OVERVIEW REPORT

Warwickshire Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of 'Richard' in May 2015

Report produced by Independent Chair
Dr Jane Monckton Smith

May 2018

Glossary

DHR	Domestic Homicide Review
CSP	Community Safety Partnership
MARAC	Multi-Agency Risk Assessment Conference
MAPPA	Multi-Agency Public Protection Arrangements
IDVA	Independent Domestic Violence Adviser
SCR	Serious Case Review
MHI	Mental Health Investigation
VCS	Voluntary and Community Sector
SIO	Senior Investigating Officer
FLO	Family Liaison Officer
IMR	Individual Management Reviews
DASH(RIC)	Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification Checklist
TOR	Terms of Reference
SHA	Strategic Health Authorities
CPS	Crown Prosecution Service
SMART	Specific, Measurable, Achievable, Realistic and Timely
DVPP	Domestic Violence Perpetrator Programme
GMPS	Government Protective Marking Scheme
FOIA	Freedom of Information Act
BME	Black and Minority Ethnic
AAFDA	Advocacy After Fatal Domestic Abuse

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1. Preface

I would like to begin this Report by expressing my sincere sympathies, and that of the Panel, with the family and friends of Richard. He was a much loved brother and father, who is deeply missed.

The death of Richard is considered to be a *victim precipitated homicide*, which means that the person to suffer fatal violence, is the person who started the chain of events. In this case, the victim was known to be violent, and was killed in an act of unpremeditated retaliation. This makes the review of his death very complex and sensitive. His family have suffered the loss of a beloved brother and father, and the young man who killed Richard is also devastated by the events.

The purpose of a Domestic Homicide Review (DHR) is to identify improvements which could be made to community and organisational responses to victims of domestic abuse, and hopefully to try and prevent a tragedy like this from ever happening again.

I would like to thank the Panel, and those who provided chronologies and information, for their time, patience and co-operation.

It is important in this Review to mention issues of confidentiality. The families of both the victim and the perpetrator have suffered terribly as a result of this tragedy and further suffering must be avoided wherever possible. For this reason, I have excluded some information which may identify individuals, such as specific dates and detail of certain incidents. Richard (victim), Hannah (victim's partner and Adam's mother) and Adam (the person who caused Richard's death, in self-defence), are pseudonyms agreed by the family.

Jane Monckton Smith

Independent Chair

2. Summary

2.1 Richard (aged 55) had been in a relationship with Hannah for 4 years, since 2011. He moved in with Hannah at an address in a small Warwickshire town, a very short amount of time after meeting her.

2.2 Adam was aged 17 and was living with his mother when Richard moved in.

2.3 Richard and Hannah were known to Warwickshire Police for eight incidents of domestic abuse. In all incidents Hannah was the victim and Richard was the perpetrator of domestic related assaults, arguments or required the police's support to remove Richard from the home. Three of the incidents were identified as high risk and discussed at MARAC. Adam is named in several of the police reports when he attempted to protect his mother resulting in assaults on Richard.

2.4 In spring 2015, Richard, Hannah, Adam and Adam's girlfriend, had been out for a meal and drinks. They returned to Hannah's address to continue socialising, and Richard and Adam were both drinking.

2.5 During the evening an altercation took place between Richard and Adam, where Richard grabbed Adam and punched him in the face and put his hands around his throat and squeezed. Hannah intervened and pulled Richard away.

2.6 Adam ran into the back garden of the property through the kitchen, where he grabbed a knife from the draining board. He went through the back gate but heard his girlfriend cry out so rushed back into the house. A scuffle ensued and Adam used the knife to stab Richard in the chest.

2.7 An ambulance was called but Richard's condition rapidly deteriorated and he died later from his injuries.

2.8 Adam was charged with murder and a trial took place in 2016. Adam was found not guilty at trial by reason of self-defence. As such, Adam will be referred to as the person who caused Richard's death, in self-defence.

3. Timescales

3.1 A decision to hold a Domestic Homicide Review (DHR) was taken by the South Warwickshire Community Safety Partnership in July 2015.

3.2 The Independent Chair was appointed in November 2015.

3.3 The initial meeting of the DHR Panel took place on 23rd November 2015 and the final meeting of the Panel took place on 26th July 2017.

3.4 There was significant delay to the DHR caused by the criminal trial and in gathering information and making arrangements to meet with the family of the deceased and with Adam's mother, who was also the partner of the deceased.

4. Confidentiality

4.1 It is important in this Review to mention issues of confidentiality. The families of Richard (victim) and Adam, the person who caused Richard's death in self-defence, have suffered terribly as a result of this tragedy and further suffering must be avoided wherever possible. For this reason, some information which may identify individuals, such as specific dates and detail of certain incidents have been excluded from the Report. Richard (victim), Hannah (victim's partner and Adam's mother) and Adam, the person who caused Richard's death, in self-defence, are pseudonyms agreed by the family.

4.2 **Richard (**victim) was 55 years old at the time of his death. He was White British.

4.3 **Adam** the person who caused Richard's death, in self-defence, was 21 years old at the time of Richard's death. He is White British.

5. Terms of Reference

5.1 To produce a Chronology of events and actions leading up to and in relation to the death of Richard from the period from 1st January 2010 until Spring 2015 including his relationship with Hannah, the mother of the person who caused his death, in self-defence, and Adam, the person who caused Richard's death, in self-defence.

Seeking information from:

- Organisations who had contact with them
- Local community organisations
- Their family and friends.

5.2 To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse in order to build up a picture of what should have happened.

5.3 To review this against actual events to draw out the strengths and weaknesses.

5.4 To review national best practice in respect of protecting adults from domestic abuse.

5.5 To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

The Review will also specifically consider:

5.6 An assessment of whether family and friends were aware of any abusive or concerning behaviour from Adam to the victim (or other persons).

5.7 A review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved knew how to report domestic abuse had they wanted or felt able to.

5.8 A review of any previous concerning conduct or a history of abusive behaviour from Adam and the deceased and whether this was known to any agencies.

5.9 A review of any Multi-Agency Risk Assessment Conference (MARAC) involvement.

5.10 An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Warwickshire.

5.11 Whether Richard and Adam had any previous history of abusive behaviour

towards each other or anyone else, and whether this was known to any agencies.

5.12 Whether family and friends want to participate in the review. If so, find out if they were aware of any abusive behaviour by Richard or Adam prior to the homicide.

5.13 Communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.

5.14 Whether the work undertaken by the services in this case is consistent and compliant with its own professional standards, protocols, guidelines, policies and procedures.

5.15 The impact of domestic abuse on children and young people.

5.16 Any other information that becomes relevant during the conduct of the Review.

6. Methodology

6.1 The method for conducting a DHR is prescribed by Home Office guidelines. The DHR followed those guidelines in the usual way. After the trial which concluded in 2016 the business of the Panel formally began. It is important that the Independent Chair observes the rules of disclosure which can become difficult if a review begins before a trial is ended, especially where family are key witnesses. This observation extended the time within which the Review was conducted and the Home Office were informed of the delay in beginning.

6.2 All agencies in the area were contacted to scope for any contact they may have had with Richard, Hannah and with Adam. If there was any contact a Chronology detailing the specific nature of the contact was requested. Those agencies with contact considered of importance to the panel were asked to provide an Independent Management Review (IMR). This allowed the individual agencies to reflect on their dealings with Hannah, her family, and Richard and identify areas which could be improved in the future and make recommendations.

6.3 In this case IMRs and/or information were requested and received from

- Warwickshire Police
- Warwickshire County Council, Children's Services
- Warwick District Council Housing and Property Services
- Warwickshire NHS Foundation Trust
- West Midlands Ambulance Service
- Warwickshire MARAC
- Stonham – Domestic Abuse Service
- GP for Hannah, Richard and Adam
- Warwickshire County Council, Adult Social Care
- Warwick District Citizens Advice
- University Hospital Coventry and Warwickshire
- Victim support.

6.4 The IMR authors for all the agencies asked to provide IMRs had not been directly involved with providing services to Richard, Hannah or Adam**.**

6.5 As is customary in such reviews, some authors were asked to revisit their IMR after scrutiny by the panel.

6.6 All panel members were asked to present their own perspectives on recommendations which they thought should be made in the final report. Each of these suggestions were discussed by the panel.

7. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

7.1 Letters inviting family members of Richard, Hannah and Adam to participate in the review were sent out in October 2016. Second letters to Richard's family members and Adam were sent out in April 2017.

7.2 The Chair met with one of Richard's sisters at a location away from their home, but other family members declined the invitation. The family of the deceased found the whole situation very difficult to deal with, and some family members were not at peace with the not guilty verdict at court. They withdrew from the review panel process.

7.3 Adam was written to twice but declined to participate.

7.4 Initially Hannah declined to participate but with the support of the Family Liaison Officer eventually decided that she would like to meet with the Chair. A meeting was arranged for February 2017 but had to be re-scheduled to April 2017 due to Hannah's work commitments. The meeting eventually took place at Hannah's home in April 2017.

7.5 Information about the charity Advocacy After Fatal Domestic Abuse (AAFDA) was given to the families in 2016, but they were not involved with supporting any family member.

8. The Review Panel Members

Dr Jane Monckton Smith	Senior Lecturer in Criminology with the University of Gloucestershire is the Independent Chair
Susan Haile	Personal assistant to Dr Monckton Smith
Kirstin Clarke	Operations Manager, Warwickshire County Council (WCC) Adult Social Care
Sue Ingram	VAWG Strategy Development Manager, WCC
Pete Cutts	Safer Communities Manager, Warwick District Council
Jenny Butlin-Moran	Service Manager, WCC Children's Services
Claire Cooper	Senior Operations Manager, Refuge
Kirstin Lord	Locality Manager, The Recovery Partnership
Chris Evans	Safeguarding Children and Adults, Coventry & Warwickshire NHS Trust
Steve Tonks	Detective Chief Inspector, West Mercia Police
Tracy Redgate	Lead Nurse Safeguarding Adults, S. Warwickshire CCG
Holly Collins	Domestic Homicide Review Officer, WCC. Until July 2017
Stavroula Sidiropoulou	Domestic Homicide Review Officer, WCC from November 2017

9. Author of the Overview Report

Dr Jane Monckton-Smith was appointed by the South Warwickshire CSP as Independent Chair and Author of the Overview Report in November 2015. Jane is a forensic criminologist specialising in domestic homicide. She lectures in forensic criminology and criminal investigation and is an active researcher in the area of domestic homicide. This research has been published and Jane trains professionals in advanced risk and threat assessment in the area of coercive control, stalking and domestic abuse. Jane also works with a number of homicide and stalking charities helping victims and professionals understand domestic homicide, and domestic abuse and stalking.

Jane has had no previous involvement with the South Warwickshire CSP nor any of the agencies involved in the domestic homicide review into the death of Richard.

10. Parallel Reviews

10.1 The DHR was halted until the end of the criminal trial. The trial took place in 2016. The jury acquitted Adam and found him not guilty of the murder of Richard.

10.2 An inquest into the death of Richard was opened and adjourned following his death and will not be re-opened.

11. Equality and Diversity

11.1 It is a requirement that all nine of the protected characteristics under the Equality Act 2010 are considered in the analysis of the antecedents, to explore whether any were relevant and impacted on services received, or barriers to accessing any services. In considering the characteristics two were considered relevant in this case, and they are age and sex.

11.2 **Age**: At the first point that Adam, who was the person who caused Richard's death, in self-defence and whom is also to be considered a victim, came into contact with agencies and with Richard, he was 17 years old. He was a young man still considered a child for the purposes of Children's Services. Adam made attempts to declare himself homeless soon after Richard moved in as he felt the home environment was unsafe for him. He did not necessarily articulate his reasons for wanting to leave the home as domestic abuse, but he wanted to leave because of Richard, and because Richard was abusive to him.

11.3 Adam was deemed not homeless as it was considered his mother was able to house him. It was suggested in conversations with Children's Services, that at the time, Adam's vulnerabilities were not recognised because of his age.

11.4 Although Adam was working and considered an adult after his 18th birthday, the vulnerability created by his age was missed on a number of occasions. Police did not always make referrals to Children's Services after domestic violence incidents in the home, and his age may have had an impact on his ability to leave the situation and support himself.

11.5 Richard was a 55-year-old man assaulting a 17/18 year old young person. Adam should have been able to access specialist support after 2013 when the definition of domestic abuse was changed to include all persons over the age of 16. This is in addition to his right to access services in accordance with the Children's Act 1989.

11.6 Adam was attempting to protect his mother and himself from a much bigger and more powerful older male.

11.7 **Sex**: It may also be relevant that Adam was male. Adam's particular vulnerability may have been missed as he was not considered as the victim. All support focus was concentrated on his mother. The growing risk to Adam was missed in his attempts to protect his mother from violence, and the particular threats to him and the violence he was suffering.

12. Dissemination

12.1 In reporting the views of individuals who witnessed the actions of the services involved, the Review Panel is not endorsing those views as an accurate or as a fair assessment of the services provided. They are the views and opinions of the family and friends and should be considered with respect, in that they may offer lessons for the services involved. The draft report was shared with Hannah and Richard's family. They described the report in its final draft as 'fair and balanced' Adam was offered an opportunity to review the final draft but chose not to.

12.2 Once approved by the Home Office Quality Assurance Panel, the executive summary and the overview report will be made available on the Warwickshire County Council, Safe in Warwickshire website and Warwick District Council's website. Both documents will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 2018.

13. Background Information (The Facts)

13.1 Richard lived with Hannah in a small Warwickshire town. They had known each other when at school and met again by accident in a pub in Warwickshire. Richard moved into Hannah's home to live with her within days of their meeting again

13.2 Richard had been living abroad and had a wife (who he was with for some twenty years) and children still living there. Records show there had been a protective order in that country to stop Richard contacting his wife and children. He also had a criminal history including violence and robbery.

13.3 Adam and his sister were both living with Hannah when Richard moved in. Adam was 17 at the time.

13.4 Very quickly, Hannah's children were alienated as Richard wanted them to leave the home. Hannah thought they would be safer if they left.

13.5 Hannah's adult daughter declared herself homeless (Sep 2011), very soon after Richard moved in, because of him. Richard, Hannah and Hannah's daughter had an argument. Richard went to apologise but an argument erupted. He stood in the doorway in a threatening manner and Hannah hit him in self defence; he did not hit her back.

13.6 Adam tried to declare himself homeless (Aug 2011), but this was denied by WDC as they considered he had permission to continue living with his mother.

13.7 Hannah and Richard's relationship was plagued with violence and aggression from Richard, from the beginning. Richard had a very quick and violent temper and was hyper-sensitive to any criticism, challenge or perceived slight, but his family report that they never saw this side of him and that he was always a happy and nice person at family gatherings and other events.

13.8 Hannah said that in her opinion Richard was two different people, he was fine when he wasn't wound up, but very violent when he was. She said she wished she could have helped him to be the nice Richard all the time. However, she was also quite clear that she felt no matter what she did he was never going to leave. She felt he would always come back and find her

and they were more or less dependent on each other with alcohol creating a toxic relationship between them.

13.9 Hannah also spoke about the complexity of their relationship and recognised that she was dependent on Richard in many ways and this affected some of the choices she made (she was afraid of being alone, didn't want to grow old on her own). Hannah recognised the dysfunctional nature of the relationship but felt that the problems were rooted in Richard's mental illness and believed that if he was given mental health support the problems could be addressed.

13.10 She was equally clear however, that she knew Richard would never leave her alone and described the relationship as heavily punctuated with unpredictable violence, control and abuse. Hannah lived her life in fear of Richard's violence.

13.11 In 2013, there was an incident when Adam discovered Richard hitting Hannah; Richard destroyed all of Adam's belongings in his room following this incident. Despite this Adam remained on good terms with Richard largely to stay in contact with his mother.

13.12 Richard had been living abroad and had a partner (who he was with for some twenty years) and children still living there. Records show there had been a protective order in that country to stop Richard contacting his wife and children. He also had a criminal history including violence and robbery.

13.13 Following a serious assault on Hannah at a public house in January 2014 where she was head butted, Richard was charged with assaulting Hannah and appeared at Coventry and Warwickshire Magistrates court where he pleaded guilty to assault. Richard was convicted of the offence but it is understood that he received a 12 month suspended sentence on the grounds that he left the UK and provided proof of ticket. 6 weeks later he returned to the UK and faced no further criminal justice outcomes despite breaching the terms of the suspended sentence. On his return, Richard returned to live with Hannah.

13.14 Richard's sister gave some detail of his early life. She clearly cared for her brother, though they did not have a great deal of contact. She recognised he could be violent, but also felt that he was in fact quite a vulnerable person in need of a lot of support.

13.15 She remembered him as a caring and friendly person who struggled with life sometimes. She was concerned that Richard may be remembered in a very one dimensional way and wanted to give some balance to the way he

may be perceived. She talked about the good characteristics he possessed, as did Hannah, which presents a more complex picture of the person Richard was.

13.16 Richard recognised he had problems and it is understood that he claimed that he suffered with bi-polar disorder and ADHD but there are no medical records to confirm this. He told Hannah he had medication but did not take it and this was the cause of his violence and unpredictability.

13.17 The GP surgery provided information which stated that Richard was an intimidating person who would insist that he was always seen by a female GP, and that the staff were frightened of him.

13.18 There are professional comments in the IMRs to suggest that Richard was controlling of Hannah and was very jealous and possessive, to the point that he even wanted her children to move out and was unpleasant and violent to them. It is also understood that he was quite threatening to animals.

13.19 Information made available to the Panel demonstrates that there were also communications between Richard and Hannah which show that he was pressuring her into sexual contact with strangers. The pressure was almost constant, and he would show her pictures of men and ask if she would go with them. Hannah was very clear that she didn't like the idea and would not participate.

13.20 Communications show a gradual breaking down of Hannah's resolve and eventual agreement to please him which created more trouble in the relationship.

13.20 On three occasions Richard and Hannah were referred to MARAC by the Police (meetings held on 16/03/12, 22/02/13 and 21/02/14). On all occasions Hannah was not in a position to accept support from the services for various reasons and as such didn't actively engage. Hannah was in a complex situation with many barriers and challenges which could have prevented her engaging with support services,

13.21 Hannah was considered a high-risk victim of domestic abuse.

13.22 Adam was known as a victim of abuse from Richard; he was not risk assessed in his own right.

13.23 In Spring 2015, Richard, Hannah, Adam and Adam's girlfriend, had been out for a meal and drinks. They returned to Hannah's address to continue socialising and Richard and Adam were both drinking.

13.24 During the evening an altercation took place between Richard and Adam where Richard grabbed Adam and punched him in the face and put his hands around his throat and squeezed. Hannah intervened and pulled Richard away.

13.25 Adam ran into the back garden of the property through the kitchen, where he grabbed a knife from the draining board. He went through the back gate but heard his girlfriend cry out so rushed back into the house. A scuffle ensued and Adam used the knife to stab Richard in the chest.

13.26 An ambulance was called but Richard's condition rapidly deteriorated and he died from his injuries as a result of stab wounds inflicted during an altercation with Adam.

13.27 Adam was charged with murder and a trial took place in 2016. Adam was found not guilty at trial by reason of self-defence. As such, Adam will be referred to as the person who caused Richard's death, in self-defence.

14. Overview

14.1 Police IMR:

14.1.1 The police made no formal recommendations for their agency as a result of their management review of this case. However, continued commitment to improve service and training were specifically documented as follows:

14.1.2 Training

14.1.3 In 2015, Warwickshire and West Mercia Police were subject of an inspection by HMIC. From that inspection, areas for improvement were identified in relation to the approach around tackling domestic abuse and vulnerability.

14.1.4 During May 2016 10 to 20 minute briefings were rolled out across the alliance, which addressed signposting the new Domestic Abuse Officer Toolkit, an explanation of what happens after a DASH is submitted, DVDS (Domestic Violence Disclosure Scheme), NCDV (National Centre for Domestic Violence), new VW1 and Special Measures.

14.1.5 Management and supervision

14.1.6 Consideration of visiting Hannah at her work place or away from the home and to address explosive environment.

14.1.7 Police state that all of the incidents that police have attended over the years, appear to have been supervised appropriately, and the necessary action taken within the relevant timescales.

14.1.8 Resources

14.1.9 Lack of resources do not appear to have impacted on this case. All requests for service were met appropriately.

14.2 Children's Services IMR

14.2.1 Children's Services recognised that there is a need to fully consider the needs of young people right up until the point they are 18 years old.

14.2.2 Adam's apparent homelessness was not reconsidered in the light of the domestic abuse situation within the home, and this was a missed

opportunity to consider the risks posed to him and the intervention that was required to ensure his safety and wellbeing.

14.2.3 These recommendations are included in the formal recommendations for this review.

14.3 Warwick District Council Housing and Property Services IMR

14.3.1 WDC Housing services recognised in their IMR that more training is needed for their frontline staff in recognising and responding to domestic abuse. In this case a homelessness application did not fully consider the issue of domestic abuse. This agency states that things have improved since 2013. Training issues are addressed in the formal recommendations of this review.

14.4 MARAC IMR

14.4.1 Many issues were raised around the operation and standard of the MARAC meetings, which included the standard of information contained in the referral forms, the standard of minute taking, the lack of information sharing by agencies, the lack of coherent actions being formed, and the lack of up to date and accurate information.

14.4.2 It is also recognised that there have been **improvements** since 2014. Specifically:

14.4.3 Referral Quality

14.4.4 The MARAC coordinator role now includes spending time with frontline teams in agencies explaining the MARAC process and encouraging agencies to make referrals. This includes information on what a good referral looks like, and the importance of the information being requested. Consent for referrals is a significant part of this awareness raising.

14.4.5 If information is missing from a referral the coordinator contacts the referrer to request they ascertain the missing information and re-send the referral.

14.4.6 'Referral quality' was included as a local performance indicator by the MARAC Steering Group from 2013-2016. At the July 2016 Steering Group meeting it was agreed to remove this as since the above measures have been implemented, referral quality has consistently been over 95%. The information that is still occasionally missing relates to ethnicity.

14.4.7 Inaccurate/Incomplete Recording of information

14.4.8 Anecdotally, this has improved over the last 2 years (as written in 2016) (based on the experience of the IMR author when attending MARACs and then reading the minutes). However, to be sure of this, as part of the new

self-audit cycle being introduced by the MARAC Steering Group, the second audit will audit the accuracy and quality of the minutes. A report will be presented to the Steering Group.

14.4.9 Non Attendance by Core Agencies

14.4.10 This was most problematic for this case at the February 2013 MARAC where both Children's Services and Housing were not in attendance, and both held information that could have assisted in risk identification and more importantly action planning. (This issue has now been resolved and attendance is good at MARAC. Back to 100% attendance. Increase in number of meetings because the caseload has increased and each case requires dedicated time to evaluate all aspects).

14.4.11 Having researched the MARAC attendance data since 2012, the housing authority, Warwick District Council, has a good attendance record varying from 85% (10/12 attended) in 2014-15 to 100% in 2015-16. Children's Services had a good attendance rate at the MARAC until 2015-16 when it dropped to 75%. In 2016-17 it fell to 33%, and the Steering Group escalated this concern with Children's Social Care for swift resolution. As a result, Children's Services attendance has greatly improved. To date in 2017-18 their attendance at the MARAC has been 100%. To ensure robust attendance a dedicated risk management post has been created by Children's Social Care, and part of their remit is to research and attend all MARAC and MAPPA meetings in Warwickshire.

14.4.12 Risk Identification and Action Planning

14.4.13 It is the IMR author's view that risk identification and action planning is the most significant area of concern having reviewed the two sets of MARAC minutes available. In both instances specific risks are not identified, and so it follows that without clear risks to address, any plan is going to lack direction, and ultimately the most vulnerable are left at risk of serious harm

14.4.14 In 2014 key staff attended CAADA MARAC Chair workshops that included action plan development. A systematic approach to working through the risks to each individual is now evident in the meetings and the minutes. If a risk is identified, but actions to mitigate this are already in place, this is recorded. If an action is considered but discarded for a particular reason (e.g. it could increase risks to someone else) this is included. If the MARAC is unable to mitigate against a risk – this is detailed.

14.4.15 All actions must have an individual assigned to them, to allow for agencies to follow up if required. The standard action where possible, is to feed back the outcome of the MARAC to the victim in each case.

14.4.16 The Domestic Abuse commissioner and key staff also worked to develop tools to support action planning in the meeting e.g. aide memoirs for each attendee.

14.4.17 Risk identification and action planning is another aspect that will be covered by the self-audit.

14.4.18 Quality of MARAC coordination

14.4.19 With support from CAADA (SafeLives) and the Domestic Abuse commissioner, the overall quality of MARAC coordination is much improved. This has also been aided by relative stability in service management at the provider agency. Effective MARAC coordination is not simply administrative. It is a service in its own right, which requires strong working relationships with partner agencies, awareness raising, training for representatives and referrers, an understanding of risk assessment, and how to manage an information system.

14.4.20 As commissioners, Warwickshire County Council have also learned the importance of providing enough detail in service specifications, the need for comprehensive handovers, and how to better performance manage partnership arrangements, this is reflected in the service specifications.

14.4.21 Specific recommendations from the IMR

14.4.22 The MARAC Steering Group to ensure that the self-audit cycle includes the quality of MARAC minutes: specifically – information is accurate, clear risks are identified, SMART actions are developed to address those risks.

14.4.23 The MARAC Steering Group to ensure that local performance measures continue to include agency attendance at MARAC.

14.4.24 WCC Commissioners must ensure implementation of new domestic violence and abuse services includes thorough and practical handover of MARAC co-ordination, including a period of shadowing by the incoming MARAC coordinator where possible.

14.4.25 The MARAC Steering Group to discuss with Warwickshire Police as providers of the MARAC Chair, and Refuge as providers of MARAC co-ordination, ways to build resilience into delivering the MARAC and thereby ensuring a quality service at all times, regardless of staff changes.

14.5 Stonham DA Service IMR

14.5.1 The IMR author notes that Hannah was not in a position to accept support from the services for various reasons and as such didn't actively engage on all of the three occasions she was referred as a high risk victim of domestic abuse. Adam was not referred for service in his own right even though he could have been supported by the service. He was known to the service as the son of Hannah. Adam's sister would also have been able to receive service from Stonham but was never referred.

14.5.2 The IMR author notes that when Richard was prosecuted for domestic violence assault, the case was heard in the remand court, rather than being referred to a specialist domestic abuse court. It was at the remand court that Richard was able to claim he was leaving the country.

While other IMRs from Partners agencies were submitted, no key learning areas were identified.

15 Analysis

15.1 This analysis will consider the chronology and decisions made, and the findings from the IMRs. There are four key areas for analysis:

- **Risk to Adam** - whether the decisions made in responding to Richard's violence fully considered the risk posed to Adam, as well as Hannah
- **History** - what was known about the history of Richard and his violent behaviour and how that information was shared
- **Repeat perpetrator** - the repeat violence exhibited by Richard and decisions made in respect of that
- **Response to high risk victims of domestic abuse** - the management of high risk services, in particular MARAC

15.2 Risk to Adam

15.2.1 Very early on, Adam made it clear to agencies that he needed alternative housing after Richard moved in with his mother. The decision made by the Local Housing Authority (supported by a Children's Services assessment) that Adam could continue to live with his mother and Richard may have been better informed with fuller intelligence gathering underpinned by professional curiosity. The information about Richard's past was available from the police, and information was available from Adam.

15.2.2 The effects of the decision that Adam was not homeless in 2011, was compounded with every subsequent interaction, and referral to Children's Services. It appears that decisions were based on that initial assessment only. No further assessment was done when new information related to domestic abuse and violence was disclosed.

15.2.3 Adam's sister also declared herself homeless around the same time and it is not known whether those two events would ever have been considered together. But they do support the idea that there was a problem within the home for these young people related specifically to Richard.

15.2.4 DASH risk assessments completed on 12 and 26 November 2011 were done with Hannah; an assessment was not done with Adam. He was just 17 at the beginning of agency involvement. A risk assessment could consider others subjected to violence, especially now that the official definition for domestic abuse covers anyone over the age of 16.

15.2.5 After 2013, as a person over the age of 16, Adam could have accessed the support of Stonham specialist DA services, however, during his housing assessment he was never referred, neither was he risk assessed in his own right.

15.2.6 Hannah was certainly dependent on the relationship to a point and was also controlled to a point. She was a high-risk victim of violence but did not feel she wanted agency support, or may have felt she was unable to accept the support. Adam did want support and this may be a gap in domestic abuse services.

15.2.7 Witnessing domestic abuse carries its own risks; feeling that he should intervene to protect his mother had repercussions for Adam and his future, he was also assaulted himself.

15.2.8 From this it could be suggested that when assessing risk, and homeless enquiries, more questions should be asked to satisfy the assessor of the spectrum of risk. This is especially important if an initial assessment will inform future decisions. In housing applications, merely asking the question may not reveal the truth. A young person complaining of the presence and behaviour of a named adult should prompt background checks.

See Recommendation 1.

In a (DASH) Risk Assessment where more than one person is identified, risk assessments should consider what the risk is to each person

In this case Adam was known to be a focus for violence, and he was known to be protecting his mother. His youth and victimisation could have made him subject of a risk assessment, and the help might have provided for him to seek alternative accommodation.

See Recommendation 2.

Local Housing Authorities to give priority need to persons who are homeless as a result of being a victim of domestic abuse.

15.3 History

15.3.1 Gathering intelligence to inform any kind of assessment where violence or harm is a potential outcome should be a priority. The sudden presence of Richard in the home of Hannah and Adam, and the almost immediate trouble, could have prompted background checks conducted by the Local Housing Authority which were then given due weight.

15.3.2 There were four police calls to Hannah's home across five weekends. A background check at the first call could have prompted the Police to inform Hannah that she had the right to request a Clare's Law disclosure and specific advice could have been given to Hannah and Adam right at the beginning. See Recommendation 5. The history could have been passed to Children's Services in the referral.

15.3.3 Richard's recent and past history could also have been considered when Richard was arrested after a violent incident towards Adam in his place of

work in 2013. Richard was transported by police back to Hannah's home where she was known to be a high-risk victim of Richard's violence. He almost immediately assaulted Hannah on his return to the home. The decision, whether or not, to take him back there could have been informed by Richard's history and the known violent incidents occurring at that property. Training for custody staff should include detail on not making decisions based on 'he's okay now'. See Recommendations 3 & 8.

15.3.4 The problem of intimidation is also relevant in this case. Hannah and Adam repeatedly expressed that they would not support a prosecution. It is understood that the only time Richard was successfully prosecuted was when there was an independent witness and CCTV footage. This makes very clear the importance of robust evidence gathering in cases of domestic abuse where intimidation is very often relevant. The HMIC report into police responses to domestic abuse in 2014 revealed that evidence gathering in cases of domestic abuse was often poor nationally. Prosecutions where the victim does not provide evidence at trial are more commonplace now and rely on evidence other than that given by the victim.

15.4 Repeat perpetrator

15.4.1 This raises the third issue, that of criminal justice responses to repeat domestic abuse and violence. Richard was routinely escaping sanction after being violent to people. His violence was also towards others outside of a domestic setting, and there are at least two such incidents documented in this case. There are reports of Richard using violence against males in public places and of violence towards police officers. Across the time span there was more often than not no further action taken, than prosecutions made. Decisions about prosecution will be based on the evidence available to police and the CPS so corroboration is very important in domestic abuse cases and could be routinely sought by police. Richard escaped custody by receiving a suspended sentence in one case by promising to leave the UK and live abroad. However, he returned only six weeks later, only part way through the suspended sentence period which was 12 months.

15.4.2 Repeated offending which results in no action may not deter perpetrators from future violence and may deter victims from taking action.

15.4.3 Richard was also never referred for any perpetrator programme.

15.4.4 In this case the result of Richard's continued violence was that he himself was killed. It could very easily have ended with Adam or Hannah's death, especially as Richard was prone to strangulation assaults in a domestic setting. Strangulation assault is an acknowledged high-risk marker for future homicide and this should be given due weight in risk assessments.

15.5 Response to high risk victims of domestic abuse

15.5.1 In this case Hannah was identified as a high-risk victim of violence. The process for high-risk victims was followed and referrals to MARAC and to Stonham were made. No referrals were made for Adam, and this is covered in the first point (16.2). The MARAC process was not effective or efficient in this case and it appeared that there was a lack of status given to the process more generally. As already discussed, there was poor information in the referrals, poor attendance and poor follow up with lack of actions.

15.5.2 The response to high risk victims needs to include proactive information sharing and high status given to the process itself. This will be best served in strong leadership in all agencies in this area. MARAC should be seen as a key safeguarding process which can save lives, and given priority in terms of staff time, attendance, follow up and proactive information gathering and sharing.

16 Conclusions

16.1 In conclusion when considering lessons to be learned from this case the key areas are around recognising high risk behaviours, considering risk to persons who may not be the primary victim, making decisions based on the best intelligence available and prompted by appropriate professional curiosity, and maintaining strong processes in response to high risk domestic abuse.

16.2 Adam and his mother were both at high risk of harm from Richard. The information to make this assessment was available to agencies.

16.3 There are already in place many responses, supportive actions, and sanctions to respond effectively, but they were not always used to their best effect.

16.4 It is recognised that since Richard's death there is new legislation which criminalises coercive and controlling behaviour in s76 of the Serious Crimes Act 2015. It is also recognised that since 2015 there have been some changes in agency policy and practice which may address some of the issues addressed in this review.

17. Lessons to be learnt

Learning Opportunity 1
When a homeless application is made by a child, i.e. a person under the age of 18, a joint assessment must be undertaken by the Housing Authority and Children's Social Care. If the child specifically states that the home environment is unsuitable, background checks should be performed on any named person who is the cause of the young person's concern before any decision is made which impacts on that person's safety.

Learning Opportunity 2
When considering risk and support, all agencies should consider the risk posed to any person within the household, especially any vulnerable person. In this case risk assessment and support was focused entirely on Hannah, when there are processes in place to support young people like Adam.

Learning Opportunity 3
Working within the parameters available to them agencies should carry out intelligence and background checks to inform any decisions and risk assessments where safety is an issue

Learning Opportunity 4
Good knowledge around high-risk markers, and why they are high-risk should be standard content in any domestic abuse training across all agencies. Key behaviours like strangulation, threats to kill and repeated violence should be given due weight in considering support and responses for victims.

Learning Opportunity 5
Consideration of intimidation should be central to the Police's assessment of any domestic abuse call for service. Where victims do not engage, accept help, or support prosecutions, intimidation should be considered and ways to alleviate fear explored with the victim.

Learning Opportunity 6
Raising the status of MARAC should be a priority for all agencies. Staff should be encouraged to give MARAC appropriate attention and should be given time to prepare and follow up actions. Professional curiosity should be encouraged and supported in all staff and this is a matter for strong leadership.

Learning Opportunity 7
Focus on perpetrators of domestic abuse, especially repeat offenders, should have a clear path for response for Police and criminal justice agencies. Full consideration of

the options available should be considered for repeat offenders before no further action is considered. This should include perpetrator programmes.

18. Recommendations

Recommendation 1

In any Homelessness Application for young people, background checks on associated individuals should be performed to inform decisions where:

- there is any evidence of any domestic abuse against any person in the home environment,
- a problem person is named,

where either situation is the reason for the application.

Recommendation 2

When any professional is performing a risk assessment, that risk should be considered in relation to any person within the household or sphere of violence. This would include anyone living with a high-risk perpetrator, or anyone subjected to domestic violence by them. Any person over the age of 16 subjected to such violence should be considered for referral to specialist domestic abuse services and considered for risk assessment in their own right.

Recommendation 3

Where an individual has a history of violence or abuse this should be considered in any response by the Police and criminal justice agencies. Efforts to respond with criminal justice sanctions should be pursued, and proactive consideration of perpetrator programmes, alcohol or drug misuse programmes, or specialist domestic abuse, mental health or stalking interventions. Sanctions can be a way to access help. The domestic violence disclosure scheme should also be considered in repeat or high-risk cases.

Recommendation 4

All frontline professionals who may deal with disclosures of domestic abuse should have a good knowledge of the high-risk markers which predict harm and how to respond to them. For example, previous history, strangulation assaults, separation, pregnancy, escalation/increase in severity, harassment, stalking, threats to kill, substance misuse and alcohol misuse.

Recommendation 5

Whenever victims of domestic abuse fail to engage or will not support prosecutions, intimidation should be considered (look for CCTV and corroboration). This would include active consideration of safe disclosure away from the home and assurance of confidentiality from the perpetrator. Strengthen CPS engagement.

Recommendation 6

The status of MARAC should be raised with immediate effect. This should be achieved through strong leadership and prioritisation of MARAC attendance and actions.

Recommendation 7

It was also noted that the commissioning cycle for domestic abuse service provision is very short, and this is not helpful. It was considered a national recommendation was needed to stress the importance of consistency of such services for victims who are reliant on them. Commissioners should ensure appropriate service contracts to enable consistent service delivery.

Recommendation 8

A clear path for responding to repeat offenders should be easily accessible to frontline and custody officers and supervisors, pointing to the available options for responding. This could potentially be achieved through a clear Flowchart designed by individual agencies

Recommendation 9

There could be encouragement for the PCC to fund perpetrator programmes and a domestic abuse integrated offender management scheme.