STOKE-ON-TRENT COMMUNITY SAFETY PATNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

STEVEN

Died October 2018

19 years of age

Chris Brabbs

Independent Chair & Overview Report Author:

September 2022

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1. CIRCUMSTANCES LEADING TO THE DOMESTIC HOMICIDE REVIEW (DHR)

1.1 This Domestic Homicide Review (DHR) was commissioned after Steven was murdered by his mother's former partner, FP, in October 2018. The fatal assault took place early in the morning while Steven was asleep in the family home where he lived with his mother, Mrs D who had left for work.

1.2 After killing Steven, FP then took his own life the same day. When his body was found hanging in woodland near to the house, police officers found documents at the scene which raised concerns for the safety of Mrs D. On attending her home, Steven's body was found behind the bedroom door having been subjected to a violent assault with a hammer causing multiple injuries.

1.3 Two months earlier, FP had been charged with a serious assault on Mrs D which resulted in her requiring hospital treatment for lacerations to her head and an injury to her eye. Following the assault, Mrs D immediately ended their 5 year relationship.

1.4 FP was subsequently granted conditional bail twice by the Magistrates Court, first when he appeared for the original offence, and second when he was arrested for breach of his bail conditions after sending text messages to Mrs D. He was due to appear at the Crown Court the day after the deaths occurred.

1.5 On behalf of the DHR Panel, and the Community Safety Partnership, the author wishes to express our sincere condolences to Steven's parents for their loss, and to thank them for the dignity and courage they displayed throughout the review. The perspectives they shared about Steven, and events that followed the assault on Mrs D, were invaluable in enabling the DHR panel to gain a full understanding of the circumstances leading to Steven's murder, and to draw out the learning from this tragic case.

2. THE DECISION TO COMMISSION THE DHR AND TIMESCALES

2.1 Section 9 of the Domestic Violence, Crime and Victims Act (2004) requires the relevant Community Safety Partnership (CSP) to conduct a DHR to review the circumstances of a death which meets the following criterion:-

- the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related, or with whom he was, or had been, in an intimate personal relationship, [1] or a member of the same household as himself. [2]

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1 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

2 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it. where a victim lived in different households at different times, "the same household as the victim" refers to the household in

which the victim was living at the time of the act that caused victim’s death.

2.2 When the circumstances of Steven's death were first considered at a DHR Panel meeting in January 2019, the recommendation submitted to the Chair of the Community Safety Partnership (CSP) was that the above criterion was not met. This was because the victim and the perpetrator had neither been in a familial, or intimate, relationship, and they were not members of the same household at the time of the fatal incident or for the preceding two months. However, it was agreed that there was potential learning which would be best explored through Staffordshire Police and the National Probation Service (NPS) conducting single agency reviews.

2.3 However, although the CSP Chair acknowledged how a strict application of the criterion would lead to that conclusion, his view was that given the particular circumstances, a more flexible interpretation was required because there appeared to be a clear link between Steven's death and the previous domestic abuse towards his mother. In addition, for 3 years, Steven and FP had been members of the same household. Accordingly, a recommendation was submitted to the Home Office that a Domestic Homicide Review should be carried out. The Home Office agreed with this proposal.

Timescales

2.4 The DHR commenced in August 2019 when a DHR Panel meeting was held, with a different Independent Panel Chair, to scope the review and agree the terms of reference.

2.5 Three meetings of the panel were held between August 2019 and January 2020. In order to maintain social distancing measures in response to Covid 19, the remaining panel processes to discuss the findings and agree the recommendations were carried out through email and video conferencing.

2.6 The final draft Overview Report, which had been endorsed by the Review Panel during April 2021, was approved at a meeting of the Community Safety Partnership held on 11th May 2021. The report was submitted to the Home office in November 2021 after the report had been shared with Steven's parents.

2.7 The time taken to complete this DHR was affected by the consequences of the national and local action taken to respond to, and control the spread of, the Covid-19 pandemic. In part, this was because of the additional work and challenges faced by some agencies in maintaining essential services, alongside the need to progress other priorities including DHRs and other statutory reviews. In addition, although the IMRs had been submitted prior to the implementation of the lock-down, there was an unavoidable delay before the DHR chair could hold discussions with Steven's parents which is explained below.

3. SUBJECTS OF THE REVIEW

3.1 This focus of this DHR was on the following people:-

Name	**Steven**	**FP**	**Mrs D**
Relationship	**Victim** Son of Mrs D	**Perpetrator** Former Partner of Mrs D	**Previous partner** of FP, Mother of Steven

Name	Steven	FP	Mrs D
Age at time of the fatal incident	19 years old	57 years old	48 years old
Ethnicity	White British	White British	White British

3.2 Although not a subject of the review, the report also refers to Mr V, Steven's natural father, both within the background information and also the sections which cover the involvement of Steven's parents during the review process.

4. TERMS OF REFERENCE

4.1 The time period covered by the DHR was from the date of the assault on Mrs D in August 2018 to the date when the victim Steven, and the perpetrator FP, died.

4.2 In addition to the standard questions to be considered as set out in the Home Office Statutory Guidance, the scoping of the DHR identified two key issues for the review to consider: -

(i) the local Multi Agency Risk Assessment Conference processes, particularly the timescale for considering a case at a MARAC meeting following receipt of a referral;

(ii) the processes around the requests and preparation of pre-sentence reports at court by the National Probation Service (NPS). In particular there would be exploration of: -

- the time allowed for the production of reports;
- the appropriateness of the use of same day / fast delivery reports for domestic abuse offences;
- the availability of relevant information from other agencies to inform the report and any sentencing proposal submitted for the court to consider;
- the process for updating the report if the case is adjourned or remitted to a crown court.

4.3 It was agreed that the findings in relation to this case would be used to identify any wider system learning. While the exploration of the MARAC process would essentially draw out local learning, it was recognised that the findings in relation to pre-sentence reports might potentially generate national learning.

5. METHODOLOGY

5.1 The DHR was conducted in accordance with the national multi-agency statutory guidance covering DHRs [3] which explains that the purpose of the 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

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[3] first issued in 2011 and was updated in 2016

- prevent domestic violence homicide, and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

Confidentiality

5.2 The findings of a domestic homicide review are confidential as far as identifying the subjects, their families or professionals. Information is available only to officers/professionals and their line managers who participated in the DHR. Pseudonyms are used in the report to protect the identity of the individuals involved. Professionals are referred to by their roles such as GP, housing officer or police officer for example.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY

6.1 Following the panel meeting in August 2019, Steven's parents were informed by the police family liaison officer that the DHR was proceeding. In late November 2019, they received written confirmation of the process with an offer from the DHR Chair to meet them, either separately or together, in order to explain the DHR process and invite them to share their experiences and perspectives. For understandable reasons, the family did not feel able to meet at this point, partly because of Mrs D's ongoing treatment for a serious health condition, and the invitation came too soon after the anniversary of their son's death.

6.2 A meeting was subsequently arranged to take place in early April 2020 but this had to be cancelled in order to avoid the possibility of putting Mrs D's health at risk, having regard to the Government's rules introduced to ensure the safety of people within the "shielded" category.

6.3 Further contact was therefore deferred while these restrictions remained in place. It was subsequently agreed with Steven's parents that it would still be unwise to hold a face to face meeting, and therefore a Skype video call was held at the end of September 2020. This was arranged with the help of the Homicide Case Worker from Victim Support who had previously provided support following Steven's death, and who resumed involvement, with the parents' agreement, to support them through the rest of the DHR process.

6.4 The information Mrs D and Mr V shared about Steven, and the issues they raised about events leading up to his unlawful killing will be covered later in Section 13.

6.5 After careful consideration, the DHR Panel agreed that approaches would not be made to friends, work colleagues, neighbours or the wider community as this would not be proportionate and any such discussions would be unlikely to add to the panel's analysis of the circumstances relating to Steven's death, and the learning that the review has identified.

7. CONTRIBUTORS TO THE REVIEW

7.1 Chronologies and Individual Management Reviews were submitted by:

- Staffordshire Police
- National Probation Service (NPS)
- Crown Prosecution Service (CPS)
- HM Courts and Tribunal Service (HMCTS)

- Staffordshire Victim Gateway

7.2 Background information reports were also received from the Stoke-on-Trent Clinical Commissioning Group (CCG) covering the GP records, and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

The Domestic Homicide Review Panel Members

7.3 The membership of the Review Panel comprised:-

Chris Brabbs	Independent Chair & Report Author	
Jason Everett	Senior Investigating Officer	Staffordshire
Police Nick Healy	Family Liaison Officer	Staffordshire
Police		
David Mellor	Major Crime Police Policy and Review Team	Staffordshire
Leanne Barnett	Senior Probation Officer	National Probation Service
Anita Price	Senior Legal Manager Tribunal Staffordshire & West Mercia	HM Courts & Service
Sean Kyne	Senior District Crown Prosecutor	Crown Prosecution Service
Jo Moss	Project Co-ordinator	Victim Gateway
Paula Brogan	Manager	New Era Domestic Abuse Services
Kim Gunn	Designated Nurse Clinical Safeguarding Adults Group	Stoke-on-Trent Commissioning
Rachael Fitton	Senior Nurse Adult Safeguarding	Stoke-on-Trent Clinical Commissioning Group
Nathan Dawkins	Commissioning Officer Community Safety Partnership	Stoke-on -Trent City Council

Independent Chair and Overview Report Author

7.4 The independent chair of the DHR panel, and report author, was Chris Brabbs, who has been on the approved list of independent chairs maintained by the Stoke-on- Trent Community Safety Partnership since 2019. Mr Brabbs, is a qualified social worker whose career saw him holding the post of Director of Social Services in 3 local authorities. He has been an independent safeguarding and social care consultant, since 1999, and from 2006 he has specialised in carrying out the role of independent chair and overview report author of DHRs, safeguarding adult reviews, and child serious case reviews

(now child practice reviews). He had no connection with any of the agencies involved in this case.

Specialist Advice

7.5 Specialist advice was provided by a representative of the New Era specialist domestic abuse service, and the Commissioning Officer for the Community Safety Partnership.

8. PARALLEL PROCESSES

8.1 The criminal investigation into Steven's death concluded that FP, acting alone, was responsible for his death.

8.2 In March 2019, inquests were held into the two deaths. A conclusion of unlawful killing was reached in respect of the death of Steven, and suicide in respect of the death of FP.

9. EQUALITY AND DIVERSITY

9.1 The review considered paragraph 40f of the Statutory Guidance and whether there were any specific considerations around equality and diversity issues for the Panel to consider. It was concluded that none of the issues applied, and that there were therefore no additional barriers to accessing services by any of the subjects of the review.

10. DISSEMINATION

9.1 The report was shared with both parents following the meeting of the Community Safety Partnership in May 2021. The Independent Chair then held a further Skype call with them to discuss the findings and learning which they supported. They also agreed the pseudonyms used within the report to maintain confidentiality. The parents did request some minor factual changes to the report which were made, and agreed with them, prior to the report being submitted to the Home Office.

11. BACKGROUND INFORMATION

11.1 Steven continued to enjoy a close relationship with both parents, Mrs D and Mr V after their separation in 2010, staying with each of them for different parts of the week. Mrs D and FP commenced a relationship in 2013 and lived together from 2016.

11.2 The relationship between Mrs D and FP did not lead to any change in Steven's weekly living arrangements, and the DHR heard that he did not regard FP as his step-father.

11.3 There had been 3 previous occasions in 2009 / 2010 when domestic incidents were reported to Staffordshire Police involving FP and a previous female partner. On each occasion this resulted in FP being arrested but none resulted in any further criminal proceedings.

11.4 FP had eleven criminal convictions recorded between 1981 and 1997:-

- 6 for dishonesty offences
- 3 for violence offences (2 of which were for assaulting police officers)
- 2 for criminal damage (1 connected to domestic abuse)

11.5 Between March 1995 and December 2008, FP received support with mental health and anger management issues from NSCHT.

12. CHRONOLOGY

12.1 In mid August 2018, police and paramedics responded to a call from Mrs D that she had been assaulted by FP with a plate, and he had attempted to gouge both her eyes with his fingers. The assault followed an argument after the couple had been out drinking and the takeaway meal they had brought home was accidentally left behind in the taxi.

12.2 Mrs D was taken to hospital where she received treatment for lacerations to the scalp and eye lid. She had also suffered temporary loss of vision and attended the eye clinic for treatment the following day. The police completed a risk assessment using the standard Domestic Investigation Assessment Log (DIAL) [4] which resulted in a score of 3. The case was referred to the neighbourhood police team (NPT) and Mrs D was referred to Staffordshire Victim Gateway.

12.3 Following FP's arrest later that evening, the Crown Prosecution Service (CPS) authorised a charge for an offence of Section 47 assault [5] and FP was bailed to appear at court a month later with conditions not to enter Mrs D's address or have any form of contact with her. FP provided an address of a friend as alternative accommodation. [6]

First Court Appearance

12.4 In mid September 2018, FP appeared before Magistrates at North Staffordshire Domestic Violence Magistrates Court. *A* probation officer had interviewed FP on the morning of the hearing and prepared a pre sentence report. This was not read by the magistrates because the court deemed that the seriousness of the assault was not suitable to be dealt with at the magistrates' court and the case was sent to the crown court for a hearing in mid October. FP was granted bail with the same conditions previously imposed by the police. Although FP did not formally enter a plea, he indicated that he would plead guilty in due course.

Victim Gateway Involvement

12.5 Three days after that first hearing, the Victim Gateway contact and assessment team telephoned Mrs D who explained that FP would be in court the following month. Mrs D was advised to ring the non emergency police number as she was unsure of the terms of the injunction in respect of FP. Mrs D declined the offer of specialist domestic abuse support.

12.6 A few days later Mrs D re-contacted Victim Gateway to request support in making an application for criminal injuries compensation. It was identified that Mrs D would also need support with preparing a victim's personal statement for the court hearing. With Mrs D's agreement, a support worker was allocated, who made initial contact the following day.

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4 Further explanation about the use of the DIAL is included later in the report in Section 9.

5 Section 47 of the Offences against the Persons Act 1861

[6] After Steven's death, it was discovered that FP had in fact been sleeping in a wooden garden building (described as a Wendy house) on an allotment rented by Mrs D near to her house.

Breach of bail conditions

12.7 The day after this contact, Mrs D informed the police that FP had breached his bail conditions by sending her text messages on 3 separate dates in August and September – the latest received that day. A statement of evidence was taken 2 weeks later, and a DIAL risk assessment completed which produced a score of 10. This score met the threshold for the incident to be referred to the Multi-Agency Safeguarding Hub (MASH). After further evaluation, the MASH referred the case in early October for consideration through the Multi Agency Risk Assessment Conference (MARAC) process. The case was added to the agenda for the next available MARAC meeting at the end of October.

12.8 Two weeks after Mrs D reported the receipt of the text messages, FP attended the police station in response to a telephone call from the police. This followed previous attempts to contact him during the previous 3 days. He was arrested for breach of his bail conditions and brought before the overnight remand court at Newcastle-under- Lyme Magistrates' Court later that morning. The file of evidence in respect of the breach of bail provided to the CPS by the police recommended that FP be remanded into custody as there were substantial grounds to believe he would commit offences whilst on bail and interfere with witnesses.

Court appearance for breach of the bail conditions

12.9 After considering the prosecutor's application for a remand in custody, and the defence solicitor's counter application for bail, the District Judge granted FP bail with the same conditions as before until his appearance at Crown Court in mid-October. The District Judge made it clear that any further breaches would likely result in FP being remanded into custody.

12.10 The following day, Mrs D rang the Victim Gateway support worker to say a friend had told her that FP had been sent to prison for the breach. After checking, Mrs D was informed that there was nothing on the system to say he had been sent to prison. She was advised that the Crown Court hearing would be going ahead, and that she would be contacted after that hearing as to whether she would be required to attend a trial.

12.11 As outlined at the start of the report, a week later, FP killed Steven, and then took his own life the day before the Crown Court hearing.

The police investigation

12.12 In evidence given at the inquest into Steven's death, it was explained that the conclusion reached by the police investigation was that FP, acting alone, had intentionally targeted Steven. The officers' hypothesis was that by assaulting or killing Steven, the person closest to Mrs D, he would cause her the most distress possible. As well as the likelihood that Mrs D would find her son's body, FP then took his own life at a location where she might also find his body given that this was where Mrs D would routinely walk her dogs. Mrs D did suffer the additional trauma that FP appeared to have intended because after returning to the house to join the attending police officers, it was Mrs D who found a knife at the top of the stairs and that Steven's bedroom door could not be opened.

12.13 The possibility that Mrs D had been the intended victim was considered but discounted, because CCTV evidence showed that FP had had the opportunity to attack Mrs D prior to the fatal incident but had not done so.

12.14 One piece of CCTV footage captured FP leaving the allotments area carrying a small bag, and another showing him approaching the house as Mrs D was setting off to walk the dogs, at which point he ran away and hid. When Mrs D left for work, with Steven asleep upstairs, FP entered the house using a spare key [7] that unbeknown to Mrs D he must have had cut before handing his main key back when their relationship had ended.

12.15 Not long after FP was captured on CCTV going back towards the area where he was later found dead. The conclusion later drawn was that he had already killed Steven by this time which would explain why Mrs D did not get a reply when she then sent Steven a series of texts at around 6.30am and tried to call him to make sure he was up for work.

13. FAMILY EXPERIENCES AND PERSPECTIVES

Profile of Steven

13.1 Steven's parents described how Steven was a loving, very caring and polite young man. He was very family orientated, and enjoyed spending time with members of their large extended family. Mr V said it was an additional sadness that Steven was the last member of the family who might have carried on the family surname as Mr V's siblings who had children were all married sisters.

13.2 Steven was an outgoing young man who had many interests – he was a supporter of Port Vale, and had been a good footballer himself when he was younger. He was also a keen fisherman. Steven had a wide circle of friends, and was extremely popular – his parents describing how his friends continue to feel bereft at losing him, and particularly given the circumstances of his death. Steven's popularity, and the respect with which he was regarded by both family and friends, were shown by the huge turnout at his funeral.

13.3 Steven was extremely conscientious and hard working. He studied electrics and plumbing at college before opting to get a job as a welder. He had been working for his employer for 2 years and doing well. He was enjoying being able to save money for holidays, and had been excited about his first trip abroad from which he had recently returned when he was killed.

The relationship between Mrs D and FP

13.4 Mrs D informed the DHR Chair that there had been no previous violence or arguments between them. During the relationship, Mrs D had not been aware that FP had previous convictions and had been arrested in the past following allegations of domestic abuse. Mrs D only discovered this from a friend after Steven's murder who when challenged by Mrs D as why she had not told her before, had said that her view was that Mrs D would not have taken any notice.

Impact of Steven's murder on the family

13.5 Mrs D and Mr V said that the loss of Steven, the circumstances of his murder, and the events leading up to that, have had a huge impact on their lives and emotional well- being. They confirmed that almost 2 years on, coming to terms with Steven's loss is proving difficult and they have good and bad days. For Mrs D, these difficulties have been exacerbated by her having some serious

ongoing health difficulties.

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7 This key was subsequently found to be in FP’s possession when his body was discovered.

Support provided to the family

13.6 Mrs D benefits from an extremely close family network. After the original assault, Steven's parents received good support from Victim Gateway which continued following Steven's death. Mrs D expressed her appreciation when the contact ended in March 2019 with Mrs D's agreement.

13.7 After Steven's murder, the family valued the support provided by a police family liaison officer (FLO) and a homicide case worker from Victim Support. With the parents' agreement, the latter became re-involved to facilitate the DHR Chair's discussion with them, and to provide support through the latter stages of the DHR process.

ISSUES RAISED BY THE FAMILY

13.8 Steven's parents welcomed the establishment of the DHR and confirmed that they understood that this was to draw out the learning from the case and was not a process where any blame is attributed.

13.9 Mrs D and Mr V shared with the DHR Chair their concerns about the following issues:-

(i) the outcome of FP's assault on Mrs D, the offence he was charged with and the decision made by the police to bail FP pending his first court appearance;

(ii) the delay before the police took a statement from Mrs D after she reported that FP had breached his bail conditions by sending her text messages;

(iii) the decisions made by the court to grant FP bail when he appeared for the first time in respect of the assault, and again when he appeared for breach of his bail conditions.

Issue 1 The assault on Mrs D

13.10 Mrs D's view is that FP should not have been given bail by the police because of the seriousness of the assault which left her with significant injuries requiring hospital treatment and an operation. In addition, Mrs D's view, based on her experience of the assault, was that FP's actions were deliberate and pre-meditated given that he first hit her with an ornament and then jumped on her and tried to gorge her eyes out.

13.11 Mrs D remains aggrieved that in being granted police bail, FP was free to walk the streets and carry on as normal as if nothing had happened, whereas she was at home recovering, and frightened of whether he might abuse her again. The view of Mrs D and Mr V was that FP should have had to wear an electronic tag so that his movements could be monitored. This was because the conclusion they had come to was that FP must have been watching Mrs D's house for him to be aware that Mrs D had very recently resumed work - information that Mrs D had not yet shared with other people.

Issue 2 Police response to Mrs D reporting the breach of the bail conditions

13.12 Mrs D's perception of the police response to her reporting the breach of FP's bail is that they did not take it sufficiently seriously. Her view stems first from her description of how she experienced the initial response when she states she was told that "this was not a blue light job" and the nature of the breach did not meet the threshold for an immediate response. Mrs D said that in response to the question put to her at the time as to whether she was scared, she had confirmed that she was very frightened for her life, but her perception was that this did not seem to make any difference to the response.

13.13 Mrs D's initial perception, as she experienced it, that her report was not being taken seriously, was then reinforced by her description of it being 2 weeks before she was asked to go to the police station to provide a statement. According to Mrs D, when she was asked what would happen to FP, she alleges that she was told he would probably just get a "slap on the wrist". In respect of the text messages she received from FP, Mrs D told the DHR Chair that she was told by the police that it would be difficult to prove that he sent the first ones as he appeared to have borrowed someone else's phone to send them.

Issue 3 FP being given bail by the courts

13.14 Steven's parents hope that the DHR will provide them with answers as to why the court granted FP bail following the assault, and the subsequent breach of his bail conditions. They said they feel let down by the judicial system, and their belief is that Steven would still be alive if FP had been remanded into custody. Their view is that in terms of decisions made about FP, everything was done wrong from the outset.

14. ANALYSIS AND DHR FINDINGS

Introduction

14.1 The review findings from the analysis of key events are organised within the following three themes: -

- Risk assessment and management;
- The processes and factors affecting the decisions made to grant FP bail;
- Issues around the use and production of pre-sentence reports in domestic abuse cases.

15. ASSESSMENT AND MANAGEMENT OF RISK

Introduction

15.1 The following analysis explores the robustness of the risk assessments carried out at the point when reports were received of domestic abuse related incidents, and the timeliness of subsequent action to build on these in order to decide if multi-agency discussion of the case was required.

Police response to incidents involving domestic abuse

15.2 Staffordshire Police has comprehensive procedures and standards to support professional judgement in prioritising the response to incidents received by its control room and 7 possible responses were listed in the Police IMR. [8] Where it is judged that police attendance is required, this will be one of the following: -

Grade 1 (Attendance within 15 minutes)
Grade 2 (Attendance within 60 minutes)
Grade 3 (Attendance within 24 hours)

15.3 The assault on Mrs D attracted a Grade 1 Response from the police which resulted in prompt action to mobilising medical care and support for Mrs D, and the arrest and charging of FP.

Police approach to risk assessment

15.4 During the period covered by this review, Staffordshire Police procedures required a Domestic Investigation Assessment Log (DIAL) to be completed by the initial attending police officer in all domestic abuse incidents.[9] The form produces a risk assessment score based on the number of yes answers to a standard list of questions. There is space alongside each which allows the officer to add additional explanation and include their professional judgment of the situation.

15.5 In addition to informing immediate safety planning, the DIAL score informs decisions as to how further risk assessment will be undertaken as follows:-.

- 10 or less - the case is referred to the relevant neighbourhood police team with a view to discussion at the Local Partnership Hub. [10]
- 10 or above - the incident is escalated to the Multi-Agency Safeguarding Hub (MASH);
- 14 and above - the case is classed as high risk which in addition to referral to the MASH, requires an immediate referral for the case to be heard at the first available MARAC meeting.

The results will also lead into consideration of whether a referral should be made for specialist support from an independent domestic abuse advisor (IDVA). [11]

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8 The 7 responses are: (i) Grade 1 (Attendance within 15 minutes): (ii) Grade 2 (Attendance within 60 minutes): (iii) Grade 3 (Attendance within 24 hours): (iv) Resolution Centre: (v) Telephone Resolved: (vi) Police Generated Activity: (v11) CID.

9 The DIAL is similar to the DASH risk assessment form developed by Safe Lives which is used by most police forces in the UK.

10 Each of Staffordshire's 11 local policing areas has its own vulnerability hub, a local partnership which enables neighbourhood police staff to share information and agree joint activity to prevent crime and support vulnerable victims.

11 An IDVA is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. They can help a victim with everything they need to become safe and rebuild their life, and represent their voice at a Multi-agency Risk Assessment Conference (Marac), as well as helping them to navigate the criminal justice process and working with the different statutory agencies to provide wraparound support.

Risk assessment following the original assault

15.6 The DIAL completed after the assault on Mrs D produced a score of 3 which placed the incident in the standard category of risk. Accordingly, the DIAL was passed to the local police vulnerability hub for review by a sergeant. However, it had been recognised at the time by the officer completing the form that this low score did not reflect the ferocity of the assault, and the seriousness of the injuries. The officer therefore added a comment on the form to that effect.

15.7 Given that observation, the police IMR author's view was that the incident should have been escalated to the MASH when the DIAL was reviewed by the supervisory police officer. Although the supervisor could not have altered the score, he could have exercised his discretion to authorise that step. In the DHR exploration of why this step was not taken, it was noted that a possible factor that would have influenced the risk assessment was that Mrs D had ended the relationship and had no intention of considering reconciliation.

15.8 Within the DHR discussions, the domestic abuse advisor made the observation that the form should have picked up the history of FP being a perpetrator of domestic violence. Although this may not have been known to Mrs D when the form was being completed with her, this information was on police systems.

15.9 The police IMR made the observation that Steven was never interviewed in relation to either the original assault, or the subsequent breach of bail enquiries. While this was understandable given that Steven had not witnessed the original assault, nor was there any information to suggest he was at risk, he could have been a potential source of information in terms of the relationship between Mrs D and FP which may have assisted the risk assessment.

Assessment of risk when the breach of bail was reported

15.10 The police call taker assessed Mrs D's report of the receipt of FP's text messages as requiring a grade 3 response. In exploring the assessment made, the police IMR arrived at the conclusion that this did not meet the standards expected. There was very limited lateral research conducted in arriving at that grading, and there was no evidence of interrogation of the "Guardian" system [12] or links being made to the previous domestic incident.

15.11 The grade 3 response resulted in the incident being sent electronically to the neighbourhood policing team (NPT) for action. However, six days elapsed before the case was allocated. It has not been established whether this was due to high demand being experienced by the team. Once allocated, immediate action was taken to take a statement of evidence and complete a DIAL. The score of 10 reflected a number of additional risk factors. In addition to the breach, the police IMR referred to these being Mrs D reporting a second domestic incident, she was experiencing some depression, and although separated from FP, she had described living in fear of FP's aggression and controlling behaviour.

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12 "Guardian" was a database used for recording referrals and management of vulnerability in cases involving children and adults at risk and contains details

of any previous DIALs or discussion at MARAC meetings. It has since been replaced by “Niche” system which is explained later in paragraph 13.5.

Evaluation by the Multi-Agency Safeguarding Hub (MASH)

15.12 The outcome of the subsequent supervisory review was the incident being sent to the MASH. After immediate checks revealed no information was held by Midlands Partnership Foundation Trust (MPFT) and Stoke-on-Trent Children's Services in respect of Mrs D or FP, the incident was assessed as medium risk with a 10 day target for completion. When the case was allocated to a MASH researcher 9 days later, it was recognised that a request for checks had not been sent to adult social care. This additional research was completed that same day, and a referral was made to the MARAC case conference team with a confirmed assessment of medium risk.

15.13 In total, it took 13 working days [13] from the date the MASH received the referral to the case being listed for consideration at MARAC. This involved 9 working days for the MASH to complete its assessment, and 4 working days for the MARAC team to list the case. Given the volume of work to be dealt with by both the MASH and the MARAC team, the conclusion reached in the police IMR was that this amount of time was not excessive in processing what had been classed as a medium risk domestic incident. It is important to note also that there were no further domestic abuse related incidents during those 13 days.

Timing of the MARAC

15.14 During the period covered by this review, centrally coordinated MARAC meetings were held every two weeks in Stoke-on-Trent. However, there was no space on the agenda for the case to be discussed at the next meeting. This meant that the case would not have been heard until five weeks after the date of the referral being received by the MASH. In the event, following the death of Steven, the case was brought forward to be heard at MARAC the following week – two weeks earlier than originally scheduled.

15.15 The implications for risk management which flow from this time delay have previously been recognised by the police and partner agencies within the Community Safety Partnership. Action that has already been taken to address these will be explained in more detail later in the report.

Risk management following second court hearing

15.16 As the assessment of risk had been classed as medium, there was no additional police involvement with Mrs D after FP was granted bail for the breach, and their role was limited to monitoring his compliance. The DHR heard that had the case been assessed as high risk, then an action plan would have been drawn up by the police which may have resulted in Mrs D being visited every day. However, that level of risk did not apply in this case.

16. ANALYSIS OF PROCESSES RELATED TO BAIL DECISIONS

Introduction

16.1 Before considering the processes around the granting of bail, it is important to clarify that it is not within the remit of a DHR to question or comment on decisions reached by the courts. These can only be reviewed through further judicial appeals processes laid down in statute and court rules.

13 MASH and MARAC staff work weekdays only.

16.2 Accordingly, the DHR's focus was confined to exploring two issues. First what factors did the police and CPS take into account in formulating their position on the bail question at various stages of the case. Second, was the robustness of the preparation and presentation of those positions at the court hearings.

Police Bail following Charging Advice from CPS

16.3 The evidence file submitted to the CPS by the police seeking authority to charge FP following the assault, included the NPCC [14]/ CPS Domestic Violence Checklist which indicated that the risk assessment had been categorised as '"standard". Consequently the Custody Sergeant was considering granting bail with conditions not to contact Mrs D. At this stage in the proceedings, it is the Custody Sergeant who decides whether a defendant is to be kept in custody or granted bail.

First Court Appearance

16.4 In considering the issue around the court granting FP bail, the DHR was informed that the following factors would most likely have been taken into account:-

- at that stage there were no reported breaches of the police bail conditions;
- FP's last conviction occurred in 1997;
- there had been no previous incidents between FP and Mrs D recorded on police systems;
- none of the previous domestic related allegations about FP's involvement with his previous partners had resulted in criminal charges.

16.5 It is important to highlight that at the time of the first hearing, the police, and therefore the CPS, were not aware that FP had breached his bail conditions by sending text messages to Mrs D.

Response to Mrs D reporting the breach of bail conditions

16.6 The four text messages sent by FP were as follows:-

Text 1 "U ok x if u don't want txt then don't answer and I wont text again"

Text 2 "As u know im in court in the morning and as iv seen u 4 the first time 18 days later 2day since that Sunday im going take a chance and txt u. can I trust u 2 keep it between us plz"

Text 3 Same day "Im sorry il delete ur number now hope ur happy with ur new partner"

Text 4 8 days later "Thanks 4 asking if im ok im very grateful. Im not brill at the mob bv il get there.Hope this is btween us 2 only thanks again. X"

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14 The National Police Chief's Council brings police forces in the UK together, working with the College of Policing to develop joint national approaches on

criminal justice, value for money, service transformation, information management, performance management and technology. It has responsibility for the national operational implementation of standards and policy set by the College of Policing and Government.

16.7 The DHR Panel agreed that it was important to include in the overview report the full content of the 4 text messages sent by FP because these were viewed by the court and formed one part of the information that would have been taken into account when the court reached the decision to grant FP bail. Taken at face value, the content did not contain any direct threats which might raise concerns as to whether Mrs D's safety was being placed at risk.

16.8 The DHR Panel did acknowledge however the important observation made during the discussions that any contact received from an alleged perpetrator, irrespective of its content, could in itself be experienced as threatening by a victim of previous domestic abuse.

16.9 Mrs D has been clear throughout with both the police, and the DHR Chair, that she did not reply to any of the text messages. It is important to emphasise that at this point because the panel was mindful that the content might infer that Mrs D had replied to some of the texts, and there had been more contact than just these 4 messages.

16.10 As outlined earlier, the police had made 3 or 4 unsuccessful attempts during the previous days to contact FP before this was achieved and he attended the police station as requested. The DHR was informed by the police that further exploration of what prompted FP to send the texts was not considered necessary as the evidence of the 4 texts being sent was sufficient to establish that there had been a breach of the bail conditions. With the benefit of hindsight, further investigation at this point might have informed the updated assessment of risk that was carried out.

Second court appearance for breach of the bail conditions

16.11 The DHR heard from the HM Courts and Tribunal Service that the judicial decision to grant bail was an informed decision made in accordance with the Bail Act 1976.

16.12 The CPS representative on the DHR Panel confirmed that the prosecutor at court had received all the relevant evidence from the police relating to the breach and the original assault, and was well prepared to make the application for a remand in custody. The observation was also made that the prosecutor was very experienced, and CPS had assured itself through its own review, that the case had been presented robustly.

16.13 In addition, significant contextual information was that statistics showed that victims of domestic abuse were well served by the CPS in the West Midlands region which achieves some of the highest figures in the UK for successful prosecutions of domestic abuse cases. As a consequence, it was reported that other CPS areas frequently sought their advice.

16.14 The DHR was informed that in circumstances where an application for a remand into custody has been unsuccessful, the prosecutor has a right of appeal to the crown court under section 1 of the Bail Amendment Act 1993. In considering whether an appeal is appropriate, CPS guidance explains that the key factor to consider is the level of risk posed to a victim, a group of victims or the public at large. This risk may be shown to be greater where there is:-

- a record which discloses previous convictions, particularly of a similar kind against the same victim, or victims with similar characteristics;

- evidence of violence, or threats of violence, to the victim or his / her family;
- evidence of undue influence over the victim, for example where there are alleged sexual offences against young people or children.

16.15 The CPS view that the court's decision to grant bail was not one where it would have been considered appropriate to lodge an appeal. Relevant factors in reaching this conclusion were: -

- the nature of the breach;
- the fact that FP had surrendered to the police station which was where the arrest took place;
- the lack of relevant previous convictions;
- the absence of threats or recent reported violence to Mrs D since the original assault.

17. ISSUES AROUND PRE SENTENCE REPORTS (PSRs) FOR COURTS

17.1 As previously outlined, a key question to be explored through the DHR is whether the process and time limits for the preparation of pre-sentence reports (PSRs) [15] in cases involving offences of domestic abuse might compromise the safety of victims, and the wider public. This line of enquiry stemmed from factors identified by NPS during the scoping of the review that there were gaps in information in the FP report, and some concerns about its overall quality.

17.2 Before setting out the DHR findings, it is first necessary to explain the context in terms of national policy and practice.

Reforms to court processes

17.3 During 2015 and 2016, reforms were implemented to the magistrates' court and crown court processes to deliver increased efficiency and create a swifter justice system with fewer hearings. A key objective was to increase the number of cases being completed at the first hearing, so that these can proceed to sentence immediately following a guilty plea or conviction, and avoid adjournments and delays to sentencing. The benefit for victims and witnesses would be they're not experiencing the additional distress that delays can cause.

17.4 The 2015 Transforming Summary Justice reforms covering the magistrates' courts included the creation of specialised courts to deal with domestic abuse cases, and the introduction of a range of performance targets. These included measuring the time between the first listing of cases to completion and the number of hearings per case. One development from these changes was the Police and CPS now using a single digital file to ensure swift transfer of all relevant information required for the court hearing.

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[15] The legislative framework for PSRs is contained in sections 156 to 159 of the Criminal Justice Act 2003 subsequently amended by the Legal Aid Sentencing and Punishment of Offenders Act 2012 and Offender Rehabilitation Act (ORA)

2014. The PSR informs the sentencing process and assists the subsequent management of the offender by providing insight to an individual's offending behaviour and future risk.

17.5 One change introduced by the 2016 Better Case Management reforms of the crown courts to reduce the number of hearings per case, was that a PSR would no longer be required unless there is a realistic prospect of an alternative to custody, or a need for an assessment of dangerousness. This stemmed from a recommendation in the Leveson review [16] that greater use could be made of the discretion to dispense with reports, and make increased use of either oral, or previous reports.

Arrangements for provision of pre-sentence reports

17.6 Sentencing Council guidance [17] provides flexibility on when a PSR should be requested, and the type keeping in mind the policy objective that sufficient information is provided to the court to enable sentencing at the earliest stage of the proceedings.
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17.7 Responding to the new expectation that advice is available on the day, the NPS re- organised its court services teams and processes. It also introduced new guidance [19] covering the provision of pre sentence reports (PSRs) which can be one of three types:-

- Oral reports
- Fast Delivery Reports (FDRs) *(***sometimes referred to as "same day" reports***)*
- Standard Delivery Reports (SDRs).

17.8 NPS guidance [20] set out the following targets on the use of the different PSR formats:-

- Oral reports to increase from 27% to 60%,
- FDRs to reduce from 50% to 30%
- SDRs to reduce from 22% to 10%.

17.9 Oral reports are intended to focus on answering specific queries from the court to inform sentencing. FDRs are shorter written reports which are prepared and submitted on the day of the court hearing, or after a short adjournment if important information is not immediately available. These are best suited for cases where the information may be too complex or sensitive to be presented orally. SDRs are usually reserved for cases that either require an assessment of dangerousness, or involve issues around safeguarding of children.

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16 Leveson (2015) Review of Efficiency in Criminal Proceedings.

17 The Sentencing Council for England and Wales promotes greater consistency in sentencing, whilst maintaining the independence of the judiciary. The Council produces guidelines on sentencing for the judiciary and criminal justice professionals and aims to increase public understanding of sentencing.

18 The requirement for a written report was removed by the 2003 Criminal Justice Act.

19 Determining Pre sentence Reports - Sentencing within the new framework (PI 06/2016) – issued 22nd January 2016 - updated March 2017

20 NPS National Operating Model: Economy, Efficiency and Excellence (E3), 2016

Time challenges in preparing reports

17.10 The time allowed for the completion of the different type of

reports is:- Oral report 2 hours 10 minutes

Fast Delivery / Short Format Report 3 hours 50
minutes Standard Delivery Report 8 hours

17.11 These time allocations require the report author to interview the offender, write the report, if this is not an oral report, update the case allocation form, calculate the Rehabilitation Activity Requirement (RSR), [21] and send requests for relevant information from the police and other relevant services such as social services, mental health, and drugs and alcohol services. The perspective of the NPS panel representative is that covering all these elements is extremely challenging within the time allowed.

Impact of the Reforms

17.12 The 2018 report from the Centre for Justice Innovation (CJI) [22] found that the total number of pre-sentence reports had reduced by a third in six years [23] with the sharpest falls in the magistrates' courts. Oral reports had nearly doubled in the previous 3 years, while both forms written reports had fallen sharply over the same period. [24] The use of FDRs also fell by roughly a quarter, while still remaining higher than the targeted 30%.

17.13 The report raised concerns that the combination of the reforms, and reduction in NPS funding, had hampered the ability of probation officers to deliver high quality pre- sentence advice in the more complex cases which had been classified as only requiring a fast delivery report. Its findings were that reports were not always as robust as they ought to be. In addition, the very low use of SDRs raised concerns as to whether all relevant information to support safe sentencing is being presented in every case.

17.14 There had previously been some corroboration of these concerns in relation to the quality of fast delivery reports in the findings of the Probation Inspectorate's review a year earlier. [25]

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21 The Rehabilitation Activity Requirement (RAR) was introduced by the Offender Rehabilitation Act 2014. It is a single new requirement that the court can include as part of a participants Community Sentence.

22 "Renewing trust: how we can improve the relationship between probation and the courts" - Centre for Justice Innovation (CJI). This followed its interim report in July 2018 "The changing use of pre-sentence reports"

23 from 185,000 in 2012/13 to 124,000 in 2017/18. In 2017/18,

24 the use of oral FDRs has nearly doubled, from 29% of all reports in 14-15 to 57% last year. Written FDRs have fallen by a quarter, from 53% to 39% and SDRs have fallen from 19% to only 4%.

25 HMI Probation (2017) The work of probation services in courts. p22. More than 90% of the Oral FDRs in their study were of sufficient quality to inform sentencing

17.15 While it was concluded that almost all the oral reports examined were sufficient to support sentencing, with magistrates and judges expressing satisfaction with the report quality, the short format written reports did not meet the quality expectations. In particular, the assessments of the risk of serious harm (ROSH) were not always sufficiently thorough due to relevant information not being available, and there were deficits in the offence analysis because of lack of exploration of the impact of offending on victims and their safety. As a consequence, the extent to which the recommendation was the same as the sentence passed was lower than for oral reports.

17.16 It was in the knowledge of these findings that the DHR approached its exploration of the issues around the production of the PSR in this case.

Issues around the request for the report in this case

17.17 The DHR heard from HMCTS that a PSR would not usually be requested where the defendant has either not entered a plea, or where the case is likely to be remitted to the crown court. On this occasion, the court file had been prepared as an anticipated not guilty plea file and therefore the case would not have been flagged up for a report at the start of the day, unless the defence solicitor had indicated that a guilty plea would be entered which did not happen.

17.18 HMCTS also explained that a PSR would normally be requested by the crown court if the latter decided this is required. In this case, further checks by HMCTS of its records during the DHR confirmed that when FP's case was sent to the crown court for trial, a Better Case Management Form was completed which stated that there could be a possible guilty plea, and the PSR box request was ticked

17.19 Given this information, which reflected the usual arrangements in these situations, the DHR explored why a fast delivery report was produced when FP appeared at court for the assault on Mrs D. Unravelling this issue did not prove straightforward.

17.20 This was because further checks carried out by NPS during the DHR confirmed that according to their records, the request had been received from the magistrates' court at the start of the day's business. Accordingly, the probation officer prepared the report with the expectation that the case was to be sentenced that day under the powers available to the magistrates' court as no indication had been received from the court that there was a possibility that the case would be sent to the crown court.
[26]

17.21 The conclusion reached through the DHR process was that this was a one off event which did not reflect normal practice, and that there was a misunderstanding and / or miscommunication about the approach the court was intending to take of sending the case to the crown court. All four agencies involved in court processes, the police, probation, CPS and HMCTS, agreed that they had never experienced this situation before.

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[26] During the panel discussions, NPS made the observation that it is helpful if the

court gives an indication in advance of how serious it views the offence as this avoids having to “second guess” the court’s intentions, and assists the probation officer’s approach to exploration of the sentencing options with the defendant and any recommendation made in the report.

17.22 In the event, although the report was submitted, HMCTS was able to confirm that the PSR had not been read by the magistrates in reaching his decision to remit to Crown Court and grant bail. NPS also confirmed that once the case was referred to the Crown Court, the service had no further involvement and the report was not updated for that hearing.

Issues around the production of the report

17.23 In addition to the face to face interview, the report was based on the CPS file containing previous conviction data, the victim statement, and police information about the assault which included photographs showing the extent of Mrs D's injuries.

17.24 As is standard practice, the probation officer also applied for information from the police regarding any previous domestic abuse call outs in relation to FP over the last 12 months. [27] This information was not received back from the police on the day.

17.25 The Report contained information provided by FP which had not been verified and now known to be inaccurate. Although there was a general disclaimer in the report that none of the information provided by FP had been verified except where stated, the fact that the report did not clarify that information from other sources had not been verified could have potentially led the court to conclude that they had been. The Probation officer acknowledged during the NPS review for the DHR that this was a significant error.

Assessment of the information provided by FP

17.26 Information gained from FP about the circumstances of the original assault elicited some important insights as to how FP experienced his relationship with Mrs D. The interview also drew out previous issues around anger management, mental health issues and his reliance on alcohol as a coping mechanism at times of high stress and difficult emotional situations. For example, FP said that he had resorted to drinking alcohol on a daily basis, and had experienced a period of depression when his previous twenty year relationship broke down.

17.27 As regards the assault, FP described how he was in a highly intoxicated state and feeling angry. He explained that this stemmed from how he experienced some insecurity over the course of the relationship, he had felt threatened with eviction from the property, and that his character has been discredited by Mrs D during conflict between them in the past.

17.28 The NPS IMR made the observation that minimisation of the seriousness of an assault, and/or victim blaming is not uncommon in perpetrators' accounts in domestic abuse cases, There is an expectation therefore that reports should not only reflect the defendant's perspectives, but also insert adequate challenge and distance where there is a clear conflict with the known facts of the offence such as the extent of victim injury.

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[27] Where sufficient reason is identified, probation officers can request an extended DV Police check exceeding the average one-year check currently undertaken, but that this was not felt to be necessary in this case.

17.29 The NPS finding was that there was insufficient exploration of the severity of the attack on Mrs D in relation to a relatively minor issue, and the report should have reflected this. There was also a lack of a rigorous examination of a possible pattern of abusive behaviour given FP's reference to there having been previous conflict within the relationship.

17.30 The NPS IMR noted that the probation officer included the observation in her report that during the interview, FP had been extremely reticent and had struggled to articulate his emotions. During discussions with the NPS IMR author, the officer conceded that she had given FP the benefit of any doubt in seeking to fill the gaps.

Appropriateness of the recommendation

17.31 The inclusion of sentencing proposals that are commensurate with the seriousness of the offence is a core role of the PSR. The right sentence can protect potential future victims by finding effective tools to manage risk in the short term while building towards a long-term reduction in re-offending. In developing their sentence proposal, NPS officers draw on the findings of a range of assessments which aim to assess the level of risk an offender poses.

17.32 NPS confirmed that the report author had explored all possible sentencing options with FP and that this included the possibility of a custodial sentence. However, the assessment of the likelihood of re-offending using the Offender Group Reconviction Scale [28] indicated that FP posed a medium risk of reconviction. [29] This result led to the recommendation that the court consider a community order. The rationale for this recommendation was that FP had taken full responsibility for his actions in relation to the assault on Mrs D, he had acknowledged its seriousness, and he had had no convictions for nineteen years.

17.33 However, the NPS IMR concluded that despite these factors, the specific community alternatives proposed were not sufficiently robust to constitute a viable alternative to custody, and an accredited programme [30] would have been a more credible proposal that the SIADA workbook. [31] The IMR acknowledged that this observation was made with the benefit of hindsight, and the knowledge that that the case was committed to the crown court, but remained a valid finding given the severity of the incident.

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[28] The Offender Group Reconviction Scale (OGRS) is a predictor of re-offending based only on static risks – age, gender and criminal history. It allows probation, prison and youth justice staff to produce predictions for individual offenders.

[29] The score of 49% and 66% indicates an actuarial calculation that, out of 100 people with FP's offending profile, 49 may be reconvicted within twelve months and 66 within two years.

[30] Accredited Programmes are nationally approved courses designed to tackle the root causes of offending. They are included as conditions of a sentence, meaning they have to be completed or the offender will be taken back to court to receive a more serious sentence.

[31] Structured Intervention to Address Domestic Abuse (SIADA) workbook aims to address the behaviour of perpetrators of Domestic Abuse against partners or ex partners.

18. EXPLORATION OF THE WIDER SYSTEM ISSUES RELATING TO PRE SENTENCE REPORTS

18.1 From the findings in respect of the PSR in this case, the DHR went on to explore the wider issues around:-

- the return of police call out information;
- the approach to safe sentencing when information is not available;
- the possibility of adjournments where information is not immediately available;
- the practice in relation to updating of reports.

Importance of police domestic abuse call out information

18.2 There were different views expressed during the DHR discussions as to what weight the court would give to the call out information. However, its importance has been highlighted in national research which has shown that a number of incidents may have taken place before a victim seeks assistance or a prosecution is pursued.

18.3 NPS guidance on cases involving serious sexual or violent offending, including domestic abuse cases where there is a current assessed risk to others, sets out how the extent and detail of previous incidents of domestic abuse can significantly alter a risk assessment and suitability for sentencing options. Therefore wherever possible, information on these should be available to inform sentencing. Where this is not available, “safer sentencing” principles are followed which are explained later in this section of the report.

The local position on return of call out information

18.4 Data provided by NPS for this DHR revealed that information was only returned on the day in approximately 33 per cent of reports produced, and that taking the return times overall for all requests made, the average return time is 4.5 days. One of the factors affecting the turn round time is that the police email / call-centre that the request is sent to, is not exclusive to enquiries made by NPS. The DHR heard from the police about action that has been taken by the police to speed up the response.

18.5 The DHR established that the probation officer might be able to obtain the call out information from the police file passed to CPS. However, the NPS representative explained that although the probation officer does receive a copy of the CPS digital file, the limited time available to prepare the FDR meant that it is not possible to read this in detail making it challenging to locate the relevant information quickly. In FP’s case for example, the CPS document was 41 pages long.

The approach to safe sentencing and adjournments

18.6 These results illustrate the tension that can arise between same day reporting and safe sentencing which remains an active issue under consideration for NPS and HMCTS.

18.7 The thrust of NPS national guidance is that increasing the safety of victims is more likely if sentencing takes place as quickly as possible. This is because

interventions will commence sooner in terms of supervision of the offender, further risk assessment and management.

18.8 Where information from other agencies is not available on the day, NPS guidance on “safer sentencing” [32] emphasises that the report writer must form a professional judgement as to whether this could have a direct bearing on sentencing or whether the information could reasonably be followed up as part of the post-sentence risk management of offenders. The determining factors will be the offence type, and whether the outcome of enquiries could significantly alter the court’s view of the appropriate and proportionate sentence for the offence. However, the court must always be informed of any requests made where the response has not yet been received, and NPS should hold a case review once the information is received as part of the case allocation process post sentence. [33]

The NPS approach locally

18.9 The DHR heard that local NPS senior managers have given clear direction to its court team that where there are complex issues, or information is not available to support sound risk assessment, the preferred option to ensure adherence to the “safe sentencing” approach is for a stronger sentence to be recommended than the offence would usually warrant. [34] However, where it is considered that the outcome of the requested information might alter the sentencing proposal, then an adjournment must be requested to enable the checks to be concluded.

18.10 The DHR received reassurance that where this is the probation officer’s view, requests for an adjournment are made. The DHR Panel noted that this decision is entirely one for the court to make, but heard that the experience of probation officers is that these would usually be considered where either NPS or the court felt that safe sentencing might be compromised. The length of adjournments granted can vary between a matter of days, or up to 3 weeks depending on the time required to obtain sufficient information and complete the risk assessment.

Updating of reports

18.11 Although theoretically there would be an opportunity for the pre-sentence report to be updated between the committal and crown court hearing, the DHR was informed that the NPS is not expected to update the report when a case is not heard on the day, and would only do this if requested by the Court. NPS also explained that the updating of PSRs by probation officers would not be feasible because it would only in very rare situations that they would have any further contact with the defendant following the interview to produce the PSR.

18.12 This is the case even where the probation officer receives new information or considers that the remittal to Crown Court might require a change to their original recommendation. In these circumstances, the DHR heard that presentation of new information at subsequent hearings would be reliant on this being put to the court by the prosecutor. Where this happens, it was noted that the court can ask for an oral report from a probation officer to advise on its significance.

32 NPS Court Report Performance Improvement Tool – 2016

33 In line with PI 05/2014 Case Allocation and PI 57/2014 Process for Community Rehabilitation Companies to refer cases in custody or the

community to the National Probation Service for Risk Review, including escalation.

34 This might be a recommendation for a full programme - for example an offender being placed onto Building Better Relationships with a 2 year operational length of a Community Order or a suspended sentence order (SSO).

19. CHANGES IN STAFFORDSHIRE POLICE AND MULTI-AGENCY PROCESSES SINCE THIS CASE

19.1 Since this case, a number of changes have been, or are in the process of being implemented, which will help to address the issues that this DHR has identified.

Triage system in the police control room

19.2 During October 2018 Staffordshire Police introduced a mechanism within the control room process to quality assure all incidents that attract a Grade 3 Response. As a result when calls are forwarded electronically to neighbourhood policing teams (NPTs) for action, they are simultaneously sent electronically for triage – a separate and comparatively new control room function. Where a grade 3 response is considered to be inappropriate, possibly because of insufficient interrogation of intelligence databases, the incident is re-prioritised as grade 1 or 2.

19.3 A further benefit of the triage process is that it identifies good practice or areas of professional development that are shared with control room personnel to supplement the existing training and development courses provided. The DHR heard that this case may be used as a scenario within future training to reinforce the necessity of interrogating all available information and intelligence to identify the appropriate response grading.

Resolution Centre

19.4 This is an alternative process for responding to incidents from personnel within the control room rather than these being re-directed to NPTs. At the time of this case, this arrangement was in its infancy but has since become more firmly embedded. This has seen a reduction in the number of incidents being sent to the NPTs for action. Coupled with the appointment system now operated by NPT's, the police assessment is that the response to grade 3 incidents has improved.

NICHE record management system

19.5 From April 2020 Staffordshire Police introduced NICHE which is a common police platform replacing numerous individual record management systems, and enables all information relating to incidents, intelligence, safeguarding records and personal data to be in one place. The system therefore enables faster application of current police processes and decision-making, including access to information required to make referral to partner agencies. [35] Given the relatively recent implementation of the new system, the DHR heard that the force is continuing to develop and refine NICHE operating practice and performance reporting.

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35 The system includes automated referral pathways into the MASH, to schools where support can be provided to a pupil affected by a domestic abuse incident, and to social care services so that further assessment can take place. These notifications are now auditable through the NICHE system

bringing improved accountability.

Harm Reduction Hubs and MARAC

19.6 Following evaluation of 2 pilot schemes, Harm Reduction Hubs (HRH) were introduced within all the ten Neighbourhood Policing Teams (NPTs) from October 2019 to replace the previous vulnerability hubs. This change has strengthened the multi-agency arrangements to identify people at risk of harm, share information and co-ordinate action to assess and manage identified risks. In addition to helping to build the resilience of those at risk, the Hubs address the behaviour of those who are seen to causing the most harm within communities with the aim of achieving a change in their behaviour.

19.7 Within these revised arrangements, each Hub has a Vulnerability Co-ordinator who is responsible for overseeing the process of triaging referrals, and ensuring relevant intelligence is gathered. This includes identifying high risk cases that reach the threshold for discussion at a MARAC. They also have responsibility for ensuring all actions are completed by partner agencies to mitigate risk and improve outcomes for victims and families. The introduction of the use of Microsoft Share-point [36] is enabling information on case developments, and progress of agreed actions, to be updated and viewed immediately by partner agencies. An additional advantage of the new arrangements is that specific Independent Domestic Violence Advisors (IDVAs) from New Era are now linked into each of the hubs.

19.8 A further important development is that revised MARAC arrangements have been rolled out across Staffordshire with the previous centralised meeting replaced by local meetings held weekly in each of the HRH areas. [37] This will further enhance effective and speedy co-ordination of the response to high risk domestic abuse cases. It should be noted that in Stoke-on-Trent, there are separate MARACs within each of its 2 policing areas. The structure for the revised MARAC arrangements also includes a Quality Assurance Officer to maintain an overview of their operation to ensure a consistent service is delivered across all localities, and to identify any further development or training needs.

Replacement of the DIAL

19.9 A further change which is designed to strengthen the assessment and management of risk has been the adoption by Staffordshire Police of Public Protection Notices (PPN) from May 2020 as part of the implementation of the NICHE system. For domestic abuse cases, this has resulted in the DIAL being replaced by the DASH PPN (Domestic Abuse, Stalking and Harassment Risk Indicator Checklist). This change means that Staffordshire police's risk assessment tool is now aligned with that already used by most other police forces and partner agencies.

19.10 The benefit of the new tool is that it helps to identify risk more effectively, recognise continuing abuse, and in particular, coercive control. This is because in addition to going through the standard questions with victims, police officers are required to include in a "free text" section, their assessment of the risk – low, medium, or high – and the reasons for the assigned level of risk. This also enables officers to include any aggravating factors that may increase the victim's vulnerability. This has addressed the difficulty which could arise previously if victims did not engage with the DIAL process, or officers considered the risk to be greater than the risk score based on victims' perceptions and their answers to the set questions.

36 SharePoint is Microsoft’s web-based system to support collaborative working by a number of teams.

37 These are chaired by a mixture of Neighbourhood Policing Commanders Community Safety Partnership Mangers, the Fire and Rescue Service and other partners across the localities.

19.11 It is important to include here the finding of the DHR that even if the DASH PPN had been in operation at the time of the case, it would not have affected the risk assessment.

20. FINAL CONCLUSIONS

20.1 The overall finding of the DHR was that the unlawful killing of Steven by FP could not have been anticipated. According to Steven's parents, he and FP had a good relationship and there had been no indication of any problems or any antagonism between them.

20.2 The review also established that prior to the assault on Mrs D in August 2018, that there had been no issues around domestic abuse, or coercion and control within her relationship with FP. In arriving at this finding, the DHR panel noted that Mrs D had always been very open and honest about all aspects of the relationship during her many contacts with the Police Family Liaison Officer, the Victim Gateway support worker, and the Homicide Case Worker from Victim Support.

20.3 A key issue which influenced professionals' risk assessments was that they had received confirmation from Mrs D that she had ended the relationship. FP appeared to have acknowledged this as shown by his comments to the probation officer that he was aware that Mrs D had "moved on" and had started a new relationship. The fact that Mrs D had started a new relationship soon after the end of their relationship may have been a "tipping point". National research has identified that the ending of a relationship can be one possible trigger for domestic homicides.

20.4 Although there had been no previous violence in FP's relationship with Mrs D before the assault in August 2018, the background information indicates there had been previous issues around FP being capable of violence. In addition to the incidences of domestic abuse in his previous relationships, FP had 3 previous convictions for violence when he was younger.

20.5 FP also had long standing issues around anger management and mental health issues which led to his receiving help intermittently from the mental health trust over a period of 13 years between 1995 and 2008. The issues emerged during the interview with the probation officer and the PSR indicated that these were still current issues for FP in the way he talked about his feeling insecure within the relationship and his resentment that he felt his character had been, in his words, "besmirched".

20.6 As outlined earlier, with the benefit of hindsight, the NPS finding was that these issues were not explored sufficiently, particularly the fact that FP committed such a serious assault on Mrs D in response to what in effect was a fairly minor frustration over the take-away meal being left behind in the taxi. However, that information elicited during the PSR preparation remained unknown to the police, the CPS or the court because the report did not play any part in the 2 court appearances that resulted in FP being granted bail.

20.7 Even if the PSR had been read by the court, it is unlikely that this would have altered the decisions to grant FP bail. The earlier analysis listed the key factors which would have been relevant to those decisions. These included the relationship having ended, there had been no previous reported incidents of domestic abuse towards Mrs D prior to the assault, there had been no further threats made by FP, and he had surrendered to the police when requested

following the breach of his bail conditions. A significant finding of the review was that given all of these factors, the decision to grant bail on this occasion and refuse the application for a remand in custody was not one where the police and CPS considered that an appeal was warranted.

21. LEARNING FROM THIS DHR

Single agency learning

21.1 The Police IMR did not identify any specific new learning from this case which required a single agency recommendation for any changes to policy, practice, or police processes. The DHR panel was informed that following the fatal incidents the police had self-referred to the Independent Police Complaints Commission who found there had been no breaches of procedures. As outlined earlier in Section 13, the Police IMR referred to a number of changes that have previously been made to policy, practice and organisational arrangements which would address any similar situations in the future that featured in this case. In addition, during the completion of its IMR, Staffordshire police provided advice to relevant officers in the light of its own findings.

21.2 The agency reviews by the CPS and HMCTS also did not identify any learning from this case.

21.3 Although this case was not referred for support from New Era, it has nevertheless identified learning for its agency when dealing with similar situations in the future. This stemmed from the involvement of its manager on the DHR panel as a specialist advisor on domestic abuse.

21.4 The significant lessons highlighted by New Era were:-

- the perpetrator's history of domestic incidents was not taken in to account;
- the context of the coercive control was not recognised;
- the finality of the situation with the perpetrator having nothing to lose.

21.5 To raise awareness of these factors, New Era is requiring all its practitioners to receive training on "The Homicide Timeline" research published by Jane Monkton- Smith which sets out the eight steps discovered in almost all of the 372 domestic homicides studied. [38] The objective of providing this training is to enable practitioners to understand the often hidden nature of coercive control, and the escalation of risk when it is challenged, so that this is taken into account into safety planning.

21.6 As outlined earlier, the NPS identified some issues about the accuracy and quality of the report while setting these in the important context of the challenges faced by probation officers in producing same day reports within the limited time allocated. These findings led to 2 recommendations for their own service that:-

(i) Report authors must ensure any report explicitly states whether information, from all sources, has been verified or not.

(ii) Report authors should ask the court to consider granting an adjournment in all cases where there is a concern that the unavailability of police call out information might undermine the required "safe sentencing" approach.

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[38] "The homicide Timeline" – Jane Monkton-Smith, Senior Lecturer in Criminology at the University of Gloucestershire – published 2019.

https://journals.sagepub.com/doi/10.1177/1077801219863876
https://www.youtube.com/watch?v=lPF_p3ZwLh8&feature=youtu.be

21.7 With regard to the second recommendation, it is important to repeat here that where such a request is made, this is a decision for the court to make taking account of all relevant factors. The DHR Panel was conscious of the impact that Covid-19 has had on the court system across the UK which has resulted in backlogs of cases both in the magistrates and crown courts, and that any decision to grant an adjournment could add to those pressures.

Multi-Agency Learning

21.8 Application of that second recommendation brings implications for the role of other agencies is therefore included in the multi-agency learning.

21.9 It is concerning that in two thirds of cases involving domestic abuse offences, the police call out information is not available to inform the risk assessment and sentencing proposal. This comment is not intended as a criticism of the police response given their continuing efforts to speed up the response time. As outlined earlier, the challenge the police face is that requests are usually required within a few hours of the request, and the call centre is also dealing with enquiries from other agencies.

21.10 Although the DHR was informed that the absence of call out information was not impacting on delivery of safe sentencing, and that adjournments would most likely be granted when requested by NPS, these assurances were based on the anecdotal experiences shared by HMCTS, NPS, CPS and the police, rather than hard data.

21.11 As a result of the DHR probing of this issue, NPS have taken the positive step in requesting its court team to track call-out information return times and the number / percentage of cases where the information has been returned in time to be included in PSRs. It had originally been planned that this would continue during the first 6 months of 2020 to provide evidence over a longer time period as to whether the position is improving. However, this further monitoring has been delayed because of Covid-19.

21.12 The key issue is to assess whether the rate of response is impacting on the court's ability to ensure safe sentencing and ensure the safety of previous and potential future victims is not being compromised.

21.13 The DHR panel agreed that when circumstances allow, it would be helpful for information to be gathered on the number and percentage of cases involving offences of domestic abuse where:-

- probation officers conclude that the absence of information means that they cannot complete sufficient risk assessment to submit a safe sentence recommendation;
- adjournments are requested by NPS, whether these were granted, and if so, the length of the adjournment.

However, the DHR Panel acknowledged that due to the impact of COVID 19 it was not feasible for this additional tracking to be commenced at this time. It was agreed therefore that there should be further exploration with the Head of Staffordshire NPS as to whether such tracking might be achievable at a later date.

21.14 Although it is acknowledged that the governance arrangements would mean that this monitoring would be confined to cases which fall within the geographical area covered by the Stoke-on-Trent Community Safety Partnership, it is also recommended that the issues be raised at the Regional Transforming Summary Justice Joint Performance Improvement Group [39] to explore whether the same trends and issues are being experienced in other parts of the West Midlands area. If that were to be the case, the Group may wish to consider whether the suggested monitoring is conducted in other areas.

Updating of information to inform sentencing by the court

21.15 The DHR identified this as an issue of potentially important national learning. As explained earlier, the decision rests with the court as to whether to seek updated information to that provided in the original PSR to inform sentencing. The DHR Panel agreed that it is essential that relevant new information is shared with the court in all cases involving domestic abuse given that this potentially could alter the original risk assessment and recommendation in the PSR.

21.16 In exploring the possible processes as how this could be achieved, the DHR heard that updating of PSRs by probation officers would not be feasible because it would only in very rare situations that they would have any further contact with the defendant following the interview to produce the PSR. This would explain why NPS national guidance does not include direction to probation officers on the updating of reports in between adjournments - both for cases remaining in the Magistrates Courts or those set to the Crown Court.

21.17 The DHR panel noted that it is most likely to be the police who may hold new information either in respect of the defendant or the victim which could be brought to the attention of the court via the CPS prosecutor. However, anecdotal evidence received by the DHR panel suggests that although this information is sometimes requested by, or submitted to, the court, it does not occur in all cases.

21.18 The DHR panel therefore explored with HMCTS whether it could become standard practice for the court, before imposing sentence, to ask the legal representatives if there is any updated information which should be taken into account. However, the HMCTS representative did not agree with the proposal that HMCTS should take responsibility for checking that information supplied in a report is up to date, and that the current arrangement were appropriate whereby it is incumbent on all parties presenting information to the court to confirm that the information is correct and up to date.

21.19 While respecting the position taken by HMCTS locally on this proposal, the DHR Author's view is that given the importance of courts having all the necessary up to date information to inform sentencing, this was an issue where there was potential national learning. Accordingly, it would be appropriate for a recommendation to be made that the Community Safety Partnership should bring the issue to the attention of HMCTS at a national level.

[39] The regional Transforming Summary Justice Joint Performance Improvement Group provides a forum where good practice can be shared or solutions explored to resolve any issues around court related process that are proving problematic. Chaired by the CPS Head of the Magistrates Court unit, this is a multi- stakeholder meeting attended by senior representatives from the CPS, HMCTS, local police forces, NPS and the Police and Crime Commissioners office.

Multi-Agency Processes to assess and address risk

21.20 The findings from this DHR underline the importance of having effective multi-agency processes which support robust assessment of risk, prompt information sharing, co- ordination of protective action and tracking of progress on actions agreed.

21.21 The steps already taken to strengthen the local arrangements through the introduction of the Harm Reduction Hubs and the local weekly MARAC meetings, are starting to resolve the issues around the quality of risk assessments and the timeliness of cases being considered at MARAC which featured in this DHR.

21.22 Notwithstanding the practical challenges created by COVID-19, anecdotal feedback received by the DHR panel from New Era indicates that although it is early days, the changes are resulting in improvements in the quality of risk assessments through the DASH PPN forms, and more effective implementation and monitoring of actions agreed. The DHR Panel noted that the switch to local MARAC meetings was still at the "bedding in" stage, with some inconsistencies in the level of partnership support and buy-in to these across the different localities. Other issues reported related to challenges around training, the roll out of the NICHE system and associated data alignment.

21.23 The DHR Panel was aware that the findings from this DHR mirror those from some previous DHRs in Stoke-on-Trent. As a consequence of recommendations made by previous DHRs, monitoring of the revised arrangements is a standing item on the agenda of the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board, with regular updates provided to meetings of the Stoke-on-Trent Community Safety Partnership.

21.24 In the light of this, the DHR Panel agreed that a further recommendation from the findings in this case was not necessary. However, the DHR Panel wished to reaffirm the importance of monitoring the impact of the revised arrangements, particularly given the potential challenges arising from the high volume of referrals in Stoke-on- Trent compared to other policing areas across Staffordshire, and the workload implications for some agencies in servicing 2 MARACs.

22. MULTI-AGENCY RECOMMENDATIONS

1. The Stoke-on-Trent Community Safety Partnership should request further information from the National Probation Service (NPS) on the number and percentage of domestic abuse cases in its area where information requested about previous police "call outs" has been received in time to be included in pre sentence reports;

2. The Stoke-on-Trent Community Safety Partnership should explore with the National Probation Service (NPS) the feasibility of gathering information, when Covid-19 restrictions allow, on the number and percentage of domestic abuse cases in its area where:-

   (i) probation officers have concluded that that they cannot complete sufficient risk assessment to submit a safe sentence recommendation due to the unavailability of information;

(ii) adjournments are requested by NPS, whether these were granted, and if so, the length of the adjournment;

(iii) how the figures in relation to Stoke-on-Trent cases compare to other parts of the West Midlands;

3. The Stoke-on-Trent Community Safety Partnership should bring to the attention of the HM Courts and Tribunal Service (HMCTS) at a national level, the issue identified through this DHR, as to how courts can check whether there is new information which should be taken into account to inform sentencing in cases concerning offences related to domestic abuse that have been adjourned, and / or committed to Crown Courts.

23 SINGLE AGENCY RECOMMENDATIONS

National Probation Service

1. Report authors must ensure Pre-Sentence Reports must always state explicitly whether information included has been verified.