SAFER STOCKPORT PARTNERSHIP

DOMESTIC VIOLENCE HOMICIDE REVIEW IN THE CASE OF MS

DATE OF DEATH 4TH FEBRUARY 2012

EXECUTIVE SUMMARY

1. BACKGROUND TO THE DOMESTIC HOMICIDE REVIEW

On the night of 3rd February 2012 an incident took place that resulted in the subject of this case, who will be referred to as MS, dying from his injuries on 4th February 2012.

The incident and the subsequent death of MS 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 29th February 2012 and concluded that a DVHR should be undertaken. This decision was approved by the Home Office on 1st March 2012 and a panel of senior officers from local agencies was formed to scope key lines of enquiry and to oversee the review. An Independent Chair and Author were appointed in line with Home Office recommendations.

2. 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 March 2011 to 4th February 2012 (date of death of MS). Key lines of enquiry were established against which 16 agencies were asked to provide Individual Management Reports. A Health Overview report was also commissioned. The DVHR panel met on eight occasions between 4th May and 7th November 2012 to review IMRs and other relevant information. The DVHR process was halted briefly on 23rd July 2012 to take account of the outcome of criminal proceedings (as set out below). The DVHR re-commenced on 4th August 2012.

3. SUMMARY OF THE CASE

MS and AF1 had known each other for around ten years and had maintained an 'on-off' relationship during this time. They lived at together at Address 1 from March 2011 to the date of the incident 3rd February 2012. AF1's two children lived at the address until late November/early December 2011.

Between 1st March 2011 and 3rd February 2012 Police attended several incidents at the address of AF1 many of which involved alcohol intoxication and domestic violence. On one occasion MS had been assaulted by AF1 and had sustained an injury to his ear. This incident resulted in AF1 being charged with assault and with MS being referred to Victim Support as a victim of domestic violence. However, MS failed to appear at court and the case was closed without trial due to a lack of evidence.

On more than one occasion AF1's children were present in the home during violent domestic disputes and on one occasion they requested that they be removed by the Police.

Despite the frequency of police call outs both MS and AF1 kept their alcohol misuse and associated domestic disputes largely hidden from health and social care services.

Police shared information with both Adults and Children's Social Care Services about incidents of domestic violence. MS was assessed for vulnerable adult status by Adult Social Care but did not meet the criteria. Children's Social Care and School Nursing Services were notified about the children's exposure to domestic violence the family did not receive a full assessment or referral to a strategy meeting.

On the night of 3rd February 2012 emergency services were called to Address 1, callers reported that a person was 'on fire in the street'. Fire, Police and Ambulance services were in attendance at the scene within minutes of receiving 999 calls. MS was transferred by ambulance to a local hospital where he died from his injuries on 4th February 2012.

Following the death of MS on 4th February AF1 was charged with his murder on 5th February 2012. AF1 appeared at Stockport Magistrates Court on 6th February 2012 where she was further remanded in custody to appear at Manchester Crown Court on 7th February 2012.

On 7th February AF1 appeared in court on a charge of murder. AF1 entered a 'not guilty' plea. A trial date was set for 9th July 2012 and proceedings commenced at Manchester Crown Court on that date.

On 20th July 2012 at Manchester Crown Court AF1 was found not guilty of murder and cleared of all charges.

Following the acquittal of AF1 the Safer Stockport Partnership sought advice from the Home Office on 23rd July 2012 as to the status and continuance of the Domestic Violence Homicide Review. The advice given by the Home Office was that the DVHR should continue as the serious case still warranted investigation. In this context AF1 remained a person of significant interest to the review and it is on that basis that information relating to AF1 remains within the purview of the overview report.

4. KEY FINDINGS

The DVHR Panel concluded that the incident that took place on the night of 3rd February 2012 could not have been predicted by any of the agencies to whom MS was known. However the panel also identified that opportunities were missed to intervene with the victim and other key individuals in the case.

The key findings from the review fall into seven thematic areas, as follows:

4.1 Male Victims of Domestic Abuse

Although MS is reported not to have considered himself as a victim of domestic abuse he did experience physical and verbal aggression from AF1. MF did not take up the offer of a domestic violence risk assessment, nor did he respond to a summons to give evidence against AF1 when she was charged with assaulting him. It is not uncommon for victims of domestic abuse to refuse to engage with services however in the case of MS little was done to encourage him to seek further support. There is no evidence that MS was treated differently by any service than if he had been a female victim however the Panel felt it important that a recommendation was made to strengthen work in relationship to male victims.

4.2 Female Perpetrators of Domestic Abuse

It is apparent from the material seen that MS and AF1 were at times violent and aggressive towards each other and the roles of perpetrator and victim in the relationship were not clearly defined or separated. It is recorded in several IMRs that MS did not perceive AF1 to be a threat saying that he was not afraid of her and that on the occasion she assaulted him on 24th August this was because she was drunk. AF1 was not identified as a perpetrator of domestic violence by any agency other than GMP.

AF1 was not offered any service in relation to either perpetration or victimisation. Without the insight of family members the review panel were unable to clearly understand both MS and AF1's roles as behaviours as victim(s) and perpetrator(s). In addition to this there are limited programmes locally and nationally for perpetrators of domestic violence and virtually no programmes specifically targeting women.

4.3 Safeguarding Children

AF1's children were exposed to multiple incidents of domestic violence whilst living at Address 1.

The frequency and severity of incidents, particularly in the period between 2nd July 2011 and 9th November 2011 did not trigger multi-agency action. The children were never the subject of strategy meetings in relation to violence and alcohol as they did not meet the thresholds

for intervention. This was however partly due to delays in referral, inaccurate information sharing, systems failures and human error.

4.4 Alcohol Misuse

There is significant evidence that alcohol misuse was a major aggravating factor in the often violent relationship between MS and AF1. Alcohol misuse featured in the domestic disputes attended by GMP, in driving offences committed by AF1 and allegations of harassment by MS's previous partner.

Despite the role that alcohol played in the relationship neither MS nor AF1 discussed alcohol issues with their respective GP or any other medical practitioner. Children's Social Care was aware of alcohol misuse by AF1 but this did not result in any form of risk assessment. AF1 was offered a family intervention service by MOSAIC but this was not taken up.

4.5 Vulnerable Adults

Although MS was categorised as a vulnerable adult by the Police following the domestic violence incident that occurred on 24th August 2011 the criteria used for this classification is not shared by other agencies. MS did not meet the criteria for categorisation as a vulnerable adult by Adult Social Care. The panel identified a need for a commonly understood language and process amongst agencies in relation to vulnerable adult status.

4.6 Criminal Justice System

Following the court hearing on 8th December 2011 the process for communicating the sentence from HMCTS to the provider (G4S) failed. Consequently the sentence was never applied. Had the sentence been applied AF1 would have been subject to curfew and been electronically tagged at the time of the incident on 3rd February 2012. An internal investigation has been completed within HMCTS.

4.7 Wider Learning

DVHRs are relatively new to local partnerships and, as such, the process of implementing a review has been a valuable learning experience.

Co-operation with the review from all agencies has been excellent and leadership shown by the Community Safety Manager enabled the review to be conducted in a professional and efficient manner, ensuring that all the agencies involved were able to respond to demands made upon them.

Despite efforts to secure family involvement this was not achieved. The timing and outcome of criminal proceedings and initial uncertainties about family composition may have added to difficulties in securing family contributions.

A 'learning event' for the wider Stockport Partnership will be held to ensure that both the recommendations and learning in relation to the process of conducting a DVHR will be progressed.

5. ACTIONS AND RECOMMENDATIONS

Single agency action plans have been drawn up by four of the agencies involved in the review – Adult Social Care, Children's Social Care, Greater Manchester Police and Stockport Homes. Each agency is responsible for the implementation of their action plan and for reporting progress to the Safer Stockport Partnership.

The Serious Case Review panel has made the following recommendations to the Safer Stockport Partnership:

1. Greater Manchester Police should put in place quality assurance measures to ensure that domestic violence referrals involving children are timely and directed to the appropriate department as set out in PPIU standards (2012).

2. Greater Manchester Police should ensure full compliance with the system of identification and referral in relation to Local Authority Designated Officer (LADO) requirements.

3. The Adult Safeguarding Board should develop a clear and commonly understood multi-agency definition and language in relation to vulnerable adults.

4. The Safer Stockport Partnership should ensure that family involvement in future Domestic Violence Homicide Reviews is prioritised.

5. The Drug and Alcohol Action Team Joint Commissioning Group should review the local alcohol strategy to ensure that all agencies have a clear and achievable service policy in relation to assessment, referral and feedback in cases of domestic abuse.

6. The local Health and Wellbeing Board should review the feasibility of establishing a referral system between GMP and General Practice where domestic abuse and alcohol misuse present significant risk to individuals and families.

7. The Stockport Domestic Abuse strategic group should review its policy and practice in relation supporting male victims of domestic abuse and make any necessary changes.

8. The Stockport Domestic Abuse strategic group should bring forward its plans to strengthen responses to intervening with perpetrators of domestic abuse. This should link to the work currently being done by Manchester DV forum to develop a shared approach to perpetrator interventions.

9. HMCTS should put in place quality assurance system for notification and implementation of sentencing outcomes.

10. The Local Criminal Justice Board should review the process of setting curfew arrangements to ensure that perpetrator curfews are not imposed at the same address as that of the victim.

6. FURTHER INFORMATION

A copy of the full report will be made available on the Safer Stockport Website
www.saferstockport.org.uk

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