRIS[22] programme has not been offered or commissioned in Liverpool. Since Janice's death domestic abuse training has been delivered by Liverpool Domestic Abuse Service [LDAS] to GP Practice safeguarding leads for cascade to all those working in their organisations. LDAS is open to direct access from victims and from referral from GPs. This enables GPs to offer help and support to those making a disclosure during a GP consultation.

5.7 Term 6

Was abuse of alcohol or drugs a significant issue in relation to this homicide and domestic violence risks? If so, how did your agency respond to this issue?

[22] IRIS - Identification and Referral to Improve Safety. IRIS is a general practice-based domestic violence and abuse training support and referral programme www.irisdomesticviolence.org.uk

5.7.1 There is no evidence to say that Janice misused alcohol or drugs. The officer who attended the report that Lucas had assaulted her, noted that she had been drinking, and it was alleged Lucas had.

5.7.2 There is ample evidence to say that Lucas misused alcohol and drugs but this seems to have dissipated after his cancer diagnosis. The Probation report submitted to the Panel had the following helpful analysis.

'Alcohol misuse was significant at the time of the section 18 assault [2010] and this was linked to risk of serious harm. Lucas completed Alcohol and Drugs awareness in Prison. During home leaves [from custody] there was no evidence of Lucas consuming alcohol. He would have been tested when he returned to Prison. After release on full licence there was some evidence of alcohol use although this presented as in control. As Lucas's health deteriorated he reported that he had ceased drinking. Certainly at the last contact with his Offender Manager, he presented in a poor and emaciated state.

Had there been evidence that there was an escalation in alcohol use, a referral to the relevant commissioned provider is standard practice. Offender Managers are also trained to address alcohol and substance misuse issues as a core skill'.

5.7.3 Sarah told the Panel chair that Janice said Lucas continued to use heroin and abuse alcohol even in the later stages of his terminal illness and that Janice accessed his bank to obtain cash for these substances.

5.8 Term 7

Are there any examples of outstanding or innovative practice arising from this case?

5.8.1 Neither the agencies nor the DHR Panel identified any.

5.9 Term 8

Are there any other issues, not already covered in 1 to 7 above which the DHR Panel should consider as important learning from the circumstances leading up to this homicide?

5.9.1 The circumstances of Janice's death are so unusual that they are unlikely to be repeated. She was assaulted in a hospital and hit on the head in an area where there was an undiagnosed aneurism.

5.9.2 What is apparent in this case, and many others, is that Janice wavered in her attachment to Lucas. Having ended the relationship she still wanted to support him through his terminal illness. This demonstrates her great compassion. His violent nature and propensity for using weapons emerged because of his impatience to leave hospital and Janice's contrary view, supported by medical opinion, that he was unfit to do so. He struck out and showed no concern or remorse for his actions. The panel felt his behaviour

and attitude to Janice could fairly be described as examples in his long history of coercive and controlling behaviour towards her. This view is supported by Janice's daughter and friends.

5.9.3 The National Probation Service identified some issues with their formulation of his risk but that did not impact on his management or the homicide of Janice.

5.9.4 Janice had three grandchildren who she saw frequently. There are references in the DHR documents that Lucas had contact with them. There is no mention in the documents that any agency considered whether the grandchildren might be at risk because of the domestic abuse between Lucas and Janice. The Panel felt that in particular the National Probation Service could have factored child safeguarding into Lucas's temporary releases on licence and his full release on licence. He was a high risk offender at the point of his release. However there was no history of violence to the children or Janice. The National Probation Service policy is now clearer on domestic violence risk assessment on release. This review of policies for high risk clients who have contact with children began on the formation of the National Probation Service in June 2014.

5.9.5 The next point is not specific to this case but is included as a learning point in that it was not considered.

'Witnessing domestic abuse is really distressing and scary for a child, and causes serious harm. Children living in a home where domestic abuse is happening are at risk of other types of abuse too. Children can experience domestic abuse or violence in lots of different ways. They might:

- see the abuse
- hear the abuse from another room
- see a parent's injuries or distress afterwards
- be hurt by being nearby or trying to stop the abuse'[23]
- **6. LESSONS IDENTIFIED**

6.1 Agency Lessons

6.1.1 No agency identified any lessons. The National Probation Services offered the follow observation.

'…there are no specific actions recommended with regard to the NPS. However, the Panel will wish to note that new National Offender Management Service Guidance for Working with Domestic Abuse and the National Partnership Framework for Domestic Homicide Reviews were issued in August 2016. In light of these key developments, it is proposed that NPS

[23] www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/domestic-abuse/

Merseyside will review all relevant operational procedures and how learning is disseminated and embedded into best practice, by March 2017. This will also be shared at the North West Senior Leadership Team meeting and across relevant partner agencies.'

6.2 Panel Lessons

6.2.1 The Panel identified the following lessons.

Lesson 1 Recommendation 1 applies

Narrative

In July 2009 Sarah made an allegation to Merseyside Police that Lucas had assaulted her mother. Officers saw Janice but she refuted the allegation. Lucas was not present and officers, in the absence of a complaint or other independent evidence, acted appropriately in not seeing him. The officers should have spoken separately with Sarah to obtain the background to the relationship between her mother and Lucas. That would have been a reasonable line of enquiry to follow given that the family and friends of victims often have significant and useful information about their domestic abuse and may be able to provide evidence. There is no record that the officers had such a conversation with Sarah.

Lesson

If reasonable lines of enquiry are not pursued following reports of domestic abuse, perpetrators go unchallenged and victims could be left vulnerable to further abuse. Family and friends often knows what is happening in a relationship.

Lesson 2 Recommendation 2 applies

Narrative

In July 2014 the National Probation Service learned from an unnamed source, that the relationship between Janice and Lucas had been volatile and ended acrimoniously. The Offender Manager asked the police for any reports of domestic abuse and recognised that Lucas might '…seek recriminations when he is released on temporary licence, particularly if he does not accept Janice's decision to end their long-term relationship'.

There is nothing in the record to say whether the detail of the volatility and nature of the acrimonious break up were explored with either Lucas or Janice. The detail would have informed a risk assessment. This has to be balanced with the Offender Manager's supervision of Lucas and contact with Janice following Lucas's release on full licence. The Offender Manager did not observe any indicators of domestic abuse.

Lesson

Not gathering information on potential risk factors such as 'volatile and ended acrimoniously' means that subsequent risk assessments and risk management plans can be weaker, leaving those at risk more vulnerable.

Lesson 3 Recommendation 3 applies

Narrative

Janice had grandchildren who she saw often. There was no evidence that their welfare was considered when planning Lucas's releases on temporary and full licences. At the time he was released he presented a high risk to members of the public and a low risk to children. In August 2015 the risk to public was lowered to medium and remained low to children. The current standard for the National Probation Service requires the contact to be regular or frequent.

Lesson

Not recognising and responding to children who might be exposed to domestic abuse could leave them vulnerable to harm.

7. CONCLUSIONS

7.1 When Lucas began his relationship with Janice he possessed several risk factors which could relate to domestic abuse. Within a few months Sarah told Merseyside Police that he had assaulted Janice who refuted the allegation.

7.2 The Panel understood why victims do not always want to make a complaint. There is no evidence that Sarah was asked for information on the relationship. Her knowledge might have opened up other lines of enquiry leading to Lucas being seen.

7.3 The relationship endured this incident. The Panel heard that Lucas was controlling and coercive towards Janice and used violence when damaging her property. Sarah said this behaviour continued after Lucas was released from prison. He also threatened Janice with his 'brothers'. Nevertheless, Janice made a statement to the police which contradicted his alibi for the 2010 Section 18 assault on a neighbour. The Panel felt this demonstrated some ability on Janice's part to stand up to Lucas. At one level Janice might have appeared assertive and able to stand up to Lucas, however his behaviour towards her overrode her wishes expressed to Sarah that she wanted peace in her life. Lucas did not allow that.

7.4 Janice was supportive of Lucas for several years during his imprisonment. She allowed him to stay with her on his temporary releases on licence. The Panel felt that during one of these stays an incident of some type must have happened between them because very soon after he returned to prison she told the authorities to remove her contact details from his file and that she was withdrawing her offer of accommodation for his release on full licence in a few months. There is no evidence that any agency considered the potential impact that a violent offender may have on Janice's grandchildren who might witness him abusing her.

7.5 Prison and probation staff knew that the relationship had been volatile and the breakdown acrimonious. There is no evidence to say that this was explicitly explored with Janice or Lucas and this was a missed opportunity to learn more about the couple and to offer them support individually or collectively. An explanation for the breakdown would have informed his risk factors.

7.6 Within a few days of being released Janice accompanied Lucas to NACRO and supported him with his quest for accommodation. She was also helping him with his benefit entitlements. By this time Lucas's cancer had been diagnosed but was not yet identified as terminal.

7.7 From conversations Lucas had with his Offender Manager it is apparent that he wanted to rebuild the relationship with Janice. That statement was made to his Offender Manager in November 2014 before he received his terminal diagnosis. In January 2016 Lucas told his Offender Manager that his

relationship with Janice was positive. Janice's compassionate nature meant she wanted to support him through his health problems.

7.8 Lucas's health deteriorated and his cancer was classed as terminal. Nevertheless Janice remained in his life and supported him to deal with his illness. Sarah learned from her mother that Lucas was drinking heavily and using heroin at this time.

7.9 On the day Lucas struck Janice with a crutch he shouted obscenities at hospital staff and Janice who remarked, 'this is what I put up with when I call round.' The Panel thought this significant and provided an insight of the dynamics of their relationship. This also supports Sarah's account of the relationship. It seems that his verbal aggression was always a factor in the relationship. The additional stresses brought about by those with life limiting conditions can be significant[24] and may have featured in this case. However, Lucas's use of violence predated his illness and the testament of Janice's daughter supports the likelihood of emotional and psychological abuse and coercive control within the relationship.

7.10 The uncommon mixture of circumstances on the day of Janice's death are so unusual that the Panel thought they were very unlikely to be repeated. However, the physical, emotional and psychological abuse perpetrated by Lucas is all too familiar in domestic homicide reviews. The lessons identified are not new and therefore require reinforcing with agencies who have contact with domestic abuse victims. Liverpool Citysafe has already reinforced the messages of what family and friends can do if they know or suspect someone is being abused.

[24] http://www.nhs.uk/planners/end-of-life-care/pages/coping-with-a-terminal-illness.aspx

8. RECOMMENDATIONS

8.1 Agencies' Recommendations

8.1.1 The agencies did not identify any recommendations.

8.2 Panel's Recommendations

1. That Merseyside Police determines whether its 2017 domestic abuse investigative practices include seeing family and friends in order to build up a profile of the relationship and gather evidence, and if not, to consider whether additional advice or direction needs to be promulgated.

2. That the National Probation Service North West determines whether its 2017 practice around exploring the details of reported volatile and acrimonious relationships within the context of domestic violence is sufficiently robust to identify risk factors.

3. That the National Probation Service North West provides a written account to Citysafe of how it safeguards children who have contact with offenders whose risks they are managing.

Appendix A

Definitions

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) is:

   "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"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.03.2013 is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

   - psychological
   - physical
   - sexual
   - financial
   - emotional

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

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

Appendix B

Domestic Homicide Review Panel Recommendations							
No	**Scope of Recommendation**	**Action to Take**	**Lead Agency**	**Lead Officer**	**Key Milestones Achieved in Reaching Recommendation**	**Target Date**	**Date of Completion & Outcome**
1	That Merseyside Police [MSP] determines whether its 2017 domestic abuse investigative practices include seeing family and friends in order to build up a profile of the relationship and gather evidence, and if not, to consider whether additional advice or direction needs to be promulgated.	Review existing policy	MSP	DCI Martin Earl	Policy Reviewed and found to be appropriate.	31.01.2017	31.01.2017 MSP Policy and Procedure clearly outlines the requirement of attending and investigating officers to identify witnesses to provide background, context and risk to inform them regarding appropriate safeguarding and safety planning. Policy outlines in 5.7.4 the necessary enquiries relating to family and friends and directs officers to make enquiries surrounding previous incidents that have been witnessed by them. It provides further context surrounding controlling and coercive behaviour and the likely impact upon family

							relationships in 5.9.6 of the policy.
2	That the National Probation Service North West determines whether its 2017 practice around exploring the details of reported volatile and acrimonious relationships, within the context of domestic violence is sufficiently robust to identify risk factors.	NPS NW is implementing a new process to oversee the quality of effective risk management by March 2017. All clusters will be using a common process to identify, assess and manage risk with a focus on high risk cases including DV.	NPS	Janet Marlow	1.6 month implementation period by Sept 17 to review impact and effectiveness. 2. Audit of cases by Performance and Quality team and local managers. 3. Report on findings to be shared with DHR chair.	September 2017 October 2017 November 2017	

3.	That the National Probation Service North West provides a written account to Citysafe of how it safeguards children who have contact with offenders whose risks they are managing.	Letter to Chair from NPS Senior Managers	NPS	Marie Orrell For Janet Marlow	Letter to be submitted to City Safe Chair- copy attached.	January 2017	Letter to be submitted and awaiting acknowledgement from Chair