SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW 1

OVERVIEW REPORT

Victim FEMALE 1

July 2012

CONTENTS

SSCP DHR Female 1

1. INTRODUCTION

1.1 On 03.12.2011 Merseyside Police – MSP - officers were called to Address 1 where they found the bodies of Female 1 and her mother Female 2. Female 1 had last been seen alive on 26.11.2011 and Female 2 on 02.12.2011. Both women had been strangled and Male 1 became an immediate suspect because of his relationship with Female 1.

1.2 On 08.12.2011 Male 1 was arrested and later charged with murdering the two women and remanded in custody. On 09.02.2012 Male 1 was found hanged in his cell at Manchester Prison. Greater Manchester Police are currently preparing a file on his death for HM Coroner for Manchester City District. To date [May 2012] a date for the Inquest has not been set.

1.3 On 24.04.2012 HM Coroner for Sefton declared that Female 1 and Female 2 had been unlawfully killed. MSP are satisfied that Male 1 killed the two women and that no one else was involved.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

Decision Making

2.1 Sefton Safer Communities Partnership (SSCP) Domestic Homicide Review Screening Panel met on 15.12.2011 and decided that the death of Female 1 met the criteria for a domestic homicide review (DHR) as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews April 2011 (the Guidance).

2.2 Section 6.2 of the Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership. Section 6.4 states it should be completed within a further six months.

DHR Panel

2.3 A chair was appointed on 15.12.2011 and plans to identify an independent author were made. The first DHR Panel took place on 26.01.2012 after which it was decided to combine the roles of chair and author. David Hunter was appointed as the independent chair and author of the DHR on 20.02.2012 and was judged to have sufficient relevant experience and independence. He is not, and never has been employed any agency working in the Sefton area. The 2nd DHR Panel took place on 09.03.2012 and met another four times.

The Panel comprised of:

Paul HOLT	Assistant Chief Officer Merseyside Probation Trust (MPT)
Lesley PATERSON	Chief Executive Sefton Women and Children's Aid (SWACA)
Steph PREWETT	Head of Corporate Commissioning and Neighbourhood Co-ordination Sefton Metropolitan Borough Council
Linda WARD	Deputy Director of Nursing, NHS Halton and St. Helens and Head of Adult Safeguarding NHS Merseyside
Rachel WILSON	Detective Inspector Merseyside Police (MSP)
David HUNTER	Independent Chair and Author

Agencies Submitting Individual Management Reviews (IMRs)

2.4 The following agencies submitted IMRs.

Merseyside Probation Trust

Merseyside Police

2.5 Health submitted a letter because it had very little relevant information. Sefton Metropolitan Borough Council had one relevant contact.

Terms of Reference

Purpose of a DHR

2.6 The purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Source: Paragraph 3.3 The Guidance.

Specific Terms of Reference

2.7 1. How did your agency respond to reports or knowledge of domestic abuse involving Male 1 and Female 1?

2. What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?

3. What impact did the services provided by your agency have on reducing the impact of domestic abuse by Male 1 on Female 1 and in identifying and dealing with the causative factors?

4. Were your agency's policies, procedures and training, that were relevant to this case, fit for purpose, including those relevant to assessing risk?

5. Were there issues in relation to capacity or resources in your agency or wider partnerships that impacted the ability to provide services to Female 1 and/or Male 1 and to work effectively with other agencies?

6. Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?

7. Did professionals working with the victim have appropriate levels of supervision?

8. Was information sharing and communication with other agencies regarding Male 1 and Female 1 and the other subjects of the review, effective and did it enable joint understanding and working between agencies?'

Subject of Review

2.8 Female 1 White British 50 + years victim; died on or about 28.11.2011

People of Specific Interest

Male 1	White British 50 + years believed perpetrator (now deceased)
Female 3	White British 40 + former partner Male 1

Other People

Male 2	Son of Male 1 and Female 6
Female 2	70 + Mother of Female 1; also believed killed by Male 1 on or about 02.12.2011
Female 4	Daughter of Female 1
Female 5	Daughter of Female 1

Female 6	Former wife of Male 1
Female 7	Victim of Male 1 in 2001
Female 8	Daughter of Female 3
Female 9	Former Fiancé of Male 1
Female 10	Best Friend of Female 1

Note: Female 2's death is outside the definition of a domestic homicide review.

Time Period

2.9 The time period under review is from 25.02.2010 to 03.12.2011. Agencies were asked to exercise their professional judgement and include any information relevant to the terms of reference that pre-dates 25.02.2010.

Notification to Family of DHR

2.10 Selected members of Female 1 and Male 1's family were written to informing them that a DHR was taking place and inviting them to contribute after the trial.

Family and Friends Contributing to the DHR

2.11 The following people were seen or spoken to by telephone during the DHR and their views are reflected in the report.

- Female 4: Telephone - Daughter of Female 1 (victim)
- Female 3: Seen - Former partner of Male 1 (perpetrator)
- Female 8: Seen - Female 3's daughter
- Female 10: Seen - Female 1's Best Friend

2.12 Females 5 and 6 and Male 2 did not want to take part in the review.

3. DEFINITION OF DOMESTIC VIOLENCE

3.1 The Government definition of domestic violence against both men and women (agreed in 2004) is:

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

3.2 An adult is any person aged 18 years and over and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

3.3 The definition and advice on Sefton Safer and Stronger Communities Partnership web site is:

"Domestic violence is a pattern of physically and emotionally violent and coercive behaviours that one person uses over another to exercise power and control. Domestic violence is physical, sexual, psychological, sexual or financial violence that takes place within an intimate, or previously intimate, relationship and forms a pattern of repeated, coercive and controlling behaviour.

... if you are experiencing any kind of violence and abuse it's very important to seek help and you can find services to help you by accessing our directory of services..."

3.4 MSP definition of domestic violence taken from its web site is:

"Domestic abuse is when one person harms another person who may be:

- a current partner
- a previous partner
- a close family member

They do not need to be heterosexual partners or live in the same property. Women, men and children can suffer domestic abuse".

3.5 MSP advice to victims is:

"If you are being abused by someone close to you:

Tell someone you trust what is happening. Have a pre-arranged key word or signal to let them know if you are in danger and need help.

Get help either from the police or one of the support groups below.

Tell your children that if the abuse starts not to get involved, to hide in the house or run and get help from a neighbour.

If you are attacked make as much noise as you can to raise the alarm".

3.6 The circumstances of Female 1 death easily fell within the various descriptions of domestic violence/abuse. The DHR Panel felt that a common definition of domestic violence applicable to agencies would be helpful and noted that in December 2011 the Home Office began a consultation titled, "Cross- Government Definition of Domestic Violence". The consultation closed on 30.03.2012 and the next steps are awaited.

4. BACKGROUND TO CASE

4.1 The following detail is an amalgamation of information drawn from agency records and interviews with family and friends. It was noted in MPT records that much of what Male 1 told them was unverified and considerable doubt exists as to its veracity. This view is supported by Female 1's family and friends.

4.2 Female 1 spent her entire life living and working in and around Sefton. She joined the Civil Service when she left school and returned after the birth of her first daughter. Female 1 spent ten years as a dinner lady in a special school and combined that with an evening and weekend job as a representative for a cosmetics firm selling to people in their homes. Thereafter she worked as a sales assistant for a national supermarket chain. Female 1 was described as being very successful at selling and was a well liked and respected person; in short thoroughly decent. She had a close relationship with her family and enjoyed socialising with her friends. Her relationship with her husband ended in 2005.

4.3 Male 1 was born and educated in Burnley. It is believed his parents died by the time he was 22 years of age. He married Female 6 a few years later and divorced in 1995. His son Male 2 remained with Female 6. All of his addresses were in the North West, save for a period in London and a reported year abroad. He described himself as a skilled engineer but his field of expertise was unknown. Male 1 claimed to have spent about a year in Saudi Arabia, returning to England in 2000 when he moved to London. In 2002 he was convicted of False Imprisonment and Indecent Assault and sentenced to four years imprisonment. He was released in September 2004 and moved to the Widnes area, then Blackpool and latterly Southport. Male 1 does not appear to have been in regular employment and it is evident from his actions in borrowing money that he struggled financially. After his divorce he formed relationships with several women. In 2007 and 2008 Male 1's general practitioner referred him to services to deal with his anger management but he did not attend.

4.4 In 2008 Female 1 was given a gift of a flying experience at the Flight Academy in Blackpool where Male 1 worked as a coordinator. Soon afterwards they began seeing each other and formed a relationship, albeit they lived at separate addresses. The relationship ended on good terms in February 2009. In April 2009 Male 1 went to live at Female 1's address as a lodger after he obtained work in the area. Female 4 who was living at home at the time described how she had a difficult relationship with Male 1, in that he tried to drive a wedge between them.

4.5 Male 1 began a relationship with Female 3 in July 2009 whilst lodging with Female 1. In November 2009 Male 1 took a twelve month tenancy on a house which was in the same street as Female 3's home. In February 2010 Male 1 assaulted Female 3 and she ended the relationship. He remained at Address 4 until the tenancy expired in November 2010 and then moved back in with Female 1 where he remained until her death in December 2011.

4.6 Sometime between the February 2010 assault and July 2010, Female 1 sought out Female 3 and they exchanged telephone numbers and remained in touch. Female 3 warned Female 1 of the danger Male 1 posed but could not persuade her she was at risk. It appears that Female 1 was strongly influenced by Male 1's account of the assault on Female 3, a supposition supported MPT's IMR which records that Male 1 minimised the incident, questioning the accuracy of Female 3's account and even queered whether it happened at all; albeit he pleaded guilty.

4.7 On the weekend of Friday 25.11.2011 Female 1 and Male 1 left for a weekend in the Lake District. It appears something happened between them as it is known they left the hotel early claiming a family emergency. Female 1 was last seen alive by a neighbour on 26.11.2011.

5. KEY EVENTS ANALYSIS

5.1 Introduction

5.1.1 The combined chronology contains dozens of entries The DHR Panel decided to focus on those events it thought key to the terms of reference. Each key event is given a "title" accompanied by a narrative and where appropriate immediately followed by a critical analysis which draws on the IMRs and the deliberations of Panel members. A synopsis of important events preceding 25.02.2010 appears first.

5.2 Synopsis 1998 to 25.02.2010

5.2.1 The following incidents are recorded on Lancashire Constabulary's SLEUTH database and are all that remain on record. The files have been destroyed in accordance with the Force destruction policy.

Note: SLEUTH is used for crime recording; intelligence management, missing persons; officer tasking and briefing and public protection.

5.2.2 In 1998 Male 1 and Female 6 (his then current partner) were on a caravan holiday in France. She described how without warning he assaulted her in the presence of four young children. He slapped, punched and kicked before trying to strangling her with his hands. The police were called but Female 6 did not wish to pursue the matter.

5.2.3 They returned to England together where Female 6 tried to end the relationship. Male 1 refused to accept this but moved out of Female 6's home shortly afterwards. He began bothering her and was arrested by Lancashire Police and charged with harassment, which was later discontinued by the Crown Prosecution Service (CPS). The case file has been destroyed in accordance with Force policy and limited information remains. It is not known if a risk assessment was undertaken on Male 1 or whether any referrals were made to children's services. Female 6 provided a statement to MSP during the investigation into Female 1's death. Female 6 recalls that Male 1 "twisted" the information and told the police that they had been in consensual contact after he moved house.

5.2.4 In 2002 Male 1 was convicted at Wood Green Crown Court of False Imprisonment and Indecent Assault on Female 7 arising from an incident on 18.11.2001 when they

were in a brief relationship. He received four years imprisonment for the first offence and 1 year imprisonment for the indecent assault to be served concurrently. He did not qualify to be registered as a sex offender.

5.2.5 It is worth describing the case to understand its significance to later events. Male 1 had offered to assist Female 7 to sell her motor vehicle. After discussion took place at her home address, Male 1 asked Female 7 to drive him home to Middlesex. Female 7 agreed and stayed for lunch. When Female 7 attempted to leave, Male 1 grabbed her and tied her wrists and feet with tape and electrical flex. Tape was also placed over her mouth then she was placed on a bed and threatened with a knife over a period of 18 hours. Male 1 also teased the victim at knifepoint, marking her skin and used a pillow to press against her face as he indecently assaulted her. Male 1 then left the flat the following morning taking the victim's bankcard and car keys. He withdrew £500 from Female 7's bank account. She eventually freed herself and left the house by smashing a window, climbing out and raising the alarm.

5.2.6 This was the second known incident where Male 1 restricted the airway of a female within a relationship.

5.2.7 In 2004 Male 1 was released on licence which ended on 30.01.2005. At the time he was assessed as posing a medium risk of causing serious harm to a known adult (Female 7) and a low risk of causing serious harm to other women.

5.2.8 On 31.08.2007 Male 1 was arrested on suspicion of assaulting Female 9 (his future fiancé) in her home. The assault ended when a relative disturbed him and held him until the police arrived. In October 2007 the CPS decided there was insufficient evidence to prosecute Male 1 and he was released from bail.

5.2.9 On 08.02.2008 Male 1 became engaged to Female 9 and obtained a cash loan from Female 9's mother to buy the engagement ring. He "repaid" her mother with a "worthless" cheque. Female 9 gave Male 1 £2,000 in cash to pay for a medical procedure for her. Male 1 kept the money and issued another "worthless" cheque to the hospital. When the deception was discovered Female 9 ended the relationship. There was no prosecution.

5.3 Key Event: Female 1's Relationship with Male 1

5.3.1 There is no recorded or verbal evidence that Male 1 used or offered physical violence towards Female 1 during their relationship at the platonic or intimate phases, until the fatal event. The post death verbal evidence from family and friends suggests that at times Male 1 exhibited several signs of domestic abuse by wanting to control, isolate and manipulate Female 1 but there was never a hint of physical abuse and they had no concerns in that respect. However, Female 1 was not influenced by their apprehension. There is evidence that on the weekend of Friday 25.11.2011 leading up to Female 1's death that the relationship was fraught. See paragraph 4.7.

5.4 Key Event: Female 3 Discloses Domestic Abuse to Off Duty Police Officer

5.4.1 On 05.03.2010 Female 8 sought advice from an off duty MSP police officer. She said that Male 1 had tried to strangle her mother - Female 3. The officer advised Female 3 to formally report the incident. However, Female 3 was reluctant to do so and went with her daughter to the officer's house and described the attack, including the

attempted strangulation and the fact that her granddaughter had witnessed the latter stages.

5.4.2 Female 3 and Female 8 accompanied the officer to address 4 where he entered the house alone and spoke with Male 1 who then agreed that Female 3 could come in. In the presence of the officer and Male 1, Female 3 disclosed that the latter had assaulted and strangled her on 25.02.2010. Male 1 apologised and officer gave them advice. He also advised Female 3 how to make a formal complaint of assault but she declined. He made an entry in his official note book and took no further action.

Analysis:

5.4.3 Female 3 felt confident enough to disclose domestic abuse to a police officer in the presence of the perpetrator. The officer's actions fell well short of those required by force policy. It made no difference that he was off duty or a friend of Female 8. He should have followed Force policy for domestic abuse procedures, viz:

- Police contacted
- Police log created
- Police attend scene
- Allegation made - statement taken from aggrieved and witness
- Force Domestic Abuse Policy to be adhered to.
- Offender arrested and taken into custody. Detention log records all activity and Police and Criminal Evidence Act compliance.
- VPRF 1 ** (Vulnerable Persons Referral Form) completed at scene, Quality Assured and signed by a supervisor and forwarded to FCIU (Family Crime Investigation Unit) by end of tour of duty.
- Consider whether any immediate child protection action needed taking
- Log closed with correct resulting code.
- Crime recorded

** A VPRF 1 is an essential element of assessing risk and officers are required to submit them to FCIU who complete a formal risk assessment.

5.4.4 The officer might have found himself in a difficult position given the "informal" approach, but he failed to recognise the wider issues of child protection and the need to formally assess the risks posed by Male 1. His action in attempting reconciliation as evidenced by Male 1's apology and his failure to arrest or arrange for the arrest of Male 1 did not support the victim of domestic abuse. His failure to complete a risk assessment, record a crime or refer the incident to FCIU also served to leave Female 3 and her granddaughter in a vulnerable position. The officer's actions in keeping the information to himself meant that any subsequent checks by agencies for information on Male 1 or Female 3 would not have identified the "admitted" allegation. He also made his decisions without the benefit of undertaking the usual police checks to determine Male 1's background. The matter has been referred to MSP Professional Standards Department and therefore it is not known at this stage why he dealt with the incident as he did.

5.4.5 When Female 3 was seen by the independent chair/author of the DHR she explained that her reluctance to officially report the assault stemmed from her belief that children's services would become involved because of the Guardianship Order she had for her grandchild. She felt that by terminating the relationship she had taken

effective protective action. Female 3 now appreciates and understands the role of children's services.

Key Event: Female 3 Repeats Allegation of assault and strangulation

5.4.6 On 10.03.2010 MSP officers attended Male 1's home in response to concerns for his safety expressed by Female 8. On arrival they found Male 1 and Female 3. She repeated her allegation that Male 1 had assaulted her on 25.02.2010. The officer took a statement in which Female 3 describes how during an argument Male 1 strangled her and she blacked out. She regained consciousness and attempted to leave with her five year old grandchild. Male 1 refused and shouted at the child to return to bed. Male 1 was arrested and denied the allegation when interviewed. He was conditionally bailed to return to the police station on 14.04.2010. He was not to approach or communicate by self, servant or agent, Female 3 or to pass her address which was in the same street he lived in.

5.4.7 The officer in the case said he completed a VPRF 1. This did not reach FCIU who learned of the incident through the closing codes on the STORM incident log which they endorsed saying they were waiting for the VPRF 1. On 13.03.2010 FCIU send an e-mail reminder to the officer to submit the VPRF 1 and again endorsed the STORM log. There the matter ceased and no further action was taken by FCIU. This meant that a risk assessment was not undertaken nor was a referral made to children's services or MARAC, leaving Female 3 and her grandchild potentially vulnerable.

5.4.8 On the 11.03.2010, just one day after his release, the Crown Prosecution Service authorised MSP to charge Male 1 with a Section 39 Common Assault when he answered his bail on 14.04.2010.

Analysis:

5.4.9 The response of MSP was mixed. The officer took positive action by arresting Male 1, thereby complying with Force policy and supporting the victim of domestic violence. There is no record of the VPRF 1 being received in FCIU who after one attempt to obtain it took no further action. FCIU staff spoken to during the DHR recall that in 2010 there was a backlog of work in the unit and resilience was an issue. The problems of VPRF 1 and backlogs in FCIU have since been addressed and therefore MSP does not make a recommendation.

5.4.10 VPRF 1 submission is an item on the daily Basic Command Unit - BCU - Command Team meetings, with lapses being dealt with by way of the Performance and Development Review system. Members of the Protection of Vulnerable Persons Senior Command Team meet monthly with the Detective Chief Inspectors from each BCU to discuss staffing and resilience issues in FCIUs and where necessary take supportive remedial action.

5.4.11 The current MSP compliance rate for submitting VPRF 1's is 96.4% and for Sefton BCU it is 96.5%.

5.4.12 The failure of FCIU to obtain a VPRF 1 for the incident had the same negative consequences as when the "off duty" officer did not report Female 3's disclosure. The opportunity to undertake a risk assessment on Male 1 and provide services to Female 3 was missed and the child protection implications of her grandchild witnessing domestic abuse were left un-assessed. Additionally, the absence of a risk

assessment meant that a referral to MARAC was not considered. The incident was not recorded on the PROTECT database. However, it was easily retrievable from other databases and would have been found during a routine, "what do you know about Male 1/Female 3" check.

5.4.13 In the absence of a VPRF 1 following the 10.03.2010 report of strangulation by Female 3, the DHR Panel retrospectively completed the Merseyside Risk Identification Tool (MeRIT) using the 40 question screening form. The Panel members put themselves in the position of what the officer could have reasonable found out from the victim and a check of the Police National Computer.

5.4.14 The DHR Panel MeRIT risk assessed score was 144. The numerical threshold for categorising a case as High Risk is 60+. Therefore a score of 144 would have resulted in referral to MARAC and immediate consideration given to the safety of Female 3 and her grandchild. Therefore MSP's failure to complete a risk assessment was a significant error and meant that Female 3 was not referred to MARAC and Male 1's level of risk to others was not assessed. The DHR Panel debated whether the fate of Female 1 might have been different had a referral been made to MARAC, but concluded that the separation in time between the spring of 2010 and the death of Female 1 in December 2011 prevented any reliable view.

5.4.15 The MSP IMR author questioned why there was a 5 week time delay between advice being received from CPS on 11.03.2012 and Male 1 being formally charged on 14.04.2010. However, there is no power under Police and Criminal Evidence Act 1984 that enables people on bail to be brought in and charged earlier than their bail date. It is not known why a charging decision was not obtained from CPS whilst Male 1 was in custody. CPS discounted the 2002 convictions when deciding what to charge Male 1 with and opted for Common Assault as being appropriate. MSP did not tell CPS of the 1998 and 2007 assault allegations. The reason appears to be that the officer in the case had not sought out the information.

5.5 Key Event: Male 1 Charged Common Assault

5.5.1 On 14.04.2010 Male 1 was charged with Common Assault and bailed to appear at Court 1 on 07.05.2010. However, the matter was adjourned to 23.07.2010 because Male 1's solicitor was not present

Analysis:

5.5.2 None needed

5.6 Key Event: Male 1 Arrested for Breaching Bail

5.6.1 On 12.07.2010 Female 3 telephoned MSP saying that Male 1 had sent her a birthday card and present (using Female 1 as the courier) in direct contravention of his bail conditions. Female 3 also reported that Female 1 had interceded on Male 1's behalf urging her to contact him. Male 1 was arrested and charged with breaching his bail conditions and kept in custody until he appeared before Court 1 the following morning when he was re-bailed to appear at court on 23.07.2010. There is no record that a VPRF 1 was completed and the incident does not appear on PROTECT. Female 1 was seen as a witness during the "breaching bail" investigation and did not realise Male 1 was breaching his bail by asking her to deliver the card and present. Female 1 also said her intercession was not prompted or sought by Male 1; she just

felt he still had feelings for Female 3. Female 1 did not make any allegations against Male 1.

5.6.2 Female 3 told the DHR independent chair/author that prior to the bail breach she visited a police station on two occasions to report that Male 1 was walking past her house in breach of his bail conditions. There is no record of Female 3's attendance or of MSP taking action.

Analysis:

5.6.3 MSP acted promptly and arrested Male 1; charged him with breaching his bail and kept him in custody for court. This appears to have stopped the harassment and was supportive of Female 3. It has not been possible to identify the dates when Female 3 visited the police station to report Male 1 for breaching his bail. Any reports taken at a police station counter should be dealt with in the same way as those received on the telephone. In this case MSP do not have a record of the visits and the "counter" staff cannot be identified. Therefore the reasons for their apparent inaction are unknown.

5.6.4 The MSP IMR author wondered whether the practicalities of imposing a bail condition that prohibited Male 1 from walking past Female 3's house had been fully thought through given they lived in the same street; almost opposite each other. The DHR Panel felt this was a fair observation.

5.6.5 The VPRF 1 was crucial to the risk assessment process and its absence directly led to the third missed opportunity by MSP to assess the risk posed by Male 1.

5.7 Key Event: Male 1 Convicted of Assault on Female 3

5.7.1 On 23.07.2010 Male 1 pleaded guilty at Magistrates' Court to assaulting Female 3 on the 25.02.2010. His 2002 conviction was known to the court. Male 1 was sentenced to:

- Suspended sentence order: four months imprisonment suspended for twelve months
- A twelve month Supervision requirement
- A requirement to attend a Community Domestic Violence Programme
- A twelve month Restraining Order: Protection from Harassment Act
- £500 compensation to the Victim
- £150 costs to CPS

Analysis:

5.7.2 The guilty plea meant that Female 3 did not have to give evidence, thereby lessening the trauma of the proceedings and the arrangement for her to give evidence from behind screens was not necessary. The application and granting of a Restraining Order was positive and supportive of the victim.

5.7.3 A major concern of Female 3's is that post this conviction she was not told of his 2002 conviction. Had Female 3 known she would have used the information to try

and further persuade Female 1 that Male 1 posed a real risk. Female 3 is fixed in her view that she was entitled to know about his offending history given that she was a victim.

5.7.4 The DHR Panel considered the disclosure issues from a broader perspective. The purpose of disclosing information about Male 1 would be to enable Female 3 to make decisions about protecting herself and her grandchild and not about protecting other females. Protecting other females through disclosure falls to the appropriate agencies where it is deemed necessary and in accordance with policies and procedures. Any disclosure to Female 3 would need to be commensurate with her degree of resistance to ending the relationship. Female 3 had successfully severed her links with Male 1 making disclosure less justifiable.

5.7.5 Female 3 should have been referred to MARAC following her assault by Male 1. Part of the protective plan for Female 3 was likely to include a full or partial disclosure of his offending history; the justification for which lay in strengthening the resolve she exhibited when ending her relationship with Male 1. However, a referral to MARAC was not made and the opportunity to disclose to Female 3 was missed.

5.7.6 Male 1 assaulted Female 3 on 25.02.2010 she and immediately ended the relationship. He was convicted on 23.07.2010. Therefore, some five months had passed between the assault and conviction, during which time Female 3 demonstrated her resolve not to reignite a relationship with Male 1. This meant that she had demonstrated her determination to protect herself and grandchild from him, lessening the need for her to be told.

5.7.7 MSP does not have a specific policy on disclosing perpetrators' previous convictions to victims following convictions. Disclosures or partial disclosure is usually made within the MARAC and/or child protection procedures.

5.7.8 On balance the DHR Panel felt that following the July 2010 conviction, Female 3 could have been told of Male 1's 2002 convictions. These were a matter of public record, albeit not easily accessible. The justification for telling Female 3 lay with her status as a victim and to reinforce her decision not to reform a relationship with Male 1, rather than enabling her to pass the information on to Female 1. However, once Female 3 knew of the conviction, she was in control of who she told and it is very likely she would have passed the information to Female 1. However, the Panel did not feel it necessary to make a recommendation on the matter, believing the existing disclosure rules were sufficient.

5.7.9 The DHR Panel noted that children witnessed domestic abuse in 1998 (incident in France) and the 2010 assault on Female 3. This meant that Male 1 posed a risk to children of female partners. The significance of that appears not to have been recognised by any agency.

5.8 Key Event: MPT's Supervision of Male 1

Pre Sentence Phase

5.8.1 MPT's involvement with Male 1 began when it prepared a Pre-Sentence Report to inform the Magistrates' sentencing decision. Male 1 was managed by PrO 1 and MPT's IMR notes that, "Verifiable information about Male 1's history was difficult to

acquire as he was evasive and well defended in terms of allowing access to information about his circumstances".

5.8.2 MPT knew the details of Male 1's 2002 conviction, including the suffocation aspect and acquired an OASys assessment from his licence supervision file following his release in 2004. MPT was unaware of the 2007 alleged assault on Female 9 and the 2008 allegations of dishonesty; "bouncing" cheques.

5.8.3 PrO 1 was aware that Female 3's grandchild had witnessed an element of domestic abuse and on 05.07.2010 enquired of children's services whether they had any contact with Female 3. Children's services had not and agreed to refer the case to the Family Support Team who carried out an Initial Assessment and were reassured by Female 3 that she had ended the relationship for good.

5.8.4 On 23.07.2010 Male 1 was sentenced for the assault on Female 3 the details of which appear at paragraph 5.7.1.

5.8.5 MPT policy requires a Spousal Attack Risk Assessment - SARA – to be completed in cases of domestic violence and reviewed each time OASys is reviewed. Male 1's SARA judged him to be a medium risk of causing serious harm to a known adult (Female 3) and a known child (Female 3's grandchild) and a low risk to all other people.

Analysis:

5.8.6 It is clear that Male 1 deliberately withheld details of his background but his motive for doing so is not known nor does it seem to have been explored. For example when and where did he train as a "highly qualified engineer" and in what specific field did he operate?

5.8.7 PrO 1's action in seeking information from children's service was appropriate and filled a gap left by MSP. It was good practice that PrO 1 did not assume that MSP had made a referral. It is better to be told twice than not at all. For example neither MSP nor MPT told children's services that Male 1 breached his bail conditions, thereby denying them the opportunity for assessing the impact on Female 3's grandchild.

5.8.8 It is concerning that Male 1's non-conviction intelligence held by Lancashire Constabulary was not discovered by PrO 1. That information would have opened a line of questioning and enabled further challenges to be made by PrO 1 to an evasive Male 1.

History of Offending

5.8.9 The MPT IMR notes that there were only two convictions; the first in 2002 and the second in 2010. PrO 1 knew that both offences involved "suffocation or strangulation" of females with whom Male 1 was in a relationship. PrO 1 was aware of the 1998 incident in France and the subsequent harassment, albeit there was no conviction. PrO 1 was not aware of the alleged assault in 2007 or the two incidents in 2008 when Male 1 is reported to have obtained cash and then "bounced" two cheques.

5.8.10 The MPT IMR author reports that:

"PrO 1 tells me that he was aware that Male 1 had been in dispute with his then partner, during a holiday in 1998. They had discussed this as part of the process of PrO 1 collecting information about Male 1's history and previous relationships. It appears that Male 1 informed PrO 1 that he and his partner had argued after she had disclosed infidelity, but at no point did Male 1 indicate that this dispute had involved violence. Indeed, if he had, it would have provided an opportunity to work with him on the CDVP group, as he would have acknowledged some responsibility for DV - albeit in the past. As there was no disclosure of violence and no other evidence (available to PrO 1) to indicate that violence had taken place, it was not seen as an indicator of increased risk".

5.8.11 In relation to the 2002 indecent assault the MPT IMR author notes:

"PrO 1 states that Male 1 'vehemently denied the sexual element of the offence - he explained that he kidnapped the female as she owed him and a colleague money. He explained that the sexual offence charge was not accurate - in that he was assisting her to remove her trousers to use the toilet - and that it was never sexually motivated'. Whilst this did not mean that the potential sexual element of the risk profile was ignored, PrO 1 assessed it as part of the wider kidnapping/assault. There is no doubt that PrO 1 viewed Male 1 as being a risk to known females - especially when in a relationship with them (either friendship or sexual/emotional), but he didn't view him as a specific risk to other, random females in the sense that a predatory sexual offender may be. In retrospect, there may well have been some sado-sexual motivation to Male 1's offending, but the only information available to PrO 1 at the time, was that in relation to two seemingly unrelated and different types (at least in terms of motivation) of offence in 2002 and 2010".

5.8.12 Male 1 was noted as minimising the 2010 assault on Female 3 and being unwilling to talk about it. He saw, "no connection between the nature and motivation associated with this offence (2002) and the subsequent (2010) index offence". The PSR did not address the 2002 indecent assault conviction.

Analysis:

5.8.13 Male 1's trait of concealing his past and making what are believed to be exaggerated claims about his work and lifestyle, coupled with a reluctance to take responsibility for his actions made it difficult for PrO 1 to, "get any genuine sense of the true motivation behind some of the acts surrounding the (2010) offence". At this stage Male 1's was assessed (OASys) as posing a medium risk of causing serious harm to Female 3 which the DHR Panel felt was appropriate given Female 3's decisive actions in ending the relationship immediately following the assault and her resolve not to rekindle it.

5.8.14 Male 1 was assessed as posing a low risk to women. It is not known how many female partners Male 1 had and therefore it is not possible to quantify the proportion which resulted in violence. Male 1 was convicted of assaulting two women, one in 2002 and another in 2010. There is other recorded police intelligence saying he assaulted two other women, one in 1998 and another in 2007. That intelligence was readily available had PrO 1 sought it and given the "slippery" nature of Male 1 the DHR Panel felt PrO 1 should have done so.

5.8.15 PrO 1 did not consider Male 1 to be above a low risk of harm to unknown women. The risk he presented to women was directly linked to those he was in a partnership

with, and then maybe not all of them. For example it is known that his former wife reported that he was not violent to her. At the time of his 2010 conviction, PrO 1 believed that Male 1 was not in a relationship and therefore his risk to unknown females was low. Perhaps PrO 1 could have recognised that being in a relationship was a key indicator of risk and put a contingency plan in place to discover when that happened and reassess Male 1's risk when it did. That plan might have included asking the police/children's services/health to let PrO 1 know should they discover Male 1 was in a relationship with an adult female.

Supervision – The First Six Months

5.8.16 Male 1 complied with his reporting schedule and national standards were met, including a home visit. However, he continued to mask his real feelings and motives, culminating in a claim that Female 3 had lied about the attack. PrO 1 recognised this as avoidance tactics but nevertheless it caused him significant difficulties in managing Male 1 effectively.

5.8.17 A pre-requisite of attending the Community Domestic Violence Programme - CDVP is for the attendee to accept responsibility for his actions. Male 1 resisted all such attempts and would not acknowledge responsibility. This effectively allowed him to avoid the programme without ever making a direct refusal and that amounted to a false willingness to attend.

5.8.18 PrO 1 sought managerial advice which concluded that the CDVP was undeliverable in this case and an application should be made to the court for its discharge and substitution with an Unpaid Hours punishment, proportionate to the seriousness of the original offence. There was no suggestion of how many hours might be proportionate.

5.8.19 PrO 1 submitted a request asking the Court to replace the CDVP requirement with one of a period of Unpaid Work and that the hours given should be commensurate with the seriousness of the original offence. The Chair of the Bench asked the Court Probation Officer for the number of hours Male 1 would have had to attend the CDVP, so that he could give that number of hours as an Unpaid Work requirement. The Court Officer explained that the two did not necessarily equate and that, given the nature of the offence, the Court should consider giving a punitive number of hours. However, on 20.12.2010, the Court removed the CDVP requirement without substituting another requirement.

Analysis:

5.8.20 The DHR Panel felt the analysis by the MPT IMR author accurately set out most the issues and reproduce it below.

"The problems encountered in this case reflect an increasingly common issue with domestic abuse perpetrators, whereby initial acceptance of some responsibility is replaced (usually after sentence) with more resistant and entrenched views. This means that a sentence proposal which may have seemed appropriate when a PSR was being prepared becomes unworkable once the Order has commenced. In circumstances where offenders simply refuse to comply with all or part of their Order, this can be dealt with by returning them to Court for Breach of the Order and a complete resentence on the original offence, with added punishment for the breach. However, where – as in this case – there is not an actual refusal to comply,

the Probation Service is in a more difficult position. It is an area that the Ministry of Justice and the National Offender Management Service (NOMS) are currently considering, as present arrangements are not felt to be adequate. As things stand, Courts are expected to revoke the original Order and resentence in a way which provides a workable Order. In this instance, it was appropriate to ask the Court to replace a rehabilitative requirement (the Programme), with a punitive one (Unpaid Work), given that it was not possible to deliver the programme on a group work basis".

5.8.21 The DHR Panel thought that MPT should have pre-quantified the number of hours Unpaid Work it judged suitable, thereby avoiding the position whereby the court deleted the CDVP rehabilitative order without substitution.

5.8.22 The MPT IMR records that "...PrO 1 worked hard to push Male 1 into accepting responsibility for his actions, though this ultimately proved unsuccessful. It is also important to note that throughout this period, there was no evidence that Male 1 was in any kind of relationship. Assessed risk levels were appropriate and I am satisfied that PrO 1 was always aware of the potential for risk to escalate if circumstances changed..."

5.8.23 The DHR Panel noted that MPT IMR helpfully contained the following:

"Although there was never any evidence provided to PrO 1 of a continuing relationship between Male 1 and Female 3 or of Male 1 being in a relationship with any other woman, none was actively sought from third parties. Male 1 was questioned on a regular basis and he was visited at home by PrO 1, but no other possible sources of information were explored. It would be good practice to schedule in regular contact with FCIU, to confirm information provided by an offender".

Supervision - The Second Six Months

5.8.24 PrO 1's interventions with Male 1 did not achieve any fundamental change in his attitude towards his offending. At one point PrO 1 recorded that Male 1 was "prone to exaggerate his achievements to the point of outright fantasy". In March 2011 PrO 1 moved during a reorganisation and Male 1's case was transferred to PrO 2, a very experienced officer. It was thought that Male 1 was not in a relationship and therefore deemed not to present an imminent risk. Accordingly Male 1's reporting was reduced to monthly.

5.8.25 Male 1 was seen by the duty officer at the end of March 2011 (PrO 2 was on leave) and by PrO 2 in April and June before the Supervision Order expired in July 2011. The MPT IMR notes that "little in the way of offence focussed work was undertaken following the case transfer and the emphasis appears to be on employment issues".

Analysis:

5.8.26 During the period March 2011 and July 2011 Male 1 should have been seen four times to satisfy national standards. He was seen on three occasions and given that PrO 2 has retired it has not been possible to establish why that was. However, the DHR Panel felt the breach was not significant to the matters under review. More concerning to the DHR Panel was why PrO 1 did not continue his supervision of Male 1 following an internal reorganisation. Male 1 was known to be a very difficult person

to manage and changing the key person with less than five months left of a twelve month supervision order did not provide sufficient time for PrO 2 to make an impact.

5.8.27 It is not known how robust PrO 1 or PrO 2 were in trying to determine if Male 1 had formed a relationship with a female or his history. If PrO 2 felt that by being in a relationship Male 1 would present an imminent risk he should have made wider enquiries to establish the relationship issue as a "fact" rather than taking Male 1's word for it, or making an assumption.

5.8.28 It is a fact that during MPT's supervision of Male 1 he was not charged or convicted of an offence and therefore in those terms is can be viewed a success.

5.8.29 The DHR Panel felt that the issues arising from MPT's management of Male 1 did not contribute to Male 1's subsequent offending against Female 1.

5.9 Key Event: Police Discover the Bodies of Female 1 and Female 2

5.9.1 Female 1 and Females 2's bodies were discovered on 03.12.2012. MSP and MPT did not hold any information about Female 1 other than she passed messages on from Male 1 to Female 3. No agency involved in this DHR had any knowledge that Male 1 had re-formed his relationship with Female 1 after he assaulted Female 3.

6. ANALYSIS AGAINST TERMS OF REFERENCE

6.1 Introduction

6.1.1 Each term of reference is commented on from material in the IMRs, the debates of the DHR Panel and the views of family members. Some commentary could fit into more than one term and the decision on where it appears was made on a best fit basis.

6.1.2 The terms appear in ***bold italics*** followed by an analysis.

6.2. Term 1

How did your agency respond to reports or knowledge of domestic abuse involving Male 1 and Female 1?

6.2.1 When this term was drawn up is was thought that there was a history of recorded domestic abuse between Male 1 and Female 1. However, it turned out that Female 1 was not known to agencies as victim of domestic abuse. Many of the terms are relevant to Female 3 and are commented on from her perspective. Effectively only two agencies - MSP and MPT - had relevant dealings with Female 3 and Male 1. The health family did not have hugely relevant material for the period under review and the older information was no longer pertinent.

6.2.2 Male 1 had a conviction from 2002 the circumstances of which included domestic abuse and whilst that was known to MSP and MPT in March 2010 following Male 1's assault on Female 3, neither agency was aware that he had formed a relationship with Female 1. The response of agencies to Female 3's victimisation appears in term 2.

6.3 Term 2

What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?

6.3.1 MSP failed to take any effective action to safeguard Female 3 and her grandchild following Female 3's disclosure of domestic abuse to an "off duty" police officer on 05.03.2010. The officer did not follow Force procedures and overlooked the child protection issues stemming from the Grandchild witnessing the latter stages of an abusive incident. His lack of action has been referred to MSP Professional Standards Department and therefore an explanation of his actions is not yet available.

6.3.2 Five days later on 10.03.2010 MSP took positive action when Female 3 repeated the allegation against Male 1. He was arrested and bailed with conditions not to approach Female 1 directly or through a third party and not to walk past her house. That action was protective of Female 3. The VPRF 1 did not arrive at FCIU and after one attempt to have it "re-sent" the matter received no further action. This meant that:

- a MeRIT risk assessment was not carried out
- a referral was not made to children's services
- a referral was not made to MARAC

6.3.3 The DHR Panel reconstructed the MeRIT risk assessment and concluded that Female 3 met the Gold Standard criteria for domestic violence and should have been referred to MARAC and children's services. The failure of FCIU in these matters meant that Female 3 and her grandchild very denied additional protective services.

6.3.4 The attack on Female 3 was the third known incidence of Male 1 restricting the airway of females within an intimate relationship. Neither MSP nor MPT discovered the bigger picture which should have lead them to consider a referral to MARAC. The DHR Panel judged that is was reasonable to expect MSP and MPT to have gathered this very relevant historical data. MSP and MPT's failure to do so was not supportive of Female 3 or any female with whom Male 1 formed an intimate relationship.

6.3.5 MSP could have liaised with CPS whilst Male 1 was in custody on the 10.03.2010 and sought the authority to charge him. There is no explanation for why that did not happen or whether the officer in the case knew of the 1998, 2007 and 2008 incidents. It is known they were not on the advice file presented to CPS. The authority to charge Male 1 came the following day by which time he had been bailed to re-appear at the police station on 14.04.2010 and because of the restrictions of Police And Criminal Evidence 1984 he could not brought back earlier.

6.3.6 On one occasion MSP acted swiftly when Female 3 reported that he breached his bail conditions. He was arrested, kept in custody and placed before the court the next day. That is supportive of Female 3 and in contrast to the two previous occasions when she went to a police station counter to report Male 1 for breaching his bail conditions. It has not been possible to trace those two visits.

6.3.7 Following Male 1's arrest for breaching his bail a VPRF 1 should have been submitted and a MeRIT risk assessment undertaken. Neither of those things happened and for the third time MSP failed to follow Force policy in this respect. As stated earlier those

weakness have been recognised and effective remedial action taken before this DHR was commissioned.

6.3.8 Children's Services acted promptly following the referral from MPT that Female 3's granddaughter had witnessed part of the domestic violence between her grandmother and Male 1. An Initial Assessment was undertaken and professionals were satisfied that Female 3 could properly protect the child. This illustrates sound practice against expected standards.

6.4 Term 3

What impact did the services provided by your agency have on reducing the impact of domestic abuse by Male 1 on Female 1 and in identifying and dealing with the causative factors?

6.4.1 It is now known that agencies did not have any information that Male 1 was abusive towards Female 1. However, the following actions were taken following his attack on Female 3 aimed at reducing the impact on her and indentifying causative factors.

- CDVP
- Bail condition,
- Risk Assessments,
- Twelve month Supervision Order
- Restraining Order, Protection from Harassment Act.
- Referral to children's services by MPT

6.4.2 Male 1 would not engage with services when referred to them for anger management by his general practitioner or MPT in their attempts to deliver the Community Domestic Violence Programme. His non-engagement meant that the causative factors for his violence towards intimate female partners were never established. The bail conditions were effective in that when he breached them he was arrested and dealt with. Male 1 was not convicted of an offence during his supervision period; July 2010 to July 2011.

6.5 Term 4

Were your agency's policies, procedures and training, that were relevant to this case, fit for purpose, including those relevant to assessing risk?

6.5.1 The DHR Panel did not detect any gaps in agencies policies, procedures or training. MSP had difficulties with some staff complying with some policies.

6.5.2 The risk assessment policies of the agencies involved are fit for purpose; it was their application which was not always so. Not all of Male 1's historical date was gathered and used to inform his risk assessment, nor was sufficient emphasis placed on discovering whether he had formed any new relationships with females.

6.6 Term 5

Were there issues in relation to capacity or resources in your agency or wider partnerships that impacted the ability to provide services to Female 1 and/or Male 1 and to work effectively with other agencies?

6.6.1 MSP was the only agency reporting capacity and resourcing issues and these impacted adversely on the services provided to Female 3. The MSP IMR readily acknowledges that in 2010 the relevant FCIU had difficulty in dealing promptly with relevant cases, resulting in some domestic violence cases not being assessed and services not being provided to victims as a direct consequence. In this case MSP was not required to provide or facilitate services to Female 3 and her grandchild.

6.7 Term 6

Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?

6.7.1 The three people looked at in this DHR are white British with English as their first language. They had no known diversity issues and they were culturally well equipped to deal with MSP and/or MPT.

6.7.2 MSP and MPT have well defined diversity policies and practices and no breaches of them were detected in the DHR.

6.8 Term 7

Did professionals working with the victim have appropriate levels of supervision?

6.8.1 PrO 1 sought managerial advice when he recognised Male 1's manipulative behaviour. PrO 2's minor breach of national reporting standards was not picked up by his supervisor.

6.8.2 MSP supervisory processes did not identify that Female 3's case had not been risk assessed within FCIU and the IMR author believes this was associated with the inadequate resourcing in 2010.

6.9 Term 8

Was information sharing and communication with other agencies regarding Male 1 and Female 1 and the other subjects of the review, effective and did it enable joint understanding and working between agencies?'

6.9.1 MSP did not share information with children's services or MARAC following Female 3's complaint of assault, because they failed on three occasions to complete a MeRIT risk assessment which would have triggered the action.

6.9.2 MPT was effective in sharing information with children's services about the potential child protection issues arising from Female 3's grandchild witnessing domestic violence, albeit they could have told children's services about the breach of bail conditions by Male 1.

6.9.3 MSP and MPT should have been more proactive in seeking out information about Male 1, particularly given his reluctance to share his history and the doubts about the truth of those bits he did.

7. LESSONS LEARNED

7.1 Professionals working with resistant and manipulative clients should make every effort to verify what they are told and look at all possible sources of information to enable them to robustly challenge difficult people and inform risk assessments.

7.2 The pattern of Male 1's violent behaviour when ending relationships with some female partners was not recognised.

7.3 Where offenders are known to present a risk to intimate female partners, agencies should put processes in place that provide the very best opportunity of detecting when such relationships are forming or have formed.

7.4 Inadequate staffing in FCIU meant that routine procedures were not followed, the consequences of which did not fully support a victim or allow for appropriate information sharing including a referral to MARAC. This issue has been addressed and police practice is reported as being improved.

7.5 PrO 1 did not assume that MSP had referred Female 1's grandchild to children's services following the 2010 assault and showed good judgement by making the referral.

8. SEFTON'S DOMESTIC VIOLENCE PROGRAMME

8.1 Sefton Safer Communities Partnership (SSCP), Local Safeguarding Children's Board (LSCB) and Health and Wellbeing Board have identified Domestic Violence as a core priority; recognising the significant impact upon Communities. The strategic governance arrangements for DV were reviewed 12 months ago to allow an effective governance structure.

8.2 A review of MARAC was conducted as part of this DHR review and highlighted a number of areas of development. An action plan was formulated and implemented with a number of positive outcomes.

8.3 A specific action related to the focus upon high level repeat victims/perpetrators looking at specific issues and actions that could be put in place to provide tailored support/action.

8.4 Current training offered:

- LSCB Level 1 DV multi agency training
- LSCB Advanced DV multi-agency training. Delivered by SWACA, FCIU, RASA, Health and Children's Social Care

8.5 A range of statutory and voluntary sector agencies offer crisis and early intervention and prevention services. Good working relationships between services remain of prime importance and Sefton partner agencies continue to build and strengthen links to ensure appropriate referral mechanisms are in place to ensure the best possible outcome for the individual.

8.6 Sefton's Voluntary Perpetrator's programme (NoXcuses) is currently running as a pilot. The 30 week programme is offered on a group work basis in order address abusive behaviours by male perpetrators.

9. CONCLUSIONS

9.1 Male 1 killed Female 1 by strangulation without any previous recorded history of domestic violence between them. However, by the time he did so, it was known that he had attempted to strangle intimate female partners on two previous occasions 1998 and 2010 and to smother one in 2001. There was another allegation of assault from 2007 and some suspected dishonest in 2008.

9.2 Therefore, when Male 1 was arrested and charged with assaulting Female 3 by strangulation, MSP and MPT should have made a greater effort to piece together his history and to consider what impact it made on his assessed risk. The intelligence was there to be had. MSP failed to complete a risk assessment thereby preventing a referral to MARAC and children's services and the opportunity to look more closely at Male 1. Part of MARAC's role could have been to consider making a partial or full disclosure of Male 1's 2002 conviction to Female 3

9.3 MPT recognised Male 1's manipulative nature as evidenced by his refusal to engage with the CDVP which was not substituted with an alternative. Male 1 was able to complete his twelve month Supervision Order without effectively acknowledging or addressing the causative factors of his offending, thereby leaving an important element of risk management uncontrolled.

9.4 Male 1 was correctly assessed as posing a medium risk of causing serious harm to a known adult (Female 3) and low risk to all other women. His pattern of being violent to some females during the ending of relationships was not recognised and therefore no plans were made to discover when he formed a new relationship.

9.5 It appears no agency knew that Male 1 had been in and re-formed an intimate relationship with Female 1. However, in July 2010 he used Female 1 as a go-between to contact Female 3 in direct contravention of his bail conditions and neither MSP nor MPT used that opportunity to explore what the relationship between Male 1 and Female 1 was.

9.6 The best predictor of criminal behaviour is a history of criminal behaviour, and past violence will suggest a probability of future violence. A history of criminal behaviour is the best predictor of criminal recidivism regardless of whether the offender is mentally disordered or normal – Bronta, Law and Hanson, 1998.

9.7 The DHR Panel concluded that based on his past history it was likely that Male 1 might cause harm to a female when a relationship was ended against his wishes. His full criminal behaviour was not known to or sought by MSP or MPT. This meant that

Male 1's assessed risk was based on incomplete information. Female 1 and Male 1 ended a relationship in February 2009 on good terms. The relationship was re-formed and it is not known why Male 1 took Female 1's life. However, the deficiencies of MSP and MPT did not directly or indirectly lead to Female 1's unpredictable death. The opportunity to discover what happened and why, ended when he was found dead in his cell at Manchester Prison and may emerge at his inquest.

10. RECOMMENDATIONS

10.1 Single Agency

Merseyside Probation Trust

1. That MPT ensures the key lessons from this review are made available to staff and used to support and improve practice.

2. That MPT develop a structured programme pack to assist Offender Managers to work with perpetrators of domestic abuse who are unable or unwilling to accept responsibility for their actions.

3. That MPT implements whatever guidance is received from NOMS/Ministry of Justice, regarding the amendment of Orders

4. That MPT reviews guidance to staff decision making in respect of frequency of reporting, as part of the development of professional judgement in Offender Managers.

Merseyside Police

5 That Merseyside Police renew and reinvigorate Domestic Abuse training for frontline uniform/Sergeants and Inspectors.

6. That Merseyside Police ensures that a dedicated Risk Assessor role is utilised in Domestic Violence Unit Administration.

10.2 DHR Panel

7. That Sefton Safer Communities Partnership satisfies itself that MSP and MPT have systems and practices in place for gathering background information on domestic violence offenders, including knowing when new partnerships have formed, and use all such information in risk assessments.

END OF OVERVIEW REPORT

NEXT APPENDIX 1 Action Plan

APPENDIX 1

Sefton Safer Communities Partnership FEMALE 1 DHR ACTION PLAN

Ref No.	Recommendation	Action	Responsible Agency/ Lead Person	By When (date)	Outcome
	MERSEYSIDE PROBATION TRUST				
9.1	**1.** That MPT ensures the key lessons from this review are made available to staff and used to support and improve practice.	That the lessons from the DHR are disseminated to staff via the Senior Management Team.	IMR Author Steve Chambers MPT ACO	31/8/12	Improved understanding and delivery
	2. That MPT develop a structured programme pack to assist Offender Managers to work with perpetrators of domestic abuse who are unable or unwilling to accept responsibility for their actions.	That a programme pack be developed and distributed to Offender Managers.	Sonia Turner MPT ACO	31/10/12	More effective intervention with those denying responsibility

	3. That MPT implements whatever guidance is received from NOMS/Ministry of Justice, regarding the amendment of Orders following non-Compliance	Guidance/Instruction will be implemented.	Anne Pakula Head of Operations	As required	More effective management of cases
	4. That MPT reviews guidance to staff regarding decision making in respect of frequency of reporting, as part of the development of professional judgement in Offender Managers.	MPT to review expectations in respect of frequency of reporting as part of an urgent revision of practice with Domestic Abuse perpetrators	Anne Pakula Head of Operations	31/10/12	Increase in contact levels with DV perpetrators
SEFTON SAFER COMMUNITIES PARTNERSHIP					
9.2	**5.** That MSP and MPT satisfy themselves that their systems and practice for gathering background information on domestic violence offenders are documented, robust and fit for purpose.	SSCP to request reports from MSP and MPT on the criteria each agency uses when conducting background checks on people suspected of domestic violence in the discharge of their responsibilities. The reports should include which databases are check and which agencies are	Steph Prewett Head of Corporate Commissioning and Neighbourhood Co-ordination	31/10/2012	Thorough Risk Assessments resulting in robust risk management plans in

	consulted.	Sefton Metropolitan Borough Council		support of victims
MERSEYSIDE POLICE					
9.3	**6.** That Merseyside Police renew and reinvigorate Domestic Abuse training for frontline uniform/Sergeants and Inspectors.	Training.	Public Protection Unit.	31/03/2013	Positive Police response by frontline officers. VPRF1 completed at scene.
	7. That Merseyside Police ensure that a dedicated Risk Assessor role is utilised in Domestic Violence Unit Administration.	Full time Risk Assessor post to be created and filled within each Basic Command Unit.	Public Protection Unit.	31/12/12	Swift input and exchange of information internally and to partner agencies.