DOMESTIC HOMICIDE REVIEW:

INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF

“Darren”

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PART 1: DOMESTIC HOMICIDE REVIEW: BACKGROUND AND PROCESS

1.1 Purpose of the review:

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 Who this report is about:

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to *'Darren'*[1], a resident of Liverpool prior to his death in November 2014. At the time of his death, Darren was twenty-one years old. He was killed by his partner '*Emily'*, who was the mother of his children. At the time of the incident Emily was 22.

Darren was born in Liverpool. His ethnicity was Black British and English was his first language. He had no siblings and was raised by his parents. Both of his parents are reported to have had mental health problems. His aunt, who lived very close to the family home, assisted with his welfare and upbringing.

There is a limited history of Police and Children's Services contacts, relating to Darren as a teenager. In 2008 his father called the police, following a reported domestic incident involving Darren and his mother. It was reported that Darren had been repeatedly asking his mother for money, to purchase cannabis. When she refused, Darren would become abusive and aggressive. In 2009, there was a further police report of an incident involving Darren and his father. Each of these incidents resulted in police referrals to Children's' Services. The referrals were logged on Children's Services' recording systems for information purposes, but did not result in any active Children's Services involvement.

[1] The pseudonyms of Darren (homicide victim) and Emily (perpetrator) are used to help protect the confidentiality of the victim, perpetrator and family members.

After leaving school, Darren attended a local college until June 2014. After leaving college, he was unemployed and in receipt of benefits. He was a very keen footballer and played for a local amateur league side.

Darren had two young children with Emily. They were aged twenty-six months and fifteen months respectively at the time of their father's death. Though Darren did not reside with Emily and his children, he had frequent contact and was actively involved in the children's care and upbringing.

1.3 Perpetrator's background:

Information presented to the DHR (based primarily on Merseyside Police records) indicates that Emily had an unstable and difficult family background. She was born in Liverpool and her ethnic background is recorded as Black British. She describes herself as being of mixed race. English is her first language. She was raised by her mother, along with her brother, a step sister and two step brothers. Her father had not lived at the family home for some years. Emily had a number of previous convictions for offences of assault, affray and failing to comply with a detention and training order.

When Emily was sixteen years old she was involved in an offence of racially aggravated affray. Emily, along with her mother and other family members, attacked and injured customers in bar / restaurant, whilst using racially abusive language. One of the victims of this attack suffered a broken jaw. The courts imposed an intensive community sentence, which Emily failed to comply with. Consequently, she spent two periods of detention in a Young Offenders Institution. As a result of the same incident, Emily's mother was also convicted of racially aggravated affray and was sentenced to one-year imprisonment.

Emily's mother has a significant history of drug, alcohol and mental health problems. She is also alleged to have been both a victim and perpetrator of domestic violence, although there have been no criminal convictions resulting from such allegations.

Between 2009 and 2011 the police were called to a number of incidents involving Emily's mother and her male partner, where alcohol related violence had been

reported. During this period Emily would have been aged around sixteen – eighteen years old. In one of these incidents, Emily's mother was reported to have stabbed her partner with a knife. No prosecution followed, due to her partner's refusal to support this course of action.

In addition to the racially aggravated affray offence in which Emily was involved, Emily's mother has a significant history of criminal convictions for offences including assault, theft, possession of drugs and burglary.

There is a history of police involvement following allegations of sexual abuse and domestic violence within the household. None of these allegations have resulted in criminal charges and are therefore unsubstantiated.

In summary Emily appears to have had a childhood affected by parental instabilities including issues of alleged domestic abuse, drug and alcohol misuse, mental health problems, crimes of violence and dishonesty and unproven allegations of sexual abuse within the household.

1.4 Darren and Emily's relationship

Darren and Emily had been friends from childhood, having grown up together in the same part of Liverpool and attending the same schools. At around sixteen years of age they formed a relationship. Over the next five years, there were quite frequent periods of relationship breakdown, followed by reconciliations.

Emily lived in a privately rented house in the same area of Liverpool as Darren's parents' address. During their time together, Darren and Emily's two children were born. Darren remained living with his parents, but spent much of his time with Emily and the children at Emily's address, though the couple had never formally cohabitated. The relationship had (temporarily) ended around 4 months previously, but the couple had then reconciled two days before the homicide. Despite this latest relationship breakdown, Darren still had regular contact with Emily and their two children. It is understood that the last separation had happened after Emily found out that Darren had previously fathered another child, as a result of a casual sexual

encounter. It is understood that Darren had no ongoing contact with the mother, or the child.

In police interviews following the homicide, Emily reported that she had lost trust in Darren, after her discovery that he had a child to somebody else. She also stated that there had been a history of violence in the relationship, including incidents when she had sustained black eyes. She also admitted that she had been violent towards him during these arguments. However, the extent (if any) to which Emily's previous violence towards Darren had been in self-defence, is unknown. On the basis of police interviews with Emily, family members and others after the homicide, it seems likely that the violence in the relationship was mutual and that each of them were both *'victim'* and *'perpetrator'*.

No previous incidents of physical violence had been reported to the police or other agencies, prior to the homicide incident, but friends of the couple have (in police interviews after the homicide) corroborated Emily's reports that there was a history of violence in the relationship. However, the police had previously attended some incidents of reported verbal arguments between the couple. These incidents are described at 2.2 below.

1.5 The homicide incident

On the evening before the homicide, Emily had been out socialising, with a female friend. Darren had agreed to babysit and was at Emily's house with their two young children. It is reported that the couple had argued over the telephone, as Darren had expected Emily to be home by midnight. Emily arrived home by taxi at around 4am on the following morning, when a further argument ensued between her and Darren.

Neighbours were disturbed by the noise of the couple arguing and entered the house, to find Darren covered in blood. Darren was taken to hospital by ambulance, but he died shortly after arrival at the hospital. The cause of death was subsequently confirmed as a stab wound. Emily initially claimed that Darren had been stabbed by an intruder. After a series of police interviews, she admitted she had picked up a knife because she felt threatened by him. She stated he had walked into the knife, causing the injury.

In the hours preceding the incident, Emily had been drinking alcohol, at her friend's house. Subsequent to the homicide, this friend stated to police that Emily had been under the influence of alcohol when she returned home in the early hours of the morning, but was not drunk.

Emily pleaded not guilty to murder, but was convicted after trial. She received a statutory life sentence, with a recommendation that she should remain in prison for at least thirteen years.

1.6 Decision to carry out a DHR

The statutory Home Office Guidance for DHRs states:

"Domestic Homicide Review means a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by—
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken."

Liverpool Community Safety Partnership (CitySafe Liverpool) concluded that the circumstances of this case clearly fell within the above criteria and appointed Richard Corkhill as Independent Chair and Overview Report Author. Mr. Corkhill is a self-employed consultant and experienced DHR Chair. He has never been an employee of any of the organisations involved in this DHR. (For further information see: about Richard Corkhill's professional experience, background and qualifications see: www.richardcorkhill.org

1.7 Involvement of family members

The DHR Chair contacted Darren's aunt, with assistance from the police Family Liaison Officer. Darren's aunt was the primary family contact, due to Darren's

parents' ongoing mental health problems. The family response was that they did not want to be involved in the DHR process.

At the draft report stage, further contact was made with Darren's aunt, offering the opportunity to meet and go through the contents of the draft report, but this was also declined.

1.8 Meeting with Emily

Mutual domestic violence was disclosed after the homicide. The DHR panel therefore felt that the perpetrator may be in a position to contribute some important learning for local agencies, including any factors which prevented her and/or Darren from seeking assistance to address the violence and its underlying causes. On this basis, a meeting was arranged between Emily and the DHR Chair / report author at the prison where she is serving her custodial sentence. Her prison based Probation Officer was also in attendance. (See section 2.8)

1.9 Contacts with Darren and Emily's friends and informal networks.

Three friends and associates of the couple were invited to meet with the DHR Panel Chair and a panel member, but two of these invitations were declined. One friend (of the perpetrator, but not of the victim) did accept this invitation. (See section 2.9)

1.10 DHR Panel membership

Name / Role	**Organisation**
Richard Corkhill Independent Chair & Overview Report Author	Independent Consultant
Angela Clarke Team Leader, Supporting Victims and Vulnerable People	Community Safety & Cohesion Service, Liverpool City Council
D.I Elaine Coulter DI Sandra Dean	Merseyside Police
Caroline Grant Head of Domestic Abuse Services	Local Solutions

Hannah Doughty Head of Targeted Services for Young People	Targeted Services for Young People (formerly Youth Offending Service) Liverpool City Council
Helen Smith Head of Safeguarding Adults	Liverpool Clinical Commissioning Group
Liz Mekki Service Manager QA and Safeguarding	Children's Services, Liverpool City Council
Jan Summerville Partnerships Coordinator Safeguarding Adults Board	Adults Safeguarding Board, Liverpool City Council
Karen Rooney CEO	Community Rehabilitation Company
Kim Garthwaite Service Manager	Children's Centres Liverpool City Council

1.11 Review Timescales:

A DHR panel was convened and met for the first time in February 2015. Home Office guidance is that DHRs should, where possible, be completed within a 6-month time scale. In this case the actual time for completion has been delayed by several months. A significant factor in this delay has been that the criminal trial was not completed until the end of May 2015. Prior to completion of the trial it was deemed inappropriate to invite family members, friends or the perpetrator to engage with the DHR process.

1.12 Confidentiality:

Pending Home Office approval for publication of the anonymised version of this report, the DHR panel and CitySafe Liverpool have managed all information about this case as highly confidential. Information sharing has been restricted to members

of the DHR Panel, their line managers and senior managers of services which provided Individual Management Reviews.

1.13 Terms of reference

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

- What knowledge/information did your agency have that indicated Darren 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 and were they accessible, appropriate and sympathetic to his 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 Emily 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 and / or mental health issues a significant issue in relation to this homicide and domestic violence risks? If so, how did your agency respond to this issue?
- Bearing in mind that the couple had 2 small children, are there any lessons which can be learned about multi-agency approaches to working with families where there are risks of domestic violence?
- 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 from February 2011, up to and including the date of the homicide in November 2014. In addition to an IMR, each agency also completed a chronology of all relevant events and contacts with the victim and perpetrator, over the course period under review.

1.14 Independent Management Reviews

An initial scoping exercise was carried out, to ascertain which local agencies had had significant involvement with the victim and / or perpetrator during the 2 years covered by the review. Agencies contacted included:

- Police, probation and other criminal justice services
- Primary and secondary health care services
- Voluntary sector services including those working with domestic violence victims or perpetrators
- Housing and housing advice and support services

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

- Merseyside Police
- Liverpool CCG (GP practices)
- Liverpool City Council (LCC) Children's Services
- LCC Children's Centres
- LCC Youth Offending Service
- Liverpool Women's NHS Foundation Trust

PART 2: ANALYSES OF AGENCIES' INVOLVEMENT

2.1 Introduction

This section describes significant service involvement, contacts and communications relating to Darren and Emily, from February 2011 until the homicide incident in November 2014. For each of the agencies, descriptive accounts of episodes of involvement are followed by commentary and analysis, highlighting key learning points, such as:

- Missed opportunities for earlier or more effective interventions
- Examples of exceptionally effective or innovative practice
- Examples of poor or ineffective practice
- Issues of communication, information sharing and joint working between the different agencies.

Commentary / analysis sections are contained in 'boxes'. This is to ensure a clear separation between factual accounts of what took place and analyses / key learning sections.

2.2 Merseyside Police

During the period under review, Merseyside police were called to two domestic incidents in which there had been reports of heated verbal arguments between Darren and Emily. There were also two abandoned 999 calls, neither of which resulted in police call outs:

Police incident 1, **May 2011**: At 02.15 a neighbour called the police reporting that there was a fight taking place, outside Emily's address. When officers attended Emily advised that there had been a heated argument between her and Darren, but nobody had been injured and Darren was no longer present at the address. Some minor damage was noted within the address, including a broken picture frame and some moisturiser spilt on the floor. Police records show that Emily appeared to be under the influence of alcohol and there was a strong smell of cannabis emanating from the address.

A Vulnerable Persons Referral Form (VPRF) was completed, noting alcohol and drugs as contributing factors. It was also recorded that no children were present (This incident was around fifteen months before Emily's first child was born). A domestic violence risk assessment recorded risk levels to Emily as *'bronze'*, which is the lowest category of risk, under the risk assessment process used by Merseyside Police.

Police incident 2, September 2013: At 16.45 a neighbour called the police reporting that domestic dispute was taking place at Emily's address. They were concerned, because two small children were present. (At this time, Emily's eldest child was 1 year old and the younger baby was 7 weeks.) When the police attended, Darren was no longer present at the house. No offences were reported by Emily and there was no sign of damage to property. Emily's children were seen to be safe and well. A VPRF was completed and the domestic violence risk assessment again resulted in a risk level of *'bronze'.* The police IMR notes that a referral was made to Children's Services, in relation to Darren and Emily's two children. Children's Services have confirmed that they have a record of a notification from the police that they attended the address, following a reported verbal argument between the couple. This was recorded by Children's Services for information purposes only, with no follow up actions.

Abandoned 999 calls, October 2014: In addition to the two incidents described above, there were two abandoned 999 calls from Emily's mobile phone, apparently made by her eldest child. On the first of these calls (2/10/14) the only sound was of a baby in background, with no evidence of a disturbance and no request for police assistance. The log was closed pending a recall and a message left on the answer phone on the mobile. There was no further police action in response to this call. There was a similar call one month later (1/11/14). On this occasion Emily took the phone and informed the call handler that her child had made the call. There was no evidence of a disturbance and no request for police assistance.

Commentary / analysis:

Police incidents 1 and 2 were each considered relatively 'low level', with no allegations or evidence of physical violence, threats of violence or the presence of weapons. One significant risk factor which was recognised and appropriately recorded following incident one, was that one or both parties appeared to have been under the influence of alcohol and there was evidence of misuse of drugs.

There was an interval of around fifteen months between these incidents, so there was very limited escalation in relation to the frequency of incidents. After the second incident the assessed risk level remained low. The fact that children were present was recognised as being of concern, resulting in the communication with Children's Services.

The DHR has highlighted a contrast in the Police records which show there was a *'referral'* to Children's Services following the second incident, whilst Children's Services recorded this communication as a *'notification'*. Whilst *referral* suggests an expectation that it may have resulted in some follow-up action (or at least some follow-up discussion with the referring agency) *notification* would suggest a sharing of information without an expectation that this would necessarily result in active follow up. This inconsistency of professional terminology between the Police and Children's Services is potentially unhelpful. Clearer and mutually consistent use of terminology used to describe *'referrals'* and *'notifications'* would be of assistance in ensuring clarity of inter-agency communication and joint working in the future.
(Key Learning Point 1)

The police IMR concluded that both incidents were dealt with according to Merseyside Police policies and procedures and that the results of domestic violence risk assessments were in line with all of the evidence available at the time. DHR findings are in line with the IMR conclusions, as the two reported incidents suggested infrequent and minor disturbances. This information could not reasonably have resulted a conclusion that either party was at anything other than low risk of harm from domestic violence.

It is noted that, in both incidents, the eventual homicide perpetrator was in fact viewed and risk assessed as a potential domestic abuse *victim*, whilst Darren was identified as the potential perpetrator. It was entirely reasonable to recognise that a female partner was statistically more likely to be a victim of domestic violence. It is also fair to observe that the evidence available at the time could not have ruled out either Darren or Emily as potential victims and/or perpetrators. However, the eventual outcome in this case highlights that any evidence of potential risks to and from both parties should always be given careful consideration in assessing risk levels, without assumptions based on the genders of the parties involved. **(Key Learning Point 2)**

The abandoned 999 calls were made quite shortly before the homicide incident, with the second call just three weeks before. For this reason, the DHR has carefully considered any potential learning arising from these calls.

The calls were understood to have been made by the eldest child, who was only just over 24 months old. It would be surprising, though not impossible, for a two-year-old to have made 999 calls, genuinely seeking help with a situation they found distressing. The police IMR is clear that recordings of the calls contained no evidence of any form of argument, disturbance or other situation which could have suggested a need for an immediate police response.

These calls may or may not have been made because the child was distressed or frightened by something they had witnessed. On the basis of the available evidence, it would be pure conjecture to express an opinion on the actual causes and motivations behind these calls. However, (without the benefit of hindsight) it is fair to observe that the call handler and their supervisors would not have had any reasonable cause to believe that these abandoned 999 calls indicated a need for officers to attend the scene. With the second call, Emily spoke to the call handler and it was made clear that there was no request for a police response.

In conclusion, the evidence presented to the DHR is that these abandoned calls were dealt with according to Merseyside Police policy and procedure. Bearing in

mind that such calls happen on a very frequent basis[2] and the vast majority do not warrant any emergency response, it would be inappropriate to recommend changes in police policy and procedure for abandoned 999 calls, on the basis of the evidence presented to this DHR.

2.3 Liverpool City Council: Children's Services

During the period specified by the DHR Terms of Reference, Children's Services had some relatively brief periods of contact with Emily and Darren, as a result of referrals in relation to potential concerns about their children:

Probation referral, August 2012: At this time, Emily was in the second trimester of pregnancy and was residing with her mother. The Probation Service (involved with Emily's mother) made the referral due to concerns for Emily's unborn child. The concerns centred on the home environment, including Emily's mother's history of violent offences, and likely exposure to alcohol. Emily engaged positively with the Children's Services assessment. Her baby was born in autumn 2012 and the case was closed to Children's Services in January 2013.

Anonymous referral, February 2013: The referrer stated that adults at Emily's address (Emily and the baby were still resident at Emily's mother's address) were misusing alcohol, raising concerns for Emily's baby who was now six months old. Children's Services carried out a further assessment, but found no evidence of cause for concern for the baby's safety or wellbeing. This assessment included contact with both Emily and Darren. The case was closed in March 2013.

Referral from Liverpool Women's Hospital, July 2013: This referral was made shortly following the birth of Emily's second child, at LWH. The referral raised concerns relating to the possibility of the baby having contact with an individual who had an alleged history of child sexual abuse. This individual had no criminal convictions for behaviour of this nature.

[2] Nationally there are an estimated 5.5 million silent 999 calls made each year, the vast majority of which are reported to be accidental calls. (Source: http://news.bbc.co.uk/1/hi/magazine/7748046.stm)

In response Children's Services carried out an assessment, which included contact with both Emily and Darren. Emily understood the concerns and agreed that there would be no unsupervised contact between this person and her children. The case was closed in October 2013.

Police referral / notification, September 2013: As noted at 2.2 above, this was recorded by the Police as a 'referral' and by Children's Services as a 'notification'. It related to the second police call out, when there had been an argument between Emily and Darren. As there was no indication that the children had come to any harm or were at significant risk of harm, this appears to have been treated as being for information purposes only and there is no record of any follow up action by Children's Services.

Children's services had no further involvement with Emily, Darren or their children, until immediately following the homicide incident.

Commentary / analysis

The referrals regarding Emily and Darren's children confirm that there had been concerns raised about misuse of alcohol and about Emily's home environment, when she and her children were living with Emily's mother. There were also concerns raised about potential risks of sexual abuse from an identified individual. (This was not Darren, or any member of Darren's family). Children's Services appear to have taken these referrals seriously and to have carried out appropriate assessments into the children's safety and wellbeing. Emily cooperated with Children's Services involvement and the assessments each concluded that there was no need for longer term involvement from Children's Services, or for formal child protection plans.

As noted at 2.2 above, Children's Services were informed about the police call out to the incident in September 2013, when a concerned neighbour had reported a verbal argument. There was no evidence of physical violence, but the neighbour had been sufficiently concerned by what they had heard, to involve the police. The

information was duly recorded, but the decision was taken that this did not warrant any active follow-up response.

At this time Children's Services were already involved as a result of the referral from Liverpool Women's Hospital in July 2013 (re possible sexual abuse risks from another individual) and had found Emily to be cooperative. They had found no evidence that the children were at risk. The new information about the police call out in September 2013 was an opportunity for discussion by the social worker with Emily about her relationship with Darren. There is no record of any such discussion having taken place.

In summary, Children's Services generally acted proportionately and reasonably in relation to their statutory child care responsibilities. However, the lack an active response to the police notification in September 2013 has been identified as a missed opportunity to open a discussion with Emily about her relationship with Darren, any problems they may be experiencing and potential impacts of this on the children. This is particularly noted, because there was a social worker already involved at the time of the police notification. **(Key Learning Point 3)**

In making this observation, it is not intended to draw a direct causal link with the homicide, fourteen months later. Even if there had been active social work follow up to the police notification, it seems unlikely that the actual potential risk for violence in this relationship would have been disclosed.

2.4 Liverpool City Council Children's Centres

In September 2013 a health visitor referred Emily and her children to a local authority run children's centre for support. The children's centre was involved for a period of just 5 weeks and this contact was limited to helping the family access grants, to fund the installation of safety equipment in the home. There was also some communication between the centre and the children's social worker who was involved at that time, following the reported concerns about the sexual abuse risks as noted at above.

Commentary / Analysis

The Children's Centre involvement was for a very short period and was focussed on practical issues of safety equipment for the home. There was appropriate information sharing between the Children's Centre and the social worker regarding the concerns raised in the hospital referral in July 2013. The information available to the Children's Centre would have raised no cause for concern about domestic violence in the relationship between Emily and Darren.

2.5 Liverpool City Council Youth Offending Service

The Youth Offending Service had contact with Darren and Emily during 2011 when they were each on statutory orders for unconnected offences. Darren was on a first tier Referral Order for Burglary and was seen on a weekly basis until finishing his Order in July 2011. He completed all identified work although there were several failed appointments. The case manager had contact with Darren's father but there is no evidence within the case record that a home visit was completed or that Darren's relationship with Emily was known about.

Emily was on a Supervision Order with an Intensive Supervision and Surveillance Programme following the offence of Affray (see 1.3 above). This sentence was a direct alternative to custody. She was given daily appointments but failed to attend on numerous occasions, resulting in a 4-month custodial sentence in May 2011 for breach. Whilst in custody the YOS maintained contact with Emily and assisted her with release planning; including supporting her with education and accommodation needs. She was released from prison in July 2011 but failed to comply with licence conditions so was recalled to custody to serve the rest of her sentence. In September 2011 Emily was released from prison with no licence and, as a consequence, she had no further involvement with the YOS.

The YOS chronology and IMR highlight a number of factors of relevance to the DHR terms of reference. These include:

- Repeated reference in case files to Emily's mother having mental health problems and using alcohol in a chaotic manner. This was seen to be

impacting significantly on Emily's emotional well-being and her ability to comply with the requirements of her statutory supervision.

- A risk assessment in February 2011 found that Emily was highly vulnerable and presented a high risk of harm to others. A further assessment a week later reduced these risk levels to medium. A further assessment, undertaken in May 2011, kept these levels at medium. [3]
- In the final assessment undertaken by the YOS (dated August 2011) these levels remained at medium. Within the evidence for 'family and personal relationships' the worker noted that *'The relationship between* (Emily) *and* (Darren) *is noted as being fraught with outbursts of violence from both parties, but* (Emily) *chooses to continue it'*. This is the only reference within YOS records to any concern about the relationship between the pair.

Commentary / Analysis
YOS records confirm that Emily had a very difficult home background and home life. It was suggested by workers that her mother's problems with mental health, alcohol misuse and reportedly violent relationships with partners, contributed significantly to Emily's own difficulties in controlling her behaviour and complying with the court order. Emily's potential for violent behaviour was evidenced by the offence of affray. The initial YOS assessment in February 2011 found that Emily was at high risk of harm to others, though a week later the assessed risk level was reduced to medium. During her contact with YOS there were no further recorded incidents of violence, which appears to be why assessed risk levels were reduced. The risk of harm to 'others' would have been related back to the index offence of affray, so would not have highlighted specific concerns about potential for domestic violence. Most significant to the DHR Terms of Reference, was the record of an assessment in August 2011 which stated that the relationship between Emily

[3] The view of the IMR author is that the May 2011 risk assessment should have recorded vulnerability as high, given that this was Emily's first custodial sentence and she was recorded as having been distressed in the cells.

and Darren was affected by outbursts of violence, from both parties. There is no other mention in YOS records of any relationship issues or domestic violence between Emily and Darren.

Unfortunately, YOS records do not clarify the source of the information about the violent outbursts, so it is unknown whether this was a self-disclosure by Emily, or information received from another agency, from a family member or another informal source. Similarly, the reference to violent outbursts does not give any indication of the frequency or severity of the outbursts. There is no reference in the records of any actions having been taken to try and manage or reduce any ongoing domestic violence risks.[4] Assuming that no actions were taken, this has to be identified as **missed opportunity** for early interventions to try and address domestic violence concerns in the relationship. **(Key Learning Point 4)**

The current Head of Service has acknowledged that the quality of recording about the nature and level of domestic violence concerns (and any actions taken as a result) was poor. Under the YOS risk management policy in place at that time, a risk management plan should have been completed following the assessments in February 2011 which found Emily to be at high (subsequently reduced to medium) risk of harm to others. The absence of a risk management plan should have been challenged through management and supervision processes, but there is no evidence of this having happened.

The YOS IMR highlights the importance of clear and accurate records when dealing with potential issues of domestic violence. It also highlights that when there is evidence of significant risk of domestic violence (including mutually violent relationships as well as those with a clear victim / perpetrator split) a risk management plan should be in place. Appropriate challenge through effective management and supervision is a key element in achieving this. The current Head of Service advises that since 2011 there has been significant

[4] As the member of YOS staff who made this entry is no longer employed by YOS, it has not been possible for the IMR author to clarify either the original source of the information about 'violent outbursts' or any information about the reported frequency / severity of such incidents.

improvement in staff and management training, awareness and practice, resulting in ongoing improvements in their responses to domestic violence.

In summary, there was a **missed opportunity** in 2011, when Emily and Darren may have been encouraged and supported to engage with services to help them address relationship issues and reduce future risks of mutually violent incidents. If appropriate to the level of risk, referral to specialist domestic violence services could have taken place. It should be acknowledged that the 'window of opportunity' available to YOS was extremely short, bearing in mind that the assessment which identified the violent outbursts took place on 23/08/11 (when Emily had been returned to prison) and YOS had no further engagement with Emily after her release from prison (without any licence conditions) on 5/09/11.

This was over three years before the homicide incident and it is unknown whether such interventions 2011 could have significantly reduced risks of continuing domestic violence, but this was at least a possibility.

2.6 GP Practices

Darren and Emily were registered at different GP practices. The involvement of both practices has been reviewed in a single IMR provided by Liverpool Clinical Commissioning Group. The IMR notes that neither practice appeared to have had any knowledge of the relationship between the couple, or of their living arrangements.

During the period under DHR review, Darren had only 3 GP consultations, which were for medical symptoms of no direct relevance to the DHR terms of reference. There was nothing in GP records which could have indicated that Darren was at risk from domestic violence, or that he was in mutually violent relationship.

During the period under DHR review, Emily had only 2 consultations at her GP practice. These were a routine midwifery appointment in May 2012 and an appointment with her GP in July 2012. The practice also received communications

from Liverpool Women's Hospital around the time of the births of each of her children. These communications were in relation to potential child protection concerns.

It is clear from background information provided by the IMR that Emily's GP practice was aware of Emily's difficult family background, including her mother's alcohol problems and history of violence. However, GP contacts with Emily were routine in nature and gave rise to no specific concerns that Emily might be either a victim or perpetrator of domestic violence.

Commentary / analysis

Darren and Emily's GP practices each had relatively little contact with their respective patients. The contacts they did have were routine in nature and could not have alerted GPs or other health professionals to risks of domestic violence.

The IMR has noted that the only indication of Emily as a potential domestic violence perpetrator related to the knowledge that her own mother had violent tendencies and was known to abuse alcohol. The DHR findings concur that these environmental influences in Emily's upbringing were very probably significant factors in this case. However, it would not be reasonable to suggest that her GPs or other primary health care professionals could have identified Emily as presenting a specific risk of violence towards her partner.

The DHR has not found any significant missed opportunities for better or different interventions from primary healthcare professionals which could have significantly reduced risks of domestic violence.

However, the IMR for the GP practices has reached the following conclusions, which are supported by the DHR findings:

In Liverpool GP practices are being encouraged to have integrated working with other primary, community service and social care providers at neighbourhood

level. There are eighteen neighbourhoods in Liverpool. Integrated working has been focused on management of the frail elderly and those with complex health problems. It is recommended that integrated working should be considered for those with risk factors for the safeguarding of adults and children.

To facilitate this any known risk factors for safeguarding should to be READ coded[5] *to enabling further and future interrogation of the patient electronic record as and when necessary.*

Any communications from other universal health service providers which contain safeguarding information should be highlighted and READ coded in a similar fashion.

Multi-disciplinary meetings or discussions may be arranged to discuss cases highlighted through this coding process, in much the same way that it is done for palliative care patients under Gold Standard Framework.

This will enable universal health service providers to work more effectively in a multi-agency arena.

It has not been found that such issues about GP record systems and integrated working were significant factors in this case. However, any developments leading to better integration, joint working and information sharing between primary healthcare services and others working in the domestic violence field should be supported.

[5] Read codes provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems across primary and secondary care

2.7 Liverpool Women's NHS Foundation Trust (Liverpool Women's Hospital / LWH)

Emily had contact with LWH for maternity / obstetric care, over the course of her two pregnancies. Both pregnancies concluded with normal childbirths and healthy babies. However, during the course of each pregnancy maternity services did identify some concerns, as summarised below:

2012: Emily was booked in for maternity / obstetric care and disclosed that both she and her partner were cannabis users. There was discussion about her accessing help via her GP. Emily reported she had reduced her use and intended to stop completely. LWH records show that Children's Services were contacted[6], but at that time there was no Children's Services involvement with the family.

2012 (22 weeks into first pregnancy): Emily attended LWH's Medical Assessment Unit (MAU), reporting that she had been kicked in the abdomen. She stated that she had been splitting up a fight at a house party and said the kick was an accident. She also said that person who kicked her was not her partner. There were no injuries and no concerns were raised by medical staff.

2012: LWH were notified that Children's Services were now actively involved, as result of concerns raised about Emily's mother's alcohol use.

2012: First child born, no complications. Emily and baby were discharged home the following day, with a written agreement that Emily's mother would not have unsupervised contact with the baby.

2013 (second pregnancy): The previous concerns about Emily's mother were noted in patient records. It was also noted that Children's Services should be notified of any concerns which may arise in the course of this pregnancy.

[6] This contact is not recorded in Children Services records. It is understood that this contact was limited to a phone call from LWH, enquiring whether or not there was current social work involvement. There is no record to indicate that there was any referral made by LWH at this stage.

2013: Second child born, no complications. On the day following the birth Darren was reported to have been seen smoking cannabis on the LWH site. LWH made a referral to Children's Services, notifying them of this incident. This referral also raised the concerns about potential sexual abuse risks from an identified individual. (This individual was not Darren, or any member of his family). Emily was discharged home three days after the baby was born.

Commentary / analysis

It is clear that LWH had significant causes for concern about the safety and wellbeing of Emily and her children, including:

- Both Emily and the babies' father were noted to be cannabis users.
- One incident when Emily said she had been kicked in the abdomen accidentally by an unknown third party, when Emily was 22 weeks pregnant
- Emily's home situation, including living with her mother who was reported to have serious alcohol problems.
- Potential sexual abuse risks from an identified individual.

The evidence presented to the DHR indicates that LWH generally communicated effectively with partners including community health services and Children's Services and shared relevant information and concerns as they arose. They also made offers to refer Emily for support to reduce or curtail her use of cannabis, but she did not accept such offers.

The only incident which might have been an indicator of risk from violence was the reported kick to the abdomen. Even if the incident was as described (i.e. Emily being kicked accidentally when trying to separate two people in a fight, at a house party) this would suggest that Emily's unborn child had been placed at some risk, as result of Emily's home circumstances, lifestyle and unwise decision making. Taken in the wider context of concerns about Emily's home situation, her mother's misuse of alcohol and her self-reported cannabis use, this incident should have resulted a referral to Children's Services. That no referral took place was a missed opportunity for a more thorough assessment of the incident. **(Key Learning Point**

5) It is acknowledged that, even if the incident had been one of domestic violence, it is likely that Emily would have persisted with her original explanation that this was an accident and did not involve Darren. In this case, it would probably not have resulted in Emily and/or Darren being referred for any specialist support from domestic violence services.[7]

2.8 Perpetrator perspective

Emily describes herself as being of mixed race. She and Darren grew up in a working class area of Liverpool, in a community with a well-established Black British population. Like Emily, Darren's ethnicity was also Black British. The area they lived in is recognised as having a significant history of social deprivation.

Emily's contributions to the DHR focused primarily on the history of mutual violence in the relationship[8] and the reasons why neither she nor Darren sought (or received) advice or assistance in respect of this. The following is a summary overview based on her responses:

- In the community where she grew up, there was a strong mistrust of the police and any other services seen to be part of the 'establishment'. If anybody reported anything to the police, they would be regarded as a 'grass'.
- She was not aware of any less formal or community based services which could have offered support or assistance with issues of domestic violence.
- In particular, Emily was not aware of any local services for young people in her community, which could have offered advice or support with issues of domestic violence at the early stages of the relationship, when she and Darren were only around sixteen years old. She felt that, had she gone to a service with a more adult focus, the problem would not have been taken seriously.

[7] DHR follow- up questions to LWH's safeguarding lead have been asked, in relation to policy and practice regarding routine enquiry about domestic abuse by maternity services. Based on internal service audits, LWH are satisfied that current policy and practice in this area is of a good standard.
[8] A history of mutual violence was reported in the course of the criminal investigation and court proceedings, after Darren's death. This overview report is unable to comment reliably on the extent to which either party was victim or perpetrator in past incidents, as the available evidence is inconsistent.

- Emily expressed the view that the issue of domestic violence needs to be *“out there”,* with a clear message for young people in violent relationships that *“it’s okay to talk”*.
- When there had been violent incidents she had threatened to tell her brothers, but had not done so, because she wanted to protect Darren. She did tell some friends about violence in the relationship, but these friends were unable to prevent further incidents.

Commentary and analysis

There is strong evidence that Emily came from a family background where violent behaviour was not unusual (though Emily did not identify this an issue in her contribution to the DHR) and it is likely that a violence in her relationship with Darren was to a large extent seen (by her, Darren and others) to be ‘normal’.

Emily has confirmed that she did not directly seek any assistance from local services, with issues of violence in the relationship. Similarly, there is no evidence to indicate that Darren sought any assistance. On this basis, no individual agency can be criticised for failing to respond to requests for help. However, Emily’s comments highlight an important area of unmet need, especially for young people from marginalised and socially deprived communities, who are likely to be at increased risk from domestic violence. If young people do not have confidence that their experiences of domestic violence will be taken seriously by local services, there is little chance of them asking for (or receiving) help.

Emily’s statement about the need for the issue of domestic violence to be “*out there”*, with a message of its “*okay to talk”,* is arguably the single most important lesson arising from this DHR. **(Key Learning Point 6)** The DHR findings support Emily’s views on this issue. This highlights a need for:

- An increase in publicity, awareness raising and preventative work to be developed (by and for) young people at risk from violent or otherwise abusive relationships. This should include s*pecific and age appropriate* educational and preventative work with adolescents and younger

- teenagers, aimed at promoting healthy relationships and preventing abusive behaviour from becoming normalised and ingrained.
- Specialist services (or specialist workers within existing domestic violence services) for young people already in abusive relationships.

The above points are supported by a research study conducted for the NSPCC [9] which also included the following finding:
"A history of family or peer violence was significantly associated with greater susceptibility to partner violence. Consequently, child welfare professionals working with adolescents, especially those who have experienced family or peer violence, need to ensure their experiences of partner violence are also addressed. As teenage partner abuse is rarely reported to adults, it is important that professionals routinely include this area in their overall assessments of young people's needs"

In this case, all of the key organisations were aware of Emily's family background and some were aware of problems in the relationship with Darren. But there is little evidence to suggest any recognition of this link between a history of family violence and increased susceptibility to partner violence.

2.9 Meeting with friend of perpetrator

This meeting was with Emily's friend *'Anne'*[10]. Anne is around the same age as Emily and they had been friends for a number of years. She describes her friendship with Emily as close, though she was aware that Emily had another friend who was much closer. Anne had little contact with Darren and did not regard him as a friend.

Several weeks before the homicide, Anne had witnessed an incident, when Darren had thrown Emily across the room. Anne had been quite shocked by this incident, which was the only occasion on which she was aware of any violence between the couple. She recalled that it seemed as if this behaviour was seen by Emily as the

[9] 'Partner exploitation and violence in teenage intimate relationships' *(Christine Barter, Melanie McCarry, David Berridge and Kathy Evans, NSPCC 2009)*.
[10] Pseudonym used to protect identity

‘norm’ and did not feel she could challenge this. Apart from the Police, Anne was not aware of any local services which might have been able to offer support to Emily in dealing with issues of violence in her relationship with Darren.

Commentary and analysis

Anne’s observations confirm that there was violence in this relationship, though Anne had been unaware of this until just a few weeks before the homicide. Anne had no prior knowledge or awareness of potential risks to Darren.

Like Emily, Anne had no knowledge of local services which might have offered advice and support in relation to domestic violence concerns. This further supports Emily’s comments about the need to for more focussed work with young people, to raise awareness of domestic violence and to ensure that appropriate advice and support is accessible to this group of people. **(Key Learning Point 6)**

PART 3: SUMMARY OF FINDINGS, KEY LEARNING AND RECOMMENDATIONS

3.1 Q1 What knowledge/information did your agency have that indicated Darren might be a victim of domestic violence and how did your agency respond to information, including that provided by other agencies?

Collectively the agencies reviewed by the DHR held information which, to varying degrees, evidenced that this was a volatile and potentially violent relationship. However, the evidence was of *mutual* violence and verbal conflict with no indications that either party could be clearly defined in the role of victim or perpetrator. The most significant information held by agencies was:

Youth Offending Service: In February 2011, a risk assessment carried out by YOS found that Emily was at high risk of harm to others, though this risk level was subsequently reduced to medium. This risk was assessed with reference to the index offence of affray, so would not have been identified as an indicator for risk of domestic violence.

In July 2011 a YOS worker recorded that there were violent outbursts in Emily's relationship with Darren. Unfortunately, there was no record of the evidence base; source(s) of the information; or how serious and frequent the outbursts were. There is also no record of any actions having been taken as a result of this information. *(See Key Learning Point 1)*

Merseyside Police: Prior to the homicide, Merseyside Police had been called to two domestic incidents involving Darren and Emily. These were in May 2011 and September 2013. In both cases the presenting evidence was that these had been verbal arguments, with no physical violence. Consequently, risk levels were assessed as being low. It is notable that the incident in May 2011 was three months after YOS had assessed Emily as being at high (subsequently reduce to medium) risk of harm to others, but this information was unknown to the Police. Had YOS implemented a risk management plan following their assessments, this

may have included sharing information with partner agencies, which might then have influenced the police risk assessment.

Children's Services: Children's services received a number of referrals raising potential concerns about the safety and wellbeing of Emily's children. These concerns were mainly about Emily's lifestyle and use of cannabis and alcohol, rather than domestic violence. Children's Service primary focus was (rightly) on the children. The only information received by Children's Services which might have indicated a domestic violence risk was the referral (recorded by Children's Services as a notification) following the second police incident in September 2013. As the reported incident was a verbal argument, with no indication of the children coming to harm, this was recorded for information purposes only. However, as there was already a social worker involved at this time, this was a **missed opportunity** for the social worker to consider this incident in more detail.

Liverpool Women's Hospital: LWH's involvement was primarily with Emily's two pregnancies, which appear to have progressed normally and resulted in healthy babies. The only incident which could have been an indicator of risk of violence was the reported kick to abdomen when she was pregnant with her first child, though this was reported by Emily as having been an accident and not to have involved Darren. There were no apparent injuries, to Emily or to her unborn child. Emily's explanation of this as an accidental incident at a party did not suggest domestic violence. However, the context of the incident was that there were already concerns about Emily's lifestyle and home circumstances (at this time she was resident with her mother and there was a reported history of domestic violence in the household) and potential impacts on her unborn child. In these circumstances, expected practice would have been to advise Children's Services of the incident, but this did not take place. This was a missed opportunity for further enquiry into the incident.

Summary: The information held by the different agencies collectively evidenced a volatile relationship, with some risk of mutual violence. There was no known history of use of weapons, or of domestic violence incidents where either party had

sustained serious injuries. On this basis, it would not be reasonable to conclude that Darren could (or should) have been identified as a high risk domestic violence victim, even if all of the evidence had been available to each of the agencies in contact with Emily and Darren.

On the other hand, there were some missed opportunities for earlier information sharing, which might have led to earlier and preventative risk management approaches.

Q2 What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to his needs?

The only service which had a significant period of involvement with Darren during the review period was the Youth Offending Service, which supervised him for some months during 2011. Although Darren's contact with YOS was concurrent with Emily's YOS supervision, this was coincidental as his and Emily's offences were completely unrelated. YOS records show that that Darren's compliance with the requirements of the Supervision Order was less than consistent, but he did complete the period of supervision. YOS records on Darren make no reference to his relationship with Emily, or him being in a violent relationship (either as potential victim or perpetrator).

The other service which had some contact with Darren was Children's Services, but this appears to have been quite limited in frequency and scope. This is understandable, because Emily was the Children's primary carer and Darren was not resident in the children's household.

When the police were called to domestic incidents (both of which were reported as verbal arguments) the resulting assessments considered potential domestic violence risks to Emily, but not to Darren. This appears to have been largely based on an assumption that the male partner would be the potential perpetrator and the female partner the victim. This was statistically likely to be true, but the presenting

evidence in this individual case was of mutual conflict, with no clear basis to differentiate between potential 'victim' and 'perpetrator' roles. This assumption based on gender was not sympathetic to Darren's needs.

However, even if the Police risk assessments had considered Darren as a potential victim, the evidence base at that time would almost certainly have resulted in a finding of low risk and not identified any need for further action or for referral to specialist services. For this reason, it is concluded that the absence of an assessment of risks to Darren was not a factor in the homicide incident which occurred around fourteen months after the second police call out.

The question of whether services were accessible, appropriate and sympathetic to Darren's needs is difficult to answer, because whether or not Darren considered himself to have domestic violence related needs, is unknown. However, based on Emily's observations there is evidence that services were not seen by many young people in the local community as accessible, appropriate or sympathetic. (See Q9)

Q3 What information and/or concerns did the victim's family and friends have about victimisation and what did they do?

Darren's family have chosen not to contribute to the DHR. As there is no other evidence available to the DHR about this question it is not possible for the DHR comment reliably on what information / concerns (if any) family members may have had.

Anne, a friend of the perpetrator (but not a friend of the victim) has confirmed that she had concerns following a violent incident some weeks prior to the homicide. However, in this incident it was the eventual homicide victim who was the perpetrator, so the friend had no information or concerns about Darren as a possible victim.

Anne (like Emily) was not aware of any local services which could possibly have offered support following this incident.

Q4 What knowledge did your agency have that indicated Emily might be a perpetrator of domestic violence?

See response to Q1 above

Q5 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?

None of the individual agencies have reported that capacity or resources issues were significant factors in this individual case. Having said this, the DHR has highlighted the importance of developing and publicising services which are more sensitive to the specific needs of teenagers at higher risk from domestic violence. Developing such services clearly requires investment of additional resources, awareness raising, training and new service development activities.

Q6 Was abuse of alcohol or drugs and / or mental health issues a significant issue in relation to this homicide and domestic violence risks? If so, how did your agency respond to this issue?

Neither Emily nor Darren appear to have had significant mental health problems, but they both had parents with significant histories of mental health problems.

Both Emily and Darren are understood to have used cannabis, but the extent (if any) to which this was a contributory factor for domestic violence is not known. Emily is reported to have been under the influence of alcohol when the homicide took place and it seems probable that alcohol was a significant factor in the incident itself. There

is also some evidence that the couple had been under the influence of substances when the police were called to earlier incidents.

Emily was offered referral for support to withdraw from cannabis use when she was pregnant with her first child, but this was declined as Emily reported that she was reducing her cannabis use, without the need for specialist support. Emily had also had support from a specialist substance misuse worker, whilst under statutory supervision with the Youth Offending Service.

In summary, there is evidence that substance misuse contributed to conflict and violence in the relationship, but it appears not to have been a primary causal factor. Emily had received some assistance with substance misuse problems, but this assistance was not linked directly to perceived domestic violence risks.

Q7 Bearing in mind that the couple had 2 small children, are there any lessons which can be learned about multi-agency approaches to working with families where there are risks of domestic violence?

The DHR has identified the following lessons:

- When Emily told medical staff at Liverpool Women's Hospital she had been kicked in the abdomen (whilst pregnant) this should have resulted in a referral to Children's Services. This was a missed opportunity for earlier enquiry into possible evidence of risk.
- There is a need for the Police and Children's Services to clarify professional terminology used to describe 'notifications' and 'referrals'.
- When Children's Services received information from the police following the second Police call out, there was a missed opportunity for the social worker to follow this with further enquiry with Emily.

Q8. Are there any examples of outstanding or innovative practice arising from this case?

No examples of outstanding or innovative practice have been identified.

Q9. 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 evidence suggests that there had been significant violence in Emily and Darren's relationship, since they were aged around sixteen years. Probably the best chances of preventing the eventual tragic outcome in this case would have been much earlier preventative work with them (as individuals or as a couple). However, as they did not ask for help, this was unlikely to happen. This highlights the need for local agencies in contact with young people (e.g. schools, colleges, youth and community organisations) to ensure that teenage partner violence is given a much higher profile (in Emily's words is *"out there"*) and that young people generally are encouraged and supported to talk about this issue. Those directly affected should have access to specialist support, geared specifically to the needs of adolescents and teenagers.[11]

Both the perpetrator and victim were of mixed race (Black British) and the DHR has considered carefully whether or not this was a factor in agency responses. No evidence has been presented which would suggest racial or cultural identity as a primary issue in this case. The DHR has not seen evidence of any individual or institutional discrimination by services based on race, culture or ethnicity.

However, the couple were from a community where mistrust of the police and other statutory services is a common issue, especially within the younger population. This is likely to have been a significant additional barrier to this couple actively seeking help and support to address issues of violence in the relationship.

[11] The NSPCC research mentioned above (reference 9) found that the majority of young people either told a friend about the violence or told no one. Only a minority informed an adult

3.2 Key Learning Points

Key Learning Point 1

There is a need for Merseyside Police and Children's Services to review processes and professional terminology, to ensure the two organisations have a mutual understanding of the terms *'referral'* and *'notification'* and the expected actions which should follow on from these processes.

Key Learning Point 2

Statistically, it is much more common for domestic abuse to be perpetrated by men, against women. This is an important factor in assessing future domestic violence risks in any male / female relationship. However, domestic violence risk assessments should not start from an assumption that the male partner will always be the potential perpetrator. Where the presenting evidence suggests violence or aggression has been mutual, risk assessments should consider potential risks to both parties.

Key Learning Point 3

When Children's Services received the second notification from the Police (July 2013) there was current social work involvement, but a decision was taken that this information did not warrant any further social work action. Given that a social worker was already involved, this would have been an opportunity to talk to Emily about the incident and further explore any possible concerns about violence in this relationship. That this did not occur was a **missed opportunity**.

Key learning point 4

In 2011 a YOS worker recorded that there were 'violent outbursts' in Emily's relationship with Darren. However, they did not record any supporting information (e.g., the source of the reference to violent outbursts; the seriousness or frequency of incidents; whether the violence was instigated by Emily, Darren or both). There was also no record of this being followed by a risk assessment or any risk management strategies having been considered. These have been recognised as examples of poor quality practice and an absence of effective management oversight.

Key Learning Point 5

When Emily was 22 weeks pregnant she attended LWH and stated she had been accidentally kicked in the abdomen, whilst trying to split up a fight at a party. There was no evidence that she or the baby had come to harm. However, considered in the wider context of concerns about Emily's lifestyle and home environment, this incident should have resulted in a referral to Children's Services. That this did not happen was a missed opportunity for closer review of the incident.

Key Learning Point 6

This case has highlighted a need for:

- An increase in publicity, awareness raising and preventative work to be developed (by and for) young people at risk from violent or otherwise abusive relationships. This should include s*pecific and age appropriate* educational and preventative work with adolescents and younger teenagers, aimed at promoting healthy relationships and preventing abusive behaviour from becoming normalised and ingrained.
- Specialist services (or specialist workers within existing domestic violence services) for young people already in abusive relationships.

3.3 Recommendations:

Recommendation 1

Merseyside Police and Children's Services should review processes and professional terminology, to ensure the two organisations have a mutual understanding of the terms *'referral'* and *'notification'* and the expected actions which should follow on from these processes.

Recommendation 2

There should be a review of multi-agency policy and procedure for carrying out risk assessments where the presenting evidence indicates mutual aggression or violence, with no clear perpetrator / victim relationship. In such

cases, potential risks to each of the parties should be assessed, avoiding assumptions based on gender.

Recommendation 3

There should be a local review of strategies and resource allocation addressing issues of young people and domestic abuse (including physical violence and all other types of abuse). High priority should be given to ensuring:

- **An increase in publicity, awareness raising and preventative work to be developed (by and for) young people at risk from violent or otherwise abusive relationships. This should include s*pecific and age appropriate* educational and preventative work with adolescents and younger teenagers, aimed at promoting healthy relationships and preventing abusive behaviour from becoming normalised and ingrained.**
- **Development of specialist services (or specialist workers within existing domestic violence services) for young people already in abusive relationships.**

Recommendation 4

All of the Key Learning Points from this DHR should be disseminated to staff working in Liverpool agencies working with young people who may be affected by abusive teenage relationships. This should particularly include schools, colleges, youth and community organisations, Children's Services and others with responsibility for working with adolescents and other young people.