



Findings from the Multi-agency Domestic Violence Murder Reviews in London

**Prepared for the ACPO Homicide Working
Group**

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1. Acknowledgements

Commander Baker is the sponsor and has driven the work of the multi-agency domestic violence murder reviews in London.

DCI Allan Aubeelack worked on the murder reviews at the inception of the project.

Philippa Sully, City University, is working in partnership with the MPS analysing five cold case DV murder reviews.

DI Phil Adams set up the Strategic Murder Review Group, has continually supported the process, as well as giving numerous presentations to boroughs and other police forces.

The Strategic Murder Review Group pan London for their commitment to the project. Members of the group are listed in Appendix I.

The Domestic Violence Working Group pan London for their commitment to the project. Members of the group are listed in Appendix II.

Members of the local borough Domestic Violence Murder panels/Forums for completing the reviews.

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2. Caveats

2.1. The information contained within the report is based on 30 out of the 56 murders committed between 01/01/2001 and 06/04/2002. For this reason, the data should be treated as *emerging findings* rather than drawing concrete inferences that may not necessarily be indicative of *all* trends, patterns or of prospective figures. However, further extensive research was undertaken simultaneously by the author. Just under 400 domestic violence cases were also analysed and utilised in formulating these findings/recommendations, particularly with regards to risk factors and risk assessment.

2.2. The analysis of the additional 26 murders will supplement this first report and will be forthcoming. This will create a much larger dataset. This report was compiled within stringent time scales. However, we felt it important that the initial findings are disseminated and not withheld for longer than necessary given the importance of the recommendations to enable quick time learning

2.3. The accuracy of the initial review report is of paramount importance to the veracity and validity of the analysis. Furthermore, information regarding previous convictions, intelligence, method of killing, weapon and antecedents to the murder and so forth were frequently missing from the review report, regardless of the fact that a template was supplied detailing the information required. Hence, more time was spent obtaining this information to ensure accurate analysis and associations to be demonstrated.

2.4. Some elements of the murder reviews regarding particular agencies are confidential until the law is changed to enable information sharing. However, they have been included for learning at the earliest opportunity.

2.5. On occasions information was lacking regarding the real picture of contact in many cases. This was due to *some* agencies being sceptical of this process and citing confidentiality as a reason for not sharing information. On occasions when agencies have shared information, *some* of the murder review panels felt that vital and relevant information was being withheld. This has led to some information gaps when assessing the negative and positive of contact prior to death.

2.6. This is not an academic document as such. However, the references cited can be found in full in the Bibliography section detailed in the MPS Risk Assessment Model [Appendix III].

3. Executive Summary

- 3.1 **Domestic homicide¹ accounts for approximately 25%² of all homicides in London and 35% in England and Wales.** Victims have often been in contact with key agencies for assistance prior to their death. The speed and/or quality of service providers' responses to abused individual's emergency requests may have a direct bearing on whether or not a serious assault becomes a homicide. Research suggests certain characteristics could be more predictive of homicide than others. As physical violence is the most frequent precursor of spousal homicide, it makes intuitive as well as practical sense to design a predictive instrument/model around characteristics related to the abuse.
- 3.2 The Understanding and Responding to Hate Crime team (URHC) have analysed data generated by the Multi-agency Domestic Violence Murder Review panels, which were set up to examine and explore the positives and negatives of the support previously offered to victims. Furthermore, the Metropolitan Police Service (MPS) in conjunction with Philippa Sully at City University, have also analysed five cold case domestic violence murder reviews. The combined murder review analysis has informed the **MPS Domestic Violence³ Risk Assessment Model** [Appendix III].
- 3.3 The MPS Domestic Violence Risk Assessment Model was developed by the Understanding and Responding to Hate Crime Team⁴. As well incorporating the findings from the murder review analysis into the model, in-depth behavioural analysis was undertaken on 253 DV sexual offences for the first four months of 2001, as well as 149 'serious' DV offences (allegations of ABH and above) for the first two months of 2001. This entailed offender profiling in every case, as well as analysing the context of the violence, behaviour, lethality and dangerousness.
- 3.4 From this in depth analysis Laura Richards and Professor Betsy Stanko have identified **6 high risk factors** for domestic violence. They can be remembered by using the mnemonic **SPECSS: Separation, Pregnancy, Escalation, Cultural Issues and Sensitivity, Stalking and Sexual Assault**. The factors should be mainstreamed into frontline policing. A tactical menu of intervention options [Appendix IV] has also been compiled which sits alongside the MPS Risk Assessment Model detailing options around risk management (this compliments the

¹ Domestic homicide is defined as the killing (including murder, manslaughter and infanticide) by one family member of another (including killings by and of children) or by a current or former partner.

² This figure is based on the average of five financial years: 1996-2001. In 2001-2002 22% of homicides were domestic, whereas 15% were domestic related in 2002-2003. Hence there has been a reduction. It could be speculated that an increased awareness around risk and the domestic violence murder review analysis in the MPS *may* have been a contributing factor to this reduction, a long with other multi-agency crime prevention initiatives.

³ Domestic Violence is defined as any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or are family members, regardless of gender. (ACPO definition/Best Value Performance Indicator 153).

⁴ This was a joint project funded by the Home Office Targeted Policing Initiative.

MAPPPs⁵ tactical menu of options). However, risk management in the form of **RARA** (Remove, Avoid, Reduce, Accept) must be employed in every case. Furthermore, the model was also built on a thorough review of existing international research and literature, developed through a comprehensive consultation exercise involving leading academics and practitioners, and includes contributions from victims of domestic violence.

3.5 The model has been extensively piloted within the MPS. It is currently being piloted by the Police Standards Unit (PSU) in West Yorkshire and soon to be piloted in Thames Valley Police. Other forces are also considering implementation at the earliest opportunity.

3.6 One of the recommendations consistently highlighted by the borough panels, **is the need for a corporate risk assessment tool/model across the MPS and partner agencies.** Practitioners need to start using a common language when talking about risk. Only then can 'we' truly start working together to safeguard victims.

3.7 A corporate risk assessment is paramount in order to standardise the process and practice across London. This should be further mainstreamed across Police Services in the UK to eliminate post-code policing. The Police Standards Unit at the Home Office are playing a pivotal role. However, consideration should also be given simultaneously to partnership agencies to ensure there is an overlap in terms of risk definition, assessment and management.

3.8 The murder review and risk assessment must remain dynamic. The MPS Risk Assessment Model must be constantly reviewed to allow for new patterns/trends that might emerge in the future.

3.9 The local borough Domestic Violence Murder Panels/Forums **own** the recommendations produced from the reviews. They should ensure that the changes occur locally if/when necessary. However, the review reports are then submitted to Laura Richards for analysis. The findings are then represented at the pan London Strategic Murder Review Group (SMRG).

3.10 The SMRG mirrors the make up of the local borough forum. The SMRG then decide which recommendations should be taken forward and at the relevant level. Some of the recommendations are relevant at all three levels:

1. The MPS
2. The National level
3. The Legislative level

⁵ Multi-agency Public Protection Panels

- 3.6. It is worthy of note that the SMRG reflected many problems identified at the local level. This was mainly regarding attendance. For example, a representative from Health came to *one* meeting out of the five, despite repeated contacts and assurances of attendance. How can we move forward on a local level if we cannot be progressive at the strategic level where there should be the will and commitment for multi-agency working?
- 3.7. **Some agencies are sceptical of the aims and objectives of multi-agency murder review.** This has had an impact on the effectiveness of the process, with many agencies voicing concerns with regards to creating blame culture and taking legal advice regarding participation. The agencies that obtained legal advice were told **not** to participate in the process due to the potential detrimental effect it might have, possibly culminating in litigation, if an agency had had contact with the family and had not dealt with it according to their policy.
- 3.8. **Many review panels felt that agencies *do* have relevant information to the review, and this is precisely *why* some chose not to participate.** Hence, there are real information gaps leading to an incomplete picture of events, making it at times almost impossible to draw any learning lessons from the review, other than lack of multi-agency information sharing and a lack of trust.
- 3.9. **Some agencies refused outright to attend** the murder reviews citing confidentiality issues: 73% of GPs, 30% of Housing, 31% of Police CPUs and 23% of Social Services.
- 3.10. In some cases the relevant **agencies were not invited** to attend the review: 70% of review panels did not invite Probation, 83% the CPS, 53% failed to invite Education and 54% the police CPU. It is crucial that the relevant agencies are identified and invited to attend the review.
- 3.11. **Some Domestic Violence Forums appear to be a smokescreen for inertia.** They need to refocus on their core business: ensuring the safety of women and children experiencing domestic violence and increasing the support available to them.
- 3.12. **Part of the core business of a Multi-Agency Domestic Violence Forum should be to conduct regular inter-agency reviews of victims identified as being at ‘serious’ risk.** This could take the form of a monthly MAPPP meeting, whereby agencies know the names of victims and offenders to be discussed to ensure research prior to attendance. Information shared should be shared under ‘serious risk to life’. A series of solutions should be sought according to the needs of the victim.

- 3.13. Cases that are not as 'serious' risk should be discussed at the Domestic Violence Action Group Forum or similar/most appropriate Forum. The victim's consent should be obtained. If it is not obtained, then cases should be discussed anonymously and general advice given.
- 3.14. **Police and agencies need to effectively risk assess and risk manage cases.** Risk factors are present in the majority of cases, however, they are not identified due to little guidance / research about what they are, compounded by not being able to gain a holistic and an accurate picture of what is occurring.
- 3.15. **Only four out of the thirty cases were risk assessed by the Police Community Safety Unit (CSU).** Identification of risk factors is an integral part of an effective investigation of all domestic violence cases. Further, all mechanisms and processes to assess and manage risk must have a sound knowledge and evidence base. Risk assessment and management should occur in every case. **At present, this area of policing is hugely lacking and will continue to remain so until the Risk Assessment Model is implemented across the MPS.**
- 3.16. **9 (30%) of police investigations of offences prior to the murder lacked positive action and suspects are not being arrested where sufficient evidence exists to do so.** Training is required for first contact officers, Community Safety Unit (CSU), Crime Management Unit (CMU) and Child Protection Unit (CPU) officers. **Safety planning does not always occur and should.** Form 78s⁶, Non Crime Book Domestic Incidents and CRIMINTs⁷ are consistently not being completed for DV incidents. The Control Room and Crime Reports should be rigorously supervised to ensure MPS policy, particularly with regards to the Minimum Standards of Investigation for Hate Crime, (Special Notice 15/00), is complied with.
- 3.17. Children were resident at the home address in 13 (43%) cases. **Child protection issues tend to be missed**, as officers do not ask if children live at the home address or complete Form 78s. **Furthermore, 30% of children are actually witnessing the murder. Many of the murders are happening as a result of disputes over separation and child contact/custody. The long-term impact to children witnessing and experiencing such crimes is not being considered or addressed.**
- 3.18. Early warning signs and symptoms of domestic violence will continue to go unreported until nurses, health visitors, General Practitioners and health workers are taught to include these in their observations.

⁶ Children coming to police notice

⁷ Criminal Intelligence log

- 3.19. **Victim vulnerability features prominently.** It should be the duty of the state to deal with offenders appropriately when victims are too vulnerable or unable to do so. **The decision to charge and prosecute offenders should not be dependent and solely reliant on the victim's willingness or capability of pursuing the allegation.**
- 3.20. There were three cases involving young vulnerable African Caribbean men who killed their mothers. They appeared to follow very similar patterns in terms of their mental health deterioration and the gaps in the multi-agency service provision. **The recommendations from the 'Untoward Serious Incident Inquiries' instigated by individual Health Trusts should be disseminated across all Health Trusts, as well as amongst practitioners working within the DV field.**
- 3.21. Risk assessment should occur whether offenders are prosecuted or not. There should always be pre-release risk assessment reviews in domestic violence cases between Probation, Police and Prisons when offenders serve a custodial sentence. The prisoner should always be contacted to undertake this prior to release. N.B. Two offenders who had received a brief sentence for domestic violence offences on their partners, went straight round to the victim's home address when released and killed the victims.
- 3.22. **Magistrates are continually bailing offenders who are dangerous and violent and have a history of offending on bail.** They do not get remanded in custody, and go straight round to the victim's address and re-offend. The magistrate needs the full case history in order to inform decision-making and risk assessment.
- 3.23. Judges and magistrates should be involved in multi-agency training so they get exposure to the issues and complexities surrounding domestic violence.
- 3.24. There should be an evaluated accredited perpetrator programme provided to all domestic violence offenders, particularly given **20-40% of the prison population have a domestic violence background** (Probation Offender Assessment Research, OASys) The Probation programme and others have yet to be evaluated to prove that they are effective.
- 3.25. Furthermore, **over half the offenders had previous convictions for other types of crime** ranging from drugs to offences against the person. Hence domestic violence offenders are **not** 'specialists' in the sense they are solely 'beating their partners', but commit other crimes as well.
- 3.26. In just under half of the cases, the **context of the argument preceding the murder was regarding separation and child contact.**

- 3.27. **'Honour killings'** have been flagged as an area meriting further research and analysis to draw out good practice when dealing with such cases. There are particular implications for multi-agency working. This is in terms of developing good partnerships when working with community groups. Commander Baker has set up a group to deal specifically with this issue and a work plan is already underway.
- 3.28. **'Family wipe out'** or 'familicide' has also been flagged as a special kind of domestic violence. Homicide-suicide rarely involves strangers. The homicide victims in such cases are almost always female. The person who usually kills, tends not to be able to let the victim go. The most common factor in homicide-suicide is that the male needs to control the relationship. If a wife or girlfriend tries to leave, the man will often threaten to kill himself. This is a manipulative move and one which needs to be taken seriously. He should be assessed not just for suicide but possibly homicide-suicide. Work is also underway to unpack the dynamics of this phenomenon.
- 3.29. Contrary to common belief, **the most common method of killing was stabbing with a sharp implement rather than strangulation**. 15 (27%) victims were stabbed, 11 (20%) died from head injuries and 6 (11%) were strangled. With additional data from the next financial year (2002-2003) this pattern remains consistent: 31%, 20% and 10% respectively.
- 3.30. **Murder review should be put on a National footing**. It makes both intuitive and practical sense for the murder reviews to be undertaken by MAPPA⁸ given that MAPPPs should *already* be risk managing the most dangerous and high risk offenders with domestic violence offenders falling into this category (albeit this is still patchy across regions).
- 3.31. **MAPPA guidance for information sharing already exists and more importantly works. It would be ideal for MAPPA to incorporate this area of work. However, it must be made more specific to cover murder review and risk assessment and be put on a statutory footing.**
- 3.32. A recommendation for a 'national register' domestic violence offenders has come out of the reviews. This is to address the problem of when offenders/victims move areas. However, rigorous thought is needed around how this 'register' would work and what it is aiming to achieve. For example, if only those who had served a 12 or 6 month sentence were to go on to the register, it would not capture the majority of domestic violence offenders; given that most do not get a custodial sentence. Those that do, and they are few and far between, tend not to be sentenced for very long. For example, **only two of the offenders served custodial sentences for domestic violence**, six months for a GBH and three months for an ABH

⁸ Multi-agency Public Protection Arrangements

respectively. **Hence careful consideration would have to be given to how it would work on a practical level.**

3.33. **The development and imminent roll out of the Violent and Sexual Offenders (VISOR) database would be more suitable and meet these needs, given that all those coming to the attention of MAPPPs would be entered onto the database.** This would also include High risk domestic violence offenders, once they have been risk assessment and flagged to the Public Protection Unit (PPU). This again is reliant on the Risk Assessment Model being used, as well as offenders being flagged to MAPPPs.

3.34. Members of the Domestic Violence Forum or Domestic Violence co-ordinators should be invited to attend the MAPPP accordingly. The reviews should then be submitted to the Strategic Management Board (SMB) to decide how the recommendations should be taken forward at the three levels: force, national and legislation.

3.35. Furthermore, the SMBs should link in with the National Criminal Justice Boards (NCJB). All the reviews undertaken should be sent to a national warehouse/post-box so that they are accessible to all. The National Centre for Policing Excellence (NCPE) appear to be the most obvious choice in terms of a central point of collation and dissemination.

3.36. **The key aim of the murder reviews is murder prevention.** It is not about creating a blame culture, but rather about identifying how to improve inter-agency working and better safeguards for victims. This report documents the findings of the reviews and lessons to be learnt for the future.

3.37. **The two pronged approach of multi-agency murder review and risk assessment has already shown its benefit and value.** This new evidence based approach to crime prevention needs to be mainstreamed and employed to enhance policing and inter agency partnership in the twenty first century.

3.38. The recommendations from the reviews have been accepted and are to be taken forward by the Diversity Directorate for consideration at the MPS Management Board.

3.39. There are also ramifications regarding the National Intelligence Model (NIM) and risk assessment. This deserves careful consideration and further liaison with the MPS NIM Team.

3.40. The findings have also been shared with ACC Gamble, the ACPO Domestic Violence portfolio holder. They will also be discussed with the Solicitor General Harriet Harman, MP, for consideration on a wider basis across multi-agencies.

3.41. **Specific guidance is now needed from the responsible ministry at the national level.** The findings will also be submitted for consideration in the feedback regarding the Safety and Justice paper (published in June 2003) as well as Green Paper produced by the government.

4. Introduction

4.1. The MPS receives just over 100,000 domestic violence calls each year, comprising 1 in 20 of all notifiable offences. The Community Safety Unit (CSU) officers handle over 9, 000 incidents of hate crime every month of which domestic violence allegations constitute the substantial majority (85% of the workload). Domestic assaults account for a notable proportion of violent crime:

- ❖ one third of all Common Assaults;
- ❖ over a quarter of Actual Bodily Harm (ABH);
- ❖ one eighth of Grievous Bodily Harm (GBH);
- ❖ two fifths of allegations of domestic abuse that come to the attention of the MPS relate to offences of violence;
- ❖ one in nine cases concern allegations of criminal damage;
- ❖ one in twelve relate to public order, and;
- ❖ one in twenty to allegations of theft.

4.2. **Domestic violence is more likely to involve repeat victimisation than any other criminalised behaviours and more likely to result in injury than other offences against the person.** Whilst there are some one-off incidents of domestic violence, invariably by the time the victim contacts the police, they have been exposed to a repeated pattern of abuse. This is particularly true where the offences are more serious. Analysis of MPS data also appears to confirm assumptions regarding escalation in frequency and severity of incidents over time. Early and appropriate intervention can help prevent escalation where patterns are not yet established. Furthermore, structured intervention can also help disrupt established patterns.

4.3. Two women are murdered every week in England and Wales at the hands of partners or ex-partners. Domestic homicide accounts for over 25% of all homicides in London. Hence a high proportion of murders are domestic violence related.

4.4. **Domestic homicide cannot be separated from domestic violence.** Victims have often been in contact with key agencies for assistance prior to their death. The speed and/or quality of service providers' responses to abused individual's emergency requests may have a direct bearing on whether or not a serious assault becomes a homicide. Research suggests certain characteristics could be more predictive of homicide than others. As physical violence is the most frequent precursor of spousal homicide, it makes intuitive as well as practical sense to ground any predictive instrument around characteristics related to the abuse experienced. The work around risk assessment and murder review analysis is inextricably linked and seeks to inform each other.

- 4.5. The Understanding and Responding to Hate Crime Team (URHC) has analysed data generated by the Multi-agency Domestic Violence Murder Review panels, which were set up to examine and explore the positives and negatives of the support previously offered to victims. The MPS Risk Assessment Model developed by URHC has been compiled simultaneously with the murder review analysis undertaken in conjunction with the MPS and City University.
- 4.6. Any model that can assess potential levels of risk/lethality to the victim is extremely important for informing tactics around intervention and prevention. Given the huge number of cases involved, **start with a gold/premium standard of intervention when dealing with the most serious offences (the volume of serious cases is relatively low⁹) and once systems are in place, mainstream across to all domestic violence related offences.**
- 4.7. The issue facing the police service today, is not underreporting or being able to keep adequate records of domestic violence incidents, but rather not being able to make use of the vast amounts of information that is available to them. It is anticipated that in the longer term, the Risk Assessment Model will prove vital for identifying victim needs by providing a focused mechanism to identify and respond effectively to repeat victims and chronic offenders.

⁹ Refer to the domestic violence sexual and serious incident analysis: 1 in 7 are high risk and dangerous offenders from a sample of just under 300 offenders/incidents (first two months of 2001)

5. Project Remit

5.1. Time scales.

The project period was from January 1st 2001 – April 6th 2002. Hence every domestic violence murder occurring within this time period will have been reviewed and forwarded for analysis to Laura Richards. However, the process of review has been mainstreamed into MPS Policy and domestic murders are now reviewed as a matter of course. Additionally, analysis of the modus operandi (method), relationship and gender is also available for the following financial year (April 6th 2003) and has been included in the report along with a graph depicting murder by borough in the MPD (Appendix V: January 2001 – June 15th 2003).

5.2. Aims and Objectives of Multi-agency Domestic Violence Murder Review

Critical incidents of domestic violence are subject to review in order to:

- ❑ Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safe guard victims of domestic violence;
- ❑ Identify clearly what those lessons are, and how they will be acted upon, and what is expected to change as a result; and as a consequence, and;
- ❑ To improve inter-agency working and better safeguards for victims.

5.3. Process

Domestic violence murders which occur across the MPD are routinely identified by the Specialist Crime Directorate's Operations Room (SCD). Notification for review, along with the protocol document and the murder review template is disseminated to the relevant borough. The Multi-agency Domestic Violence Murder panel or forum on borough then undertakes the review and the reports are forwarded to Laura Richards for analysis. The recommendations and analysis is fed straight back into the Risk Assessment Model as well as presented to the Strategic Murder Review Group (SMRG). The SMRG who decide which recommendations are relevant for a response from the relevant agency, at the national level and also regarding legislation.

6. An Overview of the Domestic Murder Analysis

6.1. A total of 30 out of the 56 homicides have been analysed to date. A further 11 have since been forwarded and will form Part Two of this report. Two are subject to sensitive independent enquiries.

6.2. In 73% of the cases, there was a *recorded or reported* history of domestic violence. It must be borne in mind that this figure, however, would probably increase given that it was felt that not all agencies shared the relevant information with the review panel. Furthermore, risk factors were present although not identified as such: in these cases the police along with a number of other agencies appear to have fallen somewhat short in terms of identifying the

'true' level of risk posed to the victim and family. The main problem with lethality centres on gaining *all* the information in a timely fashion as well as accurate information about the context and behaviour along with understanding what constitutes 'risk'. It is very difficult to risk assess and manage when there are information gaps or the information is inaccurate or misleading.

6.3. A Risk Assessment Model allows for all the information to be gathered in a timely, consistent and standardised way. It also allows for the risks to be identified and then managed using a multi-agency approach by directing the Intervention Plan, stipulating that it must adhere to the RARA model (Remove, Avoid, Reduce or Accept the risk) and detailing tactical options.

6.4. **One of the recommendations consistently highlighted by the borough panels, is the need for a corporate risk assessment tool/model across the MPS and partner agencies.** Practitioners need to start using a common language when talking about risk.

6.5. The need for a Risk Assessment Model also became apparent from the domestic violence sexual assault and serious incident analysis. It became clear that there were risk factors present in cases but they were not being identified locally due to insufficient guidance and research: this situation was further compounded by not being able to gain a holistic picture of the context of the violence. This was highlighted as a practice/policy issue in the first instance.

6.6 Factor Analysis (n=30)

Vulnerability

- In 2 (7%) cases the victims were children.
- In 5 (17%) cases involved elderly victims.
- 14 (47%) cases involved cultural issues/sensitivity.
- 13 (43%) cases involved mental health issues.

High risk indicators

- **16/21*¹⁰ (76%) cases where there was an intimate relationship cases involved separation** (4 cases the details were not recorded).
- 2/21* (10%) cases involved pregnancy / new birth.
- **26 (87%) cases involved escalation** (1 case not recorded).
- **14 (47%) cases involved cultural issues and sensitivity.**
- **12 (40%) cases involved stalking** (1 case not recorded).
- 2 (7%) cases involved sexual assault¹¹ (17 cases not recorded).

Context of the argument preceding the murder

- **14 (47%) argued about separation** (with issues of child custody and sexual infidelity/jealousy also featuring strongly).
- 2 (7%) about child contact/custody.
- 1 (3%) perceived infidelity.
- 7 (23%) there were mental health issues.
- 1 (3%) as found out cousin had previous convictions for sexual assault (there was no history of DV).
- 5 (17%) did not detail information about the events leading up to the murder.

Other factors

- **16 (53%) offenders had previous convictions for other offences** ranging from drugs to offences against the person.
- **13 (43%) offenders had also been violent to other people**, that did not always result in a conviction (11 cases not recorded).
- **Only 2 (7%) offenders had previous convictions for DV:** GBH sentenced to six months; ABH sentenced to three months.
- In 3 (10%) cases there was intelligence recorded regarding DV on previous girlfriends.
- 2 (7%) offenders committed the murder when on bail.
- 1 (3%) victim had an injunction out against offender at time of murder.
- 3 (10%) offenders had just come out of prison.
- 7 (23%) victims had previous convictions for offences ranging from theft to drugs.
- In 22 (73%) cases there was a previous history of DV (1 case not recorded).
- **14 (47%) offenders exhibited jealous and controlling behaviour** (10 cases not recorded).
- **12 (40%) offenders abused alcohol/drugs** (11 cases not recorded).
- **In only 4 (13%) cases risk assessments were undertaken.**

¹⁰ N=21 when counting intimate relationships where there is or has been a relationship

¹¹ Officers will only know if a factor has been occurring if it is disclosed to them or if they ask a question about it. Some factors may have been occurring, only those conducting the review may not have been aware of it. For example, with regards to sexual assault we do not know how many women who have been killed by partner have been victims of partner rape. I would suggest it is a lot more prevalent than is reported and recorded by police. It is certainly is a high-risk indicator for serious injury and serial abuse.

Children

- In 13 (43%) cases there were children present at home address.
- **In 9 (30%) the children actually witnessed the murder.**

'Honour Killings'

- This has been identified as an issue meriting further research and analysis from the murder reviews.
- It can be triggered from a range of actions: women exercising their right to choose a spouse, seek a divorce, or engage in any behaviour which breaches family or community norms, in particular sexual conduct.
- Working with community partners is a key requirement in identifying good practice when dealing with these cases.
- A specific group chaired by Commander Baker has been set up in London to tackle this very issue. A work plan is currently in progress.

'Homicide-Suicide' or 'Family wipe out'

- 2 (7%) cases involved the offender killing members of the family and then himself.
- 1 (3%) cases involved the offender killing members of the family and then *attempting* to kill himself.
- This has also been identified as a special form of domestic violence issue and is being closely monitored and analysed to unpick the dynamics of this phenomenon.
- It appears to be perpetrated by men and tends to occur at the point of separation. The notion of *'If I can't have you, no-one can'* features strongly throughout these cases. Offenders who are suicidal can quickly turn homicidal. The two are inextricable linked.

7. Emerging Findings and Recommendations

7.1. Multi-agency information sharing: is it working?

This section will firstly address *the process* of multi-agency murder review itself, followed by highlighting the recommendations pertaining to each agency in turn, starting with Health.

Table 1. Domestic Violence Forums specifically regarding murder review (n=30)

Agency	Attended or replied to Murder review request for information		Failed to attend, reply or disclose information to the review		Not asked to attend or supply information to the review	
	Number	Percent (%)	Number	Percent (%)	Number	Percent (%)
Health (PCT)	18	60	6	20	6	20
GP	5	17	22	73	3	10
Social Services	23	77	7	23	0	0
Probation	6	20	3	10	21	70
Education	13	43	1	3	16	53
Housing	17	57	9	30	4	13
CPS	1	3	3	10	26	87
CPU Police: relevant where children present at h/a n=13	2	15	4	31	7	54

7.1.1. On first appearance it seems there has been compliance regarding sharing and disclosing information for the reviews. However, this is misleading. It was felt by many of the panels that where agencies replied stating that they did not have information, that this was not *always* the case. This was thought to be true of Health and Social Services in particular, but not just these two agencies exclusively. **Until specific guidance is given by the government regarding information sharing, risk assessment and murder review this will continue to be problematic. MAPPA guidance already exists and should incorporate this area of work, however, it must be made more specific to cover murder review and risk assessment and be put on a statutory footing.**

7.1.2. Several agencies took legal advice and were told **not** to participate in the process due to the potential for it to cause a detrimental effect culminating in possible litigation if they had had contact with the family and had not dealt with it according to their policy.

7.1.3. One forum refused to conduct the murder review stating that until there was an agreed procedure for information sharing, as well as information about the burden such reviews would place on agencies, that they were not willing to participate.

7.1.4. Several boroughs recommended that independent advocates should provide a 24-hour service to victims. This is due to the fact that accessing services is currently a lottery with staff acting as gatekeepers filtering victims out and not explaining to them what their entitlements are.

7.1.5. Consideration should also be given at a national level to devising a mechanism for information about potential child protection (and domestic violence) issues arising from information available to a court in a criminal trial to be fed back to child protection (and domestic violence) agencies.

7.1.6. Forums should conduct regular inter-agency reviews of victims identified as being at serious risk. Offenders should be referred to the monthly MAPPP meetings, whereby agencies know names of victims to be discussed to ensure research prior to attendance. Information can be shared under 'serious risk to life' and a series of solutions should be sought according to the needs of the victim.

7.1.7. Cases that are not as serious a risk should be discussed at the Domestic Violence Action Group Forum. The victim's consent should be obtained. If it is not obtained then the cases should be discussed anonymously and general advice given. In this way, a multi-agency approach should arrive at a series of solutions packaged according to the victim's needs.

7.1.8. It is worthy of note that the Strategic Group reflected many problems identified at the local level. This was namely regarding attendance. For example, a representative from Health came to one meeting out of the five, despite repeated contacts and assurances of attendance. How can we move forward on a local level if we cannot progress at the strategic level where there should be the will to commitment to multi-agency working?

7.2. Health

7.2.1.1. Health does not seem to sit on the majority of Borough Domestic Violence Forum (BDVF).

7.2.2. It is not evident in *every* review report whether Health/GPs have been invited to attend the murder reviews panels. Furthermore, when they do participate, they tend to send back a response stating that they had not had contact with the victim and/or family, when this is not always believed to be the case.

7.2.3. The difficulty of ensuring a representative from Health to attend the review groups was also reflected in the Strategic Murder Review Group.

7.2.4. Early warning signs and symptoms of domestic violence will continue to go unreported until nurses, health visitors, GPs etc are taught to include these in their observations, particularly health visitors when they visit early post natal mothers. Risk

assessment must be undertaken. Information must be shared appropriately and joint intervention and management strategies put into place to protect women and children.

- 7.2.5. Health visitors should have a check list/risk assessment to pick up early signs of domestic violence when visiting early post-natal mothers.
- 7.2.6. There is a need for domestic violence on the agenda for new primary care service for child protection (PCT).
- 7.2.7. All visits to clients by health workers should be fully documented.
- 7.2.8. Health Trusts should review their information sharing practices. There is a need for a more co-ordinated approach for medical staff to inform Social Services / Police when dealing with victims of domestic violence suffering from serious injury. It has been recommended that when victims present themselves to health practitioners, medical staff should consider support for victims and in some instances where the assault is serious, recommend removal to a refuge. Once they are aware of a serious injury in domestic circumstances they should then refer to Social Services Duty Officer. This will also enable support services and plans for re-locating victims to be put in place at a far earlier and crucial stage.
- 7.2.9. Whilst assessing the care and mental state of the patient, there should be continued assessment of the risk to their families in parallel to that of the patient's health.
- 7.2.10. If there is knowledge that a patient is abusing controlled drugs, intervention and drug counselling initiatives should be triggered.
- 7.2.11. In cases where patients are unwilling to comply with medication, they should be seen by medical and nursing staff on a more frequent basis to monitor their progress. The issue of balancing patient choice with safety and security should be carefully considered during the Care Planning Process. When patients refuse help, all decisions and discussions with patients should be recorded. **Trusts have an overriding duty to prevent harm to others if there is a significant risk over and above the respect for patient's autonomy and right to consent/refuse to treatment** (Human Rights Act 1998, Article II: Right to Life). The patient can only make a sound judgement if they have all information. Some Trusts put the patients right first.
- 7.2.12. Trusts should pay more attention to what the family/carer is saying about a patient and the impact on them, rather than ignore their pleas for help or not take situations seriously. **Risk assessment is crucial and should always be conducted.**
- 7.2.13. Mental Health Services should adopt a policy of sharing information with the CSU in relation to risk assessments in mental health cases involving dangerous and violent offenders. Once a decision has been made to return a family member to the home or to live with another, there should be immediate liaison between the agencies. This should help ensure that the CSU are aware of vulnerability issues. A joint strategy

can then be adopted to monitor the impact on the family and intervene if appropriate when risks are identified.

7.2.14. There is a need to transfer care to another borough far quicker than the time taken in some of the reviewed cases.

7.2.15. The need for senior management involvement in negotiations is helpful to ensure the transfer of care is completed speedily. This has been identified as a priority by one reviewing Health Board and they have put training in place to ensure there is no re-occurrence of such an incident¹².

7.2.16. 13 recommendations came out of one review alone for health, all of which are vital in effecting change to ensure that an incident of a similar nature does not occur again. The recommendations are relevant to all Trusts, as similar issues have been identified in other Trust areas. At this stage there is no confirmation that the local Trust Board has agreed to implement the Recommendations coming out of the serious incident reviews. They will be put to the Trust Board to agree and implement. **There needs to be some form of monitoring mechanism to ensure that this happens and the lessons do not get lost across the different Health Trusts.**

7.2.17. Mental health deterioration appears to **follow similar patterns in the three cases involving young and vulnerable African Caribbean males who killed their mothers**, along with the gaps in the multi-agency service provisions:

- Start truanting at school in early adolescence, suspension and exclusion follows due to anti-social behaviour and violence at school
- Alcohol and drug misuse/abuse
- Violent offences and involvement with the Police. Mental health assessments follow and are admitted as in-patients
- Returned home and discontinue medication. This is not reinforced
- Start abusing drugs/alcohol, have violent outbursts and become withdrawn,
- Mother calls for assistance and mental health assessment stating she cannot cope and their sons mental health is deteriorating
- Lack of joined up working and service provision
- Lack of multi-agency decision making and risk management strategies and police not notified when dangerous and violent offenders
- Murder of the mother by the son.
- In each case a 'Serious Untoward Incident Inquiry' has been triggered and the recommendations have been very similar in each Inquiry. This needs a holistic approach to disseminating those lessons across *all* Trusts and practitioners working the field of domestic violence.

¹² Although similar issues were identified in two other murders across different Health Trusts.

7.3. General Practitioners (GPs)

- 7.3.1. GPs refused to attend in 73% of cases. Historically and anecdotally, this has always been flagged as a contentious area although no evidence has been available to date to show the prevalence of lack of information sharing.
- 7.3.2. It is crucial for GPs to participate in the reviews. There is an overwhelming reluctance for them to involve themselves when they often hold a lot of information about domestic violence victims.
- 7.3.3. Comprehensive guidance is available to GPs regarding information sharing. However, there appears to be a very apparent lack of compliance, with GPs possibly not knowing where/how to access this guidance.

7.4. Social Services

- 7.4.1. Members of Social Services are not always participating in the murder reviews. In 23% of cases, they **refused to share** information with the review panel. Even when Social Services do respond with information, some panels feel that on occasions they might be withholding information.
- 7.4.2. Members of Social Services in certain boroughs frequently state that it is problematic to retrieve information from the archive system.
- 7.4.3. Social Services should risk assess child case conferences and have an exit strategy for the parties involved. Risk assessment should not be solely based on previous meeting outcomes as things may have changed since then.
- 7.4.4. Social Services need to develop ways of managing high-risk family conferences and creating a safe environment (namely ensuring uninvited parties do not participate).
- 7.4.5. In conjunction with the CPUs, Social Services should devise a way of effectively sharing information and updating on progress. The supervisor should ensure that notification occurs.

7.5. Probation

- 7.5.1. Probation **were not invited to attend** the majority of reviews (70%).
- 7.5.2. When Probation are asked to prepare a pre-sentence report regarding offenders' appearance at Court, officers should make concerted efforts to locate the offenders in order to do so.
- 7.5.3. Judges should wait for the report **prior** to sentencing in order to be able to make informed decisions.
- 7.5.4. There should always be a pre-release risk assessment review in domestic violence cases between Probation, Police and Prisons. The prisoner should always be contacted to undertake this prior to release. Administrative errors within the prison record system should be rectified. **N.B. Two offenders who had been convicted for**

domestic violence and served brief sentences for domestic violence on their partners went straight round when released and killed the victims.

- 7.5.5. There should be an evaluated accredited perpetrator programme provided to all domestic violence offenders. The probation programme and others have yet to be evaluated to prove that they are effective. It is also a very patchy service on the whole.

7.6. Education

- 7.6.1. In 53% of cases members of Education were **not invited to attend reviews** even when children are present in the home address and subjected to abuse.

7.7. Housing

- 7.7.1 In 30% of cases, Housing are **were not willing to supply information** to the review panel and they not always being invited to attend the reviews.
- 7.7.2 Housing should review their procedures for referral of families and of vulnerable pregnant women where there is potential child protection concerns to the Social Services Department.
- 7.7.3 Housing should establish procedure for referral of young women and couples who are offered housing as result of pregnancy or parenthood, to relevant Health Service. Health professionals can then assess whether appropriate level of support is being offered.
- 7.7.4 There appears to be failure in the Housing system when identifying those victims who are truly 'at risk'. An agency should not have someone on the priority list for six months.

7.8. Crown Prosecution Service (CPS)

- 7.8.1. On occasions, the CPS has discharged serious domestic violence offences when the victim has been reluctant to proceed.
- 7.8.2. It should be the duty and responsibility of the state to deal with offenders appropriately when victims are too vulnerable or unable to do so. The decision to charge and prosecute offenders should not be dependent and solely reliant on the victim's willingness or capability of pursuing the allegation.**
- 7.8.3. Paperwork seems to have gone missing in some cases hence the CPS representatives have stated that they cannot participate in particular reviews.

7.9. Police

- 7.9.1. 9 (30%) of police investigations of offences prior to the murder lacked positive action.** Suspects should be arrested where sufficient evidence exists to do so. Safety planning should occur in **every** case. Form 78s, Non Crime Book Domestic Incidents and CRIMINTs are consistently not being completed for domestic violence incidents.

Control Room and Crime Reports should be supervised properly to ensure that MPS policy is being complied with.

- 7.9.2. In only 4 (13%) cases risk assessments were undertaken by police. All cases should be risk assessed, risk managed and supervised appropriately. A risk assessment should be undertaken regardless of whether there is a prosecution or not.
- 7.9.3. **Training** is required for first contact officers, staff within the Community Safety Unit (CSU), the Crime Management Unit (CMU), and Child Protection Unit (CPU).
- 7.9.4. Offences are not always being flagged as domestic violence (DV), so they cannot be picked up by CSU.
- 7.9.5. Appropriate cases are not always referred to VSS.
- 7.9.6. Incidents consistently being treated as isolated incidents rather than considering historical incidents.
- 7.9.7. **Supervision is lacking at every level from front line to specialist CSU staff.**
- 7.9.8. Duplication of Police systems resulting in double/triple keying. There is a very real need to co-ordinate and integrate systems to minimise patrol officers time completing reports.
- 7.9.9. There appears to be duplication of CRIMINTs stating the same information, in the rare event when they are created for domestic violence incidents.
- 7.9.10. Officers should consider interviews with extended family when dealing with family violence. This requires better availability of interpreters where language barriers. Officers should have access to Language Line. However, there is a lack of availability of interpreters.
- 7.9.11. To improve and market available support for communities where there are language barriers.
- 7.9.12. On occasions, the Murder Investigation Team has held up the review process by delaying dissemination of information pertinent to the review.
- 7.9.13. CPUs should contribute to the review when children are involved.
- 7.9.14. Children should not be used as interpreters at the scene.
- 7.9.15. International police checks should be undertaken on adults from abroad when there are child protection issues.
- 7.9.16. Officers should include all information in the report to CPS. In particular, history of offending, allegations, where offender lives in relation to victim, risk assessment, any intelligence and so forth.
- 7.9.17. Cards should be given to victims listing support groups / agencies details by frontline officers, particularly Refuge Help line.
- 7.9.18. Police need to share information with Social Services so individuals / situation can be risk assessed accurately.
- 7.9.19. If high risk offenders move geographical areas, the relevant Police Domestic Violence Unit should be informed.

7.10. Judiciary and Magistrates

7.10.1. Judges and magistrates should be involved in multi-agency training so they get exposure to issues surrounding domestic violence.

7.10.2. **Magistrates continually bail offenders who are dangerous and violent and have a history of offending on bail.** They consistently do not get remanded in custody and go straight round to the victim's address and re-offend. Magistrates need the full case history in order to inform decision-making and risk assessment outcome if one is undertaken (recommended in every case).

7.10.3. There should be compulsory programme providing rehabilitation during sentence or following its completion. There is a need for courts to include programmes in sentencing of offenders in domestic violence cases.

7.11. Relate

7.11.1. On several occasions members of Relate did not want to attend reviews citing confidentiality. It was believed that they had had contact with the victim and offender.

7.12. Victim Support Service (VSS)

7.12.1. VSS need to evaluate the way it documents and follows up contact with domestic violence victims. They should follow up clients who decline home visits in *some way*.

7.13. Refuge

7.13.1. Victims with teenage sons are unable to get into Refuges and may have no-where else to go.

8. Modus Operandi (MO) Analysis: Project period January 1st 2001 – April 6th 2002

It is interesting to note the profile of domestic murder. The profile in London and the UK is very different from the research produced from the Washington State Fatality Reviews¹³ where the weapon of choice is a gun. It is also important to understand the profile of domestic murder, particularly when there are issues of 'staging'. How are victims being killed? Is the most common method strangulation? Does it differ by gender or by relationship type?

Table 2: Domestic Violence homicides detailing MO, total number of incidents and total number of Victims January 1st 2001 – April 6th 2002 (n=56).

January 1st 2001 – April 6 th 2002	Total Number of Incidents = 56 (14 child death incidents) Total Number of murder victims = 59 (146child victims; 7 elderly victims)	
	Number of Incidents	Percentage of Incidents (%)
Shot	2 ¹⁴	3.5%
Stabbed	15 ¹⁵	27%
Throat cut	1 ¹⁶	2%
Pushed through window / down stairs	2	3.5%
Head injuries – implement used or beaten	11	20%
Strangled	6	11%
Suffocated	3 ¹⁷	5%
Fire	4 ¹⁸	7%
Forced Drug overdose	3	5%
Shaken baby	2	3.5%
Drowned	1	2%
Failure to thrive	2	3.5%
Not stated	4	7%
Total	56	100%

¹³ Hobart, M. (2000). Honouring their Lives, Learning from their deaths: Findings and recommendations from the Washington State Fatality Review (Washington: Washington Coalition against Domestic Violence).

¹⁴ 4 victims in one family

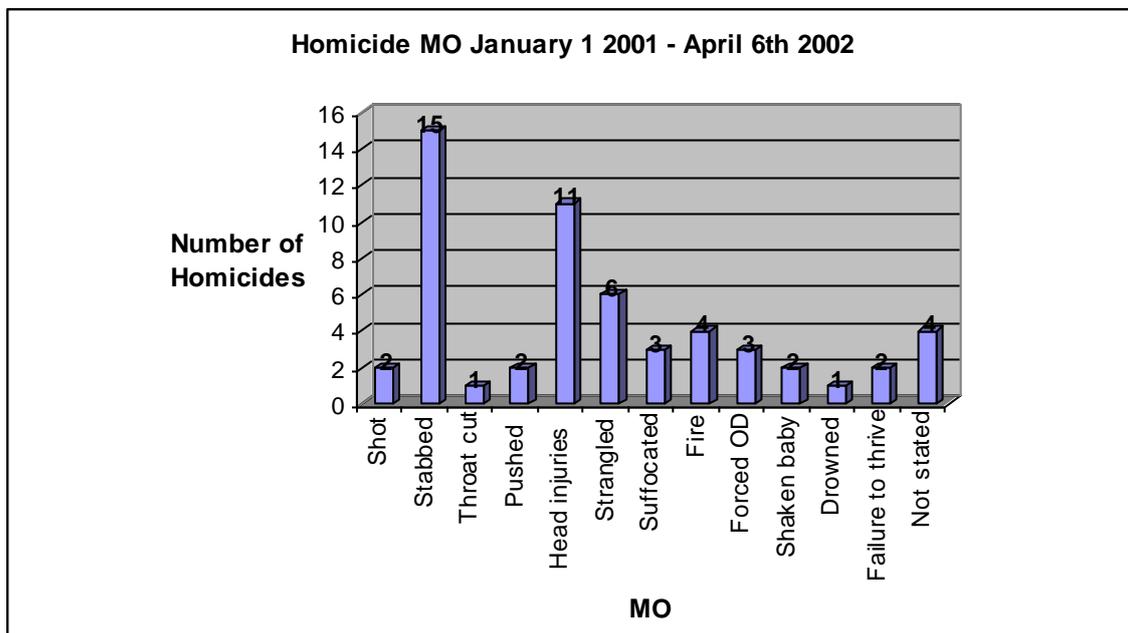
¹⁵ One incident involved 2 victims

¹⁶ Pregnant female

¹⁷ One incident involved 2 victims

¹⁸ Mother killing daughter and self

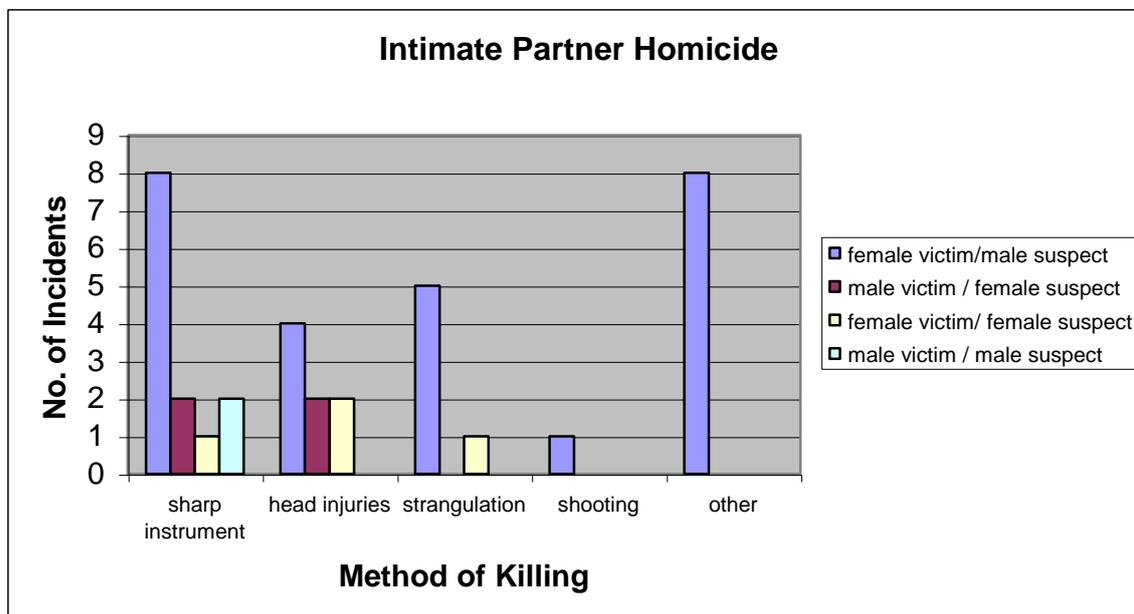
Figure 1: Graph showing Method of Killing January 1st 2001 – April 6th 2002 (n=56).



The process of homicide review has highlighted an inconsistency regarding the commonly held notion that domestic homicide is about strangulation. The information suggests that the most common method of killing is being stabbed with a sharp implement. 15 (27%) victims were stabbed, 11 (20%) died from head injuries and 6 (11%) were strangled. When adding the data from the next financial year (2002-2003) this pattern remains consistent: 31%, 20% and 10% respectively.

**Does the pattern change when looking at relationship, gender and method of killing?
(See Figure 2)**

Figure 2: Graph depicting Intimate Partner Homicide and Method of Killing, January 1st 2001 to April 6th 2002 (n=56)



The picture remains fairly consistent¹⁹. Men are more likely to stab their current / ex-female partners. They are also more likely to kill their current / ex-female partners by strangulation. Women are more likely to kill their current / ex-male partners using a sharp implement or by causing head injuries.

This outlines the value of a two pronged approach: murder review and risk assessment. It must be noted, however, that these two approaches must remain dynamic. In time, methods and patterns may change for example the emergence of ‘honour killings’ and ‘family wipe out’ identified through the process of murder review. Hence the risk assessment must be consistently reviewed in order to fit new trends/patterns that may emerge.

¹⁹ The graph excludes inter-generational murders i.e. infanticide and killing of a parent by a child

Table 3: Gender and Method Analysis: January 1st 2001 to April 6th 2002

Gender of Victim and Offender	Shot	Stabbed	Throat Cut	Pushed	Head Injuries / Beaten	Strangled	Suffocated	Fire	Force drug	Shaken baby	Drowned	Failure to thrive	Not stated	Total Number (n=56)
Victim Female / Offender Male		8	1	2	4	5	2	2 (mother in law helped husband)			1		1	26
Victim Male / Offender Female		2			2									4
Victim Female / Offender Female		1			2	1								4 (3 sisters killed their sister, 1 daughter-in-law killed their mother-in-law)
Victim Male / Offender Male		2												2 (not partners)
Family killed by Male Offender	1 (3 children)													1
Parent(s) killed Female Child								1		2		1	1	5 (4 mother's killed daughters)
Parent(s) killed Male Child	1				1				2			1	1	6
Parent(s) killed by son		2			1		1							4
Parent(s) killed by daughter														0
Victim Male / Gender of Offender not recorded					1			1	1					3
Victim Female / Gender of Offender not recorded													1 (granddaughter)	1
TOTALS:	2	15	1	2	11	6	3	4	3	2	1	2	4	N = 56 / 56

9. Risk Assessment and Risk Management:

9.1. Six high-risk identifiers, **SPECSS**, have been identified from the murder reviews. It is also supported by the domestic violence serious incident and sexual assault analysis:

1. Separation (child contact)

Research and analysis shows that victims who try and terminate relationships with men are frequent homicide victims. Notions of *'If I can't have her, then no-one can'* are recurring features of such cases and the killer frequently intends to kill himself or herself too (Wilson and Daly, 1993; MPS/URHC Murder Review Analysis, 2003). Rather than stopping the violence, it actually increases on separation: in 76% of the reviewed cases, separation was an issue (MPS/URHC Domestic Violence Murder Review Analysis, 2003).

Threats that begin with "if you were to ever leave me..." must be taken seriously. Victims who stay with the abuser because they are afraid to leave may correctly apprehend that leaving would elevate or spread the risk of lethal assault. The data on time-since-separation further suggest that women are particularly at risk within the first two months (Wilson and Daly, 1993; MPS/URHC Domestic Violence Murder Review Analysis, 2003).

Further, many incidents happen as a result of discussions and issues around child contact or disputes over custody (URHC, 2001). Children should also be considered in the assessment process.

2. Pregnancy / New birth

Pregnancy is often a time when abuse begins or intensifies (Mezey, 1997). About 30% of domestic violence starts in pregnancy. Gelles (1988) found that pregnant women had a greater risk of both minor and severe violence than non-pregnant women. Domestic violence is associated with increases in rates of miscarriage, low birth weight, premature birth, foetal injury and foetal death (Mezey 1997). In 10% of the murder cases reviewed, pregnancy / new birth was recorded/reported (MPS/URHC Domestic Violence Murder Review Analysis, 2003).

Victims who are assaulted whilst pregnant or when they have just given birth should be considered as high risk. This is in terms of future harm to them and to the child. The Violence Research Programme also found that 2.5% of pregnant women (892 women took part in the research) had experienced an assault during the current pregnancy and the lifetime prevalence of assault was 13.4%. Further, women were 10 times as likely to experience domestic violence in the current pregnancy if they had also experienced domestic violence before the last 12 months (Mezey, 2002).

Pregnancy was seen as an opportune time to ask women about domestic violence as some women commented that it made them think seriously about their future and how their children might be affected in the long-term (Mezey and Bewley 2000). Women say they would not voluntarily disclose domestic violence to a health professional without routine screening.

3. Escalation: The attacks becoming worse and happening more often

Previous domestic violence is the most effective indicator that further domestic violence will occur. 35% of households have a second incident within five weeks of the first (Walby and Myhill, 2000). In 87% of the cases reviewed, escalation of violence occurred and was reported prior to the murder (MPS/URHC Domestic Violence Murder Review Analysis, 2003).

There is a very real need to identify repeat victimisation and escalation. Victims of domestic violence are more likely to become repeat victims than any other type of crime. Research indicates that general violence tends to escalate as it is repeated. Analysis indicates times between incidents seem to decrease as number of contacts escalates. (URHC, 2002). Men who have demonstrated violent behaviour in either past or current intimate relationships are at risk for future violence (Sonkin, 1987).

4. Cultural issues and sensitivity

There is a need for cultural awareness and sensitivity when dealing with ethnic minority victims. There may be an issue of perceived racism, which is preventing the victim from seeking help. Needs may also differ and centre on language, cultural, immigration and/or structural issues. 47% of cases reviewed involved cultural issues and sensitivities (MPS/URHC Domestic Violence Murder Review Analysis, 2003). Further questions should be asked of victims who are particularly vulnerable or socially isolated in terms of:

- ❖ Disability (physical or mental)
- ❖ Difficulties speaking/reading English
- ❖ Isolated from friends and/or family
- ❖ Living in an isolated community (rural, ethnic, traveller, gay/lesbian/transgender for example)
- ❖ Does not work outside the home
- ❖ Insecure immigration status

For example, in some cases, if an Asian victim leaves her partner then he, friends, family and the community at large may exclude her or force her to return home. This means she may face being ostracised, or in extreme cases, tracked by bounty hunters or family members via networks in the widespread yet tight knit Asian Community. Issues of shame and honour, the total acceptance of patriarchy and rigid gender roles can combine lethally to *raise unique risks and barriers* for Asian women. In 'honour cultures', sexual assault and failed marriages are seen to dishonour not just the woman or girl but the family as well (Hayward 2000).

Some women, even today, would rather take their own lives rather than live with the shame, stigma and pain of their past (Women against Violence, 1999). Hence, in *some* cases there are high costs involved in reporting domestic violence in *some* Asian homes. Threats that she will be killed or that she will never see the children again are very real and persistent threats. The chances that they will be carried out are high, either in this country or outside it (Huisman, 1996).

5. Stalking

Most female victims know their stalker. Stalking commonly occurs after the relationship but can also occur before the relationship ends (McFarlane, Campbell, Wilt, Sachs, Ulrich and Xu, 1999). Stalkers are more likely to be violent if they have had an intimate relationship with the victim. Furthermore, stalking is revealed to be related to lethal and near lethal violence against women and coupled with physical assault is significantly associated with murder and attempted murder. Stalking occurred and was reported in 40% of reviewed murders (MPS/URHC Domestic Violence Murder Review Analysis, 2003).

The information available suggests that stalkers are worthy of attention because they are a potentially very dangerous group. Stalking behaviour and obsessive thinking are highly related behaviours. Stalking must be considered a high risk factor for both femicide and attempt femicide, and abused women should be advised accordingly (Campbell et al. 1999; Sully Cold Case Murder Reviews, 2001).

6. Sexual assault

The analysis of domestic sexual assaults for the first 4 months of 2001 demonstrates that those who are sexually assaulted are subjected to more serious injury. Further, those who report a domestic sexual assault tend to have a history of domestic abuse whether or not it has been reported previously. ONE IN TWELVE of all reported domestic sexual offenders were considered to be very high risk and potentially dangerous offenders (URHC 2002). In 7% of reviewed murder there was *reported/recorded* sexual assault (MPS/URHC Domestic Violence Murder Review Analysis, 2003). Again *this figure would be higher* given that it was not always asked/recorded by officers and is also underreported.

Further, Browne (1987) reported that over 75% of the abused women who killed their abuser were raped by him, while only 59% of the non-homicidal abused women were similarly sexually assaulted. Battered women who kill are subjected to greater and more frequent violence, especially of a degrading sexual nature, that resulted in more serious injuries.

Men who have sexually assaulted their partners and / or have demonstrated significant sexual jealousy are more at risk for violent recidivism (Stuart and Campbell 1989).

9.2. Risk Management: RARA

Once risk assessment has been undertaken, risk management should follow using RARA and a tactical menu of options.

- R**emove the risk: By arresting the suspect and obtaining a remand in custody.
- A**void the risk: By re-housing victim / significant witnesses or placement in refuge / shelter in location unknown to suspect.
- R**educe the risk: By joint intervention and victim safety planning, target hardening and use of protective legislation.
- A**ccept the risk: By continued reference to the Risk Assessment Model, continual multi-agency intervention planning, support and consent of the victim and offender targeting within Pro-active Assessment and Tasking pro forma (PATP) and Multi-agency Public Protection Panel (MAPPP) format.

10. Conclusion

Domestic violence is a primary health care issue as well as a social and human right issue. It is a criminal offence and should be treated as such in every case. **It must be 'criminalised'** in the same vein as drink driving if the government and Criminal Justice system as a whole are really serious about stamping out this insidious crime.

The importance of partnership in terms of risk assessment and multi-agency risk management strategies should not be overlooked. Information sharing must be enabled with common sense principles underpinning it in order to have an impact in reducing domestic violence and domestic related murders. Too often murders could have been prevented if information had been shared with the right agency at the right time. Decision-making must improve and confidence between the agencies must increase if 'we' are to make a difference and effectively begin to save lives.

The Crime and Disorder Act, 1998, for local police authorities and others to develop effective strategies for tackling crime should have already created an opportunity for developing measures for improving women's safety in which multi-agency forums can be involved.

However, the murder reviews have highlighted the fact **that information sharing is not occurring across the board**, with many agencies refusing to participate in the murder

reviews. Further specific guidance is therefore now necessary regarding risk assessment murder review.

Multi-agency Domestic Violence Murder reviews should be put on a national footing. It makes both intuitive and practical sense for the reviews to be undertaken under MAPPA given that MAPPPs should already be risk managing the most dangerous and high risk offenders with domestic violence offenders falling into this category (albeit this is still patchy across regions).

Members of the Domestic Violence Forum or Domestic Violence co-ordinators should be invited to attend accordingly. The reviews should then be submitted to the Strategic Management Board (SMB) to decide how the recommendations should be taken forward at the three levels: force, national and legislation. Furthermore, the National Strategic Management Board (NSMB) should link in with the National Criminal Justice Boards (NCJB). All the reviews undertaken should be sent to a national warehouse/post-box so that they are accessible to all. National Centre for Policing Excellence (NCPE) seem the most obvious choice in terms of a central point of collation.

More inter-disciplinary training should take place to build up relationships, trust and educate practitioners about systems, structures and processes in other agencies. Judges and magistrates would benefit greatly from inter-agency training as well. A sound knowledge base regarding the dynamics and risk of domestic violence clearly seems to be lacking.

The two pronged approach of murder reviews and risk assessment has already showed its value. This new approach to crime prevention needs to be mainstreamed and employed to enhance policing and multi-agency partnership in the twenty first century. The risk factors identified from the reviews, supported by the domestic violence sexual and serious assault analysis should be disseminated to all those working with victims of domestic violence.

The MPS Risk Assessment Model is the only model which has been piloted and evaluated. It is now being piloted in West Yorkshire to assess its transferability and adaptability. In due course it will be piloted in Thames Valley Police. The lessons learnt from this model should also be disseminated. **Practitioners need to start using a common language when talking about risk. Only then can 'we' truly start working together to safeguard victims.** Perpetrators **must** be held accountable for their actions.

The recommendations from the reviews have been accepted and are to be taken forward by the each agency on a local level and by the Diversity Directorate for consideration at the MPS Management Board. There are certainly implications for implementation and compliance with the National Intelligence Model (NIM).

The findings have also been shared with ACC Gamble, the ACPO DV portfolio holder. They will also be discussed with the Solicitor General Harriet Harman MP for consideration on a wider basis across the agencies. The MPS has been the driver for this. However, specific guidance is now needed from the responsible ministry at the national level. Safety and Justice published in June 2003 the government along with the Green Paper lends the opportunity to influence this. **The information from the murder reviews provides information, which should enable the government to make decisions based on evidence.**

11. Appendices

1. Appendix I: List of members of MPS pan London Domestic Violence Working Group
2. Appendix II: List of members of Strategic pan London Murder Review Group
3. Appendix III: MPS Domestic Violence Risk Assessment Model
4. Appendix IV: Tactical Menu of Options for Domestic Violence offenders and victims
5. Appendix V: Domestic Murder by Borough: January 2001-June 15th 2003 Borough Codes in MPD
6. Appendix VI: Glossary of Terms