Wolverhampton Domestic Homicide Review (DHR02)

Produced for Safer Wolverhampton Partnership

EXECUTIVE SUMMARY

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1 Introduction and background

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 53-year-old Wolverhampton man. In order to protect identities aliases have been used throughout the report. Police and paramedics were called to Peter 's home address, where Kate reported that he had fallen and suffered an accidental knife wound to the chest whilst peeling vegetables. She was however charged with murder and was subsequently convicted and sentenced to life with a recommendation that she serve a minimum of seventeen years before being eligible for parole.

2 Purpose of a Domestic Homicide Review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).[1] This provision came into force on 13th April 2011; responsibility for undertaking domestic homicide reviews lies with the Community Safety Partnership (CSP) within the victim's area of residence. (Where the victim's area of residence is not known, the CSP lead responsibility will relate to the area where the victim was last known to have frequented as a first option and then considered on a case by case basis). In Wolverhampton, the Safer Wolverhampton Partnership (SWP) meets the responsibilities of the CSP.

Domestic Homicide Review (DHR) means:

'A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by –

(a) a person to whom (s)he was related or with whom (s)he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself/herself

[1] Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews- Revised- 1 August 2013

A review to be held with a view to identifying the lessons to be learned from the death; this may include considering whether appropriate support, procedures resources and interventions were in place and responsive to the needs of the victim'

Intimate personal relationships include relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A member of the same household is defined in section 5(4) of the Domestic Violence, Crime & Victims Act [2004] as:

a person is to be regarded as a 'member' of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;

Where a victim (V) lived in different households at different times, 'the same household as V refers to the household in which V was living at the time of the act that caused V's death.

When victims of domestic homicide are aged between 16 and 18, a child SCR should take precedence over a DHR. However, it is vital that any elements of domestic violence relating to the homicide are addressed fully and the review includes representatives with a thorough understanding of domestic violence.

3 Process of the Review

On the 28.10.13 The Public Protection Unit of West Midlands Police notified in writing the Head of Community Safety and Chair of the Safer Wolverhampton Partnership (SWP) of the homicide. An Initial Consultation Group meeting was convened on the 15.11.13 to consider whether the circumstances fulfilled the criteria for a DHR. The group recommended to the Chair that the case did require a DHR to establish lessons to be learned. The Chair ratified the decision. The Home Office was notified of the intention to conduct a DHR .The SWP chair prepared initial terms of reference within one month of notification to the Home Office of the intention to hold a DHR.

An independent person was appointed to chair the review and to write the overview report. The appropriate representation on the Review Panel was discussed at the Initial Consultation and reviewed at the First panel meeting.

The Home Office guidance requires that the Overview Report should be completed within a further six months of the date of the decision to proceed. However once Safer Wolverhampton Partnership had received the initial scoping submissions, it became evident that some agencies had had many hundreds of contacts with the victim and perpetrator. It was the panel's view that the DHR would be involved and complex and that an extension may be required from the Home Office. Delays in presentation of some agencies' IMRs made this approach necessary. This request was sent in June 2014 and it was hoped that submission of the DHR could be achieved by September 2014. However delays with crucial IMRs from West Midlands Police and Crown Prosecution Service (CPS) required the Review to be extended.

The police in particular, made it clear from the outset that their IMR would require a time extension. Two extensions were requested before submission of a first draft on the 28.04.14 and after consideration of that first draft IMR, further questions were asked of police. Due to operational reasons, the police were not able to return a final IMR submission until mid-September 2014.

CPS had been approached at the outset of the process to engage with the DHR. However CPS reported to the chair that a decision on their participation could only be taken post trial (May 2014). Thereafter the DHR panel made several additional approaches for key information from CPS; however a final report was not received until mid-October 2014.

The Review Panel felt that with such a complex series of events and such extensive involvement by several agencies, during the period under review, it would be appropriate to adopt some features of current best practice from Serious Case Reviews. Two learning events were held.

The first was with IMR authors, after the submission of revised IMRs. The intention was to share the timeline and the key themes with authors, and consider whether strategic and agency recommendations would help to improve safeguarding outcomes in future complex domestic abuse cases. Some agencies sought to refine and improve their recommendations having

gained a significantly better insight into the case. This was felt by the panel to be a very positive outcome.
The second event, with agency managers, allowed the same discussion of the case, but concentrated on a consideration of the strategic recommendations and the actions required to improve practice.

3.1 The Domestic Homicide Review Panel and Independent Chair

The panel was formed with the following representation:

Head of Wolverhampton Community Safety (WCC)
Director of Public Health (Commissioning – WCC)
Head of Safeguarding & Quality Assurance (Adult and Child - WCC)
Director of Nursing and Quality (Clinical Commissioning Group)
Safeguarding manager Quality assurance (Adults - WCC)
Strategy and General Manager (Wolverhampton Domestic Violence Forum)
Head of Probation (Walsall & Wolverhampton)
Detective Chief Inspector (West Midlands Police Public Protection)

A Joint commissioner (Mental Health) attended a panel meeting to discuss mental health issues, but was not a member of the DHR panel.

The independent panel chair and author is a retired police public protection investigator with twelve years' experience of child and adult safeguarding and investigations. Prior to leaving the police service, he managed the Public Protection Review team, responsible for writing the force's IMR and contributing to over thirty DHRs and child and adult SCRs. He has had no involvement with the case subject of this DHR.

3.2 Parallel proceedings

The panel was aware of the on-going criminal proceedings and therefore the terms of reference were shared with the SIO, to ensure there were no disclosure issues raised. The panel commenced in advance of criminal proceedings having been concluded and for that reason the Crown

Prosecution Service informed the chair that they would not be able to contribute a written report until after the trial was completed.

3.3 Scoping the Review

The process began with an initial scoping exercise prior to the first panel meeting, to identify agencies that had had involvement with the victim and perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly.

All agencies were asked to provide a chronology of involvement from which a merged chronology was created, allowing the Review panel to commence consideration of the circumstances of the case in anticipation of the IMRs

3.4 Time period

Agencies were asked to focus on events from September 2009 leading up to the date of death on 27 October 2013, unless it became apparent to the Panel that the timescale in relation to some aspects of the review should be extended. The Review also considered relevant information relating to agencies contact with the victim and perpetrator outside the time frame as it impacted on the assessments in relation to this case.

3.5 Individual Management Reviews

An Independent Management Review (IMR) and comprehensive chronology was received from the following agencies;

- Anti-Social Behaviour Team (Wolverhampton Homes)
- Black Country Partnership Foundation Trust (Penn Hospital & Healthy Minds)
- Adult and Community Emergency Duty Team (WCC)
- General Practitioners (Wolverhampton Clinical Commissioning Group)
- The Haven- Wolverhampton (domestic abuse support services women, girls and children)
- Housing Options Team/Housing Support Division/Communities Directorate/WCC

Housing Outreach team/Housing Support/Communities Directorate/WCC
Learning Disability Team (WCC)
Adult Mental health & Emergency duty team (WCC)
NACRO / Recovery Near You (Substance Misuse Services)
New Cross Hospital – Royal Wolverhampton NHS Trust
Older Person's Services (WCC) – (Incorporating initial assessment team and South West Locality Team)
P3 (Wolverhampton homelessness accommodation and support services)
Staffordshire and West Midlands Probation Service (From 01.06.14 National Probation Service (Midland Division)
West Midlands Ambulance Service NHS Trust
West Midlands Police
Wolverhampton Domestic Violence Forum
Wolverhampton Homes
The Crown Prosecution Service (CPS) are not an agency that the Secretary of State can require to participate in a DHR under section 9(4) of the Domestic Violence, Crime and Victims Act 2004.
Due to the nature of the case, the panel requested CPS involvement at the start of the review. CPS informed the panel they were unable to consider participation before the trial process concluded in May 2014. It was therefore decided by the panel that rather than request an IMR, a list of questions to CPS should be agreed and submitted for consideration at that time. Thereafter the Chief Operating Officer authorised a report, which was submitted to the panel by the Chief Crown Prosecutor (CPS West Midlands) on 13.10.14.
Reports were also received from HMP Prisons, Avon & Somerset Police, Bedfordshire Police and SERCO.

3.6 Subjects of the review

The subjects of the review were the victim, Peter the perpetrator Kate and her daughter Louise.
The victim Peter (28.04.60) had a previous partner, Rachel with whom he had one child, Rebecca (22 years old)

The perpetrator, Kate (10.08.64) had a previous relationship and had two children; Jane was born in 1989 and Andrew 1988. She was then married to Brian and had a daughter, Louise born in 1996.

4 Terms of reference (brief summary)

Initial terms of reference were agreed by the consultation group and were reviewed and updated by the chair and panel at the first Review Panel meeting of 17.12.13 and underwent minor amendments in January/February 2014 as information considered relevant emerged, or it became clear that additional IMRs or reports were required.

The panel were clear that agencies should be encouraged to analyse safeguarding in its' widest context, since it was evident that not only the victim, but also the perpetrator, had suffered significant domestic abuse. It was the view of the panel that agencies should also consider the impact of domestic abuse upon the perpetrator's daughter, who was a child during the entire timeframe and had previously been the subject of a child protection plan and was known to have had contact from the Domestic Violence Forum when she pursued a criminal justice domestic violence case against her mother, Kate.

The intention of the terms of reference (supported by an IMR training event for IMR authors and managers held on the 18.12.13) was to encourage agencies not to concentrate exclusively upon chronicling individual events. Rather to give detailed consideration and analysis of **why** decisions were taken (or not) by professionals and supervisors, and the impact these had upon the safeguarding of anyone who should have been seen to be at risk.

The full terms of reference are included in the overview report.

In addition to the generic requirement to identify learning described below, all agencies completing an IMR were instructed to;

- Identify a definitive timeline of events leading to the homicide for the victim and the alleged perpetrator
- Establish whether failings occurred in the assessment, care or treatment of all family members

- Identify whether there were any mental health or capacity issues at the time of the homicide for the victim of the alleged perpetrator identify whether safeguarding arrangements had been considered or were effectively in place for all family members
- Establish how recurrence – if appropriate – may be reduced or eliminated
- Formulate recommendations and an Action Plan
- Provide a report as a record of the investigation process
- Provide a means of sharing learning from the incident
- Provide a report to enable the SWP to meet its responsibilities under its Domestic Homicide Review Procedures.(section 9 Domestic Violence Crimes & Victims Act 2004)

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process.

The purpose of a Domestic Homicide Review is to:

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

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to policies and procedures as appropriate; and

Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

5 Family Involvement

As far as possible the family and friends of the victim and perpetrator were given the opportunity to contribute to the review. The panel discussed

with the senior investigating officer and family liaison officers (FLOs), the timing of the review panel's introduction to family/friends, which was achieved by contact on the panel's behalf by the FLOs, followed by an introductory letter. Meetings with members of the family were sensitive to the on-going criminal proceedings.

The Independent chair met with the victim's brother and sisters, who had consulted extended family to collate any questions the extended family may have had and undertook to feedback to the family after the meeting. On a separate occasion the independent chair met with the former husband of the perpetrator, and their daughter.

6 Perpetrator Involvement

The Independent chair contacted the perpetrator Kate by letter, following her conviction for murder, encouraging her to contribute to the DHR. Kate declined to contribute to the review.

7 Key themes identified in the review

7.1 Alcohol abuse and mental health concerns

From 2010, until the murder of Peter in October 2013, Peter and Kate formed a relationship in which their abuse of alcohol was a defining and sustained feature. They exhibited many of the mental health concerns commonly linked to alcohol addiction. It appeared that Kate might have also suffered from an unidentified personality disorder. In addition, as a consequence of a significant head injury in February 2011, Kate believed both her behaviour and memory had been adversely affected.

7.2 Frequent reports and allegations of domestic abuse

The couple were well known to the police services of both Bristol and Wolverhampton during the period under review. From 2010, until Peter's homicide in October 2013, two police services recorded an almost unbroken

chain of domestic abuse incidents. made in the greater part by Kate. She was therefore generally identified by services as the primary victim and Peter as the primary offender. However both Kate and Peter suffered significant injuries at each other's hands and both spent periods on remand, albeit that few of the incidents ultimately resulted in prosecution or conviction. Peter (and for a period Kate) were on bail with conditions that failed to prevent Peter's repeat offending, or encourage Kate to keep Peter away.

It is an acknowledged feature of domestic abuse that a great deal goes unreported, before a victim discloses their abuse to friends, family or protective agencies. This did not appear to be the case with Kate and Peter whose abusive relationship seemed to be played out 'in full view' The DHR chronology and the primary care (GP) and Police IMRs demonstrate that those two agencies had by far the most significant number of engagements with Kate and Peter.

7.3 High demand for service from Primary and Secondary Care

Health services, particularly GPs and two A&Es had well over two hundred contacts with Kate and Peter. The couple presented with both injuries and physical and mental health concerns, which appeared to be the consequence of alcohol and domestic abuse. The response of primary and secondary care to suspected domestic abuse; GP and A&E engagement with safeguarding, and the extent of professional curiosity exhibited by professionals became a key feature of this review.

7.4 The impact of an apparently self-destructive relationship

The personalities and life experiences of Kate and Peter and their alcohol dependency made for a very dangerous relationship; an inter- dependence that they could not and seemingly did not want to break. Kate constantly called upon services; police, health for help, but when it arrived she rebuffed it, or refused to co-operate and abuse was commonplace. There were many professionals who persisted regardless, meeting insults with renewed offers of

help. Clearly some professionals concluded their efforts were pointless and the quality of their interventions mirrors this. As some agencies remarked, Kate would only engage on her terms.

7.5 Inconsistent use of DASH and questionable risk assessment

DASH risk assessments often did not reflect the known risk, due to systemic weaknesses and a lack of access to intelligence that should have been available, and could have been made available using existing systems. Although the LPU management and PPU recognised the risk of this high-risk couple, they worked in parallel rather than in partnership, with few signs that everyone was working to an agreed strategy, communicated effectively. When supervisors intervened some good outcomes followed, but there is little evidence that the strategy involved the robust supervision of fresh incidents, new crime reports and on-going cases.

7.6 Frequent high-risk assessments leading to multiple MARACs

The high level of risk the couple posed to each other was recognised by their listing at the Multi Agency Risk Assessment Conference (MARAC); fifteen times between August 2011 and October 2013. By the time Kate and Peter first reached MARAC, their high-risk domestic abuse was already well established and had already gone too long unchallenged.

MARAC should have been able define a safety plan with clear accountable actions. Yet significant systemic weaknesses existed within the MARAC that undermined the efforts of the participants and manager to safety plan. The MARAC was police-led and there is little evidence that partners felt able to challenge or address those systemic failings. There was a lack of awareness amongst agencies of what a properly functioning MARAC should look like and some assumed that MARAC was a separate entity able to safety plan on its' own. There was little evidence that MARAC significantly influenced the response of frontline officers to Kate and Peter although they were all too familiar to the response teams, called out countless times to their addresses.

That apparently no one challenged the fifteen appearances at MARAC (including the PPU responsible for its' management) until June 2013, is evidence of a lack of an escalation policy and management oversight at a sufficiently senior level.

Key professionals such as GPs were not brought into in the safety planning for their patients, Kate and Peter even though both were at high risk. Accident and Emergency relied upon their staff and IDVA to identify domestic abuse, but had no communication with MARAC even though Peter and Kate made repeated presentation with domestic abuse injuries.

7.7 Lack of credibility of either party as witnesses in criminal allegations

The credibility of Kate and Peter as witnesses was significantly undermined by their refusal to co-operate with police enquiries and their frequent retraction of allegations or statements of complaint. This appeared to lead to some risk assessments and responses to incidents by police, which did not comply with force domestic abuse policy or with risk assessment guidance.

Police and partners did not sufficiently offender manage Kate and Peter failing to recognise that as Potentially Dangerous Persons they could have been subject to closer supervision with better management oversight.

A sense of collective resignation which could be seen in MARAC minutes, in the notes written by PPU staff, manifested itself in the response to calls, and the failure to see warning signs in the last few weeks, which even without hindsight should have caused alarm.

7.8 Difficulties in pursuing 'victimless' prosecutions

The refusal of Kate and Peter to co-operate, their retraction of allegations, their collusion to cover up each other's offending, made them the most unreliable of witnesses. It seems that Kate and Peter were aware of how easily they could influence criminal outcomes. The police and CPS

commitment to victimless prosecutions was put to the test in this case, and in large part found wanting. It is hard to avoid the conclusion that some investigators anticipated the likely outcome and this impacted upon the crucial evidence gathering stage. That CPS decisions around important charging decisions were never subject to challenge or review is indicative of a lack of confidence in the hope for a positive outcome.

7.9 Ineffectiveness of bail in this case

When Kate and Peter were before courts, the frequency with which they were bailed despite a history of breaches was a concern. However the apparent lack of clarity demonstrated by CPS concerning introducing bad character and the history of MARAC involvement, into court, may have been a factor. If custody was the only way to secure the safety of Kate and Peter then investigators should have been provided with robust supporting evidence of risk, collated and overseen by a manager.

7.10 Refusal to engage with alcohol or mental health services and the need for escalation policies where no progress is made

Alcohol services were repeatedly tasked by MARAC to address Peter and Kate’s alcohol abuse and to try and engage with them. Despite resolute and persistent efforts they achieved little success. With one notable exception, it appeared that Kate and Peter never wanted to change at the same time; a unilateral decision to change by one or the other was doomed to failure. An escalation policy was required, so that a manager could review what had been done and propose alternatives.

Mental health assessments failed to identify mental health conditions in both Kate and Peter, yet no one coming into contact with them could fail to see mental health concerns. Pathways between mental health, adult care, or alcohol services, were ill defined or not established. Successive GPs were left to try and find their way through the services available, where a whole systems approach, could have perhaps pointed to addiction psychiatry as an appropriate response.

8 Conclusions

The almost complete refusal of Kate and Peter to engage meaningfully with alcohol and mental health services highlighted the need in the face of difficult clients, for an escalation policy for every agency with a safeguarding duty.

A tragic outcome in this case was entirely predictable, indeed was recorded as a possibility by professionals in February 2012. That both Peter and Kate were at risk for such a sustained period, mitigated only by periods of detention, is a shocking truth.

The DHR panel were told ‘everything that could be done, was done’ and there is no doubt that many professionals worked tirelessly and diligently to try and break the cycle of domestic abuse or to effect change in Peter and Kate’s lives. However it seems that they were repeating responses that had not worked, with little sign of innovation or management oversight within agencies or at MARAC. Without a change of strategy the homicide was not preventable.

The actions to improve practice and strategic and agency recommendations, we believe, could change the awareness of professionals in domestic abuses services but also alcohol misuse and mental health services as well as in police and the criminal justice system.

Complex high-risk cases, with reciprocal violence and hard to engage subjects, require partnership working in its’ fullest sense, with shared understanding of a safety plan and desired outcomes. All agencies need to recognise their part in identifying domestic abuse and intervening early in the lives of families affected by it.

9 Key Learning and recommendations

9.1 DASH and the use of risk assessment tools

1. That DASH and RICs derived from it could provide a shared language for all agencies coming into contact with victims of domestic abuse.
2. That the use of DASH and RICs should not be restricted to police and all agencies should seek to train sufficient staff to be able to include RICs as part of a domestic abuse assessment.
3. That using DASH and RICs without quality training can lead to poor assessments or a failure to identify risk; agencies using DASH should review the training of their staff
4. That the removal by police of mandatory DASH at all domestic abuse incidents has undermined domestic abuse safeguarding and should be reviewed in line with HMIC recommendations
5. That the known history of abuse is a crucial part of risk assessment. Police should review procedures relating to crime recording that are leading to hurried or poorly researched and therefore unhelpful DASH assessments.

9.2 MARAC

1. MARAC is not a separate entity, but is the sum of all participating agencies and requires full involvement in safety planning.
2. The MARAC management structure has to be sustainable and supported, with a chair and identified deputy.
3. A sustainably funded MARAC co-ordinator is essential.
4. Agencies that become aware that a high risk MARAC subject has moved area should share intelligence with the receiving MARAC.
5. MARACs must have a clear safety plan in every case, supported by actions that are detailed in CAADA-compliant minutes, which are accessible and shared with frontline practitioners.
6. MARAC should identify cases of reciprocal violence and adapt responses to meet the identified risks.

7. MARAC and all contributing agencies should have escalation policies when actions, interventions or safety plans are deemed ineffective.
8. MARAC should use special/emergency meetings for complex cases.
9. MARAC should identify a key worker (IDVA, support worker or professional) in complex cases
10. Where there are no identified protective factors, a high-risk case should not be closed when support is refused.
11. GPs have a key role in safeguarding and should be more closely linked in with MARAC
12. An accurate and reliable summary of history and intelligence in complex high risk cases should be maintained and shared where appropriate with professionals and CPS

9.3 The role of families in safeguarding victims and perpetrators of domestic abuse

1. The safety of families of domestic abuse victims and perpetrators should be a paramount consideration
2. Decisions to place perpetrators of domestic abuse with their families or friends whilst on bail, or as a safe address after a breach of the peace, requires that they be provided with full disclosure of the circumstances to allow informed decision making and contingency plans securing their safety.
4. Families of both perpetrators and victims should be provided with information around positive interventions that support the desire for change and access to appropriate signposting

9.4 The role of support/link workers

1. That where IDVAs and support workers experience difficulties achieving engagement this should be escalated to managers through an established escalation process.
2. That in the face of refusal to engage, repeatedly offering the service without analysing the reason behind that refusal, may not be effective.

3. That MARAC recognises that an understanding of a victim or perpetrators' needs can be drawn from many sources and is a key to effective support work.
4. That properly supported, the best professional to work with a victim or perpetrator as a key worker, is the one who has formed a relationship
5. That support provision should be holistic and be able to support victims and perpetrators through a range of services and needs.

9.5 Gender bias in domestic abuse

1. That work is required to ensure a better understanding of male victimisation, so that it can be put in context, and assist in cases where there appears to be reciprocal violence
2. That the gender neutrality in the Home Office definition of domestic violence has not yet led to gender neutral policy, practice, or guidance in some agencies.
3. That MARACs should show greater awareness of male victims
4. That GPs need more awareness of male victims of domestic abuse

9.6 Police responses to domestic abuse

1. Police domestic abuse policy and Home Office Counting rules must be followed in the recording of incidents of domestic abuse and in the assessment of risk
2. That rigorous recording practices ensure accuracy of domestic abuse intelligence and identifies heightened domestic abuse risk
3. That close supervision of high risk domestic abuse investigations leads to better outcomes
4. That police should normally use their powers of arrest at domestic abuse incidents where a power exists. On the rare occasions where this is not done a rationale must be recorded.
5. Where police consider removing a perpetrator to another location as a risk reduction strategy, it should be subject to a robust risk assessment around the likelihood of renewed DA.

6. That police domestic abuse training should alert officers to the techniques used by repeat offenders to manipulate and influence professionals in order to isolate the victim

9.7 Role of police and CPS in domestic abuse charging decisions and ‘evidence-led prosecutions’

1. Police should treat every domestic abuse case as a ‘victimless’ prosecution, by adopting the evidence-led approach
2. Police should take every opportunity to seek pre-charge advice in domestic abuse cases and be mindful not to resort too quickly to the evidential insufficiency criteria for not referring to CPS
3. Police should ensure that their new Domestic Abuse Teams that are now responsible for all domestic abuse investigations develop a firm understanding with CPS how the pre-charge advice protocol is applied.
4. Reliable statistics on the number of cases recorded and the number referred for advice should be maintained by both agencies
5. The CPS retention policy prevents later scrutiny of charging decisions and should be reviewed

9.8 The use of bail in domestic abuse cases

1. Where a victim encourages a breach of bail, the defendant remains in breach and enforcement should still be robust.
2. With serial domestic abusers, a very detailed report of previous breaches should be made available to CPS.
3. Enforcement of breaches of bail have to be consistent
4. Where an offender is persistently breaching bail, investigators should not miss any opportunity to charge offences committed on bail such as harassment

9.9 The orders available to the courts in domestic abuse cases

1. That when orders are imposed, closer supervision is required to ensure that they are complied with.
2. If orders are not completed, probation should seek enforcement

3. That orders need to be appropriate to the needs of the person on whom they are imposed

4. That a greater awareness of ATRs is needed at MARAC and in PPU domestic abuse teams where alcohol abuse is a factor in domestic abuse

5. That DVPOs will be crucial in separating parties in domestic abuse for a period, allowing IDVAs the opportunity to support victims

9.10 Accident & Emergency and General Practitioners' responses to domestic abuse

1. Hospital notification to GPs of presentations at A & E must include details of suspected domestic abuse.
2. Discharge notes do not always reach a GP, undermining patient safety
3. GPs must not assume domestic abuse support is already in place, or a referral has already been made.
4. GPs must be more willing to 'ask the questions' where domestic abuse is disclosed or suspected and identify a safety plan
5. GPs and staff need to demonstrate greater professional curiosity
6. GPs surgeries should identify a domestic abuse specialist within the practice to provide domestic abuse screening and referral, support and advice that follows the CAADA model.
7. Practice meetings are a vital forum for identifying the risk to patients from domestic abuse
8. There is a need for greater awareness of MARAC and domestic violence amongst healthcare professionals.
9. There is a need for healthcare professionals to have a clearer understanding of their ability to disclose information to MARAC
10. The A&E IDVA provision is helpful but may not have the capacity to provide the level of coverage required
11. A system is needed to identify when a high risk MARAC victim presents at A&E and share that information where appropriate.
12. A&E staff need to be reminded of the GMC knife wounds policy

13. A&E staff must be prepared to challenge when a patient is suspected The response of primary care, mental health and alcohol services to the presence of alcohol abuse and mental health concerns

9.11 The response of primary care, mental health services and substance misuse services to the presence of alcohol abuse and mental health concerns

1. Those patients fitting the widest definition of dual diagnosis should have clearer pathways to mental health services for support and treatment.
2. Referral pathways between services should not necessitate referral back to the originating GP.
3. That when a client is subject to MARAC, substance misuse services such as Aquarius /NACRO need to be able to escalate a case when services are repeatedly refused.
4. All practitioners need an understanding of the impact of alcohol abuse upon mental health.
5. That GPs and alcohol services should consider addiction psychiatry in complex and severe cases and know how to recognise when this level of expertise is required.
6. That a failure to engage and frequent DNAs, should be a trigger for heightened concern and not a cue to close a case.

10 Recommendations

The recommendations from the Individual Management Reviews are set out in the action plan. The recommendations by the Domestic Homicide Review panel are intended to compliment the recommendations in the IMRs and to address the agencies collectively.

10.1 Learning point

The Review had identified substantial deficiencies in the operation of the MARAC which prevented effective safety planning and meant that its' impact on the victim and perpetrator was very limited.

Recommendation 1: Addressing the shortcomings of MARAC

That an independent review of the Wolverhampton MARAC is undertaken after systemic, organisational and staffing issues have been addressed, to ensure compliance with best practice.

Actions

- Escalation policies for both the MARAC and the agencies contributing to it when interventions or safety plans are judged ineffective.
- Appropriately funded MARAC coordinator
- Actions to be linked to risk, with agencies to be more accountable for completion of actions and escalation of the case where appropriate
- Link MARAC protocol with escalation policy
- Ensure that the presence of offender managers at future MARACs leads to SMART offender management actions
- Identify a lead practitioner in complex repeat cases
- Ensure MARAC minutes are CAADA compliant and that they are available to agencies involved in the safety plan.
- Ensure that in cases with reciprocal violence a different IDVA is available for each party
- Monitor attendance of agencies with recommendations regarding representation at MARAC
- Promote use of DASH by all agencies with training where necessary
- A learning event to be delivered to all attendees at MARAC, coordinator, IDVAs, Support workers and WMP domestic abuse and safeguarding teams, specialist DV teams and agency frontline practitioners across all agencies represented on safeguarding Boards

- Repeat the CAADA self-assessment to ensure that all outstanding areas for development have been addressed.

10.2 Learning point

The review recognised that in complex cases, with hard to engage clients such as these, the role of the IDVA is crucial in recognising when a new strategy or safety plan is required. This requires properly resourced and skilled IDVAs.

Recommendation 2: IDVAs link worker role for complex DA cases

Wolverhampton CSP to highlight the need for sufficient IDVA capacity to be provided by city-wide commissioners in line with CAADA recommendations that IDVA teams should have specialisms across the team in the criminal justice system, family courts, substance use, mental health, young people, safeguarding, sexual violence, housing, and BME and male victims.

Actions

- SWP to highlight shortfall in IDVA resource to relevant senior Boards including SWP Board

10.3 Learning point

The Review recognised that DASH and similar risk assessment tools whilst useful if properly used, are not enough in themselves to identify risk. There were many other warning signs, which should have been recognised as part of the adult safeguarding process that should feature in any early alert system.

10.4 Learning point

Peter and Kate clearly posed a very high risk of harm to each other. As such there was no clear principal offender/victim and the case seemed to be one of reciprocal violence. The emphasis on Kate as a victim, ignored the known history and the risk of harm posed to Peter. The Review felt there was an absence of guidance and evidence-based research to help practitioners in such cases.

Recommendation 3: Understanding complex needs and reciprocal violence in domestic abuse

Wolverhampton Community Safety Partnership to ensure domestic violence features as part of the Safeguarding Adults and Children Board's development of a multi-agency early alert system

That Wolverhampton Community Safety Partnership highlight gaps in academic research on reciprocal violence where identifying the primary victim/offender is problematic.

Actions

- SWP to engage with the Triggers Alert system project to ensure DV is considered as part of the thresholds for a trigger.

- SWP Chair to write to Stephen Rimmer, appointed by West Midlands PCC as the strategic lead on preventing violence against vulnerable people, to highlight gaps in academic research