SEFTON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary

Victim Female Adult 1

[FA 1]

Died November 2012

October 2014

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

FA 1 [Female Adult] : The Victim and wife of MA 1

MA 1 [Male Adult] : The Perpetrator

1.2 In November 2012, FA 1 was attacked by MA 1 at their home dead and died from shock and haemorrhaging from two stab wounds to her chest. MA 1 was found with apparently self-inflicted non-fatal wounds. In December 2013 he pleaded guilty to manslaughter and sentenced to 14 years imprisonment in February 2014.

1.3 The sentencing Judge said: MA 1 was suffering from a depressive illness at the time and was self-medicating with alcohol and would be sentenced on the basis of diminished responsibility. He added: "This is on any view a sad and tragic case but there is no getting away from the fact you killed your wife in terrible circumstances... despite diminished responsibility you still bear a heavy responsibility for her death. Source: Local Media

1.4 The couple were not known to main stream agencies for domestic abuse.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 In December 2012 the Chair of Sefton Safer Communities Partnership determined that the criteria for a DHR were met and informed the Home Office.

2.2 DHR Chair/Author

2.2.1 David Hunter was appointed as the Independent Chair and Author.

2.3 DHR Panel Members

2.3.1 The Panel comprised of:

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

David HUNTER Independent Chair and Author

2.4 Agencies Submitting Information

2.4.1 A scoping exercise evidenced the Panel's belief that there was very little relevant contact between FA 1, MA 1 and agencies.

2.4.2 Only Merseyside Police had sufficient information to warrant the completion of an Individual Management Review [IMR]. Other agencies submitted chronologies supported by short reports where appropriate. Additionally MSP provided the DHR chair/author with statements from the homicide investigation. MPT shared the findings of its Further Serious Offences review.

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

2.4.2 The DHR Panel looked for other sources of information but it appears, as verified by the police investigation, that the family was unknown to agencies from a domestic abuse perspective.

2.5 Notification/Involvement of Families

2.5.1 The families were notified by letter of the DHR and invited to contribute. FA 1's family nominated her father as the family spokesman and his views are reflected in the report. MA 1's father did not reply to two letters from the independent chair/author and it was felt further attempts to contact him could be seen as intrusive. Both families were given the opportunity to see the report before it was published.

2.6 Terms of Reference

2.6.1 Purpose of a DHR

The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

2.6.2 Specific Terms of Reference

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

2.6.3 Timeframe

The review period begins on 01.08.2009 and ends on 28.11.2012.

3. DEFINITIONS

DOMESTIC VIOLENCE

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

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

On 01.03.2013 the Government definition of Domestic Violence changes to:

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

4. FAMILY BACKGROUND

4.1 FA 1 Victim

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

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

4.2 MA 1 Perpetrator

4.2.1 MA 1 was brought up in Sefton and on leaving school at 16 years was employed for many years in the bakery industry. He worked in the concrete moulding industry before leaving employment to start a similar business with his father and one partner. It appears he liked to stop for a drink on his way home from work and this became a significant feature of his life. MA 1 was also described as a good parent who loved his children.

5. EVENTS ANALYSIS

5.1 Introduction

5.1.1 There is very little information recorded by agencies on the history of domestic abuse between FA 1 and MA 1. Prior to 11.01.2012 MSP had eight contacts with the family. These were not related to domestic abuse and concerned traffic matters and minor issues.

5.2 Non-Disclosure of Domestic Abuse

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

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

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

Source:

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

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

Source:

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

5.3 MA 1 Arrested Drunk and Disorderly

5.3.1 In January 2012 MA 1 was arrested for being drunk and disorderly at a football match in the North West for which received a fixed penalty notice. This is the first recorded event associating MA 1 with excessive alcohol use.

5.4 MA 1 Arrested for Drink/Driving

5.4.1 In October 2012 MA 1 was arrested for drink/driving. He was almost three times over the legal limit. He appeared at court later that month and pleaded guilty. He was disqualified for 24 months and received a 12 month Community Order with 80 hours unpaid work. This event provides additional evidence that MA 1 was a problematic drinker. MPT assessed he posed a low risk of reoffending or of causing serious harm to anyone.

5.5 Knife Incident

5.5.1 After FA 1's homicide the following event emerged from her friends. In early November 2012, FA 1 and MA 2 were at home and argued about his drink driving

conviction. FA 1 told her friends that he threatened her with a kitchen knife. The incident frightened her but she did not disclose it to the police or her family and asked her friends to keep the matter confidential.

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

5.6 FA 1 Visits Citizens Advice Bureau [CAB] Bootle CAB

5.6.1 In late November 2012 FA 1 visited CAB asking to talk to someone about divorcing her husband on the grounds of his unreasonable behaviour which she cited as excessive drinking. FA 1 spoke to a gateway assessor and asked for financial advice about whether she could afford a mortgage on her income.

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

5.6.3 In a statement made to MSP after FA 1's death, the CAB gateway assessor said he asked FA 1 if there was any violence linked to her husband's drinking. He said that FA 1 did not give him a direct answer and appeared evasive.

5.6.4 Several days later FA 1 attended Bootle CAB and saw a generalist adviser. FA 1 discussed ending her marriage. The generalist adviser gave her a factsheet on dissolving a marriage and FA 1 said she would refer to unreasonable behaviour. She insisted MA 1 was not an alcoholic and he only drank at weekends.

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

5.6.6 The adviser talked about FA 1 seeking the help of a solicitor with the divorce and discussed fixed fee interviews. FA 1 said her husband's financial adviser was visiting him this evening. FA 1 was going to seek a preliminary interview with a solicitor. There is no record of which solicitor, nor did MSP find any evidence that FA 1 saw one. It is unlikely she did because within a few hours of the CAB meeting FA 1 was dead.

5.6.7 The generalist adviser telephoned the financial adviser at Liverpool North CAB and left a message. FA 1 said it was alright for the financial adviser to contact her direct.

5.6.8 The generalist adviser believed that FA 1 did not fear violence from MA 1; she was emotionally wrought but did not seem alarmed about taking steps to obtain legal and financial advice to move her life forward. The generalist adviser did not discuss risk or safety planning with FA 1 as there was no indication of domestic abuse.

5.7 Liverpool North CAB

5.7.1 At 4.0 pm on the day of FA 1's death, the CAB financial adviser telephoned FA 1 to arrange an appointment and checked whether it was safe to talk. The adviser thought FA 1 shut a door before confirming it was. They made an appointment for the following week. In less than an hour FA 1 was dead.

5.8 MA 1 Visits his GP

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

5.9 MA 1's Financial Adviser

5.9.1 MA 1 told his financial adviser about five months before FA 1's death that he wanted to raise a mortgage to buy FA 1 out of the house. In mid-November 2012 the financial adviser met MA 1 who said he was splitting from FA 1. MA 1 also said he had been prosecuted for drink/driving and that had changed the family dynamics and he had found a property to move to. The financial adviser had an appointment to see MA 1 at his home on the day of the homicide. When the adviser arrived at MA 1's house he found the road sealed and the police in attendance.

6. ANALYSIS AGAINST TERMS OF REFERENCE

6.1 Term 1

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

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

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

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

6.1.2 Merseyside Probation Trust knew that MA 1 had a conviction for drink/driving and assessed him as low risk offender. They did not know of and domestic abuse and there were no opportunities missed to so identify him.

6.1.3 The interaction between FA 1 and CAB in late November 2012 is the first indication that any agency had of FA 1's plans to end her marriage to MA 1. There was no disclosure of domestic abuse during the meeting. FA 1 did not to mention the knife incident and all the indicators she gave to the generalist adviser suggested she was in control of the situation. For example she said that it was alright to leave a message on her home telephone number, probably indicating she felt confident that any CAB message picked up by MA 1 would not cause difficulties. FA 1 said she negotiated an equal split of the assets with MA 1 and wanted independent reassurance on her financial position. Those things do not overtly indicate a person who was in fear of MA 1.

6.1.4 However, FA 1 was not to know that MA 1 was exhibiting behaviour which increased the risk she faced from him. The generalist adviser told the police investigation that FA 1 did not fear violence from MA 1. FA 1's concerns were centred on his drinking and driving.

6.1.5 FA 1 told the generalist adviser that MA 1's behaviour "...affected her emotionally and mentally more than physical". The adviser should have sought clarification of what that meant, but did not. The incident where MA 1 threatened FA 2 with a kitchen knife is a high tariff risk factor.

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

6.1.7 The DHR Panel specifically excluded any causal factors between FA 1's interactions with CAB, its response, and her death. Citizens Advice is developing a set of standard enquiries under a pilot project to screen debt and housing clients for gender based violence and abuse

6.1.8 No other agency knew of the domestic violence between FA 1 and MA 1. Her father said that had the family known MA 1 threatened his daughter with a knife they would have spoken to him about his behaviour.

6.2 Term 2

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

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

6.3 Term 3

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

6.3.1 No agency had an opportunity to work with MA 1 or FA 1, therefore the reasons for his abusive behaviour are not known. It is known there was long term friction between FA 1 and MA 1 over his drinking and driving and that they had separate sleeping arrangements because of his enuresis. The relationship appears to have deteriorated very quickly over a few months when MA 1 realised that FA 1 was intent

on leaving him. The evidence of them; seeking financial advice; MA 1's declaration to his financial adviser that he had found a property to rent and FA 1's statements to CAB, testify that MA 1 was very likely to know that the marriage was over. FA 1's father felt that MA 1's attitude at that time was, "if I can't have you, no one else will".

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

6.4 Term 4

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

6.4.1 CAB asked FA 1 whether it was alright to telephone her at home and asking if it was "safe" to speak are examples of taking FA 1's wishes and feelings into account. The CAB generalist advisor could have explored FA 1 wishes and feelings. Beyond that there were no other opportunities.

6.5 Term 5

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

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

6.6 Term 6

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

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

6.7 Term 7

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

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

6.8.9 Term 8

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

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

6.9 Term 9

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

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

7. LESSONS IDENTIFIED

Narrative

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

Lesson 1

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

Narrative

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

Lesson 2

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

8. CONCLUSIONS

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

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

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

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

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

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

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

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

9. RECOMMENDATIONS

9.1 Single Agency

There are no single agency recommendations.

9.2 DHR Panel

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

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

END OF EXECUTIVE SUMMARY

Next Appendixes

Appendix A

Action Plan FA 1

Recommendation	Action	Lead Agency	Milestones	Target Date	Completion Date and Outcome
1. That Sefton Community Safety Partnership raises the awareness of domestic violence in the community. The advice should include how family and friends should respond after they receive disclosures of domestic violence.	Review current advice Write new guidance Prepare material Seek opportunities to publicise Launch awareness campaign	Sefton Community Safety Partnership	Guidance approved Material prepared Campaign launched	March 2015	
2. That Sefton Community Safety Partnership ensures that professionals in its constituent agencies understand the barriers to disclosure faced by victims of domestic abuse and develop plans to overcome them. This	Incorporate barriers to disclosure as part of any training package for frontline workers Merseyside PCC and Merseyside	Sefton Safer Community Partnership	Training programme prepared in partnership with LSCB Roll out of training Outcomes	Dec'ber 2014	

could include the routine use of domestic abuse screening tools and asking direct questions.	Criminal Justice Board are currently reviewing risk assessment tools and a query will be raised with the appropriate sub group about use of domestic abuse screening tools and best practice guidance on this.		of risk assessment tools review considered and amendment to process. made as required		

Appendix B

Risk Factors and Safety Plan

Risk Factors

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

Executive Summary

Cases reviewed from 2003-2012:

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

55% of the cases reviewed were homicides.

45% of the cases reviewed were homicide-suicides.

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

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

The other top risk factors were:

- obsessive behaviour by the perpetrator
- a perpetrator who was depressed
- an escalation of violence

- prior threats or attempts to commit suicide
- prior threats to kill the victim
- a victim who had an intuitive sense of fear towards the perpetrator
- a perpetrator who was unemployed

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

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

Preparing to leave

The following link takes you to: www.womensaid.org.uk/domestic-violence-survivors-handbook, where you will find good practical information on preparing to leave a relationship and how to keep yourself safe.