SEFTON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Final

Victim Female Adult 1

[FA 1]

Died November 2012

October 2014

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

FA 1 [Female Adult]	:	The Victim
MA 1 [Male Adult]	:	The Perpetrator
FA 2	:	Adult daughter of FA 1 and MA 1
MA 2	:	Adult son of FA 1 and MA 1

1.2 In November 2012, North West Ambulance Service [NWAS] alerted Merseyside Police [MSP] to a stabbing outside Address 1. FA 1 was dead at the scene. Officers forced an entry to the house and found MA 1 with apparently self-inflicted wounds. He was taken to hospital for treatment and later arrested on suspicion of killing FA 1.

1.3 A post mortem established that FA 1 died from shock and haemorrhaging from two stab wounds to her chest. She had six other non-fatal knife injuries. MA 1 was charged with her murder. In December 2013 he pleaded guilty to manslaughter and sentenced to 14 years imprisonment in February 2014.

1.4 The sentencing Judge said: MA 1 was suffering from a depressive illness at the time and was self-medicating with alcohol and would be sentenced on the basis of diminished responsibility. He added: "This is on any view a sad and tragic case but there is no getting away from the fact you killed your wife in terrible circumstances... despite diminished responsibility you still bear a heavy responsibility for her death... FA 1 would have had many years of life ahead of her... you deprived her of those and deprived her family and friends of the love and affection she would have given them...it is particularly poignant that only a few weeks before the killing when she was on holiday with friends she told them that she did not want to go home."

Source: Local Media

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 In December 2012 the Domestic Homicide Review Screening Committee recommended to the chair of Sefton Safer Communities Partnership that the criteria for a DHR were met. The chair agreed and the Home Office was informed.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author and soon after and held a preparatory meeting with officials from Sefton Community Safety Partnership. The meeting had two outcomes. The first outcome determined there were no immediate actions arising from this case that needed to be taken to safeguard victims of domestic violence; the second discussed and developed the terms of reference and set a timetable.

2.3 DHR Panel Members

2.3.1 The Panel comprised of:

Gayle Rooney	Detective Inspector Merseyside Police [MSP]
Paul Holt	Assistant Chief Officer Merseyside Probation Trust (MPT) then Janet Marlow 15.07.2013
Gill Ward	Chief Executive Sefton Women and Children's Aid (SWACA)
Steph PREWETT	Head of Corporate Commissioning and Neighbourhood Co-ordination Sefton Metropolitan Borough Council until 13.12.2013 then Andrea Watts
Helen Smith	Head of Adult Safeguarding NHS Merseyside
David HUNTER	Independent Chair and Author

2.4 Agencies Submitting Information

2.4.1 The panel carried out a scoping exercise as a first stage; with requests to adult social care, SWACA and the Vulnerable Victims Advocacy Team [VVAT]. The panel also explored the possibility that FA 1 may have instructed a solicitor and that this might be traced through any legal aid application. It was not possible to search for FA 1 via the legal aid system. [See paragraph 5.6.7] The Panel discussed the possibility of a disclosure by FA 1 to her employers (i.e. occupational health, line manager) Merseyside Police took this away as an action and later informed the panel that no such disclosure had been made. The scoping exercise evidenced the Panel's belief that there was very little relevant contact between FA 1, MA 1 and agencies.

2.4.2 Only Merseyside Police had sufficient information to warrant the completion of an Individual Management Review [IMR]. Other agencies submitted chronologies supported by short reports where appropriate. Additionally MSP provided the DHR

chair/author with statements from the homicide investigation. MPT shared the findings of its Further Serious Offences review.

- Merseyside Police — Chronology and IMR
- Merseyside Probation Trust — Chronology and short report
- Citizens Advice Bureau Bootle — Chronology and short report
- Citizens Advice Bureau Liverpool North — Chronology
- General Practitioner — Chronology
- Southport and Ormskirk Hospital NHS Trust — Chronology
- Connexions — Chronology
- School Health — Chronology

2.4.2 The DHR Panel looked for other sources of information but it appears, as verified by the police investigation, that the family was unknown to agencies from a domestic abuse perspective. Neither FA 2 nor MA 2 said or hinted, as adults or children, to any professional, that there was anything untoward in the family.

2.5 Notification/Involvement of Families

2.5.1 FA 1 and MA 1's, fathers; FA 1 and MA 1's two adult children and FA 1's sister were written to informing them that a DHR was taking place and inviting them to contribute. The letters and Home Office leaflet on DHRs were delivered by the police Family Liaison Officers. FA 1's father was visited by the independent chair/author and his views are reflected in the report.

FA 1's two adult children and her sister said they did not want to contribute to the report and asked FA 1's father to be the family spokesperson.

MA 1's father did not reply to two letters from the independent chair/author and it was felt further attempts to contact him could be seen as intrusive.

2.5.2 Both families will be written to prior to publication and offered a briefing on the final report.

2.6 Terms of Reference

2.6.1 Purpose of a DHR

The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
  Source: Paragraph 3.3 The Guidance.

2.6.2 Specific Terms of Reference

1. Were the risk indicators for domestic abuse present in this case recognised, properly assessed and responded to in providing services to FA 1 and MA 1.
2. Were the services provided for FA 1 and MA 1 appropriate to the identified levels of risk?
3. Were the reasons for MA 1's abusive behaviour properly understood and addressed?
4. Were the wishes and feelings of FA 1 and MA 1 taken into account in the provision of services and support?
5. Were single and multi-agency policies and procedures adhered to in the management of this case?
6. Was information sharing and communication with other agencies effective and is there evidence of inter-agency cooperation and joint working?
7. Did practitioners working with FA 1 and MA 1, receive appropriate supervision and support and was there adequate management oversight and control of the case?
8. Were any racial, cultural, linguistic, faith or disability issues identified and dealt with appropriately?
9. Were there any problems with capacity or resources in this case?

2.6.3 Timeframe

The review period begins on 01.08.2009 and ends on 28.11.2012.

3. DEFINITIONS

DOMESTIC VIOLENCE

3.1 The Government definition of domestic violence against both men and women is: [2004]

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

3.2 An adult is any person aged 18 years and over and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

Notes:

1. MSP use the above definition which has been agreed between the Government and The Association Chief Police Officers [ACPO]

2. On 01.03.2013 the Government definition of Domestic Violence changes to:

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

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

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

4. FAMILY BACKGROUND

4.1 Introduction

4.1.1 The sources of information in the following paragraphs are from MSP's IMR and the father of FA 1.

4.2 FA 1 Victim

4.2.1 FA 1 came from a well-established Liverpool family who move to Sefton some years ago. She was educated locally and on leaving school at 16 years of age took up employment with Girobank [later Santander] and was still there at the time of her death. Her father describes her as a happy go lucky person who always had a smile on her face. She was very well liked and respected. FA 1 was a social drinker and organised many trips for her work colleagues. [They raised £1500 for charitable causes after her death]. FA 1 was a good mother who loved and cared very much for her children. She was married to MA 1 for 24 years.

4.2.2 FA 1 is greatly missed by her family who are struggling to come to terms with her death.

4.2.3 FA 1's father said his daughter was concerned about MA 1's drinking and driving and was fearful in case he was involved in an accident where someone was injured or killed. It is reported that a few years ago FA 1 temporarily separated from MA 1 because of his drinking. It is fair to say that MA 1's drink/driving was a source of tension between them. Her father knew that FA 1 wanted a divorce and she was content to split the marriage assets equally with MA 1. FA 1's father was unaware of any domestic abuse.

4.3 MA 1 Perpetrator

4.3.1 MA 1 was brought up in Sefton and on leaving school at 16 years was employed for many years in the bakery industry. He worked in the concrete moulding industry before leaving employment to start a similar business with his father and one partner.

4.3.2 It appears he liked to stop for a drink on his way home from work and this became a significant feature of his life. MA 1 was also described as a good parent who loved his children.

5. EVENTS ANALYSIS

5.1 Introduction

5.1.1 There is very little information recorded by agencies on the history of domestic abuse between FA 1 and MA 1, and what they had was provided to the DHR in chronologies, IMRs and short reports. Prior to 11.01.2012 MSP had eight contacts with the family. These were not related to domestic abuse and concerned traffic matters and minor issues.

5.2 Non-Disclosure of Domestic Abuse

5.2.1 There are many reasons why victims of domestic abuse do not disclose their victimisation to professionals. Her Majesty's Inspectorate of Constabulary [HMIC] reported the following:

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

The reasons the victims we surveyed gave for not reporting the domestic abuse to the police were: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent)".

Source:

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

5.2.2 Professionals should also be mindful that some victims may minimise violence as a coping mechanism. Victims may also find it hard to recognise that they are being abused, as their experiences might not appear to fit the usual stereotype of domestic violence

Source:

The Survivor's Handbook www.womensaid.org.uk

5.3 MA 1 Arrested Drunk and Disorderly

5.3.1 In January 2012 MA 1 was arrested for being drunk and disorderly at a football match in the North West for which received a fixed penalty notice.

5.3.2 This is the first recorded event associating MA 1 with excessive alcohol use.

5.4 MA 1 Arrested for Drink/Driving

5.4.1 In October 2012 MA 1 was arrested for drink/driving. He was almost three times over the legal limit. He appeared at court later that month and pleaded guilty. He was disqualified for 24 months and received a 12 month Community Order with 80 hours unpaid work.

5.4.2 This event provides additional evidence that MA 1 was a problematic drinker. MPT assessed he posed a low risk of reoffending or of causing serious harm to anyone and dealt with him as a Tier 1 offender.* MA 1 attended his unpaid work appointments but the requirement was suspended when he was arrested on suspicion of murder. Because of his arrest for murder, there was never an opportunity to discover whether his drink/driving conviction was, or had ever, impacted on his relationship with his wife/family.

*Supervision Tier**:** indicates the level of risk of serious harm and likelihood of reoffending presented by the individual, combined with the complexity of the sentence requirements, with tier 1 being the lowest and tier 4 the highest.
Source:
Ministry of Justice Offenders: Management Statistics: Definitions and Measurement April 2011

5.5 Knife Incident

5.5.1 After FA 1's homicide the following event emerged from her friends. In early November 2012, FA 1 and MA 2 were at home and argued about his drink driving conviction. FA 1 told her friends that he threatened her with a kitchen knife. The incident frightened her but she did not disclose it to the police or her family and asked her friends to keep the matter confidential. MA 1's willingness to use a knife during verbal domestic disputes was unknown to any agency before FA 1's death. Picking up a knife and threatening a person with it, is a violent act in itself.

5.5.2 The experience of domestic abuse specialists is that many instances of domestic abuse go unreported to the police or other agencies, but it is common for victims to share the information with friends and family. This aspect is developed later in the report.

5.6 FA 1 Visits Citizens Advice Bureau [CAB]

Bootle CAB

5.6.1 In late November 2012 FA 1 visited CAB asking to talk to someone about divorcing her husband on the grounds of his unreasonable behaviour which she cited as excessive drinking. FA 1 spoke to a CAB gateway assessor and asked for financial advice about whether she could afford a mortgage on her income. The gateway assessor noted that FA 1 and MA 1 were working and had their two adult children living with them.

5.6.2 The assessor made a note on the file to discuss with a supervisor whether a referral to a CAB financial adviser was appropriate. In the meantime the assessor made an

appointment for FA 1 to see a CAB generalist adviser several days later. The assessor marked the file with, "can leave message" against FA 1's home telephone number.

5.6.3 In a statement made to MSP after FA 1's death, the CAB gateway assessor said he asked FA 1 if there was any violence linked to her husband's drinking. He said that FA 1 did not give him a direct answer and appeared evasive. The gateway assessor said FA 1 provided him with information that showed she had concerns about her husband but did not tell him anything to suggest she was at any immediate risk from MA 1. However, FA 1's CAB case notes prepared by the gateway assessor do not reflect this part of the consultation. Nevertheless there was no disclosure of domestic abuse to CAB.

5.6.4 Financial advice is different from money advice. The gateway assessor's query about referring FA 1 to a financial adviser concerned mortgage products and not debt.

5.6.5 Several days later FA 1 attended Bootle CAB and saw a generalist adviser. FA 1 discussed ending her marriage. The generalist adviser gave her a factsheet on dissolving a marriage and FA 1 said she would refer to unreasonable behaviour. She insisted MA 1 was not an alcoholic and he only drank at weekends. [FA 1's father believed MA 1 drank during the week but not often at weekends.] FA 1 referred to MA 1 visiting the GP that day for help. It is not known if FA 1 told the generalist adviser the reason for MA 1's visit to the GP; as nothing was recorded.

5.6.6 FA 1 said that MA 1 had been found guilty of drink driving the previous month and was on a downward spiral in mood and outlook. FA 1 said there had never been any police intervention and she had never reported him, because his behaviour "affected her emotionally and mentally more than physical". She disclosed that he had drink related problems for a number of years. [This problem is believed to be nocturnal enuresis {bed wetting} and was known about within FA 1's extended family]. She had endured this; tried to help but now wanted to end the marriage and needed to know about her financial rights and obligations.

5.6.7 The adviser talked about FA 1 seeking the help of a solicitor with the divorce and discussed fixed fee interviews. FA 1 was going to seek a preliminary interview with a solicitor. There is no record in CAB records of which solicitor, nor did MSP find any evidence that FA 1 saw one. It is unlikely she did because within a few hours of the CAB meeting MA 1 had killed FA 1.

5.6.8 FA 1 and the generalist adviser discussed the family finances. FA 1 and MA 1 had a joint mortgage with only one year remaining and £8,000 outstanding. They also had £7,000 loan for a new kitchen.

5.6.9 FA 1 said her husband's financial adviser was also his friend who would be visiting him this evening.

5.6.10 FA 1 said she and MA 1 had talked about paying the outstanding mortgage, paying off the kitchen debt and splitting the profits from the sale of the house evenly. FA 1 thought that sounded reasonable but wanted to check matters out. She could not afford to buy MA 1 out but she wanted to buy a new property for herself and needed to know what additional funds were required.

5.6.11 In the presence of FA 1 the generalist adviser telephoned the CAB financial adviser at Liverpool North CAB and left a message. FA 1 said it was alright for the financial

adviser to contact her direct. FA 1 asked for the financial adviser's contact details in case she missed the call. The generalist adviser told FA 1 to contact CAB if she had not heard from the financial adviser in the next few days.

5.6.12 The generalist adviser believed that FA 1 did not fear violence from MA 1; she was emotionally wrought but did not seem alarmed about taking steps to obtain legal and financial advice to move her life forward.

5.6.13 The CAB computer system contains information about domestic abuse and leaving a relationship. There is a warning triangle that alerts the adviser to follow the link to the Women's Aid website which opens up the "The Survivors Handbook". It is this source material that refers to risks and safety plans. There is also reference to consider whether or not there is domestic violence in the information item on "Ending a Relationship". This topic covers a range of issues to consider.

5.6.14 The generalist adviser did not discuss risk or safety planning with FA 1 as there was no indication of domestic abuse.

5.7 Liverpool North CAB

5.7.1 At 4.0 pm on the day of FA 1's death, the CAB financial adviser saw a note on her desk requesting that she telephone FA 1 who was separating from her husband and in need of information about her options with regard to the mortgage.

5.7.2 The financial adviser telephoned FA 1 to arrange an appointment and checked whether it was safe to talk. The adviser thought FA 1 shut a door before confirming it was. They made an appointment for the following week. In less than an hour FA 1 was dead.

5.8 MA 1 Visits his GP

5.8.1 On the day FA 1 was killed, MA 1 visited his GP complaining of not being able to sleep. He had lost weight and his appetite had declined. The GP spoke to him about his health and issued a prescription. MA 1 did not disclose any relationship difficulties.

5.9 Financial Adviser

5.9.1 MA 1's financial adviser told MSP that about five months before FA 1's death, MA 1 had contacted him enquiring about raising a mortgage to buy FA 1 out of the house. The adviser said it was probable. MA 1 gave no reason for the enquiry. In mid-November 2012 the financial adviser met MA 1 who said he was splitting from FA 1. MA 1 also said he had been prosecuted for drink/driving. It appears MA 1 had secured a business contract and went drinking to celebrate. He was stopped by MSP on his way home. MA 1 said the charge had changed the family dynamics and he had found a property to move to.

5.9.2 The financial adviser had an appointment to see MA 1 at his home on the day of the homicide. At 4.23 pm MA 1 called the financial adviser to bring the meeting forward to 6.30 pm. When the adviser arrived at MA 1's house he found the road sealed and the police in attendance.

5.10 FA 1's Homicide

5.10.1 Neighbours called the police saying that a female had been stabbed and was in the street.

5.10.2 When the police arrived they found FA 1 dead. They entered the house and found MA 1 with significant self-inflicted knife wounds to his throat and wrists.

5.10.3 It appears that MA 1 and FA 1 had a row soon after the telephone call from the CAB financial adviser and that it quickly escalated to the point where MA 1 stabbed his wife. The cause of death was established as shock and haemorrhaging.

5.10.4 A report of the trial in a local newspaper said:

> "... the couple, who were getting divorced, argued in the moment before FA 1's death with her calling her husband a drunk and mocking his bed wetting and small manhood.
>
> He claims he was on his way to bed to avoid her when she started screaming and shouting at him and he went to the kitchen and grabbed the knife.
>
> MA 1, who had consumed between six and eight pints, said there was a struggle during which she was stabbed but when she ran out of the house he thought she was okay".

6. ANALYSIS AGAINST TERMS OF REFERENCE

6.1 Introduction

6.1.1 The information with which to complete the analysis is scant and therefore what can be usefully written is limited. Each term is examined.

6.1.2 The terms appear in ***bold italics*** followed by an analysis.

6.2 Term 1

Were the risk indicators for domestic abuse present in this case recognised, properly assessed and responded to in providing services to FA 1 and MA 1?

6.2.1 The risk indicators for domestic abuse in this case were:

1. Excessive drinking by MA 1
2. FA 1 taking active steps to end the marriage
3. Evasiveness of FA 1 (5.6.3) and indicators of emotional abuse (5.6.6)
4. MA 1's knowledge that FA 1 wanted a divorce and their discussions on the financial settlement
5. MA 1's use of a knife to threaten FA 1 on or about the 05.11.2012

Note: It was not known or diagnosed that MA 1 was suffering from a depressive illness at the time of the events. Had it been, it would have added to the risk.

6.2.2 Merseyside Probation Trust knew that MA 1 had a conviction for drink/driving and assessed him as low risk offender. They did not know of the tensions in the marriage or the knife incident and therefore could not reasonably be expected to connect his drink/driving conviction to domestic abuse. Merseyside Probation Trust conducted a Serious Further Offences review which concluded there were no missed opportunities to identify MA 1 as a perpetrator of domestic violence.

6.2.3 The interaction between FA 1 and CAB in late November 2012 is the first indication that any agency had of FA 1's plans to end her marriage to MA 1. There was no disclosure of domestic abuse during the meeting. The disclosure by FA 1 on the date of her death, was the first time an agency knew of domestic abuse. Given the nature of the disclosure ["affected her emotionally and mentally more than physical"] there was no realistic opportunity, or need, for decisive intervention.

6.2.4 The generalist adviser has since left CAB for an employment opportunity and has not been interviewed. Her account is derived from the case notes and her statement to the police.

6.2.5 FA 1 did not to mention the knife incident and all the indicators she gave to the generalist adviser suggested she was in control of the situation. For example she said that it was alright to leave a message on her home telephone number, probably indicating she felt confident that any CAB message picked up by MA 1 would not cause difficulties. FA 1 said she negotiated an equal split of the assets with MA 1 and wanted independent reassurance on her financial position. Those things do not overtly indicate a person who was in fear of MA 1. However, FA 1 was not to know that MA 1 was exhibiting behaviour which increased the risk she faced from him. The generalist adviser told the police investigation that FA 1 did not fear violence from MA 1. FA 1's concerns were centred on his drinking and driving.

6.2.6 The issue of domestic abuse does not crop up frequently with CAB clients. The subject is covered during basic training for new workers and at the time there were leaflets in the CAB premises which clients could read and take away. Now [but not in November 2012] there are domestic abuse posters in the CAB office signposting victims to specialist agencies. CAB Bootle has made referrals to Sefton Women and Children's Aid [SWACA] indicating that advisers are alive to domestic abuse.

6.2.7 Ideally, the generalist adviser should have asked FA 1 what she meant by, "...affected her emotionally and mentally more than physical". Did it mean there was no physical violence? Emotional and mental abuse sits within the definition of domestic abuse. The incident where he threatened her with a kitchen knife is a high tariff risk factor. FA 1 did not disclose this information and paragraph 5.2 explores why that might be.

6.2.8 Had the CAB adviser known the extent of the domestic abuse they would have discussed the heightened dangers faced by victims at the point of or soon after separation and advised FA 1 on safety planning and referred her to specialist domestic abuse support services in the area.

6.2.9 The DHR Panel specifically excluded any causal factors between FA 1's interactions with CAB, its response, and her death.

6.2.10 Citizens Advice is developing a set of standard enquiries under a pilot project to screen debt and housing clients for gender based violence and abuse (GVA). Advisers in the pilot bureaux have been trained to ask GVA questions; provide GVA information and take action on GVA issues, as part of advising clients on benefits, housing and debt problems. It is intended that the learning from this pilot will be shared across all bureaux.

6.2.11 The DHR Panel recognised this would raise the profile of domestic abuse across the organisation. The DHR Panel noted the pilot was for CAB clients who present with debt and housing needs. FA 1's presentation was subtlety different. However, the trained CAB assessors and advisers will see a range of clients and the knowledge gained from the pilot is expected to have an all-round benefit.

6.2.12 No other agency knew of the domestic violence between FA 1 and MA 1. FA 1 told several work colleagues about the knife incident. FA 1's father said that had the family known MA 1 threatened his daughter with a knife they would have spoken to him about his behaviour.

6.2.13 The point of separation as a risk factor for homicide is illustrated in Appendix B: Ontario Domestic Violence Death Review Committee: (2008). Annual report to the

Chief Coroner: Toronto, ON: Office of the Chief Coroner. The Appendix also contains useful advice of preparing a safety plan.

6.3 Term 2

Were the services provided for FA 1 and MA 1 appropriate to the identified levels of risk?

6.3.1 Merseyside Probation Trust was the only agency who assessed MA 1's risk. They judged him a low risk of causing serious harm to another person. On the information available to them that was an appropriate outcome.

6.3.2 CAB had no reason to complete a risk assessment and the judgements made by the generalist adviser on whether FA 1 was fearful of him were appropriate in the circumstances.

6.4 Term 3

Were the reasons for MA 1's abusive behaviour properly understood and addressed?

6.4.1 No agency had an opportunity to work with MA 1 or FA 1, therefore the reasons for his abusive behaviour are not known. It is known there was long term friction between FA 1 and MA 1 over his drinking and driving and that they had separate sleeping arrangements because of his enuresis. The relationship appears to have deteriorated very quickly over a few months when MA 1 realised that FA 1 was intent on leaving him. The evidence of them; seeking financial advice; MA 1's declaration to his financial adviser that he had found a property to rent and FA 1's statements to CAB, testify that MA 1 was very likely to know that the marriage was over. FA 1's father felt that MA 1's attitude at that time was, "if I can't have you, no one else will". That phrase appears in several other DHRs undertaken by the author of this one, and is a risk factor listed in risk assessment models.

6.4.2 MA 1's interaction with MPT was halted prematurely following his arrest for FA 1's murder. That meant there was no opportunity to explore what lay behind his behaviour and whether alcohol was a trigger for his offending.

6.5 Term 4

Were the wishes and feelings of FA 1 and MA 1 taken into account in the provision of services and support?

6.5.1 CAB's role was to offer impartial and accurate information to FA 1 thereby enabling her to make informed decisions based on her needs. Asking whether it was alright to telephone her at home and asking if it was "safe" to speak are examples of taking FA 1's wishes and feelings into account. The CAB generalist advisor could have explored FA 1 wishes and feelings during the interaction described in 6.2.7. Beyond that there were no other opportunities.

6.6 Term 5

Were single and multi-agency policies and procedures adhered to in the management of this case?

6.6.1 There were no reported breaches of policy or procedures. The CAB generalist adviser could have thought more laterally and considered issues outside of those presented by FA 1. This is a point identified by CAB.

6.7 Term 6

Was information sharing and communication with other agencies effective and is there evidence of inter-agency cooperation and joint working?

6.7.1 There were no relevant opportunities to seek or share information from or between agencies.

6.8 Term 7

Did practitioners working with FA 1 and MA 1 receive appropriate supervision and support and was there adequate management oversight and control of the case?

6.8.1 The CAB gateway assessor who saw FA 1 in November 2012 sought advice from a supervisor about referring FA 1 to financial adviser.

6.9 Term 8

Were any racial, cultural, linguistic, faith or disability issues identified and dealt with appropriately?

6.9.1 FA 1 and MA 1 were white British with English as their first language. The two agencies involved with the couple routinely record and monitor such statistics to ensure their service provision is appropriate to their clientele. The DHR Panel judged there was no bias in this case.

6.10 Term 9

Were there any problems with capacity or resources in this case?

6.10.1 No agency reported problems with capacity or resources nor did the DHR Panel find any.

7. LESSONS LEARNED

Common Themes in DHRs

7.1 The Home Office 2013 publication, Domestic Homicide Reviews Common Themes Identified as Lessons to be Learned [ISBN 978-1-78246-095-4] examined 54 quality assured domestic homicide reports submitted between 13.04.2011 and 31.03.2013 and identified the following themes.

1. **Awareness Raising and Communication**, which was around gaps in what constituted domestic violence.
2. **Risk Assessment**, the inconsistencies in approach.
3. **Information Sharing and Multi-Agency Working**, failing to share relevant details.
4. **Complex Needs**, victims and/or perpetrators with one or more of the following elements: mental health needs, substance misuse and sexual abuse.
5. **Perpetrators and Bail**, inadequate information sharing when released from prison or bail.
6. **Awareness of the Safeguarding Needs of Children**, there some missed opportunities to referral cases to children's services because the impact of domestic violence on children was not recognised.

7.2 In this DHR, lessons 2, 3, 5 and 6 did not apply and there was only a tangential link to lesson 1. Two CAB staff [the gateway assessor and the generalist adviser], spoke face to face with FA 1 and the financial adviser had a very brief discussion with FA 1 on the telephone. None of them had any reason to suspect that FA 1 was in danger from MA 1. The national work by CAB to raise awareness of domestic violence will benefit victims because CAB staff/volunteers will be more likely to identify victims of domestic abuse and signpost them to services.

Lessons

7.3 The following lessons are preceded by a narrative.

Narrative

Victims often limit their disclosure to family or friends. Several of FA 1's friends knew she was the victim of domestic abuse and supported her in their own way. However, there is no readily accessible independent professional advice available for friends and family who receive disclosures from victims of domestic abuse.

Lesson 1

Without readily accessible independent professional advice, family and friends may not be able to offer the best support and safety advice to victims of domestic abuse.

Narrative

Professionals need to understand and overcome the barriers which prevent domestic abuse victims from making full or partial disclosures of their victimisation.

Lesson 2

Having skills with which to overcome barriers to disclosure will enable professionals to support victims.

8. CONCLUSIONS

8.1 This DHR did not uncover a history of domestic abuse where opportunities for agencies to intervene were missed. FA 1 and MA 1 were married for many years and prior to day of her death; it was not known to agencies that she was a victim of domestic abuse.

8.2 The emotional and mental impact on FA 1 of MA 1's drinking and longstanding enuresis appears to have impacted significantly on her decision to leave him. MA 1's conviction for drink/driving and his assault on her with the knife may have accelerated her decision to make the break. FA 1 did not disclose the knife assault to any agency.

8.3 The barriers to disclosure meant that when FA 1 spoke with CAB staff she made a partial disclosure of non-violent domestic abuse. CAB staff judged she was not in danger from MA 1. His misuse of alcohol was a risk factor, as was his knowledge that FA 1 was making active plans to leave him and seek a divorce.

8.4 Merseyside Probation Trust supervised MA 1 for 30 days. He was assessed as low risk and complied with his unpaid work requirements. There was no hint that he was a domestic abuse perpetrator.

8.5 Some of FA 1's friends knew she was the victim of domestic abuse but complied with her wishes not keep the information confidential. That placed them in a difficult position, but one that is fairly common for friends and family of domestic abuse victims.

8.6 However, there came a point when MA 1 must have realised the marriage was over and that FA 1 was determined to leave. As research shows that placed her at an increased risk of violence but there was nothing known about MA 1 to suggest that he would harm or kill his wife.

8.7 As stated in paragraph 1.4, the sentencing remarks by the judge said MA 1 was suffering from a depressive illness at the time and was self-medicating with alcohol and would be sentenced on the basis of diminished responsibility.

8.8 The DHR Panel concluded that the death of FA 1 was not predictable or preventable.

9. RECOMMENDATIONS

9.1 Single Agency

There are no single agency recommendations.

9.2 DHR Panel

9.2.1 That Sefton Community Safety Partnership raises the awareness of domestic violence in the community. The advice should include how family and friends should respond to disclosures of domestic violence.

Note: In November 2006 the Greater London Authority published as leaflet titled: "If someone you know is experiencing domestic violence". The leaflet provides sound advice to family and friends on how to support victims following disclosure.

9.2.2 That Sefton Community Safety Partnership ensures that professionals in its constituent agencies understand the barriers to disclosure faced by victims of domestic abuse and develop plans to overcome them. This could include the routine use of domestic abuse screening tools and asking direct questions.

END OF REPORT

Next Appendixes

Appendix A

Action Plan FA 1

Recommendation	Action	Lead Agency	Milestones	Target Date	Completion Date and Outcome
1. That Sefton Community Safety Partnership raises the awareness of domestic violence in the community. The advice should include how family and friends should respond after they receive disclosures of domestic violence.	Review current advice Write new guidance Prepare material Seek opportunities to publicise Launch awareness campaign	Sefton Community Safety Partnership	Guidance approved Material prepared Campaign launched	March 2015	
2. That Sefton Community Safety Partnership ensures that professionals in its constituent agencies understand the barriers to disclosure faced by victims of domestic abuse and develop plans to overcome them. This could include the routine use of domestic abuse screening tools and asking direct questions.	Incorporate barriers to disclosure as part of any training package for frontline workers Merseyside PCC and Merseyside Criminal Justice Board are currently reviewing risk assessment tools and a query will be raised with the appropriate	Sefton Safer Community Partnership	Training programme prepared in partnership with LSCB Roll out of training Outcomes of risk assessment tools review considered and amendment to process. made as	Dec'ber 2014	

	sub group about use of domestic abuse screening tools and best practice guidance on this.		required		

Appendix B

Risk Factors and Safety Plan

Risk Factors

The publication of the 2012 Annual Report of the Domestic Violence Death Review Committee (DVDRC) is a milestone occasion as it represents the tenth year that the Office of the Chief Coroner has reported on its reviews and on the incidence of domestic homicide and domestic homicide-suicide in Ontario. Since its inception in 2003, the DVDRC has reviewed 164 cases involving 251 deaths.

Executive Summary

Cases reviewed from 2003-2012:

Since its inception in 2003, the DVDRC has reviewed 164 cases, involving 251 deaths.

55% of the cases reviewed were homicides.

45% of the cases reviewed were homicide-suicides.

73% of all cases reviewed from 2003-2012 involved a couple where there was a history of domestic violence.

72% of the cases involved a couple with an actual or pending separation.

The other top risk factors were:

- obsessive behaviour by the perpetrator
- a perpetrator who was depressed
- an escalation of violence
- prior threats or attempts to commit suicide
- prior threats to kill the victim
- a victim who had an intuitive sense of fear towards the perpetrator
- a perpetrator who was unemployed

In 75% of the cases reviewed, seven or more risk factors were identified.

Source:
http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/DVDR/2012Report/DVDR_2012.html

Safety Plan

Making a safety plan:

A personal safety plan is a way of helping you to protect yourself and your children. It helps you plan in advance for the possibility of future violence and abuse. It also helps you to think about how you can increase your safety either within the relationship, or if you decide to leave.

You can't stop your partner's violence and abuse - only he can do that. But there are things you can do to increase your own and your children's safety. You're probably already doing some things to protect yourself and your children – for example, there may be a pattern to the violence which may enable you to plan ahead to increase your safety.

Plan in advance how you might respond in different situations, including crisis situations.

Think about the different options that may be available to you.

Keep with you any important and emergency telephone numbers (for example, your local Women's Aid refuge organisation or other domestic violence service; the police domestic violence unit; your GP; your social worker, if you have one; your children's school; your solicitor; and the Freephone 24 Hour National Domestic Violence Helpline run in partnership between Women's Aid and Refuge: 0808 2000 247).

Teach your children to call 999 in an emergency, and what they would need to say (for example, their full name, address and telephone number).

Are there neighbours you could trust, and where you could go in an emergency? If so, tell them what is going on, and ask them to call the police if they hear sounds of a violent attack.

Rehearse an escape plan, so in an emergency you and the children can get away safely.

Pack an emergency bag for yourself and your children, and hide it somewhere safe (for example, at a neighbour's or friend's house). Try to avoid mutual friends or family. See the suggestions below on What to pack if you are planning to leave your partner.

Try to keep a small amount of money on you at all times - including change for the phone and for bus fares.

Know where the nearest phone is, and if you have a mobile phone, try to keep it with you.

If you suspect that your partner is about to attack you, try to go to a lower risk area of the house - for example where there is a way out and access to a telephone. Avoid the kitchen or garage where there are likely to be knives or other weapons; and avoid rooms where you might be trapped, such as the bathroom, or where you might be shut into a cupboard or other small space.

Be prepared to leave the house in an emergency.

Preparing to leave

Whatever coping strategies you have used – with more or less success - there may come a time when you feel the only option is to leave your partner.

If you do decide to leave your partner, it is best if you can plan this carefully. Sometimes abusers will increase their violence if they suspect you are thinking of leaving, and will continue to do so after you have left, so this can be a particularly dangerous time for you. It's important to remember that ending the relationship will not necessarily end the abuse

Plan to leave at a time you know your partner will not be around. Try to take everything you will need with you, including any important documents relating to yourself and your children, as you may not be able to return later. Take your children with you, otherwise it may be difficult or impossible to have them living with you in future. If they are at school, make sure that the head and all your children's teachers know what the situation is, and who will be collecting the children in future. (See below, protecting yourself after you have left).

Thinking about leaving and making the decision to leave can be a long process. Planning it doesn't mean you have to carry it through immediately - or at all. But it may help to be able to consider all the options and think about how you could overcome the difficulties involved. If at all possible, try to set aside a small amount of money each week, or even open a separate bank account.

What to pack if you are planning to leave your partner

Ideally, you need to take all the following items with you if you leave. Some of these items you can try to keep with you at all times; others you may be able to pack in your 'emergency bag'

Some form of identification

Birth certificates for you and your children

Passports (including passports for all your children), visas and work permits.

Money, bankbooks, cheque book and credit and debit cards

Keys for house, car, and place of work (You could get an extra set of keys cut, and put them in your emergency bag)

Cards for payment of Child Benefit and any other welfare benefits you are entitled to.

Driving licence (if you have one) and car registration documents, if applicable

Prescribed medication

Copies of documents relating to your housing tenure (for example, mortgage details or lease and rental agreements)

Insurance documents, including national insurance number

Address book

Family photographs, your diary, jewellery, small items of sentimental value

Clothing and toiletries for you and your children

Your children's favourite small toys

You should also take any documentation relating to the abuse - e.g. police reports, court orders such as injunctions and restraining orders, and copies of medical records if you have them

In an emergency, always call the police on 999.

Source:
www.womensaid.org.uk/domestic-violence-survivors-handbook

Appendix C

Glossary of Terms

ACPO	Association Chief Police Officers

CAB	Citizens Advice Bureau
DHR	Domestic Homicide Review
GVA	Gender based Violence and Abuse
HMIC	Her Majesty's Inspectorate of Constabulary
IMR	Individual Management Review
MSP	Merseyside Police
MPT	Merseyside Probation Trust
NWAS	North West Ambulance Service
SWACA	Sefton Women and Children's Aid
VVAT	Vulnerable Victims Advocacy Team