The Safer St Helens Community Safety Partnership

Domestic Homicide Review

Overview Report

'Maria'

Died August 2022

Chair and Author: Ged McManus

Supported by: Carol Ellwood-Clarke QPM

Date: December 2023

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Maria, a resident of St Helens, prior to her death. The panel would like to offer its condolences to Maria's family on their tragic loss.

1.2 Maria and David had been in a relationship since the summer of 2020. David moved into the flat that Maria rented (in her sole name).

1.3 Maria and David are pseudonyms chosen by the DHR panel from a list of names.

1.4 During the summer of 2022, a number of domestic abuse incidents were reported to the police, in which Maria was the victim and David the perpetrator.

1.5 On a date in August 2022, David murdered Maria in her flat by punching and strangling her. David left the flat and withdrew £1000 from Maria's bank accounts (using her bank cards). Much of the money was spent on cocaine and alcohol. David went on to stab two men, whom he suspected of having relationships with Maria, before he was arrested by the police.

1.6 David pleaded guilty to Maria's murder, two offences of attempted murder, and possession of a bladed article in a public place. He was jailed for life, with a minimum term of 28 years. The sentencing judge said:

"I express my remorse and condolences for all of the victims in this case and all of those connected to them.

"This was undoubtedly a brutal murder. It was apparent that the victim, I regret to say, must have endured significant mental and physical suffering before she died.

"I accept that there was no premeditation, but I do not consider that to be a particularly significant factor given that the trigger for your murderous attack appears to have been information you gained when scrolling through the victim's mobile phone. That behaviour is an indication of controlling behaviour on your part.

"I accept there is an element of remorse, but your explanations and admissions - full and candid though they were - appear to me to have been accompanied at all times by an air of justification, as if you were in a position that there was nothing else you could have done. What you did, you did by choice."

1.7 In addition to agency involvement, this review will also examine: any relevant background or trail of abuse before Maria's death; whether support was accessed within the community; and whether there were any barriers to accessing support.

By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.8 The review considers agencies' contact and involvement with Maria and David from 27 May 2020 until Maria's murder in August 2022. This time period was chosen because David was released from a previous prison sentence on this date. There is no evidence that Maria and David were in a relationship prior to this.

1.9 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.10 **Note:**
It is not the purpose of this DHR to enquire into how Maria died: that is a matter that has already been examined during David's trial.

2 Timescales

2.1 This review began on 8 February 2023 and was concluded on 8 November 2023.

More detailed information on timescales and decision-making is shown at paragraph 5.2.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 Pseudonyms have been used in the report to protect the identity of the subjects of the review.

4 Terms of Reference

4.1 The purpose of a 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 inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe Under Review

The DHR covers the period from 27 May 2020 until Maria's death in August 2022.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Maria, aged 49 years

Perpetrator: David, aged 43 years

Specific Terms

1. What indicators of domestic abuse were your agency aware of that could have identified Maria as a victim of domestic abuse, and what was the response?

2. What knowledge did your agency have that indicated David might be a perpetrator of domestic abuse against Maria, and what was the response? Did that knowledge identify any controlling or coercive behaviour by David?

3. How did your agency assess the level of risk faced by Maria? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. How did your agency respond to any mental health issues, or substance misuse, when engaging with Maria and David?

5. What services did your agency provide for Maria and/or David; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

6. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

7. Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were any gaps identified?

8. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Maria and/or David, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.

9. What knowledge did family, friends, and employers have that Maria was in an abusive relationship, and did they know what to do with that knowledge?

10. Are there any examples of outstanding or innovative practice arising from this review?

11. What learning has emerged for your agency?

12. Do the lessons arising from this review appear in other reviews held by the St Helens Community Safety Partnership?

5 Methodology

5.1 On 5 September 2022, Merseyside Police made a referral to St Helens Community Safety Partnership for the case to be considered for a DHR. On 10 November 2022, St Helens Community Safety Partnership held a Standing Group Meeting to consider multi-agency information held in relation to Maria and her partner, David. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review and recommended one should be conducted. The Home Office was informed of the decision to undertake a review on 5 May 2023. The delay in notification was due to an administrative oversight and did not affect the commissioning of the DHR.

5.2 On 16 November 2022, Ged McManus was commissioned as the Independent Chair of the review. Due to other commitments, he was unable to start work on the review until February 2023.

5.3 DHR meetings took place using Microsoft Teams video conferencing: the panel met five times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 5 September 2023, after which minor amendments were made to the report that were agreed with the panel by email. The report was not finalised until December 2023 due to significant delays in seeking a contribution from the perpetrator, David.

6 Involvement of Family, Friends, Work Colleagues, Neighbours, and Wider Community

6.1 Family

6.1.1 Maria's parents were supported by a Victim Support Homicide worker. The Chair wrote to them, inviting them to contribute to the review, and included appropriate Home Office leaflets. Through their support worker, they indicated that they did not wish to take part in the review because they were too traumatised following Maria's death. The panel agreed to respect their wishes. The Chair kept in touch with the Victim Support Homicide worker throughout the review, providing updates and regular opportunities for the family to contribute if they wished to do so. The family felt unable to contribute at any stage.

6.2 Friends

6.2.1 Merseyside Police provided the statements made by Neighbour 1 and two friends of Maria's, which had been made for the purposes of the murder investigation. Specific information from the friends' statements is referenced in the review as

appropriate. [section 13]. General information from the neighbour is shown in the following paragraph. The friends and neighbour have not been seen or spoken to by the DHR Chair.

6.2.2 Neighbour 1 told the police that he knew Maria and David from living in the same apartment block. During the warm weather of summer 2022, they heard Maria and David arguing and shouting: both inside and outside the apartment block. If the balcony window was open, the neighbour would hear shouting and swearing, and Maria accusing David of having affairs. On some occasions, David was outside in the car park shouting up at Maria in the apartment. Maria would lean out of the window and shout back at him. On these occasions, the subject matter would be David wanting to get back into the apartment or retrieve his mobile phone and charger.

6.2.3 The DHR panel was unable to identify other friends with which it could seek engagement. On the anniversary of Maria's death, a friend posted a tribute to Maria on social media. The DHR panel reached out to the friend on social media to ask for their contribution; however, the friend felt unable to become involved.

6.3 Employer

6.3.1 The Chair of the review wrote to Maria and David's employer and, after establishing contact, met with three managers who had worked with Maria and David.

6.3.2 Maria's employment

Maria worked at a distribution centre for a large retailer. Her job involved packing and organising orders for delivery to retail stores. She had worked for the same employer for around 20 years.

6.3.3 Maria was an established and well-liked employee who was popular with colleagues. Maria did have some issues with sickness absence and had received a written warning. On her return to work from absences, managers followed the company policy of completing a return-to-work interview on every occasion. During the summer of 2022, managers became aware – through rumours that were circulating in the workplace – that there may have been domestic abuse in Maria and David's relationship.

6.3.4 During return-to-work interviews, Maria did not disclose specific problems, and managers describe her as 'keeping things to herself'. As the return-to-work interviews were conducted by a male manager, Maria was offered the opportunity

to speak to a female manager but declined this. She was also signposted to two external organisations that are contracted to provide occupational health and confidential counselling services for employees.

6.3.5 Latterly, managers became aware of the domestic abuse that Maria had suffered and the fact that David had appeared at court. Managers were told that an order was in place to keep David away from Maria and were reassured by that. Although Maria had some absences through this period, managers were as flexible as possible by swapping rest days and rearranging shifts so that Maria did not breach the sickness absence policy and receive another warning.

6.3.6 Following Maria's death, colleagues organised a memorial for Maria, which was placed in a garden at her place of work.

6.3.7 Maria's employer agreed to distribute a letter from the Chair of the review to Maria's colleagues, inviting them to contribute to the review. This was accompanied with the relevant Home Office DHR leaflet. At the time of the conclusion of the review, no response had been received from Maria's colleagues.

6.4 **David's employment**

David obtained employment with the same employer as Maria: this was through an agency, and he was not employed directly. He initially worked as an order picker before moving to another section of the business. He disclosed his convictions during an interview for the internal move of role.

6.4.1 David's colleagues observed that he sometimes appeared hyper alert. He could appear especially sweaty even when it was cool, and colleagues suspected that he may sometimes have taken some type of stimulant. This was monitored by managers, but there was insufficient information to require a drugs test.

6.4.2 In June 2022, after asking for time off at short notice, David did not attend work again and did not answer any communication. As he was an agency worker, his role was filled by another worker. In early July, David contacted a manager and asked for his job back; however, this was declined due to the nature of his unexpected absence previously and that the role had been filled.

6.4.3 On several occasions after this, David was reported by staff to be standing outside the workplace gates asking for named male members of staff to come out to see him. When this was reported to managers, a manager went outside to speak to David, but he had left. The people who David wanted to speak to were friends with Maria.

6.5 **David**

6.5.1 The Independent Chair of the review wrote to David, inviting him to contribute to the review. His prison offender manager gave him the letter and explained it to him. David indicated that he would like the opportunity to contribute to the review. Arrangements were made for the Chair to visit David in prison. However, access to the prison was denied by the governor because the Chair is not a public official. [see appendix A]. A request was made for the probation prison offender manager to ask questions on behalf of the DHR panel. This was declined, as the statutory guidance for Domestic Homicide Reviews does not contain reference to interviewing perpetrators in prison. David was contacted in prison by a probation officer and provided with contact details for the Chair of the review, so that he could write or telephone the Chair to make a contribution to the review if he wished to do so. In the meantime the decision not to allow the Chair to visit David in prison was challenged by the Community Safety Partnership.

6.5.2 Whilst the challenge against the prison governor's decision was ongoing, David was able to use his permitted telephone contact with people outside the prison to telephone the Chair on several occasions. Each telephone call was limited to ten minutes in line with prison rules. However, over the span of the calls the Chair was able to speak to David to the extent that a visit to see him in prison was no longer required. David's contribution is referenced appropriately throughout the review. David's comments have not been challenged and are his views alone.

6.6 **Housing**

6.6.1 The Chair of the review wrote to the private sector landlord from whom Maria rented the flat in which Maria and David lived, seeking their contribution to the review. No reply was received.

7 Contributors to the Review / Agencies Submitting IMRs[1]

7.1.1	**Agency**	**Contribution**
	Merseyside Police	IMR
	NHS Cheshire and Merseyside Integrated Care Board	IMR

[1] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Maria and/or the perpetrator.

Mersey Care NHS Foundation Trust	Chronology
St Helens Borough Council Adult Social Care	Brief information
St Helens and Knowsley Teaching Hospital NHS Trust (now known as Mersey and West Lancashire Teaching Hospital NHS Trust)	Chronology
Probation Service	IMR
Safe2Speak	IMR
The National Centre for Domestic Violence (NCDV)[2]	Chronology
Merseyside Fire and Rescue Service	Chronology
Crown Prosecution Service	IMR

7.1.2 In addition to the IMRs, each agency provided a chronology of interaction with Maria and the perpetrator, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of Maria or the perpetrator, nor had any involvement in the provision of services to them.

7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Maria and the perpetrator; and any other action taken.

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

[2] https://www.ncdv.org.uk/

7.1.5 The IMRs in this case focussed on the issues facing Maria. Further elaboration by IMR authors during panel meetings, was invaluable. They were quality assured by the original author, the respective agency, and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.2 Information About Agencies Contributing to the Review

7.2.1 Merseyside Police

Merseyside Police is the territorial police force responsible for law enforcement across the boroughs of Merseyside: Wirral, Sefton, Knowsley, St Helens, and the city of Liverpool. It serves a population of around 1.5 million people, covering an area of 647 square kilometres. Each area has a combination of community policing teams, response teams, and criminal investigation units.

7.2.2 NHS Cheshire and Merseyside

NHS Cheshire and Merseyside – an Integrated Care Board – holds responsibility for planning NHS services, including primary care, community pharmacy, and those previously planned by clinical commissioning groups.

7.2.3 Mersey Care NHS Foundation Trust

The Trust provides specialist inpatient and community services that support mental health, learning disabilities, addictions, brain injuries, and physical health in the community.

7.2.4 St Helens Borough Council Adult Social Care

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils, and providers of services to make sure that people who need care and support have the choice, flexibility, and control to live their lives as they wish.

7.2.5 St Helens and Knowsley Teaching Hospitals NHS Foundation Trust

The Trust provides acute and community healthcare services at St Helens and Whiston Hospitals: both of which are modern, high quality facilities. Community Intermediate Care services are delivered from Newton Community Hospital in Newton-le-Willows. The Trust also provides the urgent treatment centre, operating from the Millennium Centre, which is in the centre of St Helens.

Alongside these community and secondary care services, the Trust also provides primary care services from the Marshalls Cross Medical Centre, which is situated inside St Helens Hospital. In addition, all St Helens community services were transferred to the Trust in April 2020.

7.2.6 North West Ambulance Service

NWAS serves more than seven million people across approximately 5,400 square miles – the communities of Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire, and Glossop (Derbyshire). They receive approximately 1.3 million 999 calls and respond to over a million emergency incidents each year. NWAS makes 1.5 million patient transport journeys every year for those who require non-emergency transport to and from healthcare appointments. NWAS delivers the NHS 111 service across the region for people who need medical help or advice: handling more than 1.5 million calls every year.

7.2.8 Safe2Speak

Safe2Speak offers support to any resident of St Helens who is a victim of domestic abuse, whatever their living situation.

The service is free, confidential, supportive, informative, non-judgmental, and available to anyone experiencing domestic abuse of any kind: sexual, physical, emotional, economic, psychological.

Since 2011, Safe2Speak has been co-ordinating and delivering domestic abuse services. In that time, the service has received over 4,000 referrals, providing each and every victim with a safe place to speak and access to the right support for their needs.

7.2.9 Crown Prosecution Service

The Crown Prosecution Service (CPS) prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales. The CPS is independent, and they make their decisions independently of the police and Government.

7.2.10 The Probation Service

The Probation Service is a statutory criminal justice service that supervises offenders released into the community, while protecting the public. It is responsible for sentence management in both England and Wales, along with accredited programmes, unpaid work, and structured interventions. The Probation Service's priority is to protect the public by the effective rehabilitation of offenders,

by reducing the causes that contribute to offending and enabling people on probation to turn their lives around.

8 The Review Panel Members

8.1	Ged McManus	Chair and Author
	Carol Ellwood-Clarke	Support to Chair and Author
	Leanne Hobin	Detective Chief Inspector, Merseyside Police
	Jane Arrowsmith	St Helens Borough Council. Community Safety Team Manager
	Sarah Platt	Operational Manager, St Helens & Knowsley Probation
	Francesca Smith	St Helens Borough Council. Head of Safeguarding Adults
	Lindsay McAllister	NHS Cheshire and Merseyside. Designated Nurse Safeguarding Adults
	Hanna Roslund	Mersey Care NHS Foundation Trust. Named Professional Safeguarding Adults
	Lisa Forshaw	St Helens & Knowsley Teaching Hospitals NHS Trust. Named Nurse Safeguarding Children
	Donna Birch	St Helens Borough Council. Housing Options & Advice Team Manager
	Martine McLear	Change Grow Live (CGL). Quality Lead
	Anna Lock	Safe2Speak. Domestic Abuse Service Team Leader
	Sharon Hymes	St Helens Borough Council. Legal Adviser to the panel

Bev Jonkers	St Helens Borough Council. Community Safety Team
Aksha Shahid	Deputy Chief Crown Prosecutor, Crown Prosecution Service

8.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author was the same person.

9.2 Ged McManus was chosen as the DHR Independent Chair and wrote the report. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside or an adjoining authority).

9.3 Carol Ellwood-Clarke supported the Independent Chair. She retired from public service (British policing), during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[3].

9.4 Both practitioners served for over 30 years in different police services (not Merseyside) in England. Neither of them has previously worked for any agency involved in this review.

9.5 Between them, they have undertaken over 60 reviews, including the following: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking

[3] https://safelives.org.uk/

DHRs. They have also completed accredited training for DHR Chairs, provided by AAFDA.[4]

10 Parallel Reviews

10.1 The coroner opened an inquest after Maria's murder. The inquest was closed without a hearing, following David's conviction for murder.

10.2 The Probation Service completed a Serious Further Offence Review. That review was not seen by the DHR panel but was used to produce the Probation Service IMR. The panel was assured that all relevant aspects of the SFOR were covered in the IMR. There are no other parallel reviews in this case.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the

[4] Advocacy After Fatal Domestic Abuse

need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].

- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'I faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
  (a) P has a physical or mental impairment, and
  (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 Maria was a white British female. She was heterosexual and was involved in a relationship with the perpetrator, David. The couple lived together and were not married.

11.3 Maria had limited contact with agencies involved in the review and did not have a significant medical history. She had consulted her GP for anxiety and depression between 2015 – 16 and again for a short time in 2019. In June 2022, Maria complained to her GP of stress at home and was recommended to refrain from work for a week.

11.4 Following a report of domestic abuse, the police submitted a referral to Adult Social Care, as Maria mentioned being depressed. Adult Social Care did not identify any care and support needs.

11.5 David is a white British male. He is heterosexual and was involved in a relationship with Maria. David has a child to a previous partner; however, it is believed that contact, if any, was limited.

11.6 Probation Service records indicate that David may have served in the armed forces and stated that he had a diagnosis of post-traumatic stress disorder. This cannot be confirmed because the review did not have access to his medical information.

11.7 David stated to the Probation Service that he was a cocaine user but that his use was not problematic.

11.8 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Use of illicit drugs is not, therefore, covered by the Act.

11.9 No agency has any information to suggest that Maria or David were disabled within the meaning of the Act.

11.10 The panel did not identify any of the protected characteristics which inhibited Maria or David from seeking help or inhibited the provision of services.

11.11 The panel thought it appropriate to include information on disparities in the way that women are affected by domestic abuse. Domestic homicide and domestic abuse predominantly affect women – with women making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. According to the Office for National

Statistics homicide report 2021/22[5], there were 134 domestic homicides in the year ending March 2022.

Of the 134 domestic homicides, 78 victims were killed by a partner or ex-partner, 40 were killed by a parent, son or daughter, and 16 were killed by another family member.

Almost half (46%) of adult female homicide victims were killed in a domestic homicide (84). Of the 84 female victims, 81 were killed by a male suspect.

Males were much less likely to be the victim of a domestic homicide, with only 11% (50) of male homicides being domestic related in the latest year.

12 Dissemination

12.1 Home Office
St Helens Community Safety Partnership
Merseyside Police and Crime Commissioner
Domestic Abuse Commissioner
All agencies contributing to this review
Maria's family

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, and material gathered by the police during their investigation following Maria's death. The information is presented in this section without comment. Analysis appears at section 14 of the report.

Risk Assessments – Contextual Note

Merseyside Police assessed each incident using the Merseyside Risk Identification Toolkit, or (MeRIT), on the VPRF1. It consists of 40 questions designed to assess the extent to which the relationship has broken down, a brief social assessment, and a violence assessment. The answers inform a score that is graded bronze, silver, or gold accordingly. The results are conveyed to the MASH (Multi Agency Safeguarding Hub) via the VPRF1, and to the custody officer in cases where there

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

has been an arrest. If urgent measures are needed, the matter is escalated to the senior officer on duty. In every case, a secondary risk assessment is undertaken at the police Vulnerable Persons Referral Unit, where assessors correct any obvious errors and gather additional information; thus, providing an opportunity for the grade to be adjusted, according to professional judgement. The final grade informs the appropriate level of intervention and determines the necessary referrals.

Not all agencies in Merseyside use MeRIT. Some health agencies use the DASH risk assessment.

13.1 **Relevant History Prior to the Timeframe of the Review**

13.1.1 David was convicted for offences of violence against other men in St Helens in 1997, 1999, and again in London in 2001.

13.1.2 In 2009, Maria reported domestic abuse to the police when she was strangled by her then partner of two years. This resulted in the partner being recalled to prison and serving a concurrent sentence for the assault on Maria. This ended the relationship. The incident was risk assessed as silver.

13.1.3 In 2015, Maria reported domestic abuse to the police when she stated that her then partner had pushed her onto a bed and refused to let her out of the property. When located by the police, she stated that this was not the fact and that it was a verbal argument only: no complaint was made. The incident was risk assessed as bronze.

13.1.4 Maria was treated by her GP for anxiety and depression between 2015 and 2016.

13.1.5 In 2017, David attended at a local hospital, having taken an intentional overdose. He was seen by a mental health liaison practitioner from Mersey Care. He attributed the overdose to relationship difficulties with his partner [not Maria]. He stated that he had binged on alcohol and cocaine over the past month and had a debt of £12,000. It was documented that David was preoccupied with his own low mood whilst his partner was dealing with other difficulties in her family. David said that he had fleeting suicidal ideation in response to his partner not taking his low mood issues seriously, which caused arguments.

13.1.6 In 2018, David attended at a local hospital and was assessed by the Mersey Care Mental Health Liaison Service. David said that he had attempted to hang himself. Cocaine and alcohol binges remained a problem, and he reported that he had been dependent on cocaine for the past two years: using the substance on a near daily basis. David described having very poor finances – at this point, in excess of

£25,000 debt – and was unable to make payments. He also reported that his partner was planning on leaving him.

13.1.7 On 28 June 2018, David received a prison sentence of four years for being concerned in the evasion of prohibition/restriction on import imposed by s.3(1) of Misuse of Drugs Act 1971 – Class A drug. David was stopped by Border Force officers at Heathrow Airport on his way back into the UK from Brazil, and following a search of his bag, it was found to contain a large quantity of cocaine. David's offending was assessed as not crossing the serious harm threshold, and he was managed as a low Risk of Serious Harm (RoSH) case. This offence was linked to David's own substance misuse, which is described in earlier assessments as 'heavy cocaine use'. He claimed to have become involved in the offence in order to pay off a debt.

13.1.8 Maria was treated by her GP for anxiety and depression in 2019. The cause is not known.

13.2 **Events within the Timeframe of Review**

13.2.1 On 27 May 2020, David was released from prison on licence and was supervised by the Probation Service.

13.2.2 David told the chair that he and Maria had met in June 2020, when they both attended an outdoor garden party. They quickly formed a relationship and decided to live together. David told the Chair of the review that as he had credit difficulties due to being in prison, Maria rented the flat in her sole name. David contributed by paying all the bills which were in his name. David told the Chair of the review that he and Maria had a good lifestyle. David said they enjoyed a nice home together and had enough money for nice clothes and a busy social life.

13.2.3 On 15 May 2021, David attended the local urgent treatment centre. David said that he had injected steroids into his upper arm four days ago and it had now become red, hot, swollen, and painful. David was given advice but declined to wait for treatment.

13.2.4 In approximately August 2021, Maria and David met friends of Maria in a local pub. Whilst David was at the toilet, Maria confided that David had hit her. Friend 1 went into the toilet and confronted David about the assault on Maria. Friend 1 told the police after Maria's murder that David admitted to assaulting Maria and said that he "didn't mean it".

13.2.5 On 4 January 2022, Maria was issued with a fit note[6] [not fit for work] due to a foot injury. She subsequently complained of pain in her knee following a fall over Christmas. This was treated and resolved by March 2022. Maria took time off from work as a result of the injury.

13.2.6 On 30 May 2022, David's period of supervision by the Probation Service expired: this was following his prison sentence for the drug offence.

13.2.7 On 16 June 2022, David contacted his manager at work. He stated that he could not come to work. The manager arranged for David to take a rest day rather than be shown as absent. After this, David did not respond to any communication and did not attend work again. David told the Chair of the review that this absence was as a result of a crisis in his relationship with Maria after she found out that he had been unfaithful with another woman.

13.2.8 On 29 June 2022, Maria had a telephone consultation with a GP. Maria complained of stress at home, of feeling anxious, and that she had been off work. She requested a fit note for one week, which was issued. The GP states that Maria did not give any reason for the cause of stress and was given the opportunity to disclose. This is not documented.

13.2.9 At the beginning of July 2022, David contacted his manager to ask for his job back. Due to the nature of his unexpected absence previously, and that the role had been filled, this was declined.

13.2.10 On 8 July 2022, a neighbour (living in the same block of apartments as Maria and David) called the police to report a domestic incident between Maria and David. The neighbour said that they had heard arguing in the past. On police attendance, Maria and David were spoken to separately. David disclosed that he had been unfaithful, and the couple had argued about it. Maria said that David had punched her to the face, although there was no injury. Maria did not provide a statement, and David was removed from the apartment to prevent a further breach of the peace.

13.2.11 Less than an hour later, David returned to the address. Neighbours again called the police. On police attendance, David assaulted the attending officers. He was arrested for assaulting a police officer. A VPRF1, including a MeRIT risk assessment, was completed: this was graded as bronze. This was later upgraded to silver on review, due to the allegation of assault. A referral to Safe2Speak was

[6] https://www.gov.uk/government/collections/fit-note

made. It was recorded on police systems that a referral to NCDV had been made. However, due to an individual error, the referral was not made.

13.2.12 On 9 July 2022, whilst in police custody, David was seen by a Mersey Care mental health practitioner [Criminal Justice Liaison]. David declined an assessment of needs but confirmed that he was not experiencing any mental health issues at that time and that he had no thoughts of harming himself. David displayed capacity and understood the reason for arrest. David was released under investigation regarding the assault on a police officer. There were delays in processing the matter due to evidential issues, and the matter was not resolved before Maria's murder.

13.2.13 On 11 July 2022, Safe2Speak [IDVA[7] service] received a referral for Maria from the police.

13.2.14 On 12 July 2022, Safe2Speak telephoned Maria and received no reply.

13.2.15 On 18 July 2022, Safe2Speak telephoned Maria. A man answered the call before passing the telephone to Maria. The staff member explained who they were and why they were calling. They asked whether Maria would like a call at a different time, which Maria stated: "would be better yes".
Subsequently, Maria did not answer further calls. It was deemed unsafe to send a letter. Enquiries were made with other agencies, but no agency was in contact with Maria. On 2 August, a decision was made to close the case.

13.2.16 On 13 August 2022, Maria called the police to report that David was smashing her door down. Due to the commotion and not wanting to upset her neighbours, Maria allowed David into the apartment whereupon he stole cash and a bankcard and poured vodka over her head, threatening to set fire to her. David left the premises prior to police arrival. Officers spoke with Maria, and she detailed a history of abuse that had been ongoing for some time. She told the officers that she was in pain and believed that this was from suspected broken ribs after a previous assault. Maria's pain was evident to attending officers. Maria had bruising to her body, which she showed the officers, and she provided a statement. The statement detailed her fear in reporting these incidents and the fear that she held that David would kill her at some point. She stated that she would send photographs of her injuries to the police and detailed how they were in places that were not public view, so that no suspicions were raised. A VPRF1, including a MeRIT risk

[7] Independent Domestic Violence Advocates (IDVAs) are specialists who are SafeLives accredited. IDVAs provide high-risk victims of domestic abuse with a tailored and person-centered safety and support plan so that victims and their families are protected from abusive behaviour.

assessment, was completed: this was graded as silver. The assessment was later upgraded to gold on review. A referral was sent to the NCDV.

13.2.17 On 14 August 2022, Maria contacted the police to report that David was at her apartment with an iron bar and was banging on the door. David left before police arrival but was located nearby and arrested. David was interviewed, and a file was referred to the Crown Prosecution Service for a charging decision.

13.2.18 At 00.51 on 15 August 2022, Crown Prosecution Service Direct[8] reviewed the case and authorised charges of common assault by beating, theft, and criminal damage (in respect of the incident on 13 August 2022), and a further offence of criminal damage to the front door on the 14 August 2022.

Whilst charges were authorised, the lawyer set a case action plan asking the police to obtain further evidence regarding the previous incident from July 2022: referred to by Maria in her witness statement and injuries noted by the police officers who attended the scene.

The lawyer also advised the police to seek the views of Maria regarding a restraining order and requested a draft order.

13.2.19 David was charged with assault, criminal damage, and theft. He was kept in police detention and would appear at the next available court. Referrals were sent to Safe2Speak and MARAC. A Treat As Urgent (TAU) flag was placed on the police computer system to ensure that any further calls from Maria were prioritised.

The case was scheduled to be heard at MARAC on 9 September 2022.

13.2.20 On 15 August 2022, David appeared at Liverpool Magistrates Court when he pleaded guilty to, and was convicted of, the following offences:

Section 39 [common] assault on 13.8.22.
Criminal damage on 13.8.22.
Theft on 13.8.22.
Criminal damage on 14.8.22.

David was sentenced to a community order for 18 months, with the following requirements:

[8] CPSD are a virtual team that provide charging decisions on priority cases. Many of the cases they advise upon are 'out of hours,' which usually means the police or other law enforcement agencies require an urgent charging decision. They deal with cases from across the country, 24 hours a day, 365 days a year.

Building Better Relationships Programme – 31 sessions.

Rehabilitation Activity – David to comply with any instructions of the responsible officer to attend appointments (with the responsible officer or someone else nominated by them), or to participate in any activity as required by the responsible officer, up to a maximum of 10 Days.

Exclusion – not to enter for a period (a named area around Maria's apartment). Period of exclusion: 28 Days. End date of exclusion: 12/09/2022.

Unpaid work – 80 hours.

Given the speed of proceedings, no information had been supplied by the police in response to the case action plan, either in respect of the additional incident in July or the terms of any restraining order.

13.2.21 On 15 August 2022, Safe2Speak received a referral from the police for Maria. A Safe2Speak worker contacted Maria the same day. Initial safety planning was completed, and an appointment was booked with an IDVA for 23 August 2022.

13.2.22 On 15 August 2022, NCDV called Maria; she answered on the third call. Maria provided initial information about her circumstances, which was enough to assure NCDV that the threshold for an application for a non-molestation order was met. Maria did not reply to further contact after this. A message was left and NCDV sent a letter to her. No reply was received.

13.2.23 After the case was concluded at court on 15 August 2022, Maria was contacted by a police witness care officer the same day, and she was updated regarding the court outcome. The record of that conversation states:

Maria updated re outcome. Letter to go out. It looks like the prosecution did not ask for a restraining order although an exclusion order has been imposed to keep the deft out of Maria's road for the next 28 days. However, while Maria does not mind being in spoken or written contact with the deft (as his ex-partner is dying), Maria would like the exclusion order to be extended to more than 28 days and if possible to prevent the deft from both entering [name of street redacted] in [name of area redacted] and ideally keeping out of [name of area redacted] altogether.

13.2.24 On 16 August 2022, Adult Social Care reviewed the VPRF1 that had been sent to them by the police following the incident on 14 August. No care and support needs were identified, and the report was filed.

13.2.25 On 16 August 2022, David attended an induction appointment with the Probation Service. He was visibly upset during the appointment and said that his son's mother was terminally ill. During the appointment, Maria contacted him by phone.

13.2.26 On 17 August 2022, Merseyside Fire and Rescue Service visited Maria and carried out fire safety and target hardening work.

13.2.27 On 17 August 2022, NCDV made an information request to Merseyside Police for the details of David – to assist with a restraining order. Unfortunately, the only known address details supplied were those of the flat shared with Maria.

13.2.28 On 20 August 2022 (in a lengthy exchange of text messages), Maria told Friend 1 that David had been assaulting her since May, had broken her ribs, and given her black eyes. Also, that David had been arrested on 15 August. Maria said that David had been OK until his period of supervision by the Probation Service ended, and that he had lost his job at about the same time. Maria told Friend 1 that David had told her that he was going to "call the Albanians" and "order a gun".

13.2.29 On 23 August 2022, an IDVA telephoned Maria as planned. The call was not answered.

13.2.30 On 23 August 2022, David did not attend a probation appointment but made contact: the appointment was rearranged for 26 August. David attended the appointment on 26 August, but the content of the meeting was not recorded.

13.2.31 On 25 August 2022, Maria told Friend 2 (in an exchange of text messages) that David had been hitting her since May and had broken her ribs on one occasion. [note: there is no available medical evidence to confirm these injuries.]

13.2.32 On 26 August 2022, an IDVA telephoned Maria. The call was not answered.

13.2.33 On 26 August 2022, David attended a probation appointment. David said that he was still of no fixed abode and was sofa surfing. He claimed to be going to Housing Options. [there is no record of him doing this]. He was also signposted to a local homelessness charity. [there is no record of him contacting the charity].

David stated that he had no contact with his family because they had all turned their backs on him due to being on probation. He had no update regarding the health of the mother of his child.

David stated that Maria had been phoning him and wanted to get back together after the exclusion ended in September. David was advised that this was not ideal. He was reminded of the exclusion and that he was not allowed to attend Maria's flat. David was also told that he must complete the Building Better Relationships Programme. David was told that the police had placed a 'Treat as Urgent' marker against Maria's flat. David said that he was aware of that and if they got back together, Maria wished for the 'Treat as Urgent' marker to remain.

David stated that he regretted laying hands on Maria and became tearful. David said that Maria was an alcoholic and they needed to stop drinking together if it was ever going to work.

David said that he went back on cocaine by accident on a night out with friends. He didn't like the person it made him, and he hadn't taken cocaine for several weeks.

David was given a further appointment for 2 September 2022.
The panel is aware that some of these comments, which are taken from contemporaneous records, are victim blaming, and the panel does not endorse them. However, the panel made the decision to include the comments because they judged the comments to be indicative of David's attitude. They were also included to highlight David's minimisation of his own conduct and his transference of blame onto Maria – even after his conviction for assaulting her.

13.2.34 On Saturday 28 August 2022, a neighbour who knew Maria and David, and was aware of previous domestic incidents between them, saw them sitting together in a park near to Maria's apartment. They appeared to be getting on. This information was only reported to the police after Maria's murder.

13.2.35 Police enquiries after Maria's murder, suggest that Maria and David spent the next few days together at Maria's apartment. During that time, David formed a suspicion that Maria had been unfaithful with two men, one of whom he thought of as his best friend.

13.2.36 On a date later in August, neighbours called the police to what was thought to be a domestic incident at Maria's apartment. On police arrival, it was discovered that Maria had been murdered.

14 Analysis

14.1 What indicators of domestic abuse were your agency aware of that could have identified Maria as a victim of domestic abuse, and what was the response?

14.1.1 On 29 June 2022, in a telephone appointment with a GP, Maria requested a fit note [not fit for work] complaining of stress at home and feeling anxious. The note was issued, but Maria did not discuss the reason for the stress. This was a missed opportunity to identify key indicators that Maria was experiencing domestic abuse and discuss the risk of domestic abuse. This is a learning point for primary care [14.11.1]. It is now known that Maria later disclosed to friends that David had been assaulting her since May 2022.

14.1.2 Merseyside Police responded to three incidents of domestic abuse when Maria was a victim of abuse by David: on 8 July, 13 August, and 14 August 2022.

14.1.3 On 8 July 2022, a neighbour reported that an incident was ongoing. Maria said that David had punched her in the face; however, there was no injury. As Maria did not provide a statement, David was removed from the apartment to prevent a breach of the peace. He returned within an hour and was arrested for assaulting a police officer. A MeRIT risk assessment, graded as bronze by the attending officer, was upgraded to silver on a review of the incident.

14.1.4 On this occasion, there was no attempt to explore an evidence-led prosecution. Evidence could have included body worn video of Maria's disclosures, body worn video of David's demeanour, the condition of the apartment, evidence from the 999 call, and evidence from neighbours if they were willing to provide a statement.

14.1.5 The police could have considered applying for a Domestic Violence Protection Notice (DVPN)[9]. The College of Policing[10] states: 'Officers have a duty to take or initiate steps to make a victim as safe as possible. Officers should consider Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) at an early stage following a domestic abuse incident as part of this duty. These notices and orders may be used following a domestic incident to

[9] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

[10] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/

provide short-term protection to the victim when arrest has not been made but positive action is required, or where an arrest has taken place, but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action (NFA), or when the suspect is bailed without conditions. They may also be considered when a case is referred by MARAC'.

14.1.6 A DVPN is designed to give breathing space to victims by granting a temporary respite from their abuser and allowing referral to support services without interference. A DVPN/DVPO can be pursued without the victim's active support, or even against their wishes, if this is considered necessary to protect them from violence or threat of violence. The victim also does not have to attend court, which can help by removing responsibility from the victim for taking action against their abuser. DVPNs and DVPOs are governed by sections 24 to 33 of the Crime and Security Act 2010 (CSA). The victim does not have to be living with the abuser for a DVPN to be issued.

14.1.7 Given that David was in police custody for assaulting a police officer, the service of a DVPN on him would have been a straightforward matter.

14.1.8 Missed opportunities to explore evidence-led prosecutions have been a feature of several other DHRs across Merseyside. As a result of which, Merseyside Police have taken the following action.

14.1.9 As part of the Domestic Abuse Intensification Period 2022, training was provided across the Force via a series of online sessions (also recorded for those unable to attend), in relation to quality investigations, res gestae, and evidence-led prosecutions. The aim of the training was to improve domestic abuse outcomes via the use of evidence-led prosecutions, incorporating the following:

1. Provide clear information as to how officers could strengthen cases where the victim or witness at scenes of domestic incidents, either refuse or are reluctant to support a prosecution or provide a statement.
2. Support officers and staff to investigate domestic abuse incidents 'proactively', with a view to building an evidence-led case and not necessarily relying on the support of the victim, and with ELP to be considered in every case (considering withdrawal could happen at a later date). This includes a presumption to arrest at scene.
3. To change the mindset around dealing with domestic abuse – to understand the impact that this offence type has upon all of those involved, not only the adults involved, but children who are often also present, and discussing the actions that officers can and should take.

The specific slides relating to evidence-led prosecutions, particularly focussing upon res gestae evidence, but also incorporating the hearsay gateway of fear of giving evidence, were further widely distributed, and specific guidance was given to supervisors regarding the expectations of ELP. Note that all officers have not only been reminded to consider evidence-led prosecution at the point when a victim indicates an inability or unwillingness to support an investigation, but also to have this as a consideration from the start of any investigation, in anticipation that a willing and able witness may later withdraw support. Therefore, training was provided in relation to obtaining suitable evidence that could be introduced via res gestae or hearsay gateways and the importance of obtaining such evidence, at an early stage in the investigation, to allow prosecutions to be sought, regardless of whether a victim is assisting.

It was specifically stated in the training:
"It is important to understand that it is a longstanding national policy for the police and CPS to prosecute without victim's support if necessary in appropriate cases. All staff need to see evidence-led prosecution as a realistic option from the moment a report of domestic abuse is made. If a victim doesn't want to support prosecution or expresses a wish that they do not want the suspect brought to justice, this is not a reason for the police to step back but is a reason to be MORE proactive in gathering evidence. 'It needs to be made clear through police action, that it is not the victim's responsibility to bring domestic abusers to justice, but the job of everyone who works within the Criminal Justice System'".

No further recommendation is therefore made on this point.

14.1.10 Following the incident of 8 July 2022, Safe2Speak received a referral for Maria from the police but were unable to contact Maria apart from one brief call on 18 July, when Maria indicated it was best to talk another time. The case was closed after a check with other agencies showed that no other agency was in contact with Maria. Safe2Speak did not check back with the police before closing the case. Had they done so, it may have been possible to arrange a joint visit to ensure the safety of all concerned. In relation to the same incident, the police recorded that a referral had been made to NCDV. In fact, due to an individual error, the referral was not made. This has been addressed as a training issue.

14.1.11 On 13 August 2022, Maria reported a further assault by David, which resulted in police attendance and ultimately a gold or high-risk MeRIT risk assessment. David was not traced on the day but was arrested when he returned to Maria's apartment the following day. David was subsequently charged with appropriate

offences and detained to appear at court the following day, with a request for a remand in custody.

14.1.12 On 15 August 2022, Safe2Speak received a second referral from the police regarding Maria and contacted her the same day, providing initial safety planning advice. A telephone appointment was made with an IDVA for 23 August 2022. Maria did not answer the telephone. Requests were again made for information from other agencies, but no other agency responded positively. No contact was made with the police.

14.1.13 NCDV received a referral from the police on 13 August 2022. This was to potentially assist Maria with an application for a non-molestation order. After an initial phone contact on 15 August 2022, when it was assessed that the case met the threshold for an application for a non-molestation order, NCDV was unable to make contact with Maria again.

14.1.14 Following David's arrest on 14 August 2022, the case was received by the CPS from the police. The safeguarding log provided by the police, indicated that there was one previous incident regarding the parties on 8 July 2022. This was finalised by the police without referral to the CPS: based on the victim withdrawing support. The CPS review of the incidents on 13 and 14 August 2022, references the incident in July and requested further information from the police to consider further charges. This was not provided, as the case concluded when David was sentenced on 15 August 2022. This is further commented on at paragraph 14.2.5.

14.2 **What knowledge did your agency have that indicated David might be a perpetrator of domestic abuse against Maria, and what was the response? Did that knowledge identify any controlling or coercive behaviour by David?**

14.2.1 Within Maria's witness statement taken by the police after the report of assault on 13 August 2022, it states that after she challenged David about suspected infidelity, she went through his phone. This caused him to become enraged, and he assaulted her, continued to assault her, and she was subjected to physical violence and mental abuse on a daily basis after this point. Maria described David assaulting her with such ferocity on one occasion that she thought he broke her ribs. Maria had previously helped to secure David employment at her workplace. She described feeling unable to disclose the abuse to anyone in her workplace for fear it would get back to David. She also described feeling afraid to report the abuse to the police in fear that the assaults would get worse. Maria said David told her that he knew people who would 'take care of her'. In a second witness

statement, she said that David would degrade her and tell her to get tested for sexual diseases, and that she feared he would kill her.

14.2.2 The Probation Service supervised David following his conviction for being concerned in evasion of prohibition/restriction on import imposed by s.3(1) of Misuse of Drugs Act 1971 on 26 June 2018. David's compliance with probation supervision was good and expired on 30 May 2022. During that supervision, there was no suggestion that David posed a risk in relation to domestic abuse.

14.2.3 David appeared at Liverpool Magistrates Court on 15 August 2022, following his arrest and detention for the assault on Maria. The Probation Service was supplied with detailed information in relation to the allegations against David and also the background to them, including 'daily assaults', although there had been only one previous police incident. The Probation Service was also aware that a MeRIT risk assessment graded as silver had been upgraded to gold because the risks to Maria were considered to be high.

14.2.4 The Probation Service used the available information to assess the likelihood of further serious harm caused to Maria by David and how to manage this at:

1) sentencing stage and

2) upon being sentenced.

A Domestic Abuse Perpetrator flag was added to the probation record on 15 August 2022.

On 24 August 2022, using the Offender Assessment System (OASys), David was assessed as posing a medium risk of serious harm to Maria. An assessment of medium risk indicates that there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. The Probation Service pre-sentence report indicated that this 'change in circumstance' may be reuniting with the victim, continuing in the relationship with the other female he is involved with or forming a new relationship. David's attitude was not linked to Risk of Serious Harm (RoSH) within the OASys assessment. Based upon Maria's information, it was a critical area linked to risk that was missed. Sexual jealousy was a factor linked to the initial offence by David's own admission and was also clear within Maria's witness statement. Whilst a feature of David's offending, it did not feature as a thread running throughout the OASys assessment and therefore was not picked up as a critical factor linked to RoSH.

14.2.5 The CPS was provided with the evidence in this case (relating to the incidents of 13 and 14 August 2022). The information provided, included a safeguarding log of an

incident on the 8 July 2022. From the incidents on 13 and 14 August 2022, there is some evidence of controlling behaviour within the statement provided to the CPS by the police. Within this statement, there is reference to Maria being subject to multiple beatings. There are no specific dates of these incidents; however, one incident where she described being beaten and having sore/broken ribs, could be attributed to the incident on the 8 July 2022. The lawyer providing charging advice, requested further information for this to be considered in the future through an action plan when completing the charging advice. This was not provided to the CPS, as the case concluded on 15 August 2022 when David was sentenced. The police did not provide this information on a separate file for consideration to the CPS.

14.2.6 The panel considered whether David had subjected Maria to coercive control. In doing so, the panel referred to the Crown prosecution Service guidance.

14.2.7 The Crown Prosecution Service's policy guidance on coercive control states:[11]

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance

[11] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

Note: This guidance was current at the time of the offending and the start of the review. It has since been updated.

14.2.8 The panel reflected that David had subjected Maria to threats, assaults, and had damaged her property. He had degraded her and told her to get tested for sexually transmitted diseases, when it was he who had been unfaithful. He also attended at her workplace and wanted male friends to come out to see him, which the panel interpreted as an attempt to control who Maria could have as friends. The panel was in no doubt that based on the information now available to it, David had subjected Maria to coercive and controlling behaviour.

14.3 **How did your agency assess the level of risk faced by Maria? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?**

14.3.1 Using the MeRIT risk assessment tool, the police assessed the risk to Maria on two occasions. [see paragraph 13 for detail of the tool]. On the first occasion, an initial risk grading of bronze was upgraded to silver on review. On the second occasion, an initial grading of silver was upgraded to gold on review and a referral to MARAC was made. This provides good evidence that the system of secondary review of domestic abuse risk assessments, employed by Merseyside Police, worked well in this case.

14.3.2 The CPS rely on the risk assessments conducted by the police and do not conduct their own risk assessment. The victim was identified as vulnerable and identified as requiring the CPS enhanced service to victims. When the police referred the case to the CPS, they recorded the risk to Maria as high. Due to this case being charged on the Threshold Test, it can be assumed that the CPS thought this case was serious enough to charge with an incomplete file, thus the risk was thought to be high/significant.

14.3.3 On 15 August 2022, the Probation Service completed a Spousal Assault Risk Assessment (SARA) in relation to the risk that David posed to Maria. This was to assist with the risk assessment and inform the court report. The outcome of this assessment was a medium risk of violence towards partner and low risk of violence towards others. Reuniting with the victim – Maria and/or ongoing contact with 'the neighbour' were identified as potential indicators of risk of serious harm needing to be reviewed.

14.3.4 The SARA was based on David claiming to be single and making a convincing statement about plans to move away from the area. The court also included in the community order, an exclusion from the area around Maria's residence, which was considered to be a protective factor. The Probation Serious Further Offence author felt that this was a protective measure only so long as David's plans did not change, and that too much emphasis was placed on David's assertion that the relationship with Maria was over, and he was committed to moving out of the area. The SFO author felt that there would have been merit in assessing the risk as high initially, in order to test the information that David had given.

14.3.5 A further SARA and OASys assessment were completed on 24 August 2022. The second SARA also indicated a medium risk of violence towards partners [Maria]. This later assessment increased the risk of violence to others from low to medium.

The SFO review highlighted that this assessment was not of sufficient quality and did not use all the available information to hand.

14.3.6 Safe2Speak did not have the opportunity to conduct an independent risk assessment in relation to Maria. A thorough review of the risk faced by Maria was conducted by exploring the MERIT risk assessment (included within the VPRF1), which was referred to the service from the police.

14.3.7 It was understood that when attempting to establish contact with Maria, that David could have been present. Adopting a discreet approach was imperative to ensure that the risk was not escalated, should David have become aware that a domestic abuse support service was attempting to work with Maria for her safety.

14.3.8 When contact was established with Maria, the service endeavoured to capture her voice and experience on the initial call. Maria was asked if she currently felt safe, if she required Refuge as an immediate place of safety, and if she required support with the security of the property. Maria declined Refuge but did accept an appointment with an IDVA for ongoing support. The allocated IDVA's later attempts to contact Maria were unsuccessful.

14.4 **How did your agency respond to any mental health issues, or substance misuse, when engaging with Maria and David?**

14.4.1 GP records for David were unavailable to the review because the records had been transferred to the prison where he is detained, and it was not possible to obtain his consent to access the records which was required by the prison.

14.4.2 Prior to the period under review, David reported taking an overdose in 2017 and an attempt to hang himself in 2018. This information was contained in medical records held by Mersey Care and was not known to other agencies.

14.4.3 During interview with the Probation Service for the purposes of the pre-sentence report, David disclosed that he used alcohol and cocaine at weekends and that he did not consider this problematic.

14.4.4 The Probation Service had information to suggest that David was previously in the military and that he had a diagnosis of PTSD.

14.4.5 Whilst David had previously disclosed historic mental health issues, depression, and anxiety, during the previous period of supervision when on licence [period up to May 2022], those concerns were not current in August 2022. It was noted within a

previous OASys assessment that David stated that he had been diagnosed with post-traumatic stress disorder. This was not picked up in August 2022 and therefore was not carried forward. Whilst David presented as distressed and was recorded to be extremely emotional at the time of his initial appointment with Probation, there was no referral to mental health services. The intention was to explore this further during supervision. It was reasonable to not submit a referral to mental health services at this time, as further information would be needed around this before an action could be taken.

14.4.6 Information from Maria's witness statements and the account of David's behaviour (contained within the Crown Prosecution pack along with the police call out log), indicated to the Probation Service that around May 2022, at the time his last sentence was coming to an end, David began using Class A drugs (including steroids and cocaine) and that this brought about a change in his behaviour. Consideration of a Drug Rehabilitation Requirement or a Primary-Mental Health Treatment Requirement may have added value to David's sentence in August 2022. However, it is acknowledged that during the time frame of being sentenced and the murder of Maria, these interventions would not have had time to have any impact. Substance misuse was not linked to risk of serious harm within the OASys assessment. Based upon a number of different sources, there is evidence that substance misuse was linked to serious violence and abusive behaviours towards Maria. On that basis and in spite of David's claims that his substance misuse was not problematic, it should have been linked to the RoSH he presented.

14.4.7 David disclosed his use of cocaine to health services in 2017 and 2018. In 2018, he was convicted of a drugs trafficking offence said to be linked to his own drugs use. In 2021, he disclosed misuse of steroids. Arising from his conviction for assaulting Maria, David disclosed to the Probation Service that he was using cocaine. David had only two appointments with the Probation Service after his conviction for assaulting Maria. Although it is possible that his drugs issues would have been addressed at a later appointment, good practice would suggest that drugs issues should be addressed at the earliest possible time. The panel has seen no evidence of referral, signposting, or provision of any information on drug and alcohol services within the community.

This is a learning point.

14.4.8 The police sent a referral to Adult Social Care for Maria: after Maria made disclosures to them of suffering anxiety and depression. Adult Social Care did not identify any care and support needs for Maria and therefore simply recorded the information. Alcohol appeared to be a factor in the relationship between Maria and

David from the onset of police involvement, and this was indicated within the VPRF1 referral for partner's information.

14.4.9 Maria sought advice for anxiety and depression in 2015 and then again in 2019: she was offered treatment for this. She further contacted her GP practice in June 2022, requesting a fit note due to stress at home: this was issued. This is a learning point for primary care that has already been discussed at paragraph 14.1.1.

14.4.10 David told the Chair of the review that he and Maria worked hard and enjoyed themselves on their days off. Between them they earned enough money to fund a good lifestyle. The flat they lived in was nicely furnished, they had nice clothes and gym memberships. On their days off work David said that he and Maria had an active social life.

14.4.11 David also said that he attended a gym often and was a long term user of illegal steroids, which he used in order to help improve his physique. In around March 2022, David significantly increased the dose of steroids that he was taking. On reflection he now thinks that taking a higher dose of steroids was a factor in his behaviour towards Maria.

14.5 **What services did your agency provide for Maria and/or David; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?**

14.5.1 One of the CPS' main functions is to decide whether a suspect should be charged with a criminal offence and, if so, what that offence should be. The CPS prosecutor must apply the Code for Crown Prosecutors (the Code)[12] when doing so. It is important that cases can be presented in a clear and simple way. A prosecutor should never proceed with more charges than are necessary. The Code makes clear that prosecutors should select charges which reflect the seriousness and extent of the offending, to give the court adequate powers to sentence and impose appropriate post-conviction orders. The prosecutor must decide, firstly, if there is sufficient evidence to provide a realistic prospect of conviction, and secondly, if so, if it is in the public interest to prosecute. This is called 'the Full Code Test'.

[12] https://www.cps.gov.uk/publication/code-crown-prosecutors

For the Full Code Test to be applied, the police must have finished their investigation and carried out all reasonable lines of enquiry. However, sometimes, the police may not have finished their investigation but feel that the seriousness or circumstances of the case justifies the making of an immediate charging decision, applying the 'Threshold Test'. This can be found at paragraph 5 of the Code.

In this case, the Threshold Test was applied. This is not unusual in cases involving domestic abuse. In this case, the Threshold Test was applied because the police investigation was incomplete, but the police and CPS considered that the following conditions were met:

a) There were reasonable grounds to suspect that David had committed the offences.
b) That further evidence could be obtained within a reasonable period of time, to provide a realistic prospect of conviction.
c) The seriousness of the case justified an immediate charging decision.
d) There were substantial grounds for objecting to bail and it was proper to do so.
e) That it was in the public interest to charge David.

For the Threshold Test to be applied, all five of the above conditions must be met, in any case.

The lawyer considering this case, considered that all five conditions were met, and of note, they considered this case to be a high-risk domestic abuse case. There were grounds to believe that David would commit further offences and interfere with witnesses if released.

14.5.2 The CPS was first referred this case on 14 August 2022 at 22.20 and made an immediate charging decision later that night. The charging decision was timely and proportionate, and David was held in police custody for court the following day, in anticipation of a request for David to be remanded in custody by the court. This decision was based in part on the identified levels of risk.

A review by the police of the handling of the case shows that the file indicated a request for a restraining order but that no conditions were requested. The file was completed late at night, and the potential conditions for a restraining order were not discussed with Maria. This could have been done the following day, had other officers been tasked with speaking to Maria before David's court appearance. It is likely that an assumption that David would be remanded in custody, reduced any urgency in speaking to Maria about the restraining order.

14.5.3 Despite the CPS decision being timely and proportionate, the information supplied by the police to CPS was incomplete. This related to the appropriate requirements for Maria, in support of an application for a restraining order. The CPS should have sought an adjournment of the sentence to another date or for the case to be stood down till later in the day. This would have allowed enquiries to be made for the terms sought for a restraining order and an appropriate application could then have been made by the prosecutor in court.

14.5.4 On 15 August, when David appeared at court, the court requested the preparation of an 'on the day' pre-sentence report, which allows for 90 minutes for the report to be completed. As part of the SFO review, concerns have been raised with regards to the suitability of completing a complex domestic abuse report 'on the day' and the time constraints making it difficult to take account of all information.

PI 04/2016 Pre-Sentence Reports: Guidance on Report Format, stipulates that the Probation Service is tasked with deciding the format of report to be delivered to the court to assist with sentencing. The paper aims to provide practitioners and managers with more clearly defined guidance on pre-sentence report delivery by report format. It is underpinned by and works within current national policy (PI 04/2016 and NPS Operating Model 2017), and it is considered that the overriding principles for decisions on the format of report delivery to court are:
a. That sufficient knowledge is available to the pre-sentence report author and the court on the day of sentence.
b. That the complexity of the risk assessment required is reflected in decisions over when reports are delivered to courts and the format used.

The Probation Service considers that, in hindsight, it may have been wise to request an adjournment to allow more time for completion of the report. The probation officer completing the report, acknowledged that they were under pressure and their reading of some of the information, which was received during the preparation of the report, was not in depth. However, the probation officer stated that having more time would not have changed their risk assessment or sentencing proposal.

14.5.5 The DHR panel thought that it would be helpful if the review was able to understand the District Judge's rationale in dealing with the case. The Chair of the DHR approached His Majesty's Courts and Tribunal Service with a request for information and, as a result, received a written response from the District Judge.

The response is as follows:

"I am sorry to hear about the tragic death of Maria.

I have been asked to assist where I can in a review of the Criminal Justice process concerning the earlier prosecution of David.

I have no independent recollection of the case given the passage of time and the number of matters that have I have seen since.

I have looked at the prosecution papers and the short form Pre-Sentence Report which was prepared on the day. I note the police papers do emphasise risk from David.

You will appreciate that we are encouraged to progress cases and that means moving to sentence where possible. Progress should be taken to mean making correct decisions and is not simply a way of moving things along. In David's case, there were prompt guilty pleas and the availability of a probation officer to interview him and produce a Pre Sentence Report to move to sentence. In those circumstances, there would be no purpose to any longer adjournment of the case. The case had been put back from the morning list for the assessment to take place. I had been in a different court in the morning and took over the afternoon domestic list.

My notes of the court hearing are brief as they don't form a verbatim record of everything that is said.

My notes indicate that the assault was assessed at category B2 on the Sentencing Guidelines issued by the sentencing council. That would have a starting point for sentence of a low community order with a range between a fine and a medium level community order.

The offence was obviously aggravated by its domestic context and the fact there were repeated contacts over a number of days, but the assault was the most serious matter and formed the starting point for the sentence. Factors relevant to sentence would be the Sentencing Guidelines and the content of the Pre Sentence Report which placed David as a Low Risk offender if safeguarding measures were put into place. He had employment and stated he intended to move to Bristol. He had expressed remorse for his actions, which the probation officer took as genuine. His records showed good previous response to supervision.

He was entitled to maximum credit for his guilty plea – affording him an automatic 30% reduction in any penalty.

The underlying causes of his behaviour would be addressed in the community as part of the intensive Building Better Relationships Programme. He had confirmed willingness to co-operate.

My note reads 'No restraining order sought – CPS have no instructions on the file according to the prosecutor.'

As the matter had been put back from the morning, it was the type of enquiry that would ordinarily have been made.

However, to allow the community order to engage and to allow the victim to make any concerns known, I did exclude David from [address redacted] for a period of 28 days. I was conscious that the report indicated he would be moving out of the area in any event. The timescale is similar to what is often requested in Domestic Violence Protection Orders".

14.5.6 The panel also asked about any consideration the District Judge may have given to electronic monitoring, given that sentencing council guidance states:[13]

14.5.7 "The court must impose an electronic monitoring requirement where it makes a community order with a curfew or exclusion requirement save where:[7]

- there is a person (other than the offender) without whose co-operation it will not be practicable to secure the monitoring and that person does not consent;[8] and/or
- electronic monitoring is unavailable and/or impractical;[9] and/or
- in the particular circumstances of the case, it considers it inappropriate to do so.[10]

The court may impose electronic monitoring in all other cases. Electronic monitoring should be used with the primary purpose of promoting and monitoring compliance with other requirements, in circumstances where the punishment of the offender and/or the need to safeguard the public and prevent re-offending are the most important concerns".

[13] https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/imposition-of-community-and-custodial-sentences/#:~:text=The%20court%20must%20impose%20an,or%20exclusion%20requirement%20save%20where%3A&text=there%20is%20a%20person%20(other,not%20consent%3B8%20and%2For

The panel's probation representative advised the panel that, in the circumstances, it was impractical to impose a curfew order because David was of no fixed abode: a curfew order requires a fixed address.

14.5.8 The District Judge responded:

"I don't have any specific notes on the topic of electronic monitoring of the exclusion and, given the passage of time, I don't recall giving it specific consideration or comment on the day

The exclusion was an additional step I took because there was no restraining order and I felt there needed to be creation of space along the same lines that we have when DVPO's are made for 28 days

The fact that the defendant was assessed as low risk and was said to be relocating in the south of England are most likely the factors which meant electronic monitoring would have been inappropriate or impractical as the expectation was that he would leave the area anyway".

14.5.9 The panel was conscious that both the police and CPS acknowledge that an application for a restraining order should have been made. The panel thought that the actions of the District Judge in imposing an exclusion requirement as part of the community order, were reasonable in providing a low-level protective measure for Maria in the absence of an application for a restraining order.

At the conclusion of the review, the report was shared with HMCTS. The District Judge confirmed that they were content for their information to appear in the report.

14.5.10 The details of the sentence were recorded on the Police National Computer. This included details of the exclusion.

14.5.11 The exclusion was made by the court as part of a community order. Community orders are monitored and enforced by the Probation Service. There was no active monitoring of the exclusion by the Probation Service, which is not equipped to conduct that type of active monitoring. If David had been found to be in breach of the exclusion, for example, by a police officer, then the correct action would have been to report that breach to the Probation Service, where enforcement action for breach of the order would have been considered. Although the exclusion requirement as part of the community order was a protective measure for Maria,

breach of the requirement would have resulted in no immediate action to protect or safeguard Maria unless other offences were committed.

14.5.12 David told the Probation Service that he was staying with friends whilst intending to arrange to move out of the area. His exact whereabouts were not known. He was given appropriate information regarding homelessness and housing services. The panel concluded that with the benefit of hindsight, David's lack of established accommodation and his known contact with Maria, were signals that could have provoked more professional curiosity. This could have prompted a reassessment of risk, as the lack of established housing would generally be thought to increase the risk of a perpetrator migrating back to live with a victim. It is now known that David spent time in Maria's apartment and in the local area: these were a breach of the exclusion order.

14.5.13 David told the Chair of the review that he was aware of the requirements of the exclusion made by the court. When he left court, he had nowhere to go. David could not recall being given any advice about accommodation. David stayed with different friends 'sofa surfing' for a few days. This was difficult for his friends as they had children, and it was a significant disruption to their family life. During this time David was in touch with Maria on the telephone regularly and did not consider that they had ever split up. After a few days Maria and David met up and he moved back into Maria's flat. David was aware that his presence at the flat was in breach of the exclusion.

14.5.14 The absence of accommodation for a domestic abuse perpetrator and potential increased risk to the victim, is a learning point that leads to panel recommendation 5.

The learning point around professional curiosity links to wider learning for the Probation Service, shown at paragraph 14.8.3.

14.5.13 Safe2Speak aims to attempt first contact with standard- and medium-risk victims of domestic abuse within 48/72 hours and aims to attempt initial contact with high-risk victims within 24 hours.

14.5.14 When the referral for Maria for the incident on 8 July was received by Safe2Speak on 11 July 2022 (standard risk upgraded to medium risk on professional judgement), the first contact attempt was made within 24 hours. There was some drift between the first contact attempt and the second contact attempt on 18 July. The weekend break (Safe2Speak operate Monday – Friday) and annual leave for the Risk Identification Officer, contributed to the delay. When contact was established on 18 July, Maria was unable to talk: a follow-up contact was booked

in for the next day. This considered the timely way that contact was required to be established, including the context of the call and that a male had been present. When contact wasn't established, wider enquiries were made with partner agencies the same day.

14.5.15 Upon receipt of the further referral received on 15 August, contact was established the same day – within timescales set by the service (24 hours). The initial assessment with an IDVA was booked for 23 August: an eight-day gap. The reasons for that delay are not recorded, but it is known that this period coincided with a period of very heavy demand on IDVA services.

14.5.16 Safe2Speak has since changed the approach to initial contacts for high-risk victims of domestic abuse. To support the demand on the Risk Identification Officer and the ability to process and respond to all referrals in a timely risk-focused way, the IDVAs now complete their own initial contacts with clients that are assigned to them. The aim of this is to ensure that more timely and creative attempts can be made to establish contact with clients. It supports the relationships forged with the client and professional and negates the requirement for the victim to repeat their circumstances to different professionals. No recommendation is therefore made.

14.6 **When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?**

14.6.1 Maria's wishes were considered when reporting the first incident to the police on 8 July 2022. Maria did not wish to make a complaint against David or attend court. This resulted in no action being taken in relation to domestic abuse – when the police could and should have considered an evidence-led prosecution and/or a Domestic Violence Protection Notice. [as set out in Term 1].

14.6.2 Prior to establishing contact with Maria, Safe2Speak reviewed the MERIT risk assessment to inform the approach in attempting to create engagement. Safe2Speak is highly skilled in recognising the stage of change that a victim may be at. The Stages of Change approach provides a framework that helps to understand not only the process involved in making changes, but also the activities individuals can engage in to make self-changes, or to assist others to make changes.

14.6.3 Although limited information was provided in relation to the risks identified with the first referral, the VPRF1 did indicate that Maria was open to a referral to the NCDV to access a non-molestation order. This indicated that Maria was at contemplation/

preparation stage and intent on taking action. The referral also stipulated that Maria and David were ex-partners.

14.6.4 Upon the receipt of the second referral, the information stated that Maria appeared petrified and felt that she was at risk. This informed the decision to contact Maria immediately. Upon establishing contact, immediate safety planning advice and guidance was offered, including the option of Refuge as an immediate place of safety. This was declined; however, Maria was informed that she could make contact with the 24/7 helpline at any time, should this be required. Maria also declined target hardening measures (door brace and a personal safety alarm) but did say that her door was due to be repaired. Maria was informed that she had a 'Treat as Urgent' marker on her property, and the functionality of this was explained. The option to call the police, should she have any further contact with David, was also covered so that Maria was aware of her rights.

14.6.5 The file supplied by the police to the CPS had limited information regarding Maria's views on a restraining order. The relevant boxes were ticked to confirm that a restraining order was sought but no detail regarding the terms required. An action plan was set to determine these, but the information was not supplied by the police, prior to David's sentence, due to the speed of the court proceedings. CPS should have made attempts to obtain the information on the day or sought an adjournment to obtain this information from Maria and ensured an appropriate application was made at court.

14.6.6 A witness care communication was received by the CPS in this case, indicating that Maria was spoken to post sentence. [paragraph 13.2.9]. Maria asked if the exclusion could be extended beyond 28 days. She confirmed that she did not want to stop David from having contact with her, as his ex-partner was dying; however, she did want the period to be extended, and the area extended to the whole of Maria's local area. No response was received from the CPS however by this point the opportunity to seek a restraining order had been missed.

14.7 **Were single and multi-agency policies and procedures, including the MARAC followed? Are the procedures embedded in practice, and were any gaps identified?**

14.7.1 Where gaps in single agency policies are evident, they have been addressed under other Terms of Reference.

14.7.2 The risks to Maria were assessed using the MeRIT risk assessment, and following a review, the risk was considered to be gold. This appropriately generated an immediate referral to MARAC on 14 August 2022.

14.7.3 The process for MARAC in St Helens establishes a cut-off date for referrals two weeks prior to a MARAC meeting. An agenda for the meeting is then sent to agencies one week prior to the meeting.

In Maria's case, the referral to MARAC was made promptly on 14 August. The next MARAC meeting was scheduled for 26 August. This meant that the referral for Maria missed the cut-off date of 11 August for the MARAC meeting of 26 August. The referral was therefore listed for the next available MARAC meeting of 9 September. Sadly, Maria was murdered before then.

The panel heard that the current system allows time for agencies to research cases before attending MARAC meetings, in line with a previous DHR recommendation.

Recommendation – In order to facilitate effective risk assessment, organisations must acknowledge that staff representing them at MARAC meetings, require sufficient time to adequately research cases and individuals before attending the MARAC and afford them that resource.

Action – Implement a system to ensure a minimum of one week's advance notice of cases prior to MARAC meeting via issue of the agenda. MARAC Chair to ask agency representatives if they have been allowed enough time to research MARAC cases and issue an instruction to employing organisation as necessary.

The panel heard that local policy allows for an urgent referral to MARAC. This is used only in the most urgent of cases, and the features of Maria's case did not suggest such urgency.

14.7.4 The panel discussed whether the delay of almost four weeks in hearing a case at MARAC was normal. The panel was informed that due to the volume of gold [high risk] referrals received, that delays such as this were not unusual.
The panel acknowledged the pressures facing MARAC but thought that a delay of almost four weeks in cases being heard was likely to reduce the effectiveness of the process.

14.7.5 The offences David was convicted of, in relation to Maria, did not make him MAPPA eligible. However, had the risk been assessed as high or deemed to have escalated, consideration could have been given as a Category 3 offender – other. Nonetheless, as he was due to be discussed in another multi agency forum

[MARAC], then MAPPA may not have been appropriate.

14.8 **Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Maria and/or David, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.**

14.8.1 The Probation Service SFOR found that the assessment of Risk of Serious Harm upon sentencing was not of an appropriate quality standard and did not take into consideration the fact that David and Maria were still in contact. It is accepted that this assessment was rushed due to the Probation practitioner's pending leave and the absence of quality assurance when countersigning.

14.8.2 In a nationwide report published in July 2023:

'A thematic inspection of work undertaken, and progress made, by the Probation Service to reduce the incidence of domestic abuse and protect victims'.

HM Inspectorate of Probation found that despite some positive developments by the Probation Service to reduce domestic abuse and protect victims, little appears to have improved in practice since its last report in 2018[14].

Its inspection found that 30 per cent of people on probation are current or previous perpetrators of domestic abuse.
It also found that only 28 per cent of those on probation had been sufficiently assessed for any risks of further domestic abuse.

Meanwhile, 45 per cent of the cases examined, should have had access to an intervention but had not.

Only 17 out of the 60 cases looked at by HM Inspectorate for Probation for this report, had a 'sufficiently clear and thorough analysis' of the risk of domestic abuse the person on probation might pose.

The Inspectorate also found that recent changes in legislation, such as the recognition of children affected by domestic abuse as victims in their own right, have not been incorporated into probation practice, and the sharing of information between services – probation, police and social services – was 'inconsistent at best'.

[14] As reported by policeoracle.com 4/7/23

14.8.3 An inspection of probation services in Knowsley and St Helens, published by HM Inspectorate of Probation in June 2023, rated the service as inadequate. The report highlighted a vacancy rate of 22% for probation officer posts.

The report made the following recommendations:

1. improve the quality of work to assess, plan for, manage and review risk of harm
2. ensure information relating to domestic abuse history is obtained promptly and sufficiently analysed to support the management of risk of harm to others
3. ensure information relating to child safeguarding is routinely obtained and used to ensure risks to children are understood and safety arrangements are in place
4. provide the necessary training and learning opportunities to support practitioners to apply professional curiosity
5. ensure managers are providing effective management oversight, focusing on the quality of work relating to risk of harm
6. ensure that the interventions necessary to improve desistance and reduce reoffending and risk of harm are provided in all cases.

The panel noted that areas 1 and 4 were similar to issues highlighted during this DHR, which are subject to single agency recommendations made by the Probation Service. The regional Director of Probation must submit an action plan to HM Chief Inspector of Probation, setting out a response to the recommendations.
The Knowsley and St Helens PDU has put an action plan in place in response to the recent inspection: this has outlined the steps in place to address the recommendations within the recent inspection report. This report will be presented at the 6-month stage to the Chief Officer of Probation, outlining the progress made to date with regards to the recommendations – the main priority is ensuring that information is received from the police to inform risk assessments and that this is carried out in a timely fashion, with delays of 16 weeks not being unusual. Positively, this action has progressed with pace, and further work will be undertaken with staff to ensure that this information is then utilised to devise robust risk management plans.

14.8.4 Safe2speak was not completing cold calls (unannounced visits) when attempts were made to establish contact with Maria. This was following on from a decision made when Covid-19 restrictions were in place. Operationally, there were also resource issues impacting the ability to complete unannounced visits, which would require two members of staff and access to transport. A home visit may have

enabled the team to establish contact, and gain wishes and feelings of the client. However, they would not complete cold calls if information suggested the victim remained in a relationship. The MERIT stipulated the relationship was over, but the male answering, indicated that David could still have been present in Maria's life. This decision is taken so that risk is not escalated for the client and to protect the safety of the caseworker.

Safe2Speak received a high number of referrals over July and August 2022: this will have impacted the ability to follow up with further contact attempts, once the initial contact was attempted within the timescales set. In July 2022, IDVA received 73 new cases, and in August 2022, IDVA received 103 cases. In July 2022, DVO received 90 new cases, and in August 2022, DVO received 73 new cases. Operationally, Safe2Speak had four IDVAs and three Outreach workers responding to clients. The average case load for the IDVAs across July and August was 51. The average case load for DVO across July and August was 62 cases. The Risk Identification Officer had an open case load of 78 clients.

These figures do not include cases that are already open that are re-referred and cases that are referred for information purposes only. The ability for the Risk Identification Officer to respond to these referrals would have been impacted by the high volume of referrals received.

The panel heard that there had been a period of recruitment resulting in new posts of complex case IDVA and court IDVA. A primary care IDVA had been trialled – with the post now being subsumed into general work – with the service being available to primary care as required.

14.8.5 Other agencies did not identify resource issues that had affected the provision of services.

14.9 What knowledge did family, friends, and employers have that Maria was in an abusive relationship, and did they know what to do with that knowledge?

14.9.1 It is known that Maria confided her experiences of domestic abuse to two friends. Their statements to the police, given after Maria's murder, were seen by the DHR. One of them confronted David. A neighbour called the police when they were concerned for Maria's safety.

14.9.2 Unfortunately, Maria's close family do not feel able to contribute to the review, as her murder is still too raw and emotional for them. The panel was therefore unable

to understand their views.

14.9.3 Although colleagues have felt unable to contribute to the review, her managers were aware (through rumours in the work place) that Maria may have suffered domestic abuse from David. The fact that there were rumours, suggests that Maria disclosed domestic abuse or colleagues recognised indicators of domestic abuse.

14.10 Are there any examples of outstanding or innovative practice arising from this review?

14.10.1 No examples of outstanding or innovative practice were identified by agencies. The panel acknowledged that the review and upgrading of the MeRIT risk assessment (on two occasions) was good practice.

14.11 What learning has emerged for your agency?

14.11.1 GP Practice – Maria

Key learning for the practice is that Maria disclosed stress at home during a telephone consultation on the 29/06/22. However, the cause of the stress was not disclosed by Maria during the consultation. This was a missed opportunity to ask Maria about why she was feeling stress at home and the reasons.

14.11.2 Safe2Speak

Safe2Speak now completes cold calls (unannounced visits) when attempts are being made to establish contact with a client. In March 2023, the approach was revised so that cold calls are completed in a timelier and risk-focused way. Previously, cold calls were added to a 'cold call list', and the duty officer would complete with a colleague over two periods in a fortnight, usually a Tuesday and Thursday. This has now been revised, recognising that if the opportunity becomes available and it is safe to do so, the caseworker should endeavour to complete as soon as possible with the support of a colleague to continue to ensure safety.

Safe2Speak is conducting monthly meetings with the police to strengthen partnership working and ensure they have effective links to support clients to the best of their ability. It is recognised that the police could act as a key partner in supporting Safe2Speak with cold call visits. This would ensure safety of the caseworker and would provide Safe2Speak with information that could inform their approach. Safe2Speak is also looking to co-locate at the police station: a case worker would be based there for half a day, once a week.

Safe2Speak reviewed the approach to contacting wider partners and raising a multi-agency resolution should they not get a response. It was also recognised that email is not always the best form of communication for case discussion, and the use of telephone and Microsoft Teams meetings should also be considered. This is upon reflection of agencies who did not respond to email enquiries that were made relating to Maria.

14.11.3 Probation Service

Quality assurance by senior probation officers with regards to the quality of (1) pre-sentence reports and (2) completion of OASys assessments. With regards to the latter, the importance of quality over targets.

The use of professional curiosity.

Sharing areas of concern linked to an increase in risk of serious harm with other agencies, i.e., sharing information with the police and IDVA services that David had resumed contact with Maria. Furthermore, seeking management consultation as an opportunity to develop an appropriate and immediate response to safeguard.

14.11.4 Crown Prosecution Service

The CPS prosecutor correctly requested additional information from the police via an action plan, but when the case was dealt with the next day at court, the prosecutor in court did not make enquires with the police regarding the terms required for a restraining order and period requested by Maria to make an application to protect Maria. An adjournment should have been sought to obtain the relevant information or attempts made on the day to try and obtain the information before the defendant was sentenced. An application should have been made for a restraining order for a minimum of 12 months once the terms required were known to the advocate.

Where communications are sent to the CPS from witness care, these must be considered and responded to accordingly by the CPS. However, in this case, the opportunity to seek a restraining order has passed by the time the witness care communication was received.

14.12 Do the lessons arising from this review appear in other reviews held by the St Helens Community Safety Partnership?

14.12.1 The Community Safety Partnership has identified two previous areas that may be relevant to this review.

2016 Review

Recommendation – Increase the number of companies and businesses making literature available, detailing the support available to victims of domestic abuse and substance misuse.

Action – Working with the Chamber of Commerce to make literature available (for display in employee meeting areas) to businesses in St Helens.

The panel thought that Maria's case showed that further work on this area would be helpful and have made an appropriate recommendation.

2020 Review

Recommendation – Additional accommodation be secured to ensure that victims and perpetrators who are homeless and suffering complex needs are able to be accommodated.

Action – Mapping and identifying gaps in local housing provision.

The panel thought that Maria's case showed that further work on this area would be helpful and have made an appropriate recommendation.

15 Conclusions

15.1 Maria had been the victim of domestic abuse in two relationships prior to meeting David after his release from prison in 2020. David, who had several convictions for violence, although not previously for domestic abuse, was to be her third abuser.

15.2 In August 2021, Maria confided in a friend that David had hit her. This is the first indicator that the DHR has seen that David subjected Maria to domestic abuse. This was not reported to the police or any other agency.

15.3 In May 2022, David's period of supervision by the Probation Service expired, following his conviction for a drug trafficking offence. This may have been the catalyst for an escalation in his behaviour. Maria later described in a statement to the police, how David's use of cocaine and abuse of her escalated when he was no longer supervised by the Probation Service.

15.4 Maria had a number of absences from work that, in hindsight, may have been linked to domestic abuse. Maria asked for a fit note with authority to refrain from

work due to stress at home. This was not followed up by the GP and again, in hindsight, may have been linked to domestic abuse.

15.5 The police response to the first reported instance of domestic abuse (in July 2022) was ineffective in protecting Maria. Although David was arrested for assaulting a police officer, no action was ultimately taken against him, and no protective measures were put in place for Maria. Safe2Speak was unable to effectively engage with Maria.

15.6 When domestic abuse was again reported in August 2022, the initial police response was effective on that occasion. David was arrested, and the police and CPS followed their procedures to ensure that David was charged and kept in police custody, with a view to asking the court for a remand in custody.

15.7 David's immediate guilty plea and the court's ability to deal with the case and sentence him immediately, negated any reason for a remand in custody. Both the police and CPS did not follow established processes to apply for a restraining order. The District Judge, perhaps recognising that deficiency, put in place an exclusion requirement as part of community order to which David was sentenced. Any enforcement of the exclusion requirement would have been problematic because there is no legal power to immediately take action on such a requirement, and the case should have been followed-up by the police and CPS with an application for a restraining order.

15.8 David told the court and Probation Service that he intended to move out of the area. This may have been one reason why there was no focus on where he was living. At probation appointments, David said that he was staying with friends. The DHR panel thought that from the information known to them, it was highly likely that David had moved back to live with Maria within a short time.

15.9 The panel judged that from the information available to it, David had subjected Maria to domestic abuse through assaults and by controlling and coercive behaviour. The fact that after Maria's murder, David went on to stab two men fuelled by his jealousy over his suspicions about Maria's contact with them, gave the DHR panel further confidence that David had subjected Maria to controlling and coercive behaviour.

15.10 The panel regret that little of Maria's voice is heard in the report. Attempts were made to engage with colleagues, friends, and family; however, all attempts were unsuccessful. At the end of the review process, the DHR Chair again contacted

Maria's parents, but they still felt too traumatised to become involved in the review.

16 Learning

This multi-agency learning arises following debate within the DHR panel.

16.1 Narrative

The review identified that people knew that Maria was being abused by the perpetrator. This finding is consistent with many other DHRs. The panel felt that additional publicity is required so that people who know or suspect someone is a victim of domestic abuse, know what they can do and should not do.

Learning

The absence of clear guidance on what members of the public can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring and/or placing the victim in greater danger.

16.2 Narrative

David's use of cocaine and misuse of steroids was known to health and/or Probation Services over several years. There is no evidence in the community of referral or signposting to drugs services.

Learning

Failure to signpost or refer to the available local services, reduces the chances of engagement with those services.

Panel recommendation 2

16.3 Narrative

Maria's managers contributed to the review and shared that there was a lack of information about domestic abuse and reporting within the workplace.

Learning

The availability of information around domestic abuse, reporting, and available support in the workplace, is likely to encourage more reporting.

Panel recommendation 3

16.4 **Narrative**

There was a significant delay in Maria's case reaching a MARAC meeting.

Learning
Prompt consideration of cases and review of risk is likely to lead to enhanced safety for victims.

16.5 **Narrative**
After his appearance at court, David was in effect homeless. He did not engage with Housing Options or a charity to which he was signposted.

Learning
A lack of accommodation for a domestic abuse perpetrator may increase the risk of them gravitating back to the victim and therefore increase the risk to the victim.

17 Recommendations

DHR Panel

17.1.1 The Community Safety Partnership should review the effectiveness of – and if necessary, strengthen – the information provided to family, friends, neighbours, and diverse communities about recognising the signs of domestic abuse and where they can go (anonymously, if necessary) with such information.

17.1.2 Health and Probation Service should provide assurance and evidence to the Community Safety Partnership that their staff are providing signposting information and making referrals to local drug and alcohol services appropriately. This could be tested by an audit of referrals received by those services.

17.1.3 The Community Safety Partnership should work with partners to engage employers in its area in order to ensure that information about domestic abuse, reporting, and the support available, is widely disseminated in work places across St Helens.

Engagement with the Employers Initiative on Domestic Abuse[15] should be considered as part of the process.

17.1.4 The Community Safety Partnership / Domestic Abuse Partnership should work with partners to review current MARAC processes, with a view to shortening the time before cases are considered. This might include benchmarking and establishing best practice amongst other Merseyside and neighbouring authorities.

17.1.5 The Community Safety Partnership should explore the provision of accommodation for domestic abuse perpetrators, which could reduce the risk to victims.

17.1.6 The Home Office should include guidance on seeking a contribution from perpetrators in its pending update of the statutory guidance for Domestic Homicide Reviews.

17.2 Single Agency Recommendations

17.2.1 Probation Service

PP1 develop their SARA practice, to ensure their assessment is appropriately evidenced and includes a view on critical factors.

PP2 to ensure their case recording evidences, professional curiosity and that the CRISS model of recording is used for recording contacts to evidence a focus on effective risk management and intervention.

Assurance is needed that all court SPOs are undertaking Quality assurance activity in accordance with the practice guidance.

17.2.2 Crown Prosecution Service

Area CPS staff to be reminded of the CPS guidance on restraining orders and to be proactive in requesting the terms of the required order from the police at every stage of the case.

Area CPS staff to be reminded that they must respond to witness care communications as part of their duties under the Victims Code.

Feedback to lawyer who presented the case at court and their failure to make enquiries regarding the requirement of a restraining order and subsequent terms.

[15] https://www.eida.org.uk

Feedback to the reviewing lawyer who read the witness care communication and failed to respond to it.

17.2.3 **Primary Care**

Any disclosures of stress at home and feeling anxious to be explored and documented in the patient's care records. Practice staff to ensure professional curiosity and seek clarity on the causes, if domestic abuse is a possible factor.

17.2.4 **Safe2Speak**

Promote and monitor impact of primary care work and embed as standard IDVA work.

Improve links with the police for partnership working.

Develop client-led options for direct contact.

Appendix A

HMP Frankland, Brasside, Durham, DH1 5YD
Governor: Darren Finley
www.hmprisonservice.gov.uk
Tel: 0191 376 5000
Fax: 0191 376 5001

HM Prison & Probation Service

[redacted]

I am responding to the correspondence received into HMP Frankland regarding [redacted]. I am aware of the PSI 16/2011. However, you are not a public official but a private company carrying out and chairing a domestic homicide review on behalf of a public body.

I have attempted to contact St. Helens Borough Council but the number they have provided isn't recognised.

I have taken further advice from our partner agencies and have been advised that this type of review relates to failures of systems. [redacted] is convicted of this offence and all information from him would have been disclosed to the court during his trial.

At this point permission to have a legal visit won't be permitted.

[redacted]

Yours sincerely

Governor A Turpin
Head of Operations

Purpos[redacted]sciplo Pride Pride Moving Forward with Moving Forward

Appendix B Action Plan – Maria DHR – St Helens Community Safety Partnership

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
St Helens Community Safety Partnership							
1	St Helens CSP should review the effectiveness of – and if necessary, strengthen – the information provided to family, friends, neighbours, and diverse communities about recognising the signs of domestic abuse and where they can go (anonymously, if necessary) with such information.	Local	Review of existing publicly available information on existing websites across partnership. Maintain ongoing awareness raising campaigns targeted at family and friends on the issue of	Community Safety Team in partnership with Communications Team	Initial review of website and updated if required Campaign approved and launched	Initial review: May 2024 Campaign: Summer / Autumn 2024	In Progress
2	Health and Probation Service should provide assurance and evidence to the Community Safety Partnership that their staff are providing signposting information and making referrals to local drug and alcohol services appropriately. This could be tested by an audit of referrals received by those services.	Local	CSP to write to representatives from both Health and Probation Services seeking assurance that the actions have been taken. Request for updates on any audits and learning to be presented to future CSP meetings	Community Safety Team in partnership with Health and Probation Services	Initial engagement with Heath and Probation Updates to CSP following audit and learning processes	Letters to be sent to providers as recommended with an Agenda update to the CSP in November 2024.	In Progress

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
3	The Community Safety Partnership should work with partners to engage employers in its area in order to ensure that information about domestic abuse, reporting, and the support available, is widely disseminated in work places across St Helens. Engagement with the Employers Initiative on Domestic Abuse[16] should be considered as part of the process.	Local	Develop a resource pack for employers of posters, awareness materials and links to training available. Exploration with the EIDA and future update to the Domestic Abuse Partnership Board	Community Safety Team, St Helens Council	Resource pack developed Engagement with larger employers in the borough Signposting to resources available Evaluation of potential for EIDA	Summer / Autumn 2024 Ongoing as part of the wider DA communication strategy	As above, to be included in future campaigns during Autumn 2024. No Chamber of Commerce in the borough due to recent closure – alternative source information will be required.
4	The Community Safety Partnership / Domestic Abuse Partnership should work with partners to review current MARAC processes, with a view to shortening the time before cases are considered. This might include benchmarking and establishing best practice amongst other Merseyside and neighbouring authorities.	Local	Learning from other areas / alternative models of delivery Exploration of moving to a weekly MARAC – scoping to be presented to a future meeting of the Domestic Abuse Partnership Board	MARAC Steering Group to report to Domestic Abuse Partnership Board	Scoping of alternative models Review of evidence and recommendations to Board	By October 2024	In progress. Day of MARAC has been amended to accommodate partner views and feedback – March 2024 - Completed DAPB has received an update from Wirral Council re: daily MARAC process – March 2024 MARAC process is in review across the Merseyside area.

[16] https://www.eida.org.uk

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
5	The Community Safety Partnership should explore the provision of accommodation for domestic abuse perpetrators, which could reduce the risk to victims.	Local	Housing Options Service to be provide an update on pathways to respond to perpetrators upon release from prison	Housing Services	Consideration for review of existing referral pathways and housing information provided on release from prison. Update to be provided to September meeting of the Domestic Abuse Partnership Board	September 2024	In Progress. Update on Prison Release Protocols to be presented to the Domestic Abuse Partnership Board in 2024.
6	The Home Office should include guidance on seeking a contribution from perpetrators in its pending update of the statutory guidance for Domestic Homicide Reviews.	National	Action to be highlighted within the submission of this report.			N/A	Draft Statutory Guidance consultation has now concluded.
Single Agency Recommendations							
Probation Service							
1	PP1 develop their SARA practice, to ensure their assessment is appropriately evidenced and includes a view on critical factors.	Local	PP1 to undertake refresher training through My Learning in order to develop her SARA practice.	Probation	SPO1 to dip sample 1 case per month for 3 months to confirm that they are satisfied that PP1's SARA practice is of the expected standard. This is to be noted in PP1's supervision notes and any concerns raised during the audit to be addressed in reflective supervision.	March 2023	Progress update sought. June 2025

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
2	PP2 to ensure their case recording evidences, professional curiosity and that the CRISS model of recording is used for recording contacts to evidence a focus on effective risk management and intervention.	Local	PP2 to familiarise themselves with the resource on professional curiosity and the effective recording practice presentation.	Probation	SPO3 to dip sample 3 cases per month for 3 months to confirm that they are satisfied with professional curiosity and case recording practice of PP2 and/or identify any ongoing activity required.	April 2023	Progress update sought. June 2025
3	Assurance is needed that all Court SPOs are undertaking quality assurance activity in accordance with the practice guidance.	Local	The Deputy Head of North West Courts (DHC) to communicate with all Court SPOs with line management responsibilities of the expectations around quality assurance of Pre-Sentence Reports and accompanying risk assessments. DHC to provide staff with any relevant documents, such as the AQA.	Probation	DHC to report to the Head of North West Courts, when this activity has been undertaken.	January 2023	Progress update sought. June 2025
Crown Prosecution Service							
1	Area CPS staff to be reminded of the CPS guidance on restraining orders and to be proactive in requesting the terms of the required order from the police at every stage of the case.	Local	Briefing to be shared with lawyers and advocates	Crown Prosecution Service	Updated communications have been sent out to all reviewing lawyers and advocates on the Magistrates Court Unit.		Completed – December 2023

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome	
					Advocates have also been asked to ensure that any application made for a restraining order is adequately recorded on the hearing record sheet, including full details recorded of the reasons given for by the court for granting/refusing the application. Dip sampling will be done by the unit's domestic abuse lead.			
2	Area CPS staff to be reminded that they must respond to witness care communications as part of their duties under the Victims Code.	Local	Briefing to be shared with lawyers	Crown Prosecution Service	This message has been communicated to all lawyers.		Completed December 2023	
3	Feedback to lawyer who presented the case at court and their failure to make enquiries regarding the requirement of a restraining order and subsequent terms.	Local	Direct contact with reviewing lawyer	Crown Prosecution Service	This action is now complete and individual feedback has been given to the reviewing lawyer and the advocate who dealt with the case.		Completed – December 2023	
4	Feedback to the reviewing lawyer who read the witness care communication and failed to respond to it.	Local	Direct contact with reviewing lawyer	Crown Prosecution Service	This action is now complete and individual feedback has been given to the advocate who		Completed – December 2023	

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					dealt with the case.		
Primary Care							
1	Any disclosures of stress at home and feeling anxious to be explored and documented in the patient's care records. Practice staff to ensure professional curiosity and seek clarity on the causes, if domestic abuse is a possible factor.		Comms with all practice staff. Posters on domestic abuse placed in the practice to encourage patients to seek support.		Evidence of comms to practice staff. Domestic abuse awareness poster to be placed in patient areas in the practice.	30/4/23	Improved professional curiosity regarding disclosures of stress and anxiety to determine the cause 30/4/23
Safe2Speak							
1	Promote and monitor impact of primary care work and embed as standard IDVA work.		Training events for the CCG. Regular briefings to primary care services.		Training events for the CCG. Regular briefings to primary care services.	To be reviewed Aug 2023	Confirmed as completed 6 June 2025
2	Improve links with the police for partnership working.		Co-location at the police station. Link in with the police to complete cold calls and home visits.		Co-location at the police station. Link in with the police to complete cold calls and home visits.	Aug 2023	Confirmed as completed 6 June 2025

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
			Monthly meetings with the police and Safe2Speak.		Monthly meetings with the police and Safe2Speak.		
3	Develop client-led options for direct contact		Consultation with staff. Consultation with clients. Liaise with Health and Safety team (Torus).		Arrange dates and identify cohort of clients to consult.	Aug 2023	Confirmed as completed 6 June 2025

End of overview report