DOMESTIC HOMICIDE REVIEW

SAFER WAVERLEY PARTNERSHIP

Report into the death of AA

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Standing Together Against Domestic Violence
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1. SAFER WAVERLEY PARTNERSHIP

AA

Overview Report

Introduction

1.1 Outline of the incident

1.1.1 On x February 2015, BA, a 51-year-old man, attended a Police Station in Dorset. He told police that he had been involved in an incident with his 47-year-old brother AA. It had taken place at the home they shared, situated in the Borough of Waverley, Surrey. BA told police that his brother went for him with a knife and in defending himself BA may have killed his brother. Surrey Police went to the address given by BA and found AA dead inside the premises. AA had died as a result of stab wounds.

1.1.2 BA was later found guilty of murdering his brother AA and was sentenced to life imprisonment; to serve a minimum of twelve years.

1.1.3 The Review Panel expresses its sympathy to the family of AA for their loss.

1.2 Domestic Homicide Review and Timescales

1.2.1 Domestic Homicide Reviews (DHRs) were established under *Section 9(3), Domestic Violence, Crime and Victims Act 2004*.

1.2.2 The Safer Waverley Partnership (SWP), in accordance with the Revised Statutory Guidance for Domestic Homicide Reviews (March 2013), commissioned Standing Together Against Domestic Violence to Chair this DHR.

1.2.3 Surrey Police notified SWP on x February 2015 that the case should be considered as a DHR. The SWP made a decision to conduct a DHR, and having

agreed to undertake a review, the Home Office was notified of the decision in writing on x February 2015.

1.2.4 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The SWP commissioned the services of an Independent Chair for the Review in July 2015. There were delays in starting the review process as the SWP Chair wished to conduct a scoping exercise to establish if there was necessity to hold a full DHR, therefore the SWP Chair and the Chair of the Review met with the Senior Investigating Officer (SIO) for the homicide investigation. It became apparent that there had been contact with statutory agencies in the years leading up to the homicide, with reported incidents in the Dorset Police area. The SWP took the decision to go ahead with a full DHR process at the start of 2016.

1.2.5 The purpose of Domestic Homicide Reviews is to:

(a) 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.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.2.6 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.2.7 The first meeting of the Review Panel was held on 27 April 2016. There were subsequent meetings on 29 June 2016 and 22 September 2016. The report was submitted to the Safer Waverley Partnership on 13 February 2016.

1.3 Terms of Reference

1.3.1 The full terms of reference are included at **Appendix 1.** The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3.2 The Review Panel comprised agencies from Waverley, as the victim and perpetrator were living in that area at the time of the homicide. During the SWP scoping exercise prior to the first panel meeting, it was established that the perpetrator had contact with agencies in Dorset and therefore agencies from Dorset were invited to join the Review Panel. Dorset Police provided representation to the Review Panel.

1.3.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from x February 2013 to the date of the discovery of the victim's body. This two-year period of review was chosen to consider all local agency contact and to include known incidence of domestic abuse in Dorset. Agencies were asked to summarise any relevant contact they had with AA or BA outside of these dates.

1.3.4 At the first meeting, the Chair of the Review and the Review Panel discussed those issues particularly pertinent to this review. The particular issue of this review concerned adult familial violence. There were no agencies specialising in this area known to the SWP. The local domestic violence non-government organisation was represented on the Review Panel.

1.4 Independence

1.4.1 The Independent Chair and author of the DHR is Mark Yexley, an associate of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. Mark has received training from Standing Together. Standing Together has been involved in the DHR process from its inception, chairing over 50 reviews.

1.4.2 Mark is a former Detective Chief Inspector in the Metropolitan Police Service with 32 years' experience of dealing with domestic abuse. Mark retired from the MPS in 2011. He was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. He was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Mark was a member of the Department of Health National Support Team and London lead on National ACPO and HMIC Reference Groups. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent review of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course. Mark has no connection with the Safer Waverley Partnership, Surrey and Dorset Police or any other of the agencies involved in this case.

1.5 Parallel Reviews

1.5.1 Following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review. There was no inquest for this case.

1.5.2 The criminal trial process was completed before the DHR process formally started and there were no issues on disclosure.

1.6 Methodology

1.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with AA and BA. Whether they had contact was established at the first meeting and through letters and telephone calls to those not in attendance.

1.6.2 It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. This included Chapter 1, a non-government

organisation providing practical advice support and help to victims of domestic violence in Surrey.

1.6.3 The following agencies reviewed their files and notified the DHR Review Panel by letter that they had no involvement with AA or BA and therefore had no information for an IMR:

(a) Chapter 1 (Specialist Domestic Abuse and Outreach Services)

(b) National Probation Service

(c) Surrey and Borders Partnership NHS Foundation Trust – Mental Health

(d) Surrey County Council

It should be noted that the National Probation Service had conducted interviews with the perpetrator as part of the Criminal Justice process for the case under review and were able to assist the Review Panel greatly.

1.6.4 Chronologies and IMRs were requested from:

(a) Dorset Police

(b) Guildford and Waverley Clinical Commissioning Group (CCG)

(c) Surrey Police

(d) Waverley Borough Council

1.6.5 Chronologies of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period were provided.

1.6.6 The completion of IMRs was undertaken by agency members not directly involved with the victim, perpetrator or any family members.

1.6.7 The letters and IMRs received were of high quality and enabled the Review Panel to analyse the contact with AA and/or BA, and to produce the learning for this Review. Where necessary further questions were sent to agencies and responses were received.

1.6.8 The Review Panel members are listed below

Agency represented	**Review Panel Members**
Chapter 1	Pauline Disley
Dorset Police	Stewart Balmer
Guildford and Waverley Clinical Commissioning Group	Phillip Tremewan
National Probation Service	Jennifer Parsons
Surrey and Borders Partnership NHS Foundation Trust (Mental Health)	Debra Cole
Surrey County Council – Adult Social Care	Wendy Hale
Surrey Police	T/DCI Martin Goodwin
Standing Together Against Domestic Violence (Independent Chair)	Mark Yexley
Waverley Borough Council – Housing Services	Annalisa Howson
Waverley Borough Council	Clare Arnold (Administration)

1.6.9 The chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.7 Contact with the family and friends

1.7.1 In this case the Review Panel were informed by the police that the victim's mother was suffering from dementia. All family contact had previously been made through the victim's brother CA. The Independent Chair wrote a letter to CA, informing him of the review and that the Review Panel would value contribution from the family. The letter was hand delivered by the Surrey Police Family Liaison Officer (FLO). The letter encouraged the family to take part in the review and contained the appropriate Home Office DHR leaflet for families and the Terms of Reference for this review. The letter made clear that the family could contribute in different ways, through face to face meetings, email or telephone and could be at a time or place of their choosing.

1.7.2 There was no response from the victim's brother. Consideration was given to contact with the wider family and friends. It was noted that family and friends of both victim and perpetrator had provided information to Surrey Police. This detailed information was made available to the review. It is appreciated that the new Statutory Guidance for the Conduct of DHRs (2016) provides a heavier emphasis on the involvement of friends and support networks. The guidance also advises that the review should be proportionate to the nature of the homicide. Given the scope of this review and the lack of identified agency interaction, the Review Panel initially decided not to take further steps to interview family and friends.

1.7.3 As the review progressed it was apparent that the overview report would feature information concerning the wife and family of the perpetrator, DA. It was considered by the chair and SWP that DA should be invited to speak with the chair concerning the review. The chair has written to DA and invited her to contribute to the DHR process and read the report before publication. At the time of writing there has been no response from DA.

1.7.4 It is recognised that neighbours of the victim had contact with Surrey Police. The Review Panel considered that Surrey Police provided a great deal of information to the Review Panel from all witnesses in the case and that further interviews with neighbours would not be proportionate to this level of review.

1.8 Ethnicity, Equality and Diversity

1.8.1 The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). It was considered that domestic abuse is a gendered crime and the majority of victims are female. In this case both victim and perpetrator were male siblings. There was nothing in the circumstances of this case that was considered to require any additional specialist input or advice for the Review Panel.

1.8.2 Special attention was given to the fact as to whether any Mental Health issues could be present. A check was carried out of mental health service providers and there was nothing to indicate that there were any mental health issues for AA or BA. The criminal justice process would have also revealed any special circumstances or defence related to mental health. This was not an area of concern for the criminal trial.

1.9 Confidentiality

1.9.1 Throughout this report the identity of the family has been anonymised using initials that do not match those of the family members concerned. It is appreciated that in some reviews it is practice to use pseudonyms to replace the names of all parties concerned. In this case the chair has attempted to gain the views of the family to support the process but they have not engaged with the DHR. The chair decided not to select a random pseudonym as this may have had some unforeseen impact on the family.

2. The Facts

2.1 The death of AA

2.1.1 On x February 2015, BA left the home he shared with his brother AA to go out with his daughter, FA, and her boyfriend for the day. Having spent the day in London, BA returned home in the late afternoon. BA briefly went into the house to collect his wallet and then went out again with his daughter and her boyfriend for a meal. BA was later dropped off at his home.

2.1.2 At around 21:30, neighbours heard noises coming from AA and BA's house. The neighbours were of the view that a fight was taking place. They heard loud noises and shouting. The incident was not reported to the police. The neighbours saw BA walk by their house at 11:00 the following morning.

2.1.3 On x February 2015, BA spoke with his daughter and arranged to meet her at a pub in Bournemouth. FA met her father and noticed he had some injuries. BA told his daughter that he was in trouble and needed to hand himself into the police. FA asked her father if he had killed AA. BA nodded and started to cry. BA said that AA had a knife and he had tried to disarm him. BA said the incident took place not long after he had been dropped off on the night of x February 2015.

2.1.4 BA then made arrangements to meet a friend for a meal. He told his friend he was going to see the police the next day and would probably go to prison.

2.1.5 On x February 2015, BA met again with his daughter. He had his hair cut, bought clean clothes and tried to seek legal advice. At 16:00, BA attended a Police Station in Dorset. The station was closed, so he used the emergency phone outside to call police and tell them he had been involved in a fight.

2.1.6 At 17:00, Dorset Police officers met BA outside the police station. BA told them that he had been involved in an incident with his brother at their home in Surrey. BA said that his brother AA had gone for him with a knife and he had defended himself. He stated that he may have killed AA. Dorset Police contacted Surrey Police and requested that they check on the welfare of AA.

2.1.7 Within the hour Surrey Police had forced entry to the house and found AA dead in an upstairs bedroom. Dorset Police were informed of the Surrey Police findings and BA was arrested on suspicion of murdering his brother. A homicide investigation was commenced by the Surrey and Sussex Major Crime Team.

2.1.8 Forensic examination of the house established that there had been attempts to wash bloody items in the sink. There were a number of kitchen knives recovered. It was apparent the main assault had taken place in AA's bedroom. Some small bags of cannabis were found in AA's bedroom. Police were of the opinion that the amount would indicate personal use.

2.1.9 **Post-Mortem:** A post mortem examination was carried out. AA was found to have died from 14 stab wounds, caused by two different knives. The pathologist was of the opinion that AA died from blood loss from stab wounds to the chest and thighs.

2.1.10 BA was transferred to the Surrey Police area where he was interviewed. He made no comments during the interview.

2.1.11 Whilst in police detention BA made no disclosures concerning his mental health or any substance misuse issues when asked. BA was examined by a forensic medical examiner (FME). He was found to have superficial injuries to his hands. The FME described the injuries as not being typical defence wounds, although that could not be discounted. BA was charged with AA's murder on x February 2015.

2.1.12 **Criminal Trial Outcome:** BA stood trial at Guildford Crown Court where he pleaded 'Not Guilty' to the indictment of murder on the grounds of self-defence. He was found guilty on 28 August 2015 and sentenced to life imprisonment, with a recommendation to serve twelve years.

2.2 Information relating to AA

2.2.1 The victim's parents had three children, all male. BA, the perpetrator, was the eldest and 51 years old at the time of the attack. The victim AA was 47 at the time of the attack. They had a younger brother, CA, who was 43 years old. The victim's father died in 1999. The victim's mother, EA, started a relationship with

her new partner AB in 2002. At the time of the murder, it was believed that EA was suffering from dementia.

2.2.2 BA married and lived in Dorset until his marriage broke down in 2013. CA lived in the Surrey area and had limited contact with his brothers.

2.2.3 The victim was a single man. He held a degree in sports science and was employed as a personal trainer until 2008. In 2008 he lost his job and his home was repossessed. When AA became homeless, his mother's partner AB allowed him to move into a house owned by him in Waverley, Surrey. AA lived alone until October 2013 and was in receipt of benefits. It is believed that BA moved in to live with his brother AA at this point.

2.2.4 AA had historic convictions in the 1980s for offences against property and no convictions for violent offences.

2.3 Information relating to BA

2.3.1 Information on BA came from the Surrey and Sussex Police homicide investigation team interview of his wife, friends and family. BA is married to DA and they have a daughter, FA, who was born in 1993. The family lived in Dorset for many years. DA described the relationship with her husband as being good for a number of years. DA later told the homicide investigation team that the relationship changed in 2007 when BA took on work in Thailand. When BA came back his behaviour changed and he stopped working. DA became the sole earner for the house and arguments started. She later told police that BA became violent at this time. She told the homicide investigators that on one occasion he held a pillow over her face and on another he knelt on her chest.

2.3.2 DA later discovered that her husband had a large amount of money in an account that she had not been previously aware of. DA became angry that her husband had not disclosed this money to her whilst she had been working hard to support the family. She started to take money from BA's account. When BA discovered that DA had taken the money he pushed her into a bedroom. She told the murder investigation team that BA locked the door and told her that he would beat her black and blue if she left him. This incident concerning money

would later result in an allegation to Dorset police by BA that his wife had stolen from him.

2.3.3 DA reported the incident to Dorset Police and took out a Non-Molestation and Non-Occupation order out against BA. BA moved out of the marital home in September 2013. DA has only seen BA on one occasion since he left and there were no incidents. At the time of writing this report DA was still legally married to BA.

2.3.4 BA had a large number of convictions mainly for dishonesty offences recorded in the 1980s. There were no convictions for violent offences and his PNC record did not warn of any risk of violent behaviour before his arrest for murder.

2.4 Dorset Police

2.4.1 BA was known to Dorset Police through a reported incident of domestic abuse. There had been previous reported intelligence on BA in 2004. This intelligence had no relevance to the DHR review. He had no other contact with this police service until he surrendered himself after killing his brother.

2.4.2 On 20 July 2013, DA reported to Dorset Police that her husband BA had subjected her to domestic abuse over a 20-year period. At the time of the incident DA had left the marital home and was staying with a friend. A police officer attended the friend's address and reported the incident. DA told the reporting police officer that her husband had been; 'mentally abusing her worse and worse over the past year' and that he tried to control her actions at home. The control would extend to telling her to stay upstairs and whether she could go into the garden. She stated that she had been physically assaulted over a period of 20 years, although she could not give specific detail. DA said that she had not been assaulted for approximately 2 years. She had not reported previous assaults due to fear. A Domestic Abuse Stalking and Harassment (DASH) Risk Assessment was completed by the reporting officer and DA was assessed as being of 'high risk.' DA told the police officer that she would call the police over the next couple of days if she wanted to report the historic offences.

2.4.3 The matter was recorded by Dorset Police under a holding code for Domestic Violence (DV) investigations. The reporting officer noted the report asking that

the case be allocated to him for further investigation, if the victim wanted to proceed with the case. The report was not classified as a crime. Subsequent review, generated by this DHR, has led the Force Crime Registrar to conclude that the report should have been classified as Assault Occasioning Actual Bodily Harm (ABH).

2.4.4 The Dorset Police Domestic Violence Officer (DVO) made numerous attempts to contact DA over the following days and left messages for her. When the DVO eventually spoke with DA on 25 July 2013, DA confirmed that she had suffered emotional and physical abuse for 20 years from BA. The DVO provided advice and support. This included providing details of the National Centre for Domestic Violence who could also support DA. DA said that she intended to apply for a Non-Molestation Order against her husband. DA stated that BA was due to leave the family home on 31 July 2013 and would be served an Occupation Order on 1 August 2013. At this point DA told the DVO that she was living away from home with a friend 'where she felt safe'.

2.4.5 At the time of this incident the DVO position was part of a support team within the Safeguarding remit of Dorset Police. The DVO requested that an alarm be installed to DA's home on her return.

2.4.6 As the case had been designated as 'High Risk' the DVO referred DA to the services of an Independent Domestic Violence Advisor (IDVA). The DVO also made the referral to the local Multi-Agency Risk Assessment Conference (MARAC).

2.4.7 The commissioned IDVA service at the time of this report was provided by Bournemouth Church Housing Association (BCHA). At that time the IDVA worked independently of police and was not co-located.

2.4.8 The IDVA was interviewed by the Dorset Police IMR author. The IDVA stated that the case was challenging because the abuse took place over a long period of time and there was no way of corroborating any of the allegations made by DA. It was stated that DA recognised that the police would find it difficult to prosecute her husband and she wanted to manage her situation through civil court orders.

2.4.9 There was no attempt by the police to interview BA concerning the reported abuse. The IMR author states that this appears to be due to DA disengaging from the investigation process and her decision was respected by the police. In considering the investigation of abuse the IMR author considered that to others reviewing this matter it would appear to be unresolved.

2.4.10 On 21 July 2013, police were called to the family home by FA. It was reported that there had been a verbal argument between FA and her father. This was recorded by the police as a 'Non-Crime related incident'. Dorset Police believed that the argument stemmed from the breakdown in the marriage between DA and BA. There was no further risk assessment recorded.

2.4.11 A record of this incident and the original report of abuse was uploaded to the Police National Database (PND) on 25 July 2013.

2.4.12 On 25 July 2013, BA reported to police that his wife had been stealing cheques from his business account. The IMR author records that this appears to be as a direct response, and in retaliation to, DA leaving the family home and reporting domestic abuse. This was recorded on a police control room log. The report was recorded as theft of cheques.

2.4.13 DA was interviewed by police and explained the taking of the cheques was as a result of her abusive marriage situation. A police sergeant considered that DA had made admissions to the theft of several thousand pounds but this was mitigated by her domestic circumstances. DA was eventually cautioned for this matter.

2.4.14 On 29 July 2013, DA successfully applied for a Non-Molestation Order at Bournemouth County Court against her husband. Checks of the Dorset Police transactions on the Police National Computer (PNC) indicate that the Non-Molestation order was received by police on the same day and uploaded to the PNC database.

2.4.15 On 16 August 2013, DA's case was considered by the local MARAC. It was reported that IDVA services were ongoing but DA had not contacted the police further.

2.4.16 On 6 September 2013, DA reported her car stolen from the family home. She named BA as a possible suspect for the theft. The vehicle was recovered and there was no evidence to implicate BA.

2.4.17 On 27 September 2013, DA obtained an order for BA to leave the matrimonial home.

2.4.18 There was no further contact with Dorset Police until BA's arrest for murder in 2015.

2.5 Surrey Police

2.5.1 Both victim and perpetrator had previous dealings with the police. The only prior contact with Surrey Police came as a result of a domestic incident and dispute with neighbours.

2.5.2 On 31 July 2014, BA made a 999 call to Surrey Police from a local shop. He stated that his brother, AA, was dealing drugs from their home. He also reported that AA was becoming rude and aggressive and walking around with a knife in his back pocket. He said that AA had not threatened him with the knife, but he had left their home due to his volatile behaviour.

2.5.3 Police officers went to meet BA away from his home. BA reported that he was living with his brother following the breakdown in his marriage. He was having a disagreement with his brother over their living arrangements. It was established that at the time of the argument AA was washing up and held a knife when he turned to speak to his brother. He had not made any threats with the knife and BA did not want to make any formal complaints. He said that he would go and stay with his mother until things calmed down.

2.5.4 The police officer completed a DASH risk assessment with BA on his mobile data terminal and assessed the risk level as 'standard.' In completing the assessment, it was recorded that BA alleged that his brother had previously tried to stab him and hold him in a head lock. Neither incident had been reported to police.

2.5.5 The officers then went to the brothers' home where they spoke to AA. AA said that he had been arguing with his brother whilst washing up. When he turned to

speak to his brother he was holding a small vegetable knife. The police officers were under the impression that AA was 'fed up' with his brother.

2.5.6 The reporting Police Officer recorded the report on the NICHE single records management system. The system holds all Surrey Police crime reports and intelligence on people and places. The officer also recorded an intelligence report on information provided by BA that AA was dealing cannabis.

2.5.7 The NICHE record was supervised and it was agreed that there were no offences reported and the risk level was correctly recorded as 'standard.'

2.5.8 There was no record of the reporting officer conducting PNC or PND checks on either party.

2.5.9 The reporting police officer told the IMR author that both parties were calm when they were seen by police. There was no indication that the situation could escalate and the best outcome would be for both parties to have some time apart to let the situation cool down.

2.5.10 All victims of reported domestic abuse in Surrey can be offered a referral to Outreach Services by the officer completing a DASH risk assessment. For a standard risk assessment, it would have been for the officer conducting the DASH to offer the service a referral. A DASH form is completed electronically by an officer using their Mobile Data Terminal (MDT). At the time of this incident the DASH template available to MDT users did not contain an Outreach Referral check box to prompt the officer completing the form to ask the victim if they would like a referral to be made. A reporting officer or supervisor would have to remember to offer a referral without systems prompting them to do so. There was no outreach referral made in this case.

2.5.11 On 28 September 2014, a next door neighbour of the brothers telephoned the police and reported a dispute with AA. It was reported that AA had been banging a hammer on a fence in response to his neighbour using a pressure washer inconsiderately on a Sunday morning. AA was also said to have told the neighbour that he would be offensive towards the neighbour's girlfriend and children when they next visited. The neighbour also reported that he been told by others that AA had sold drugs from his home.

2.5.12 Due to higher priority incidents police were unable to attend to the call for several hours. When an officer did visit the neighbour he told them that he did not want to make a formal allegation and wanted the incident logged in case the situation escalated. The officer then spoke with AA who apologised for his behaviour.

2.6 Guildford and Waverley Clinical Commissioning Group (CCG)

2.6.1 Both the victim and perpetrator were registered with the same General Practitioner Medical Centre.

2.6.2 Whilst the Review Panel were unable to access the medical records of BA without his consent, the CCG representative was informed that they could seek advice from the CCG and NHS England if they felt the GP held material that would assist this DHR process or undermine the review. Safeguarding and legal advice could then be sought. It should be noted that nothing within the criminal investigation or criminal justice process revealed that there would be any information contained in BA's medical records indicating any health or mental health issues that would assist this process.

2.6.3 During the period under review there was one contact with AA in April 2013 for an unrelated matter.

2.6.4 The IMR author confirmed that all GPs within the practice are trained to Level 3 in Safeguarding Children and Safeguarding Adults, including domestic abuse. All other clinicians and non-clinicians have had had training in Safeguarding Adults and Children.

2.6.5 The practice has posters and leaflets on safeguarding visible in the waiting areas. All consultant and treatment rooms have safeguarding protocols clearly visible. The protocols show contact numbers for support, advice and referral. Safeguarding information is also available on the practice intranet site, available to all staff.

2.6.6 There are no areas within the CCG area that require any further analysis in this report.

2.7 Waverley Borough Council

2.7.1 The local council had minimal contact with AA and BA. Neither party was registered on the electoral roll and they had no contact with environmental, communities or housing services. The only contact came through council tax and benefits.

2.7.2 AA was initially liable for the council tax at the home provided by his mother's partner. AA had a history of non-payment. He did not initially apply for benefits and court orders were issued against him.

2.7.3 From July 2014, AA was in receipt of Council Tax Benefit following his claim that he was then a recipient of Job Seeker's Allowance.

2.7.4 BA was liable for 50% of the Council Tax on the premises from April 2014. BA received Council Tax Benefit from October 2014. It was confirmed that he was in receipt of Employment and Support Allowance. The Review Panel considered that it was not proportionate to request examination of medical records to verify if there were any medical reasons for this claim.

2.7.5 There were no indicators to the council that either party was suffering stress as a result of any financial hardship. There were also no indicators within council records that they were at risk. All staff dealing with claims are aware of the council's safeguarding policy and referral pathways. The IMR author assessed that all staff were professional and caring in their dealings with the household.

2.7.6 There are no areas within the Waverley Borough Council remit that require any further analysis in this report.

2.8 National Probation Service

2.8.1 The National Probation Service did not have any records of dealing with AA or BA before the homicide. They were not required to provide an IMR. The service was able to provide information given to them by BA post-sentence.

2.8.2 BA said that the property where he lived with AA was owned by his mother's partner AB. AA had been allowed to live in the house rent free for many years. BA moved in with AA after his marriage break up in October 2013. BA moved into the house against AA's wishes. After the brothers started living together

there were several violent arguments. BA alleged that AA had previously tried to choke him and in a separate incident AA threatened to stab him. There was no action taken over these incidents.

2.8.3 BA said that he feared for his life as his brother was 'unstable' and violent. BA admitted that during the fatal attack on AA he lost control and lashed out stabbing his brother repeatedly.

2.9 Information from Family and Friends

2.9.1 Given the scope of this review and the identified agency interaction, the Review Panel decided not to take further steps to interview family and friends. There was a very comprehensive IMR provided by Surrey Police concerning the views of family and friends. This report will reflect the information provided in that IMR.

2.9.2 The house occupied by AA and BA, was owned by the AB. AB is the partner of AA and BA's mother. AB told police of his dealings with AA and BA. AA was described as being unhappy with the arrangement that BA should share the house with him; AA had been on his own at the premises for some time before BA moved in. AB described AA as being a bully and aggressive, having been pushed down the stairs by him. AB said the relationship between the two brothers deteriorated in November 2014 when BA reported AA to the police for suspected drug-dealing. AA denied dealing drugs when AB asked him about the allegations.

2.9.3 BA's daughter described AA as being aggressive and had witnessed him walking around the house in a temper slamming doors and verbally abusing her father over the phone. Another friend of BA states that he disclosed to him that AA was aggressive and he had previously needed to fend off his brother. BA had used a knife to do this.

2.9.4 A good friend of AA described him as being 'gentle and kind.' Although the friend had never met BA, AA told him there had been altercations between them. The altercations started after BA had reported AA to the police for drug dealing. The friend disclosed that he had smoked cannabis with AA.

2.9.5 Another friend of AA told police that he would visit him at home twice a week. He described AA as being 'friendly, out-going and slightly eccentric.' The friend stated that AA would have 'bags of weed' at home but he was not a drug dealer. The friend also described BA as being 'unstable, dirty, aggressive and angry at life'. Whilst visiting AA the friend had seen BA hit his brother on a number of occasions. They argued over household bills and shopping. The last assault witnessed by the friend had been 18 months before the homicide and the friend had never reported any incidents to the police.

2.10 Information from the Perpetrator

2.10.1 The Review Panel appreciates the value that gaining an understanding of the perpetrator's view can add to a DHR. In this case the chair made attempts to interview the perpetrator in prison. He initially wrote to the prison authorities asking for information to be passed to BA informing him of the DHR process and the request for the chair to interview him. The prison responded stating that a request should be made directly to BA. The chair requested that BA's offender manager within the prison service should consider the value to the perpetrator's rehabilitation, from a post sentence interview; as part of the DHR process. This correspondence was ignored.

2.10.2 The chair then wrote directly to BA in prison requesting his consent to interview. BA was also sent Terms of Reference for this DHR and a Home Office leaflet on DHRs. There has been no response to this letter.

3. Analysis

3.1 Domestic Abuse/Violence Definition

3.1.1 The following analysis is based on the limited information available in this case. It is very clear that AA's life was taken in an act of extreme violence by his brother BA.

3.1.2 The government definition of domestic violence and abuse (2013) is:

"*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; and emotional.*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

3.1.3 The evidence gathered by Surrey Police in the murder investigation show that AA was subject to physical domestic abuse from his brother BA resulting in his death. Information provided by Dorset Police also shows that BA had previously subjected his wife to domestic abuse before he moved into his brother's home. The domestic abuse reported by BA's wife indicates behaviour amounting to coercive control. The level of abuse was such that it justified a judicial order requiring non-molestation and a requirement for BA to leave the marital home.

3.1.4 Surrey Police also provided information that alleged that BA had been a victim of domestic abuse from his brother AA. This amounted to a reported verbal argument and information from BA that his brother had previously assaulted him.

3.1.5 In analysing the information provided it will need to be considered that previous intimate family violence is a possible risk factor for adult family violence.

3.2 Dorset Police

3.2.1 On 20 July 2013, BA was living with his wife DA in Dorset when she reported to police that she had been victim of domestic violence from her husband over a period of 20 years. The level of threat was such that she had left her family home and was staying with friends. It was clear that on at least one occasion DA reported that she was locked in a room by her husband. He had physically assaulted her and subjected her to sustained emotional abuse. DA said that she would call the police in the next couple of days if she wanted to take the report of the historic offences further. The initial investigating officer completed a DASH risk assessment based on information supplied by DA and this indicated that the case was 'High Risk.'

3.2.2 The initial investigating officer noted in his report that he would undertake an investigation, if the victim wanted to pursue the matter further. There were no immediate steps taken by the initial investigating officer to find DA or to secure any further evidence from witnesses. It was reported, by DA, that at this time her daughter was staying with her boyfriend and not at the family home. She was found to be visiting the family home the next morning when police attended another domestic incident.

3.2.3 At 09:39 on 21 July 2013, the police were called to the home address of BA, where he was reported to have been arguing with his 20 year-old daughter over the break-up of his marriage. BA and FA denied any offences had taken place that day. There was no information provided to indicate that the police officers took any positive steps to deal with BA over the report made by his wife the previous day.

3.2.4 It is clear that Dorset Police made appropriate referrals to a Domestic Violence Officer (DVO), IDVA and MARAC.

3.2.5 It took the DVO several days to speak to DA. Messages were left for DA, but she had not responded. The DVO eventually spoke with her on 25 July 2013, five days after the initial report. The DVO is a police support staff role and it is not

apparent that a police officer took any further role in the investigation of the reported abuse. This contact with the DVO did not result in police taking steps to arrest or interview BA.

3.2.6 The DVO confirmed that DA would be applying for Non-Molestation Order and an Occupation Order at the local County Court. DA told the DVO that she was living away from home with a friend 'where she felt safe'. DA applied for the Non-Molestation Order on 29 July 2013. It appeared to the Review Panel that Dorset Police took no positive steps to provide any form of legal protection for DA over the 9-day period between the report and Non-Molestation Order even though they had assessed her as being at high risk of further harm. The Dorset Police IMR author considered that DA was assessed as being High Risk and had been safeguarded by her removal from the family home. It was also considered by Dorset Police that at this point DA was being supported by the IDVA throughout but did not formalise her complaint to enable the criminal investigation to proceed.

3.2.7 During this period the perpetrator made an allegation of theft against his wife. This was investigated by an officer unconnected to the ongoing domestic abuse investigation. DA was interviewed by the police concerning the matter and disclosed that the theft arose from circumstances of her own domestic abuse. This report was classified as Theft. The circumstances were subject to review by an Evidential Review Officer who authorised that an adult caution be given to DA.

3.2.8 The IMR author has concluded that DA did not proceed to the point of making formal disclosures on either tape or written statement which meant that no further action was taken in relation to BA. Whilst no formal written statement was taken by police, there is no evidence that DA provided any evidence retracting the statement. In reviewing the case, Dorset Police considered that this not uncommon in domestic abuse investigations of this type where there is no corroboration and the wishes of the victim determine the police response.

3.2.9 In considering the allegation of theft against DA it was apparent that DA made a disclosure of her abuse to the police during the interview. DA provided mitigating

circumstances that she took money from her husband as she was being abused. This disclosure was considered by the custody sergeant in reaching a decision to caution DA, but it was not considered in pursuing the allegations of abuse against BA.

3.2.10 When a victim of abuse applies for a Non-Molestation Order a sworn statement is required. It is advised in making such a statement that the victim should provide precise information on the ways that they have been abused or harmed by the perpetrator. In some cases, this information is supplied to police to be used in a criminal investigation. It should have been apparent to a DVO that such information would have been available on 29 July 2013. Consideration could have been given by the police to use this information and the disclosure of the interview as evidence of the offences committed. In reviewing the case Dorset Police considered that the wishes of the victim had to be balanced against the ongoing investigation.

3.2.11 When considering the management of the report of domestic abuse made by DA against her husband it has been confirmed by the Dorset Police Crime Registrar that DA's report of abuse should have been classified as ABH and this was not done. Where a report is classified as crime there should be clear management oversight to consider detection of that crime. That would normally entail interviewing the suspect and considering case disposal options. As this case was never recorded as a crime it was not subject to scrutiny for possible detection. There is no evidence that the report made by DA has been supervised to consider the correct classification, and whether all investigative avenues have been exhausted.

3.2.12 Whilst Dorset Police promote a domestic abuse policy that strongly advocates positive action, it is apparent that no positive action was taken against BA. Initial positive action could have included taking steps to interview the suspect, and to consider interviewing the couple's 20-year-old daughter. Both daughter and father were seen on the day after the initial report was made. It is appreciated that positive action does not only equate to arresting a suspect, and action was taken in safeguarding the victim and supporting her in civil proceedings.

3.2.13 It should be noted that Dorset Police informed the DHR Review Panel that their internal processes have changed since the summer of 2013. They are confident that there has been an improved awareness of the standards for correctly recording domestic abuse across the service. Dorset Police also report that they have improved their levels of training on risk assessment and coercive and controlling behaviour.

3.2.14 Dorset Police took positive action to investigate the allegation of theft against DA, whereas the report of 20 years of physical and emotional abuse remains unresolved.

3.2.15 The IMR author considered that the case remains unsolved as there was no written statement obtained from DA. They also considered whilst there was no apparent Criminal Justice outcome, the safeguarding and long term needs of the victim were served by the non-molestation order and support provided by the IDVA and DVO.

3.2.16 Dorset Police did make an appropriate referral to an IDVA from the locally commissioned service and a MARAC. These services would have been focused on the needs of a victim. It should be noted that the IDVA services in Dorset are now under new commissioning arrangements and co-located with the police.

3.2.17 There was no consideration of the potential threat presented by the perpetrator outside of the marital setting in Dorset. BA had been named as a perpetrator of serial domestic abuse and that behaviour had not been challenged by the criminal justice agencies in Dorset.

3.2.18 As BA had not been brought to account for his abusive behaviour, there was a missed opportunity to engage with services for offenders. Engagement with probation services could have provided opportunities to address BA's violent behaviour. However, in this case BA left Dorset and moved to Surrey with his abusive behaviour in a domestic environment unchallenged by criminal justice agencies.

3.3 Surrey Police

3.3.1 Surrey Police dealings with AA and BA came seven months before the homicide. In July 2014, it was reported by BA that his brother was drug-dealing from home. He also said that his brother was rude and aggressive and was at home walking around with a knife. BA stated that he had been assaulted by his brother in the past. BA told police that he was not threatened on that date.

3.3.2 It appears that the initial report to police was focused on AA as a drug dealer. The reporting officers did recognise that this was followed by information on previous domestic incidents, however BA did not wish to make an allegation concerning this. In dealing with this report the officers ensured that that they completed a DASH risk assessment at the time of report and took steps to speak with AA. On speaking with AA it was clear that he offered an innocent explanation for holding a knife when he was arguing with his brother.

3.3.3 It was clear from subsequent interviews with family and friends that there was friction within the house since BA reported that he suspected his brother of drug dealing. It is not apparent that the allegation of drug dealing was brought to AA's attention by the officers who spoke to him. It is not considered that the police handling of this intelligence contributed to the friction between the two brothers.

3.3.4 The officer dealing with the report assessed the risk level to be 'standard'. It is not apparent that the police officer conducted checks of local police intelligence databases to inform the risk assessment. A check was made on the address on the Surrey NICHE system when the officer was despatched to the address, but there was no intelligence relating to the brothers on the Surrey system. A check of the PNC would not have revealed any details of domestic offences involving BA. If checks were made of the PND at that time it would have shown that BA had previously come to notice for violence in a domestic setting. It is not known whether this would have had impact on the level of risk assessed but it may have given the officers a better understanding of the background of BA. Access to the PND is only available to officers dealing with serious incidents and is not routinely available. Given the intelligence supplied on suspected drug dealing, it

may have been appropriate to conduct intelligence checks after the initial report in order to further investigate that matter.

3.3.5 In considering communication and multi-agency action it was not police practice at this time for reporting officers to consider referral to domestic abuse outreach services for cases presenting 'standard risk'. There were no failings in referral protocols at the time. It should be noted that in January 2016, Surrey Police introduced an Outreach Referral check box prompt in MDTs, for all officers conducting DASH risk assessments.

3.3.6 Substance misuse is often a factor mentioned in Domestic Abuse enquiries. There is no suggestion in this case that there were any issues with the use of alcohol by either party in this report.

3.3.7 This DHR has shown that there were references to AA dealing in drugs. This information came from the perpetrator BA and through third party information given to a neighbour. The homicide investigation and crime scene examination revealed the presence of cannabis, there was no evidence that AA was involved in the supply of drugs. The only confirmed information comes from a friend of AA who states that he smoked cannabis with him and the amount drugs found that would indicate personal use. There is no indication that either party was under the influence of drugs at the time of the homicide.

3.3.8 This process has not revealed any issues concerning communication and referral between agencies in Surrey. Surrey Police have informed the Review Panel of a new protocol for sharing information on Anti-Social behaviour across agencies through SafetyNet.

4. Conclusions and Recommendations

4.1 Preventability

4.1.1 The information examined by the Review Panel has not shown that this death was predictable or preventable. Whilst there were incidents coming to notice to the police indicating there was a level of domestic abuse within the household it could not be anticipated that the abuse would escalate to such level that would result in the loss of life.

4.2 Conclusions

4.2.1 This case has allowed examination of the current statutory systems and processes in relation to domestic abuse. There is no evidence that there were any failings in communications between agencies.

4.2.2 The review has identified breaches of police processes in the Dorset Police area and an area for improvement in Surrey Police risk assessment processes.

4.2.3 It is concerning that the perpetrator had left his previous domestic environment without having his abusive behaviour challenged by the police. The Dorset Police investigation into the 20 years of abuse reported was not completed and BA was never interviewed by police. It is appreciated that BA had been in receipt of County Court orders, but there was no criminal justice intervention. It is known that the level of abuse and threat presented by BA was sufficient to enable a Judge to remove BA from his marital home.

4.2.4 The Surrey Police Investigation and risk assessment was in line with the police procedures. The response may have been improved if domestic violence risk assessment processes routinely examined the PNC and PND national databases for victims and suspects. In this case that would have identified that the perpetrator had come to police attention in another police area. Access to this level of intelligence would have also notified Surrey Police that a potential domestic abuser was living in their area.

4.2.5 It is apparent from police interviews with family members and friends that there appeared to be an unstable relationship between AA and BA at home. There are different views on which party was the aggressor. No party, who was aware of the problems within the relationship, had reported any issues to the police. Whilst there is a growing awareness of domestic abuse, it is not apparent that the public are made aware that domestic abuse extends to those in non-intimate relationships.

4.2.6 Surrey Police are currently conducting innovative campaigns using social media to challenge domestic abuse, including coercive control. The campaign focuses on people in intimate relationships. It is not known if publicity identifying that domestic abuse exists outside intimate relationships would have helped friends and family to report concerns in this case. It would be a constructive step to ensure that future tragedies did not take place. Surrey Partners should consider the full definition of domestic abuse in commissioning awareness campaigns. There needs to be consideration that the element of coercive control may not feature in many incidents of adult family violence.

4.2.7 In considering other statutory partners this case has revealed that the victim of the homicide only came into contact with Primary Care GP practice. This contact was some time before the incident and there is no evidence that there was abusive behaviour at that time.

4.2.8 There are two clear issues raised in this review concerning positive investigation strategy and intelligence processes. It is hoped that improving these processes will result in more positive outcomes for all persons reporting domestic abuse. In addition to the issues it is important that partners dealing with domestic abuse ensure that the public are aware that domestic abuse can also be present in adult family violence as well as intimate partner violence.

4.3 Lessons to be learnt

4.3.1 *Lack of positive action by Dorset Police to fully investigate reports of serious domestic abuse.*

(a) This review has demonstrated that there were not robust systems and processes in place to ensure that a report of domestic abuse was fully

investigated. This resulted in a failure to correctly classify a report of domestic abuse as a crime.

(b) The review has also evidenced that there was a failure to take positive action to address the behaviour of a man reported to be responsible for 20 years of domestic abuse.

4.3.2 *Lack of protocols within Surrey Police to ensure that National intelligence checks are conducted on both victims and suspects in reported domestic abuse.*

(a) This review has identified that Surrey Police do not routinely carry out research on intelligence databases for both victims and suspects of abuse. If checks had been undertaken in this case it would have revealed that a person reporting abuse and known to be involved in a domestic incident had also been subject to a police report and court orders in another area.

(b) Checks of national intelligence databases would have also facilitated a flow of intelligence between police force areas on the movements of a domestic violence perpetrator.

4.4 Recommendations

The recommendations below should be acted on through the development of an action plan, with progress reported to the Safer Waverley Partnership within six months of the review being approved by the partnership.

4.4.1 Recommendation 1

That Dorset Police develop audit processes to ensure that all reports of domestic abuse are correctly classified and that positive steps are taken to fully investigate domestic abuse in line with service policy. Dorset Police should ensure that Community Safety Partnerships are updated with the result of the audits, which should be available for review by the Pan Dorset Domestic Abuse Strategic Group.

4.4.2 Recommendation 2

That Surrey Police ensure that domestic abuse risk assessment processes require officers to routinely check the details of victims and suspects on the

Police National Computer (PNC). This will ensure that officers have the best available intelligence to deliver robust risk assessment processes. This process should be supported by a system of internal audit and compliance monitoring. Surrey Police should ensure that the Surrey Community Safety Board are updated with the result of the audits.

4.4.3 **Recommendation 3**

That Surrey Police evaluate the routine use of the Police National Database (PND) in the investigation and risk management for all reported domestic abuse. This could ensure that a full intelligence picture is established to support risk assessment processes and work with partner agencies. Consideration needs to be given to the logistics of conducting checks in each case and whether the use of the PND is focused on high risk investigations and all cases referred to MARAC. This work should be undertaken in coordination with the Home Office to ensure that any good practice is considered at a National Level.

4.4.4 **Recommendation 4**

That Surrey Community Safety Board evaluate their current Domestic Abuse awareness campaigns and consider how existing or new campaigns could be focused on those at risk from domestic abuse as a result of adult family violence.

Appendix 1: Domestic Homicide Review Terms of Reference

Waverley Domestic Homicide Review (AA)

Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with ***AA***, and his brother, ***BA*** following his murder on ***x February 2015***. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the Review Panel until Review Panel agree what information is shared in the final report when published.

2. To explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies.

3. To review the involvement of each individual agency, statutory and non- statutory, with ***AA*** and ***BA*** during the relevant period of time: **x February 2013 – x February 2015.**

4. To summarise agency involvement prior to **x February 2013**.

5. The contributing agencies to be as follows:
   a) **Chapter 1**
   b) **Dorset Police**
   c) **Guildford and Waverley CCG**

d) **National Probation Service**
e) **Surrey Police**
f) **Surrey County Council**
g) **Surrey and Borders Partnership**
h) **Waverley Borough Council**

6. For each contributing agency to provide a chronology of their involvement with the ***AA*** and ***BA*** during the relevant time period.

7. For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

8.
   a) For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with ***AA*** and/or ***BA***, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.
   b) To consider issues of activity in other boroughs and review impact in this specific case.

9. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following five points:
   1. Analyse the communication, procedures and discussions, which took place between agencies.
   2. Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
   3. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
   4. Analyse agency responses to any identification of domestic abuse issues.
   5. Analyse organisations access to specialist domestic abuse agencies.
   6. Analyse the training available to the agencies involved on domestic abuse issues.

And therefore:

i) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
ii) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
iii) To improve inter-agency working and better safeguard adults experiencing domestic abuse.

10. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought ***AA*** or ***BA*** in contact with their agency.

11. To sensitively involve the family of ***AA*** in the review, if it is appropriate to do so in the context of ongoing criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process.

12. To coordinate with any other review process concerned with the children of the victim and/or perpetrator.

13. To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

14. To establish a clear action plan for individual agency implementation as a consequence of any recommendations.

15. To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

16. To provide an executive summary.

17. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Safer Waverley Partnership.

Appendix 2: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1.That Dorset Police develop audit processes to ensure that all reports of domestic abuse are correctly classified and that positive steps are taken to fully investigate domestic abuse in line with service policy. Dorset Police should ensure that Community Safety Partnerships are updated with the result of the audits, which should be available for review by the Pan Dorset Domestic Abuse Strategic Group.	Local - County Police Area	Review current practice of classification of Domestic Abuse (DA). Establish new audit process	Dorset Police – Det Supt Noyce	Establish regular compliance checks on reported DA - Complete. Training programme - Complete Establish audit process Present to Pan Dorset Domestic Abuse Strategic Group	July 2017	
2.That Surrey Police ensure that domestic abuse risk assessment processes require officers to routinely check the details of victims and suspects on the Police National Computer. This will ensure that officers have the best available intelligence to deliver robust	Local - County Police Area	Develop systems to ensure that that victims and suspects in DA cases are	Surrey Police – DCI Goodwin	Policy and system completed. Implementation programme established.	September 2017	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
risk assessment processes. This process should be supported by a system of internal audit and compliance monitoring. Surrey Police should ensure that the Surrey Community Safety Board are updated with the result of the audits.		routinely checked on PNC. Implement system for operational staff. Monitor compliance and develop.		Process implemented		
3 That Surrey Police evaluate the routine use of the Police National Database (PND) in the investigation and risk management for all reported domestic abuse. This could ensure that a full intelligence picture is established to support risk assessment processes and work with partner agencies. Consideration needs to be given to the logistics of conducting checks in each case and whether the use of the PND is focused on high risk investigations and all cases referred to MARAC. This work should be undertaken in coordination	Local - County Police Area	Review a sample of DA reports and consider potential for PND use to improve investigation. If PND considered useful – review how service could	Surrey Police - DCI Goodwin	Evaluation report on use of PND. Present policy to Surrey CSB	September 2017	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
with the Home Office to ensure that any good practice is considered at a National Level.		implement within Public Protection work. Devise and deliver policy to implement				
4. That Surrey Community Safety Board (CSB) evaluate their current Domestic Abuse awareness campaigns and consider how existing or new campaigns could be focused on those at risk from domestic abuse as a result of adult family violence.	Local - County Police Area	Analyse the problem of adult family violence (AFV) working partner agencies to establish any areas where reporting could be improved. Review current DA campaigns to consider	Surrey Community Safety Board	Profile of AFV completed Review of DA campaigns complete and presented to Surrey CSB Surrey CSB commission new campaign to focus on AFV – if required	September 2017	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		effectiveness and whether these could be adapted or new steps can be considered to include AFV				