DOMESTIC HOMICIDE REVIEW:

INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF

"JANET"

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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 *'Janet'*[1], a resident of Liverpool prior to her death in March 2014. At the time of her death, Janet was 44 years old. She had been in a relationship and living with the perpetrator *'Ian'* for around 15 months. Ian was 52 years old. Following the homicide, Ian was charged with murder and remanded into custody. He committed suicide in prison in April 2014, whilst awaiting trial.

Janet was the youngest of 5 children, with two brothers and two sisters. One of her sisters has described them as having had a happy and secure childhood, with loving parents. Both parents passed way over a short period of time, in 2010 and 2011.

Her sister recalls that Janet was an attractive woman, who took great pride in her appearance. She describes her as having had a friendly and outgoing personality which "*could light up any room*". Janet had worked in the catering industry and had operated her own mobile catering business.

At the time of her death, Janet had three sons, aged 21, 17 and 15. The youngest 2 boys were resident with their father. Her oldest son still visited Janet and stayed with her, on occasions.

[1] The pseudonyms of Janet and Ian are used to help protect the confidentiality of the victim, perpetrator and surviving family members.

Janet married in 1991 but this marriage broke down, following the birth of her eldest son in 1992. From the age of around 4, Janet's oldest son was cared for by her parents, and then by her sister. Janet formed a new relationship, resulting in the birth of her 2 younger sons. Janet's sister describes this as a good relationship, but unfortunately it broke down. She married again in 1999 and this relationship lasted around 4 years. Following a number of other relationships, she met Ian (perpetrator), about 15 months prior to the homicide incident. Within a few weeks of meeting Ian, she had moved into his accommodation in Liverpool, where he was a tenant of the social housing provider, South Liverpool Homes.

Janet was a heavy drinker from her early 20's. The onset of excessive alcohol consumption appears to have coincided with the breakdown of her first marriage. Although Janet's parents and other family members tried to persuade and support Janet to bring her drinking under more control, she continued to be a very heavy drinker. It appears that this gradually reached a stage where Janet was alcohol dependent. Excessive use of alcohol and reports of alcohol related incidents increased significantly after she met Ian, who was also alcohol dependent.

1.3 Perpetrator's background:

Ian was born in Liverpool in 1961 and raised by his parents, along with his two sisters and a brother. His father is deceased whilst his mother still lives locally. He had two children from previous relationships. His eldest child, a daughter with whom he had little contact, committed suicide aged 25, some months prior to the homicide incident.

Ian had separated from his first wife some years ago and she left the marital home taking their son with her. Following this he had a breakdown during which he received psychiatric help. His family have stated that he was an alcoholic, took medication for depression and had attempted suicide in the past.

1.4 The homicide incident

In March 2014 (time of day: 11.35 am) Merseyside Police were called by the Ambulance Service to an address in Liverpool, where Janet had been living with Ian, for the past 15 months. Janet was collapsed behind the front door and the

ambulance service had been unable to gain entry. Paramedics on the scene reported that they had heard her crying for help, but she had gone quiet. Police attended and forced entry and Janet was found collapsed behind the door, with stab wounds to her chest. She was taken to Royal Liverpool University Hospital, where it was confirmed that she was deceased. A subsequent post-mortem confirmed the cause of death was shock and haemorrhaging, resulting from multiple stab wounds.

On the day following the homicide, Ian was located and arrested by Merseyside Police. In a prepared statement, he admitted having been with Janet at the relevant time and having argued over money. He also acknowledged that blood on his clothing was Janet's. He stated he had had a blackout and could not remember anything else, until after he had left his address the previous day. Ian was charged with murder and a Magistrates Court remanded him into custody, pending trial at Crown Court. Two weeks later, he was found dead in his prison cell. Police and prison service investigations concluded that he had committed suicide.

1.5 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 16 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.

1.6 Involvement of family members

The DHR Chair wrote to Janet's eldest son and her sister, inviting them to contribute to the DHR process. Her eldest son was the family member with who had had most contact with Janet and the perpetrator, during the period covered by the terms of reference. However, he chose not to be actively involved in the DHR process.

The DHR Chair and the Merseyside Police representative from the Panel had a meeting with Janet's sister. Although she had had limited contact with Janet during the period of the relationship with the perpetrator, she provided very valuable insight into Janet's family background and past relationships. This highlighted the many positive aspects of Janet's personality, as well as some of difficulties and challenges she faced. Janet's sister was invited to meet again to go through a final draft of this report in advance of final approval and publication. For personal reasons, she declined this invitation.

1.7 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
Sandra Dean Detective Chief Inspector	Merseyside Police
Caroline Grant Head of Domestic Abuse Services	Local Solutions
Sharon Marsh Community Safety Manager	South Liverpool Homes
Helen Smith Head of Safeguarding Adults	Liverpool Clinical Commissioning Group
Liz Mekki Service Manager QA and Safeguarding	Childrens Services, Liverpool City Council
Jan Summerville Partnerships Coordinator Safeguarding Adults Board	Adults Services, Liverpool City Council

1.8 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. There were some delays caused by agencies not being able to complete Individual Management Reviews (IMRs) within specified time frames, due to capacity issues within those organisations.

1.9 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.

1.10 Terms of reference

Each of the agencies which had been identified as having significant and relevant involvement with the deceased and her husband 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 Janet 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 offered to the victim 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 Ian 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?

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 of two years, up to and including the date of the homicide in March 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 the two year period.

1.11 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)
- South Liverpool Homes

Adult Social Care (Liverpool City Council) were asked to provide a chronology of contacts. As this chronology clarified that that they had in fact had no direct involvement with the victim or perpetrator, they were not asked for an IMR.

PART 2: ANALAYSES OF AGENCIES' INVOLVEMENT

2.1 Introduction

This section describes significant contacts / communications which services had involvement with Janet and Ian, over the 2 year period leading up to the homicide. 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 and 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

Merseyside Police had significant involvement with Janet and Ian, from March 2013, through to the homicide incident itself, some 12 months later.

15/3/13 Police incident 1

Ian contacted the police by telephone in the early hours of the morning, requesting police assistance to remove Janet from his home. Officers visited him and found that he was alone at his address. He said he had taken 30 tablets, and an ambulance was called as a precaution. This was not recorded by the police as a domestic incident, on the basis that there was no evidence to show that the couple were in a relationship, or that they were living together. Officers informed the police operator *"this is not a domestic, it is drunken friends"*

Commentary / analysis

The police view (as reflected in their IMR) is that the decision not to record this as a domestic incident was correct, on the basis that there was no evidence that the couple were in a relationship or were living together, but it is unclear to what extent (if any) officers on the scene actively enquired as to the nature of the relationship between Ian and Janet.

There was no specific allegation that any abuse had occurred, though the fact Ian had asked for assistance to remove Janet from his property and had then (reportedly) taken an overdose of tablets, could have been viewed as significant risk indicators. It was entirely appropriate that officers prioritised Ian's immediate safety, after he reported having taken a possible overdose

However, assumptions about gender roles in this incident may have been a factor in the decision not to record this as a domestic incident and then carry out a risk assessment. Had a female requested police assistance to remove a male friend from her home, then told officers that she had taken an overdose, this may have resulted in closer enquiry into the nature of the relationship between the two parties, followed by closer consideration of risk factors for domestic abuse.

Key Learning Point 1:

When responding to incidents of this nature, police officers should not make assumptions based the genders of the *'complainant'* and *'victim'*.

25/04/13 Police incident 2

Ian telephoned the police to report that his ex-partner Janet had stolen some items from his house, whilst he was out. The items were a mobile phone, TV remote control, house and car keys. Police arranged to meet him the following day. However, on the following morning Ian advised that all items had been returned by Janet and that he no longer wanted police involvement. The matter was recorded as requiring no further police action. It was not recorded as a domestic incident.

Commentary analysis

As all of the missing items were returned the following day and the complainant no longer wanted police involvement, the police response to the alleged theft was proportionate. However, the police IMR notes that this should (under Merseyside Police procedures) have been recorded as a domestic incident, as the initial referral specified that Janet was Ian's ex-partner. This would have resulted in completion of a Vulnerable Person Referral Form (VPRF 1)

Key learning point 2

This was a very minor domestic incident, which would have been unlikely to highlight any significant risks of domestic abuse or violence. As the alleged victim was Ian, it is even less likely that risks to Janet would have been identified. However, it is important that even such minor incidents are appropriately logged, so that any future incidents can be risk assessed in the light of a full knowledge of all previous incidents. As has been repeatedly highlighted in previous DHRs in Merseyside [2] and elsewhere, whilst an individual incident may seem insignificant, patterns of repeated incidents – *provided they are properly recorded and logged* - can build a cumulative picture of significant risk. But if they are *not* properly recorded in line with local procedure, future risk assessments will be based on incomplete information and therefore be less likely to accurately identify the true level of risk.

20/08/13 Police incident 3

This incident was an allegation made against both Janet and Ian. The alleged victim was Janet's ex-partner, who at this point in time was in hospital, but subsequently died of natural causes.

The allegation was that Janet and Ian had ordered goods (including alcohol), using Janet's ex-partner's bank account. They were eventually jointly charged with this offence. However, as the criminal case was still ongoing at the time of Janet and

[2] See, for example, Liverpool DHR into the death of Mr. A. liverpool.gov.uk/council/strategies-plans-and-policies/crime-and-community-safety/citysafe-community-safety/domestic-violence-homicide-reviews

Ian's deaths (March 2013 and April 2013 respectively) this allegation did not reach a conclusion in the criminal court process.

Commentary / analysis

This allegation against Janet and Ian had no direct relevance to domestic abuse, but was further evidence to indicate that the couple had alcohol dependency problems, contributing to a chaotic life-style.

13/09/13 Police incident 4
(See also follow up to police incident 4 on 12/10/13)

Janet contacted the police at 19.25, alleging that she had been assaulted by Ian earlier that evening and that he had subsequently smashed her mobile phone and locked her out of the house. Police attended the scene immediately and Ian was arrested under suspicion of assault and criminal damage. Police records show that, as Ian was being escorted from the house, he was heard shouting: *"(Janet) this is fucking serious now, you'd better fucking retract"*

The main points from Janet's statement were:

- They had gone to a local pub at around 17.00 and had had a few drinks. Ian took exception to her talking to other men and punched her to the side of the face, before leaving her in the pub.
- Janet stayed for around another hour, before returning to their home address, where Ian continued to argue with her, before breaking her mobile phone.

Ian denied the allegation, stating that she had attacked him in the pub and she had been accidentally struck in the face as he tried to defend himself.

The interviewing police officer recognised potential ongoing risks of domestic violence and contacted Janet by telephone, to enquire if she could arrange to stay at another address, but this was apparently not possible. He advised Janet that Ian would be bailed with a condition to reside at his brother's house, pending ongoing police investigations.

Janet was subsequently advised that Ian was being released on bail, pending further investigations. However, Ian was then released without any conditions, meaning that he was free to return to his home address, where Janet was also resident. This was contrary to the original advice that Janet had been given, that Ian's release would be with a bail condition of residence at his brother's address.

A VPRF1 was completed and recorded that alcohol was an issue with both parties. Janet was risk assessed as "bronze", which is the lowest level of risk. No referrals were made to other agencies.

Commentary / analysis

This was the first occasion on which there had been a direct allegation of domestic violence by Ian, against Janet. The Police IMR has highlighted some significant shortfalls in the police response to this incident, especially in relation to the absence of bail conditions. Matters of particular concern are:

1) Janet was wrongly advised that Ian would be subject to bail conditions, including residence at his brother's address. It would have been usual practice for such conditions to include a requirement not to approach, or make any kind of contact with, the alleged victim.

2) Given the implied threat in Ian's comment that Janet *"better fucking retract",* bail conditions could have played a significant part in reducing the risks of coercion to make Janet retract.

3) The police IMR has established that the primary reason for no bail conditions being imposed was that the custody sergeant was (wrongly) of the belief that he could not impose conditions, because he thought this could only be done where the police are already in a position to charge the detained person. The police IMR clarifies that this would have been the case had Ian been detained under section 37(2) of the Police and Criminal Justice Act (PACE) but it did not apply in this case as the detention was under section 34(5). The conclusion is that the custody sergeant had either failed to check the legal basis of the detention, or had

insufficient knowledge of PACE.

Key learning point 3

The DHR Panel concur with the conclusion of the Merseyside Police IMR author that the absence of bail conditions following the first reported incident of an assault by Ian on Janet was a missed opportunity, as bail conditions could have provided a period of physical separation between the perpetrator and Janet. This was further compounded by Janet being wrongly advised that bail conditions *were* to be imposed. This may well have reduced Janet's confidence in the ability of the police to take effective action in the event of any future incidents, making it less likely she would seek assistance.

It is unknown whether bail conditions at that stage would have changed the eventual tragic outcome some six months later, as it is entirely possible that the relationship would have continued on the same trajectory as before, even with bail conditions. On the other hand, it is possible that imposition of bail conditions could have presented a window of opportunity for Janet to consider other choices, such as seeking outside assistance, finding alternative accommodation and ending the relationship.

Where an adult is assessed at a "bronze" risk level, Merseyside Police procedures require that following actions are considered:

1. Officers at scene spoken to parties (At scene intervention)
2. Provide with contact details on VPRF 1 (At scene intervention)
3. Arrest (At scene intervention)
4. QA of action at scene (Immediate intervention)
5. Letters to victims offering help from FCIU (Immediate intervention)

It appears actions 1 to 4 were carried out, but action 5 was not, though there were several unsuccessful attempts by the police to make contact with Janet in the weeks following the incident. It is recognised that sending a letter to a victim who is

still resident with the alleged perpetrator may have been seen as potentially increasing risk, should the perpetrator open the letter. **This further highlights the benefits of imposing bail conditions to protect the alleged victim from further abuse and coercion.**

Had police incident 1 on 15/3/13 (see above) been recorded as a domestic incident, then this would have been the third recorded domestic incident involving the couple, within a period of 6 months. In a number of other force areas, a third reported incident (even if each individual incident had been assessed as low risk) within a 6 month period would have resulted in automatic escalation and referral into MARAC, but Merseyside Police do not operate such a policy. It is understood that such a policy would potentially result in an unmanageable increase in the volume of MARAC referrals.

Key learning point 4
A recommendation could be made for a change of policy so that three incidents within 6 months would lead automatically to a MARAC referral. But if this resulted in MARAC becoming an unmanageable and 'paper led' process, the overall outcomes for people at high risk from domestic abuse would be negative. An implication from this is that MARAC may be insufficiently resourced.

Notwithstanding the above point, the conclusion of the DHR is that, even considered in isolation from the previous two incidents, police incident 4 was a serious incident in its own right. There were a number significant risk indicators, including not only the allegation of a violent assault, but also criminal damage to Janet's mobile telephone, which may have been an attempt at socially isolating her from family, friends and support networks. Another risk factor was the threat which was very directly implied by Ian's comment *"you better fucking retract".* Taking all of these factors into account, the DHR has concluded that the police assessment of risk at 'Bronze' (the lowest level of risk on the scale) was incorrect and should in fact have been recognised as Gold (the highest risk level) This would have automatically triggered a referral into the MARAC process, and a multi-agency risk

management plan. That this did not happen at this stage was a **missed opportunity.**

16/09/13 Police incident 5:

In the early hours of the morning, Janet phoned the police, reporting that she had been locked out of her house as Ian had changed the locks. She also reported (incorrectly) that he was on bail conditions and should not be in the house. Officers attended immediately and found Janet to be very intoxicated and causing a disturbance. Having ascertained that there were no bail conditions in respect of Ian, officers arrested Janet to prevent a breach of the peace, as her behaviour was continuing to cause a disturbance. She was placed before the next available court and bound over to keep the peace. This was identified as a domestic incident and a VPRF was completed. Ian was identified as the victim and assessed as being at a bronze level of risk, with warning signs recorded as alcohol and violence.

Commentary and analysis

This was a relatively minor incident which was correctly recorded by the police as a domestic incident. It is not clear why Ian was identified as the victim, when the allegation was that Ian had prevented Janet from entering her home address. This was possibly because it was Janet who was subsequently arrested, even though on this occasion it was Janet who had called the police. It is probable that Ian's actions in changing the locks was a primary factor (combined with Janet's excessive alcohol consumption) leading to her arrest to prevent a breach of the peace. This highlights the fact that recording perpetrator / victim roles can be down to individual judgement. There are likely to be considerable inconsistencies in how this judgement is applied, especially in relationships where both partners have combined substance misuse / mental health problems and chaotic behaviours.

The IMR author was unable to locate VPRF 1 document, so has been unable to clarify why Ian was seen as the victim on this occasion. The fact that the document appears to be missing is itself a matter of concern, as this means that contextual information about this incident would presumably not have been available to help inform any future risk assessments.

Key learning point 5

Where there is a blurring between "victim" and "perpetrator" roles, a decision about which individual to record as the victim may not be obvious or clear cut and there may be allegations and counter-allegations between couples. Evidence from previous DHRs[3] suggests that where there are mutual allegations of domestic violence (especially where the couple have alcohol problems and chaotic lifestyles) there is a significantly increased risk of extreme violence and potential homicide. This highlights a need to review local policy and procedure, to ensure that (regardless of which partner is defined as victim or perpetrator) repeated incidents involving the same couple are appropriately risk assessed and if necessary escalated into the MARAC process.

18/09/2013 Police incident 6:

Ian contacted the police (mid-afternoon) reporting that he was arguing with Janet and that she had a knife and was self-harming. The police operator recorded that arguing could be heard in the background. Officers attended within about 8 minutes of the call, by which time Janet was upstairs and Ian (now in possession of the knife) was downstairs. Both were intoxicated and neither could recall arguing. Janet was spoken to alone and told officers she suffered from depression. There were no signs of any fresh injuries, though Janet was recorded as having some scratches. Janet was asked if she wanted to speak with a member of the mental health Crisis Team or for paramedic attention, but she declined.

A VPRF 1 was completed, highlighting issues of violence and alcohol as risk factors. On this occasion, Janet was identified as the victim and was risk assessed as 'bronze' police records show that a referral was made to Adult Social Care (ASC)

[3]See, for example, Liverpool DHR into the death of Mr. A. liverpool.gov.uk/council/strategies-plans-and-policies/crime-and-community-safety/citysafe-community-safety/domestic-violence-homicide-reviews

relation to Janet's depression and possible self-harming behaviour. However ASC advise that they have no record of receiving such a referral.

Commentary / analysis

This was the first occasion when there was any reference to either party possessing a lethal weapon during a domestic incident. There was no evidence that the knife had been used by either party to attack or threaten the other.

There was clear evidence that each of them had possessed the knife, there had been verbal conflict and both parties had been under the influence of alcohol, but the assessed risk level stayed at the lowest level of bronze. There is a growing awareness from other DHRs[4] which shows that a history of combined alcohol and knife related incidents should be recognised as a very significant domestic violence risk factor. This observation may well be described as *"basic common sense"*, but unfortunately the evidence from this DHR and many others is that risk assessments frequently give insufficient weight to the highly dangerous combination of a lethal weapon and excessive alcohol consumption, particularly within a relationship where there is a known history violence.

Key learning point 6

Domestic incidents which involve excessive alcohol use, people with mental health problems and possession of a knife (or indeed any other lethal weapon) should be very carefully risk assessed, even if no injuries have occurred. The assessment should take account of the fact that, in any future domestic conflict, this combination of risk factors will significantly increase the possibility of serious injury or death.

Police records show a referral was made to ASC, for follow up with mental health problems and possible risk of self-harming behaviour, but ASC appear to have no record of receiving this referral. This is evidence of a communications systems failure, either within the police service, ASC, or both. Follow up enquiries with ASC suggest that in this instance, if a police a referral had been received, possible

[4] Liverpool DHR 3 (see previous reference) is one of many examples. In 8 out of the last 9 domestic homicides in Liverpool, the weapon used was a knife. A recent Femicide Census found that 42% of victims were killed with a knife. (Femicide Census conducted by Womens Aid and nia, launched Feb 2015)

outcomes would have included liaison with the GP, a welfare visit by a social worker, or a letter offering support in relation to the incident.

Key learning point 7
This systems failure resulted in a missed opportunity to assess Janet's needs as a person with alcohol dependency and mental health problems and possibly to offer interventions to address these areas of need.

12/10/13, Follow-up to Police incident 4:
On this date the police received a written note from Janet, stating that she wished to withdraw her allegation relating to the assault and criminal damage. An attempt was made by the officer who received the note to visit Janet, but she was not in when he called. He left her note requesting her to contact him. The next contact was on the afternoon of 18/10/13, when Ian phoned the police and told them he was bringing Janet to the police station to make a retraction statement. They arrived 15 minutes later and Janet was interviewed by an officer. Ian waited outside the police station.

This account of what followed is quoted directly from the police IMR:
"When interviewed (Janet) was described by the officer as being frightened, nervous and upset. She was insistent on withdrawing the allegation and stated that if she didn't then she was afraid that Ian would kill her. She then recounted how Ian had prevented her from getting in touch with the officer and how he controlled her life. Whilst making the retraction statement Janet left the station and went outside to speak with Ian. The officer followed and heard Ian say, "What are you telling them, the truth?" She told him that she was and he then said, "If you tell them the truth, don't bother coming home again." He then walked off and Janet came back into the police station and completed the retraction statement. She was adamant that she did not want him arresting again as it would make matters worse. The officers noted that both parties were under the influence of alcohol."

Later that day, Ian was arrested on suspicion of attempting to pervert the course of justice. At his arrest he asked the officer *"Has the assault job been dropped then, has she made a retraction?"*

A hostel placement was arranged for Janet over the weekend, but she refused to go to the hostel, insisting on staying at her home address. She was also given contact numbers for other local support services, but it is understood that she did not make contact with any of these services.

Ian denied the allegation of attempting to pervert the course of justice and was given police bail with a condition to reside at an address outside the area and to have no contact with Janet. The matter was investigated by the Family Crime Investigations Unit (FCIU) but as Janet would not provide evidence to support the allegations (of assault, criminal damage or of perverting the course of justice) it was subsequently decided by the Investigations Manager that Ian would not be charged with any offences.

On this occasion, no VPRF1 was completed and consequently no risk assessment was completed by the police.

Commentary and analysis

Janet's retraction statement and the events surrounding it did not result in completion of a VPRF 1 or a risk assessment. The police IMR describes this as minor procedural error, stating that a risk assessment based on these facts would probably have resulted in Janet still being assessed at low level of "bronze". However, the DHR has reached a conclusion that the absence of any further risk assessment at this stage was in fact a serious error, because there was clear evidence of very significantly increased risk compared to the point at which the previous risk assessment had been completed, immediately following the alleged assault one month earlier. This evidence included:

- Janet's statement to the police that she feared Ian would kill her, if she refused to retract her allegations.
- Janet's presentation of being frightened and nervous at the interview was an indication that her comment that 'he would kill her' could have been a genuine expression of fear for her life.
- The disclosure that Ian had prevented her from getting in touch with the

police and that he was 'controlling her life' was evidence of controlling and coercive behaviour by Ian. This should also have been considered in the context of the allegations that he had assaulted her when she spoke to other men and had then smashed her mobile phone. Both of these incidents could signify attempts by him to impose coercive control and to isolate her from outside contacts and support.

- The incident outside the police station when Ian told her not to bother coming home again '*if you tell them the truth'* was further evidence of coercive behaviour. It also strongly implied that the *'truth'* was that Janet's original allegations of assault and criminal damage had been based on fact.

Taking the above factors into account, the conclusion of the DHR is that the failure to carry out new risk assessment at this stage was a serious error of judgment and a **missed opportunity**. Had a risk assessment properly considered all of these factors the DHR has concluded that this should have found Janet to be within the highest risk banding of Gold. This would have resulted in referral for Independent Domestic Violence Advocacy (IDVA) services and in referral into the Multi Agency Risk Assessment Conference (MARAC) process.

Key learning point 8

When an alleged domestic violence victim makes a withdrawal statement and there is clear evidence that the retraction has been made under coercion by the alleged perpetrator, this should always result in a re-assessment of risk, with serious consideration given to the need for referral into the Multi Agency Risk Assessment Conference process. That this did not happen in this case was a serious missed opportunity.

The DHR has considered the police Investigation Manager's decision not to charge Ian with any offences in connection with the allegations of assault, criminal damage and perverting the course of justice. It has to be recognised that Janet's retraction of the original allegations and refusal to support a charge of perverting the course of justice would have created significant challenges for the prosecution, in any subsequent criminal trial. However there was evidence which could have

supported a prosecution, even without Janet's ongoing support. In this case the decision not to charge Ian with any offences was made by the police, without consulting the Crown Prosecution Service. The IMR has established that a file requesting CPS advice had in fact been prepared, but was never forwarded on to the CPS. In seems that the Investigating Manager had based his decision on discussions with the investigating officers, but had not seen the file which had been prepared for the CPS until after the decision not to charge had been made.

In summary, the conclusion reached by the DHR is that the decision on whether or not to charge Ian with any offences should not have been a unilateral police decision, but should have followed CPS advice. The CPS could have evaluated the prospects of securing a conviction, supported by evidence (including police witnesses) of coercive pressure placed on the victim to withdraw her complaint.

It is unknown whether or not the CPS would have advised that Ian should be face criminal charges, as they never had the opportunity to evaluate the evidence. But at the very least their involvement would have provided independent legal scrutiny as to the appropriateness (or otherwise) of the decision not to charge Ian with any offences.

Key learning point 9

Where an alleged victim of domestic abuse withdraws support for a prosecution and there is evidence that they have been subjected to coercion by the alleged offender, the police (where appropriate in consultation with CPS) should seriously consider the option of continuing the criminal prosecution, if there appears to be a realistic chance of securing a conviction. If there is a decision (by the police or the CPS) not to prosecute, the rationale for the decision should be clearly set out in police records.

9/11/13 Police incident 7:

Ian's sister made an allegation that he assaulted her, while they were at their mother's house. Their mother had dementia and Ian and his brother were carers. The context was that Ian understood his sister wanted their mother to enter

residential care. His sister advised that Ian was in receipt of Carer's Allowance[5] and did not want to lose this source of income, which would happen if she went into care. She stated that Ian and his brother spent all of the carer's allowance on alcohol. Ian was alleged to have become very aggressive and to have forcibly dragged his sister from the house. She said this had made her very frightened and she believed he would have seriously injured her, but for the fact that there were care workers in the house at the time.

When Ian was interviewed by police he denied the allegation. He was not charged with any offence, on the basis that there was insufficient evidence to support the allegation. The care workers did not provide statements.

Commentary and analysis

This incident did not involve Janet, but was further indication of a pattern of domestic violence, by Ian. The police decision to take no further action was based on there being insufficient evidence, but it is unclear from the police IMR what attempts (if any) were made locate and interview the care workers who may have been independent witnesses[6].

Although any successful prosecution for what appears to have been a common assault allegation would probably have resulted in a non-custodial outcome, this would have at least sent a clear message to Ian that further domestic violence incidents could have serious consequences. That the independent witnesses were not interviewed possibly resulted in **a missed opportunity** to send this message**.** Unfortunately, that he allegedly behaved in this way and did not face criminal charges, could have reinforced the opposite message: He could behave in this way, without facing legal consequences.

The fact that Ian was spending his Carer's allowance on alcohol could have been reported to DWP, who may then have been in a position to review his entitlement

[5] Under current regulations, Carers Allowance may be payable, if the claimant spends at least 35 hours per week caring for a relative who themselves are in receipt of specified disability allowances, such as Attendance Allowance or Disability Living Allowance. The current standard rate is £62.10 per week.

[6] It may be that the care workers were present in the house, but did not witness the incident. This is not specified in police records.

to this benefit. Although it is understood that DWP do not have powers to dictate how recipients spend benefits, they may have been able to review whether or not he was genuinely his mother's primary carer and entitled to receive this benefit. From what is known about his own health, lifestyle and excessive alcohol use, it seems highly doubtful whether he was genuinely acting in this role. Reducing his disposable income may have helped to curb his alcohol use, which in turn could have reduced the risks of violent behaviour. However, it is acknowledged that alcohol dependent people often go to extreme lengths to satisfy their addiction, so it should not be assumed that curbing his income in this way would necessarily have had the desired effect on his alcohol use, or on risks of violent behaviour.

20/01/14 Police incident 8

The police received a phone call from Ian, stating that he wanted Janet to be removed from the house, following an argument. He later said she had cut his hand with a brush, but not seriously. When police attended, they found Janet outside the house. Both she and Ian were intoxicated. No offences were recorded and Janet was taken to a bus stop where she could catch a bus to stay with her son. A VRPF 1 was completed, Ian was recorded as the victim, with an assessed risk level of bronze. A referral was made to ASC, but this was logged on their system as 'for information only' and there was no further action from ASC.

Commentary / analysis

This was a minor 'domestic incident' and considered in isolation from the previous incidents could not have been seen to suggest high levels of risk of domestic violence. However, if considered in the context of all of the previous incidents over the preceding nine month period, there was cumulative evidence of risk.

The referral to ASC was an example of the police attempting to encourage some wider agency involvement, but this resulted in no further action. If ASC were considering this as an isolated incident, it is perhaps understandable that they would not make any pro-active response. However, the reality was that this was

very far from being an isolated incident. This highlights the importance of all agencies having access to historical information about patterns of events, when considering risk and planning an appropriate level of response.

20/02/14 Police incident 9

Merseyside police were contacted by Cheshire police, who had Janet's eldest son in custody. Her son, who at the time was under the influence of alcohol, had informed Cheshire police officers that Ian had been attacking Janet. A patrol was dispatched to the address in Liverpool, but there was no reply. Later that day Janet was seen by a police patrol. She said there had been an argument involving her son, but no assault had taken place. Ian was present when this conversation with the police officer took place. It was recorded by the police that there was no evidence that a crime had taken place.

A VPRF 1 was completed and records that there was no evidence that either party had been drinking when they were spoken to by the police.

Commentary / analysis

This was a further example of a cause for concern, with no direct evidence that an assault had occurred.

For the police to interview the alleged in victim of domestic violence in the presence of the alleged perpetrator was inappropriate and could potentially have placed her at increased risk. This would apply to any investigation into domestic abuse, but was even more of an issue in this instance, because of the recent evidence (from police incident 4 and Janet's subsequent withdrawal of this complaint) that Ian had subjected Janet to coercive pressure to withdraw an allegation of abuse. Given this recent history, it should have been very clear to the officers involved that Janet would be highly unlikely to disclose any domestic abuse, whilst Ian was present.

Key learning point 10:

Reasonable attempts should have been made to interview Janet on her own, without a need for Ian to even be aware that the interview was taking place. That this did not happen was very poor practice on the part of the police and a missed opportunity to review risks and then consider the need for police intervention with the alleged perpetrator and/or strategies to reduce ongoing risks of violence. This indicates an urgent need for Merseyside Police to evaluate the effectiveness of domestic abuse training and awareness raising for front line officers.

26/02/14 Police incident 10

Between around 3pm and 6.30pm, the police received 3 separate reports from Ian, of Janet being outside his property or his mother's address, causing a disturbance:

- 15.02: Ian phoned police stating they had had an argument and Janet was outside his house, banging on the doors and windows. When the police attended they found Janet nearby, hiding in an alleyway. She was advised to leave the area. Both Ian and Janet were under the influence of alcohol.
- 17.57: Ian phoned the police again. Janet was reported to be outside his mother's address and causing a disturbance by banging on the doors and windows of a neighbour's property. However she left the scene before the police patrol arrived.
- 18.29 Ian phoned the police and advised Janet was now back at his house, again causing a disturbance. She was arrested at the scene, to prevent a breach of the peace.

On each occasion, officers were dispatched. On the last occasion she was arrested, to prevent a breach of the peace. (She was later bound over by the Court)

During these incidents, both Ian and Janet were recorded as having been under the influence of alcohol. VPRF forms were completed for each of the 3 reports, with Ian being recorded as the victim and risk assessed at the bronze level.

Commentary / analysis

Looked at in isolation, this may have been viewed as relatively minor sequence of disturbances, but the fact of three police call outs within the space of three and a half hours represented a significant escalation. This should have been viewed in the context of the nine previous police incidents in the preceding period of less than one year. Eight of these incidents involved reported violence or verbal conflicts between Ian and Janet. Alcohol misuse was clearly a major factor and the presence of a lethal weapon (even though it was not used) at one previous incident, should also have been taken into account in assessing current risk levels.

That risk was again as assessed as being at Bronze level, and the consequent failure to refer into the MARAC process was a **missed opportunity** to formulate a multi-agency strategy, including referral to an IDVA and other relevant support services for both Ian and Janet. In this instance, Ian would have been formally identified as the potential victim, but any meaningful analysis of the history of events by MARAC partners would have confirmed that Janet was at significant risk.

9/03/14 Police incident 11

Ian contacted the police, stating he wanted Janet to be removed from his address. Police records show that he was acutely aware of the risk if he tried to forcibly remove her, there would be allegations of assault against him. Following the advice of the call handler, he removed himself to the rear garden, until officers arrived. When officers arrived, they found both Ian and Janet were drunk. Janet was moved to a friend's address. A VPRF was completed. Janet was risk assessed at the bronze level.

Commentary and analysis

The police IMR has noted that on this occasion the VPRF 1 identified Janet as the victim, even though the details of the incident suggested Ian was the aggrieved party. The officer who completed the VPRF1 has explained that, on the basis of her observations when she dealt with the incident, she believed that Janet was

more at risk from Ian, which is why she was recorded as the victim.

A feature of this case is that it was Ian who most frequently instigated police involvement in domestic arguments. Partly for this reason, assessments of risk often focussed on him as the potential victim and Janet as potential perpetrator.

On this occasion, the officer on the scene did not assume that the party requesting police assistance was necessarily the party at most risk. This was an **example of good practice as the officer applied professional judgement, based on direct observations of the couple and their interactions.**

The call handler's advice to Ian to physically remove himself from the conflict situation was **another example of good practice**, as it significantly reduced the risk of a violent incident occurring, before officers arrived on the scene.

10/03/14 Police incident 12

This incident was a phone call from Ian, initially stating that he was receiving threatening phone calls from Janet, then saying she wanted to come and collect her property. He later said he feared his windows would be put in. He was advised to call 999 in the event of any such incident. There was no further police action.

Commentary / analysis

As there was a reported threat from Janet towards Ian, this should have been recorded as a domestic incident. Merseyside police have since identified this as a training issue for call handlers and has implemented training packages for control staff.

19/03/14 Police incident 13

Ian contacted the police and reported that Janet had stolen £30 and some car keys, whilst visiting him. At this stage Janet had moved out of the property and was staying with a male friend, nearby. When the police attended, both Ian and Janet were drunk. Ian withdrew his allegations of theft. A VPRF 1 was completed and recorded

that Janet had gone to Ian's to collect her property, but he had then tried to persuade her to return. He had been jealous of the fact that she was living with another man, though Janet had been clear that this was just a lodging arrangement and she was not in a new relationship. On this occasion, the VPRF identified Ian as the victim the risk level was assessed as bronze.

28/0314 Police incident 14: The domestic homicide

The circumstances of the homicide incident have already been described at 1.4 above.

Commentary and analysis on police incidents 8-13

It is notable that there was a significant increase in the frequency of police contacts, during the period from 20/01/14, leading up to the homicide on 28 March 2014. It is also of note that 5 out of the 6 police contacts during this period were instigated by the eventual homicide perpetrator, not by the victim.

Key learning point 11

When police are repeatedly asked to intervene by parties to apparently minor domestic disputes, the risk assessment which follows should carefully consider not only the content and outcome of the dispute, but should also seek to understand *why* the parties involved felt that a police response was necessary. **However, the police themselves may not be the most appropriate agency to ask this question, so consideration should be given to referring to an IDVA or another agency with the relevant skills and knowledge base. The last incident, nine days prior to the homicide, was risk assessed as a minor property dispute. However the fact that the couple were at the point of separation could have been identified as an additional risk factor.**

2.3 South Liverpool Homes

Introduction

South Liverpool Homes (SLH) are a registered Social Landlord, of the property where the homicide took place. There had been a previous history of Anti-Social Behaviour (ASB) complaints from neighbours, going back as far as 2008.

Ian held the sole tenancy for the property and was already resident there when he met Janet, around 15 months before the homicide incident. Although Janet was resident at the property for most of this 15 month period, there was never any joint tenancy arrangement in place. Consequently, there was never any direct contact between SLH staff and Janet. Following the start of his relationship with Janet, there were further incidents and complaints:

January / February 2013

SLH received a number of complaints from a neighbour, reporting loud music playing late into the night and frequent incidents when there had been shouting arguing and use of foul language, going on until the early hours of the morning. The neighbour was of the view excessive alcohol use was a significant factor. SLH wrote warning letters to Ian, asked him to meetings at their office and visited him at home. He confirmed he was in a new relationship and that drinking with Janet had resulted in some late nights, with music and drinking. SLH pointed out that alcohol seemed to be a root cause of the disturbances and offered to refer him to specialist services. He acknowledged that he liked a drink, but denied that he had a drink problem.

March 2013

Problems of anti-social behaviour and neighbour complaints continued. On 26/3/13 an SLH officer made a home visit and reminded Ian that a final written tenancy warning had been issued.

May 2013

Ian applied for Discretionary Housing Benefit. The basis of the claim was that he needed an overnight carer, as result of mental health problems and a self-reported brain injury which he stated had been caused by a violent attack, in 2008. This claim

was subsequently approved. From the evidence seen by the DHR, the legitimacy of this claim was questionable.

2/12/2013

Ian phoned SLH and reported that Janet was refusing to leave his home and that he had been advised by the police to contact SLH for advice. He stated that Janet had attacked him the previous night and when he tried to eject her, she threatened to tell the police he had hit her. The SLH officer offered a referral to a domestic abuse support service, but Ian refused this, stating he was not suffering from domestic abuse, but wanted Janet out of his house. Ian was advised to seek advice from Citizens Advice Bureaux. Following this call the SLH officer discussed the circumstances with the Community Safety Team and was assured that the correct advice had been given to Ian.

Commentary and analysis

SLH staff had no contacts with Janet, primarily because she was not a tenant of the property, or even registered as being resident there. Consequently there were no opportunities for them to identify her as being at significant risk from domestic abuse.

The complaints from a neighbour in early 2013 included several incidents where shouting and foul language was used, but the accounts suggested that these were mutual arguments, rather than one party subjecting the other to prolonged verbal abuse.

The only specific reference to physical violence was when Ian alleged that Janet had attacked him, in December 2013. That he was offered the option of referral to a domestic abuse services was an example of good practice. It was also good practice that he was offered referral for support with alcohol problems, as it was clear that alcohol was a major contributory factor to the problems with his tenancy.

The SLH IMR reaches the conclusion that staff correctly followed policies and procedures in place at the time. The DHR would agree with this conclusion, on the

basis that there was no direct evidence or allegations of domestic abuse.

However, SLH have noted that there had been a previous history of incidents at Ian's property, in 2009 and 2010, when he was with a previous partner. These incidents included damage to windows and a broken door, which could have been indications of violent incidents. This leads to an important learning point, which is acknowledged in SLH's IMR:

Key Learning Point 12
When neighbours complain to landlords of anti-social behaviour which indicates a domestic conflict has occurred (e.g. shouting and foul language between household members) past records should be checked for any evidence of a history of violent behaviour at the property. If such a history is evident, the landlord response should include consideration of potential domestic violence issues.

2.4 GP Practice

GP involvement with Janet

Janet had been registered with a GP practice in Runcorn, until July 2012. She registered with a practice in Liverpool in November 2012. In June 2013, she transferred her registration to the same GP practice at which Ian was registered.

Although Janet and Ian were registered with the same GP and at the same home address from June 2013, they were treated very much as two individual patients, with no cross-referencing of information.

During the period of this review Janet was seen at her GP practice on fourteen occasions. The attendances were for mental health issues relating to low mood, previous and current alcohol use. Janet was offered treatment for depression (antidepressants / sleeping tablets) and crisis intervention. She was questioned about alcohol consumption at registration and opportunistically when she attended to see the GP. Alcohol consumption was recorded in the GP records as within acceptable limits, throughout the review period.

The IMR for GP services notes that there is no record of Janet having disclosed domestic violence as an issue, during any of her GP consultations and no evidence to show that GPs had any concerns about risks of domestic abuse. However, the IMR also observes that there was little evidence of enquiry by GPs into why Janet was experiencing depression, sleeplessness or using alcohol inappropriately. Similarly, there was little evidence of enquiry into her living circumstances or relationship issues.

Commentary and analysis

There is no evidence which suggests that GPs missed specific opportunities to identify that Janet was at risk from domestic violence. However, the DHR has highlighted a number of issues arising from records of GP contacts:

- The Liverpool based GPs did not have full access to records from the Runcorn practice. These records would have highlighted significant risk factors, including past allegations of Janet suffering from domestic violence and sexual abuse, in a previous relationship, as well as a history of mental health problems and homelessness.
- GP records showed a lack of enquiry into underlying causes of Janet's symptoms of depression and sleeplessness. This could have included enquiry about her home circumstances and relationship.
- GPs were aware (from electronic records) of a history of alcohol dependency and did regularly ask her about her alcohol use. In December 2013 her alcohol use was recorded as being under control, though other evidence from the DHR (in particular the numbers of police incidents where alcohol, was a factor) would seem to contradict this.

In summary, the Liverpool based GP practices lacked knowledge of Janet's history and background, or of her current circumstances. The perception was that Janet was not drinking excessively and that her mental health problems were under control. There was no active enquiry into her home situation or her current relationship. Anti-depressant medication was prescribed, but there is no record of consideration of any other therapeutic approaches such as psychology or

counselling services.

Key learning point 13

When treating people mental health and alcohol problems, GPs should routinely ask patients about their home circumstances and any relationship issues, which may be underlying causes for these types of problems. This approach can at least provide an opportunity for patients to talk about domestic violence issues, in a safe and confidential setting.

GP involvement with Ian

Ian had been registered with the same GP practice since 2008 and this was the last GP practice at which Janet had registered, in June 2013. Ian's GP records showed a significant longer term history, which included:

- A prolonged history of alcohol dependency
- Mental health problems, including depression
- A documented record that he had physically assaulted his wife, whilst under the influence of alcohol.
- He had been the victim of several physical assaults, whilst under the influence of alcohol.
- It was also documented that he had served time in prison.
- There had been an escalation of mental health problems, after his previous marriage broke down.

Ian was recorded in GP records as living with Janet, from November 2013. GP records show no evidence of disharmony in this relationship. During the period under review Ian was reviewed on a regular (almost monthly) for alcohol misuse and depression. During this period his 25 year old daughter took her own life, resulting bereavement issues, which compounded his alcohol misuse and mental health problems.

It is notable that the monthly GP assessments showed an improvement in Ian's condition, after his relationship with Janet commenced, suggesting that she had been a stabilising factor in his life.

Commentary and analysis

As with GP involvement with Janet, there is no evidence which suggests that GPs missed specific opportunities to identify that domestic violence was an issue in his relationship with Janet.

However, his GP records did evidence of a history of domestic violence in a previous relationship, which may have indicated that his new partner (Janet) could potentially have been at risk, given that he continued to present with mental health and alcohol dependency problems. Significantly, the IMR author for the GP practice makes the following observation: *"never was an enquiry made as to how* (Ian's alcohol misuse and depression) *impacted on his relationships with others currently associated with him. The focus was on his individual needs and not on the wider aspects of safeguarding"*

Key Learning Point 14

GP records included evidence of alcohol related domestic violence perpetrated by Ian, in a previous relationship. It was also known that Ian continued to have co-exiting alcohol and mental health problems and that he was in a new relationship. Given these factors, it would have been good practice for the GP's monthly monitoring to include assessment of how Ian's alcohol and mental health problems may be impacting on his relationship. Whilst it is perhaps unlikely that Ian would have self-disclosed as a perpetrator of domestic violence, this could have provided an opportunity to explore relationship conflicts and offer possible interventions such as relationship counselling.

PART 3: SUMMARY OF KEY FINDINGS

Introduction

The following is a summary overview of key findings, structured around the Terms of Reference questions:

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

There were 11 occasions during the last 12 months of Janet's life when Merseyside police were called to incidents involving Janet and Ian. Common factors in most of these incidents were verbal aggression, actual or threatened violence and excessive alcohol consumption. In some cases Janet was recorded as the victim and in others Ian was recorded as victim. Some incidents were serious, whilst others could be described as minor disturbances.

In one case there was very strong evidence that Janet was coerced into withdrawing an allegation of assault, under threat of further violence from Ian. In a police interview she stated a belief that he would kill her, if she did not withdraw the allegation. Despite mounting evidence, at no stage was the risk (to either party) ever assessed as being above the lowest level of 'bronze'. This appears to be mainly because each incident was considered in isolation, even when the frequency police call outs was steadily increasing.

The DHR has concluded that police risk assessment processes and findings in this case were seriously flawed. For example, when there was direct evidence of coercion by Ian and Janet expressed a fear that he would kill her this should have resulted in "Gold" risk assessment and referral into the MARAC process. In fact, this incident of coercion did not even result in a new risk assessment being carried out.

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

As already outlined above the DHR has identified **serious** shortfalls in the police responses and in particular the flawed risk assessments. As a consequence, there was no referral into MARAC and no referral to IDVA services, or any other specialist domestic violence services.

GP services provided to Janet were accessible. However, the DHR has found that there was a lack of any pro-active enquiry into underlying causes of her mental health problems and an absence of interest into her living circumstances and her relationship with Ian.

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

On one occasion, Janet's son told police (in another force area) that his mother had been assaulted by Ian. This was passed to Merseyside police, who then asked Janet about this allegation, which she denied. However, as the officers asked Janet about this in the presence of Ian, her denial would have been expected. This has been identified as an example very poor police practice. To interview the alleged victim in the presence of the alleged perpetrator suggests a very low level of awareness and understanding of domestic violence. Another interpretation could be that the couple were viewed collectively as a 'problem' due to the number of police call outs to alcohol fuelled disturbances, with the result that this allegation not taken as seriously as it should have been.

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

As already outlined, the repeated police call outs to domestic incidents provided substantial evidence that Ian was a perpetrator. One notable factor is that the person who called the police to incidents was, in most cases, Ian. One outcome from this was that, when risk assessments were carried out it was often Ian who was identified as the victim and Janet as perpetrator. This has resulted in some important learning about chaotic relationships (especially where both partners have significant alcohol and mental health problems) where there is often a complete lack of clarity between

the roles of 'victim' and 'perpetrator'. In such cases, risk should be assessed and recorded as being mutual – with both parties recorded as potential victim and perpetrator. It should be also be recognised that in such chaotically and mutually violent relationships, there may be more risk of an incident of extreme violence, leading to homicide.

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?

There is local recognition that patterns of repeat low level incidents should ideally act as a trigger to escalate the matter, either to MARAC or at least some additional screening and referral process. Within existing resources in Liverpool, automatic referral to MARAC (e.g. after any 3 incidents within a 6 month period) would completely over-load the MARAC process and potentially reduce the overall ability of the system to work effectively, placing more people at risk. This is a systems and resource issue that requires urgent attention.

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?

Both Janet and Ian had long term mental health and alcohol problems and it is very clear that these were highly significant in relation to all of the reported police incidents and the homicide itself. Janet and Ian each saw their GPs on a regular basis and were prescribed medications for mental health problems, with some ongoing monitoring of their alcohol consumption. However, in both cases, there was a lack of any pro-active enquiry by GPs into the impacts that their mental health and alcohol problems were having on the relationship. Consequently, there was no awareness by GPs that domestic violence was an issue in this relationship, despite the fact that a number of risk factors were known. Most significantly, it was recorded in Ian's notes that he had been violent towards a previous partner, whilst under the influence of alcohol.

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

The DHR has not identified any examples of outstanding or innovative practice.

PART 4: RECOMMENDATIONS

4.1 Single agency recommendations:

The following recommendations are reproduced from IMRs:

Merseyside police:

1. When a perpetrator of 'domestic violence' has been arrested and bail is a consideration, either following or prior to any charge, then the application of conditions to keep the subject away from the victim and ensure their safety, must be applied.

2. When dealing with repeated low key 'domestic incidents' that involve alcohol abuse as a continued factor, then interventions and referrals to other agencies must be considered.

3. When there is information available indicating that an individual is abusing the benefit system, then details of that abuse must be shared with the Department of Works and Pensions. This is particularly relevant to parties with a history of domestic incidents and alcohol abuse.

4. When a person has been remanded to the custody of the courts and there is information available indicating that the person may be a suicide risk, then that information should be fully documented under the risk section of the Person Escort Record (PER) form that accompanies them to court and / or prison. It should also be highlighted personally to those other custodians.

5. When arrests and subsequent charges are made in relation to 'domestic incidents' and alcohol abuse is a contributing and continued factor, then officers dealing must ensure that the court is informed of this and consideration be given to applying for the necessary Alcohol Treatment Referral Order (ATRO) as part of a community service order.

6. The current Force 'Domestic Abuse' Policy and Procedure should be amended at paragraph 10.2 to reflect that the subsequent interventions will be considered when a victim withdraws their allegation even before a suspect has been arrested. At present it is ambiguous and appears to indicate that such interventions can only be considered after charge.

South Liverpool Homes

1. During the initial investigation of anti-social behaviour complaints, SLH will confirm the identity of any person present at the property at that time.

2. Consideration should be given to conducting a home visit where there is a request for support and historical records indicate a potential issue at the property.

3. Refresher training to be given to all staff who record details of initial referrals relating to anti-social behaviour, to re-iterate the importance of capturing times of incidents.

GP Practice

1. 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. The presence of abusive relationships is not specifically questioned.

4.2 Overview recommendations

Overview recommendation 1: Merseyside Police and MARAC

(See key learning points 2, 4, 11)

There should be review of current guidance in relation to repeat domestic incidents. The review should consider the following areas:

- Does current policy and procedure ensure appropriate escalation, when the police are called repeatedly to 'low level' incidents, when risk may be assessed as bronze?
- Should there be a secondary trigger point resulting in automatic escalation (e.g. referral into MARAC, Multi Agency Safeguarding Hub (MASH) or referral for IDVA services) if there a certain number of incidents, within a specified period? If so, what is the appropriate trigger point? (e.g. 3 incidents within 6 months).
- Where there is evidence of mutual violence, should all incidents involving the same couple (regardless of recorded 'victim / perpetrator roles) be counted in relation to the above bullet point?

Overview recommendation 2: Merseyside Police

(See key learning points 9 &10)

There should be a review of policy, guidance and training needs in relation to:

- Domestic violence risk assessments, with a focus on circumstances where there is evidence that a victim has withdrawn a statement under direct threat and coercion by the perpetrator.
- Ensuring that alleged victims are not interviewed in the presence of alleged perpetrators.

Overview recommendation 3: Merseyside Police and Adult Social Care

(See key learning point 7)

There should be a review of referral systems and communications between Merseyside Police and Liverpool ASC, to establish why the police referral for mental health services was not received, or (if received) was not recorded by ASC and acted on.

Overview recommendation 4: GP practice

(See key learning points 13 and 14)

Liverpool CCG should ask to the GP practice to review and report back on local domestic violence guidance and practice, in the light of learning from this case. The review should consider:

- How primary care records may be flagged, to ensure that GPs are aware of evidence that a patient may be a perpetrator or victim of domestic violence.
- Pro-active enquiry into potential relationship problems and domestic abuse risks with patients who have mental health problems, alcohol dependencies, chaotic lifestyles, or other known risk factors.
- Any training needs relating to the above two points.

Appendix 1: Summary of Key Learning Points

Key learning point 1

When responding to incidents of this nature, police officers should not make assumptions based the genders of the *'complainant'* and *'victim'*.

Key learning point 2

This was a very minor domestic incident, which would have been unlikely to highlight any significant risks of domestic abuse or violence. As the alleged victim was Ian, it is even less likely that risks to Janet would have been identified. However, it is important that even such minor incidents are appropriately logged, so that any future incidents can be risk assessed in the light of a full knowledge of all previous incidents. As has been repeatedly highlighted in previous DHRs in Merseyside [7] and elsewhere, whilst an individual incident may seem insignificant, patterns of repeated incidents – *provided they are properly recorded and logged* - can build a cumulative picture of significant risk. But if they are *not* properly recorded in line with local procedure, future risk assessments will be based on incomplete information and therefore be less likely to accurately identify the true level of risk.

Key learning point 3

The DHR Panel concur with the conclusion of the Merseyside Police IMR author that the absence of bail conditions following the first reported incident of an assault by Ian on Janet was a missed opportunity, as bail conditions could have provided a period of physical separation between the perpetrator and Janet. This was further compounded by Janet being wrongly advised that bail conditions *were* to be imposed. This may well have reduced Janet's confidence in the ability of the police to take effective action in the event of any future incidents, making it less likely she would seek assistance.

Key learning point 4

A recommendation could be made for a change of policy so that three incidents within 6 months would lead automatically to a MARAC referral. But if this resulted in MARAC becoming an unmanageable and 'paper led' process, the overall outcomes

[7] See, for example, Liverpool DHR into the death of Mr. A. liverpool.gov.uk/council/strategies-plans-and-policies/crime-and-community-safety/citysafe-community-safety/domestic-violence-homicide-reviews

for people at high risk from domestic abuse would be negative. An implication from this is that MARAC may be insufficiently resourced.

Key learning point 5

Where there is a blurring between "victim" and "perpetrator" roles, a decision about which individual to record as the victim may not be obvious or clear cut and there may be allegations and counter-allegations between couples. Evidence from previous DHRs[8] suggests that where there are mutual allegations of domestic violence (especially where the couple have alcohol problems and chaotic lifestyles) there is a significantly increased risk of extreme violence and potential homicide. This highlights a need to review local policy and procedure, to ensure that (regardless of which partner is defined as victim or perpetrator) repeated incidents involving the same couple are appropriately risk assessed and if necessary escalated into the MARAC process.

Key learning point 6

Domestic incidents which involve excessive alcohol use and the possession of a knife (or indeed any other lethal weapon) should be very carefully risk assessed, even if no injuries have occurred. The assessment should take account of the fact that, in any future domestic conflict, this combination of risk factors will significantly increase the possibility of serious injury or death.

(Recommendation for Home Office: They should carry out a statistical analysis of DHRs completed to date, to include how many homicide incidents included combined misuse of alcohol and knives as primary factors and in how many of these cases there had been previously recorded incidents where alcohol consumption and possession of a knife had been reported.)

[8]See, for example, Liverpool DHR into the death of Mr. A. liverpool.gov.uk/council/strategies-plans-and-policies/crime-and-community-safety/citysafe-community-safety/domestic-violence-homicide-reviews

Key learning point 7

This systems failure resulted in a missed opportunity to assess Janet's needs as a person with alcohol dependency and mental health problems and possibly to offer interventions to address these areas of need.

Key learning point 8

When an alleged domestic violence victim makes a withdrawal statement and there is clear evidence that the retraction has been made under coercion by the alleged perpetrator, this should always result in a re-assessment of risk, with serious consideration given to the need for referral into the Multi Agency Risk Assessment Conference process. That this did not happen in this case was a serious missed opportunity.

Key learning point 9

Where an alleged victim of domestic abuse withdraws support for a prosecution and there is evidence that they have been subjected to coercion by the alleged offender, the police (where appropriate in consultation with CPS) should seriously consider the option of continuing the criminal prosecution, if there appears to be a realistic chance of securing a conviction. If there is a decision (by the police or the CPS) not to prosecute, the rationale for the decision should be clearly set out in police records.

Key learning point 10

Reasonable attempts should have been made to interview Janet on her own, without a need for Ian to even be aware that the interview was taking place.
That this did not happen was very poor practice on the part of the police and a missed opportunity to review risks and then consider the need for police intervention with the alleged perpetrator and/or strategies to reduce ongoing risks of violence.
This indicates an urgent need for Merseyside Police to evaluate the effectiveness of domestic abuse training and awareness raising for front line officers.

Key learning point 11

When police are repeatedly asked to intervene by parties to apparently minor domestic disputes, the risk assessment which follows should carefully consider not only the content and outcome of the dispute, but should also seek to understand *why*

the parties involved felt that a police response was necessary. However, the police themselves may not be the most appropriate agency to ask this question, so consideration should be given to referring to an IDVA or another agency with the relevant skills and knowledge base.

Key learning point 12

When neighbours complain to landlords of anti-social behaviour which indicates a domestic conflict has occurred (e.g. shouting and foul language between household members) past records should be checked for any evidence of a history of violent behaviour at the property. If such a history is evident, the landlord response should include consideration of potential domestic violence issues.

Key learning point 13

When treating people mental health and alcohol problems, GPs should routinely ask patients about their home circumstances and any relationship issues, which may be underlying causes for these types of problems. This approach can at least provide an opportunity for patients to talk about domestic violence issues, in a safe and confidential setting.

Key learning point 14

GP records included evidence of alcohol related domestic violence perpetrated by Ian, in a previous relationship. It was also known that Ian continued to have co-exiting alcohol and mental health problems and that he was in a new relationship. Given these factors, it would have been good practice for the GP's monthly monitoring to include assessment of how Ian's alcohol and mental health problems may be impacting on his relationship. Whilst it is perhaps unlikely that Ian would have self-disclosed as a perpetrator of domestic violence, this could have provided an opportunity to explore relationship conflicts and offer possible interventions such as relationship counselling.