

REPORT INTO THE DEATH OF ADULT A FOLLOWING A DOMESTIC HOMICIDE REVIEW

REPORT PRODUCED BY:

Gavin Butler, Chair of Domestic Homicide Review Case

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Redacted Version

Executive Summary

1. The Review Process

This summary outlines the process undertaken by Warrington domestic homicide review (DHR) panel in reviewing the involvement of public agencies before the murder of Adult A by Adult B in July 2012.

Adult B pleaded not guilty to murder and was convicted of Adult A's murder on 19 April 2013 and sentenced to life imprisonment.

The review process began with an initial meeting of the DHR panel on 13 August 2012. The panel sought to identify all agencies that could potentially have had contact with Adult A, Adult B or their Adult Children Adult C and Adult D between 2007 and July 2012.

Agencies participating in this review included:

- Clinical Commissioning Group (CCG)
- Two Police forces
- Crown Prosecution Service
- Adult Social Care, [] Borough Council
- [] Housing Association
- Children & Young People's Services, [] Borough Council
- [] Community Safety Partnership
- NSPCC
- [] Women's Aid
- Benefits Team, [] Borough Council

- Refuge (Independent Domestic Violence Advocate service)
- [] Probation Trust
- Two Hospitals NHS Foundation Trust
- [] Drug and Alcohol Action Team
- [] Community Mental Health Trust
- [] District Citizens Advice Bureau
- The Relationships Centre
- [] Mental Health NHS Foundation Trust

Nineteen agencies were asked to provide IMRs to the panel. Eighteen of the nineteen agencies responded. In addition to the above, a neighbouring Police force and the CPS provided advice to the panel.

The panel considered agency responses given to Adult A, a White European woman, who was a resident of [] (born in 1962) prior to the point of her death in July 2012. The report also refers to agency involvement with Adult B, a white European male, born in 1955, who is the former husband of Adult A and the convicted perpetrator of the homicide, and their adult children, Adult C a white European male born in 1994, and Adult D, a white European female born in 1992. Adult A's sister is referred to in this report as Adult E.

The review identified significant agency involvement with Adult A and her family dating from 2007, when the first reported incidents of domestic abuse occurred.

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

Letters and appropriate Home Office information were sent to Adult C, Adult D and Adult E in April 2013 seeking their input following the criminal justice outcome and initially no response was received. Contact was eventually made with Adult C and Adult D via other support services, and meetings took place in May and June 2013. A decision was made not to seek contact with Adult B until there was a criminal justice outcome as he had entered a 'not guilty' plea. Sentencing took place on 19 April 2013. Adult B responded to a subsequent

request for a meeting with the Panel Chair and this is took place in June 2013 at the appropriate HMP. Adult A's sister was identified by the panel in March 2013 and a letter and appropriate Home Office leaflet was sent in April 2013 to her via the [] Police Family Liaison Officer. No response was received. It was not possible to identify a friend of Adult A's referred to in an Individual Management Review (IMR). A letter was sent on 9 May 2013 to Adult A's most recent employer, but no response was received.

Key issues arising from the review

The area has robust information sharing and Multi-Agency Risk Assessment Conference (MARAC) arrangements in place and the case was discussed at MARAC in December 2011 with all appropriate agencies present. The panel have not identified any critical failure to share information between agencies, and so better information sharing seems unlikely to have been able to prevent this homicide.

With four exceptions, reported incidents of domestic abuse appear to have been responded to in a timely manner, graded appropriately and offers of support and assistance made to Adult A. These four exceptions are:

1. Adult A should not have been able to visit Adult B while he was in custody in December 2011. Adult A gave a Pocket Note Book entry account to a police officer when she was in hospital but would not make a statement. She went on holiday and on her return visited Adult B in custody; she then decided that she did not want to proceed with a complaint. This visit may have affected Adult A's decision to formally support criminal proceedings, subsequently leading to the discontinuation of the case by the CPS. This has been addressed by [] Police in their 11 May 2012 change to their weekly orders (reference MG061) and the use of a newly created witness contact prevention form.
2. The burglary incident of 5 July 2012 should have been regarded as a domestic abuse incident (due to the critical marker placed on the address) and not primarily a burglary, and therefore police should have attended more quickly. Addressing this issue will require that all officers are reminded that the 2008 force domestic abuse policy remains in place, and takes precedence over the 'Transforming Policing' ethos of 'doing what matters to the victim'.
3. The decision to release Adult B on unconditional bail on 5 July 2012 in order to undertake house to house enquiries remains a concern. While force policy and procedures appear to have been followed, the decision

should have been informed by a wider view of the situation as relating to domestic abuse, rather than as acquisitive crime.

4. A build-up of cases following the transition between two IDVA providers in June 2012 appears to have led to a two day delay in the IDVA responding to Adult B following the 9 July 2012 referral, and the failure to correctly refer the case to the 1 August 2012 MARAC. Contact was made and services offered to Adult B on 13 July 2012. It does not appear that these procedural errors would have made a significant difference to this case.

Appropriate supports appear to have been offered to Adult A, including sanctuary schemes and a women's refuge.

The [] Domestic Abuse Partnership offers a range of training and awareness opportunities for a wide range of staff.

The main relevant mental health interactions were with Adult B in 2012. Adult B had a diagnosis of depression from his GP in Jan 2012. Adult B's subsequent presenting problems appear to have been in relation to low mood, suicidal ideation (albeit with no plans or intent), poor motivation, broken sleep, poor appetite and anxiety. Adult A stated to his GP that he felt angry and stressed, with increased feelings of anger. Given that Adult A's risk rating (using the 'Consequence and likelihood Matrix') was assessed as 'Serious', Adult B should not have been discharged from the Access and Advice Team on 7 June 2012 without further attempts at engagement. The assessment and the decision to close the case were not sufficiently informed by liaison with criminal justice agencies. While the murder of the 18 July 2012 could not have been predicted, an opportunity to liaise with other agencies and attempt more robust engagement with Adult B was not exploited.

2. Conclusions from the Review

No specific issues in relation to equality and diversity presented themselves during the course of the review. There was no evidence that any elements of this case related to discrimination or oppression on the grounds of age, race, sexuality, religion or disability.

The IMR's presented to the DHR Panel provide a picture of a family with complex, challenging issues, presenting with a wide range of needs to a wide range of agencies over a long period of time. There is a clear pattern of a number of crises prompting the involvement of a service and then one or more members of the family withdrawing, or refusing or failing to engage with services.

A number of agencies reference the issue that the specific presenting problems of individual family members were usually addressed (or attempts to address them were made), but there was little sense that the family was actually a complicated system in itself, and that the symptoms presenting to agencies related to the damaged and damaging interactions between the family members. As one IMR stated, there was too little recognition that the main issue was domestic abuse: records reference 'family arguments and communication issues' (prevention Family Support and Youth Division IMR). While Adult C and D presented with a range of needs over a long period of time, the central issue remained Adult B's violence to Adults A and C.

Adult C and Adult D have also both stated that they believe that more attention should have been paid to the family as a whole, with its attendant strengths and weaknesses, and with more analysis of the root causes of the problems, rather than just responding to crises.

While there was no single notable incident of a major failure to provide a significant service, assess a meaningful risk or follow policies or procedures, the fact is that Adult B was on bail for a related offence at the time of the murder. It follows, then, that the decision to bail Adult B in July 2012 remains of concern.

This decision appears to have stemmed from a view of this incident as an isolated burglary, rather than as a domestic abuse incident in a long series of domestic abuse incidents, where the risks appear to have been escalating and the victim had stated to the officer dealing with the case that Adult B's mental health "had recently deteriorated" (Police IMR). While it cannot be said that this would have prevented the death of Adult A, it is clear that the risks around this incident did not sufficiently inform the decision to grant bail.

Recommendations from the Review

A detailed Action Plan with 28 separate actions for single agencies has been developed and will be monitored by the Community Safety Partnership. The four multi-agency recommendations follow:

1. Promote a 'whole family' approach by partner agencies in cases where domestic abuse is a feature, to ensure that an holistic assessment of risk/need is undertaken and the required safeguarding actions are implemented and support provided.
2. Domestic Abuse cases with no children-or with children aged 18 and over-to be reviewed to explore if additional safeguarding can be provided following Standard Risk incidents.

3. Merseyside and Cheshire CPS to be consulted on Cheshire-wide policy to
 - notify CPS of any potential DHRs and
 - CPS to agree to preserve any records in relation to any potential DHR
4. Separation / Divorce should be regarded as a High Risk Factor, and therefore needs to be recognised and addressed in assessing risk and protective factors in domestic abuse cases.

1.0 Introduction

- 1.1 This domestic homicide review (DHR) combines agency responses given to Adult A, a White European woman, who was a resident of [] (born in 1962) prior to the point of her death on 18 July 2012. The report also refers to agency involvement with Adult B, a white European male, born in 1955, who is the former husband of Adult A and the convicted perpetrator of the homicide, and their adult children, Adult C a white European male born in 1994, and Adult D, a white European female born in 1992. Adult A's sister is referred to in this report as Adult E.
- 1.2 The review identified agency involvement with Adult A and her family dating from 2007, when the first reported incidents of domestic abuse occurred.
- 1.3 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and, most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
- 1.4 The following agencies were involved in this review:
- Clinical Commissioning Group (CCG)
 - Two Police forces
 - Crown Prosecution Service
 - Adult Social Care, [] Borough Council
 - [] Housing Association
 - Children & Young People's Services, [] Borough Council
 - [] Community Safety Partnership
 - NSPCC
 - [] Women's Aid
 - Benefits Team, [] Borough Council

- Refuge (Independent Domestic Violence Advocate service)
- [] Probation Trust
- Two Hospitals NHS Foundation Trust
- [] Drug and Alcohol Action Team
- [] Community Mental Health Trust
- [] District Citizens Advice Bureau
- The Relationships Centre
- [] Mental Health NHS Foundation Trust

1.5 In addition to the above, [] Police and [] and [] CPS provided advice to the panel. [] CAB did not respond to requests for an IMR.

1.6 Letters and appropriate Home Office information were sent to Adult C, Adult D and Adult E in April 2013 seeking their input following the criminal justice outcome. No response had been received on 23 April 2013. Contact was eventually made with Adult C and Adult D via support services, and meetings took place on 28 May 2013 (Adult C) and 14 June 2013 (Adult D). A decision was made not to seek contact with Adult B until there was a criminal justice outcome as he had entered a 'not guilty' plea. Sentencing took place on 19 April 2013. Adult B responded to a subsequent request for a meeting with the Panel Chair and this is took place on 6 June 2013 at HMP []. Adult A's sister was identified by the panel in March 2013 and a letter and appropriate Home Office leaflet was sent in April 2013 to her via the [] Police Family Liaison Officer. No response was received. It was not possible to identify a friend of Adult A's referred to in an Individual Management Review (IMR). A letter was sent on 9 May 2013 to Adult A's most recent employer, no response has been received.

2.0 Terms of Reference and Scope

2.1 The Review Panel will be chaired by Gavin Butler Dip SW, MBA of Cheshire West and Chester Council. Gavin Butler is a qualified social worker, has managed Domestic Abuse Services in Cheshire County Council since and its successor authority Cheshire West and Chester Council, and currently manages Adult Safeguarding services, which includes multi-agency investigations and assessments of abuse and neglect against vulnerable adults. Gavin Butler undertook NHS commissioned training in Commissioning, Monitoring and Reviewing

Safeguarding Investigations on 21 January 2011, and has chaired two DHRs for another authority. Gavin Butler chairs this DHR as part of a formal reciprocal arrangement between local authorities, which seeks to ensure that skills and learning in relation to domestic abuse are exchanged between the councils.

3.0 Purpose of the review

3.1 The purpose of the review is to:

- Establish the facts that led to the death of Adult A on 18 July 2012 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked individually and together to safeguard the family
- Identify what those lessons are, how, within what timescales they will be acted upon, and what is expected to change as a result
- Establish whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend any changes as a result of the review process

4.0 Scope of the review

4.1 The review will

- Seek to establish whether the events of 18 July 2012 could have been predicted or prevented.
- Consider the period of September 2007 to the event on 18 July 2012, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Internal Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Take account of the coroner's inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations

regarding safeguarding of families and children where domestic abuse is a feature

- Aim to produce the report by 14 January 2013, subject to responding sensitively to the concerns of the family, particularly in relation to the inquest process, the internal management reviews being completed and the potential for identifying matters which may require further review.

4.2 The agencies responsible for providing details of their involvement, through chronologies of contact and Individual Management Review's (IMR's) will be as follows:

NHS Trust

Police

Probation Trust

Clinical Commissioning Group

Community NHS Trust

Community Safety Team

Children and Young People's Services

Adult Social Care

RSL (if relevant)

Hospital NHS Foundation Trusts

[] Housing Association

Acute Trust

NSPCC

Refuge (provider of the Independent Domestic Violence Advocate Service)

DAT (Drug & Alcohol Services)

Women's Aid

Civic Sector

Citizens Advice Bureau

4.3 Each of the above contributing agencies will be required to:

- Provide a chronology of their involvement with Adult A and Adult B during the relevant time period.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an Individual Management Review (IMR)

4.4 The Review will specifically analyse the following

1. Communication and co-operation between different agencies involved with the couple

2. Opportunity for agencies to identify and assess domestic abuse risk.
3. Agency responses to any identification of domestic abuse issues.
4. Organizations' access to specialist domestic abuse agencies.
5. The training available to the agencies relating to domestic abuse issues.
6. Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.
7. Equality and diversity issues: any issues arising from IMRs, contact with family and friends or any other source, will be included in the review.

5.0 Family involvement

- 5.1 The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people the family think relevant to the review process.
- 5.2 The review will also agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.
- 5.3 Finally the review will identify the timescale and process of the Coroner's inquest and criminal trial and ensure that the family are able to respond to this review, the inquest and criminal trial avoiding duplication of effort and without undue pressure.

6.0 Legal advice and costs

- 6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at "their responsibility".
- 6.2 There may be a requirement to access independent legal advice on the part of the review team, and the team will seek funding for this advice from the Community Safety Partnership statutory partners and agree from which source this advice will be sought.

6.3 At this stage it is not anticipated that the review will require additional resources or funding for their time to undertake this review. Should the scope of the review extend beyond the anticipated internal review, the review team will raise this through the Safer Communities Partnership for further guidance.

7.0 Expert witnesses and advisors

7.1 It is not intended at this stage to consult with any expert witnesses or advisors. Representatives on the DHR panel include domestic abuse specialists from the provider of the IDVA service and from [] Women's Aid.

8.0 Media and communication

8.1 The management of all media and communication matters will be through a joint team drawn from the Domestic Homicide Review Panel which Panel members' organisations.

8.2 There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

8.3 However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process.

8.4 An executive summary of the review will be published on the Community Safety Partnership's website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

8.5 All written communication from the review team will be sent under the Community Safety Partnership logo, using business addresses for the review team members.

9.0 Background

Chronology (summary) of events relevant to domestic abuse against Adult A

Date	Event
27 December 1987	Adult A presents at A&E following an assault by an unnamed partner
1992	Adult D born
1994	Adult C born
1996	Adult A and B marry
4 Sept 2007	Adult A reports to [] Police that Adult D was damaging property
17 April 2008	Member of the public reports 'dispute in the street' (verbal argument) between Adult A and Adult B
20 May 2009	Adult A moves out of family home
1 October 2009/15 October 2009	Adult A moves back in with Adult B/Adult B then moves to new property
9 October 2010	Silent call to 999 from Adult A, subsequently states verbal argument with Adult B
9 September 2011	Adult A reports verbal altercation with Adult B
18 October 2011	Adult A reports criminal damage by Adult B
27 October 2011	Adult A provides retraction statement
11 Nov 2011	Adult B referred for mental health support by []. Adult B did not engage
30 Nov 2011/1 December 2011	Adult A attends A&E following an assault by Adult B

6 December 2011	Adult A visits Adult B in custody and then states that she does not want to formally proceed with the case
14 December 2011	Adult retracts statement. Case against Adult B discontinued by CPS
21 December 2011	Adult A discussed at Multi Agency Risk Assessment Conference (MARAC) marker placed on her address by [] Police
5 July 2012	Adult A calls 999, alleging burglary of her home by Adult B, Adult B eventually arrested, makes no comment in interview and is eventually bailed to 2 August 2012
13 July 2012	Independent Domestic Violence Advocate (IDVA) contacts Adult A offering support. Target hardening arranged for 18 July 2012
18 July 2012	Adult B presents at [] station [] with the body of Adult A in his car.
19 April 2013	Adult B sentenced to life imprisonment for the murder of Adult B

9.1 Press reporting of the trial of Adult B referenced a previous serious assault on Adult A by a partner, and made mention of ‘thirty years’ of domestic abuse. It does appear from historical A&E records that, on 27 December 1987 Adult A attended the hospital via 999 arriving at 02:20 and stated that she had been assaulted by her boyfriend and had been punched repeatedly in face and ribs to the point where she lost consciousness. Adult A had a laceration to the bridge of her nose, multiple hematomas (bruising) on head and bruising all down her left side. There is no record of this offence being reported to [] Police. This would not have been unusual in 1987. No name is given for the boyfriend who committed this assault.

In interview with the Chair of this review, Adult B denies that this was him. Adult B also denies having a conviction for assault from 1982, which Police records have identified. No further information is available.

Apart from the above events, recorded agency involvement with this family dates back to 2004, when a long series of interactions with education services commenced. Many of these interactions are outside the terms of reference for this review.

- 9.2 In relation to the specific issue of domestic abuse, the first recorded interaction is dated 4 September 2007, when Adult A contacts [] Police and reports that Adult D (then aged 13) was damaging property and assaulting her at her home address.

Between 4 Sept 2007 and 29 Sept 2011 there are some 28 reported incidents between Adults A, B, C and D involving allegations of theft, criminal damage and violence. [] Police use the National Risk Assessment Model referred to in this report as DASH (Domestic Assault Stalking & Harassment) RIC (Risk Indicator Checklist).

- 9.3 On five occasions (4 September 2007; 17 April 2008; 9 September 2011; 18 October 2011; 1 December 2011) Adult A contacts the police, or a silent call is made and the police attend, but then declines to give a statement or retracts any allegations that have been made in the days following the event. On at least five occasions the service standard is applied and a DASH RIC (Risk Indicator Checklist) is completed, with the risk being graded as 'Standard' four times, and on one occasion as HIGH RISK (the incident on 1st December 2011). There was a MEDIUM RISK incident 5th July 2012, for which Adult B was on bail at the time of the homicide.

10.0 History of the relationship

- 10.1 Adult A and Adult B were partners for 30 years and had been married for 18 years. They had two children, Adult C (aged 17 at the time of Adult A's death) and Adult D (aged 18 at the time of Adult A's death).

At the time of her death, Adult A worked part time as a school taxi escort for children with disabilities. Adult B was unemployed at the time of the death but had previously worked in a skip-yard. Adult A and Adult B had separated in 2011, with Adult A moving a short distance away from the home they had previously shared.

- 10.2 This review provides evidence of a family with multiple problems, with frequent inputs from a number of agencies including health, Children and Young People's Services, education and police services, responding to presenting behaviours but with minimum evidence of holistic historical view of a family with systemic problems combined with withdrawal after crisis. It is striking to note that the submitted IMR's

do not reveal any significant recording of alcohol use as a contributory factor to disharmony or tension within the family.

The panel noted that significant features manifest in the IMR's reflect the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in both children and the stresses that this may have put on the family. Adult A was a school governor between 2004 and 2008, and was involved in charitable work in relation to ADHD.

11.0 IMR Summary

Number	Agency	Dates of contacts and number of interactions taken from analysis of the DHR Chronology document)	Recommendations from IMR authors
1	Head of Assurance & Risk, NHS [] CCG	Adult B treated for depression and related matters from 11 November 2008 to 9 July 2012.	<ol style="list-style-type: none"> 1) All GPs to be reminded that patients with a new diagnosis of depression should be viewed within 2-12 weeks following diagnosis. 2) All GPs to be reminded that it is good practice not to put anti-depressant medication on repeat. 3) Mental Health Hospital Trust to be reminded that GPs should be advised of any appointments that are arranged with their patients so that non attendances can potentially be chased.

2	Head of Assurance & Risk, NHS [] CCG	<p>Adult A seen by GP and a nurse for 'a range of problems' between Sept 2007 and July 2011.</p> <p>Adult C received support from the looked after children's health team in 2009.</p> <p>Range of health issues for Adult A, including sexual health and a road traffic accident between 2010 and 2012.</p>	<ol style="list-style-type: none"> 1) All GPs to be reminded of the Directory of Services to ensure effective signposting. 2) All GPs to be reminded of the need for depression screening. 3) All GPs to be advised of the need to explore information in the event of there being a potential safeguarding issue. 4) All GPs to be advised of the signs of domestic abuse and appropriate course of action if abuse is escalating.
3	Detective Sergeant [] Police	89 incidents with Adult A and the family recorded between 2007 and 2012.	<ol style="list-style-type: none"> 1) All Police Officers and staff to be reminded that where cases of domestic abuse are evident the 'Domestic Abuse Management and Investigation of Incidents Procedure 2008' should be applied in all cases. 2) Positive action will be taken regardless of whether a victim wishes to make a formal complaint, and will override the 'transforming Policing' principle of 'do what matters to the victim'.

			<p>3) This be issued as a weekly order entry at the earliest opportunity, and circulated to all police officers and staff.</p> <p>4) [] Police to review and amend their Domestic Abuse Procedures to reflect the need to ensure that decisions relating to police bail in domestic abuse investigations are informed by a thorough risk assessment of the incident, history, identified risk factors and that any decisions made involve communication with the victim.</p>
4.	Adult Social Care, [] Borough Council	<p>Adult C referred to Mental Health services in Sept 2011 following an incident where C 'damaged the family home'. Case closed after seven weeks, 25 attempts to engage, and only 2 successful attempts to engage. C 'did not wish to engage'.</p> <p>Adult B referred to New Directions on</p>	<p>1) Managers should ensure that the Professional Instruction Notice 'File Quality Audit/Quality Standards in practice and recording (PIN 08/11) is adhered to by staff in providing accurate and comprehensive assessment of risk.</p> <p>2) Managers should ensure that staff are viewing and recording on Care First and are able to access historical records in</p>

		<p>11 Nov 2011 for mental health support by</p> <p>[] Police concerned by B's 'Irrational behaviour'. B did not engage.</p>	<p>order to better inform practice in line with PIN 08/11.</p> <p>3) Develop proposal on resolving the risks posed by dual recording on Care First and OTTER.</p> <p>4) Information from the Out of Hours Service should remain assigned to the allocated worker until they have read the information first hand and do not rely on either a verbal summary from colleagues or messages in a book prompting them to access the system.</p>
5	[] Housing Association	2 incidents of damage to Adult A's home by Adult B in Oct 2011 and June 2012.	No recommendations. Policy and procedure were followed and damage repaired.
6	Prevention, Family Support and Youth Division, Children & Young People's Services, [] BC	16 interactions with the family (primarily Adult C) between 2007 and 2011.	<p>1) A review of case management recording for targeted interventions would help to establish if practice has improved.</p> <p>2) Services within Prevention, Family Support and Youth to focus on 'whole family' assessments and care planning.</p> <p>3) Staff training to be delivered on dealing with the causes of poor behaviours or emotional well being</p>

			and not focusing on dealing with the symptoms.
7	[] Community Safety Partnership	0 interactions.	None
8	Inspector, NSPCC (provider of IDVA service from 2009-2012)	19 interactions with family between 5 December 2011 and 2012. 5 December 2011 contact with IDVA and Adult A. Service declined by A.	Despite identifying that 'NSPCC standards for case recording, supervision, monitoring and paramourncy were not fully met'. The NSPCC declined to make any recommendations as they are reviewing '...compliance with practice standards, including paramourncy across all services as part of the NSPCC's annual inspection programme' (NSPCC IMR).
9	[] Women's Aid Ltd,	No (0) interactions.	N/A
10	Benefits Team, [] BC	19 contacts with the family between 2007-2011.	N/A: Routine work and a complaint conducted in line with agency policy and procedures.
11	Service Manager, Quality Assurance and Safeguarding, Children & Young People's Services, [] BC	73 contacts recorded with the family/Adult C and D as children and young people between 2007 and 22 June 2012.	<ol style="list-style-type: none"> 1) To ensure that all social workers and frontline managers attend DASH Training that is targeted to their specific role. 2) To review process for feedback to social work teams from Targeted Services Social Work representatives who attend Multi Agency Risk Assessment Conferences (MARAC) and Multi Agency Public

			<p>Protection Arrangements (MAPPA) operational meeting.</p> <p>3) Social Work teams to be reminded about the need to ensure that information about child protection concerns are referred on and highlighted in adult's medical records.</p>
12	Senior Operations Manager, Refuge	<p>12 contacts in relation to this case between 9 July 2012 and 13 July 2012.</p> <p>One hour phone call on 13 July 2012. Adult A being supported by a friend.</p>	<p>1) Police referral document should be amended so that references to previous MARAC referrals are more prominent at the top of the report.</p>
13	Senior Probation Officer, [] Probation Trust	No (0) contacts with the family.	N/A

14	[] and [] Hospitals Foundation Trust	42 contacts with the family between Sept 2007 and 18 July 2012.	<ol style="list-style-type: none"> 1) Continue to promote the awareness of domestic violence policies with front line staff. 2) The trust is to further develop the identification of patients attending the hospital by adding additional information to client's clinical records and recording an alert on the IT (Meditech) system when there is a history of domestic violence requesting staff to contact the safeguarding children's team for additional information.
15	[] Drug and Alcohol Action Team	No (0) contacts with the family.	
16	[] Community Healthcare Trust, [] Division	<p>9 contacts with the family, mostly routine appointments for children, follow-up to missed immunisations etc.</p> <p>No references to domestic abuse in relevant records.</p>	None

17	11-19 Learning and Achievement, Children & Young People's Services, [] BC	118 contacts with the family from Sept 2007. Contacts relate primarily to the educational needs of Adult C and Adult D when they were young people. In a March 2007 meeting at school, it was noted that 'Adult B became verbally aggressive and intimidating'.	<ol style="list-style-type: none"> 1) Key messages around communication between schools where siblings attend other schools and there are identified risks/vulnerability issues could be disseminated through Designated Senior Person (DSP) networks and training. 2) Audit of all schools on CAF completion. 3) Information about domestic abuse and how it impacts on children who live with an abusive household should be disseminated to all schools, via DSPs.
18	CAB	No advice or assistance requested or provided	None
19	The Relationships Centre	Support to Adult C and D in 2008 and 2009.	None
20	[] Mental Health NHS Foundation Trust	1 telephone contact for assessment, 1 assessment meeting, 1 scheduled meeting with psychiatrist that Adult A failed to attend.	<ol style="list-style-type: none"> 1) In all incidents where referrals indicate criminal history, liaison should be undertaken with Criminal Justice Services. 2) In all instances GPs and service users should be informed of discharge from [] services. 3) Procedures regarding service users who do not attend appointments should be followed up.

12.0 Incident on 18 October 2011

12.1 Adult A called [] Police on 18 October 2011 reporting criminal damage by Adult B. Adult A alleges that Adult B has used an axe to damage the rear door of her property and gained access. The axe is later believed to be a shovel. The direct antecedent to this offence is given by Adult A as the discovery by Adult B of text messages from a new partner on Adult A's mobile phone. This was considered an emergency and police officers deployed straight away. Attempts were made to find and arrest Adult B. These were unsuccessful and Adult A then withdrew her statement. The case was not pursued. This incident was not regarded as relating to domestic abuse by the Constable dealing with the case, and the [] Police IMR notes that this was in contravention of the existing [] Police 'Domestic Abuse Management and Investigation of incidents 2008' policy. The officer responsible has been subject to a 'management action plan' as a result of the failure to follow force policy.

12.2 The four weeks leading up to this incident involve a range of contacts between the family and local agencies:

- Adult B refers Adult C to Children & Young People's Services.
- Adult A and B report Adult C and D to the police for theft and criminal damage, but then decline to make a formal complaint.
- Adult D referred for support and a DASH RIC completed for Adult A following an incident with Adult D.
- Adult B's behaviour reported as being increasingly difficult for Adult A to cope with.
- Increasing contact with Adult Social Care from Adult B, attempting to refer Adult C for support; attempts by Adult Social Care to engage with Adult C.

12.3 The picture appears to be one of increasing tensions between all four members of the family,

Incident of the 30 November 2011

12.4 Medical staff reported to [] Police that Adult A had attended hospital. She was making an allegation that she had been subjected to a physical assault lasting for a period of four hours by Adult B.

The Police report states that the assault had taken place at Adult A's home, and involved Adult B ripping Adult A's clothing; striking her with stereo equipment; punching her head; strangled and pinned to the stairs; struck with a hammer to the head and pushed into the bath. Adult B continued the assault by pouring toiletries over Adult A, dragging her and then kicking and punching her to the point where she passed out. Cuts and bruises to Adult A's head were observed at the hospital.

- 12.5 Adult A was charged with S47 Assault and remanded in custody. On the 5 December an IDVA employed by the NSPCC contacted Adult A and discussed the incident. Adult A stated that the incident on 30 November '*...had been provoked due to the revelation of her relationship with another man and him [B] discovering that...*' there were additional financial burdens. (NSPCC IMR). On 6 December Adult A stated that she did not want to formally proceed with the case to [] Police and on 14 December 2011 the case was discontinued. Adult A stated that she was concerned about the mental and physical health of Adult B.
- 12.6 An enquiry to the Crown Prosecution Service (CPS) on 12 March 2013 about the decision not to pursue this case identified that in line with the National Case Retention Policy of that agency that papers relating to this incident had been destroyed twelve months after the decision was made. The CPS referred to the Code for Crown Prosecutors and the CPS Domestic Violence Policy for the appropriate dates in their decision making. The Panel will be seeking to agree a policy with CPS where records are locked down on the commencement of any domestic homicide review.
- 12.7 The period from 18 October 2011 to the 30 November 2011 reveals a continuing chaotic situation resulting in family contact with various agencies including, Adult Social Care; GP; Children & Young People's Services; [] Police and others. Adults C and D presented as homeless in November 2011 and were offered support, and the tensions between Adult B and Adult C and D appear to increase. It is hard to identify any direct antecedent to the incident of the 30 November/1 December 2011 other than the apparently escalating, unresolved tension between the family members.

- 12.8 The case was discussed at MARAC (Multi Agency Risk Assessment Conference) on 21 December 2011. Multi-Agency Risk Assessment Conferences (MARAC's) are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies.

By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. The information shared by the IDVA included that Adult A '...is minimising what has happened. She has stated that she wants to retract her statement and will be visiting [Adult B] in custody. She wants to resume the relationship when he is released.' (MARAC Minutes, 21 December 2011). Actions from MARAC included: a 'critical marker' being placed on the address in order to inform police responses and further contact from the IDVA.

13.0 Incident on the 5 July 2012

- 13.1 On 12 April 2012 Adult B's General Practitioner referred him to the Access and Advice Team for 'problems with anger, self-control and relationships and who had recently been in prison for violent outbursts' (from [] Individual Management Review). Adult B had been on a prescription for anti-depressant since January 2012. Adult B contacted the Access Team on 24 April 2012 and was screened via telephone and offered an assessment meeting on 24 April 2012, which he attended. Adult B did disclose his perpetration of violence towards Adult A. Following this an appointment was arranged for Adult B to meet with a Consultant Psychiatrist on 21 May 2012. Adult B did not attend this meeting and the case was closed without further contact, or attempts at contact, on 7 June 2012.
- 13.2 Adult C stated in interview (on 23 May 2013) that he believed that Adult B presented at [] Hospital at an unknown date in 2012 in some distress. [] provides services to people with mental health problems, learning disabilities and substance misuse issues. Adult C states that he felt that this was notable as it was unusual for his father to seek help. It has not been possible to identify an exact date for this event. The NHS Trust responsible for [] searched their records again and were unable to identify any evidence of a presentation by Adult B outside of the appointments made for him. Adult B stated that he attended [] without an appointment, possibly in December 2011, due to problems sleeping and functioning on a day to day basis.

He gave the Chair of this review the example being unable to recall where he had parked his car. He states that staff at [] advised him to attend A&E. He did not attend A&E.

- 13.3 On 9 June 2012 Adult A reported Adult B and C as being involved in a disturbance outside her home which involved damage to Adult A's front door, apparently caused by Adult C.
- 13.4 Adult A attended her GP on 4 July 2012 reporting stress and financial problems. Significantly the GP reports that alcohol and drugs were not problematic. Adult A ascribed Adult B's behaviour to his desire to resume their relationship, something she did not want. Apart from the continuing tensions between the family members and the impact that the situation is starting to have on Adult A's mental health, there are no obvious direct antecedents for the burglary.
- 13.5 At 13.54 hours, [] Police received a 999 call from Adult A stating that Adult B had burgled her house and stolen thirty-five pairs of shoes and a dress. Due to the incident of 1 December 2011, a 'critical marker' had been placed on the [] Police Command and Control system. This highlighted that the victim should be considered as vulnerable to harm and an emergency 'Grade 1' response should be considered. However, the grade 1 response was not applied to the incident as it was viewed as a burglary and reassessed as a grade 2 response. The failure to give a grade 1 response has been identified as an operator error. The operator has been advised accordingly and the matter brought to the attention of his supervisor.
- 13.6 Operators made numerous attempts via telephone to contact Adult A that proved negative. At 14.31 hours the decision was made to leave a message on Adult A's mobile phone asking her to call [] Police. It was noted that 'if no contact was made, deployment would be requested to check on Adult A's welfare'. Deployment was not actioned due to other ongoing policing demands. At 18.54 hours, Adult A contacted stating that she was now at her friend's home address. At 19.50 hours an officer was assigned and at 20.09, telephone contact was made with Adult A. The officer attended and spoke with Adult A, who made a formal complaint regarding the burglary and provided a written statement.
- 13.7 At 20.40 hours Adult B was arrested for an unrelated public order offence. Whilst in custody Adult B was arrested for the alleged burglary.

- 13.8 The time delay between Adult A reporting the incident and [] Police allocating a resource to respond, may have resulted in a delay in arresting Adult B.
- 13.9 Adult B was interviewed under caution but made 'no comment' responses to questions asked of him. At the time there was no corroborating evidence, but house to house enquiries near the scene needed to be completed.

Due to the lateness of the hour (03:11 hours) this was deemed impractical and Adult B was bailed without conditions during the early hours of 6th July 2012. Adult B was due to surrender to police bail on 2nd August 2012. The Custody Sergeant stated that conditional bail was considered, but the practicalities of this often meant that, if there was a breach in the conditions, the defendant would return to custody for the original offence. The Police and Criminal Evidence 'custody clock' (which allows 24 hours before the consideration of extension) would start again, thus ultimately reducing the time allowed to deal with the defendant for the original offence. A breach of conditional police bail does not carry a charging tariff and therefore the defendant would very often be released again without charge. When consulted for this report, the Custody Sergeant stated that he preferred to issue a verbal warning to the defendant regarding interfering with witnesses and committing further offences for which a substantive charge could be imposed.

- 13.10 *The* DASH RIC was completed and the risk to Adult A was assessed as 'medium'.
- 13.11 The provider of IDVA services had changed from the NSPCC to Refuge in 2011, a charitable organisation (not to be confused in this context with an actual 'refuge' building for victims fleeing domestic abuse). Refuge accepted the referral from [] Police on 9 July and Refuge IDVA Service contacted Adult A and had a one-hour conversation steered by the CAADA (Co-ordinated Action against Domestic Abuse) DASH RIC. Financial issues were highlighted by Adult A. The Refuge worker offered to facilitate a move to a women's refuge in order to address the risks she had identified to Adult A's 'immediate safety' (from IMR). Adult A declined, stating that '... [Her] own views of her potential risk were mixed.

On the one hand, [Adult A] stated that she believed the perpetrator capable of carrying out his threats, but at the same time [Adult A] said that she had now lived with the harassment for three years since separating from her ex-partner and she did not seem immediately concerned for her personal safety' (IMR). Adult A stated that she was able to stay at a friend's house. Advice on making her home safer and non-molestation orders was provided. A referral was made to the local Sanctuary scheme to make Adult A's property safer.

A text was also sent to Adult A offering further support and the name and contact number for a solicitor who could deal with a non-molestation order. The Sanctuary scheme advised that they had been in contact with Adult A and an appointment had been made for 18 July 2012.

13.12 Adult C states that he believes that Adult B "should have been remanded" and "should have been charged" for this alleged offence. In discussion about the events of 2012, Adult C states that Adult B had remained "obsessed" with Adult A and was unable to move on, as she had. Adult C stated that he believed that "someone should have challenged [Adult B], the police knew him as an angry man".

13.13 Adult D broadly agrees with Adult C. In a meeting with the Chair of this review Adult D stated that if Adult B "...had been convicted of an offence, he might have got over her."

14.0 Death of Adult A on 18 July 2012

14.1 The period from 5 July 2012 to 18 July 2012 includes a visit to his GP by Adult B, where he revealed that he had stopped taking anti-depression medication prescribed in February 2011. Adult B had also missed a psychiatry review (date not identified). The GP referred Adult B for anger management and diagnosed a 'suspected personality disorder'. Adult B is described as having a 'low mood - good insight'.

14.2 Adult A also attended her GP (on 11 July 2012). Adult A reported to the GP that she was engaging with the Citizen's Advice Bureau (CAB) over debt issues, but still felt significant stress over the burglary incident. CAB have no record of a referral or interaction with Adult A.

- 14.3 On 18 July 2012 Adult B presented at [] Police Station with the body of Adult A in his car. Adult B entered a 'not guilty' plea. Adult B was found guilty of and sentenced on 19 April 2013 to Life (in this case 18 years), to serve a minimum term of 17 years and 92 days).
- 14.4 Adult B was therefore on unconditional bail for an offence of burglary which was a crime connected to Adult A at the time when Adult A was killed. [] Police have reviewed the circumstances of the decision to grant Adult B bail in connection with the burglary investigation and concluded that bail conditions in these circumstances would not have been appropriate as Adult B was not bailed pending a CPS charging decision, but to allow further enquiries to be carried out. It is not considered that any conditions placed upon the bail of Adult B on 6 July 2012 would have prevented the death of Adult A.

15.0 Conclusions

- 15.1 Records dating as far back as 1987 appear to reveal a picture of a difficult and volatile relationship between Adult A and Adult B. Adult B appears to have been a violent, angry man, with significant problems in his attitudes to his wife and children and problems in engaging effectively with the people who might have helped the family. Adult D tried very hard to present a balanced picture of her parents. She talked about her father's strengths as a financial provider, while recognising the enormous harm that his behaviour had caused. Both Adult C and Adult D remain in contact with their father, and express real distress when talking about their situation.
- 15.2 It has been very hard to gain a clear view of Adult A during this review. Adult A was obviously a resourceful and resilient woman, able to make changes in her life and to act as a school governor for a significant period, to work and to attempt to parent effectively. It has not been possible to gain insight into why she felt unable or unwilling to engage with domestic abuse services and criminal justice agencies. It seems likely that the coercive nature of her relationship with Adult B, and her concerns for Adult B's health may have influenced her. Adult D states that she felt that her mother remained financially dependent on Adult B and that this maintained a connection between them.
- 15.3 During interview at HMP [] on 6 June 2013, Adult B presented as agitated, making disordered and sometimes contradictory statements. He stated that his problems originated in family stress, principally due to his children's behaviour in school.

He was unable or unwilling to discuss the events of 2011 and 2012. He repeated that “more should have been done for the kids” several times. He consistently blamed other people or agencies for Adult A’s death, including various public bodies and Adult A herself.

During the interview Adult B was unable or unwilling to discuss alternative scenarios and there was little, if any, evidence of responsibility or remorse. He eventually stated that “her lying through her teeth did it” and then left the interview. He left the Chair of this report six pages of notes that set out his dissatisfaction with Police, Council and NHS services.

- 15.4 Adult C and Adult D present in interview as serious, articulate and dignified young people, who have undergone significant trauma and are still struggling with understanding the events of 2012 and knowing how to respond to the loss of their mother and their care for their father.

Adult C and Adult D both stated that they felt that the problematic situation between their parents was escalating in 2011 and 2012, and that Adult B’s behaviour, weight loss, physical health problems and difficulties in seeking and accessing help should all have alerted someone to the fact that he was in some distress and needed help. Both Adult C and Adult D stated that, although they never considered that their father would murder their mother, they had strong fears in 2012 that the “volatile relationship” (Adult D’s description) between Adult A and Adult B would end in Adult B’s suicide. Adult C and Adult D feel strongly that Adult B is sorry for the effect that the murder has had on them.

- 15.5 Adult D stated in interview that her parents had what she described as a “weird” relationship, with intense periods of both apparent devotion (she states that Adult A and Adult B went on holiday together in August 2011, after their separation) as well as control, rejection and violence. Adult D describes her father as being intensely emotional about Adult A, manifesting extreme distress and anger in 2011 and 2012. She feels strongly that “men of his generation don’t seek help”, and public services should more proactively target men who have problems managing their anger following separation. Adult D stated that agencies wishing to prevent a similar homicide should “...see the bigger picture, not just what happened that day [18 July 2012]. People need to speak to the kids...”.

16.0 Addressing the Terms of Reference

17.0 DHR Communication and co-operation between different agencies involved with Adult A and Adult B

[] has robust information sharing and MARAC arrangements in place and the case was discussed at MARAC on 21 December 2011 with all appropriate agencies present. The panel have not identified any critical failure to share information between agencies that was deemed likely to have prevented this homicide.

18.0 Opportunity for agencies to identify and assess domestic abuse risks.

With four exceptions, reported incidents of domestic abuse appear to have been responded to in a timely manner, graded appropriately and offers of support and assistance made to Adult A. These four exceptions are:

- i) Adult A should not have been able to visit Adult B while he was in custody in December 2011. Adult A gave a Pocket Note Book entry account to a police officer when she was in hospital but would not make a statement. She went on holiday and on her return visited Adult B in custody; she then decided that she did not want to proceed with a complaint. This visit may have affected Adult A's decision to formally support criminal proceedings, subsequently leading to the discontinuation of the case by the CPS. This has been addressed by [] Police in their 11 May 2012 change to their weekly orders (reference MG061) and the use of a newly created witness contact prevention form.
- ii) The burglary incident of 5 July 2012. Due to the critical marker, this incident should have been regarded as a domestic abuse incident and not primarily a burglary and therefore attended more quickly. Addressing this issue will require that all officers are reminded that the 2008 force domestic abuse policy remains in place, and takes precedence over the 'Transforming Policing' ethos of 'doing what matters to the victim'.
- iii) The decision to release Adult B on unconditional bail on 5 July 2012 in order to undertake house to house enquiries remains a concern. While force policy and procedures appear to have

been followed, the decision should have been informed by a wider view of the situation as relating to domestic abuse, rather than as acquisitive crime.

- iv) A build-up of cases following the transition between two IDVA providers in June 2012 appears to have led to a two day delay in the IDVA responding to Adult A following the 9 July 2012 referral, and the failure to correctly refer the case to the 1 August 2012 MARAC. Contact was made and services offered to Adult A on 13 July 2012. It does not appear that these procedural errors would have made a significant difference to this case.

19.0 Organisations' access to specialist domestic abuse agencies.

19.1 Appropriate supports appear to have been offered to Adult A, including sanctuary schemes and a women's refuge.

19.2 The training available to the agencies involved on domestic abuse issues

19.3 [] Domestic Abuse Partnership offers a range of training and awareness opportunities for a wide range of staff.

19.4 Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care

19.5 The main relevant mental health interactions were with Adult B in 2012. Adult B had a diagnosis of depression from his GP in Jan 2012. Adult B's subsequent presenting problems appear to have been in relation to low mood, suicidal ideation (no plans or intent), poor motivation, broken sleep, poor appetite and anxiety. Adult B stated to his GP that he felt angry and stressed, with increased feelings of anger. Given that Adult B's risk rating (using the 'Consequence and likelihood Matrix') was assessed as 'Serious', Adult B should not have been discharged from the Access and Advice Team on 7 June 2012 without further attempts at engagement. The assessment and the decision to close the case were not sufficiently informed by liaison with criminal justice agencies.

While the murder of the 18 July 2012 could not have been predicted, an opportunity to liaise with other agencies and attempt more robust engagement with Adult B was not exploited.

19.6 No specific issues in relation to equality and diversity presented themselves during the course of the review. There was no evidence that any elements of this case related to discrimination or oppression on the grounds of age, race, sexuality, religion or disability.

20.0 Summary

20.1 The IMR's provide a picture of a family with complex, challenging issues, presenting with a wide range of needs to a wide range of agencies over a long period of time. There is a clear pattern of a crisis prompting the involvement of a service and then one or more members of the family withdrawing, or refusing or failing to engage with services.

20.2 A number of agencies reference the issue that the specific presenting problems of individual family members were usually addressed (or attempts to address them were made), but there was little sense that the family was actually a complicated system in itself, and that the symptoms presenting to agencies related to the damaged and damaging interactions between the family members. As one IMR stated, there was too little recognition that the main issue was domestic abuse, records reference 'family arguments and communication issues' (prevention Family Support and Youth Division IMR). While Adult C and D presented with a range of needs over a long period of time, the central issue remained Adult B's violence to Adults A and C.

20.3 Adult C and Adult D have also both stated that they believe that more attention should have been paid to the family as a whole, with its attendant strengths and weaknesses, with more analysis of the root causes of the problems, rather than just responding to crises.

20.4 While there was no single notable incident of a major failure to provide a significant service, assess a meaningful risk or follow policies or procedures, the fact is that Adult B was on bail for a related offence at the time of the murder. It follows, then, that the decision to bail Adult B in July 2012 remains of concern.

This decision appears to have stemmed from a view of this incident as an isolated burglary, rather than as a domestic abuse incident in a long series of domestic abuse incidents, where the risks appear to have been escalating and the victim had stated to the officer dealing with the

case that Adult B's mental health "had recently deteriorated" (Police IMR). While it cannot be said that this would have prevented the death of Adult A, it is clear that the risks around this incident did not sufficiently inform the decision to grant bail.