SAFER STOCKPORT PARTNERSHIP

DOMESTIC VIOLENCE HOMICIDE REVIEW IN THE CASE OF MV

PERIOD UNDER REVIEW

1ST SEPTEMBER 2011 TO 20TH NOVEMBER 2012

Executive Summary

1. BACKGROUND TO THE DOMESTIC HOMICIDE REVIEW

MV died on 20th November 2012 following an incident at Address 2 in which he received a fatal stab wound. His common law partner, referred to in this Executive Summary as MVP, was subsequently arrested and charged with the murder of MV. Following trial MVP was convicted of manslaughter and is currently serving a custodial sentence.

The incident and the subsequent death of MV resulted in a referral to the Safer Stockport Partnership from Greater Manchester Police Public Protection Investigation Unit (PPIU). This referral proposed that the case met the criteria for undertaking a Domestic Violence Homicide Review (DVHR).

The Safer Stockport Partnership held an initial scoping meeting on and concluded that a DVHR should be undertaken. This decision was approved by the Home Office and a panel of senior officers from local agencies was formed to scope key lines of enquiry and to oversee the review.

A senior officer from a partner agency who was entirely independent of the case Chaired the Review and Independent Author was appointed in line with Home Office statutory guidance.

2. OVERVIEW OF THE CASE

Key People and Locations

PSEUDONYM	RELATIONSHIP TO SUBJECT	ADDRESS AT TIME OF INCIDENT
MV	SUBJECT	Address 1
MVP	PERPETRATOR	Address 2
MVD1	DAUGHTER	Address 2
MVD2	DAUGHTER	Address 2
MVD3	DAUGTHER	Address 2
MVS	SON	Address 2
MVS1	SISTER OF MV	Address 1
MVBL	BROTHER IN LAW OF MV	Address 1
MVPNP	FRIEND OF MVP	N/A

3.1 Background to MV and MVP

MV previously lived with his common law partner MVP and their four children MVD1, MVD2, MVD3 and MVS. Three of the four children have complex and enduring health needs that require daily contact with health care professionals.

At the time that the fatal incident took place, MV and MVP had been in a relationship for approximately 13 years. MV and MVP were the primary carers for the three children with complex needs. Despite her young age, MVD1 also provided care to the children and was classed as a young carer.

Both MV and MVP had experienced mental health problems during the 18 months prior to the incident leading to MV's death. Both MV and MVP had been referred to, and received treatment and interventions from, specialist mental health services. MV took an overdose of drugs combined with alcohol two weeks before his death. He told his family and medical staff that this overdose was an attempt at suicide and that he wanted to die. He was said to have written a suicide note, although the DHR panel did not have sight of this.

As part of the DHR process the Independent Chair and Independent Author of the Review conducted an interview with MVP in prison in which she informed them that the relationship between herself and MV had been turbulent for some time.

The panel gave specific focus to the pressures brought to bear on the family because of the complex and enduring nature of the illness suffered by three of the children. There is no doubt that this must have placed additional strain on the family. The long-term caring responsibilities of MV and MVP may have impacted their mental health, although this was not formally assessed as a factor in either of their diagnoses. There is no evidence to suggest that these caring responsibilities resulted in domestic abuse. In large part professionals reported that both MV and MVP placed all of their energy and resources into caring for the children.

Other risk factors were present in the relationship. Both MV and MVP were treated for mental health conditions. MP was treated by his GP for depression and MVP experienced a form of psychosis. Neither partner cited any aspect of their relationship as contributing to their illness, and neither referred to any physical or other abuse as a factor in their illness. Both MV and MVP used alcohol excessively on occasion, with MV this was a more recent occurrence and was discussed with healthcare professionals. MVP said she had used alcohol in the past but had not done so with any frequency since the children were born.

Despite the presence of these risk factors there is no evidence of domestic abuse in the relationship. MVP confirmed that, other than the incidents that took place on 15th November and the fatal incident, there had not been physical violence in the relationship. This testimony must be considered in light of the source, however, there is no other evidence to support any other conclusion than that MV and MVP had a fractious and difficult relationship, but not one that was characterised by control, manipulation or violence.

According to MVP, the relationship deteriorated after MV had an illness in 2011. MVP referred to this illness as a stroke, however, this is not substantiated in any of the medical records (on further investigation the panel were able to ascertain that there is no medical record or evidence that MV had ever suffered a stroke).

The relationship between MV and MVP finally broke down in October 2012 with MV moving out of the family home at Address 2 and residing with his sibling at Address 1.

MVP had developed a close friendship with a male friend, referred to as MVPNP in this report. This became a cause of heightened tension between MV and MVP, as MV had been troubled by rumours about MVPNP's past.

3.2 Background to the Case

During November 2012, two significant incidents occurred which, in the view of the DHR panel, were precursors to the incident of 20th November 2012 in which MV sustained fatal injuries.

The first of these events took place on 5th November 2012 when MV made an attempt at suicide and was admitted to NHS1 for medical care and referred for psychiatric assessment.

The second event took place on 15th November 2012 when a dispute occurred at Address 2 to which police were called. It appears that during an altercation between MV and MVP, MV received a stab wound to the abdomen. There are conflicting reports as to how this injury occurred and whether or not it was self-inflicted.

According to information given by MVP at interview with the DHR Chair and Author, MV had inflicted the wound upon himself, this cannot be proved or disproved. MV did not seek medical treatment for this injury and medical staff only observed the injury when MVP was admitted to hospital following the incident on 20th November that led to his death.

The incident that took place on 15th November 2012 was referred to the Independent Police Complaints Commission (IPCC) and has been subject to investigation by them. Further information regarding the process and findings of the IPCC investigation are provided in the overview report.

3. THE DOMESTIC HOMICIDE REVIEW PROCESS

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

The period under review was to 1st September 2011 to 20th November 2012. Key lines of enquiry were established against which agencies were asked to provide Individual Management Reports and summary reports.

The DVHR panel met on six occasions to review the reports and other relevant information.

The panel established sixteen key lines of enquiry in relation to the review. Individual Management Reports were received from the following agencies:

- General Practitioner
- Greater Manchester Police
- North West Ambulance Service
- Pennine Care NHS Foundation Trust
- Primary School
- Signpost for Young Carers
- Stockport MBC Children's Social Care
- Stockport NHS Foundation Trust
- University Hospital of South Manchester

Prior to the commencement of the DVHR MVP had been charged and tried for the murder of MV. MVP was found guilty of manslaughter and received a custodial sentence of nine years imprisonment.

MVP was interviewed in prison as part of this review by the Independent Chair and Author.

The case had been referred to the Independent Police Complaints Commission for investigation into the actions of officers at a precursor incident that took place on 15th November. The IPCC referral was as follows:

> *"It is alleged that the attending officers failed to investigate the circumstances of the domestic incident and failed to take positive action. It is also alleged that the officers falsely cited that the DASH (Risk Assessment Process) questions had been refused and failed to report the true circumstances which led to an inappropriate risk assessment and a lack of safeguarding measures being implemented'.*

The IPCC have now produced a report with findings, which has been submitted to Greater Manchester Police for consideration. The Chair of the Panel and Author of this report were given sight of the IPCC investigation findings, however, these are not yet in the public domain and were not detailed in the DVHR overview report.[1]

The conduct and disciplinary findings of the IPCC investigation are being pursued. The IPCC has made two recommendations to Greater Manchester Police that are relevant to this report, these are:

Recommendation 1

The force should identify a method in which a supervisory review of the DASH form is recorded. In doing this the force should identify a suitable method to report on the quality of DASH forms and an effective method to identify learning and/or training requirements in this area.

Recommendation 2

The force to consider an effective system to ensure that DASH forms are being used and completed as intended.

[1] The IPCC Report was published in March 2015

4 SUMMARY OF THE CASE AND LESSONS LEARNED

There are however areas where agencies can learn from this case and where practice could be improved. These are set out below and in the recommendations section.

4.1 It is clear that the MV and MVP were subject to significant pressures and stress arising from the demands placed upon them in managing three children with very complex and enduring health needs.

4.2 There was good practice by professionals in helping MV and MVP to deal with the demands placed upon them as primary carers.

4.3. Medical and social care interventions with the children were of a good standard and coordination of care services to the three children was effective.

4.3 MVD1 required additional support as a young carer and, whilst the services provided by the young carer's service were of a good standard, there was insufficient focus by Children's Social Care (CSC) on MVD1's needs. MVD1 did not receive a CAF assessment and was therefore not an 'open case' to CSC.

4.5 Engagement with the adults in the family lacked coordination or a 'whole family approach' by Children's Services and by Mental Health Services.

4.6 There was good practice by professionals in helping MV and MVP to deal with the demands placed upon them as primary carers.

4.7 Professionals involved in Team around the Child meetings appear to have under-estimated, and therefore not fully taken into account, the degree to which these pressures exacerbated the pre-existing mental and physical health problems of both MV and MVP. The panel judged that the multi-agency professional response to the complex needs of the children obscured and overshadowed the needs of their parents and of MVD1 who acted as a young carer.

4.8 Although TAC meetings brought professionals together to review and plan for the children's health needs, many of the actions emerging from these meetings lacked an integrated approach to working holistically to address the needs of the adults and the impact that these had on all the children in the family.

4.9 There was an absence of thorough, ongoing and integrated assessment of the needs of the parents and children.

4.10 Mental Health Services did not link MV and MVP (the IT recording system does not have the facility to produce a family genogram) therefore mental health services were unaware that MV and MVP were living together. As a consequence neither MV nor MVP received a full assessment of the impact of their individual mental health problems on their parenting capacity.

4.11 There was good practice in the local hospital when a 'cause for concern' was raised following MV's admission following an attempt at suicide on 5th November 2012.

4.12 Alcohol misuse was a feature in MV's attempt at suicide on 5th November and was assessed as being a significant co-factor in his self-harming behaviour. MV consented to referral to the local alcohol service however, he was advised to self refer and did not do so. This was not followed up and therefore an opportunity was missed to engage MV in alcohol treatment.

4.13 There was some liaison between professionals working with the adults in the family at TAC meeting although neither Adult Mental Health professionals nor the GP were in attendance at these meetings. Because of the focus on the children's health needs in this forum, it proved an ineffective way of addressing the whole family's circumstances and needs.

4.14 MV and MVP sought and received interventions for their mental and physical health, initially through their GP who co-ordinated services and was proactive in following up appointments with other secondary services. It is the view of the panel that there was considerable good practice demonstrated by the GP.

4.15 The incident that took place on 15th November 2012 is clearly significant. It is the panel's view that the actions of police officers in relation to this incident present a number of missed opportunities.

4.16 The DASH risk assessment (a standard tool used to assess risk of domestic violence) was not completed at the scene but was completed the following day by an officer. It is the view of the panel that this contributed to a down-grading of risk to 'standard'.

4.17 Some of the police officers who attended the incident on 15th November did not take seriously MV's complaint of a knife wound, nor did they adequately assess or attempt to clarify who was the victim and who the perpetrator at the incident was.

4.18 MVP was clear that she felt threatened by both MV and MVBL and that she wanted them removed from Address 2. In MVP's conversation with representatives of the DHR panel she said that the police officers present at the incident did not respond to her request, leaving her feeling unsafe.

4.17 It is the view of the panel that some police officers attending on the 15th November did not make an accurate assessment of who may be the victim of domestic abuse and who may be the perpetrator. When the DASH risk assessment was completed after the incident, the assumption was made that MVP was the victim. Whilst there is no evidence to suggest that MVP had assaulted MV, MV did complain of a stab wound. This was not taken into account by police officers in risk rating the incident, nor was it followed up in any way by officers. It is not possible to say why officers at the scene perceived MVP to be the victim of domestic as the DHR panel have not been able to speak to police officers due to the IPCC investigation.

4.18 The panel will ensure that, in future reviews, any advocates working with the family are invited to support the family's participation in the review.

4.19 The panel recognised that violence can be present where there is no apparent physical violence.

4.1 Conclusion

After careful consideration and investigation, it is the view of the Panel that the events that took place on 20th November 2012 that led to MV's death could not have been predicted or prevented.

Whilst both MV and MVP had been previously known to the police prior to the incidents that took place in November 2012 there had been no incidents of domestic abuse between them, nor any precursor or trigger events before that time.

In summary the DHR panel has identified a number of areas in which lessons can be learned and services strengthened.

5 RECOMMENDATIONS

In addition to the single agency actions submitted to the DHR panel (which can be found in the overview report) the DHR panel has carefully considered all material presented in this case and makes the following recommendations to the Community Safety Partnership.

An action plan setting out the detail of these recommendations and proposals for implementation and monitoring is available with the overview report.

Recommendation 1a

The case highlights a number of missed opportunities in relation to safeguarding the children in this case. The Panel recommends that the **Local Safeguarding Children Board** should initiate a multi-agency practice review of safeguarding children living in families where there are multiple complex needs and where one or both of the parents have mental health problems.

Recommendation 1b

The needs of MVD1 were not fully assessed or responded to. Despite her significant responsibilities as a young carer and the fact that she lived with two vulnerable adults and three siblings with chronic medical conditions she was not an open case to CSC, having never received a CAF assessment.

As recommended in 1a above, the LSCB should ensure that the learning review considers the fitness for purpose of multi-agency policies and procedures in relation to the needs of Young Carers.

Following the learning review all agencies should update their policy in relation to supporting young carers, recognising and meeting their specific needs.

Recommendation 1c

As part of the LSCB learning review the processes and systems for information sharing with voluntary sector agencies should receive focus. This should ensure that voluntary and third

sector agencies have equal access to relevant information to safeguard vulnerable adults and children.

Recommendation 2

The CCG should be assured, by audit evidence, that the training delivered to and the supervision received by Pennine Care NHS FT (Mental Health) staff thoroughly explores the impact of adult mental health on parenting capacity including staff's responsibilities if concerns are identified.

Recommendation 3

MV was advised to refer to alcohol services and consented to this however, current practice does not require self referral advice to be followed up by services. The DHR panel recommend that it would be good practice to initiate referrals in cases where the adult is particularly vulnerable or high risk (i.e. where there has been a serious attempt at self-harm).

The **Drug and Alcohol Joint Commissioning Group** should develop the assessment and referral pathways for alcohol misuse where there are co-factors of mental health and domestic abuse. The aim should be to ensure that high risk adults with complex needs are referred to services and that the referral is followed up

Recommendation 4

Developing the skills and capacity of the local workforce in relation to identifying, referring and responding to domestic abuse is key to the success of the local domestic abuse strategy. The **Community Safety Partnership** should give specific focus to workforce development in its revised domestic abuse strategy, the focus should be on ensuring that all agencies build confidence amongst their workforce in dealing with domestic abuse.

4. FURTHER INFORMATION

When published, the full report of this review can be found at www.saferstockport.org.uk