

Domestic Homicide Review

The AB Case

Overview Report

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Section 1:

Introduction

1.1 Commissioning the Review

This review was commissioned on 25th August 2011 by Rob Tinlin the Chief Executive of Southend on Sea Borough Council in his capacity as Chairperson of the Southend Community Safety Partnership. It followed the death of AB on 24th July 2011, for which YZ was subsequently convicted of murder.

The threshold for the commissioning of a Serious Case Review in respect of the involvement of children in this case was not deemed to be met. As AB and YZ had previously been in an intimate relationship, a Domestic Homicide Review was instigated, to be undertaken under the auspices of the Southend Community Safety Partnership.

1.2 Agency Contact

It was known that AB had considerable contact with Southend agencies, including Essex Police, Southend Borough Council, Victim Support and others, in respect of domestic abuse carried out by YZ. AB had been in an intimate relationship with YZ, but this had been ended by AB by the time of her death.

1.3 Contributory Processes

In addition to Individual Management Reviews produced by individual partner agencies as listed in S 1.8 of this report, other reports included for consideration in this review were the Independent Police Complaints Commission investigation which looked primarily into the Essex Police response on the day of AB's murder, and the Serious Incident Report undertaken by South Essex Partnership University NHS Foundation Trust.

1.4 Status and Purpose of the Review

The primary purpose of this Review is to determine whether there are any lessons to be learned in terms of how agencies worked together, and to make improvements in services.

Home Office Guidance identifies the following points as the purpose of a Domestic Homicide Review;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In addition, Home Office Guidance states that:

- DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate.
- DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.
- The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.
- The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

In this case, despite the fact that due to the murder trial it was not possible to complete the Review until the end of 2012, the panel proceeded to identify any immediate learning and recommendations, and to make recommendations about these to the Community Safety Partnership at the earliest opportunity, through the mechanism of an Interim Overview Report, then by completing the review when the trial was complete and the remaining information could be made available.

1.5 Legal framework for the Review

This review has been conducted under Section 9 of the Domestic Violence, Crime and

Victims Act 2004, which came into force on 13th April 2011, inter alia:

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

- a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship;

or

- a member of the same household as himself/herself

1.6 Subjects of the Review

The subjects of this review are AB, DOB 11th March 1964, and YZ, DOB 30th May 1968. AB died on 24th July 2011.

1.7 Chairperson of the Review

Christine Doorly, an Independent Consultant, was appointed to conduct this Review, and to produce the Overview Report. Christine is an experienced professional with a lengthy career in Social Care Management and in the Regulation of Care Services. More recently Christine has been Independent Chair of Southend Local Safeguarding Children Board and Southend Safeguarding Vulnerable Adults Board, as well as holding other such positions elsewhere.

Christine has a degree in Sociology, professional Social Work and Teaching qualifications, and management qualifications which include a Master of Business Administration (MBA).

Christine has overseen a number of Serious Case Reviews in her capacity as Independent Chair, and has undertaken both the e-learning training modules provided by the Home office for the purpose of undertaking Domestic Homicide Reviews, and the training previously provided by the Government Office of Eastern England for Overview Report Authors.

1.8 The Review Panel

The Review commenced with the appointment of a suitable Panel to advise and support the process. The Panel consisted of the following agencies and their representatives:

a) Representing agencies involved in the case:

Southend Borough Council Children's Specialist Services
Southend Borough Council Adult and Community Services
Southend University Hospital NHS Foundation Trust
Essex Police
Southend Borough Council Housing Services
Essex Probation
Victim Support
South Essex Partnership University NHS Foundation Trust

NHS South East Essex Primary Care Trust (now the South Essex PCT Cluster)
Representatives from Her Majesty's Courts and Tribunal Service and the Crown
Prosecution Service

b) Co-opted as experts to the panel:

South Essex Homes
Southend Drug and Alcohol Action Team
Southend Domestic abuse Partnership Manager
Southend Community Safety Partnership Manager

Representatives from Her Majesty's Courts and Tribunal Service and the Crown
Prosecution service.

1.9 The Terms of Reference for the Review

This Panel determined the Terms of Reference for the Review as follows:

- Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or a perpetrator? Was it reasonable to expect them, given their level of training or knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for DASH (Domestic abuse, Stalking and Harassment and Honour Based Violence) risk assessment, and risk management for domestic violence victims or perpetrators, and were these assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC (Multi-Agency Risk Assessment Conference)?
- Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
- What were the key points for opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were there appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options /choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about the perpetrator? For example were they

being managed under MAPPA (Multi Agency Public Protection Arrangements, which exist to manage the threat to the public from high risk offenders)?

- Had the victim disclosed to anyone, and if so was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions which may be appropriate which could add to the content of the case? For example was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were services to the victim and the perpetrator?
- To what degree could the homicide have been accurately and predicted and prevented?

The panel also identified the following issues as of particular concerns in this case, and requested that Individual Management Reviews address these areas:

- How the alarm, and Sanctuary Scheme modifications to the victim's home, were used.
- How the criminal history of the perpetrator and the impact of the justice system and decision affected the outcome for the victim and alleged perpetrator.
- The impact of the MARAC process on the outcomes for the alleged perpetrator and all significant other persons.
- Analysis of each agency's involvement with the victim and alleged perpetrator should be undertaken with particular reference to the agencies policies and procedures and the agency context to their involvement.

- When considering the risk that the alleged perpetrator presented to other partners, did agencies consider the potential risk to the victim?
- The impact of any substance misuse by the alleged perpetrator, victim, or other significant persons.

1.10 Time Period Covered by the Review

With reference to the victim and alleged perpetrator, agencies were asked to supply any information related to any contact with both, where the Individual Management Review (IMR) author felt the information would possibly relate to the identification of vulnerability issues; and to provide detailed information and analysis about all contacts from 1st January 2008.

With reference to any other associated persons or events, agencies were asked to supply relevant information regarding contacts or events since 1st January 2008, where the IMR author felt the information would possibly relate to the identification of vulnerability issues, and to provide detailed information and analysis regarding any contacts since 1st January 2011.

IMR authors were asked to include details and analysis of any relevant significant events or incidents which occurred outside of these time periods, but which are relevant to the case.

1.11 The Review Process

The process adopted by the Panel followed the draft Essex Protocol for the conduct of a Domestic Homicide Review, and the Home Office Statutory Guidance on Domestic Homicide Reviews, on which the above is based. As this is a new process, it was also agreed that the Review would identify any opportunities to make recommendations which would lead to future improvements in conducting a Review.

1.12 Producing the Individual Management Reviews

All the agencies which had involvement in this case were asked to produce an Individual Management Review (IMR) as defined in the Terms of Reference, these IMRs to be written in an objective manner by an appropriate professional who has had no active involvement in the case under consideration. Fourteen IMRs were produced in total, from the following agencies:

Essex Police
 Essex Probation
 Southend Borough Council Children and Learning Department
 Southend Borough Council Adult and Community Services
 Southend Borough Council Housing Service
 Victim Support
 Southend University Hospital NHS Foundation Trust
 South Essex Partnership University NHS Foundation Trust
 NHS South East Essex Primary Care Trust
 Multi Agency Risk Assessment Conference (undertaken by the Southend Domestic Abuse

Partnership Manager)

South East Essex Community Health Care (now delivered by South Essex Partnership University NHS Foundation Trust, previously delivered by NHS South East Essex Primary Care Trust delivery arm)

Crown Prosecution Service (after the trial)

SERCO

Each of these IMRs were undertaken with a range of suitable methods, including staff interviews as appropriate, analysis of paperwork and case records, and evaluation of the organisation's policy and procedural documentation and other material factors. They made reference to local and national policy where appropriate, and contained analysis and conclusions, with recommendations mainly of a single agency nature. All of the IMRs were deemed by the overview report writer to be of an acceptable standard. In addition, as previously mentioned, the IPCC report and the SEPT Serious Incident report were also reviewed. Her Majesty's Courts and Tribunal Service (HMCTS) have not provided an IMR but have provided input and comment at appropriate stages and a representative has attended the review meetings.

In addition, these reports contained a chronology of all the agency's contact with the two parties to the review, and these single agency chronologies were assembled into a combined chronology for the purposes of the producing the Overview Report.

1.14 Other inputs to the Review

In addition to the fourteen IMRs which the panel considered, there was also a very helpful meeting held by the Chairperson of the Review with the family of the victim, which was organised by the Essex Police Family Liaison Officer, at which it was possible to gain a much increased insight into the concerns and perspectives of AB and her family.

(Redacted paragraph)

The Chairperson also considered relevant research and other study findings, drawing on the expertise and input made available on the advice of the Domestic abuse Partnership Manager. Reference is made to local and national information about domestic abuse and various policy matters at appropriate points in the report.

Section 2:

Short summary of what happened

It is believed that AB began an intimate relationship with YZ sometime in mid 2010, although they had already known each other for about eight years. Both AB and YZ were of a white ethnic background and had other family members in the locality of Southend.

At this time, AB, aged 46, had three children from her marriage to DE, whose ages were approximately 19, 16 and 12 years old. AB's two older children had left home, and her youngest child stayed part of the time with AB, and part of the time with his father. The children did not like YZ and kept away from the house when he was visiting. They were part of a large and supportive extended family which included DE, AB's husband. Both

AB's and (redacted) were in Southend.

YZ, aged 42, had three children from his 22 year marriage to (redacted).

YZ and AB never lived together, and it is not clear at times where YZ was in fact living.

YZ had a considerable history of criminality. Between 1986 and 2011 he had acquired a total of 79 convictions, including one in 2008 which involved an offensive weapon, five offences against persons, and four offences against court, police and prison staff. He also had a history of mental health and substance misuse needs, and was known to those services.

By the beginning of 2011, AB began to report concerns to Essex Police about YZ. In January 2011 the first such report was made, that AB was concerned as YZ had threatened that he was waiting outside her home to "sort her out". The Police attended this incident and noted that AB had two black eyes which she did not at this time want to make a report about. However she told the Police that she had been in a relationship with YZ, that she had ended the relationship, and he had made a threat against her. This incident was correctly assessed as High Risk due to the black eyes which AB was seen to have received, and as a result, a referral was automatically made to the Multi Agency Risk Assessment Conference (MARAC), which works across agencies in Southend to reduce risks from in domestic abuse, and which meets on a monthly basis. A notification was also made to Southend Borough Council Children's Specialist Services, as appropriate, via the DV1 form, which is completed for all domestic incidents by Essex Police, which is also used to identify risks to children and young people.

Following this, as 2011 continued, there were a number of further incidents involving YZ which were reported to, and attended by, the Police. These included further assaults on AB, criminal damage in respect of her property, and assaults on both a Police Officer and a neighbour (redacted). There was an incident of YZ causing a disturbance at (redacted) and driving away in an uninsured car whilst drunk.

There were other incidents of YZ creating a disturbance, and a report of an assault made (redacted). In addition it became known to the Police that AB was being subjected to a very high degree of harassment and stalking behaviour by YZ, which included phone texting, many mobile phone calls, and his frequent presence in the vicinity of her home. It was known that AB had taken to sitting in the dark with the curtains drawn to avoid YZ discovering she was at home.

The Police were very concerned for AB's safety, and as well as the referrals to the MARAC, there was a lot of effort made to engage AB with victim support services, and through the offices of the Independent Domestic Violence Adviser (IDVA), to try and encourage AB to both make a witness statement against YZ, and to take steps to secure her property from an intrusion by him.

It is clear from the records reviewed in this case that AB was very fearful of the consequences of making a statement against YZ. In addition her father had died in early 2011 and she was in a low and depressed state. As the number and intensity of threats and attacks on her increased, she did take steps to secure her property and to have an Essex Police alarm fitted, and she did provide a witness statement to the Police, to be

used in court on 23rd March 2011. Unfortunately when the date of the hearing arrived AB was not strong enough to give the statement, and the case was deferred.

Various stages of the other cases involving YZ were also heard in court during the first half of 2011, and a range of disposals and sentences ensued in respect of him. In respect of any sentencing which involved fines or costs being awarded against YZ, it has emerged in the course of this Review that YZ did not pay these, nor did he complete the unpaid work orders attached to these sentences.

There were issues in respect of some of these court appearances which meant that Probation Pre-Sentence Reports were not considered by the Court, and one consequence of this was that a full risk assessment of YZ was not completed by Essex Probation during this period.

For a period of time in 2011, between 20th May and 22nd June 2011, YZ was refused bail, and was remanded in custody in respect of some of the charges pending against him. However by 22nd June 2011 his defence team were able to make a case for bail, and he was released from custody with numerous charges pending, subject to bail conditions which included not using a mobile phone, not going near AB's home and other areas, and not contacting prosecution witnesses. He was also subject to a 6pm to 6am curfew to be enforced by electronic tag.

Despite appearing to breach bail conditions on this, and other, occasions, it appears that YZ was re bailed to addresses within the local community, on the same, or similar, conditions. These addresses included (redacted), and it is clear from the records that at times (redacted) were not happy to have YZ at their home due to his ongoing behaviour, but also that they were, at times, fearful of the consequences of formally reporting this behaviour.

Throughout 2011, discussions were held at three MARAC meetings in respect of YZ and AB and at one (different) MARAC meeting in respect of YZ and (redacted). AB had, by the time she died on 24th July 2011, installed a panic alarm at her home, which had also undergone security improvements to strengthen it from intrusion, and she had provided a witness statement to the Police in respect of YZ's harassment towards her.

On 24th July 2011, YZ, who was known to have openly made threats to (redacted), that he intended to kill AB, entered her home, and attacked her using a kitchen knife. He had earlier that day been seen in the vicinity of her home, and AB had reported this to the Police, who had scheduled a follow up response to this incident which had not been carried out before the time of her death in the early evening. This matter of the Police response was the subject of a separate Independent Police Complaints Commission (IPCC) enquiry.

At the time of her death, YZ still had outstanding against him a number of the cases which were still pending. He had apparently breached his bail conditions repeatedly but was still in the community, and subject to those conditions. Although AB had taken steps to improve her security, sadly these had proved inadequate in the circumstances.

Section 3:

Chronology of Key Events, with Overview Writer Commentary

This is a chronology of the key events which occurred, complete with comments from the overview report writer where it is felt that there is any particular significance to the event, or it poses a question about inter agency working. The chronology is drawn from the content of the fourteen Individual Management Reviews, the IPCC report, the SUHFHT Serious Incident report, and comments provided by HMCTS in assisting the understanding of the court processes.

7.10.2007 :

(redacted)

19.1.2008 :

YZ commits an offence of possession of an offensive weapon.

31.01.2008 :

It is noted by Southend Borough Council that YZ has moved back into the family home with (redacted)

2.2.2008 :

(redacted)

12.02.2008 :

(redacted)

25.4.2008 :

YZ appears at Basildon Crown Court in respect of the 19.1.2008 offence and pleads guilty to possession of an offensive weapon, and is remanded on Bail. At this time it is noted that YZ has a full time job as a grounds worker.

27.5.2008 :

The Probation Pre Sentencing Report outlines that YZ has issues with alcohol, anger, worrying, depression, but there is no mention of domestic abuse.

28.5.2008 :

YZ appears at Basildon Crown Court, regarding the offence of possession of an offensive weapon from 19.1.2008.

Heavy drinking on the part of YZ is noted in the Probation Pre-Sentence Report. Previous convictions, including violent offences, are also noted in respect of YZ.

YZ is sentenced to a 12 month Community Order with 12 months supervision. An Alcohol Treatment Requirement is the Pre-Sentencing Report proposal, and becomes a component of the Community Order. £400 costs are awarded against YZ.

The Probation IMR author notes that an Alcohol Treatment Requirement may not have been suitable as the available evidence suggests YZ was more of a binge drinker. Alcohol Treatment Requirements are, therefore, not now used in these circumstances.

The Community order ends on 28.5.2009 without completion of the Alcohol Treatment Order or repayment of the fines.

29.7.2008 :

The initial sentence plan on YZ is completed. Information on file suggests that YZ and (redacted) are at (redacted) home and (redacted)

YZ relates that he witnessed domestic abuse whilst growing up between his parents and that at one stage he and his mother were in a women's refuge. YZ is assessed as Medium Risk of Harm to the public. This Risk of Harm Assessment comes out of the Probation Offender Assessment System (OASys), an assessment tool used nationally to provide a consistent assessment of an offender's risk of harm, and the likelihood of their reoffending.

ORW comment: witnessing/experiencing domestic abuse as a child is known to be risk factor in domestic abuse as an adult.

29.1.2009 :

YZ commences alcohol treatment with the provider of this service at this time. He is seen weekly by the counsellor for three consecutive weeks. This is seven months into the commencement of the order of which the Alcohol Treatment Requirement is a part.

ORW comment: alcohol is also a known factor in domestic abuse.

17.2.2009 :

YZ is seen by the Essex Probation Offender Manager who identifies that YZ never took full responsibility for his offending behaviour, and that YZ could be threatening on occasion.

ORW comment: another risk factor, in that YZ identified as not fully taking responsibility for his actions.

18.2.2009 :

YZ is discharged from alcohol counselling. The Counsellor reports that counselling was exacerbating YZ's anger, and that YZ fails to see he has a problem with alcohol. The Probation Offender Manager supports the retraction of the Alcohol Treatment Requirement by writing to the Court, requesting that it be removed as part of the Community Order. It is

noted that YZ is angry with himself. There is reference to YZ having angry outbursts, but these specific incidents are not recorded on the files.

ORW comment: yet more indications of risk in that YZ is seen as not taking responsibility for his actions and fails to see he has issues with alcohol. He has not completed all the requirements of the Order. There are issues of the recording of YZ's outbursts not being clear, which would have better identified risk factors. YZ does not appear to comply with any of the requirements of the Order, yet there is no apparent sanction.

16.3.2009 :

The Probation log records YZ is agitated and aggressive and verbally abusive on a routine Probation visit.

ORW comment: a firm record of YZ's aggressive behaviour.

15.4.2009 :

The termination of YZ from the Essex Probation Offender Assessment System, before the actual end of the order. The termination meets Probation national standards and takes place before the end of the Order so that progress can be discussed.

27.5.2009 :

The actual termination date of the previous Community Order in respect of YZ.

1.8.2009 :

Essex Police receive a 999 call from (redacted). (Redacted) states YZ is at an address in Southend. States that YZ is drunk on the premises and has hit someone, and that he "does it all the time". It is reported that YZ punched (redacted) in the face (redacted). (Redacted) had then intervened, and YZ had pulled the door off its hinges and driven away in a car which he was uninsured to drive.

Police Officers attend the scene and YZ is later apprehended. A DV1 is completed and the risk assessed as Moderate (now called Medium). YZ is charged with driving offences, and is committed to South East Essex Magistrates Court (Southend) for 5.10.2009 in respect of these. The assault charges are later dropped.

10.8.2009 :

(Redacted) retracts statement in respect of the assault (redacted).

ORW comment: (redacted)

24.8.2009 :

GP notes outline that YZ drinking approx 105 units of alcohol a week. No action noted in respect of this.

11.9.2009 :

YZ attended Community Drug and Alcohol Service, requesting help with alcohol misuse. Given a prescription for home detoxification a key worker for 1:1 support.

ORW comment: most likely this was as a result of the GP visit as above. The GP recording is noted to be a little limited. There is concern that although the GP referred YZ to the Community Drug and Alcohol Service, the GP was not linked to the MARAC, information about YZ was not shared with other agencies, and the referral process was too informal.

29.9.2009 :

YZ completes a Home Detoxification programme in respect of his alcohol use, and counselling sessions, and is discharged from Community Drug and Alcohol Services, with ongoing GP prescribing if helpful or required.

5.10.2009 :

YZ appears at South East Essex Magistrates Court (Southend). The two assault offences arising from incident on 1.8.2009 are not proceeded with. The Police IMR author notes this is probably because the complaint was retracted. YZ is sentenced to a Conditional Discharge for 12 months for criminal damage to the property, and fined £200 with £60 costs for driving without insurance. The conditional discharge ends 1 year later, on 5.10.2010, without these fines being paid.

ORW comment: (redacted) retracts her statement,(redacted).

Information subsequently supplied by Her Majesty's Courts and Tribunals Service (HMCTS) states that this date was the listed trial hearing for the assault offences. Neither of the aggrieved parties who were the key prosecution witnesses were present at Court. Although the CPS had previously secured witness summons to gain their attendance, enforcement of such a summons would have needed a very heavy handed approach towards gaining the witness evidence, as it would have required the court to push for contempt of court. The witnesses had retracted their statements and would not support the prosecution. It is believed that that the prosecution did not secure witness warrants and instead offered no evidence on the two offences of beating and assault, this cannot be verified as CPS files relating to this matter have been destroyed in line with policy. However securing witness summons for a first offence would have been very onerous for the witnesses and was not likely to have been thought appropriate. The Court had therefore no option but to dismiss charges. The criminal damage and insurance charges were sentenced as above. It seems that there was insufficient thought given to other forms of evidence to secure a conviction.

There was therefore, possibly a missed opportunity to secure convictions here. However this would have required witness warrants to secure the necessary evidence from YZ's victim, and was not felt to be appropriate.

16.3.2010 :

The Primary Care Trust IMR refers to a letter from Community Drug and Alcohol Service to YZ's GP, identifying that YZ has relapsed and has been drinking to excess every day for the last four weeks. A home detoxification is suggested with a relapse prevention group and prescription.

16.8.2010 :

(Redacted)

ORW comment: (redacted)

12.11.2010 :

YZ attends Southend Hospital Accident and Emergency with back and abdominal pains. He reports having stopped drinking suddenly, having been drinking to excess for the last six months following the split with (redacted).

ORW comment: there should have been a referral to the Community Drug and Alcohol Service (CDAS) at this point, given the level of reported drinking. Liaison services subsequently put in place at the hospital would now result in a CDAS referral.

7.1.2011 :

The Police receive a telephone call from AB who reports she has received a telephone call from YZ to the effect that he is waiting at her house to "sort her out". The Police attend her home and note that AB has two black eyes. AB tells the Police that she received these last week but doesn't know how. AB agrees to call the Police if YZ appears.

The events are recorded on the Police system and a DV1 is completed in respect of the incident, which is assessed as High Risk, following which the specialist Essex Police Domestic abuse Liaison Officer is to be involved.

AB is recorded as very concerned about whether YZ would be told she had given the Police this information.

A High Risk assessment identifies that there is deemed to be a serious risk of harm in the current circumstances. It also ensures that there is an automatic referral to the Multi Agency Risk Assessment Conference (MARAC).

The Essex MARAC which covers the Southend area is held on a monthly basis and discusses all High Risk domestic abuse cases. The objective of the MARAC is to reduce risk for the victim and to share information across all agencies in order to understand the whole picture for the victim and their family. This conference is chaired by Essex Police and attended by representatives of the local agencies including the Police and the Local Authority.

A High Risk MARAC assessment is the threshold at which agencies understand that they

are enabled to share information about a person, or someone who poses a risk, because the legal threshold for multi agency information sharing has been reached.

ORW comment: this is an appropriate risk assessment from the Police in respect of this incident. AB's concerns about YZ being told of her report indicate her level of fear about his behaviour in response to knowing this.

7.1.2011 :

Southend Borough Council Children's Specialist Services records on its Care First system the DV1 information with no further action required. DV1 shows a child in the family and as having been spoken to by the Police.

ORW comment: this is standard practice within the risk management and assessment system, given that no risk to children is identified.

8.1.2011 :

The Police IMR outlines that the incident is followed up by a telephone call by the Domestic Abuse Liaison Officer (DALO), a specialist role within the Police to support the management of domestic abuse victims, and AB reports that there is stalking and harassment by YZ, and that he has stopped her seeing her children because they blame him for the breakup of her marriage.

She reports that YZ calls her a lot, that YZ wants her to commit to him, and to be available at certain times, but he does not make the same commitment. She says that YZ is an alcoholic. AB has ended the relationship which was of eight months duration. It was noted that AB was withdrawn and low during this telephone conversation. Some safety aspects were discussed, including her front door and its side panels, and AB said she wanted to take action to secure these.

Although a referral is made to the MARAC (see above), AB is not informed of this.

ORW comment: not letting AB know about the MARAC referral could in some cases be appropriate, as, if the perpetrator finds out, it may increase the victim's risk. Good practice would however be that, wherever possible, a referral should be discussed and agreed with the victim, as this may help them to understand the degree of risk being perceived by professionals, and enable the MARAC to gain a clearer understanding of the victim's perspective and wishes.

If the victim is not told about the referral they cannot input into the process their wishes about what could be done to protect them, so these then become inferred from other interactions, rather than coming directly from the person themselves.

The information provided by AB in her telephone call regarding YZ's behaviour towards her children and herself, and the stalking and harassment, shows controlling behaviour by YZ and also that the relationship has ended, which is a major risk factor in escalating domestic abuse by perpetrators.

9.1.2011 :

AB makes a 999 call to the Police to the effect that YZ is in her house, and she wants him removed. AB states that he is her boyfriend, they have had an argument, and her husband has turned up. The Police attend, but the immediate situation has resolved itself by AB's husband removing YZ from the property. A DV1 is completed and the situation is assessed as Standard Risk. The duplicate DV1 reviewed on the file (the original had been lost) does not show any children. No offences are considered to have occurred by the Police.

ORW comment: the Police IMR author identified that it was not acceptable that this incident was graded as Standard Risk in the light of previous incidents and knowledge, but this is explained by the IMR author as being caused by the existence of a backlog of DV1 incidents to be entered onto the police system, and hence the incident of two days previous may not have been on the system. This is one of the important issues highlighted by the review – the importance of all relevant information being on files and in records in a timely manner. This becomes critical later when the rate of YZ's offending increases and there are gaps in information due to records not being updated immediately.

If it had been on the system, its presence there would have automatically upgraded this notification to the same risk level, namely High. Therefore this new information was entered without reference to the previous incident record. A backlog had grown up within Essex Police at this time, which was subsequently cleared. The Police IMR author has identified that all DV1s are now entered on the same day, although for the period of the backlog this was not the case.

12.1.2011 :

An Independent Domestic Violence Advisor (IDVA) referral is made by the Police to Victim Support, categorised as High Risk. The IDVA service is an arm of Victim Support which is funded especially for domestic abuse work, and the IDVA's role is to support victims and offer links to a range of services which exist locally. In many areas the IDVA receives referrals for every case referred to the MARAC. In Essex however there is insufficient IDVA capacity to allow for this.

The IDVA makes three unsuccessful attempts to contact AB by phone.

ORW comment: the IDVA continued to make significant attempts to contact AB following this referral, showing good practice and persistence in her efforts.

26.1.2011 :

The IDVA sends AB a letter outlining what support she can access. No response was received.

8.2.2011 :

The IDVA gets another phone number for AB from the Police and makes successful contact with her. AB declines the services offered.

ORW comment: the IDVA should have undertaken a risk assessment in this case

and this has been addressed in the Victim Support IMR. However, it would not have made any difference in this instance, as the risk was already known.

It continues to be good practice that the IDVA was persistent.

17.2.2011 :

The Multi-Agency Risk Assessment Conference (MARAC) meets and discusses AB and YZ for the first time. 26 Southend cases were discussed this day. This referral was triggered by the incident of 7.1.2011.

The 9.1.2011 incident is not discussed, although the minutes show that the Police may have updated the MARAC on this.

Actions arising out of the MARAC discussion include: Connexions to see if support can be offered to AB's youngest child, who still lives at home with her some of the time. It is subsequently (after the meeting) decided by Connexions that he is not eligible for the service identified because of his age (over 13 years). This was not followed by Connexions the MARAC Team or other MARAC partner agencies, to see if other, more appropriate services were available.

The provision of additional security to AB's home is discussed but was refused by AB as she says that her landlord is her employer and she wishes not to have him know of the situation, and AB did not feel the extra security was required.

There are no actions required for Southend Borough Council Children's Specialist Services in respect of her son, and a MARAC flag is added to the Southend Hospital records in line with their Domestic abuse Protocol which commenced in March 2011. The MARAC flag is also added to the Essex Probation Case Recording and Management System (CRAMS) on 17.2.2011.

ORW comment: this would seem an appropriate list of supportive actions arising from the specific menu of risk reduction actions which the MARAC has at its disposal.

With regard to the MARAC itself, there is an issue about the length of meetings and the number of cases being heard, which is very high. It leads to the question of whether every case can be given due consideration, or whether the process becomes limited by the pressure of time.

There is an issue about representation at the MARAC from South East Essex Community Health Care Services, who did not have a representative on the MARAC at this time. They could have been one of the agencies who could have supported him, for example through the school nursing service. There were at this time some health services which were not represented at the MARAC, and this matter is addressed in the discussion and recommendations.

Finally it is of note that at the MARAC the risk minimisation approach towards AB focussed primarily on AB herself, and did not discuss how management of YZ (for example, within / through the criminal justice system) could have been part of

minimising the risk for AB.

These matters aside, it can be seen that the MARAC did operate positively in terms of identifying the security aspects of AB's home. There is however a question as to whether the MARAC discussion and actions were explicitly expected to lower the risk to YZ.

26.2.2011 :

There were two incidents on this day involving YZ.

The first incident of the day occurs at 6.43am, where records show that AB was visited by YZ at her address, ostensibly to console her on the death of her father, and that he became abusive and there was a verbal altercation, YZ was then asked to leave and refused. The Police attended, and no children were recorded as present. The Police completed a DV1 assessment which was recorded as being initially set at Medium Risk (which assesses the situation as being a serious risk only if a modifiable factor should change) but this was later upgraded to a High Risk assessment by the Police Domestic Abuse Liaison Officer (DALO). No offences were recorded as occurring by the Police.

The second incident occurs at 7.47pm when YZ is at (redacted) and (redacted) returns to find YZ drunk and abusive, shouting at (redacted). The Police were called by (redacted) and (redacted) fled the home with (redacted). YZ assaults a Police Officer and is arrested and is accordingly charged with assault of a Police Officer and with Disorderly Conduct (S5 POA). YZ is unconditionally bailed by Essex Police to appear at court on 9.3.2011 for these offences. Is bailed then and reappears at court on 23.3.2011.

The Police IMR show that no domestic abuse offences are believed to have occurred. The (redacted) and the DV1 shows a risk of Medium. The DV1 shows notification to Southend Borough Council Children's Specialist Services of (redacted).

ORW comment: the upgrading of the DV1 risk assessment was appropriate and shows effective action by the DALO.

HMCTS have advised that Police Custody Officers have the same powers as Court in relation to Bail. Although two offences were committed, of which the assault on a Police Officer was the most serious, this latter offence is still known as a summary only offence, which limits the possibilities of bail or of imposing conditions. The release of YZ on bail to appear at Southend Magistrates Court on 9.3.2011 was therefore deemed to be reasonable in relation to these offences.

27.2.2011 :

The DALO follows up the previous day's incident by phoning AB who advises that she is now prepared to report that the previously noted two black eyes were received from YZ: she describes him as having knocked over her son's motorbike and then spat in her face, then threw a glass of water at her face. AB is advised by the Police DALO that this constitutes assault. AB says she doesn't understand domestic abuse – she has been in a 20 year relationship with no experience of it.

AB described to the DALO how she sits in the dark because then YZ will not know she is in the house. She parks her car around the corner for the same reason. YZ is calling and texting a lot since the recent incident, some of these are abusive. AB is advised to keep a log of the harassment and to report ongoing issues. AB is referred to the Sanctuary Scheme, with a view to protecting her whilst in her home, and there is discussion about security improvements to her house. The Sanctuary Scheme is led by Southend Borough Council Housing Department and is designed to assist victims of domestic abuse who are at risk from perpetrators to make their home safer, primarily in order to prevent the need for them to leave for their own safety and therefore become homeless. There is a range of options available within the Southend Sanctuary Scheme, including the provision of a safe room within the house, and security arrangements to the property, such as locks, bolts, window reinforcement etc. She also reports that she is concerned that YZ knows how to enter her house through a window.

AB is referred to the MARAC for the second time, and it seems AB may have been advised of this on this occasion. The Police then e-mail MARAC partners and advise them of the new information regarding the black eyes incident. High Risk remains the assessment of the situation. AB also advises that her father has recently died and she is low in mood and is "all over the place".

In respect of the DV1, again there is delay caused by the same operational issues already highlighted, of a backlog within the Police in entering these onto the IT system. It was recorded on the DV1 that AB was worried about some comeback from YZ if she co-operated with the Police.

ORW comment: the content of the conversation here seems to reinforce the fact that AB didn't know much about domestic abuse and may at times have lost perspective about the danger she was in from YZ. The adaptive behaviours she had taken to protect herself from YZ indicate a quite extreme degree of interference in her daily life. Her mood being low, being in a bereaved state, she was at risk of failing to take strong enough measures to protect herself.

The question mark over whether AB was informed about the MARAC indicates that consideration of whether this has happened is not formalised. It is important to note clearly whether in fact the victim is aware of the referral and what considerations went into this decision. There is no evidence of discussion about what AB wanted from the MARAC, and how this was conveyed to the MARAC, and its impact on any actions.

The conversation does however show AB becoming more engaged in taking some steps towards protecting herself, but it also shows how strong her fear of YZ's reaction to her reporting his behaviour was, this being a very strong risk factor.

The information about YZ's obsessive behaviour towards AB adds a significant dimension to the risk level he posed when added to his offending pattern. The MARAC focus tended to be on AB and not on YZ. Research material in respect of domestic homicides and men who kill, identifies the type of obsessive and possessive behaviours that YZ displayed as high risk factors in relation to the risk of homicide.

1.3.2011 :

(redacted)

Essex Police records show that a Domestic abuse Liaison Officer reports that she called AB again and reiterated the availability of support groups and the Sanctuary Scheme.

4.3.2011 :

(redacted)

ORW comment: (redacted)

9.3.2011 :

YZ attends Southend Magistrates Court in answer to conditional bail of 26.2.2011. The Court files states that the CPS had no paperwork from the Police and that if there is no paperwork next time the case is likely to be dropped. The case is adjourned without a plea and unconditional bail continues because there is no evidence of a breach of bail.

HMCTS have subsequently advised that it was noted that on 9.3.2011 the CPS had no paperwork from the Police, and that it was reported that the defendant had lost wages of £170 by attending. CPS files have been destroyed in line with policy so it not possible to further verify whether the alleged lack of police paperwork was correct.

14.3.2011 :

AB visits her GP to report stress, and domestic abuse giving rise to a head injury, and some hair loss. AB also reports that her father has died. GP notes show that AB was "reassured" and that blood tests were ordered.

ORW comment: the level of recording here by the GP was low, and the need for advice to be given to GP's regarding more thorough records is picked up in the Primary Care Trust IMR. Once a case is referred to the MARAC the "High Risk" status means that all agencies have permission to share information. It does not appear that the GP was operating within this system and aware of the MARAC process.

15.3.2011 :

A 999 call is made by AB: she reports that YZ has attended her premises and has stolen her mobile phone, and pushed her to the floor, causing her to hit her head. The Police attend, an ambulance is called, and AB is taken to Southend Hospital Accident and Emergency.

During the course of AB's treatment at the hospital, domestic abuse is identified by the Emergency Nurse Practitioner, but she does not complete the Domestic abuse Pro Forma

which would have led to a Domestic abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment. This would trigger amongst other things, police involvement as appropriate.

The reason is identified by the Southend Hospital IMR author as being possibly because Essex Police were already present, and therefore the assault was understood by the nurse to already be in the legal process.

A Police statement and photos of the injury are obtained. Hospital records show that AB advised that she did not wish to make a statement regarding her injuries. YZ is arrested and charged with criminal damage regarding the phone, and S39 assault on AB, and is bailed to court. These charges were dealt with on 30.3.2011 at Southend Magistrates Court.

The CPS records show that YZ claimed the damage to the mobile phone was pre existing and that he did not intend to assault AB but that he had pushed her gently because she was stopping him from leaving the premises.

Southend Borough Council Children's Specialist Services receive the appropriate DV1 incident notification the same day.

The IMR author for the Police notes that he is surprised that YZ was bailed, but that remand in custody may have been seen as inappropriate because AB was not prepared to give evidence against YZ, or to make a statement. However she had already described being fearful of his reaction to this, and that being the reason she did not wish to do so.

ORW comment: On the face of matters, this last point is a stronger reason for denying bail rather than undermining it. However it demonstrates the challenge of dealing with these matters, from the victim's perspective, within the legal system. Bail works to the strength of evidence, the stronger the evidence, the less the likelihood of bail being granted.

The matter of the domestic abuse risk assessment not being completed in Accident and Emergency is addressed by the IMR author for Southend Hospital.

16.3.2011 :

Crown Prosecution Service (CPS) records show that given that the offence of 15.3.2011 was a domestic abuse offence, it was referred to the CPS in accordance with the guidance on charging. The charging lawyer had sight of the key evidence and was aware of the existence of photographic documentation in relation to AB's injuries. The Police advise CPS that the victim is willing to provide a statement and that YZ is on bail for a non domestic incident and that he has two recent convictions: offensive weapon and criminal damage. It is noted to be unclear if this latter is within a domestic context, but if so, this not with the "current aggrieved", namely AB.

It was recognised by the CPS that AB had support needs, and the idea of special measures to assist her in giving her evidence was flagged up. YZ was bailed with a condition not to contact AB directly or indirectly.

The Police IMR show that in follow up to the 15.3.2011 incident AB reveals that YZ is jealous of any contact which she has with other men, that the telephone calls he makes are of an abusive nature, she does not want the matter proceeded with because if YZ receives a custodial sentence as a consequence "he will not be happy that she called the Police over a phone".

Reports show that the Domestic abuse Liaison Officer (DALO) tries to help AB see that "she is not responsible for his actions". The DALO encourages AB to consider giving evidence should YZ plead "Not Guilty", and she records that the Police will be looking to get bail conditions imposed which will prevent YZ contacting AB.

The Police IMR states that an e-mail was sent from the Officer in the Case to the DALO informing them that bail conditions had subsequently been imposed on YZ with regard to the incident against AB on 15.3.2011.

ORW comment: The main emphasis of this interaction with AB was on the matter of trying to persuade AB to come to court and give evidence. The CPS considered applying for special measures, which would have assisted her in giving her evidence, and it is not clear whether AB was made aware of this approach.

23.3.2011 :

YZ appears at Southend Magistrates Court in respect of his assault on a Police Officer and disorderly behaviour of 26.2.2011 at (redacted). He receives a 12 month Community Order with a 40 hour Unpaid Work Order. The work order is not completed and the sentence is later revoked. He is sentenced without a Pre-Sentence Report or other assessment from the Probation Service, because it is not appropriate for the court to request this for this type of offence. There is a requirement from the Court for YZ to see a named Essex Probation Requirement Organiser on 29.3.2011.

The Community Payback Coordinator should have carried out a risk assessment once the sentence had been given: this did not happen. The MARAC flag (on the Probation system since the MARAC meeting of 17.2.2011) does not appear to have been noticed. Such an assessment might have gathered more information about his offending behaviours and the risk he posed, potentially changing the course of the case.

Although YZ related to Probation some detail of his alcohol issues and treatment at the Taylor Centre, this did not trigger a risk assessment or any other action.

Probation have stated that in the operation of the Early Administrative Hearing Courts and the Early First Hearing Courts (which are what they referred to as "Narey Courts") they did not always have access to their own copies of the relevant documents, and had to duplicate them from CPS files at these hearings, and therefore were not always able to assess the domestic abuse context or retrieve other useful information which might affect matters such as pre sentencing reports and other process matters potentially affecting the outcome in terms of Bench decisions; however they have informed the Review that this is no longer the case and they now receive all information. HMCTS have advised that in all courts, the principles of natural justice should be applied, and the nature of the court should not affect matters such as sentencing, pre sentencing reports etc.

Information from the Probation IMR shows that the sentence notification is missing from the archived file. In addition , there are no CPS papers relating to this incident on the Essex Probation file.

ORW comment: it seems this sequence of events highlights that a set of expectations and habits had grown up around the operation of this court which contained some degree of differing expectations between the key partners, and which led to decisions being made at court in this particular case, without the full availability of all potentially relevant information. A different approach now applies, and probation are now e mailed a copy of the relevant information as held by the CPS.

To ensure this situation does not in future occur, the following matters seem to require attention: that the Police National Computer is up to date, that the Probation Service look at the CPS file, and that therefore all the significant information held by Police, CPS and the Probation Service is shared, so that the CPS and Probation can be effective in the matter of how evidence is presented and what information the Bench need before making a verdict or passing a sentence. In addition it is essential that all parties effect this within natural justice principles and are not influenced by expectations about the desired speed of disposals of cases. These matters are therefore addressed in the recommendations of this review.

Events on the day also highlight a commissioning gap, whereby although the Probation Service were aware of YZ's treatment at the Taylor Centre, this did not trigger a risk assessment or any further action on this matter.

29.3.2011 :

YZ attends for an appointment with his Essex Probation Requirement Organiser. An Unpaid Work Assessment is completed. There is no OASys screening and no Risk of Harm screening, for the reasons outlined above.

YZ tells the Requirement Organiser that he is due in court tomorrow for another offence. The Probation Officer correctly assesses that YZ is not suitable for an individual placement. Reporting instructions are given to YZ in respect of attending for a pre-placement work session on 9.4.2011. YZ gives his address as (redacted). One hour is credited to YZ for attending his appointment. YZ is noted as begrudging of the time and involvement he has to have with the service.

On the same day, YZ voluntarily attends the Taylor Centre for help with his alcohol problems.

ORW comment: the situation in Probation therefore continues without a Risk Assessment.

30.3.2011 :

YZ appears at Southend Magistrates Court regarding offences of 15.3.2011. He pleads guilty to criminal damage of the mobile phone and is sentenced to a further 12 months Community Order with 50 hours Unpaid Work. He was ordered to pay £300 compensation and £50 costs, and these were never paid. The record notes the offence was committed on bail but this does not constitute an additional offence. In respect of the s39 charge of battery of AB, recorded as being on 16.3.2011, but actually arising from the same incident, he pleads not guilty, and this charge is carried forward for trial on the 23.5.2011.

The hearing was held in what Probation refer to as a “Narey Court” where it seems Probation understood that there was an expectation that cases are dealt with on the day. This is in part their explanation for the lack of Pre -Sentence Reports, although it has also been stated that Pre -Sentence Reports can be delivered on the day using an Oral Delivery report. (There are three types of Pre-Sentence Report: Oral, Fast Delivery and Standard, the latter is the most comprehensive and would have been normal in these circumstances, but takes longer than a day to prepare). A Pre -Sentence Report was not requested because Magistrates were not alerted to the the value or the need for this. One factor influencing this was the possibility that the presentation of the offences in a non domestic abuse context meant that the Magistrates were not alerted to the value of further reports before sentencing. Whilst Pre-Sentence Reports are understood to be primarily designed to assist in decisions about whether a particular sentence is suitable, in this case such a report would also have potentially highlighted the domestic abuse context.

This represents a missed opportunity because Probation Service policy allows for the fact that offence can be apparently non domestic abuse in nature , yet still be considered as such, if it occurred in this context. The Probation Service has a number of suitable resources for perpetrators of domestic abuse, including a programme designed to support offenders in changing their behaviour, as well as support for victims. This is an IDAP programme for domestic abuse perpetrators , with 27 sessions contained within 9 modules , which can form part of a Community Order Sentence. The programme also offers the possibility of a Women's Safety Worker which could have been provided, and might have assisted, AB.

The Probation IMR author outlines that the Probation Officer who was in Court that day recalls telling the Judge that sentencing on the day, using either an Oral or written Fast Delivery Report, was not appropriate in a domestic abuse case. No report was requested

from the Probation Service. However, again, it is claimed by the Probation IMR author that this hearing was in a “Narey” Court, where there is an expectation that cases are dealt with quickly. HMCTS would contradict this view stating that the process of justice should be correct and not influenced by the setting in which it operates.

Another option open to the Court is to put off sentencing until the second of the two linked offences had also been concluded. This would have alerted the Court to the context of the damage to the mobile phone charge being a domestic abuse scenario, which again would have allowed for a Pre-Sentence Report.

It is also unclear as to whether the Court was aware that YZ had been sentenced to a further Unpaid Work Order a week previously. Normal practice would be for the CPS to advise of a previous conviction prior to sentencing. The CPS have advised they are dependent of receiving this from the Police and this is usually as a PNC print out. On this occasion the Police National Computer printout predated 23.3.2011 and did not therefore reflect the full history outcome because it was not up to date.

The CPS prosecutor noted that AB was considered to be a high risk case and that the case should proceed despite the retraction. They were given 14 days to apply for special measures in respect of how AB would be supported in giving her evidence. YZ was bailed again on the same conditions.

The Court result was incorrectly logged on Probation records (CRAMS) as a Conditional Discharge (due it seems to administrative error) and hence YZ was never instructed to work on this order. An e-mail from court administration correctly records the sentence as being a 12 month Community Order with 50 hours of Unpaid Work.

The Probation IMR author notes that it would appear from records on the Probation file that although the sentence notification from 30.3.2011 was missing, if it had been logged correctly, the case would have been allocated to a Community Payback Co-ordinator.

ORW comment: In the Probation account, the Judge, despite apparently being advised by Probation, proceeded to sentence in a domestic abuse case without Pre-Sentence Reports, in addition to not employing the option of deferring sentence until both incidents had been heard. The Probation Service IMR author identifies that damage to a mobile phone could appear trivial without the full domestic abuse context.

Again, the Probation IMR author identifies that the case was again being heard in what they termed a “Narey Court”, with an expectation of fast disposal, and again HMCTS, in their subsequent comments, disagree with this interpretation and restate the formal definition of this court and that the principles of justice always apply.

The domestic abuse context of this offence has been recognised by the court Probation Officer who spoke to the Judge. The court Probation Officer therefore appears to have acted well in giving this advice.

In conclusion, the Overview Report Writer notes that the situation would still have been that the two offences were heard and sentenced separately, meaning that the domestic abuse context would have been effectively lost. The administrative error in

data transfer to Probation exacerbates the situation, but if a Pre -Sentencing Report had been done, presumably this may have been corrected.

HMCTS have challenged this interpretation of the situation and state that consequences do not flow from lack of pre sentencing reports. They state that Pre Sentencing Reports are a tool to aid sentencing and not a risk assessment.

In the view of the Overview Report writer , whilst this may be the case, the commissioning and production of Pre-Sentence Reports on YZ does seem to offer the possibility that his risks and need might have been better understood through the gathering of intelligence about him.

The comments made previously about the importance of all information being both up to date, and presented if relevant, therefore also apply to this hearing. It was good practice that the CPS were looking to the use of special measures to support AB in giving her evidence.

30.3.2011 :

The Probation contact log shows that the Probation Unpaid Work Co-ordinator completed her file review with an entry made in CRAMS, unaware of this further offence. The IMR author identifies that a question mark was put against the Risk of Harm Assessment. A Risk of Harm Assessment should have been completed, and if it had been, it would have led to a Risk of Harm Analysis being undertaken. YZ should not have been assessed for unpaid work without a full OASys Risk of Harm Assessment.

In addition the MARAC flag was either overlooked or ignored, which if it had been acted upon would have led to reallocation to an offender manager. This would have meant a Risk of Harm Screening would have been completed and a full OASys record. Incorrect logging of the 30.3.2011 court outcome onto CRAMS meant that the domestic abuse conviction was overlooked and the unpaid work hours were not added to the previous ones.

ORW comment: mistakes are made in this process, therefore. These will be addressed in an overview recommendation regarding the Probation Service.

30.3.2011 :

YZ presents at Accident and Emergency, Southend Hospital, having taken an overdose of alcohol and tablets. He was aggressive and assaulted a female member of staff. Security staff were therefore involved. YZ states that he has anger management problems, and alcohol abuse, that he has recently been dealt with harshly by the Judge in Court. YZ was reviewed by the Psychiatric Liaison Nurse at Accident and Emergency, and no psychiatric disorder was detected, according to the notes.

31.3.2011 :

YZ is seen in Basildon Hospital and is diagnosed with "adjustment disorder with continued

alcohol abuse and maladaptive coping skills". YZ is referred back to his GP and subsequently sees the GP a few times in follow up appointments.

1.4.2011 :

YZ visits GP who notes he will contact the Community Drug and Alcohol Service (CDAS) regarding his alcohol abuse.

1.4.2011 :

The Independent Domestic Violence Adviser (IDVA) is shown in the Police notes as making three attempts to contact AB regarding supporting her in court on 23.5.2011. The notes show that AB has retracted her statement.

9.4.2011 :

YZ fails to attend his unpaid work appointment and is sent a warning letter from Probation.

16.4.2011 :

YZ attends his unpaid work appointment, is given a reporting instruction for 19.4.2011, and is credited with two hours attendance.

19.4.2011 :

YZ telephones Probation to say he is depressed and cannot attend. He is advised by the Probation Community Payback Co-ordinator that he can submit up to three self certification medical certificates, or he can visit his GP.

YZ provides a medical certificate for the period 19.4.2011 to 19.5.2011 from his GP, whom he visits the same day. The GP diagnoses depression and alcohol misuse, no domestic abuse is recorded as being disclosed. He is removed from the unpaid work group until after 19.5.2011.

ORW comment: HMCTS have identified in response to this point that Probation have the option of returning the offender to court here for the breach and can request amendment, or revoke in accordance with the provisions of the Criminal Justice Act 2003. In this situation the court can replace the order with another, or revoke and re-sentence for the original offences. No such applications were made.

Probation have advised there would be no reason to return YZ to court. He missed one session which was advised to be covered by sick note. Whilst technically this was the case, the previous lack of more detailed assessments means that at this point there was a gap in information about the risks YZ posed. In addition, looking back over the recent sentencing history of YZ, he had failed to meet the requirements or fines of other sentences too. Therefore, if this gap in information had not existed it is possible a more assertive approach would have been appropriate in relation to this situation.

20.4.2011 :

The Community Drug and Alcohol Service Psychiatrist liaises with YZ's GP as regards YZ's appointment of 11.4.2011. It is stated that YZ had reported improvement in alcohol consumption, with it being down to three cans per day. He reported some "domestic problems with a friend" that he feels uncertain about the future and has referred himself to IAPT (Improving Access to Psychological Therapies) for psychotherapy.

21.4.2011 :

The MARAC meeting is held which arose from the incident between YZ and AB on 15.3.2011. 20 Southend cases were discussed this day.

The Police records show that the IDVA is to support AB before the court case to help her with it. The Police are to contact school liaison regarding her son, and it is noted that AB is still being constantly harassed by YZ.

The Probation Offender Manager and representative at the MARAC correctly identifies that YZ's case requires reallocation to an Offender Manager, although this was not noted as a MARAC action point. This reallocation takes place six weeks later due to the Probation Offender Manager's absence for almost a month on leave, until 16.5.2011.

Southend Hospital updates their system to log the most recent event involving AB as domestic abuse.

No action for Southend Borough Council Children's Specialist Services.

Education Welfare Service are to feed back re AB's son.

ORW comment: when it is identified by the service that took the action that AB's son comes under Southend Education Welfare Service (EWS) rather than Essex EWS, this action isn't followed up. The Probation reallocation is not logged as an action point by the MARAC.

The Probation IMR author identifies that this meeting is very significant because this is the point at which Essex Probation become aware of YZ as a high risk domestic abuse perpetrator. Although the MARAC "flag" was already on the Probation file, meaning that anyone looking at this file should know the perpetrator posed a high risk, this had previously been missed. YZ should have been from this point on allocated to an Offender Manager, in line with Essex Probation Policy. Unfortunately the action does not take place due to staff absence until six weeks after the MARAC meeting.

If this had happened then the case would have been reviewed and it would have been identified that a Probation Offender Assessment System, Risk of Harm assessment, and Spousal Assault Risk Assessment (SARA) in terms of domestic abuse, would all have been triggered. Whilst it is not possible to know what the outcome of these would have been, it would have meant that the Probation file would have contained a risk assessment on YZ, which might have influenced future events.

In addition, again all the focus of discussion seems to be on AB and her family, there is no focus on YZ and the threat he poses, or ways of managing the situation with YZ.

The Essex MARAC purports to identify and follow up action points, but this clearly needs strengthening as on this occasion one action point was not recorded and another one was not followed up by the MARAC.

Knowledge of the harassment and stalking of AB by YZ should have meant that the risk to AB was understood as being very severe. However, there is nothing in the minutes to suggest that the MARAC attendees believed that through the actions they would lower the risk to AB.

9.5.2011 :

AB is seen by GP to whom she discloses harassment and physical violence.

ORW comment: again the issue of harassment should have meant that the GP was aware of a very high risk here; had the GP been linked in with the MARAC process, this could have led to more comprehensive safeguarding and support for AB.

16.5.2011 :

The Probation Requirement Organiser requests the unpaid work administration to re-instruct YZ as regards unpaid work, as his medical certificate is about to expire. The Probation IMR author identifies that it would appear from the Probation records that the Probation Requirement Organiser is unaware of the further MARAC discussion via the MARAC flag.

ORW comment: this represents an appropriate response by the worker within the framework that Probation were (wrongly) working within. The Probation worker should have known about the MARAC further discussion. The system needs strengthening to address this.

16.5.2011 :

AB is contacted by the Independent Domestic Violence Adviser (IDVA) regarding support in giving evidence in court. AB advises that she doesn't want to go to court as she doesn't want to get YZ into trouble. The IDVA and AB make further arrangements, should AB want support.

ORW comment: again potential evidence of fear on the part of AB.

17.5.2011 :

CPS file notes contain a message from IDVA to the effect that AB was ambivalent about attending court and also about the need for special measures. However the IDVA reports that she believes AB will attend to give evidence.

18.5.2011 :

The Police contact AB and explain that the situation is serious and that she could be arrested if she doesn't attend the court. AB says she can't cope. The Police speak to AB's friend with her permission, who advises that AB is not feeling strong and that she gets 90 plus phone calls a day from YZ and that he sits outside the house. Essex Police patrols are asked to cover the road where AB lives and watch out for YZ whose description and photograph is circulated. It is outlined that if he is seen in the vicinity of AB's house it is a breach of his bail conditions, which can be dealt with without AB needing to make a statement.

ORW comment: This puts information in the hands of the Police about the extreme degree of harassment and stalking behaviour being carried out by YZ towards AB. These are activities which indicate the very severe risk he poses in terms of homicide. Because the Essex DV1 does not contain the additional ACPO recommended module, which covers stalking and harassment, (although the Police do respond to this information, for example by stepping up patrols around AB's home), the information doesn't have any formal status within the inter agency process, for example it does not inform the MARAC or lead to a changed strategy in respect of AB's danger, or the handling of the cases against YZ. These issues are addressed in the overview recommendations.

20.5.2011 :

AB's GP gives a statement to the effect that AB is not fit to attend court.

20.5.2011 :

Two new offences are committed by YZ, Breach of Bail and Assault. Firstly YZ assaults AB, s 39 Battery. A DV1 is completed with AB assessed as High Risk. YZ is arrested the next day and taken to the cells due to his violent and aggressive behaviour. YZ is later charged with the offence, he denies assault in the interview, but is also arrested for Breach of Bail with regard to assault on AB of 15.3.2011, and detained in custody until the next available court date, which by coincidence was 23.5.2011 when he was already due to appear in respect of his not guilty plea of assault on AB of 15.3.2011.

CPS papers indicate that in this incident, YZ again visited AB, an argument ensued, and YZ pushed AB's head against the wall. AB advised the Police that YZ has bail conditions which preclude him from contacting her. CPS papers indicate that YZ had consumed 6-7 cans of lager prior to the assault.

It is not clear on Probation records what the bail conditions are, and there is no entry on the Probation CRAMS system. YZ is held in custody pending court on the 23.5.2011, and is refused bail.

Southend Borough Council Children's Specialist Services receive the DV1 notification, no further action in relation to the children is noted. A child in the family is shown, not present at the time of the incident, but spoken to by the Police.

Essex Police liaise with AB regarding court on 23.5.2011, and make a mobile phone arrangement on her behalf, to enable her to replace the one which YZ has smashed.

21.5.2011 :

The Police report shows that AB provides a medical certificate showing she is not fit to attend Court on 23.5.2011.

AB says her father died recently and she has been struggling. She thought the situation with YZ had gone away, as YZ had agreed to leave her alone. However, he contacted her again yesterday. AB appreciates the help being given, but is looking at the security aspects of her property herself. Later AB calls back and asks for an alarm to be provided.

23.5.2011 :

YZ appears in court in relation to the two s 39 assaults on AB of 16.3.2011 and 20.5.2011 and for breaching his bail conditions. The Bench finds the breach of Bail proven. A bail application is made and refused. YZ pleads not guilty to the two assaults. CPS plan a hearsay application for the offence of 15.3.2011, which will mean that AB doesn't have to give the evidence directly herself. The two above pending assault cases are adjourned until 31.5.2011.

The CPS make arrangements after the hearing to support AB to court with an IDVA, a GP statement, and a statement in relation to the assault on 20.5.2011.

A strong application opposing bail was made by the CPS, supported by using the GP's report, police information and the Independent Domestic Violence Adviser giving AB's perspective. YZ was remanded in custody on this occasion, remaining there despite the attempts of his defence team, until 21.6.2011.

CPS records show that consideration was actively being given to making an application to use hearsay evidence in respect of the 999 call and the Police notebook as well and recruiting the neighbour as a potential witness. (The latter was subsequently dropped on the basis that identifying YZ as present at the scene would not be additional evidence as the police had already covered this matter).

ORW comment: HMCTS have identified that the trial originally set for 23.5.2011 was adjourned at the request of the CPS on the grounds that it would be detrimental to AB's mental health and well being for her to attend court. AB attended court on this day according to the court file. The CPS showed good practice in the arrangements they made to support AB.

24.5.2011 :

The IDVA visits AB at home. AB outlines she is frightened of YZ. AB fears she will not be a credible witness because she has been depressed since the death of her father, she has had nightmares, flashbacks, and memory difficulties. Friends and family are supportive. Some safety planning was done. The IDVA agreed to arrange the Sanctuary Scheme referral, and AB had an Essex Police temporary alarm fitted.

AB visits her GP and outlines that she was assaulted again by her partner, he is now in prison and she is anxious and fearful.

The IDVA updates the CPS.

ORW comment: The mental conditions described by AB indicate the damage which domestic abuse can inflict and the difficulties of a victim in presenting evidence.

25.5.2011 :

YZ was discharged from IAPT (Improving Access to Psychological Therapies), having attended one session on 20.5.2011, where he was diagnosed as having moderate anxiety and some depression, and with no further action noted.

Police discuss with the CPS the difficulties of AB giving evidence and their fears for her wellbeing. The CPS stress the importance of getting a conviction, and ways of securing this without compelling AB to give evidence.

31.5.2011 :

Essex Probation log shows YZ was reallocated to Offender Manager in order to complete OASys, as it's a MARAC case which was discussed on 21.4.2011 and deemed therefore to be unsuitable for Community Payback Case.

The Offender Manager (OM) doesn't complete OASys because YZ is remanded in custody and Offender Manager wants to do a community assessment, therefore it is put on hold. Assessment at this point would have identified the risks this offender posed, and would have prompted a SARA completion.

ORW comment: this was a correction of the previous omission a risk assessment. In that sense it was a good decision. However, the decision to log the OASys assessment as being needed, but yet to defer this as YZ was already in custody and that doing it in the community would be more realistic, meant that in reality, as circumstances develop, it does not get done at all.

31.5.2011 :

YZ attends Southend Magistrates Court for the assault on AB of 20.5.2011, the next appearance to be 21.6.2011, by video link, adjourned and working to a date of 29.6.2011 at Mid South Essex Magistrates Court (Basildon Magistrates). A bail application was refused and YZ was remanded in custody. YZ was assessed by Probation, however, as suitable for a BASS community bail scheme in another town.

ORW comment: although the Probation assessment wasn't used because YZ was remanded in custody, it does raise the issue of the quality of this assessment and YZ's suitability for BASS, which is a community based bail scheme, given the circumstances of the strength of YZ's stalking and harassment of AB.

3.6.2011 :

YZ appears at Basildon Crown Court for bail application. Bail was refused. There is appropriate recording on Probation logs.

The IDVA sends an e-mail to the Police and CPS regarding the bail application.

The IDVA chases the Sanctuary Scheme for AB, and contacts her over this.

8.6.2011 :

The CPS lodge an application to produce AB's evidence in respect of 15.3.2011 and the Police notebook of 20.5.2011 as hearsay. This was supported by AB's GP.

9.6.2011 :

Essex Police files show concerns recorded that AB may not be fit to give evidence, and a proposal for a restraining order on YZ is therefore mooted.

15.6.2011 :

The CPS file is reviewed by a senior manager, and the conclusion is drawn that unless the hearsay application is successful or AB gives evidence, there is little reasonable prospect of a successful prosecution for the two outstanding assaults.

16.6.2011 :

AB sees a counsellor again – she is depressed and bereaved, and has no inclination towards self harm. AB refers to domestic abuse and the court process whilst in the session.

16.6.2011 :

The MARAC meets and has discussion of the incident of 20.5.2011.

16 Southend cases were heard at the MARAC on this day.

The minutes show AB has the Sanctuary Scheme in place. Probation gave an update on the court case pending, which was due on 21.6.2011. AB is known to the mental health service. This is the third discussion of AB at the MARAC. The Probation Offender Manager reports YZ as remanded in custody at present.

No further actions are noted for Southend Borough Council Specialist Children's Services or Adult and Community Services.

AB is noted to be known to Adult Mental Health Services. Southend Hospital noted no additional actions for Adult Mental Health through its liaison psychiatry arrangements. YZ is noted as known to Community Drug and Alcohol Services.

ORW Comment: Once again, there is nothing to indicate that the MARAC attendees expected the actions or discussions would lead to the risk to AB being lowered.

17.6.2011 :

CPS list the Hearsay Application at Southend Magistrates Court. They are advised that YZ's defence will oppose the application. The court legal adviser states that he will be advising the Bench to refuse the application. There is not enough evidence: there is no statement AB is in fear, medical evidence is insufficiently detailed, there is nothing more in the notebook than police incident notes. The Court is not convinced that enough efforts have been made to secure AB attendance through special measures.

Defence indicate YZ will be prepared to plead guilty of assault 15.3.2012 on reckless basis but will not change the plea of 20.5.2012. The offer of pleas was accepted by the CPS because with hearsay not being granted, and AB not willing to attend, a witness summons would otherwise be served on her to force her to court, which worries about her mental health meant the CPS did not wish to put her through.

ORW comment: whilst it appears that agencies were trying to do their best for AB in the matter of giving her evidence, the evidence was not strong enough to be successful. It raises a question as to whether this could have been different if for example the evidence from officers or the GP had been stronger, e.g. citing risk factors from DASH and MARAC.

21.6.2011 :

YZ appears at Southend Magistrates Court. It's a mention hearing. YZ pleads guilty to assaulting AB on 15.3.2011 on a "reckless" basis, a less serious form of assault than intentional assault. There was a risk of acquittal of YZ if a less serious charge was not accepted. The CPS accepted this plea. The Unpaid Work Orders of 23.3.2011 and 30.3.2011 are revoked and an 18 month Conditional Discharge sentence is imposed by the Bench for both of the offences of 15.3.2011, the CPS and the Court being made aware that these were arising from the same incident. In making this sentence, CPS report that the Bench would have to take into account that YZ had been remanded custody for 29 days, which they state is equivalent to a two month sentence.

The review panel has been advised by HMCTS in respect of the 18 month Conditional Discharge, of their understanding that this is a more severe sentence than the Community Orders which it replaced, and that this was imposed on justice grounds rather than for any breaches of the previous orders.

(Essex Police records wrongly show this as a 12 month Conditional Discharge.)

In examining these events the Review Panel agreed that although YZ had spent time in custody he could still in fact have been given a custodial sentence, even though, depending on its length, he may already have been deemed to have served this time due to the remand in custody. Therefore there is agreement amongst the parties to this Review that the sentencing here was an inappropriately light response, even given the amount of time already served, and it was also agreed that YZ should have been sentenced to a Community Order and not a Conditional Discharge.

The CPS offer no evidence in relation to assault on AB on 20.5.2011. This is because the hearsay application has been refused and AB is unable to attend and give evidence. The Bench had no option but to dismiss this case.

The CPS records show that they applied for a Restraining Order under the Protection from Harassment Act 1997, using the limited information which was on file, and this is unsuccessful. Their records show the defence oppose the order and bench do not agree it, citing the "victim's volatility" (referring to AB) as a reason.

It is not noted in the records as to whether any intervention was requested from the Probation Service. It is standard practice for Probation to be provided with disclosure of the prosecution case at all Early First Hearings such as this. HMCTS believe that the Probation Service were asked for such a report, the Probation Service do not believe this was asked for it. However the Court could have asked for Pre Sentencing reports if they deemed this appropriate.

Statutory contact between Probation and YZ ends at this point. No Probation Risk Assessment had been completed, as this was pending due to the decision by Probation Offender Manager to undertake this when the offender was in the community instead in custody.

Essex Probation did not instigate breach proceedings regarding the previous Unpaid Work Orders. There is no evidence that Probation asked for these orders to be revoked. The offender, YZ, is credited with three hours for one of the Unpaid Work Orders prior to their being revoked.

ORW comment: Although the previous Unpaid Work Orders were revoked in the face of a less severe sentence (a Conditional Discharge), they had never been worked, as only three hours had been credited to them. They were replaced with a lesser sentence. An opportunity was missed in respect of a possible custodial sentence.

HMCTS state that there is no information that a restraining order or exclusion order was requested. S5 of the Protection From Harassment Act 1997 allows the court to make an order when sentencing for an offence, prohibiting the defendant from doing anything in order to protect witnesses, prevent harassment or which will cause fear. There is no information on the court to suggest this was done. CPS say there was an application for a Restraining Order made, therefore there would appear to be a disparity in the records as regards this point. HMCTS question whether this would this have made any difference as YZ had already failed to comply with bail conditions.

HMCTS identify that the court could have considered an IDAP programme, (a programme for perpetrators of domestic abuse) since if it thought it was good idea, the court could have asked for pre sentence reports and considered this as indicated.

22.6.2011 :

YZ is released from prison and the release address is given as (redacted). (Redacted) MARAC minutes show YZ's address as (redacted)

ORW comment: YZ is released to home of (redacted)

24.6.2011 :

YZ allegedly commits an offence of further harassment of AB. No further details are known. The record of this is in the Probation Court Process Form. This would be a breach of the terms of the Conditional Discharge of 21.6.2011 YZ is currently not an offender and therefore a Probation response is not required

ORW comment: this wasn't discussed at MARAC on 22.7.2011 and it is not clear from where the information came that was on the Court Process Form. The Conditional Discharge has replaced the earlier Community Orders, and although it carried no actual requirements, once a Conditional Discharge is breached it should carry some consequences. There is a question as to where this information came from to Essex Probation, as they are no longer engaged with YZ, and additionally what they could have done that information in terms of the safety of AB.

24.6.2011 :

Arrangements are made for the Sanctuary Scheme at AB's house. A sensor, mortice lock, 2 security bolts, and film to cover the glazing are all provided. Locks and sash windows are repaired.

26.6.2011 :

A number of other disturbances occur, involving YZ, this day.

Firstly, at 3.35am, (redacted) calls the Police to report that YZ is out of prison and is making threats to kill AB. Police attend (redacted) who doesn't want to make a statement. AB has been advised by (redacted) that YZ has a weapon. AB's welfare is checked and YZ is later arrested.

The second incident is that AB makes a call to the Police YZ is making threats to kill. Records show that AB reported receiving up to 40 voicemails from YZ mainly of an abusive nature, she had 50 plus texts and 100 missed calls. YZ had been abusive on 26.6.2011. AB was taken to the Police station to provide witness statement MG11, YZ was arrested for harassment.

The third incident is a 999 call from (redacted) to the effect that YZ has created a disturbance at (redacted). He is drunk and abusive towards (redacted). (Redacted). (Redacted) calls 999 and the Police attend. It is reported to be not clear if any offences have been committed. There is no record of any Police action in response to this event.

The fourth incident is that a member of the public calls the Police, (redacted) because YZ has knocked on their front door, which was opened by her (redacted) , who was then attacked by YZ. YZ is described as drunk and being restrained by (redacted)

The Police circulate details of YZ with an instruction that he be arrested.

HMCTS have subsequently advised that on 27.6.2011, YZ was charged with two offences, harassment of AB under S2 of the Protection from Harassment Act and Actual Bodily Harm in respect of JH under S47 of the Offences Against the Person Act, and put before court.

(Redacted) was not immediately asked to provide a statement against YZ. YZ is refused bail and is to appear in court on 28.6.2011. He is subsequently bailed by the court on 28.6.2011, with stringent conditions which included not contacting witnesses, including AB, and not attending the area where they live, and not to use or be found in possession of a mobile phone. Also he was to reside at (redacted) with an electronic tag and a curfew of 6pm to 6am to be enforced. There was a general expectation that YZ would not be granted bail and therefore a degree of surprise when this was granted by the court.

No charges of threats to kill were placed before the court and there is no information to suggest that the court were even aware that such charges were being investigated. The Police could not charge this offence because they did not have the necessary evidence the bail was granted to bring YZ back to the court when they has gathered this evidence. Information provided on YZ to accompany the subsequent murder allegation suggests that in respect of the threats made towards AB, YZ was not charged with threats to kill but was instead given police bail, wrongly described by the Police IMR as "technical bail" (which is actually a different type of bail) until 30.8.2011 to return to the Police station whilst this matter was further investigated (Essex Police have explained that this term means that, although YZ was bailed, he was not in fact released, due to being denied bail on another charge). An application for remand in custody was actually made the next day. In respect of YZ's threats to kill towards JH, the ABH charge was deemed a more appropriate charge, and was therefore proceeded with by the CPS.

A DV1 is sent to Southend Borough Council Children's Specialist Services, and consideration is given to making an initial assessment. This is the fifth DV1 in respect of him, but consideration is given at this point as to whether an initial assessment is called for. The rationale for not doing so is recorded on file that his mother is protecting her son, safety measures such as the alarm are in place and the Sanctuary Scheme is in hand, and he spends a lot of time at his father's house.

ORW comment: with regard to Children's Specialist Services this is a reasonable decision in respect of the available evidence of the threat to AB's son. However, policy dictates that an initial assessment should be considered after three referrals. This matter is considered by the IMR author and a suitable recommendation is made regarding managerial oversight of the decision not to proceed to an initial assessment after three or more referrals.

HMCTS does not recognise or use the term "technical bail", which is a term used within the Police IMR, and state that they can only presume it is a term the Police use to describe situations where they have placed YZ before the court in custody on the harassment and actual bodily harm charges but had technically released him from police bail pending investigation of the threats to kill matter. HMCTS state that "technical bail" is not a legal remand status and has been severely criticised in the recent case of Sonnex. This matter is picked up in overview recommendations to

the Police regarding their management of bail processes.

In conclusion, there is clearly a missed opportunity here to present the court with the fuller picture regarding ongoing investigation of YZ's threats to kill. It seems to the Overview Report Writer that at this point there are serious issues regarding the granting of bail.

26.6.2011 :

(redacted)

ORW comment: this was a reasonable response to this incident, but the full picture wasn't being looked at anywhere regarding the increase in danger signals coming from YZ. (redacted)

27.6.2011 :

(redacted)

ORW comment: these matters have been addressed in the respective IMR's of the Children's and Adults services of Southend Borough Council.

27.6.2011 :

The Police contact AB regarding safety measures.

28.6.2011 :

YZ appears at South East Essex Magistrates Court (Southend). He pleads not guilty to harassment of AB on 26.6.2011, this case is adjourned until 17.8.2011. In respect of ABH of member of the public on 26.6.2011, this is adjourned to the Crown Court with a committal date 23.8.2011. Remand in custody was applied for by the CPS on grounds that if released he would continue to commit similar offences and that he would interfere with witnesses and pervert the course of justice. The defence requested bail and put forward the agreed conditions.

The trial for these offences was discontinued following YZ's murder conviction.

Court decided to grant YZ bail on these conditions: not to contact prosecution witnesses, including AB and (redacted) and not to enter certain areas, which included AB and (redacted) addresses, not to use his mobile phone, a 6pm-6am curfew with use of electronic tag, YZ to attend Court on 4.7.2011 to see a Criminal Justice Psychiatrist Mental Health Specialist. YZ's bail address is provided as (redacted).

At the time of these hearings YZ was subject to a Conditional Discharge. The Probation Service have commented on the fact that this was not referred to.

Court process records show that YZ had an appointment to Dr A of the Criminal Justice Mental Health Team on 4.7.2011 at 10.30am.

28.6.2011 :

The Sanctuary Scheme work is completed at AB's home.

28.6.2011 :

(redacted)

29.6.2011 :

An electronic tag is fitted to YZ at 19.54.19 hours. At 19.54.59 hours (40 seconds after fitting) it was tampered with. YZ was reported by SERCO to have become abusive and uncooperative during the attempted fitting of the tag. He grappled with the female operative grabbing her arms and attempting to retrieve an item from her kit bag. He was described as not drunk but smelling of alcohol. SERCO did not pursue charges on this matter.

ORW comment: it does not appear to be appropriate that SERCO have the discretion, under the terms of their contract, to decide whether or not to press charges or report assaults on their staff carried out whilst in the course of carrying out the courts instructions. It leaves an information gap, and a criminal offence unchallenged.

30.6.2011 :

YZ has his tag replaced.

3.7.2011 :

A SERCO automatic report is generated to Essex Police that YZ is in breach of his electronic tag. He was absent until 6pm the next day. SERCO monitoring service responded to automated notification by calling bail address and find that YZ is reported to be drunk and abusing people and has left the address.

The next day YZ 's (redacted) report to the Police that YZ has made threats to them and that he is also threatening self harm and suicide. DV1's on the two victims are completed and assessed as Moderate (Medium) Risk.

ORW comment: the Police IMR author identifies this response is poor as the matter is not followed up until the next day. YZ's whereabouts should have been ascertained. The risk to AB should have had higher consideration and priority.

4.7.2011 :

YZ's (redacted) reports to the Police that YZ was bailed to (redacted) but left last night. He has been making threats against himself and was drunk. SERCO make an absence notification to the Police.

YZ is risk assessed by the Police Duty Inspector as High Risk and a missing person. YZ's

(redacted) also contacts the Police to say she is not happy with the fact that YZ has been bailed to (redacted). YZ has returned there and has been abusive. Police records show it was reported that (redacted) are scared of YZ and protection is discussed with them. DV1's (redacted) are completed and assessed as Moderate (Medium) Risk. YZ is located and arrested on a breach of bail. YZ has ingested tablets and is threatening suicide.

5.7.2011 :

The Police IMR outlines that YZ was released from custody not having been dealt with for the curfew breach. The reason is that he had to be put before the court within 24hrs of his arrest for the breach. This was not possible because he was in no fit state to appear before court during the 24 hour period. He had to be released from custody pending his scheduled appearance on 6.7.2011. He is currently at (redacted) which is believed to be a breach of bail conditions because (redacted) is a prosecution witness. (Subsequently this breach was clarified not to be the case as (redacted) was not a prosecution witness).

Police notes show SE, sister of YZ, was very frightened, but would not make statement against her brother.

SERCO receive a call from YZ at 12.30 to say he cannot stay at the curfew residence. A SERCO absence notification is made to the Police: YZ is absent until 6am on 6.7.2011

ORW comment: there is an issue here of a perpetrator of domestic abuse being bailed to (redacted)

HMCTS have identified subsequently that it seems that the Police did not realise the implications of the 24 hour rule until YZ came to court. He could in fact have been presented before the court whilst drunk, or he could have been represented in his absence through his advocate which in the absence of any other could have been the duty solicitor; the court would not allow intoxication to be a reason for not dealing with the matter. There is further learning here for the Police in terms of the bail management process.

6.7.2011 :

YZ appeared at South East Essex Magistrates Court (Southend), in respect of bail.

(Redacted). The Court nevertheless granted bail to reappear with same conditions except change of bail address to (redacted) house. Nothing is on file to say that the Police opposed the variation. CPS opposed the variation but the court granted it.

A further appointment for YZ to see the Criminal Justice Psychiatrist Mental Health Specialist was rescheduled for 11.7.2011. It is also possible to see from the Police papers that an assessment for an alternative bail address had been undertaken, but this wasn't used.

SERCO were unable to install a new tag as there was no answer at the property when they attended; therefore YZ was not being monitored.

ORW comment: the Police IMR author identifies that this appears to be a ridiculous situation: YZ has appeared before the Court, has been bailed with stringent conditions, has breached these immediately, and bail is renewed with some minor, possibly inappropriate, changes.

HMCTS have subsequently stated that as of this date no breach of bail conditions had come to court in respect of YZ. It is not accurate therefore to state that YZ had breached his bail in law. The question can only be revisited when the individual has had an opportunity to respond. An application to vary the bail conditions was made on 5.7.2011 and was listed at the request of the defence for 6.7.2011.

Written notice was served on the CPS indicating the nature of the variation. The Police did not oppose bail according to the CPS. The CPS did not object to bail because they had no information about breaches which would have implied they should do.

In conclusion, there are some issues here about the management of YZ's bail which would have enabled the breach to have gone before the court within 24 hours despite his inebriated condition (5.7.2011), and the question of whether CPS had information about the bail breaches (6.7.2011). If so it is not clear why this was not presented. Again therefore this appears to be a missed opportunity to address the matter of the bail breach, and again it seems that all the relevant information about YZ was not collected and shared between the Police, CPS and Court. Contact between YZ and AB would have been viewed by the court as a very significant and serious factor, had the Court known about this matter.

6.7.2011 :

(Redacted) makes 999 call to the Police: YZ was bailed to (redacted) that day, he is drunk and has therefore broken his bail conditions. The Police establish that his bail conditions are not breached by either being at this address or by being drunk. (Redacted).

(Redacted)

(Redacted)

ORW comment: there is more evidence of (redacted) fearing YZ. These incidents raise the whole question of the use of suitable addresses for bail – each of the addresses put forward by YZ's defence team had unsuitable aspects leading to risk –(redacted). More care should be taken during the court process of granting bail to ensure that the bail arrangements do not put others at risk and are suitable.

The Police and others need to be assertive in bringing this information forward to assist the CPS in challenging the arrangements, and need to fully understand all of the technicalities of the bail process. For example, the question can be asked as to how did (redacted) come to believe YZ should not get drunk and that this would breach his bail, when this was not actually the case.

7.7.2011 :

A new tag is installed on YZ by SERCO.

9.7.2011 :

YZ's (redacted) reports to the Police YZ was bailed to (redacted), he returned drunk and has thrown (redacted) out, and he has removed his electronic tag. The Police attend and find the tag on the premises having been removed. They circulate YZ's details for breach, and for arrest, locks are changed to protect the occupants. A DV1 is completed and assessed as High Risk.

(Redacted).

SERCO submit tamper report regarding damage to the tag to the Police.

YZ is believed to have spent the few days between this event, and being found and arrested, in a variety of places in Southend, with Police efforts to find him, and contact with family, between 9.7.2011 and 14.7.2011.

YZ is finally arrested in Southend Police Station on 14.7.2011, having attended of his own accord.

(Redacted)

ORW comment: (redacted)

It is not clear whether sufficient priority was given to the issue of finding and re-arresting YZ given the danger he posed.

11.7.2011 :

(Redacted)

12.7.2011 :

(Redacted)

13.7.2011 :

The CPS drafts and lodges with the court an application for special measures in relation to AB's court appearance as a witness. Bad Character evidence is to be submitted in respect of YZ. These are cited for determination on 22.7.2011.

14.7.2011 :

YZ presents himself at Southend Police station and is arrested for breach of bail on 9.7.2011 and appears at South East Essex Magistrates Court (Southend). Bail is granted

on the same conditions, except the bail address is now to be (redacted), there is no apparent action taken regarding his removal of the electronic tag and the breach of bail.

However, in response to question raised within the DHR, the Overview Report Writer was in receipt of correspondence from an Essex Justices Clerk, HMCTS, on 8.12.2011. In this correspondence, it is clarified that YZ admitted to the breach of his bail regarding the tag on 14.7.2011 and he admitted not staying at the bail address.

HMCTS further note that The Bail Amendment Act of 1993 provides for immediate appeal of a Magistrates decision to grant bail at a Crown Court. The effect of such a decision delays the defendants' release until this Appeal is heard.

The CPS say they had no information regarding YZ's breaches of bail through contact with AB at this hearing. The CPS say they had no information from the Police regarding whether they wanted YZ to be remanded in custody.

There was a memo from SERCO given to the Police to the effect that they did not wish to pursue a charge in relation to YZ's assault in respect of the tag fitting.

ORW comment: there was an opportunity here therefore for CPS to challenge the bail decision through an appeal. However it appears that the CPS did not have all the relevant information to support this.

On 12.12.2011 a Crown Advocate in the CPS, in a letter to the Overview Report Writer also identified that there were three definite breaches of bail by YZ. On the first of these occasions the offender was not brought before the court within 24 hours and therefore had to be released by the Court on the same Bail conditions as before. On the second and third of these occasions the CPS did not raise any objection to Bail due to the information provided by the Police, which did not identify to the CPS those breaches of the bail conditions which involved the condition that the offender should not contact the victim, AB.

The Police referred only to the breaches of bail relating to the breaches involving the electronic tag, which in the circumstances detailed could not properly give rise to grounds under the Bail Act that would lead to bail being opposed.

Essex Police say that they were unaware that YZ had breached bail in relation to contact with AB. The breaches were in relation to curfew and residence only, not more offences. YZ had attended court with the presumption of a right to bail. The two breaches of bail related to tag offences and curfew, there was no evidence of interference with witnesses, therefore these were not breaches that would be sufficient for the CPS to consider an application to deny bail.

It remains to be my opinion that insufficient attention and co-ordination was paid to the matter of bail and the key agencies of the Police, Courts, and CPS did not work effectively enough on this matter.

14.7.2011 :

AB sees her counsellor and advises she is still being harassed by YZ. He has breached

his bail. She is encouraged to report this, and is encouraged to seek support from friends and family.

15.7.2011 :

(Redacted)

18.7.2011 :

(Redacted)

18.7.2011 :

YZ is seen in the Out Patients Department of Southend Hospital by Consultant Dr Davidson (the assessment having been deferred because YZ was too drunk to be assessed when he was in Court). Dr Davidson records (YZ) as: "Dysphonic slightly angry and anxious". No suicidal thoughts or psychiatric disorders are detected, mild to moderate depression diagnosed, YZ is given a prescription, and a letter discharges YZ back to the care of his GP.

19.7.2011 :

(Redacted)

ORW comment: there is an issue here about record keeping and filing of information.

20.7.2011 :

YZ was arrested and appears at South East Essex Magistrates Court (Southend) in connection with his arrest of 14.7.2011 for non compliance with his curfew conditions. YZ is re-bailed with the same conditions by the Court. No evidence was presented regarding YZ's contact with prosecution witnesses including AB. There is no evidence that the Police requested a remand in custody. The CPS did not oppose Bail. The CPS IMR comments that successive breaches of bail by YZ should have led to the prosecution applying for a remand in custody.

(Redacted)

ORW comment: There seems to be insufficient attention paid to breaches of bail. Breaches of curfew and residence conditions, and removal of the tag, are not viewed in the light of other conditions and there is no evidence that follow up was done with AB to find out if, while breaching certain conditions, YZ was also breaching the condition not to contact her. Although this was the wrong decision about bail, it was reasonable given the absence of key information given to the Magistrates about the breaches.

Magistrates do receive three yearly refresher training about bail, it was suggested

that this could include training specifically about the use of conditions of bail and their consequences, encouraging them to use fewer conditions , which would simplify matters of enforcement of these, and dealing with breaches.

Having made all of these points , there would still have been practical issues in getting AB to report and evidence these breaches of bail by YZ.

22.7.2011 :

YZ appears at South East Essex Magistrates Court (Southend). This was a mention hearing. The applications for Bad Character in respect of YZ and Special Measures to assist AB in giving evidence at the planned hearing on 23.8.2011 were brought.

Conditional bail was continued as previously, with YZ to reappear at Court on 12.08.2011.

22.7.2011 :

(Redacted)

ORW comment: (redacted).

24.7.2011 :

At 2.38pm the Police receive non emergency call from AB, to the effect that she is continuing to be harassed by her ex-partner YZ. He was constantly calling her and had turned up at her garden fence yesterday, and today, whilst she was hanging out washing. He had asked her to go to his mother's to talk to her. AB described the demeanour of YZ as begging rather than threatening, but states that she is scared of him.

Police confirmed with AB that the only child in the household was out and safe. AB said she was going to town and would be back 4.30pm. AB described the contact by YZ as being in breach of his bail conditions. The incident was deferred in the Police STORM system for a later response, and was reactivated at 4.30pm.

At 5.05pm the call was forwarded to the Essex Police Southend Duty Sergeant, with no response having been made before 7.30pm, when the temporary police alarm was activated at AB's address, and also immediately thereafter the Police received a 999 call to the effect that AB had been assaulted. AB's husband also called the Police.

The Police IMR states that this response was outside of force policy, as it should have been given priority due to the risk factors involved. Possible mitigating factors were identified as the high level of operational demand, and the demeanour of AB when making the call. The Independent Police Complaints Commission (IPCC) looked into the matters occurring on this day in order to assess the Police response.

AB died.

ORW comment: The IPCC report into events on this day outlines weaknesses in the decision making and operational systems which led to the deferral of the response to AB, the failure to retrieve all the relevant information to support the decision

making about a response, the operation of the decision making outside of policies and procedures in force at the time, and the workload pressures on the day which exacerbated the situation.

These matters have been addressed through a reorganisation within Essex Police of how these systems operate and how responses are made to domestic abuse reports. Whilst it is possible to see that these changes are designed to address the issues arising in this review, a recommendation has been made in this Overview Report which is designed to test that these changes have been effective in achieving these planned improvements and outcomes.

Section 4:

Analysis of the IMRs, IPCC report and SI report

All of the IMR's submitted were deemed by the Overview Writer to be of an acceptable, or higher, standard.

4.1 The Essex Police IMR

The Police IMR contains a comprehensive analysis of the Police activity in relation to this case. It makes reference to the fact that the Police made a self referral to the Independent Police Complaints Commission of their actions and responses on the day of AB's death. These findings are considered later and have been incorporated into this review.

The key issues identified in the Police IMR are as follows:

The Police IMR identifies that as a result of analysis of a previous recent domestic homicide, steps had already been taken to review the Essex Police Force's Policies and Procedures in respect of domestic abuse.

Since 7th July 2011, a revision to the force policy has emphasised the importance of prompt submission of DV1 notifications, the means by which knowledge of domestic abuse risk, gained from Police attendance at incidents, is shared with other agencies and acted upon collectively. The delayed completion of DV1 notifications was one of the areas of concern highlighted by the Police IMR in this case, in the period pre-dating this policy change, and this has now therefore been addressed.

The IMR also reports that, in addition, there is now a strengthened risk assessment, to be carried out by Divisional Crime Managers (who are at Detective Chief Inspector or Detective Inspector level), and improved incident investigation and supervision in domestic abuse situations.

All High Risk domestic abuse cases are now to be investigated by Serious Crime Teams, and following the death of AB, since 26th September 2011, all STORM (the Police emergency operational system) incidents of domestic abuse must be responded to at the time, so that responses cannot be deferred until later in the day. There has also been the introduction of a more specialist response to domestic abuse within the Force Intelligence Room.

The DALO showed persistence and good practice in her attempts to engage AB in a process of protecting herself. This was evident from the report.

In terms of the additional specific learning from this review, the Police IMR highlights that there is a need for Police Officers to be more aware of the needs of people with disabilities when making DV1 notifications, and therefore there are suitable recommendations about how Police training needs should be met in order to achieve this, and how this information will be transferred to partner agencies, within the notifications.

4.2 The Essex Probation IMR

The Probation IMR identifies the sequence of contacts with YZ in the period under review and highlights the fact that a key issue was, in contravention of the service policy, that a risk assessment was not carried out on YZ. It describes how this omission came about.

The risk assessment should have been done immediately, not least due to the MARAC flag that had been placed on the system following the MARAC meeting of 17th February 2011, prior to YZ's involvement with Probation. At the later MARAC meeting of 21st April 2011, Probation did identify that this flag had been missed and that YZ should be re-allocated to an Offender Manager, and a risk assessment done. However this re-allocation did not take place until 16th May 2011. The Offender Manager then did not complete the risk assessment as YZ was remanded in custody, at the end of which his sentence was a Conditional Discharge, thereby ending his involvement with Probation.

On 16th March 2011, the outcome of YZ's charge of criminal damage to AB was incorrectly logged onto the Probation information system due to an administrative error. By the time of the second MARAC meeting, with recognition that this needed addressing, YZ was in custody, and a decision was made that the risk assessment be deferred until YZ was in the community. The assessment was therefore never carried out.

The IMR author identifies that in order for offenders to be sentenced and dealt with in such a way as to address the risks they pose to themselves and others, correct risk information, arising from such an assessment is needed. This also has the advantage of opening doors to other suitable resources, such as potentially in this case, perpetrator groups to address domestic abuse, a Spousal Assault Risk Assessment (SARA), and support services for partners affected by domestic abuse. These might have been appropriate in this case.

The Probation IMR identifies that on 23rd March 2011 and 30th March 2011, both of these being hearings of charges against YZ at South East Essex Magistrates Court (Southend), Pre Sentencing Reports, whilst not being an absolute requirement, were not requested. The IMR author therefore questions why these reports were not requested by the Court.

The Probation IMR author states that the reasons the Court revoked YZ's Unpaid Work Order on 21st June 2011 are not clear, and there is no evidence that Probation Service requested this.

The IMR identifies that whilst the Probation had suitable policies in place, for a range of reasons (which include administrative mistakes, an officer judgement about deferring the assessment, and an apparent lack of requests by the courts in respect of Pre Sentencing Reports) these policies were either not followed, or were unable to be used to their full

potential.

The Probation IMR identifies that the use of what the Probation Service refer to as a “Narey Court”, where there is an expectation of cases being dealt with speedily, may have been a factor in this case. It seems expectations had grown up about how these courts operated, and were serviced by the Probation Service which were to some extent, within the process of this review, disputed by HMCTS. For example, the Probation understanding that cases needed to be dealt with on the day. HMCTS have commented that there is no such court as a “Narey Court”, this term was being used to refer to Early First Hearing and Early Administrative Courts. Despite their title and role, the principles of natural justice should still hold sway and the procedures adopted should support this.

The Probation IMR author makes a number of recommendations, which include a policy change that risk assessments will not in future be deferred, and will always be carried out when a sentence is given without Pre-Sentence Reports.

However it is the opinion of the Overview Report Writer that whilst the analysis of events in this IMR is excellent, some of the recommendations tend towards reiteration of the need for compliance with existing policies and procedures, and therefore these recommendations needs to be revised in order to be made in a more SMART manner, so that they can be clearly measured in terms of their impact and outcomes.

4.3. The Victim Support IMR

The Victim Support IMR gives an adequate review of the events under consideration, and shows that the Independent Domestic Violence Advisor (IDVA) made pro-active attempts to both contact and gain the trust of AB, and that she succeeded in assisting her in responding to her risk, mainly through the installation of the Sanctuary Scheme at her home. The IDVA displayed good practice in her persistence in trying to engage with AB, in which she was eventually successful.

It identifies that although a formal risk assessment should have been undertaken in this case, this was not done, in contravention of the service policy. Although the IDVA did not record the reason, the IMR author identifies that this was probably because a risk assessment was already in place (done by the Police), that would have been sufficient for the IDVA to make initial contact with AB. Had contact continued, the IDVA would have reviewed and updated the risk assessment. Although this had no impact in this case, there is an appropriate recommendation regarding improving timeliness and content of case recording, in particular where risk assessments are not done on first contact.

4.4. The Southend Borough Council Children's Specialist Services IMR

This IMR records that DV1 notifications were appropriately sent by the Police to Children's Specialist Services, and that they were responded to in a proportionate way. It identifies that within Children's Specialist Services there was some incorrect recording regarding schools, family relationships and siblings in respect of the children of AB and (redacted).

The Children's Specialist Services policy in respect of DV1s is that after three notifications where there is a child in the family, an Initial Assessment should be considered, as there is likely to be an impact on children in the family. In this case there were five reports

regarding AB's son before an Initial Assessment was considered, and there were four before an Initial Assessment was considered in respect of (redacted). A recommendation is made that in future, whilst not implying that the decision making was incorrect in this case, it would be good practice for any decision not to proceed to an Initial Assessment following three referrals to be made in conjunction with, and authorised by, a senior member of the team concerned. It should be stressed that it was felt this would have made no difference in this case.

In terms of the MARAC, it is identified that Children's Specialist Services were not held to account by the MARAC in respect of the matter of Initial Assessments, and this matter will be picked up in the MARAC recommendations.

In terms of working with families, the IMR author identifies that the role of significant men in families should have a higher profile. This is a matter which had already been identified within the Children's Specialist Services, and suitable recommendations are made in order to strengthen this approach.

4.5 The Multi Agency Risk Assessment Conference (MARAC) IMR

As already stated, it was felt by the Overview Report Writer that a separate review of the MARAC was called for in this case. Whilst the MARAC is not a service, it is a process which is very central to the management and reduction of risk in the context of domestic abuse cases which have been assessed as High Risk, the criteria for High Risk being that there is a risk of serious harm arising in the current circumstances which prevail.

In particular, all agencies understand that referral of a case to the MARAC automatically allows agencies to share information about the victim, the perpetrator, and their families.

MARAC arrangements are a nationally agreed process, and are underpinned by national guidelines emanating from CAADA (Co-ordinated Action Against Domestic abuse). The IMR author identifies that the Essex MARAC deviates from these guidelines in three ways: that the MARAC Co-ordinator is the Chair (and not a Detective Inspector), that the Essex MARAC sends out reminders to agencies in terms of agreed actions, and that the Independent Domestic Violence Adviser (IDVA) service does not take referrals for all MARAC cases, as the CAADA guidelines state they should, due to the fact that IDVA capacity is insufficient to allow for this.

In the Essex MARAC therefore, unless the IDVA is already involved with the victim via the Police referral, the responsibility for representing the victim's view lies with the referring agency, which in this case was the Police, for each of the referrals for AB.

In terms of discussions at the MARAC, AB and YZ were discussed a total of three times, and (redacted), in the period under review. The MARAC IMR identifies that there was appropriate discussion of the risk to AB (redacted), and that agreed actions were carried out and reported back to the meeting. It would appear that AB was not always aware of being referred to the MARAC, and therefore her perspective on events and her thoughts about what she might have wanted from the MARAC were of necessity sometimes inferred by the MARAC, rather than being more directly communicated.

The IMR identifies that there was no focus on the management of YZ in terms of reducing

the risks that he posed, (redacted) was not strong. It was questioned as to whether, despite analysing risks in relation to AB, the MARAC had a strong enough focus on achieving a definite outcome from these discussions.

It is also identified that there is a felt to be a very high volume of cases heard at the MARAC and it is questioned as to whether this level of sustained input and scrutiny is realistic. Representation by agency partners was also identified as an issue, with good representation generally, but gaps identified in terms of some health services, and these matters are addressed later in the analysis and recommendations sections of this report.

4.6 The Southend University Hospital Foundation Trust (SUHFT) IMR

This IMR identifies that although there was an initial omission to carry out a risk assessment on AB when she attended Southend Hospital Accident and Emergency, this was probably because the staff member was aware, by their presence, that the Police were already involved in this case. It was not a material factor therefore.

The IMR further identifies that since February 2010 there has been a Domestic abuse Working Group at Southend Hospital, which has been working in conjunction with the Partnership Manager of the Southend Domestic abuse Forum in order to develop a policy and procedure for the management of domestic abuse within Accident and Emergency at Southend Hospital.

There has been the introduction of Domestic Abuse Pro Forma containing the DASH risk assessment, and a training programme which was launched on 1st June 2010, and there is now a structure in place for the management of these referrals which is compliant with the wider Southend Essex and Thurrock safeguarding procedures.

The DASH risk assessment enables the identification of cases which should be referred to the MARAC. In addition the Patient Administration System, has, since the time of the introduction of this policy, been able to carry a “flag” for domestic abuse, and the IMR report identifies that this system was seen to work well in this case.

Some appropriate recommendations are made in this IMR regarding the need for further training of Accident and Emergency staff, and strengthening and reviewing the policy framework on domestic abuse.

4.7 The Southend Borough Council Adult and Community Services IMR

The IMR identifies that a vulnerable adult safeguarding referral could have been made in respect of AB on 27th / 28th June 2011. However this would have not been material in this case, as the information which would have been shared was already known to the Police.

(Redacted).

The DV1 notifications need clearer identification of the involvement of any vulnerable adult, and better systems for transferring this knowledge within Southend Borough Council, as the notifications are sent by the Police only to Children's Specialist Services at the Council, and this matter is already in hand.

Appropriate recommendations are made regarding the development of information sharing protocols in respect of the MARAC, and recommendations in respect of supervision, recording and training of Adult and Community Services staff to strengthen practice in the light of these findings.

4.8 The South Essex Partnership University NHS Foundation Trust (SEPT) IMR

This IMR deals with services which were delivered by the specialist mental health and substance misuse services in the period under review. Subsequent to this death, as part of local service reorganisation, SEPT has become the provider of a wider range of community services, which include the South East Essex Community Health Care Service (SEECHC).

The SEPT IMR finds that AB received counselling from the Trust and YZ was referred at various times primarily in relation to substance misuse services focussed on his alcohol consumption, and the services provided were deemed to be appropriate.

At the time of these events there was no stand alone domestic abuse policy, although there was a section in the Safeguarding Children Policy. Since this time there has been the development of a specific appendix in relation to domestic abuse within the Children's Safeguarding Policy.

The Serious Incident report which took place in relation to this case is referenced by the IMR author who reports that it is likely recommendations from this will include the establishment of a Trust wide Domestic abuse policy, and mandatory training in domestic abuse for all Trust staff.

The Serious Incident Report is separately covered by this review.

4.9 The Southend Borough Council Housing Department IMR

The Housing Department were involved because they offer and administer the Sanctuary Scheme, which is a series of possible aids and adaptations to be made to the home of a domestic abuse victim, and which are designed to make staying there safer in the face of a threat from a perpetrator who is an ex partner. The scheme commenced in 2008.

The IMR identifies that a menu of features was offered to AB by the scheme, and security features were added to her home, which included additional locks and other security features.

The recommendations made in the IMR include better identification of whether the Sanctuary Scheme is in fact suitable for the victim, and that a review of how the scheme is delivered therefore be undertaken. It is also recommended that confusion between the two schemes in operation in Southend (through Southend Borough Council and South Essex Homes) is cleared up by providing better information to victims and their families about the particular scheme in operation.

4.10 The South East Essex Primary Care Trust IMR

This IMR identifies that AB attended her GP for alcohol issues, and with various physical symptoms, some of which were connected to her domestic abuse by YZ. In January 2011 and May 2011, AB disclosed domestic abuse to her GP, and was referred to counselling in response, AB having made known to the GP that these offences were in the legal domain.

YZ attended his GP in relation to alcohol abuse, and a Community Drug and Alcohol Service referral was made on two occasions, in 2009 and in 2010.

The services provided by the respective GPs were deemed to be of an acceptable standard.

The main issue identified by the IMR report author is the need for GP recording to be more comprehensive, and a suitable recommendation is made regarding this. There is also the matter of the GP being properly connected to the MARAC and therefore able to share, and receive, information as appropriate.

4.11 The South East Essex Community Health Care IMR

The role of the service was the provision of children's health care in respect of the two families, that of AB and (redacted). This includes school nursing services, and community health care.

From November 2010 a new process for the triage of domestic abuse notifications was adopted by the Trust, and they are now assessed within Children's Social Care.

The Service itself does not use the DASH risk assessment tool.

The IMR report also notes that the agency was not represented at the MARAC and therefore was missing some important information about the families. Whilst this situation continues there is an ongoing risk that practitioners in this service will not have potentially significant or important information about vulnerable children or their parents. This has been the subject of debate between the Health Commissioners of this service, currently the Primary Care Trust (but due to be transferred to Clinical Care Commissioning Group in 2013). The Overview Report Writer understands that health representation at the MARAC should be secured through a general duty in respect of safeguarding, but that in this case constructive discussions are underway to facilitate this representation.

Recommendations are made that the triage process for domestic abuse notifications should be reviewed in order to make sure that all appropriate information is shared and correct actions are taken. It is noted this has commenced already, and is to be evaluated through an audit process. There is also a recommendation about training on domestic abuse.

4.12 SERCO IMR

This detailed numerous violations of curfew arrangements known to SERCO, caused by YZ tampering with the tag, or being absent from the curfew premises. The IMR concludes that these violations were all reported to the Police in line with the standard operating procedures under the terms of SERCO's contract.

In addition the SERCO material supplied covers an incident on 29.6.2011 when the tag

was being fitted to YZ at his sister's house, he became uncooperative and abusive, grappling with the female operative and attempting to retrieve an item from her kit bag. He was described as having been drinking but not drunk.

He made a phone call to SERCO shortly afterwards swearing and saying that he believed the tag to be incorrectly fitted. The tag did not properly activate which is believed to be due to YZ having tampered with it immediately on fitting. The assault on the operative and the tamper were reported to the Police although no action was taken in respect of the assault. This information does not appear to have been more widely shared.

4.13 CPS IMR

The actions of the CPS in preparing cases for prosecution of YZ in the timescale of this review are covered by the CPS IMR. It identifies that the offences against AB were all correctly charged and were properly identified as domestic abuse cases. It does very helpfully identify where more action could be taken in future in similar cases. For example this includes ensuring that the full domestic abuse history is made known to the prosecutor, including in relation to breaches of bail conditions. This is dependent on Essex Police information on domestic abuse cases, (carried in DV1 Notifications), breaches of bail or of bail conditions, and records on the Police National computer all being up to date and entered appropriately on the recording systems on which this reliance is placed. The CPS were recorded in the IMR as having attempted to use Hearsay Evidence, and Special Measures to support AB because they knew she was very fearful about giving evidence, and their practice was generally sensitive to her needs in this respect. The IMR makes some recommendations about strengthening practice particularly in respect of supporting vulnerable witnesses in domestic abuse cases.

4.14 The IPCC Report

The IPCC report deals primarily with events on the day of the AB's murder and covers the matter of the Police's response to her calls on that day. It finds that no particular officer was individually accountable for what went wrong on that day. The non-emergency call which AB made at 2.40pm because YZ was harassing her was deferred for action by the Police because AB said she was going into town until 4.30pm. It had still not been dealt with by the time that her alarm activated at 7.40pm that day.

However the IPCC report outlines a number of significant factors as context to these events. Firstly that the effectiveness of the operational system in the Force Information Room for call handling (which included background research, and information retrieval, before officers are despatched), was impeded on the day by shortages of staff in call handling capacity. In addition there was confusion about whose role it was to retrieve information. Southend operational capacity was stretched in that the normal operating level of 1 sergeant and 11 constables was actually 1 sergeant covering 2 areas, and 6 constables, of which 2 were already committed. In these circumstances, although there was a formal policy that domestic abuse calls could not be deferred for later responses, the reality was that a combination of errors in the call taking, short staffing, and deficiencies in the management oversight of the shift, which included confusion locally as to whether domestic abuse calls could or could not be deferred (custom and practice having grown up that they were deferred when resources were stretched, especially if they were deemed non urgent) meant that the call by AB was wrongly deferred, and the background information to it which would have alerted operatives to its risk context was not retrieved.

AB's call was therefore wrongly deferred and the seriousness of her situation not assessed. The existence of a backlog of DV1 notifications not yet entered into the Police system, the fact that Essex Police had previously been advised of shortcomings in their responses to domestic abuse, and the parallels with another domestic homicide case occurring at about the same time as this one, are all noted.

Another significant factor identified in the report is the fact that Essex Police did not use the ACPO recommended additional assessment module, added to the DASH assessment and triggered by certain responses, which covers matters such as a perpetrator's behaviour in terms of stalking and harassment. This assessment helps to identify these very high risk behaviours which it has been shown seem to be strongly associated with homicide risk, in a domestic abuse context. This amended high risk DASH had been circulated to DALO's on 23 March 2011, but these additional sections were not supported by Essex Police, and the prompts which triggered them were removed from it. This decision has now been reversed.

4.15 The SEPT Serious Incident Report

Both AB and YZ received services from the Trust. AB was seen in relation to anxiety symptoms primarily experienced regarding her relationship with YZ. YZ was seen for alcohol consumption and depression. The report outlines that YZ was assessed on three occasions by senior psychiatric staff and was deemed to have mild to moderate depression, with no evidence of major mental illness or psychotic features. Alcohol consumption was seen as influencing his offending behaviours.

There is no evidence to indicate that YZ was given anything other than appropriate and sensitive services from the Trust. He was identified as posing a risk of assault to others through his anger and alcohol abuse, however the practitioner did not appear to act on this information, on the basis that YZ promised to neither drink nor go near the women to whom he posed a risk. This suggests that too much weight was given to what he said, and in the absence of any process for checking the situation and YZ's previous and current behaviour, e.g. through the MARAC, the practitioner could not know that this promise was unlikely to be kept and in the event was not.

The main issues identified in the Serious Incident report are the lack of clarity regarding relationships between the mental health and substance misuse services around clients with dual diagnosis needs. Suitable recommendations are made to address this, although it was not identified as a material factor in this case.

The other issue identified is the lack of Trust presence at the MARAC, the failure of the IAPT therapist to consider safeguarding procedures in respect of possible victims of YZ, and the issue of linking information about YZ with the Criminal Justice Mental Health Team when a psychiatric assessment was undertaken at Southend Magistrates Court. An action plan to address this is also included in the IMR report. The issue of the MARAC and information sharing will be covered in the Overview Report Writer analysis as it is an area requiring addressing in this review.

Section 5:

Information from the family meeting

The Overview Report Writer met with the family of AB on 3rd November 2011. A wide range of AB's extended family was present at this meeting, including two of her children.

The key purpose of this meeting was to try and find out more about the perspective of AB and to try and make sure that this was as strongly represented as possible within the review.

The family contributed their thoughts to the review in three main areas: the legal system, the victim's perspective, and their thoughts about what could have been done, if anything, to prevent her death.

The family were very critical of the criminal justice system and expressed a strong view that it had let AB down, in that YZ appeared to be able to "get away with" so much of his behaviour.

In terms of their own involvement, they were obviously distressed that they did not know the degree of harassment and threat that YZ was making to AB on an ongoing basis. None of the family liked YZ.

It seems that all family members had access to a limited amount of information, but that no one member of the family really had any great insight as to the overall picture for AB. This meant that they were limited in what they were able to achieve in terms of support and influence, and they were unaware of the high risk AB was in. With hindsight they also felt that AB may have been protecting them from the situation and trying to manage it by herself.

As regards AB herself, the family felt that she was probably unaware of her risk level, and that if she had known this she might have taken stronger steps to protect herself. They felt that AB had a very busy life, she held down a full time job and cared for her children, she would not have been inclined to read leaflets about domestic abuse, and that if she had it is unlikely they would have had the required degree of impact. They made the suggestion that it might be a more powerful tool for victims of domestic abuse to be given a DVD to watch, one which is supportive and positive in respect of victims, which contains material designed to assist victims in gaining a better understanding of perpetrators behaviour and which gives positive messages about the options open to victims who want to take action to try to become free of an abuser. This seems a very good suggestion.

The family also felt that better information could be given to victims about the nature of the protective options open to them, or provided to them, through the Sanctuary Scheme and the Essex Police alarm scheme for example. This would both assist in making informed choices and avoid unrealistic expectations about the level of protection provided against a very determined perpetrator. My overall conclusion as Overview Report Writer is that greater consideration should be given as to how the involvement of family members in domestic abuse cases can be promoted. Whilst recognising this is not always simple, again the MARAC could be one forum where this approach is considered.

Section 6:

Service Context in Southend

6.1. The Development of Policy and Practice in addressing Domestic abuse in Southend

Responsibility for leadership in addressing Domestic abuse in Southend lies with the Community Safety Partnership.

Across the Partnership there has been mapping of the incidence of domestic abuse and the development of a policy framework. In 2002-3 there were 1541 Southend cases reported, in 2008-9 there were 3846 cases reported. This steady rise in the number of cases being identified is believed to be due to better reporting and increased confidence in responding, rather than an increase in domestic abuse per se.

The first domestic abuse strategy was produced in 2010 covering the years 2010-2013 and this sets out 5 strands to the approach: access to services for victims, challenging perpetrators, guidance and training for practitioners, a communication strategy to ensure messages and information are disseminated to support work in domestic abuse and finally leadership and governance in terms of the partnership.

Southend is reported as having a higher than average number of cases being reported but also higher than average confidence in services, and there have been a range of services developed to support victims of domestic abuse and their families. These are listed in the relevant strategy documents and many of these services such as the MARAC, came into play in this case. In addition, there is a particular stress on prevention, with a significant amount of awareness raising in schools and the community being central to this. However this work has not been fully developed yet.

Essex Police have a policy which includes obtaining successful prosecutions, training in domestic abuse awareness, public awareness, support for children witnessing domestic abuse, local partnership working and data improvements.

The Southend Together Partnership commissioned a “Deep Dive” exercise in relation to domestic abuse services in early 2011. Whilst this seems to have identified an ambitious programme, particularly in respect of recommending the establishment of dedicated courts for domestic abuse, it did not lend itself quite so well to a more incremental programme of action, which might have been more achievable in the local circumstances. However, the value of the Deep Dive is that it does highlight how significant the issue of effective working within the criminal justice process is, and the challenges of achieving this, which is one of the drivers leading to the establishment of special courts elsewhere, as conviction rates in domestic abuse cases remain generally low.

In summary, the development of services in Southend has been given focus and impetus by the Community Safety Partnership and whilst, as elsewhere, Southend is at the early stages of taking these issues forward, there is evidence of leadership and progress in this area, to which this review will contribute as appropriate.

Section 7:

The national context: findings from research and other significant factors

Whilst there is a very significant body of research data and evidence in the field of domestic abuse, I would particularly like to reference a very significant report undertaken by CWASU London Metropolitan University on the issue of intimate partner homicides (2007).

This study found that a common set of indicators were in place in respect of the perpetrator all the cases which the report considers: these included jealous partner surveillance and relationship conflict, controlling behaviour, actual or potential separation, histories of violence and the potential for suicide. The research is critical of existing risk assessments, which focussed on the actual violence and tend to overlook the above factors in assessing risk (the research pre-dated the introduction of the DASH risk assessment).

The research also found that informal networks were mostly supportive of the female victim, but that women's frustrations and challenges could be misread not as emanating from the perpetrators control, but rather as volatility of the victim. The research found that an element of coercive control was at play in the perpetrator dividing the woman from her family and friends, and the common view of the family after the homicide was that of: "if only we'd known".

It is very striking to the overview author that all of these behaviours and factors were present in this case. This research reinforces the need for risk assessments to be focussed not just on the degree of violence, but also the other factors identified above which are associated with a high risk of homicide.

Section 8:

Analysis of the specific terms of reference of this review

8.1 Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or a perpetrator? Was it reasonable to expect them, given their level of training or knowledge, to fulfil these expectations?

Overall throughout this review there is evidence that sensitivity was shown to both victim and perpetrator. In respect of the victim there were persistent efforts made to engage her in making a statement and securing protection for herself. The CPS applied to use hearsay evidence and to arrange for Special Measures. Some staff were especially persistent in attempts to engage her, the DALO and the IDVA in particular. The offences were correctly seen as domestic abuse. However the very high risk posed by YZ's stalking harassment and controlling behaviour was not as effectively factored in as it could have been. Furthermore the fact the YZ was assessed as high risk and discussed at the MARAC was not known to all those involved with YZ and, partially in consequence of this, not all information was therefore shared, high risk being understood amongst professionals as allowing for otherwise confidential information to be shared.

8.2 Did the agency have policies and procedures for DASH (Domestic abuse, Stalking and Harassment and Honour Based Violence) risk assessment, and risk management for domestic violence victims or perpetrators, and were these assessments correctly used in the case of this victim/perpetrator? Did the agency

have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC (Multi-Agency Risk Assessment Conference)?

Each agency has assessed its policies and procedures in their IMR's and appropriate recommendations are made in respect of developing or strengthening these. The victim was presented to the MARAC on three occasions (redacted). The case was sent to the MARAC as appropriate, in relation to the high risk assessments made regarding YZ's domestic abuse on these occasions.

Because the Essex MARAC cannot follow the guidelines issued by CAADA, in that an Independent Domestic Violence Adviser (IDVA) does not support every victim who is referred, the victim's perspective, which it would be the IDVA's role to establish and then represent, is not necessarily present at the MARAC.

The Police, who will therefore, by default, undertake the advocacy role when they make the referral, which will be in the majority of cases, have a primary interest in securing a conviction. They may not always be the best placed agency to act as advocate for the victim. It is suggested that if the IDVA capacity cannot be enhanced to ensure the victim is always represented at the MARAC by an IDVA, then at least a "lead professional" role could be considered, with a clear remit to represent the victim's view, within a practice that wherever possible the victim should know about the MARAC discussion, unless this knowledge is deemed to enhance rather than reduce their risk.

In terms of the MARAC and the views of AB as a victim, it has been identified that AB's voice, and the representation of her wishes, was not as strong as it could have been, and this would be addressed if the MARAC adopted a policy that wherever possible and appropriate the victim should be consulted about the MARAC discussion and asked for their views about what they would like as an outcome. The lead professional's role would then include a responsibility to represent this.

There is evidence within this Review that the MARAC has become a very busy agenda with a large number of cases being heard at each meeting. This Review highlights that although all cases heard there are, by definition, high risk, there was insufficient attention paid in this case to YZ as the perpetrator of abuse towards AB (redacted) The focus was, rather, more on a risk reduction model of a menu of actions in respect of victims. In addition, in general terms, analysis of the role of the MARAC in this case found that it did not have a strong focus on achieving outcomes.

The Panel felt that a focus on YZ would have identified some of the ways in which the very extreme risk he posed might have been identified. These included: his stalking and harassment, substance misuse and mental health issues, personality issues such as that historically YZ did not take responsibility for his actions, his obsessive behaviour, the history of offending which included violence and weapons, the threats to kill and the escalation in the frequency of incidents.

The MARAC was felt to have potential, in this situation, in terms of linking with the criminal justice process, to enable material disclosed at the MARAC to be used to support better victim protection. For example, it could have been used to oppose bail applications,

perhaps with more success.

Although the high risk assessments led to the correct referrals to the MARAC, the MARAC has been identified as having limitations which hampered effective working in this case. Firstly the MARAC tends to work to a menu of set risk reduction actions on behalf of the victim. It is not always clear that the victim is aware of the MARAC discussion. There should be a clear decision as to whether this is or is not appropriate and the MARAC should be aware of this. In respect of actions agreed by the MARAC although the Essex MARAC set out to follow up actions agreed, on two occasions this was not done. This process therefore needs to be tightened up.

Some agencies, especially in Health, were not linked to the MARAC and therefore were not sharing relevant information or aware of the high risk assessment in respect of YZ and his victims. Information, such as that held in one Health Trust about YZ's depression and drinking and suicidal tendencies, was seen in isolation in that agency rather than as informing a bigger picture about the risk he posed when taken in conjunction with other information. Most significantly in respect of the MARAC, it was not used to co-ordinate any activity in respect of the criminal justice system. The CPS for example have no link to the MARAC at all.

It would not appear that the MARAC had any sense of working towards a managed conclusion in this case, even though dealing effectively with YZ in the criminal justice system was clearly so central to achieving this.

The DV1 notifications and assessments were all appropriately graded although on one occasion this was done retrospectively, when a medium risk was upgraded to high risk due to it being discovered that a high risk assessment had already been noted.

There are two areas of particular concern in respect of DV1 notifications. The first is that there was at this time a delay in entering DV1 notification onto the Essex Police system due to a backlog. Although this has now been cleared, the importance of all records being immediately made is highlighted in this review. That is because, due to the rapid escalation of YZ's offending and his repeated breaches of bail or bail conditions, it is clear that on numerous occasions not all the relevant information was available to the professionals involved in the criminal justice process. Reliance is made on these records in undertaking proceedings.

The other area of policy and procedure which would have potentially impacted on this case was the use of the additional ACPO recommended assessment questions relating to stalking and harassment. The association of these behaviours with very high risk of homicide being posed by a perpetrator makes this a useful tool in planning victim protection and potentially in managing a case. This is especially since the MARAC, even though it is restricted to reviewing cases deemed high risk, still has a very high caseload.

It is pleasing to hear this has now been adopted by Essex Police.

8.3 Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

The arrangements within the Police to involve the DALO and the IDVA seemed to work

well in this case. Both the IDVA and the DALO worked hard to support AB and were persistent and professional.

Generally it can be seen that agencies worked within the framework of the MARAC and shared information. However some professionals, such as GP's, SEPT, and community health services, were not signed up to the MARAC and were not aware of the high risk assessment which had been made, both in relation to YZ and AB on three occasions (redacted) It is understood that the general duty of safeguarding which is laid upon health services should cover their involvement as appropriate in this process. In addition, there had been discussions with Health commissioners about this involvement. Without involvement in the MARAC it is not likely that relevant information will be shared as a professional working with a client or patient will not know about the risk assessment and permission to share information. This needs to be addressed therefore.

In respect of the criminal justice process, at times, not all the information which should have been available to prosecutors or the bench was identified. Causes of this seem to be: the backlog of DV1 notifications leading Police records to be out of date, the absence of requests for Probation reports leading to missed opportunities for the bench to be provided with more comprehensive information which would have led to better decision making, and the Police National Computer not being updated within the 24 hour timescale which was a recommendation of the Bichard enquiry. Again this meant that on at least one occasion recent offences committed by YZ were not made known at the time of court hearings. In addition to this, it can be seen that whilst agencies were involved in supporting AB, there was no link between them and those responsible for monitoring and investigating YZ -so that for example there was no follow up with AB to ascertain whether, in addition to breaching curfew conditions, YZ was also contacting AB.

Breaches of bail were not always made known to the CPS. SERCO reported all such breaches of electronic monitoring to the Police but it seems that these were not made known to prosecutors, especially during the latter period covered by this case when YZ's disruptive behaviour was escalating.

The significance of the MARAC for multi agency working is that once a case is referred to the MARAC, all agencies know that it is High Risk, and that they have permission to share information. However this review found that more effort could be made to co-ordinate within the MARAC, how the support aspects of this work could be co-ordinated with the investigative aspects , to deliver a more purposeful approach towards securing a good outcome for the case.

In the case of domestic abuse incidents which are classed as Standard or Moderate Risk, this is not the case, and a more complex situation exists in relation to data sharing, with Data Protection concerns playing a significant role. For all agencies, the sharing of information is a complex area. To identify a situation as high risk may in itself require some data to be shared, in order to gain the complete picture.

In addition, the review found that appropriate responses to domestic abuse were best understood in the context of safeguarding children, and that there was increasing understanding in relation also to vulnerable adults, but that there was a lesser degree of understanding of the proper response where domestic abuse presented outside of these two contexts.

Some agencies were, in consequence, beginning to identify the need to either instigate, or strengthen, their policies in relation specifically to domestic abuse.

In view of the complexities of multi agency working, including the need to share information, it would appear to be very unrealistic that fully effective multi agency working in respect of domestic abuse can be carried out without recourse both to policies and procedures which support inter agency approaches, and to the necessary workforce development, training, supervisory programmes, audit activity, and governance, with which to support this practice. The development, review, monitoring and governance of suitable policies and procedures on domestic abuse by all partners is therefore seen as a key task for all agencies across the partnership.

The Southend Domestic abuse Forum carried out a “Deep Dive” exercise in early 2011 designed to look at these issues, and it is recommended that the Community Safety Partnership reviews these matters and engages more clearly with Her Majesty’s Courts and Tribunal Service and the Crown Prosecution Service in particular, to look at the national learning, in order to identify how this can be built upon locally. This is particularly important given the high rate of domestic abuse identified within the South East Essex Community Health Care IMR as prevalent within Southend.

8.4 What were the key points for opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

In terms of individual agency assessments and decision making, subject to some improvements which are covered by recommendations in the individual IMRs these were generally of a good standard. The area where assessment and decision making did not work as effectively in this case was essentially within the criminal justice process. Some of the reasons for this have already been covered in terms of the need to strengthen systems for ensuring appropriate information is both gathered and transferred between the Police, CPS and Probation Service, ensuring that all the relevant information is made available to the Bench during Court hearings.

There was a failure to put YZ before the court in respect of a bail breach which stemmed from the Police’s misunderstanding of the 24 hour rule. HMCTS have advised that YZ should have been out before the court whilst intoxicated. This is an important learning point for the Police.

8.5 Did actions or risk management plans fit with the assessment and decisions made? Were there appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

The assessment of AB as a high risk domestic abuse victim was appropriately followed up by the DALO and IDVA and appropriate and strenuous efforts were made to engage her in looking at her safety and security. It was clear to all professionals concerned that securing a conviction against YZ was central to this case. Professionals were aware that AB was extremely concerned about giving evidence against YZ. Efforts were made to support her in doing so, ranging from the support of the IDVA, the CPS attempts to use Hearsay

Evidence, Special Measures, Application for a Restraint Order against YZ, and objections to bail.

However in making these applications, there were gaps and omissions in making available all the information which could potentially have been used in support of this. To some extent this was due to the rapidity of YZ's repeat offending and, towards the latter end of the period covered by this review, his disruptiveness in terms of compliance with bail conditions. However, it was these very behaviours which indicated YZ's escalating lack of control, deterioration in terms of anger management, and danger he posed to AB.

In addition, throughout the whole of the period covered by this review, with the benefit of hindsight, it is possible to see that YZ was known by some professionals not to take responsibility for his actions, he was known to be at high risk of assaulting others, and he did not fulfil the sentences previously passed on him, both in terms of the unpaid work elements of his community sentences or the fines. At a critical point in the criminal justice timeline of this case the community sentences were replaced with a Conditional Discharge. Although this was described by HMCTS as a technically more severe sentence, it had the unfortunate effect of releasing YZ yet further from structure and requirements. It also ended his formal relationship with the Probation Service. Pre-Sentence Reports might have identified early on in this series of hearings that resources within Probation Service, such as the IDAP programme, would have been a more suitable approach, and would also have opened up to AB a further victim support programme. We cannot know whether these would have been effective. However, they would also have kept YZ within the remit of the Probation Service and this might have affected outcomes later on as the case developed, as it has been identified that Probation can return offenders to Court for breaches of their orders.

In any case, there was an oversight in respect of the Probation Service which led to there being no risk assessment on YZ. Errors were made in the allocation of YZ to a Requirement Organiser and in the deferring of the Probation Risk Assessment, leading to key gaps in the availability to the bench of important information about YZ.

8.6 When and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options / choices to make informed decisions? Were they signposted to other agencies?

In respect of the victim, AB was given good support by the DALO and the IDVA. It was a difficult situation because AB was, for good reason, reluctant to give evidence against YZ. She was also initially reluctant to improve security at her home. However through the persistence of these professionals AB did come eventually to provide a witness statement and to receive security adaptations to her home. Neither of these actions saved her. And could question whether they would have – and what thought was put in to identifying what she needed, rather than what was on offer.

It is felt that the information about the Sanctuary Scheme should be made clearer to victims, in terms of the level of actual protection offered. There are two different schemes in operation in Southend and there was confusion amongst professionals about the actual arrangements these offered.

AB did not disclose what was happening to her family. It seems that a number of friends and family had partial or limited information, but no-one had the whole picture. It is believed that AB thought she was protecting them by this approach. AB came from a very supportive extended family and it is clear that they would have acted to assist her had they known more about what was happening.

Further consideration should be given by the relevant agencies about how families can be involved in protecting vulnerable victims, including the families suggestion that material for victims be improved, for example through their suggestion of a DVD or downloadable material which might motivate victims to seek assistance, through a better understanding of their risks.

8.7 Was anything known about the perpetrator? For example were they being managed under MAPPA (Multi Agency Public Protection Arrangements, which exist to manage the threat to the public from high risk offenders)?

These matters have been dealt with elsewhere. YZ was not covered by MAPPA arrangements.

8.8 Had the victim disclosed to anyone, and if so was the response appropriate?

These matters are covered generally above. AB did make some disclosures to a friend, who subsequently reported them, and these were taken in to account.

8.9 Was this information recorded and shared, where appropriate?

This was done as appropriate, but there were some gaps, especially where agencies were not part of the MARAC. This includes the CDAS counsellor and the GP. It is very important that all key agencies are part of, or represented at, the MARAC, as this enables them to know when the threshold for sharing information has been reached, resulting in more comprehensive and effective risk assessments and treatment plans.

8.10 Were procedures sensitive to the ethnic, cultural linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

There is no evidence that services were anything other than appropriate in this respect. AB and YZ were both of a white British ethnicity.

8.11 Were senior managers or other agencies and professionals involved at the appropriate points?

There was evidence in the IMRs that management oversight and advice was taken at appropriate points in this case. There were some improvements which were identified in IMRs for example management oversight of decision making in children's social care in respect of repeated DV1 notifications, but these did not affect this case.

8.12 Are there other questions which may be appropriate which could add to the content of the case? For example was the domestic homicide the only one that had been committed in this area for a number of years?

This was the only domestic homicide in the Southend Borough Council area in recent years, apart from a recent case involving an elderly married couple which has been the subject of a serious case review, and which does not have significant parallels with this case. However parallels have been drawn between this case and at least one other recent case in the county of Essex, outside of Southend, but involving similar themes in respect of Essex Police.

8.13 Are there ways of working effectively that could be passed on to other organisations or individuals?

No specific areas of good practice which would be open to greater generalisation were identified by this review, other than the fact that professionals were persistent and flexible in seeking to build trust with AB and to address concerns about her risks.

8.14 Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

There are a wide range of lessons to be learned from this review, many of which were identified in the IMRs. In overall terms the lessons to be learned from this case were difficult to draw out, as they emanated largely from the complexities of the criminal justice system. These are covered in the summary analysis conclusions and recommendations.

8.15 How accessible were services to the victim and the perpetrator?

There is no evidence that services were other than accessible to AB and YZ. In respect of YZ although he often missed appointments or avoided commitments, these were always re scheduled by the professionals involved. AB's only meaningful engagement appeared to be with the IDVA service; a possible explanation of this is that the IDVA came to AB's home in the evening, thereby working around what AB needed.

8.16 To what degree could the homicide have been accurately predicted and prevented?

It is clear that YZ's behaviour was deteriorating during the period covered by this review, with an escalating pattern of disruption alcohol abuse and offending. In addition, the high degree of obsessive and controlling behaviours which occurred, and which were made known to the Police and others by AB, were very significant risk factors, in addition to the various acts of domestic abuse he was known to have carried out against both AB (redacted).

YZ had a long history of offending, including convictions involving an offensive weapon. He was known to have anger management issues and to abuse alcohol. He committed other, non domestic, assaults in the period under review, including on professionals. He was noted as not taking responsibility for his actions. He did not complete (or even commence) any of the sentences given to him. He did not repay any portion of the various fines or

costs. He did not accept the conditions of the electronic curfew, he tampered with the tag and he repeatedly breached bail. He assaulted the SERCO operative fitting the tag. His bail addresses had to be changed because of his intolerable behaviour whilst staying there.

AB reported her fears in respect of being a witness. These fears were accepted by professionals as being justified. (Redacted). YZ made threats to kill.

In terms of assessing whether the homicide could have been prevented, the above factors, if assessed "in the round", should have led to an agreed understanding by professionals of how dangerous YZ was. There are a number of issues in relation to this point. Firstly that such an assessment "in the round" did not occur and was not part of the process. The MARAC is felt to have potential to play a wider role here.

Secondly that there were weaknesses, and some mistakes, within the criminal justice process in terms of how the four key agencies (the Police, CPS, Probation and the Courts) interacted, and which led to decision making which appeared to be reasonable, but which was actually made on a partially informed basis. In terms of recommendations, the areas looked to in rectifying these matters are those which relate to the timeliness of recording, especially by the Police, the use of the ACPO recommended module within the DV1 assessment, the operation of the courts in terms of pre sentencing reports, further training of magistrates in respect of domestic abuse and the recommendation that these four agencies establish a specific task group to look further at these areas.

In conclusion, the opinion of the Overview Report Writer is that, if all the information held in the multi agency context by all those who dealt with YZ had been professionally evaluated "in the round", the risk of serious harm to AB, or even her homicide, could have been predicted. However it is very difficult to make a firm finding on this point. The most that can be said is that there were, clearly, very serious issues of risk in the position of AB.

However for the homicide to have been prevented required both an effective strategy for dealing with YZ and a suitable level of protection for AB. AB took steps to protect herself, which turned out to be inadequate due to the determination of YZ. The strategy for dealing effectively with YZ was not present. The Overview Report recommendations which are made in respect of this represent significant and considerable changes to current practice and systems. I have made these in the belief that they will make a difference in terms of identifying those very small number of cases where there is potential for homicide, and managing them more effectively through the criminal justice system. I hope in this sense the homicide could be seen as preventable, as I am making these recommendations to prevent future incidence.

In terms of this particular case, there were a series of errors, lapses and missed opportunities which occurred and which these and other recommendations are designed to address. It is not possible to say whether the homicide would have been prevented if any or all of these had not occurred. This review has uncovered the extreme complexity of the interfaces within the criminal justice process, which were exacerbated by the rapidity of YZ's offences. However the criminal justice process must be robust enough to deal with all offenders, and especially those as dangerous and volatile as YZ. It highlights the importance of getting every part of the process right, and of getting the right decisions, even, indeed especially, in such a fast moving case. Whilst it is not possible to determine

whether the homicide was preventable it is possible to say it should have been preventable, and this is what the recommendations are designed to achieve.

8.17 The panel also identified the following issues as of particular concerns in this case, and requested that Individual Management Reviews address these areas:

- **How the alarm, and Sanctuary Scheme modifications to the victim's home, were used.**
- **How the criminal history of the perpetrator and the impact of the justice system and decision affected the outcome for the victim and alleged perpetrator.**
- **The impact of the MARAC process on the outcomes for the alleged perpetrator and all significant other persons.**
- **Analysis of each agencies involvement with the victim and alleged perpetrator should be undertaken with particular reference to the agencies policies and procedures and the agency context to their involvement.**
- **When considering the risk that the alleged perpetrator presented to other partners, did agencies consider the potential risk to the victim?**
- **The impact of any substance misuse by the alleged perpetrator, victim, or other significant persons.**

These matters were all addressed as appropriate by the IMR's and any significant issues were covered by their respective action plans. However the panel felt that it was very important to add that, during the next two years in particular, there are very challenging issues arising from the reorganisation and restructuring of local services. This will result in loss of continuity of personnel, challenges to maintaining organisational memory, and a context of service reductions caused by budget restraints. In view of these factors, it was felt to be extremely important that the action plan arising from this review is carefully matched to the new organisational structures and closely monitored for its completion.

Section 9:

Summary Analysis

This was a very complex case to review due to the rapidity with which YZ's offending behaviour escalated and the way in which the court processes in response to these offences were overlaid by his further offending behaviour and his breaches of bail. The review identified a number of mistakes which were made in recording court decisions and sentences, missed opportunities for passing on significant information and delays in recording information which meant that was not available when it should have been. Because of the particular complexity of the progress of cases involving YZ through the courts in the period under review, a criminal justice timeline has been added as Appendix One, to support the consideration of these matters.

Whilst none of these events were critical in themselves, the review has highlighted some missed opportunities which might have taken the case in a different direction. For example a sentence making YZ subject to a Probation Service perpetrators programme could either have modified his behaviour or led to a better understanding of the risk he posed. Using the opportunity to present YZ before the Court for breach of bail whilst drunk, or through use of a representative, might have led to bail being refused. Better recording of his previous sentences, and his failure to serve them, might have altered the court's views about suitable sentencing, or led to Pre-Sentence Reports being requested.

Looking at the situation from AB's perspective, a more effective use of the MARAC process might have been that it looked at the overall management of the case rather than focussing mainly on risk reduction actions AB could take. The management of the court process was central to this case, but the MARAC focus was almost exclusively on the question of supporting AB in giving evidence, and reducing her personal risk, and did not consider the other opportunities which could have been used to protect AB, such as more effective challenges to bail, more effective information gathering into the court process, and other types of sentences and services which could have been more protective of AB. The criminal justice process and the MARAC process were running in parallel rather than being seen as an opportunity to co-ordinate action.

Not all information was shared at the MARAC and more consideration could have been given to involving AB's family. AB was not professionally advised of the very high risk she was in because the professionals themselves had not identified this, other than in terms of the DV1 high risk assessment. This did not demarcate the way this case was managed in the MARAC from the other, considerably numerous, high risk cases also under consideration there. However, having considered the research about homicide risk, whilst not wishing to diminish any risk assessment placed at high, it is possible to see with hindsight that YZ posed a high risk of homicide in view of the fact that all of the behaviours identified by the research were present. Use of the additional ACPO module (now reintroduced by Essex Police) should assist this in future.

The recommendations therefore are designed to address these points.

Section 10:

Conclusion

Whilst there is some learning about how multi agency services work together, this is primarily a case where the majority of the learning lies within the complexity of the criminal justice process in respect of YZ's offending behaviour.

Even within this process, there are no simple or obvious points of learning, since it was the accumulation of numerous errors, missed opportunities or gaps in information, rather than any single "catastrophic" error, which led to these tragic events unfolding as they did.

The review has uncovered a need for the agencies key to the criminal justice process, the Police, Crown Prosecution Service, Probation and the Courts themselves, to address themselves towards developing a tighter, technically more informed and better co-ordinated process, in terms of how they respond to domestic abuse.

From a lay perspective, the series of events by which YZ was able to evade serving sentences imposed, was able to obtain bail and then repeatedly breach this bail, and was able to continue harassing AB and others throughout this period, appears incomprehensible and unacceptable. It must not be forgotten that this would be the victim's perspective, and that it can hardly have seemed reassuring to a vulnerable and terrified witness, who was expected to provide evidence against a high risk perpetrator in order to secure a conviction, to see him apparently able to evade, on numerous occasions, the reaches of justice.

Although a factor was the rapidity at which, towards the end of this time period in particular, events were unfolding and his behaviour was deteriorating, this should have generated a strengthened response in terms of the criminal justice system, and cannot be deemed to explain why, at times, agencies appeared to be on the "back foot" – in relation to bail for example.

However, having examined these events, and the learning from them, in considerable detail, it would appear that numerous changes within the criminal justice process, which may appear small in and of themselves, are needed if these gaps are to be avoided in future. These are therefore now addressed in the further recommendations which have been added to those emanating from the previous (interim) Overview Report, and which are already well underway, if not already completed.

In addition to these are some further recommendations, which deal with the issues of degrees of risk and dangerousness in perpetrators, multi agency co-ordination, and the monitoring of improvements in practice through the Community Safety Partnership. It is my belief that these recommendations do address the key issues identified in this very complex case, and for this I would like to thank the honest, open and constructive input of all those who contributed to the review.

Finally, and most importantly I would like to thank the family of AB for their input and support and to express my very sincere condolences to them. Whilst clearly nothing can compensate for the loss of a beloved family member, I do hope that there can be some reassurance that acceptance of the report, and its recommendations, will prevent such a tragic sequence of events recurring.

Section 11:

Recommendations made in the Interim Overview Report

1. That following the completion of the criminal case in respect of YZ, the CPS and HMCTS be requested to complete a full IMR, using the terms of reference of this Review, and that the findings within these should be integrated within the Overview Report, along with the outcome of the criminal case and any other findings, such as the Coroner's Inquest.

The recommendations of the Overview Report should then be reviewed with a particular emphasis on any learning which derives from a better understanding of the interaction of key agencies within the Criminal Justice process.

2. A recommendation will be made to the Home Office to the effect that the CPS and HMCTS should be made statutory partners to a DHR, by amending the Home Office Guidance.

3. It is recommended that the Community Safety Partnership undertakes a review of the leadership and governance arrangements for domestic abuse within the local system. This should include consideration of how HMCTS and CPS could become part of the Community Safety Partnership in order to develop a better understanding of working effectively within the “whole system” in addressing domestic abuse.

4. There should be clear links made between the Community Safety Partnership and Domestic abuse Strategy Group, the Health and Wellbeing Board, and the range of partners who link to it, to ensure that all these partners have governance systems, and policies and procedures, in respect of domestic abuse.

These policies and procedures should include a clear and comprehensive section on information sharing. This should include sections on data protection, permissive opportunities and should promote consent to share information as one of the clear strands of good practice.

The work undertaken in the “Deep Dive” should be reviewed, and lessons learned from this should be incorporated as appropriate into the local service strategy for domestic abuse.

5. The local MARAC should be reviewed. Matters to be considered by this review should include the following areas:

a. The membership should be sufficiently comprehensive to allow for effective engagement with all partners, particularly those within the health system. Every partner within the local system should understand who their link is to the MARAC, how they can access this link, and what sort of matters they should report to their link person for the purpose of sharing information. The health service requirement to input into the MARAC is covered by their general duty co-operate on safeguarding matters. Consideration needs to be given to ensuring that Clinical Care Commissioning Groups are aware of the need for GPs to be linked to the MARAC, and that the Drug and Alcohol Services provided via the DAAT should continue to have input commissioned via the Southend Borough Council public health function under the new arrangements now coming into force.

b. There should be greater focus on the perpetrator as well as the victim in assessing risk, in particular whether there could be greater focus on assessing and addressing the issue of levels of dangerousness of the perpetrator and how these can be dealt with.

c. Actions arising from the MARAC need to be carefully minuted and followed up in all cases.

d. In the absence of IDVA representation at the MARAC, this matter should be reviewed and robust arrangements for locating case responsibility should be identified. Local IDVA capacity should be reviewed. If IDVA capacity remains insufficient to allow this role to be undertaken by the IDVA, then it could be formally assigned within a lead professional role arrangement, within the partnership, in respect of each case.

e. The victim should wherever possible be aware of the MARAC discussion and process and should be supported in gaining a full understanding of it, and have their views clearly represented and recorded at the MARAC. Where it is not deemed to be appropriate that they are informed (for their own protection) this should be a clearly documented decision with supporting grounds.

f. Consideration should be given, within the MARAC process, to the opportunities to use information shared within the MARAC to better support the court process, in the victim's interests. In doing this MARAC should consider both the risks and potential benefits, and wherever possible act on the victims wishes in this matter.

6. Local services to support victims should be strengthened in the following ways:

a. The production and delivery of a DVD based, or downloadable, informative suite of materials for victims which powerfully exposes the way that perpetrators manipulate victims, and which outlines the danger which they pose to victims and their families. The involvement of victims in the production and editing of this material would be highly effective. Grants or charitable funds for to cover the cost of this could be explored.

b. More detailed information should be given out at local level about the separate elements of the Sanctuary Scheme, and what realistic degree of protection they offer.

c. In the very small number of cases where the assessed level of dangerousness indicates the need, there is consideration given to advising victims, through the MARAC process, that the Sanctuary Scheme is unlikely to be sufficiently protective, and an offer of suitable alternative housing should be strongly recommended to them.

7. That immediate action should be taken to clarify the interface between the Police reporting of DV1 notifications to Southend Borough Council, to ensure that the referral clearly identifies any vulnerable adult or children's safeguarding needs, and that the notification reaches the correct service within Southend Borough Council in a timely manner. In addition, a Southend Borough Council practice should be adopted so that after three notifications a firm decision as to whether or not to allocate the case for an assessment is made, with appropriate supervisory input, and is clearly recorded with reasons given.

8. That these recommendations are agreed by the CSP and are then converted into a clear action plan with appropriate timescales. In addition the action plans of the IMRs, which are attached as Appendix 3, are also aggregated and given timescales, both of these sets of actions to be monitored for progress by the CSP. In respect of the Probation IMR, where the action plan was felt by the Overview Report Writer to be comprehensive in its coverage, but insufficiently clear as to how the intended outcomes would be achieved, it is recommended that the CSP agrees to receive a full update at an appropriate time of an evaluation by that service of its means of assessing that the intended outcomes have been achieved.

Section 12:

Further recommendations added to the final Overview Report

9. The Police DV1 module to contain the extra section on stalking and harassment that ACPO recommend – this should be introduced and then audited to ensure exactness of completion.

10. A random sample audit of Essex Police responses to domestic incidents in Southend to be undertaken and reported to CSP, to include responses (including comprehensiveness of evidence gathering), timeliness, deferrals and other significant issues. (Timescale to be added).

11. An audit of Police DV1 completion and entering on system1 in respect of cases in Southend to be undertaken and reported to CSP, re reported and audited until 100% reached on at least 2 successive audits.

12. Training for appropriate members of the criminal justice system and police: to cover all matters of bail including the issues raised in the review of understandings about technical bail, what constitutes breach of bail conditions, what types of bail should be opposed, and the opportunities offered to deal with the 24hour rule when a defendant is not fit to plead themselves. (Timescales to be added)

13. There should be a review between the key legal services – the CPS, judiciary, Police and Probation. They should look at the learning from this review in terms of bail and bail conditions and the availability and suitability of sentencing options in the context of domestic abuse. The task group should report back to the CSP on a suitable action plan to improve these matters. This should include how Magistrates will be briefed on this case and the learning from it in terms of use of suitable bail addresses understandings of the behaviour of high risk perpetrators and their impact on victims as vulnerable witnesses.

14. The CPS and HMCTS should have a formal link to CSP, targets should be set on securing improved rates of convictions in domestic abuse cases, and these should be monitored by the CPS.

15. This case shows the reliance of relevant information being available in real time. The Police should be monitored in terms of entries to the PNC being in line with Bichard recommendations at 24 hours for input. The CPS will have access to this information in order to inform prosecution strategies. (this recommendation is in

progress but the police should add a suitable timescale for completion)

16. The use of bail addresses which are unsuitable will be addressed within the Court process by means of CPS checking with Police records and other information as appropriate to ensure that unsuitable addresses (sheltered housing, addresses with children or vulnerable adults, or those where former victims of domestic abuse are resident.)

17. The SERCO contract should be revised making it a requirement that assaults on SERCO staff by defendants are both reported to the Police and suitably prosecuted.

18. Improvements should be made to the systems for entering sentences on the records of agencies in the criminal justice system. There should be a follow up audit to ensure these improvements have occurred, to be reported to the CSP.