Final Report 05/01/2015

ANONYMISED VERSION

DOMESTIC HOMICIDE REVIEW:

INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF Mr. A

EXECUTIVE SUMMARY

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1) THE DOMESTIC HOMICIDE REVIEW PROCESS

1.1 Who the report is about:

This report of a domestic homicide review examines agency responses and support given to **Mr. A**, a resident of Liverpool prior to his death on 28/11/2012. Mr. A was 48 years old when he died.

The review considers agencies' contacts and involvement with **Mr. A** and his partner and cohabitee **Ms. B**, who was 24 years old when the homicide occurred.

1.2 Purpose of the review:

The key purpose for undertaking DHRs 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.

1.3 The homicide incident and the decision to carry out a Domestic Homicide Review:

On 28/11/12, Mr. A was stabbed at his home address in Liverpool. He was taken to the Royal Liverpool Hospital, had a cardiac arrest and died later. A murder investigation was established and his partner / cohabitee Ms. B was arrested and charged with his murder. On 19/12/12 a meeting of Liverpool CSP's Standing Group for DHRs reviewed the circumstances of the homicide and concluded that the criteria for holding a DHR were met. The Home Office was duly notified that a DHR was to be conducted.

1.4 Ms B's Conviction for manslaughter:

On 21/6/13 at Liverpool Crown Court Ms. B, who had denied murder but admitted manslaughter, was convicted of manslaughter on the grounds of diminished responsibility. She was sentenced to life imprisonment with a recommended minimum term of 12 years.

1.5 Review timescales:

Home Office guidance is that DHRs should, where possible, be completed within six months of the initial decision to carry out the review. In this case, this six month time frame has not been achieved. The main reasons for delay have been:

- A decision was taken not to commence the DHR until after criminal processes were completed. This was based on advice that DHR related enquiries would carry a significant risk of compromising the criminal process.
- The victim and perpetrator had, until a few months prior to the homicide, lived an itinerant and at times chaotic lifestyle. Consequently they had had significant contacts with agencies in different regions across England. This resulted in the complex task of collecting, collating and analysing information from a number of different CSP areas.
- As the DHR progressed, it became apparent that much of the learning was likely to be of particular relevance to agencies in the Somerset CSP area where the couple had been resident until a few months before Mr. A's death. It was therefore agreed by the respective CSPs in Liverpool and Somerset that each area would convene a DHR Panel, with the same Independent Chair / Overview Report Author working with each Panel. This approach helped to ensure that issues of inter-agency cooperation and communication within and between regions could be properly explored, but it also required additional time to allow for meetings in both locations, with cross-checking of information, key learning and

recommendations.

1.6 Confidentiality:

Home Office guidance makes it clear that this report **must be treated as strictly confidential and should not be circulated, other than to members of the DHR Panel and their line managers.** Once the Community Safety Partnerships have signed off the overview report and executive summary, these will be forwarded to the Home Office Quality Assurance Group, together with supporting documents.

The anonymised executive summary will be published, after clearance has been received from the Quality Assurance Group.

1.7 Terms of Reference:

Each of the agencies which had been identified as having significant and relevant involvement with the victim and / or perpetrator carried out an Individual Management Review (IMR) of that agency's involvement. The terms of reference included a requirement for the IMRs and this overview report to specifically address the following questions:

1.71 What knowledge / information did your agency have that indicated Mr. A might be a victim of domestic violence and how did your agency respond to information including that provided by other agencies.

1.72 What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to his needs?

1.73 What information and/or concerns did the victim's family and friends have about victimisation and what did they do?

1.74 What knowledge did your agency have that indicated Ms. B might be a perpetrator of domestic violence?

1.75 Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to Mr. A and Ms. B, or on your agency's ability to work effectively with other agencies?

1.76 Were there any issues relating to this couples' itinerant lifestyle which affected your agency's ability to effectively identify and manage risks of domestic violence?

1.77 Are there any examples of outstanding or innovative practice arising from this case?

1.78 Are there any other issues, not already covered above, which the DHR Panel should consider as important learning from the circumstances leading up to this homicide?

1.8 DHR Contributors:

The following individuals and organisations have contributed to this DHR:

MERSEYSIDE		
Name	**Organisation**	**Contribution to DHR**
Richard Corkhill	Independent Consultant	Independent Chair/ Overview Report Author
Michelle Lesbirel-Jones	Community Safety & Cohesion Service, LCC	DHR Lead for Liverpool CSP (until Dec 13)
Jill Summers	Community Safety & Cohesion Service, LCC	DHR Lead for Liverpool CSP (from Dec 13)
Jayne McPartland	Community Safety & Cohesion Service, LCC	Administrative support
Sue Coombs	Merseyside Police	Panel member / IMR

Margaret Dickson	Whitechapel Centre	Panel member / IMR
Sam Atkinson	Liverpool Clinical Commissioning Group	Panel member / IMR
Helen Smith	Liverpool Clinical Commissioning Group	Shadowing Sam Atkinson
Ann Dickinson	Merseyside Probation Trust	IMR
Barbara Davis	Wirral Council Housing Options Service	IMR
Sheila Jacobs	Wirral Council Housing Options Service	Panel member
SOMERSET		
Richard Corkhill	Independent Consultant	Independent Chair/ Overview Report Author
Suzanne Harris	Senior Commissioning Officer, Somerset County Council	DHR Lead for Somerset CSP
Steve Brewer	South Somerset District Council	Panel member
Scott Weetch	Taunton Deane Borough Council	
Chris Absolon	Somerset Clinical Commissioning Group	Panel member / IMR
Amanda Cole	Turning Point	Panel member / IMR
Peter Maguire	Mendip District Council	Panel member / IMR
Duncan Marrow	Musgrove Hospital	Panel member / IMR
Martin Turner	Adult Social Care	Panel member / IMR
Rebecca Reade	BCHA	Panel member / IMR
Jo Leworthy	Somerset Partnership	Panel member / IMR
Caroline Howard	Avon and Somerset Police	Panel member (Merseyside Police IMR covered both forces)
Emma Rossi	Elim Connect Centre	IMR
Janet Ebdon	Yeovil District Hospital	IMR

Each of the Panel members has received a copy of the report, in advance of signing off by the two Community Safety Partnerships and forwarding to the Home Office Quality Assurance Group. **(See section 1.5 above re confidentiality)**

1.9 Independent Chair and Overview Report Author:

Richard Corkhill has a professional background in statutory and voluntary sector social care, including senior management of services for vulnerable young people and adults. As an independent consultant since 2004, his work with public sector organisations has included research into safeguarding adults policy and practice and production of independent reports for safeguarding adults Serious Case Reviews and DHRs.

1.10 Contact with victim's family and informal networks:

The Independent Chair has written to family members of the victim, advising them of the DHR process and inviting them to meet with the Chair and contribute directly to the DHR. To date, they have chosen not to take any active role in the DHR.

There has been no contact by the DHR with any friends or other informal networks who knew the victim or perpetrator. As their lifestyle was itinerant and chaotic, informal networks and associates are believed to have been intermittent and short term contacts who will similarly have had chaotic lifestyles including homelessness, substance misuse, mental health problems and low level crime. On this basis, it seems unlikely that contact with informal networks, even if the relevant people could be identified and located, would provide significant additional learning.

1.11 Contact with perpetrator

The Independent Chair / Report Author had one meeting with Ms. B in December 2012, at the prison where she is serving her custodial sentence. She was supported at this meeting by her prison based mental health support worker.

2: BACKGROUND INFORMATION CONCERNING Mr. A & Ms. B

The following is based primarily on information provided by Merseyside Police. Mr. A was born in 1964. He was brought up in Merseyside, where he lived with his parents and younger sister. He left school when he was sixteen years old. He had a number of different jobs, which are only described as involving his 'creative talents'. During the early 1990s he began a relationship which resulted in three children. The relationship ended in 2000, when Mr. A left his family and began to travel around the country, intermittently selling the 'Big Issue' magazine, and attending Glastonbury and other music festivals. He had little contact with his children during this period but did speak to his mother by telephone.

He had been arrested on eighteen different occasions since 1981, for offences relating to dishonesty, assault, drug possession and drunkenness. This had resulted in him having twelve previous convictions and two cautions. He had a warning signal on the Police National Computer (PNC) of 'ailments' which were listed as 'diabetes', 'asthmatic' and 'alcoholic'.

Mr. A claimed to have served in the army. However, checks by the police disclose no record of him having served in any of the regular or territorial armed forces in the United Kingdom.

Ms. B was born in 1988, in London. Her background details are rather scant in relation to police records. According to interviews conducted after she was arrested for the homicide of Mr. A, she grew up in West Kent and lived with her

paternal grandparents. After finishing her GCSE's she went to the Cambridgeshire area, where she undertook a course in animal husbandry. She states that she "could not cope" with her father, and left home for life on the streets.

Prior to the homicide, Ms. B had been arrested on fifteen separate occasions for offences relating to dishonesty, assault and disorder, resulting in her having eight previous convictions and two cautions. Her first arrest was in 2006. This relates to her having taken a kitchen knife into the Agricultural College she was attending at the time, but was later expelled from.

Mr. A & Ms. B's relationship: Ms. B reports that she began her relationship with Mr. A the week before her eighteenth birthday. From then on they began a relationship, in the form of an itinerant lifestyle, travelling around various counties in the South of England. They would live in tents, dens, derelict property, sheltered accommodation and rented flats. They were both alcohol dependent and would associate with street drinkers in the various town centres. Neither of them was employed and there is no evidence of them seeking work. During this period, they were arrested on several occasions for anti-social type offences which included drunkenness, assault and disorder. They were also themselves subject of assaults by other parties.

In May 2012, the couple had moved to Merseyside and were living in a tent on the Wirral. Towards the latter part of that month they had been provided with bed and breakfast accommodation in Liverpool. Some three months on, they moved to their last residence, a privately rented flat in Liverpool, which was the location of Mr. A's death on 28/11/12.

Both Ms. B and Mr. A suffered from grand mal epilepsy, and it is understood that this was one of the factors which helped maintain the relationship, as they were

able to provide each other with mutual support and understanding. The evidence seen by the DHR indicates that this was a very close, co-dependent relationship, but with frequent short term conflicts and episodes of mutual violence.

The wider evidence seen by the DHR confirms that both Ms. B and Mr. A were susceptible to periods of heavy drinking, at which times their lives and behaviour became more chaotic and violent incidents were more likely to occur. They used other substances on occasions, but the extent to which illicit drugs impacted on the relationship and their behaviors is not clear.

3) SUMMARY OVERVIEW AND KEY LEARNING POINTS

This section briefly summarises key conclusions and learning points, with reference to the Terms of Reference questions for IMR authors:

3.1 What knowledge/information did your agency have that indicated Mr. A might be a victim of domestic violence and how did your agency respond to information including that provided by other agencies.

Individually and collectively, a range of agencies in Somerset had information which confirmed both Mr. A and Ms. B as being at high risk from mutual domestic violence. For Mr. A, the identifiable risks of serious injury or death were increased significantly, because of the known history of incidents where Ms. B had threatened him with knives. There were multi-agency attempts to address the risks resulting from this mutually violent relationship, including referrals into the MARAC process and attempts at engaging Ms. B with an IDVA service. There were also criminal justice interventions and one unsuccessful attempt to prosecute Ms. B following an incident in June 2011, when she physically assaulted Mr. A before threatening him further with a knife. The prosecution was withdrawn at court, as Mr. A was not willing or able to act as a prosecution witness.

Key learning point 1

There may well have been little prospect of continuing with this prosecution, after it became apparent that Mr. A would not attend court as a witness. However, it is important to recognise that some prosecutions for domestic violence offences are appropriately and successfully continued, even where the victim has withdrawn support. In this case a successful prosecution would have potentially offered opportunities for focused work with both Ms. B and Mr. A, to try and address the significant risks (to both parties) which were clearly present in this relationship. This may have included work with Ms. B within a custodial setting, or as an element of a community sentencing option. Clearly, had the result been a custodial sentence, this would also have prevented any further incidents of domestic violence, at least for the period of imprisonment.

3.2 What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to his needs?

At various stages, Mr. A was offered services, including:

- Homelessness advice and support, including placements in bed and breakfast / hostel accommodation and support to access private rented accommodation.
- Voluntary sector drop-in and advice services for homeless people
- Support and treatment interventions for alcohol dependency
- GP and other primary health care services
- Treatment at hospital emergency departments
- Information about a telephone based advice service for male victims of domestic violence.

The evidence presented to the DHR indicates that Mr. A did access quite a wide range of services. However, with the exception of being given contact details for

the telephone advice service, services were primarily responding to his immediate health and social care needs, with no clear focus on him as a high risk domestic violence victim. When there was a recognition of domestic violence concerns, he was most usually perceived as the perpetrator (which he quite frequently was) although Somerset Police and MARAC partners did recognise that both parties were at risk.

That he was given contact details for the Mankind service for male victims is a good practice example, but as this service could only have offered telephone advice it was unlikely that somebody with such complex needs as Mr. A would engage effectively with such a service.

Key Learning Point 2

Whilst telephone and internet based advice is an important and valuable resource, male victims of domestic abuse should be able to access to face-to-face services with specialist knowledge, awareness and understanding of the needs of male victims. It is very unfortunate that no such services were made available to Mr. A. This is clearly not just an issue for Somerset, but is widespread throughout all parts of the UK.

Both Ms. B and Mr. A had periods when they recognised alcohol dependency as being a major problem. They did seek specialist help and support from Turning Point, but were unable to maintain any meaningful level of engagement with interventions.

In summary, both Ms. B and Mr. A did access a wide range of services, usually when they were in crisis as a result of various combinations of health emergencies; relationship breakdowns, mutually violent incidents, homelessness, alcohol dependency, low level crime, etc. The repeated pattern was that, following each crisis, they would reconcile the relationship and disengage from

services which were attempting to intervene. It is important to acknowledge that this pattern of engagement and disengagement, further complicated by a chaotic and itinerant lifestyle, made it extremely difficult for services to formulate or implement strategies to safeguard them from further mutually violent incidents.

It can therefore be concluded that services were generally *accessible* but frequently not resourced to adequately meet the very complex needs presented by this couple.

Key learning point 3

People who have multiple and complex needs are often those who are at the greatest risk of domestic violence and potential homicide. They also present major challenges to services trying to engage with them, to reduce risks. This is evidenced, for example, by a review of 54 DHRs presented to the Home Office between April 2011 and March 2013, which highlighted complex needs as a common theme. [1]

There are no simple solutions for overcoming barriers to effective engagement with domestic violence victims who have multiple and complex needs. However, it is essential that all agencies working with domestic abuse and multiple / complex needs regularly review - and where possible improve - their responses in the light of learning from this DHR and others. Areas for improvement may include increasing levels of staff awareness and understanding of domestic violence risks and supporting staff to continually develop skills in working with difficult to engage individuals.

[1] *Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned.* Home Office Nov 13

3.3 What information and/or concerns did the victim's family and friends have about victimisation and what did they do?

Mr. A's family had minimal contact with him during the period of his relationship with Ms. B and have chosen not to contribute to the DHR process. Due to the itinerant and chaotic lifestyle of Ms. B and Mr. A, the DHR has not identified any other friends or informal networks which would be able to offer reliable insights into Mr. A's experience as a victim (or perpetrator) of domestic violence. Therefore, this element of the Terms of Reference is not addressed fully. However, the evidence seen by the DHR has not included any references to concerns having been raised or actions taken, by the victim's family or friends.

3.4 What knowledge did your agency have that indicated Ms. B might be a perpetrator of domestic violence?

As already noted (5.1 above) there was substantial evidence held by a range of agencies in Somerset that Ms. B was both a perpetrator and victim of domestic violence. However, the evidence presented to the DHR shows that agency responses often tended to be based on a view that her primary role in the relationship was 'victim', whilst Mr. A's was 'perpetrator.' This was particularly the case after the couple moved to Merseyside, because agencies there had no knowledge of the recent history of mutual violence. Bearing in mind that male violence on women is generally much more prevalent than female on male violence – and far more likely to lead to domestic homicide - this was an understandable but incorrect assumption. The age difference between Mr. A and Ms. B may have been an additional factor in how "victim / perpetrator" roles were perceived.

Key learning point 4

Whilst male perpetrator / female victim is recognised as by far the most common form of physically abusive relationship, it is essential that risk assessments carefully consider the evidence of each individual case, without making

assumptions based on the genders (or ages) of the parties involved.

Assessments should also be informed by research [2] which confirms that women perpetrators of domestic violence are significantly more likely than male perpetrators to use weapons, especially in the context of mutually violent relationships.

This was clearly a mutually violent relationship where both parties were at high risk. However, Ms. B's pattern of incidents with knives (which was not a known feature of Mr. A's behaviour) could have been seen to place him at even greater risk.

Unfortunately, this information about past incidents and the use of weapons by Ms. B was not known to services in Merseyside. As a result, the nature and level of risks which existed were not subject to an informed risk assessment process.

Prior to the homicide, the police and other services in Merseyside had assessed domestic abuse risks, solely on the basis of a low level incident in August 2012, where Ms. B was identified as a potential victim of Mr. A. This incident, considered in isolation, was insufficiently serious to trigger referral into the local MARAC process. Whilst Ms. B was offered support and advice, there were no strategies in place to manage possible risks to Mr. A, because no such risks were identified. There were a number of missed opportunities when key historical information about domestic violence risks could have been shared, but was not:

Missed opportunity: When Mendip District Council Housing Options first became aware (as a result of contact from counterparts at Wirral Housing Options in May 2012) that Mr. A and Ms. B had re-located to Merseyside, this

[2] See, for example: *"Who Does What to Whom? Gender & Domestic Violence Perpetrators. Professor Marrianne Hester, School for Policy Studies University of Bristol, 2009.* Findings included that 77% of dual perpetrators (i.e. those in mutually violent male / female relationships) using weapons were women. The study observed that this use of weapons tended to be for reasons of self – protection.

should have resulted in a MARAC to MARAC referral. Subsequent contact from the Whitechapel Centre should also have prompted this process. Contrary to Somerset's MARAC Operating Protocol, this did not happen.

Key learning point 5

People with chaotic lifestyles who are victims and/or perpetrators of domestic violence are often in frequent contact with homelessness services. When they re-locate to a new area, homelessness teams are likely to be a first point of contact with an agency which has links into the local MARAC. Homelessness Officers will frequently contact counterparts in the previous area for information relating to eligibility for homelessness assistance.

For this reason, it is essential that homelessness and housing options services have systems in place (and staff awareness of those systems) which ensure that information about domestic violence risks is shared appropriately with counterparts in the new location. Where the case has MARAC involvement a MARAC to MARAC referral should take place.

Missed opportunity: When Merseyside Police were involved in a low level domestic violence related incident in August 2012, a full check on the Police National Database would have revealed a history of violence between the couple, including 2 incidents where Ms. B had threatened Mr. A with a knife. It would also have alerted them to the fact of recent MARAC processes in Somerset. However, such a check was not required under Merseyside Police procedures in place at the time.

Key Learning Point 6

As Merseyside Police deal with around 35,000 domestic abuse incidents each year, carrying out a PND check following every single incident would have major resource implications. However, if initial risk assessments ask whether the couple

have previously lived in another area, this could then act as prompt for a PND check to be carried out. As a result of learning from this case, Merseyside Police are reviewing their procedures in line with this learning point.

Key learning point 7:

Although a PND check by Merseyside Police would have revealed a history of mutual violence including the 2 incidents of threats with knives and the involvement of MARAC in Somerset, it would not have provided a comprehensive history of police involvement in domestic violence incidents, because inconsistent practice in a number of other force areas meant that not every incident was recorded on PND.

Key learning point 8:

The analysis provided by the Merseyside Police IMR has highlighted that, in a number of force areas, intelligence resulting from domestic violence incidents was not entered on PND. Consequently, any subsequent risk assessments were based on incomplete information.

Missed opportunity: If Merseyside Police had carried out a PND check (and thus been aware of the MARAC process in Somerset) the DHR has been advised that this would probably have triggered referral into the local Merseyside MARAC process. This, in turn, would have ensured that other key services in Merseyside would have been informed about the high risks of mutual violence in the relationship.

Key learning point 9:

The DHR finding that this would *probably* have resulted in a MARAC in Merseyside suggests a possible need to review local MARAC procedures, to ensure that, in similar circumstances (where a couple are identified as having been subject to recent MARAC input in their previous area of residence and there

is evidence of current risk) then referral into the local MARAC will *definitely* occur.

Missed opportunity: When Ms. B and Mr. A registered with GPs on Merseyside, their GP medical files were transferred from their last GP practice in Somerset. The DHR has established that both of these sets of notes should have included a letter from Somerset MARAC stating that the patient had been identified as being at high risk from domestic violence from their partner and requesting that files should be flagged accordingly. The letter was not included in Ms. B's GP records in Merseyside and her file was not flagged. The letter was found in Mr. A's GP records in Merseyside, but his file was not flagged. The date on which the letter was received by the practice is unknown, so it is not clear that they had this information prior to the date of the homicide.

Key learning point 10:

Discussions with the CCG representatives on the Somerset and Liverpool Panels confirm that there are ongoing issues for primary healthcare services nationally, about how information on domestic violence risks is stored, shared and flagged in NHS records generally and GP patient notes in particular.

This case has further highlighted that key information about risk (including domestic abuse, but also other key areas such as safeguarding children and vulnerable adults) is quite commonly 'lost', especially when people transfer from one GP practice to another. Evidence from this case and discussions with CCG representatives on both panels suggests that the possibility of this happening appears to be even greater when people re-locate to different regions and practices covered by different CCGs.

It has also been reported that, even in those cases where full information is forwarded to the new GP practice, there can be delays of several months between the new patient registration and receipt of patient files from the previous

practice.

To complicate matters further, there is ongoing national debate about whether flagging of GPs notes of domestic abuse victims and perpetrators could increase risks of domestic abuse, in the event that a perpetrator sees the notes.

These appear to be issues requiring urgent review and action at a national level, led by NHS England.

3.5 Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to Mr. A and Ms. B, or on your agency's ability to work effectively with other agencies?

The DHR has identified the following capacity and resource issues:

- **Merseyside Police** report that capacity and resource issues prevent them from carrying out PND checks on every domestic violence incident.
- At the time of their contacts with Ms. B and Mr. A, the **Elim Centre** was a recently established service with limited experience / capacity for working with higher risk service users and working effectively with multi-agency partners. It is understood that, in the intervening period, the service has developed significantly in these respects.
- At the time of their contacts with Ms. B and Mr. A **Turning Point** did not have pro-active outreach and housing related support services, which might have helped to maintain effective engagement with this couple, to address alcohol dependency issues. Such approaches have since been developed.

3.6 Were there any issues relating to this couples' itinerant lifestyle which affected your agency's ability to effectively identify and manage risks of domestic violence?

The couple's itinerant lifestyle whilst living at various locations in Somerset and other parts of the South West region created some major challenges for agencies in that area. Despite these challenges, the MARAC process in Somerset did succeed in identifying risks and helped to ensure that key agencies in the area were aware of these risks, though Ms. B was largely assumed to be primarily the victim and Mr. A the perpetrator. Their itinerant and often chaotic lifestyle created even greater challenges for services attempting to intervene to reduce risks, because workers were unable to establish consistent contact or working relationships with Ms. B and Mr. A, either as a couple or individually.

Agencies' ability to effectively identify risks was also a clear issue when the couple relocated to Merseyside, because Merseyside agencies in contact with them (including housing options, police and the Whitechapel Centre) were working without key information about the history of high risk domestic violence. The main point of learning is that this information was not provided via a MARAC to MARAC referral, even after MARAC partners in Somerset became aware of the relocation. (See key learning point under 5.4, above)

3.7 Are there any examples of outstanding or innovative practice arising from this case?

Several examples of good practice by agencies which had contacts with this couple are identified in the analyses of agency involvement. There are no examples which could be described as outstanding or innovative.

3.8 Are there any other issues, not already covered above, which the DHR Panel should consider as important learning from the circumstances leading up to this homicide?

The DHR has raised a question for Yeovil District Hospital about the

appropriateness of domestic violence policy and procedures being placed with a vulnerable adults' policy framework, because not all victims of domestic violence would necessarily meet the formal (No Secrets) definition of a vulnerable adult. This raises the possibility that patients who may be domestic violence victims may not be recognised by staff as falling within this policy and procedural framework.

4) RECOMMENDATIONS

Recommendations are divided into single agency recommendations (reproduced directly from IMRs) and overview recommendations.

The Action Plan (appendix 1) provides more detail of actions required to deliver the overview recommendations, with time scales for completion. It is suggested that the two CSPs should prioritise and actively monitor progress in relation to Overview Recommendations, but they may also request agency updates in relation to single agency recommendations

6.1 Single Agency Recommendations

Somerset County Council:

- *To ensure that it's client case records accurately record engagement in all relevant DV cases.*

Elim Connect Centre, Somerset:

- *Response to lack of coordinated work among agencies with rough sleepers in Mendip.*
- *Observing and supporting rough sleepers outside of day services. Targeted support for isolated RS and those who are disengaged from services.*
- *Accurate recording of work carried out with client, and of interactions, and*

insights.

Taunton & Somerset NHS Foundation Trust

- *Increased engagement with multi-agency partners*
- *Clear internal and external pathways for referral*
- *Key staff to have essential Domestic Abuse training*

Merseyside Clinical Commissioning Group

- *CCG to lead on ensuring learning from the DHR is shared with appropriate personnel and practices.*

Whitechapel Centre

- *Ensure persistence in risk gathering*

Wirral Housing Options

- *Wirral need to consider asking a question regarding domestic violence directly in their dealings with other agencies or local authorities as part of their investigation, almost as part of a check list so that we are not reliant on information being passed on. In this way we can be more pro-active.*

Merseyside Police

- **An additional section should be included on the VPRF/1 (Vulnerable Person Referral Form) form titled 'Background to the relationship', and inserted immediately after the twenty one tick box questions. In this section the question should be asked, "Has the Victim or Perpetrator ever resided outside the Merseyside area?" If the answer is 'yes', then the location of that abuse should be recorded. In relation to other forces, the question should be included on whatever system they operate, for completion by the officers initially dealing with the incident.*
- **When a history of residence outside of the reporting force area has been recorded on the VPRF/1, then the FCIU (Family Crime Investigation Unit)*

risk assessor responsible for that assessment must conduct a PND check on all parties involved.

- **When 'domestic abuse' has been discovered in other areas and is recorded on PND, then contact must be made with agencies in that other area and information shared.*
- *Ensure that there are sufficient trained and licensed staff to access and interrogate the PND within each FCIU within the force. This is to prevent blockages in the risk assessing process, and facilitate the sharing of information with other agencies.*
- *All persons who conduct risk assessments within the force FCIUs should receive formal training to ensure a uniform approach across the force.*
- *Ensure that staff who deal with 'domestic abuse' incidents are fully aware of the dangers of contacting a victim via the alleged perpetrator.*
- *Ensure that FCIU supervision properly finalise all allegations of 'domestic violence', and reinforce compliance with the National Crime Recording Standards.*
- *Allocation queues of 'domestic abuse' Storm logs allocated to FCIUs must be checked on a regular basis and at least once a day.*

*** The first 3 Merseyside Police recommendations are suggested for national implementation across all force areas**

6.2 Overview Report Recommendations

Some of the following recommendations are for local actions by individual organisations in Somerset or Merseyside. However, they may well be equally relevant and applicable to similar services operating in either area, or indeed other regions of the country:

Overview Recommendation 1

See key learning point 6

Merseyside Police should review policy and practice on the use of PND checks following reported domestic violence incidents. Specifically, they should consider adapting the initial risk assessment format, to include the question of whether the victim or perpetrator have resided outside of the Merseyside Police area. If this question is answered in the affirmative, a change of policy and procedure should be considered, which would stipulate that a PND check is conducted on both victim and perpetrator, to establish whether the system shows evidence of any history of domestic abuse.

Overview Recommendation 2

See key learning point 5

Housing Options services delivered by district councils in Somerset and Wirral should review policy, procedure and staff training around responses to domestic abuse issues affecting people who present as homeless. This should specifically include staff awareness and processes in relation to the MARAC Operating Protocol, MARAC to MARAC referrals and sharing risk information with housing options / homelessness services in other areas.

Overview Recommendation 3

See key learning point 1

Where victims withdraw support for a prosecution following an allegation of domestic abuse, the possibility of continuing the prosecution should always be given due consideration by the CPS, in liaison with the police and other partner agencies. If the decision is then to discontinue the case / offer no evidence, a clearly recorded rationale should then be available for future scrutiny, including any subsequent DHR relating to the victim.

Overview Recommendation 4

See Key learning point 2

Somerset Community Safety Partnership should review levels of need, demand and supply of advice and support services for male victims of domestic violence. Findings should be used to inform future commissioning priorities for domestic violence services in the county.

Overview Recommendation 5

See key learning point 3

Liverpool and Somerset CSPs should consider commissioning multi agency training on domestic abuse involving adults with complex needs. [3]

Overview Recommendation 6

See key learning point 9

Liverpool CSP and Merseyside partners should review local MARAC policy and procedure and consider including a requirement that, when it becomes apparent that anybody subject to MARAC in another area has moved into the Merseyside Police area, this should be referred for local MARAC discussion and multi-agency responses.

Overview Recommendation 7

See key learning point 10

Somerset and Liverpool CCGs should review policy and procedure around the recording, flagging and sharing information about patients who are known to be at risk of domestic abuse. This should aim to ensure that, when patients transfer to a new GP practice (either within the CCG or into a new geographical location) information about domestic abuse risks follows the patient and is appropriately

[3] A recommended training pack / e learning guide on working with adults with complex needs who are vulnerable to abuse is published by **Against Violence and Abuse**: **http://tinyurl.com/noa4j3t**

flagged. This should include consideration of a coding system to reduce the possibility of a perpetrator becoming aware that medical notes were flagged for domestic abuse.

Overview Recommendation 8

See key learning point 10

Somerset and Liverpool CCG's should inform NHS England of local review findings (from recommendation7) including any issues which require a coordinated national response to ensure that GP records about domestic abuse risks follow patients promptly and efficiently, when they register with a new GP. This may require consideration of a nationally agreed coding system.

Overview Recommendation 9

The Home Office should circulate the Merseyside Police recommendations (6.1 above) to all English force areas, for information purposes and consideration of possible actions in relation to the first three of those recommendations

Overview Recommendation 10

A copy of the anonymised version of this report should be forwarded to the Chief Constables of each of the force areas which had involvement with Mr. A and Ms. B, but were not directly involved in the DHR process:

- Devon and Cornwall
- Kent
- Thames Valley
- Cambridgeshire
- Wiltshire