Domestic Violence Homicide Review in the case of Female V1 and Female V2

EXECUTIVE SUMMARY

Period covered by the Review: 1st January 2000 to the 28th November 2013

1. Introduction and Background to the Case

The victims in this case are referred to as Female V1 and Female V2. Female V1 was 55 years of age when her Husband, Male P, murdered her. Female V2 was 29 years of age when her Father, Male P, murdered her. Both Female V1 and Female V2 were found deceased at their home address, where they had lived for more than 5 years.

The Review Panel wishes to acknowledge the sad and tragic circumstances surrounding this case and to offer its sympathy to the family of the victims of the case.

The Chair of the Panel wishes to express his personal appreciation to the colleagues who have contributed to the completion of the Domestic Homicide Review – particularly so for their time, co-operation and patience.

1.1 The circumstances of the death of Female V1 and Female V2

In the late morning on the day of the incident in 2013, Male P was seen wandering around outside the Police Station in Huyton, in the District of Knowsley, Merseyside. Male P was approached by a Merseyside Police Service Community Support Officer who offered assistance to Male P and enquired about the nature of his visit to the Police station. Male P informed the Community Support Officer that he had murdered both his wife and his daughter at their home address.

When Police Officers arrived at the home address, they gained access with keys held by the perpetrator, Male P. They found Female V1 dead in the living room of the property with two wounds to the head. The Police found Female V2 dead in her bedroom. The assessment by the Police at the time was that Female V2 had suffered a sustained attack with a weapon. A Home Office post mortem was completed and reported that the cause of the deaths was “blunt force trauma – more violent and sustained for Female V2”.

The report of the investigation conducted by the Merseyside Police Service concluded that there were no signs of significant struggle, no signs of third party involvement and the premises were locked and secured, with the key held by Male P (the perpetrator).

The investigation led by the Merseyside Police Service resulted in the perpetrator, Male P, being found guilty of murder and sentenced to a term of imprisonment of 23 years.

2. The Domestic Homicide Review Process

The Safer Knowsley Community Safety Partnership (CSP) commissioned the Domestic Homicide Review. The Review has been completed in accordance with the regulations set out by the Domestic Violence, Crime and Victims Act (2004) and in accordance with the revised guidance issued by the Home Office to support the implementation of the Act.

The time period under review was agreed by the DHR Panel to be from the 1st January 2002 to the 28th November 2013. As is usual, the Authors of Individual Management Reports, Short Reports, and other submissions were invited to exercise their discretion when submitting information out-with these dates and to do so if they considered the information would be relevant to the context of the case.

The Authors of Management Reviews and Short Reports were not directly connected to the subjects of the case and did not sit on the Review Panel.

There were no criminal proceedings associated with the case. The Chair of the DHR Panel informed the local Coroner of the Review procedure and its expected time frame.

2.1 Agency Involvement

The Safer Knowsley Community Safety Partnership DHR Panel sought information concerning the subjects of this case from a number of organisations. The Panel identified the following services and agencies:

- Merseyside Police Service
- NHS England (commissioning a IMR from General Practice)
- North West Ambulance Service
- Knowsley MBC Adult Care Service
- Knowsley MBC Department of Human Resources
- Knowsley Housing Trust
- Knowsley Community College
- Knowsley Domestic Violence Services
- Knowsley Carers Centre
- The Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Aintree University Hospitals NHS Foundation Trust
- St Helens and Knowsley Teaching Hospitals NHS Trust
- 5 Boroughs Partnership NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- Knowsley MBC Children's Social Care Service
- Knowsley MBC Procurement and Exchequer Services

2.2 Panel Membership

Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings.

Officers with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were invited to serve on the panel, specifically the lead for community safety; a commissioner of the local domestic violence service; an officer with extensive experience in the provision of social housing; two senior social workers covering both child and adult service provision and a

representative from the local Mental Health NHS Trust. Additionally, the Chief Executive from Knowsley Disability Concern (who had interrogated her files and found no contact with any subjects of the case) was invited to join the Panel in order to provide expert opinion from the perspective of the independent service sector. Additionally, because the Knowsley domestic violence service had telephone contact with Female V1 and it was decided that they should not join the Panel, a domestic violence service from another Borough (via Wirral Metropolitan Borough Council) was invited to review the draft overview report and submit comments, expert opinion and any necessary amendments. These comments have been incorporated into the final overview report.

Name	**Designation**	**Agency**
Mr Gary Oakford	Chair of the Panel	A senior manager from the Merseyside Fire and Rescue Service with experience of chairing senior multi-agency working groups, public protection proceedings and community safety. The Chair of the Panel had not had any previous involvement with the case or any affiliations to any of the organisations involved in the review
Ms Paula Sumner	Head of Safer Communities	Knowsley Metropolitan Borough Council
Ms Jemma Jones	Legal Adviser	Knowsley Metropolitan Borough Council
Ms Joyce Greaves	Chief Executive	Knowsley Disability Concern
Mr Peter Davidson	Director of Housing and Neighbourhoods	Knowsley Housing Trust
Mr John Middleton	Detective Chief	Merseyside Police Service

Ms Sue Coombs	Inspector Detective Chief Inspector, Protecting Vulnerable People	
Ms Michelle Cox Ms Michelle Creed	Nursing and Quality Directorate	NHS England
Mr Jeremy Hunt	Social Care Service Manager	Knowsley Metropolitan Borough Council
Mr Steve Hull	Assistant Director, Nursing and Safeguarding	5 Boroughs Partnership NHS Foundation Trust
Ms Helen Smith	Designated Nurse for Safeguarding	Knowsley Clinical Commissioning Group
	In attendance	
Ms Caroline Lundstrom	Safer Knowsley Partnership Co-ordinator	Knowsley Metropolitan Borough Council
Mr John Doyle	Author of the report	Independent Practitioner with experience of writing Domestic Homicide and Serious Case Reviews. The Author has no formal connection with the District of Knowsley or with any of the agencies involved in the Review. The Author of the report had not had any previous involvement with the case or any affiliations to any of the organisations involved in the review

There were no conflicts of interest recorded during the Review.

2.3 Family Involvement

The Panel sought to involve the family of the victims in the Review. The Panel ascertained, via the Family Liaison Office appointed by the Merseyside Police Service, that Female V1 had two brothers. One of the Brothers agreed to act as a channel of communication between the Panel and both Brothers.

The Chair of the Panel contacted the Brother of Female V1 in order to invite him to participate in the Review – in whatever form he chose. This invitation has remained open for both Brothers to participate.

Information from friends and neighbours of the subjects of this case was collected and collated as a part of the investigation conducted by the Merseyside Police Service and the appointed Family Liaison Officer maintained these channels of communication with the Panel.

2.4 Terms of Reference

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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; and

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this report.

2.5 Key Lines of Enquiry

The DHR Panel agreed eleven key lines of enquiry. These are set out with summary responses at Section 3.1 of the Overview Report.

All of the agencies involved in this Review reported that, given the presentation of Female V1 and Female V2 at each point of service, it was not possible to predict or prevent the harm that came to the victims.

3. Summary of the case

This is a case where two adults, a Mother and her Daughter, died. Taking account of the information gathered at the presentation to services and the assessments undertaken by the agencies involved in this Review, the outcome could not be predicted or prevented.

The victims had consistent and relatively long-standing contact with public service agencies, particularly the NHS, prior to the incidents cited in the Overview Report.

Female V2 had a medical history including, among other diagnoses, Diabetes Mellitus, a diagnosed learning disability, a moderate physical disability and a number of allergies.

Female V1 also had diabetes and a number of other medical diagnoses; and Female V1 had been 'fast-tracked' for an investigation into a suspected cancer a number of weeks prior the incidents occurring. Following investigations cancer was excluded.

The Merseyside Police Service had relatively minimal contact with the subjects of this case – this contact was focused upon responding to calls made by the subjects of this case concerning anti-social behaviour in their neighbourhood.

The North West Ambulance Service had no contact with the subjects of this case prior to the incidents described by the Review.

There was no involvement between the Drug and Alcohol services and the subjects of this case.

Female V1 did make telephone contact with the local Domestic Violence Service but no formal contact was made – i.e. no formal assessment was made and consequently no service was offered prior to the incidents occurring. However, it is worthy of note that Knowsley Domestic Violence support Services did not at that time operate a domestic abuse helpline.

4. The outcome of the Domestic Homicide Review Process

The essential learning in this case may be focused upon the change to the family dynamic that may occur when one family member provides care for another family member. Female V2 was well cared for and, considering the information submitted to the Review Panel, this is a safe assumption to make.

However, what the Panel cannot ascertain and cannot assume, is the stress this care may have placed upon Male P when his caring role may have been magnified to include the care of Female V1.

The importance of involving all relevant agencies in the process of completing a DHR cannot be over-stressed. Producing a clear chronology is key to the DHR process – not just for the agency involved with the subjects but also for other agencies involved in the process.

Key Lines of Enquiry (KLOE) are also a very important element in the DHR process. A considered response to each KLOE offers the DHR Panel the opportunity to, firstly, ascertain if the agency submitting information to the Panel complied with its own professional service standards and, secondly, whether the agency is in a position of preparedness with regard to issues such as tackling domestic violence and abuse. This cannot be over-stressed.

5. Conclusion

The Panel concluded that the incidents that occurred in November 2013 could not have been predicted or prevented by any of the organisations that were in contact with the subjects of the case nor by any of the organisations involved in the management and investigation of the incidents.

6. Recommendations

The DHR Panel has made five multi-agency recommendations to the Knowsley Community Safety Partnership. These are in addition to the single agency recommendations set out in Appendix 1 of the Overview Report.

6.1 Recommendation 1

As a part of the learning from this Domestic Homicide Review, all agencies will be reminded of the importance of monitoring, recording, collating and storing all relevant information concerning diversity issues and protected characteristics.

6.2 Recommendation 2

Record keeping systems should be reviewed and each agency should be assured that their client records are accurate and up to date.

6.3 Recommendation 3

Agencies who have a statutory duty to participate in the Domestic Homicide Review process should be reminded that their involvement should be comprehensive and timely.

In co-operation with the Community Safety Partnership, each agency involved in this DH Review will be invited to develop and implement a learning action plan.

6.4 Recommendation 4

The oversight of the process of commissioning voluntary and independent organisations to provide services should be reviewed and, if necessary, strengthened in order to ensure that compliance with policy and procedure is consistent with the policies and procedures of the commissioning organisation and that where surges in demand place pressure upon capacity there is a mechanism to escalate this issue so that it can be properly managed.

6.5 Recommendation 5

Ensure that from April 2015 all agencies comply with the statutory guidance concerning carer assessment and can demonstrate their compliance before the date of commencement.

7. Actions from the Review

The Safer Knowsley DHR Panel expects that the single agency action plans and the five multi-agency recommendations to be delivered within six to twelve months from the date of this review. These Action Plans are described in the Overview Report.

The Community Safety Partnership should performance manage and monitor the delivery of these action plans.