
# EXECUTIVE SUMMARY

# DOMESTIC HOMICIDE REVIEW
# DHR6

## INDEPENDENT OVERVIEW REPORT
## INTO THE DEATH OF

## "Anna"

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**5 October 2015**

**(Revised Sept 16)**

# EXECUTIVE SUMMARY OF A DOMESTIC HOMICIDE REVIEW

## 1) Who this report is about:

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to ***'Anna'[1],*** a resident of Liverpool prior to her death in July 2014. At the time of her death Anna was 39 years old.

Anna was raised in the Merseyside area, with her parents (both now deceased) and four siblings. She was born with a rare genetic disorder called homocystinuria, resulting in learning disabilities, poor eyesight, physical disabilities and a range of physical health problems.

Despite these challenges, Anna attended a mainstream primary school. Her secondary education was at a 'special school', which she left at the age of 16. She is understood to have attended some work related 'schemes', but not to have had any periods of employment. She had her first child when she was 22 years old and went on to have four more children, one of whom died very shortly following birth.

Anna had past experience of domestic abuse, including in her relationship with the father of her 4 children. This was a volatile relationship, with periods of separation until the relationship ended in 2009. By 2010 all of her surviving children had been taken into care, due to child protection concerns arising from the domestic violence perpetrated on Anna, by the children's father and issues of child neglect.

At the time of her death, Anna no longer had contact with any of her four surviving children. It is understood that (prior to meeting the perpetrator, Adult 1) she had been living alone with no contact between her and the children's father, for a number of years. She had some contact with her brother, his partner and their children.

[1] The pseudonym of **Anna** is used to help protect the confidentiality of the victim and surviving family members. The person convicted of her murder is referred to as **Male 1**.

**2) Anna's brother's views:**

Anna's brother met with the DHR Chair and a Panel member in July 2015. There was a further meeting in September 2015, when the final draft report was discussed. Her brother confirmed that he was satisfied that the report gave an accurate account of events and appropriately highlighted the key learning arising from these events. He did not request any amendments or additions to the report.

He described his sister as having been a very kind, trusting and generous person, who often gave money to people if she felt they were in need, even if this meant she was then unable to buy food and other basic essentials for herself. He believes that this was often to her detriment, as she was unable to recognise that people took advantage of her learning disability and her open and trusting nature. He had observed 'friends' who would visit her at times when she had some money, but quickly disappeared when her money ran out.

Anna's brother feels she was very lonely, especially after her children had been taken into care. He was aware that she suffered from depression and was often worried that she did not look after herself properly. He describes conditions in her flat as very poor. He was concerned that she did not eat properly, was seriously under-weight and prone to general self-neglect. He and his partner tried to visit regularly and offer as much support as possible, but with the demands of their own young family, they felt unable to meet all of her emotional and practical support needs.

He states that she sought out male friendships and affection, but had little or no self-awareness of how prone she was to forming relationships with abusive men, who were attracted precisely because of her vulnerabilities.

**3) The Perpetrator (Male 1)**

Male 1 was 33 years old when the homicide happened. He had no previous convictions.

He originated from the Burnley area. From the age of eighteen he had formed relationships with a number of women which resulted in him fathering three children. Based on statements given by these ex-partners, it appears that Male 1 had a history of alcohol abuse. On occasions when he had been drinking to excess, there were domestic violence incidents, but these were not reported at the time. There were also incidents of self-harming behaviour.

The historical reports of domestic violence referred to above were disclosed to Merseyside Police, in the course of the homicide investigation. It has been confirmed that local and national police records[2] have been checked and there is no record of previous domestic violence complaints or allegations having been made against Male 1.

In 2013 Male 1 moved to North Wales, to be with a new girlfriend he had met through an internet dating site. He moved in with this girlfriend in the autumn of 2013 and moved out a few weeks prior to the homicide incident in July 2014. This ex-partner has also been interviewed by the police, following the homicide. She said the relationship ended as a result of his excessive alcohol use and incidents of verbal abuse. However, she also stated that he had never been physically violent towards her.

**4) Anna's relationship with Male 1:**

The couple initially made contact through an internet dating site. It is understood that this internet contact had commenced shortly before they met face-to-face. Having met Male 1, Anna very quickly agreed that he could move into her flat. It is understood that they had been cohabitating in Anna's flat for around 10 days, prior to her death. Anna's brother had been concerned about this relationship, as he was very aware of Anna's history of forming relationships with abusive men. Attempts by her brother to meet Male 1 proved unsuccessful. He tried to persuade Anna to end the relationship, but she refused to do so.

[2] Including local Merseyside Police systems, Police National Computer and Police National Database.

## 5) The homicide incident

In July 2014, in the early hours of the morning, Male 1 contacted Merseyside Police, reporting that his partner Anna was deceased, following an argument. When the police arrived at the scene they found Male 1 present and Anna was lying on the floor of her flat, deceased. Although he initially claimed he had acted in self-defence, he subsequently admitted that this was not the case. It is unknown what had prompted the argument which led to the homicide. Police enquiries following the incident indicate that Male 1 had consumed around fifteen cans of lager in the hours immediately preceding the homicide. Anna is understood to have consumed some alcohol, but not to the same extent as the perpetrator.

A post-mortem examination revealed that Anna had more than seventy knife wounds to her body, including wounds to her heart, liver, lungs, spleen and bowel. The cause of death was multiple stabbing.

Male 1 has been convicted of Anna's murder, resulting in a sentence of life imprisonment, with a recommended minimum term of seventeen and a half years.

## 6) DHR Panel membership

| **Name / Role** | **Organisation** |
|---|---|
| Richard Corkhill<br>Independent Chair & Overview Report Author | Independent Consultant |
| Angela Clarke<br>Team Leader, Supporting Victims and Vulnerable People | Community Safety & Cohesion Service, Liverpool City Council |
| Sandra Dean<br>Detective Inspector | Merseyside Police |
| Caroline Grant<br>Head of Domestic Abuse Services | Local Solutions |
| Sharon Marsh | South Liverpool Homes |

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| Community Safety Manager | |
| Helen Smith<br>Head of Safeguarding Adults | Liverpool Clinical Commissioning Group |
| Liz Mekki<br>Service Manager QA and Safeguarding | Childrens Services,<br>Liverpool City Council |
| Jan Summerville<br>Partnerships Coordinator<br>Safeguarding Adults Board | Adults Services,<br>Liverpool City Council |

**7) Review timescales**

A DHR panel was convened and met for the first time September 2014. Home Office guidance is that DHRs should, where possible, be completed with a 6-month time scale. In this case the actual time for completion of the DHR has been 12 months. Delays have been due mainly agencies being unable to produce IMRs within target time frames, due to capacity issues.

**8) Terms of reference**

Each of the agencies which had been identified as having significant and relevant involvement with the deceased and the perpetrator carried out an Individual Management Review (IMR) of that agency's involvement. The terms of reference required that IMRs and this overview report to address the following questions:

**What knowledge/information did your agency have that indicated Anna might be a victim of domestic violence and how did your agency respond to information, including that provided by other agencies?**

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

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

**What knowledge did your agency have that indicated Male 1 might be a perpetrator of domestic violence?**

**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?**

**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?**

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

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

The Terms of Reference required each of the IMRs to address the above questions, with a review period starting 1 July 2013[3], up to and including the date of the homicide in July 2014. In addition to an IMR, each agency also completed a chronology, summarising all relevant events and contacts with the victim and perpetrator, over the course this period.

### 9) Individual Management Reviews

The following agencies were asked to provide full chronologies and Independent Management Reviews (IMRs), addressing the Terms of Reference, as set out above:

- Liverpool City Council Children's Services: Social Work
- Liverpool City Council Children's Services: Children's Centre

[3] Although the formal review period was from 1/7/2013, agencies were able to share information from earlier records, where it was judged that this would provide relevant context.

- Liverpool CCG (GP practice)
- Merseycare (mental health services)
- Merseyside Police

Additionally:

- Liverpool City Council Adults Services provided a copy of a Learning Disability assessment in respect of Anna and
- Liverpool Women's hospital provided an IMR summarising a brief contact with Anna

## 10) Summary of Key Learning

All of the local agency contacts with Anna pre-dated her relationship with the perpetrator. In the case of Liverpool Council's learning disability services, their contact was some six years before Anna died. None of the agencies had had any contact with (or knowledge of) the perpetrator. There had been no police contacts with Anna for several years before the homicide and the there was no record of police involvement (in Merseyside or any other police force areas) with Male 1 as a potential perpetrator of domestic abuse. Taking these factors into account, the DHR did not identify any direct causal links between areas where practice could have been improved upon and the homicide incident. However, the DHR did identify the following learning points, which should inform improvements to future practice:

**10.1 Key Learning for Liverpool City Council's Learning Disability Team:**

In 2008 the learning Disability Team carried out an assessment of Anna's needs, under *'Fair Access to Care Services'*[4] (FACS). At the time of this assessment Anna was resident in a women's refuge, following an alleged assault by her partner (the father of her children). She had been referred for assessment under FACS, by Children's Services. The outcome of the assessment was that Anna was found not to have any eligible care needs. Consequently, there was no further contact

[4] Under FACS (now superseded by the Care Act 2014 and associated statutory guidance), only care needs categorised as 'critical' or '*substantial*' were eligible for council funded care services. Anna's assessment found she had *moderate* needs relating to her physical health, but all other care needs including 'risk factors' were *low*.

between Anna and LD services. The written assessment format included a risk assessment, which did not identify any risks, including *'risks from others'* This was despite the fact that she was resident in a women's refuge as a result of an assault by her partner and she was expressing a wish to resume this relationship.

In response to the issues outlined above and highlighted by the DHR, the Council's Learning Disability Team have carried out a further review of the assessment which took place in 2008. This review recognises that, in the interim period, there have been major changes in national guidance and legislation[5], contributing to significant improvements in how social care needs are assessed and potential risks to service users is responded to. Notwithstanding these improvements, the review has highlighted the following lessons learned for future practice, as a result of this DHR:

- ***The implementation of the Care Act (2014) puts more of a focus on prevention and the wellbeing principle is fundamental to the Act.***
- ***Information sharing across children's and adult services should have been better.***
- ***The Care Act strengthens local authorities' arrangements in relation to co-operation and information sharing between adult care and children's services.***
- ***Since the assessment was completed in 2008, Liverpool City Council now offers training for their staff in domestic violence which would have led to a better insight into these issues during the assessment process, this may have increased awareness of the issues and may have led to a better risk assessment and subsequent referral to more appropriate services to manage the risks.***
- ***The implementation of Multi-Agency Safeguarding Hub (MASH) with health services and the police would have allowed for better information sharing and the joint approach to managing risk could***

[5] Fair Access to Care Services is longer in place and has been replaced by statutory duties, laid out in the 2014 Care Act.

***have led to a more successful preventative strategy in this case. The local authority is currently reviewing an Adult MASH.***

**10.2 Key Learning Point for Liverpool City Council's Childrens Services and Adult Social Care Services:**

Anna's brother is very supportive of Childrens Services actions in gaining Care Orders and ensuring the safety and wellbeing of Anna's children. He is firmly of the belief that this was in the best interests of the children, who would otherwise have been at serious risk of harm.

However, he is also very critical of what he sees as a lack of recognition of his sister's ongoing needs for care and support, after the children had been removed from her care. He believes that she was very clearly vulnerable to forming relationships with abusive males. However, once all of the children had been removed from Anna's care, her brother feels she was 'abandoned' by services which should have offered her ongoing support.

The DHR findings strongly support Anna's brother's opinion that this is the most important learning point arising from this homicide:

**When children are removed from a parent who is an adult at risk (as defined by the 2014 Care Act and previously referred to as a vulnerable adult under No Secrets), appropriate risk assessments should be carried out and a risk management plan put in place. Where the risks include domestic abuse by current or future partners, the plan should include referral to suitably skilled and equipped specialist DV services. In high risk cases this should include referral into the MARAC[6] process.**

[6] Multi Agency Risk Assessment Conference. MARAC was not an available option in Liverpool until 2010, so would not have been an option at the time when Anna's children were placed on care orders.

**10.3 Key Learning for Anna's GP practice:**

As Anna's last contacts with her GP were before the relationship with the perpetrator had started, so there were no opportunities for the practice to be aware of any specific risks associated with this relationship. However, the practice had very considerable evidence of Anna's *general* vulnerability, as evidenced by her physical health, mental health, learning disability and an unwanted pregnancy. As the IMR author has observed, this vulnerability appears to have been touched on, but never analysed in detail. Similarly, there was limited enquiry into her home circumstances.

A referral was made for counselling support, which does show that Anna's underlying emotional and psychological needs were not being completely ignored. However, when she did not engage with this service, there was no follow up, to try and support her to engage. There may have been a lack of motivation, but it could equally have been a very simple issues such as problems with literacy (which Anna's brother has confirmed was an issue) or with transport arrangements. For patients with Anna's range of vulnerabilities and disabilities, there should have been follow up, to explore this further. **That this did not happen was a missed opportunity, as appropriate counselling support may have helped to build her self-esteem and reduce her vulnerability to entering into abusive relationships.**

## 11) Recommendations

### 11.1 Single agency recommendations:

The following recommendations are reproduced from IMRs:

**GP Practice:**

- GPs should make routine enquiries about domestic circumstances when conducting any assessment regarding mental health, drug, or alcohol misuse. There are templates designed for use when patients present with mental health problems. Psychosocial, family and environmental aspects are included.
- GPs should use the recognised pathways of referral into multi-disciplinary and multi-agency arenas if risks to individual safety cannot be managed in-house.

### 11.2 Overview recommendation:

**Adult Social Care***

There should be an internal management review of the risk assessment section of the FACS assessment carried out with Anna, in 2008. The review should consider the following questions:

- Was risk appropriately assessed, with reference to all of the information held by both Children's Services and the Adult Social Care Learning Disability Team?
- If it was not appropriately assessed, what were the reasons for this and what lessons can be learned from this.
- Bearing in mind that this assessment was conducted some seven years ago, have there since been improvements in policy / procedure, and staff training. If this assessment was being carried out today, would it have more accurately identified risks the risks which were present?
- Taking account of the above points, what actions (if any) are required to improve practice in this area?

***The above recommendation has already been implemented, resulting in the key learning set out at 10.1 above.**