East Herts
Community Safety Partnership

East Herts Domestic Homicide Review

Executive Summary of the Overview Report

Into the homicide of M in July 2014

Report Commissioned by East Herts Community Safety Partnership and produced by an Independent Panel

Report completed: December 2016

Table of Contents

Preface ... 3
EXECUTIVE SUMMARY ... 4
1. Introduction ... 4
2. The Review Process ... 5
3. Findings of the review ... 7
4. Conclusions ... 13
5. Recommendations ... 16
6. Glossary ... 18

Preface

Domestic homicide reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) which came into effect on 13 April 2011.

Under guidance issued by the Home Office, any incident of domestic violence or abuse which results in the death of the victim requires a DHR to be carried out by the local Community Safety Partnership. In East Herts this is called the East Herts Community Safety Partnership.

The purpose of the DHR is to ensure that agencies are responding appropriately to victims of domestic abuse and to apply any lessons learned through recommendations and an action plan. To achieve this, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This document contains the executive summary of the East Herts 2014 DHR. The overview report and action plan has not been made public, but are complete.

EXECUTIVE SUMMARY

1. Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of M who was murdered on 2 July 2014. She died as a result of acts committed by J, who had previously been in a relationship with M. J was arrested and charged with her murder and on 8 June 2015 he was sentenced to life imprisonment to serve a minimum of 22 years.

1.2 The following is an excerpt of the remarks made by the sentencing Judge.

"The blows you struck to her head with that hammer were so savage and brutal and the injuries caused so severe that your intention can only have been to kill her. Among the aggravating features of this horrific killing are that you have a long history of domestic violence, including convictions for assault upon M, and that you went to her home in breach of a Restraining Order prohibiting you from having any contact with her at all.

I am in no doubt that your motive for murdering M lay in the fact that you could not accept her decision to end her relationship with you and were jealous of the new relationship she had begun with a man with whom she had recently returned from holiday. She wanted to move on with her life without you but you were not prepared to permit her to do so. You decided that the only way to prevent her from finding happiness with someone else was to kill her.

Your visit to M's home on the night of the killing was the culmination of months of violent and threatening behaviour towards her including at least three separate incidents of violence. You took no notice at all of the Restraining Order imposed upon you by the Magistrates' Court on 3rd June 2014.

At the time of her death, M was the mother of a six-year old boy who was then living with his father. I have read and take account of the Impact Statement made by M's father, which fully describes the deep pain and sorrow which your appalling crime has left her son, parents and whole family having to endure for the rest of their lives".

1.2 Prior to her death there had been three reports to Hertfordshire police about domestic abuse against M, one in August 2013 which did not progress to prosecution and the others in April and May 2014, following which J pleaded guilty to assault and criminal damage and was given a suspended prison sentence, on 3 June 2014. He was also placed on probation supervision and required to attend the Integrated Domestic Abuse Programme (IDAP) as well as an Alcohol Treatment Requirement (ATR). In addition he was made subject to a restraining order.

1.3 J had previous convictions for offences against two women with whom he had a relationship; he was sentenced to a community rehabilitation order in February

2002 for criminal damage, in March 2007 he was imprisoned for 59 days following breach of a non-molestation order and in April 2008 he was sentenced to 30 months imprisonment for assault.

2. The Review Process

2.2 Following M's death a Domestic Homicide Review started on 3 September 2014 by an independent Domestic Homicide Review Panel, on behalf of East Herts Community Safety Partnership. This review was completed by the end of October 2016, and includes the considerations made by the Home Office Quality Assurance Panel on 20 July 2016.

2.3 The following agencies participated in the review by providing information about their contact with M and J. In addition the Hertfordshire County Council Health and Community Services and Hertfordshire County Council Community Safety Unit participated in the review as members of the DHR panel.

- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company (BeNCH)
- East Herts District Council - housing options team
- East Herts District Council Community Safety and Health Services
- Hertfordshire Community NHS Trust
- Hertfordshire Constabulary
- Hertfordshire County Council Children's Services
- Hertfordshire Partnership University NHS Foundation Trust
- NHS England Hertfordshire and South Midlands Area team
- Princess Alexandra Hospital
- Spectrum Drug and Alcohol Services
- Victim Support
- Westminster Drug Project

2.4 The panel included senior managers from agencies known to have provided a service to M and J as well as the county's programme manager for domestic abuse and hate crime and a representative of the County's Strategic Programme Board for Domestic Abuse. The panel was chaired by Mr Jeff Stack, Chief Executive of Broxbourne Borough Council and Ms Carole McDougall, a management consultant, was appointed as the overview report writer; neither had previous knowledge of or management responsibility for the case and both are independent of the agencies with which M and J had contact.

2.5 Family members were invited to participate in the DHR and although they did not feel able to the panel had access to their statements made to the police, and the impact statement made by M's father; a copy of the final report has been shared with the family and they have endorsed this executive summary.

2.6 Agencies known to have provided a service to M and/or J were asked to give chronological accounts of their contact prior to the M's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Where the chronology indicated that more significant contact had taken place the agency was asked to provide an individual management review (IMR), each of which covers the following:

- a chronology of interaction with the victim, perpetrator and/or their family; and analysis of involvement
- whether internal procedures were followed; and
- examples of good practice, lessons learned and recommendations from the agency's point of view.

2.7 The accounts of involvement with the victim and perpetrator cover different periods of time prior to M's death and some of the accounts have more significance than others.

2.8 As required by the Ministry of Justice, BeNCH have conducted a separate Serious Further Offence review which has informed their IMR.

2.9 The purpose of the review, as contained in the Terms of Reference agreed by the review panel, was to:

2.9.1 Establish how effective agencies (which includes organisations and community groups) were in identifying the victim's health and social care needs and providing support, taking into account any relevant cultural issues.

2.9.2 Establish the appropriateness of agency responses to the victim and perpetrator - both historically and within a month of the victim's death

2.9.3 Establish whether single agency and inter-agency responses to any concerns about domestic violence were appropriate.

2.9.4 Identify, on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures in Hertfordshire and more widely.

2.9.5 To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults and children where domestic violence is a feature.

2.10 In conducting the review the following Key Lines of Enquiry have been considered:-

- **Information:** How was information about the victim's health and social care needs received, assessed and addressed by each agency and how was this information shared between agencies?

- **Assessments and diagnosis**: What was the impact of the perpetrator's mental health on the victim's physical and mental health? Were there any recent changes in the physical or mental health of either the victim or perpetrator that

may have affected their behaviour? Was there any evidence to suggest there to be any physical conditions or behaviours that had an impact on the victim's or perpetrator's mental health? Is there any information in relation to domestic violence? Were any agency assessments completed? Were there opportunities for referral or signposting to, and within, agencies? Were there any additional needs? Were the appropriate referrals and service provision put in place?

- **Contact and support from agencies:** What contact did each agency have with the victim and perpetrator? What support did they receive and from whom? Were there any indicators or history of domestic violence?

- **Any additional information considered relevant:** If any additional information becomes available that informs the review this should be discussed and agreed by the independent chair and the review panel. The chair of the county's Domestic Abuse Partnership will be advised of the change.

2.11 The review focused on events from 1 May 2013, which was when it is understood M commenced a relationship with J, until her death on 3 July 2014.

3. Findings of the review

3.1 The findings have been drawn from a review of the contents of the IMR's and the comments made throughout the above chronology. In addition consideration has been given to how agencies measured up in respect of each of the Terms of Reference. The questions outlined in the key lines of enquiry have also been taken into account.

3.2 M's first contact with police was on 22 May 2013 when they made a welfare visit following a telephone referral from Spectrum who were concerned about her because she had threatened suicide; she was vulnerable and had undergone a failed detoxification from alcohol abuse. The police found that M was with her parents and no concerns were raised. Between 15 and 21 June 2013 M stole items from shops in her home town; she was apprehended and cautioned by the police. On 5 March 2014 M was cautioned again for an assault on a security guard who had tried to stop her following an incident of shoplifting. The police noted that M had been drinking when she stole from shops.

3.3 On 16 June 2013 the police made two welfare visits to M at her home, the first following her call to them to say she had taken an overdose and the second when she had discharged herself from hospital. Hospital staff were concerned she was a risk of suicide. The police made a further welfare visit on 19 June following a request from Spectrum and although they did not find her in they spoke to neighbours who described her as "up and down" but fine. The way police dealt with M during this period demonstrates a sympathetic and appropriate response to her welfare.

3.4 The first report of assault by J against M was made to the police on 2 August 2013. M was adamant she did not want to pursue the complaint, which had been called in by a neighbour, and J denied assault. The police response was in line with set procedures; risk was assessed as medium using Domestic Abuse Stalking and Harassment and Honour Based Violence assessment tool (DASH) and information about J's convictions for assaulting a previous partner and breach of a non-molestation order were accessed. The information was forwarded to the Crown Prosecution Service (CPS) but they concluded there was insufficient evidence to charge. The IMR completed by the police questioned whether this was an appropriate decision.

3.5 Within three weeks of this incident M reported to the police that she had received threatening texts from a male she named (not J) and the next day advised that Essex police had been in contact with her about counter allegations from her ex-partner. The police did not pursue the matter further and, as stipulated in the IMR, this was a missed opportunity to explore whether the texts were actually from J.

3.6 On 19 April 2014, there was a second report of assault by J on M. Although M was reluctant to give a written statement the police recorded what she had said using a body camera, which was considered good practice. J was arrested and interviewed when he admitted criminal damage but denied assault, and CPS decided there was evidence to charge him with the criminal damage only. DASH was used to assess the incident and this was recorded on the computerised information system as medium risk which reflected the score against the DASH criteria. The attending officer, however, thought it was high risk and wrote this on the DASH booklet which was filed in Records Management in line with procedures. Medium and high risk cases have to be reviewed by the Harm Reduction Unit (HRU) and as they take their information from the information system they will have seen this as a medium case, and took no further action. Had they seen it as a high risk case they would have considered a referral to the Domestic Violence Officer (DVO) and Multi Agency Risk Assessment Conference (MARAC), which would have provided further opportunity to assess and manage risks to M. The attending officer placed a Sig marker on M's address which meant that any further call outs would be dealt with as a matter of urgency; again this was good practice. The police IMR assessed that the fact there was a Sig marker should have led the HRU to give the case further attention.

3.7 The police made a welfare visit to M on 21 April 2014 after she had telephoned in upset about the previous days' events; her concerns were acknowledged and she was given reassurance.

3.8 After J was charged with criminal damage on 20 April 2014 he appeared in court the following day and was bailed until 6 May with conditions not to contact M and not to attend her address. Within two weeks, on 4 May 2014, he had attacked her again in her new home, to which she had moved because her landlord had asked her to leave the previous address due to the incident on 19 April. On this occasion J struck M in the face with her mobile telephone causing cuts and bruises. The incident had been reported to police by M's father and M confirmed that J had done it. DASH was used and on this occasion risk was assessed as high with a

score of 17. In line with policy the case was referred to MARAC and a DVO was appointed. The DVO provided M with information and advice on safety planning and support services which was good practice as was placing a Sig marker on M's new address. J was arrested and interviewed and admitted breaching bail conditions but denied the assault on M and damaging her mobile telephone. M was reluctant to report but did confirm J had assaulted her.

3.9 J appeared in court on 7 May and the offence of 19 April (criminal damage) was joined with the new offences of assault and criminal damage. J pleaded guilty and the CPS requested a remand in custody. However the court bailed him with conditions until 3 June 2014 for the preparation of a pre-sentence report. The police IMR expressed concern and surprise that J was not remanded in custody given that he had committed offences whilst on bail and had previous convictions for serious assaults on a partner.

3.10 The police last recorded involvement with M was on 17 June 2014. She had returned to her home, from a holiday abroad, for the first time since 29 May, and found she could not get in because the door lock had been damaged deliberately. When interviewed M referred to being targeted by her ex-partner, J, and that he had assaulted her and sent her numerous malicious texts, including when he was subject to bail conditions, and whilst she had been in Spain. Although the incident was recorded as domestic related criminal damage it was not investigated sufficiently, and in particular J was not interviewed and the links with previous events were not made by either the investigating police officer or the HRU. DASH was not completed until after M was interviewed which is not in line with policy, and may account for the medium risk rating. Had there been a more thorough investigation it would most likely have established that the crime was committed by J after he had been sentenced by the court on 3 June 2014, thus demonstrating he had no respect for the court's authority and represented a high risk to M. The DHR concluded the police missed a significant opportunity to provide further protection for M.

3.11 Following reports, from the police, of domestic abuse in August 2013, April and May 2014, Victim Support offered contact to M in line with their procedures. Although she spoke with an adviser over the telephone M declined ongoing contact. On 13 May M was referred to an Independent Domestic Violence Advocate (IDVA) via the MARAC co-ordinator, managed by Victim Support. M first told the IDVA that J was breaching bail conditions on 21 May and repeated this in subsequent telephone calls. The IDVA discussed safety measures with M and encouraged her to report J to the police. She was also instrumental in ensuring that there was a restraining order made on 3 June. On 26 June 2014 M told the IDVA about her door lock being damaged and that she had seen J at an AA meeting at which he had blamed her for his court appearance. The IDVA re-enforced that he was breaching the restraining order and that M should report him to the police. However the IDVA did not follow procedures in either completing a risk assessment or discussing the case with her manager. Although she understood M was ending the relationship and would report J to the police she had no evidence for this, and the DHR panel concluded that the threats reported to the IDVA on 30

June 2014 were so serious that this information should have been shared with other agencies as a matter of urgency.

3.12 As a result of a referral from the police M's case was considered at the MARAC on 5 June 2014. This was an opportunity for information to be shared amongst the agencies and actions agreed to help with protecting M. The meeting was advised by the police that safety measures were in place and M had said she felt safe. When later providing evidence as part of the DHR, the MARAC chair advised that MARAC members would have been re-assured by this information. Most of the actions relied on M reporting J to the police and there were no contingencies made if she did not do this. Although the meeting required actions to be completed by 20 June the minutes were not circulated until 17 June which the DHR Panel found to be poor practice given that the meeting was considering high risk cases and those agencies not in attendance, in this case Spectrum, would not have been aware of the action points until nearly two weeks after they had been agreed.

3.13 M had numerous contacts with Spectrum in respect of her alcoholism. She attended key work and counselling sessions as well as group work. She did not attend all the appointments offered, and feedback from M's parents indicates that there were occasions when staff at Spectrum were not available to see her. Overall it seems they worked hard to keep her engaged. Their own IMR stated that they did not observe the engagement and re-engagement policy sufficiently and this is being addressed by the organisation. Staff made requests to the police for welfare checks when they were concerned M might be a suicide risk. They became aware M was the victim of domestic abuse in August 2013 when she told them and they checked this out with police; they were therefore aware that the case was considered medium risk at that time. The police have no record of this contact from Spectrum and it would have been advisable for Spectrum to consider putting something in writing, to confirm what M had told them. This may have provided an opportunity for CPS to re-visit their decision not to prosecute J for the assault on 2 August 2013. The organisation did not have specific procedures for managing domestic abuse cases which are not registered at MARAC and have seen this as a learning point from the DHR which they are addressing. Spectrum were aware that M was to be considered at MARAC on 5 June 2014; although they were not able to attend they submitted a report. When they received the notes of the meeting it was not clear who had responsibility for ensuring they were circulated appropriately and as a result the recovery worker with responsibility for M did not receive them and therefore was not aware what had been discussed and decided. The organisation has subsequently worked on their procedures to make it clear who has responsibility for ensuring information is provided to and disseminated from MARAC.

3.14 In June 2014 staff at Spectrum made a referral to Safer Places which is a local resource for victims of domestic abuse. Although this was good practice it should be undertaken much sooner when they became aware that M was a victim.

3.15 M had regular contact with her GP in connection with alcoholism and related physical complaints, and was in receipt of medication. When she attended with an injury on 11 July 2013, which she explained as a fall due to drinking, the GP sent

her to A & E at Princess Alexandra Hospital. The last time M saw her GP was 10 April 2014. M did not divulge to the GP service at any stage that she was a victim of domestic abuse and this information was not passed on to the GP by other agencies.

3.16 M attended Princess Alexandra Hospital on several occasions when she was treated for her injuries and symptoms linked to alcoholism. Staff made referrals to the alcohol liaison team and Crisis Assessment and Treatment Team (CATT), in order to provide help for M. The first incident was 16 June 2013 when M attended the hospital following an overdose; documentation was not available to the hospital's IMR so there were no details other than M was not admitted to the hospital. On 11 July 2013 she had an injury which was said to be as a result of a fall. The hospital did not use their safeguarding tool to ascertain if the injuries may have been as a result of violence or unexplained. However the injuries were consistent with a fall and had they been as a result of domestic abuse it does not necessarily follow that M would have disclosed this. M was admitted for detoxification and discharged three days later.

3.17 The hospital's IMR acknowledged that there were missed opportunities to explore with M, using professional curiosity, what she described as relationship problems when she presented to A & E on 18 July, 21 August and 23 September 2013. M presented to A & E on 17 February 2014 having taken a large number of paracetamol with alcohol, and once it was established that the levels were within normal parameters she was offered the opportunity to speak with a member of CATT but she declined. M final attendance at the hospital was on 5 May 2014 when she had injuries as a result of the assault by J. She confirmed she had been attacked and that the perpetrator was in police custody. It seems no questions were asked about M's safety and there was no consideration of a referral to the Daisy Project which is a joint project between the hospital and Safer Places for victims of domestic abuse. M would have had to agree to a referral and had she done this it would have presented an additional opportunity for risk assessment and safety planning.

3.18 A letter was sent to M's GP as a result of her attendance at the hospital on 5 May but the discharge summary did not mention domestic abuse. The hospital's IMR reported that clinical recording was of varying quality, in terms of detail and legibility. Also, although there is a requirement to use body maps, these were not completed in M's case. Neither was she examined for other injuries when she attended in July 2013 which would have been expected in the case of a patient under the influence of alcohol. Had other injuries been identified, other than those M had explained, this may have triggered staff to take further safeguarding action.

3.19 CATT had contact with M on 23 May 2013 when she referred herself saying she was alcohol dependant, had low mood and felt suicidal. She described a number of problems in her life but did not disclose domestic abuse. A needs assessment and risk assessment were completed and a plan was agreed which did not require ongoing involvement of CATT. The actions required M to refer herself to MIND and ask her GP to refer her on for behavioural and alcohol related therapies. On 16

June 2013 CATT received a referral on M from the Princess Alexandra Hospital but they did not see her as she left the A & E department.

3.20 M underwent two periods of detoxification, paid for privately, with Passmores House which was run by Westminster Drug Project; the first was 25 June – 3 July 2013, and the second which was followed by three months rehabilitation, was 20 November 2013 – 12 February 2014. On arrival on 20 November 2013 M was said to be intoxicated, anxious and tearful, but settled reasonably well after a few days and coped well with the 10 day detoxification. She struggled with her emotions but had no thoughts of self-harm or suicide. She had visits from her family including her son. At her request she also maintained contact with J. During the rehabilitation period, on 12 February 2014, M was found intoxicated and in possession of alcohol. As a result of this she was discharged and arrangements were made for her to see a worker from Spectrum.

3.21 Although details are not available it is understood M attended a further period of rehabilitation in late March 2014 and it was here that she met the man with whom she went on holiday in May/June 2014.

3.22 Aside from his contact with police the DHR panel is only aware that J had contact with two agencies; GP and Probation.

3.23 J had regular, at least monthly, contact with his GP when he discussed his alcoholism and steps taken to control this, as well as his mood and problems with sleeping. From October 2013 the main concerns were medical for which he was undergoing treatment. He was referred for cognitive behavioural therapy by his GP, which was offered by the Enhanced Primary Care Mental Health team; there is no evidence he took this up.

3.24 Following his conviction for assaulting M and causing criminal damage to her property J was given a suspended sentence on 3 June 2014; this included requirements for probation supervision, attendance at the Integrated Domestic Abuse Programme (IDAP) and an Alcohol Treatment Requirement (ATR). J was also made subject to a restraining order. The pre-sentence report (PSR), which assessed J as high risk of causing serious harm to M and any future partners, was prepared by a probation officer from National Probation Service (London) as J was staying with his brother in the area. It was known by the PSR author that he would be returning to his mother's address in Hertfordshire and she should have consulted a local NPS manager about his suitability for IDAP and allocation of the case post sentence, but did not. After sentence the papers should have been sent to NPS Hertfordshire and an appointment made for his first interview with an NPS offender manager. However the papers were returned to London by mistake and when the court duty officer contacted a manager in the area of Hertfordshire to which J was returning, instead of speaking with an NPS manager she spoke with a manager from Bedfordshire Northamptonshire Cambridgeshire and Hertfordshire (BeNCH) Community Rehabilitation Company (CRC) whose service manages medium and low risk cases rather than the high risk case J was. This manager assumed she was being asked to provide an appointment for J because he was a medium risk case and she allocated his case to one of the BeNCH offender

managers. This mistake was compounded by the fact Hertfordshire did not have the relevant paper documentation and BeNCH did not gain access to computerised case files held by NPS until 3 weeks after sentence. In these circumstances the DHR panel concluded BeNCH should have accessed the information by another means.

3.25 Despite the mistakes made in allocating the case the probation IMR concluded that the OM, who was very experienced in dealing with domestic abuse cases, had managed J's case effectively and this included commencement of the pre-group work for IDAP. When the OM gained access to the computerised case records, which included all information available to the PSR author, he conducted a further risk assessment and concluded the offender was a medium rather than high risk of causing serious harm to M. In the risk management plan the OM stated that "any breaches of the restraining order would lead to risk of harm level being reviewed and potentially increased". However it should be noted that the OM was not made aware of the damaged lock incident and breaches of the restraining order reported by M to the IDVA which would have impacted on the risk assessment and risk management of the case. If J had been assessed as posing a high risk of causing serious harm to M consideration would have been given to a referral to the Multi-Agency Public Protection Arrangements (MAPPA).

4. Conclusions

4.1 Agencies in contact with M recognised her as vulnerable, initially because of her alcoholism and related health problems, and so she received support from Spectrum, her GP and the Princess Alexandra Hospital. She was given advice by CATT, and the police, whose officers conducted a number of welfare visits, demonstrated a sympathetic response by cautioning her, rather than recommending prosecution, for several events of shoplifting.

4.2 As far as the DHR panel are aware GP services was the only agency with which J had contact during the period of the review, other than police and probation which resulted from his prosecution for violence against M. He saw his GP regularly and received assistance and advice in respect of his health and well-being.

4.3 M commenced a relationship with J in April 2013 having met him at an Alcoholics Anonymous meeting. He had a history of domestic abuse against other women and it was only 4 months before the first assault of M was apparent, when it was reported to the police by one of M's neighbours. At this stage M was unwilling to confirm to the police that J had assaulted her which research suggests is not unusual for a victim of domestic abuse. Women's Aid cite a number of reasons why women do not report and those included here are pertinent in M's case; that the victim is in denial, feels somehow she is to blame, she sees that sometimes the

perpetrator is “charming”, hopes he will change and thinks she may be able to help him achieve this, and does not want to get him into trouble.

4.4 During the period in 2013 when M was subject to abuse but did not want to report it to the police, there were some events when she may have been enabled to take that step. First she was admitted to hospital on 11 July 2013 and had injuries which were consistent with her report of having fallen. The hospital did not use the available safeguarding tools to assess how the injuries had occurred and although M may not have chosen to discuss the domestic abuse this was an opportunity missed for her to disclose. Second, M told a staff member at Spectrum on 2 August 2013 that she had been assaulted and she named J. Spectrum have a record of contacting the police Harm Reduction Unit by telephone to discuss this but the police do not have a record of receiving a call. Had they been aware this would have been a further opportunity for the police to make additional enquiries and ask CPS to re-visit their decision not to prosecute J. Later in August 2013 M reported to the police that she had received abusive texts. Had this been fully investigated, it could have been another opportunity for M to disclose. In addition M referred to relationship problems when she attended A & E on 21 August and 23 September 2013, and these were both missed opportunities to explore, in more detail, what the reasons were behind these difficulties. The DHR panel considered that the knowledge of M being an alcoholic could have clouded further questioning into her situation.. As a consequence the panel concluded further training would be needed to ensure agency staff have a full awareness of domestic abuse and an ability to look beyond presenting problems.

4.5 Safety planning was discussed with M when she had contact with the police and in detail by the DVO and IDVA once J had been arrested for assaulting her. The panel considered that staff at Spectrum and the A & E Department of Princess Alexandra Hospital missed opportunities to talk to M about safety planning, and encourage her to take up specialist help through Safer Places. The DHR panel concluded that all agencies should be clear how they will conduct safety planning and what information they will provide by way of available resources for victims of domestic abuse.

4.6 Indications are that J’s risk to M was increasing after he was placed on a suspended sentence, with probation supervision, and made subject to a restraining order. The risk to M was made more significant by the fact she was moving on with her life after she had commenced a new relationship with R and went on holiday with him. J told the OM that he was not in contact with M, and he appeared to not be consuming alcohol. However he was continuing to harass M by text and this together with the lock damaging incident confirms he was not accepting that his relationship with M was over. The police officer who interviewed M after her lock was damaged did not investigate the matter fully and J was not interviewed, which he should have been. Although M had already been assessed as high risk and the appropriate referrals made as a consequence, this specific case was assessed as medium risk demonstrating that the abuse had not been connected with previous events either by the officer or within the HRU. The DHR panel understands that the police officer subsequently received formal words of advice about his practice in this case, and that HRU staff are to receive further

training. In addition the panel concluded that where a case has already been assessed high risk as M was; there should be a regular review within HRU of how the case is being managed.

4.7 Information sharing between agencies was not satisfactory. The GP was unaware that M was a victim of abuse because A & E staff at Princess Alexandra Hospital did not pass this information on after they had treated M for injuries caused by J. Had GP services disclosed this information it would have provided context to their own contacts with M and given another opportunity for safety planning and offers of assistance and support. Following the MARAC on 5 June 2014 there was a delay in the minutes being produced and circulated which was unreasonable. Although there was re-assurance from the police that safety measures were in place not all of the actions were achieved by the date stipulated, and there was a reliance on M reporting J to the police without consideration of what could be done if she did not. These factors led the DHR panel to question the efficacy of the MARAC in M's case. Those present at the MARAC understood J was returning to London, but as there were actions for the probation representative which depended on knowing who the supervising offender manager was, the DHR panel considered she should have made more urgent enquiries to establish who it was.

The panel understands that resources to support MARAC within the county have now increased, so that there are no longer delays in circulating minutes.

4.8 The IDVA was aware from M that J continued to harass her after he had been made subject to a restraining order, and this included the very serious threat he made to stab R and that M should enjoy her last few days. The DHR panel understands that the IDVA role is as an advocate for the victim but in circumstances where the threat is so serious, the panel concluded that the IDVA should have conducted a risk assessment, consulted her manager and shared information with other agencies. In the first instance this should have been with the police HRU, and given they would have been aware that J was subject to probation supervision the police should then have contacted probation. The information that J was making these threats would have significantly impacted on the assessment of the risk he posed and although any intervention would have to be carefully considered so as not to make the risk to M worse, there should have been an inter-agency discussion about how best to protect her. The DHR panel understands that as a result of the DHR the IDVA has received additional training in respect of risk assessment, disclosure of information and client confidentiality, re-enforced in management supervision and case reviews.

4.9 As part of the terms of reference for the DHR the panel has considered whether M's murder was predictable & preventable.

4.10 Based on evidence available to agencies at the time of the murder the panel did not consider that it was predictable. However there were a number of factors which increased the likelihood of it happening. J had been convicted of violent acts against previous partners and his violence towards M was escalating. He had broken into her home to assault her and although not proven, evidence suggests he had damaged her front door lock whilst she was absent on holiday. He

demonstrated little respect for the law having breached a non-molestation order and prison licence conditions in 2007 and 2009, which were in place to protect a previous partner; and prior to the murder, he breached bail conditions and a restraining order intended to protect M. He had threatened to kill M and her friend, and on the night of the murder, a fact which was not known to any of the agencies, J made threats against M to one of the AA members and later went to an AA meeting with a weapon, a hammer, which was taken off him by other AA members.

M was ending the relationship with J and moving on with her life, and this increased the risk that he would harm her.

4.11 The panel concluded there were two significant missed opportunities for agencies to protect M just prior to her death and that had action been taken, M's murder may have been prevented.

First, M reported to the police that her front door lock had been deliberately damaged whilst she was in Spain and that J had continued to harass her by text during her holiday. These were serious incidents given the assessment of risk to M was already high, and they could have resulted in J's imprisonment as he was subject to a restraining order and suspended sentence. However the police did not conduct an investigation or share information with other agencies.

Second, M told the IDVA that J had threatened her life and that of her friend, and although the IDVA encouraged M to report this to the police she did not pass on the information herself.

The panel also considered whether it could have reasonably been expected that AA members report J to the police, and concluded that without understanding the significance of J's actions and given AA expectations about confidentiality, it would not have been reasonable. Nevertheless the panel concluded that events in this case provide a learning opportunity which should be explored with AA at national level.

5. Recommendations

5.1 In its findings and conclusions the DHR has identified a number of practice issues which have given rise to the following recommendations. In addition each of the agencies which have produced IMR's for this DHR have recommendations for their agencies.

5.2 Training and Development:

5.2.1 Princess Alexandra Hospital, Hertfordshire Constabulary, Victim Support (IDVA Service) and Spectrum should assure Hertfordshire Domestic Abuse Partnership that initial and refresher training is provided to staff; drawing on the learning

from this and other DHRs including using them as case studies should be effective in enabling staff to develop their awareness and understanding of domestic abuse.

5.3 Information sharing:

5.3.1 The MARAC Steering Group should revise the terms of reference for MARAC to ensure that they include a requirement for timely circulation of the minutes of MARAC meetings.

5.3.2 The MARAC Steering Group should review the MARAC process to ensure contingency planning is in place for individual cases.

5.3.3 Victim Support should review guidance given to IDVA's to ensure information is shared where risk of serious harm is imminent.

5.3.4 All agencies in the case should re-enforce to staff the need to share relevant information in line with their information sharing protocols.

5.4 Safety planning:

5.4.1 All agencies in the case should ensure staff are clear about how they will conduct safety planning with victims of domestic abuse.

5.4.2 The Hertfordshire Constabulary Harm Reduction Unit should conduct regular reviews of the management of high risk cases.

5.5 Services to victims:

5.5.1 Victim Support should ensure IDVA's undertake risk assessments in all cases referred to them.

5.5.2 The Domestic Abuse Partnership should seek assurance that agencies are consistently providing information to victims of domestic abuse on the resources available to them.

6. Glossary

A & E	Accident and Emergency Department (Princess Alexandra Hospital)
ABH	Assault occasioning Actual Bodily Harm
ATR	Alcohol Treatment Requirement
BeNCH CRC	Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company
CAADA	Co-ordinated Action Against Domestic Abuse (now renamed safelives)
CATT	Crisis Assessment and Treatment Team, Hertfordshire Partnership University NHS Foundation Trust
CBT	Cognitive Behavioural Therapy
CPS	Crown Prosecution Service
CRI	Crime Reduction Initiatives (now Spectrum)
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment and Management Model
DASPB	Domestic Abuse Partnership Board
DHR	Domestic Homicide Review
DVO	Domestic Violence Officer
GP	General Practitioner
HRU	Harm Reduction Unit, Hertfordshire Constabulary
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
MARAC	Multi-Agency Risk Assessment Conference
MAPPA	Multi - Agency Public Protection Arrangements
MIND	Mental health charity
NA	Narcotics Anonymous

NPS	National Probation Service
OASys	Offender Assessment System
OM	Offender Manager
PSR	Pre-Sentence Report
SARC	Sexual Assault Referral Centre
TAS	Targeted Advice Service
WSO	Women's Safety Officer