TELFORD AND WREKIN COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW IN THE CASE OF M

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2015 to JANUARY 2018

OVERVIEW REPORT

(September 2021)

Independent Author: **John Doyle**

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Preface

The author and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family and friends of M, the victim. The author would like to extend his thanks to the friends of M for sharing with the Panel their thoughts and perspective on the case and particularly to M's child, L for sharing their perspective, their memories and their considerations on this review. Lastly, the author would like to extend his thanks to those services that participated in the review and assisted the Panel in its work.

1 Background

This Review is about M, who was murdered by her partner in January 2018.

At the time of her death, M was working as a manager at a local healthcare service near to where she lived.

In early July 2016, M married the perpetrator. They both lived at the home of the perpetrator, in Staffordshire. The child of M, referred to in this report as L, also lived with them.

The perpetrator was a livestock farmer and a shoot manager (he was a licensed firearms holder) and worked from his home. He also helped to manage his family's farm.

Following the breakdown of their marriage, they separated around Christmas 2017. M and L moved out of the home in Staffordshire and took residence at a property in Shropshire, within the West Mercia Police area. The perpetrator remained living at his home, which was situated in the Staffordshire Police area.

1.1 Incident leading to the Domestic Homicide Review

At 23.15 on a day in January 2018, West Mercia Police were contacted by a resident of Newport, a town in Shropshire. The resident told the police that a woman had been shot whilst in her car. When the police attended the scene, it was established that M – who had been driving the car with L as a front seat passenger – had returned to her home address and before she could get out of the car, the perpetrator appeared, smashed the front driver side window of the car and shot M. L managed to get out of the car and sought assistance from neighbours.

The West Midlands Ambulance Service received a 999 call at 23.16 on the same day and attended the scene at the same time as the West Mercia Police. Paramedics from the ambulance service examined M and CPR was commenced. At 23.53, the MERIT Team arrived – a doctor and a critical care paramedic – and took over the management of the case and administered advanced life-saving procedures. No improvement was identified and sadly, M died at the scene at 00.00.

The perpetrator had left the scene immediately after shooting M, leaving his fatally injured wife in her car and L alone in the street. He returned to his home address and this is where the West Mercia Police found him. The perpetrator was suffering from a significant gunshot wound. At 00.23, the West Midlands Ambulance Service received a call and arrived at the home of the perpetrator. Armed police officers were in attendance and had seized the weapon. The perpetrator was arrested on suspicion of the murder of M and was then transferred to hospital by the Ambulance Service. The perpetrator remained in hospital for a significant period (11 months) to receive life-saving treatment and reconstructive surgery.

The Major Investigation Unit undertook the investigation.

1.2 Significant people in this case

Pseudonyms have been used in relation to the subjects of this case and the significant people referred to within this Overview Report are described, in brief, below:

Pseudonym	Relationship to subject (if applicable)	Ethnicity or diversity category
M	Victim	White European
The Perpetrator	Partner of M	White European
L	Child of M	White European
Perpetrator's child	Child of perpetrator	White European
Perpetrator's step child	Step-child of perpetrator	White European
Perpetrator's Ex	Ex-wife of perpetrator	White European
M2	A friend and associate of the perpetrator	White European
F1	A friend of M	
F2	A work colleague of M	

1.2.1 The use of pseudonyms

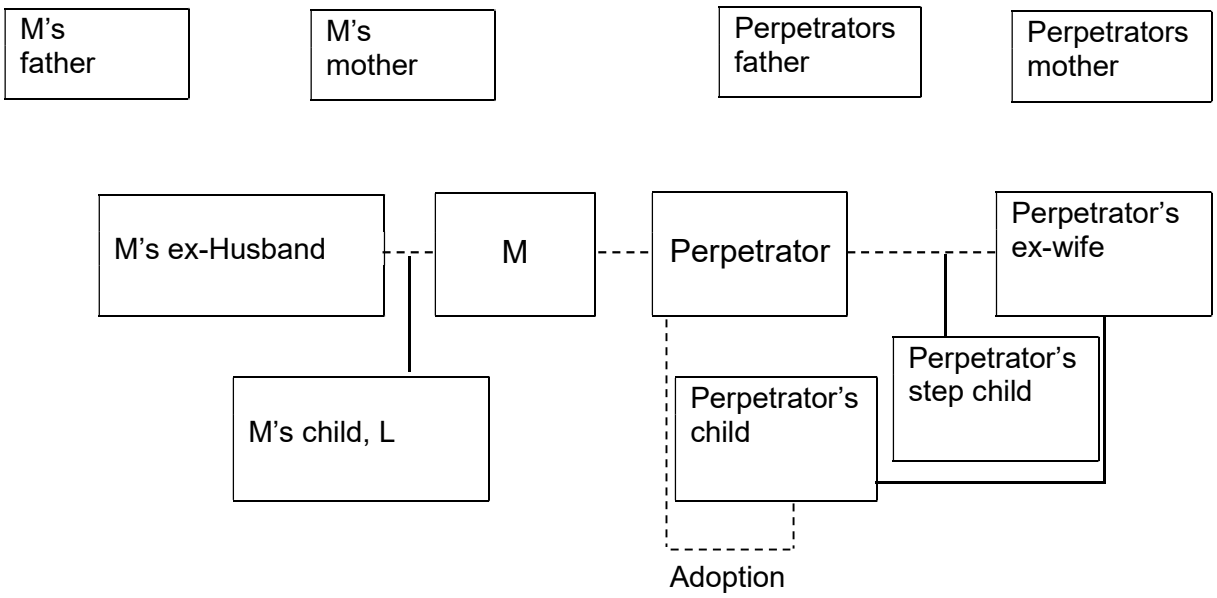
The review panel sought to involve M's family in the review and approached this with sensitivity and respect. The author of the Review received contact details from the Family Liaison Officer appointed for the family and, subsequently, contacted the family to seek their involvement. The author shared the purpose of the DHR (and what the process was intended to achieve) and invited them to participate in the process. No set timeline was established for their participation – the Panel and the Chair considered it more appropriate to allow time for the family to consider the request.

In January 2020, the Author met with the child of the Victim in this case, L, who was 16 at the time. As part of the discussion, the Author explained the use of pseudonyms within the report, stating that it is very often the case that members of the family of the Victim are given the opportunity to select a name for the Victim and the perpetrator.

L wished for theirs and M's name to be used throughout the report, as this was how the Victim's friends and family knew her. However, in line with statutory guidance this report has been anonymised to protect the identity of other witnesses who may have been impacted by the murder.

The Author informed L that the Panel had chosen the term 'perpetrator' and L stated that they preferred that term rather than his real name or pseudonym.

1.3 Family genogram



Section 2. The Conduct of the Domestic Homicide Review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance, i.e.:

> *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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"*

Following the publication of the associated Home Office Action Plan in March 2012, guidance on the conduct and completion of DHRs has been updated. It is under this revised guidance that the Telford and Wrekin Community Safety Partnership commissioned this DHR.

This Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the latest revisions of the guidance issued by the Home Office in 2016. The purpose of the DHR is to:

- Establish what lessons are to be learned from the 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 the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all Victims and their children through improved intra and inter-agency working.

The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this Report at **Appendix 3.**

2.1 The time period under review

At the initial meeting of the DHR Panel in June 2018, it was agreed that the time-frame for the Domestic Homicide Review should cover the period from the 1st of January 2015 (19 months prior to the marriage of M and the perpetrator) to the date of the murder in January 2018.

As is usual, participating agencies were reminded that if issues arose that were pertinent to the discussions of the Panel that fell outside this time frame, then they should be submitted in order to provide context for the case.

2.2 The time-scale of the Review

The first panel meeting was held on the 12th of June 2018. The panel met on five occasions. At its first meeting, the panel agreed several objectives, actions and terms of reference. This set the course for the completion of the report.

Two submissions were made to the Home Office by Telford and Wrekin Council to request an extension to the target date for the completion of the Overview Report. One was made in early September 2018 – the rationale being to draw attention to the possibility that there may be a significant delay in progress due to the medical status of the perpetrator, since they were not medically fit to make a plea. The perpetrator was deemed fit to make a plea in December 2018 and submitted a plea of not guilty. The second request to the Home Office was made in February 2019 to draw their attention to the probability of another significant delay in progress due to a continued delay concerning the commencement of the trial of the perpetrator.

A court date for the trial was set for June 2019. The trial lasted three weeks and on the 21st of June 2019, the perpetrator was found guilty of murder. The tariff set by the court was a life sentence with a minimum of 31 years.

2.3 Statement of Confidentiality

The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professionals out-with the DHR process.

2.4 The Review Process

This Review, commissioned by the Telford and Wrekin Community Safety Partnership has been completed in accordance with the regulations set out by the Domestic Violence, Crime and Victims Act (2004) and with the revised guidance issued by the Home Office to support the implementation of the Act.

At its first meeting, the DHR Panel approved the use of a locally devised Individual Management Review (IMR) template and integrated chronology template. The Chair of the Panel contacted each participating agency, as appropriate, and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was excellent. The IMRs and integrated chronology were used to determine the nature and frequency of contact each participating agency had with M.

Home Office Guidance requires that:

“Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim’s experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator’s networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances”, and:

"Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

The review panel sought to involve M's family, friends and colleagues to participate in the review and approached this with sensitivity and respect.

With the assistance of the Family Liaison Officer appointed by West Mercia Police, the Author contacted members of M's family, informing them of the DHR (and what the process was intended to achieve) and invited them to participate in the process, if they felt comfortable to do so. Due to the delay described in paragraph 1.5, no set timeline was established for their participation. At a later meeting, the Panel considered it more appropriate to allow enough time for the family of M to consider the request, once the criminal proceedings had concluded.

The Author attended the court where the trial was conducted in June 2019 and made an introduction to M's family – re-assuring the family that involvement in the DHR was entirely at their discretion.

In September and October 2019, the Author, via the family's AAFDA representative, contacted the family – with a brief update of progress – and invited them to consider contributing to the Review. The Author remained in contact with the nominated AAFDA representative through October and November. The AAFDA representative confirmed that the family were keen to participate in the completion of the Report.

In December 2019, the Author contacted a representative from Victim Support (part of the domestic homicide team) who was in contact with the family and they confirmed that, after much deliberation, M's parents did not wish to participate but L did wish to participate. The representative from Victim Support arranged a meeting with L in January 2020 and L agreed the transcript of the meeting with the Author later that same month. The meeting with L is outlined later in this report.

A friend of M and a work colleague of M also agreed to assist with the Review and their contribution is outlined later in this Report.

The perpetrator in this case was also informed of the DHR process, with an invitation to participate once the trial had been completed. The perpetrator did not respond to the invitation. The panel discussed the relative merits of repeating the invitation to the perpetrator to participate in the review. Due to his injuries, coupled with the attendance at Court by the Author of the Review, the length of the trial and the details of the perpetrator's testimony, it was not considered fruitful to the Review to pursue this further.

The details of the testimony provided by the perpetrator, are, of course, reflected across this Overview Report. The Panel noted that the length of the trial was notable because it had to be extended to take account of the injuries

the perpetrator was living with and how difficult it was for the perpetrator to communicate. Neither the Author nor the Panel felt compelled to repeatedly invite the perpetrator to contribute, partly because of the injuries he had endured. Moreover, the Panel could not clearly identify what value would be added to the Review by pursuing this action.

2.5 The Terms of Reference

The Panel approved these specific terms of reference at its initial meeting in June 2018 and agreed to keep them under review as the process evolved. This was to ensure that they could be amended in order to capture any additional information revealed as a part of the Review process.

It was agreed that the time-frame for the Domestic Homicide Review should cover the period from the 1st of January 2015 to the date of the murder in January 2018. At the first meeting of the Panel in June 2018, the following terms of reference were approved:

1. To establish what contact agencies had with the victim, (and children, where appropriate) and the perpetrator; what services were provided and whether these services were appropriate, timely and effective.
2. To establish whether agencies knew about any incidents of domestic abuse and what actions they took to safeguard the victim and risk assess the perpetrator.
3. To establish whether there were other risk factors present in the lives of the victim, and perpetrator.
4. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns via appropriate safeguarding pathways
5. To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
6. To identify clearly what those lessons are, how and within what timescales they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
7. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review
8. To take full account of the terms of reference and timetable for completion of the independent investigation conducted by the Independent Office for Police Conduct (IOPC)

The Panel also agreed a number of key lines of enquiry pertinent to this case and these are set out below:

2.6 Key Lines of Enquiry

- Did any agency know or have reason to suspect that the victim was subject to domestic abuse by the perpetrator at any time during the period under review?
- If so, what actions were taken to safeguard the victim and were these actions appropriate?
- What happened as a result of these actions?

- Was the perpetrator known to any agency as a perpetrator of domestic abuse?
- If so what actions were taken to reduce the risks presented to the victim and/or others?
- Were the victim and/or the perpetrator known to misuse drugs and/or alcohol, including the misuse of prescription medication?
- Were any mental health issues self-disclosed by the victim and/or the perpetrator?
- Were there any other issues that may have increased the victim's risks and vulnerabilities?
- Did any of the subjects of this case disclose domestic abuse to family and/or friends, employer/school? If so what action did they take?
- Did the perpetrator make any disclosures regarding domestic abuse to family and/ or friends/ employer? What action, if any, did they take?
- Are there any matters relating to safeguarding vulnerable adults and/or children that the review should take account of?
- Were there any issues concerning the purchasing, licensing and storage of fire-arms that the review should take account of?
- Were issues of race, culture, religion and any other diversity issues considered by agency when dealing with the victim and perpetrator?

2.7 Contributors and Panel members

Following the notification of the death of M, the Telford and Wrekin Community Safety Partnership (CSP) was instructed by the Home Office to undertake a Domestic Homicide Review and to commission this Review under the auspice of Telford and Wrekin Council.

The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

The Commissioning Authority (Telford and Wrekin Council) appointed an independent Author, John Doyle, to oversee and compile the Review, in accordance with the Home Office Guidance. John has extensive experience in public health management within the NHS, was a full member of the UK Public Health Register (achieving Consultant level) and has acted as author in several DHRs and Safeguarding Reviews. John has completed the Home Office training concerning the completion of DHRs and had no connection with the case or with any of the agencies involved in the review.

Panel members were invited to support the Panel based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. Additionally, colleagues with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were invited to support the panel.

The views and conclusions contained within this overview report are based on findings from both documentary evidence and interview transcripts and have been formed to the best of the Review Panel's knowledge and belief.

Panel member	**Name**	**Organisation**
Author	John Doyle	Independent
Commissioning officer and Partnership Manager	Jessica Tangye (who assumed the role from Sarah Constable)	Telford and Wrekin Council
Group Manager for Access and Inclusion (School Performance and Organisation)	Cathy Hobbs	Education and Skills service, Telford and Wrekin Council
Manager of the Prevention Team	Derek Taylor	Shropshire Fire and Rescue Service
Detective Chief Inspector (DCI)	Steve Tonks	West Mercia Police
Detective Sergeant	Sophie Wade	West Mercia Police
DCI and Senior Investigating Officer	Mark Bellamy,	West Mercia Police
Detective Superintendent	Simon Brownsword	Staffordshire Police
Service Manager	Sue Coleman	West Mercia Women's Aid
Safeguarding Team Manager	Emma Martin	Family Connect, Telford and Wrekin Council
Manager, Community Safety, Cohesion & Environmental Enforcement	Jas Bedesha	Telford and Wrekin Council
Safeguarding Team (Named Nurse for Adult Safeguarding)	Kathy George	Telford and Wrekin Clinical Commissioning Group
In attendance		
Administrative support	Kelly Griffin/Angela Davies	Telford and Wrekin Council

2.7.1 Contributors to the Review

Organisation	Nature of the submission	Completed and submitted by
Family Connect (Telford and Wrekin Council)	IMR	Safeguarding Team Manager. The author had no direct involvement with the subjects of the case. The IMR was quality assured and approved by a Senior Manager within the Council.
Education and Skills service (Telford and Wrekin Council)	IMR	Group Manager for Access and Inclusion within the School Performance and Organisation Team. The author had no direct involvement with the subjects of the case. The IMR was quality assured and approved by a Senior Manager within the Council.
Staffordshire Police	IMR	Manager of the Crime Review Team. The Author has no line management responsibilities for Officers or Staff required to deliver a Policing Service. The IMR was quality assured and approved by a senior officer within the Service.
Clinical Commissioning Group/General Practice	IMR	Named Nurse for Adult Safeguarding for the CCG. The author had no prior knowledge of any of the parties under review within the IMR. The IMR was quality assured by a senior officer within the CCG.
West Mercia Police	IMR	Review Officer with Warwickshire and West Mercia Police Statutory and Major Crime Unit. The Author had no previous operational involvement in the case.
West Midlands Ambulance Service	Short Report	Kelly Starkey. Safeguarding Officer, Clinical and Quality Directorate. The author had no direct contact with the subjects of the case.
Independent School Counsellor	Short Report and personal communication with the author	Counsellor and Systemic Practitioner. The counsellor had contact with L and the perpetrator's step child

Several organisations, in addition to those listed above, were contacted during the 'scoping phase' of the Review in order to establish if they had contact with

either the Victim and/or the perpetrator. Each of the organisations listed had secured and examined their records and confirmed that they had no contact with either subject:

Organisation	Confirmed no contact within the scope of the Review
National Probation Service	Confirmed no contact
Warwickshire and West Mercia Community Rehabilitation Company	Confirmed no contact
Shrewsbury and Telford Hospitals NHS Trust	The Trust saw the perpetrator for the treatment of one minor injury (work related) that occurred outside the scope of the Review
North Staffordshire Hospitals NHS Trust	Confirmed no contact
Adult Social Care Services	Confirmed no contact
West Mercia Women's Aid	Confirmed no contact

2.8 Parallel Reviews

Setting aside the criminal investigation and the notification to the Coroner, there was one pertinent parallel process necessary for the Panel to consider. Following the murder, both the Staffordshire Police and the West Mercia Police submitted, under their own direction, their performance in the case to the Independent Office for Police Conduct (IOPC). The Author communicated with the lead investigator from the IOPC and exchanged information with them, co-ordinated the timing of contacts with the friends and family of M and shared the relevant time-line for the completion of the Review.

The lead investigator from the IOPC kindly shared the outcome of their investigation with the Author of this DHR and, where necessary and appropriate, reference is made to the IOPC Review throughout this report.

The Author also communicated with the Office of the Coroner and informed them that the DHR was taking place and the expected time frame for the completion of the Review.

2.9 Equality and Diversity

The review panel were committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to M, L, members of M's family, and the perpetrator.

There was no evidence that M, L, their family or the perpetrator were directly discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender),*

Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.

The Chair of the Panel was not required to challenge any member of the Panel on the grounds of diversity or sensitivity to equality legislation throughout the process of completing the Review.

The Panel noted that whilst none of the agencies contacted in relation to this Review identified any specific diversity issues concerning M, L or the perpetrator, this did not mean to suggest that these agencies were unaware of Disability discrimination as it pertains to the Equality Act 2010.

The Panel noted that sex (gender) is a protected characteristic under the terms of the Act and were cognisant of the fact that there is a disproportionate prevalence of women as victims of domestic abuse and violence.

The Panel included members with, amongst other matters, specialist knowledge of domestic abuse, the management of fire-arms, and the safeguarding of adults and children. This combination of knowledge and insight was particularly valuable for the Panel.

2.10 Dissemination of the Overview Report

The dissemination of the final Overview Report and Executive Summary will be undertaken in accordance with the procedure approved by the commissioning authority and the Home Office. The Overview Report and Executive Summary will be circulated to:

- The Telford and Wrekin Community Safety Partnership
- The family of M
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for West Mercia
- All agencies involved in the review

Section 3 – The Facts

3.1 The perspective of M's family, colleagues and friends

As referred to under paragraph 1.7, above, the Panel, cognisant of the advice received from members of the panel specialising in domestic abuse, took the decision to contact L and M's parents when the trial of the perpetrator had concluded. A Family Liaison Officer from West Mercia Police was in contact with the family during this period and the Senior Investigating Officer had a very good relationship of trust with the family, providing them with support and advice regarding the investigation.

The Author attended the court where the trial was conducted in June 2019 and made an introduction to M's family – re-assuring them that involvement in the DHR was entirely at their discretion.

In late September 2019, the Author contacted a representative from Advocacy After Fatal Domestic Abuse (AAFDA) who were in contact with M's family and were providing support to them and L. The AAFDA representative agreed to be the contact between the family and the Panel and to alert the Author as to if and when it would be convenient and appropriate for the Author to speak to the family of M.

In late November 2019, a homicide specialist from Victim Support, who also had contact with the family and was providing support to L, informed the Author that, after much deliberation, M's family did not wish to participate in the review, but that L did wish to participate. The Author contacted the representative from Victim Support to discuss the case and to discuss the current needs of M's family.

The representative from Victim Support arranged a meeting between the Author and L in January 2020. The representative from Victim Support – because they were providing support to L – joined the Author in the meeting with L. L agreed the transcript of the meeting with the Author later that same month. The meeting with L is outlined later in this report.

The Panel also agreed to contact a friend and a colleague of M who, in the view of the panel, may have been able to offer further insight into the circumstances leading to the murder in January 2018 and further insight into M's character, personality and outlook.

Set out below is the information shared with the Panel that, in turn, helped the Panel to form a fuller picture of M's life, and experiences.

3.2 Summary of key points from the meeting with L, M's friend (F1) and with M's colleague (F2)

3.2.1 Meeting with L

The Author outlined the purpose of the Domestic Homicide Review and the process the Panel had, to the date of the conversation, completed. A number of issues and perspectives were discussed, and these are set out below:

L told the Author that M was always interested in the welfare of others. For example, she ran – as a leader – a 'Kids Club' and she always wanted to help other people and often commented that she couldn't say 'no' to people who she could help. L said that one of their grandparents was an engineer and that their mother had learnt a lot from them and it made her self-sufficient and competent doing DIY around the house. L said that M was clearly optimistic and capable – being a lone parent, working and helping people all demonstrated this. L said that M was always optimistic and would often say 'don't frown' and 'chin-up' as an encouragement to keep going.

L said that it was apparent that M had a lot of friends – many of whom she'd known for many years. The number of friends that M had was demonstrated by there being four books of condolence.

L said that, from her perspective, there was a degree of disharmony in the relationship between M and the perpetrator that gradually escalated through the summer and autumn of 2017. L said that M would occasionally say that she remained in the company of the perpetrator in order to keep him happy – and this was particularly the case during the Christmas of 2017. L said that a prominent issue that stuck in their mind was when the perpetrator took M's car (using a spare key) without her knowledge or consent. L said that they thought that this incident probably led to M deciding to leave the perpetrator's home – and that this was either the 9th or 10th of December 2017. L recalled an incident when a TV was smashed, and told the Author that the perpetrator smashed the TV knowing that L would be able to hear it, alongside the argument he was having with M. L said that along with their step-sister they urged M to contact the police so that they could log the incidents as they occurred, and that being in the same house as the perpetrator was not safe. L said that eventually M took the advice and left the home and began looking for other properties elsewhere.

L told the Author that the perpetrator confronted M when he discovered she was looking at other properties and this occurred just before she left. L said that when M found a new place to live, several friends advised her not to tell the perpetrator where her new home was. However, L said that M was concerned that the perpetrator was not looking after himself very well and so invited him to her new home for dinner.

L discussed what happened when M contacted the police and said that, from L's perspective, M thought that she had no evidence at all about domestic abuse and that her view was that people wouldn't be able to do anything. L said

that they kept encouraging M to do something and L shared information with their school. L said that the school knew about the TV being smashed and the threats of suicide made by the perpetrator. L told the Author that M had said that if the perpetrator did commit suicide, his death 'would be on her hands'.

L said that M would sit with the perpetrator for long periods of time, pleading with him to set his gun aside and to not have thoughts of suicide.

L said that when their school received information from L, they contacted M and urged her to contact Family Connect and, in turn, Family Connect urged M to contact the police. L reflected that they were pleased to have 'got the ball rolling'. L recalled M saying that she was concerned that if she did contact the police, the perpetrator would lose his guns.

L said that the school, responded really well and offered the services of a Counsellor after the information had been shared with them about the situation. L said that, after some discussion, they didn't take up the offer because they didn't consider that they would 'enjoy' the experience and that there were certain members of staff in the school who knew everything, and that L could "….go to see them whenever they wished to, and they were always supportive".

L recalled that they knew that M had contacted the police in Staffordshire and that the case had been passed to the West Mercia Police. L knew that the police had missed at least two appointments made with M. L said that they were aware of and had read the report produced by the Independent Office for Police Conduct (IOPC) and that in their opinion these appointments were missed simply because of a lack of resources. L stated that it seemed that Staffordshire Police and West Mercia Police 'had got their wires crossed' over this case.

L recalled that they had not been spoken to independently by the police – or any other service that was in contact with M. L said that when the police met with M, the conversation was directed mostly at her and not to L. On reflection, L said that even if they had been spoken to independently, this would not have stopped the perpetrator from killing M, but that it may have helped the case, it may have helped the perpetrator and it may have helped the police 'control' the perpetrator. L held this view because if they had been spoken to alone, they 'would not have held back' views and opinions regarding the situation L and M were in.

L said that, like many people in the same age bracket, they felt that it was important to let children speak…. they usually know the truth and are not frightened to share what they know – so long as it is in a safe place and with a person that they trust, most often someone in school. L told the Author that Teachers are invaluable when thinking about domestic abuse, that you can trust them but that they must be more open, and they must be able to spot changes in behaviour and pick up on changes in attitude and attention at school.

3.2.2 Meeting with F1 – a friend of M

F1 said that they knew M from Church and that M was a frequent visitor, particularly on a Sunday evening service and would attend this service at least once each month. F1 also knew L, who was involved in the youth-work of the church.

F1 told the Author that M was married at the church and that they had met the perpetrator, as they were preparing for their marriage. F1 stated that M was very positive about…. everything, very optimistic for the future and that M was also very empathic and expressed a sense of care for the people around her.

The Author asked F1 to try to recall the months leading to the murder in January 2018 and to identify if there were any changes, slight or otherwise, in the way M behaved.

- F1 said that there were no definite signs that M was troubled in any way, though they noted that they saw slightly less of M after she was married. When they did see her, F1 recalled that she was the same as always: bright and helpful as ever. F1 was aware that, after M was married, she moved into the home owned by the perpetrator, which was some way away, but not too far to prevent her from visiting the Church;
- F1 recalled that, around the Christmas of 2017, they noted some sense of anxiety amongst M's friends – a sense that perhaps M wanted to speak, but F1 didn't recall a degree of urgency in this respect;
- F1 said that 6 or 7 weeks before Christmas 2017, the perpetrator appeared at their home and wished to speak to F1. The perpetrator said that the relationship with M wasn't going well. F1 recalled that during the conversation with the perpetrator they referred to mediation and/or other sources of professional help and F1 advised the perpetrator to be patient and to consider the longer view.

The Author asked F1 to try to recall the weeks immediately prior to the murder in January 2018 and to identify if there were any events or occurrences, slight or otherwise, that remain in his mind.

- F1 recalled that – perhaps two weeks before the murder – another member of the congregation had arranged to see F1 with M but closer to the time, called it off. F1 recalled having a telephone conversation with the perpetrator at around the same time where, once again, they urged the perpetrator to seek mediation, to be patient and to consider the longer-term future of his relationship with M. On the same day, F1 recalled they received a text message from M expressing concern for the welfare of the perpetrator;
- F1 did recall a telephone call they had received from M – around the time M was due to move into her new home. M was asking for help to move some of her belongings from the marital home. During this telephone call, M spoke to F1 about some of the reasons why she was moving out and why she felt it was the best course of action for her and for L.

- F1 said that it may have been the case that M felt reticent – perhaps even embarrassed – to speak to F1 about her marriage and the possibility that it may not have been as fulfilling as expected.

3.2.3 Meeting with F2 – a colleague and employer of M

F2 explained that their children attended the same baby and infant group as the child of M and that F2 had known M since approximately 2004.

F2 said that they employed M in 2013, initially as a receptionist and, latterly, as the Manager of the service. F2 said that he had regular contact with M at work but also, because they knew one another as friends, outside of the workplace

F2 said that M was dedicated, very capable, professional and hard working. F2 emphasised that M was kind and sensitive and a devoted Christian, she had a lot of friends inside and outside of work. F2 noted that M was also practically capable – learning a number of skills from her father, that made her independent in her own life and home.

The Author asked F2 if they knew the perpetrator

F2 confirmed that they only knew the perpetrator via M and did not consider him to be a friend or associate during the time leading up to the murder.

The Author asked F2 to try to recall the weeks and months immediately prior to the murder in January 2018 and to identify if there were any events or occurrences, slight or otherwise, that remain in their mind.

F2 stated that it was apparent that the relationship between the perpetrator and M had not been harmonious for a number of months prior to the murder occurring and stated that M held the view that he had some degree of dependence to alcohol and that whenever there were periods of disharmony, he would drink.

F2 recalled one incident – when M was still living in the same home as the perpetrator. F2 recalled that M had said that one evening the perpetrator had a shotgun by his side whilst watching TV. M told F2 that she thought that he was going to commit suicide on that evening. F2 stated that M was never anxious that the perpetrator would harm her but was anxious that he would kill himself. F2 reflected that shotguns seemed to feature prominently in the perpetrator's behaviour and in his relationship with M. F2 had the recollection that the perpetrator had threatened suicide on more than one occasion.

F2 recalled an incident – around Christmas 2017/New Year 2018 – when the perpetrator was drunk and a TV was smashed and F2 recalled that M's child (L) was frightened by this incident and refused to stay in the home with the perpetrator. F2 stated that on the 2nd of January 2018 (the first day of work following the Christmas break), the perpetrator attended the address of M's workplace in the family car and was seen in the car park. M went to speak to him and later told her colleagues that she had noticed that he had a shotgun in the car with him. F2 – and other staff/friends at work – urged M to contact the

police and inform them of this incident. M said that she did not want to do this because she was concerned that the police may remove the perpetrator's shotgun license…F2 reflected that this was the kind of person M was – always more concerned about the perpetrator than about herself

At around this time, M told F2 that the perpetrator had asked her to remove her belongings from the family home – that she must pick them up otherwise they would be left outside. F2 recalled that at this time, the perpetrator had removed M's car and so (on the 7th of January – or thereabouts) M asked F2 if she could borrow their car – and F2, of course, agreed. M's friends at work also helped her move her belongings elsewhere.

The Author asked F2 to try to recall the days and weeks leading to the murder in January 2018 and to identify if there were any changes, slight or otherwise, in the way M behaved.

F2 stated that M was resolute that she would not return to the same home as the perpetrator and appeared to concentrate upon settling into a new home and settling into a new routine and her behaviour appeared to settle into a period of calm

The Author asked whether F2 thought that something could have been done following the incident when the perpetrator *appeared in the car park with a shotgun in the car*

F2 said that they, and M's friends at work, vigorously urged M to contact the police – following the incident in the car-park and also the incident following the smashing of the TV but M was reluctant to do so, because of the risk of the perpetrator losing his shotgun license. Eventually, everyone felt that it had to be M's own choice to disclose the details of these incidents to the police and to do so in her own time.

3.2.4 Consideration of a submission from M2

The Panel considered at length, inviting the perspective of M2 (the friend of the perpetrator who held the firearms license) to inform the Review. The Panel noted that M2 – and a number of other colleagues and friends – were witnesses in the Trial. The police representatives on the panel suggested that it would be acceptable to contact M2 as soon as the Trial had concluded. With the guidance of the Panel, the Author of the report received the contact details for M2 and drafted a letter to them which was sent in late September 2018 (following the Panel meeting held on the 7th of September). M2 did not respond to the request to offer their perspective. The Panel concluded that, taking account of the support provided by M's friends, colleagues and Daughter, coupled with the evidence offered at the Trail by M2, their direct involvement would not offer significantly enhanced value to the Review.

3.3 Abridged chronology of agency contacts and key events

3.3.1 Prior to the formal scope of the DHR

February 2007 (23rd)
Staffordshire Police recorded an incident of domestic abuse involving the perpetrator and his ex-wife. The report stated: "...my husband has got me around the throat...he has hurt me...and I am scared". There was also a record made that a child was resident at the address where the assault took place. There were also counter allegations. Liaison occurred with West Mercia Police and they attended the address where the incident occurred, the home address of the perpetrator.[1] Staffordshire Police followed up the investigation commenced by West Mercia Police and recorded that the perpetrator's ex-wife declined to support a prosecution but provided a witness statement. The formal entry onto the system for this incident also held a record that in 2004, the perpetrator broke into the home of, at that time, his ex-wife. The perpetrator was carrying a carving knife and intended to threaten to kill his ex-wife and her new partner. It was recorded by the Public Protection Unit that, at this incident, the perpetrator threatened to kill himself with a shotgun.

July 2013 (24th)
Staffordshire Police noted that the perpetrator made an application for a shotgun certificate. The certificate was granted to run for 5 years (expiring in July 2018).

3.3.2 Within the scope of the DHR

*Contributions to this abridged chronology from the review undertaken by the Independent Office of Police Conduct are signified by being under-scored and referred to by "IOPC".

July 2016
M and the perpetrator were married.

December 2017 (14th)
The Telford Education and Skills service were informed by the school attended by L that M and L had sought refuge from the perpetrator at the address of M's parents. A domestic incident had occurred at the home of the perpetrator. The details noted by the school stated that this was a verbal altercation[2].

December 2017 (21st)
The GP for the perpetrator noted a surgery consultation, the details of which referred to an 'adjustment reaction' following M moving out of the family home. The perpetrator reported that he had felt similar feelings following the breakdown of his first marriage. The perpetrator reported that he had received antidepressants at that point but took them for only 3 weeks. The perpetrator

[1] This address was the matrimonial home shared – latterly – by the perpetrator, M and L.
[2] The details concerning the smashed television was not known by the school at this point

reported that he was not, at the point of the consultation, drinking to excess but had been drinking more alcohol in the days leading up to the consultation. The GP considered suicidal ideation with the perpetrator but noted none and advised a self-referral to Improving Access to Psychological Therapies service (IAPT).

January 2018 (2nd)
M2, a friend of the family, spoke with M on the telephone. M2 recalled that M was in tears and told M2 she had walked in on the perpetrator holding a gun to his throat, and earlier in the day she had been on the 'phone to the perpetrator and he was threatening to kill himself. This was not reported to the police at the time. M2 went to the address of the perpetrator and took possession of his six shotguns and his firearms certificate and took them to the West Midlands Shooting Ground (WMSG – a registered and licensed service for the storage, servicing and repair of firearms, based in Shropshire). M2 paid for them to be stored there. WMSG sent six storage notification letters to the Staffordshire Police Firearms Licensing Unit, detailing the perpetrator's six firearm's being stored with West Midlands Shooting Ground.

The perpetrator's 'Holder Summary' on the National Firearm's Licensing Management System (NFLMS) was updated and detailed that his six shotguns were in storage with West Midlands Shooting Ground.[3]

January 2018 (3rd)
The GP for the perpetrator noted a surgery consultation. The perpetrator reported poor concentration at work; poor appetite and poor sleep. The perpetrator stated that he was going to contact IAPT.

January 2018 (3rd)
The Telford and Wrekin Education and Skills service noted an e-mail from M to the school of L. The information concerned the Christmas holiday, referring to an incident whereby the TV was smashed. It was noted that L had told the school that they and M had moved into the home of M's parents. The school gave advice concerning support services provided by the police and others.

January 2018 (4th)
The Telford and Wrekin Education and Skills service noted that the perpetrator's step child had reported in school that they had witnessed a domestic incident. The school noted that they intended to check this with the mother of the perpetrator's step child.

January 2018 (4th)
The Telford and Wrekin Education and Skills service noted the receipt of an e-mail from M to the school of L. The e-mail described a 'disastrous' Christmas and focused on L's needs. The e-mail referred to suicide threats and an incident 2 weeks prior to the e-mail when a TV was smashed. The school noted that

[3] The Author contacted the West Midlands Shooting Ground in order to have a conversation with them concerning their procedures and what they knew of M2 and the perpetrator. The details are included within the analysis section of this review.

they intended to offer pastoral support and counselling to L and advice, support and information to M.

January 2018 (4th)
The GP for the perpetrator noted a surgery consultation. It was noted that the perpetrator stated he felt more "upbeat", simply by knowing what was going on. It was noted that the GP discussed with the perpetrator the report the GP had heard from a third party suggesting that the perpetrator had made suicidal threats. When the GP raised this matter, the perpetrator stated that the comments were "stupid things he had said in the heat of the moment" to try to get M not to leave the family home. The perpetrator stated to the GP that he had never attempted such actions and had no actual suicide intent. The GP noted that the perpetrator had been clear that he was aware of the concerns of others regarding his firearms, so had made arrangements for these to be taken into storage to remove any concerns other may have had. The GP made the perpetrator aware that he could refer for crisis support if suicidal ideation became an issue.

January 2018 (9th)
The school of L noted an email from the school to M providing details of police contacts (101), the safer neighbourhood team and the domestic violence contact number at West Mercia Police.

January 2018 (10th)
The school of L noted information stating that L had shared details relating to an incident with the perpetrator and a gun. The agreed actions included discussing the information with M and seeking advice from Family Connect (the Local Authority Multi-Agency Safeguarding Hub). On the 12th of January, the school noted a confirmation of advice given by Family Connect and that M had stated that the advice would be acted upon.

January 2018 (12th)
Staffordshire Police noted a call received from M. The call recorded that M stated she had been advised by the school of her child to log activity with Staffordshire Police. The account, given over the telephone, provided a number of details: M stated that she had gone through a separation with the perpetrator and things had happened that had made her child uncomfortable. M stated that the issue commenced with the perpetrator smashing the TV; that the perpetrator had also threatened to kill himself and that the perpetrator had taken M's car without her knowledge or consent. M stated that her child was in a different room when the TV was smashed by the perpetrator and that L was not present when the perpetrator referred to the suicide attempts; but that L was present when M discovered that her car had been taken; M stated that the perpetrator's doctor had been informed and his friends were helping him; M stated that L was worried that '…the perpetrator was going to follow M and L around and watch us'. M stated that she had asked the school if L could have someone to talk to and that it was the protocol of the school to make Family Connect aware and that Family Connect had said M needed to contact Staffordshire Police. M stated that she had recovered her car – the perpetrator

had said that M could have it back and he had said he didn't know why he did it.

10:23 AM (IOPC review)
The call-taker clarified some details with M and the call-taker explained to M that, as she was reporting a domestic incident, officers would have to see her. M was advised to attend her local police station, as she did not live in the Staffordshire Police force area. M said she had spoken to West Mercia Police and was told Staffordshire Police had to log the details of the incident as the perpetrator lived in the Staffordshire Police force area.

The call-taker confirmed that as the incidents had happened in the Staffordshire Police force area, they 'owned' the incident, but rather than have M go to Stafford, her local station could take a statement from her. Her statement could then be given to Staffordshire Police to be dealt with. The call-taker told M that they would pass the incident on to West Mercia Police. West Mercia Police would then contact M to arrange a time to take her statement. M was advised that should there be any further incidents, to call 999 as the incidents M was describing would be things responded to as an immediate response.

10:32 (IOPC review)
The call-taker tagged the incident for the MASH (Multi Agency Safeguarding Hub)[4] and child protection, as M had originally called with concerns about the effect these incidents were having on her child.

Staffordshire Police sent an e-mail to West Mercia asking them to take a statement. The email consisted of a copy of the Staffordshire command and control Log and the following request:

> *Please see the attached log regarding a domestic incident on ourselves. The IP (Injured Party) lives on your area, please can contact be made for a Statement to be taken so we can then deal. Staffordshire Police control room'*

13:19 (IOPC review)
Subsequently, the MASH tag was deleted. This was based upon the rationale that the incident was suitable to be dealt with through the Domestic-Abuse Incident Assessment Log (DIAL)[5] or, if L visited the Staffordshire area and there were on-going concerns, the Multi Agency Referral Form (MARF) would have been used. As L lived in the West Mercia Police Force area, it would have

[4] MASH is a partnership between seven key public sector organisations who work together to improve safeguarding outcomes for children, adults with care and support needs and those people involved in serious domestic abuse situations. To help improve safeguarding outcomes, MASH is organised for agencies to share information so that this decision is made in a more informed way than if only single-agency information were available.

[5] DIAL is a form completed by Staffordshire Police on domestic related incidents.
MARF is used by Staffordshire Police and should always be completed when making a referral to Stoke on Trent Children's Social Care/ Staffordshire Children and Families First Response Service in the MASH

been for West Mercia to refer L to their appropriate social care service (if necessary).

The West Mercia Police Operational Information System (OIS) log stated:

> *"It would appear that all this has happened on Staffordshire Police area whilst they lived together…..but clearly there are still on-going problems. Staffordshire are asking we attend to record this matter for forwarding back to them".*

At 18:23 that day a text message was sent to M asking her to contact West Mercia Police with details of her availability. The incident log was then shared with the West Mercia intelligence department, I24.

At 18:36 it was requested that the log be brought to the attention of the Local Policing Area for deployment. It was simultaneously noted by I24 that the perpetrator was recorded on the National Firearms Licensing Management System (NFLMS) as being in possession of six shotguns, which, as of the 5th of January 2018, were in storage with the West Midlands Shooting Grounds.

At 18:41, after reviewing the narrative, West Mercia Police noted that officers were to be deployed. M and L were to be fully de-briefed regarding the allegations and any offences disclosed were to be recorded and investigated. The incident was changed from: "*PS DOMESTIC INCD"* to: *"GE ENQ/ACTION/ACTION REQD*". The rationale for altering a domestic incident to a general enquiry was that the request was for West Mercia Police to gain details of the domestic incident that had occurred in the Staffordshire Police force area.

<u>January 2018 (13th – IOPC review)</u>
At 16:26, a message was left for M, via voicemail, quoting the Operational Information System (OIS) log and requesting her availability for her to be seen by the police. At 19:47 that day an officer was asked to place a note through M's door. However, due to the Officer being engaged on other enquiries and assisting with an arrest, the note was not delivered.

<u>January 2018 (14th – IOPC)</u>
A calling card was placed through M's front door by West Mercia Police. The log was updated as requiring action, allocated and then changed back to un-resourced, requiring further action.

<u>January 2018 (15th – IOPC)</u>
A routine daily triage check, for any logs that had a firearms marker placed upon them, was undertaken by the firearms department of Staffordshire Police. The log was brought to the attention of an Office Supervisor who collated all the information in relation to the perpetrator.

Staffordshire Police decided that a voluntary surrender of the perpetrator's shotguns was necessary whilst they established what the domestic circumstances were following the initial information and allegations on the log.

A revocation notice was compiled if the perpetrator was not compliant with a voluntary surrender of his firearms.

January 2018 (15th)
The perpetrator collected his firearms from the West Midlands Shooting Ground (WMSG) and the necessary letters were sent by WMSG to the Staffordshire Police Firearms Licensing Unit informing them of this transfer.

January 2018 (15th – IOPC)
West Mercia Police had not recorded a crime at this time and were still trying to contact M to determine her availability. It was decided that the Staffordshire Police Crime Report would **not** be closed at this point, not until West Mercia had clarified with M her statement outlining the crime locations. Staffordshire police noted a further email from West Mercia - stating they hadn't been able to send anyone to see M.

January 2018 (16th – IOPC review)
M was spoken to on the telephone, by a West Mercia Police call handler. It was established that she was available to be seen between 18:15 and 22:00 on the 17th of January 2018. It was recorded that M had suffered no further problems. M was advised to call the police if she needed them in the meantime. Her availability for a visit was secured for the following day. The log was updated for further action.

January 2018 (17th)
The Firearms Enquiry Officer contacted the perpetrator by telephone and the perpetrator told them that two days earlier he had visited the West Midlands Shooting Ground and received his guns back into his possession. The perpetrator was told by the firearms enquiry officer to remove the guns from the house and place them with another certificate holder – in this case, M2. The perpetrator was compliant with this request.

January 2018 (17th)
At 18:41 the West Mercia log was updated, thus: "we have had no one free through late shifts, can this be attempted in the AM please." At 21:10 the log was updated: further action required at 07:00 on the 18.01.2018.

January 2018 (18th – IOPC review)
At 06:51 the log was updated, and the incident state was changed to un-resourced. Officers had been committed all evening, further action being required at 07:00 on the 19.01.2018.

January 2018 (19th – IOPC Review)
The Staffordshire Police Firearms Unit received the letters concerning the transfer of firearms from the West Midlands Shooting Ground to the perpetrator and that the perpetrator was invited to voluntarily surrender his firearms and certificate to another certificate holder. A Staffordshire Police Firearms Enquiry Officer visited the perpetrator, as arranged, and he handed the officer his certificate, as requested. The perpetrator had transferred his shotguns to M2 and the Officer was handed a copy of M2's certificate that correctly documented

the transaction of guns from the perpetrator to M2. All of the perpetrator's legally held firearms were in M2's possession

January 2018 (19th)
The GP for the perpetrator noted a surgery consultation. The perpetrator stated to the GP that he had spoken to M; she was concerned for him as she said he had not been eating since Christmas; the perpetrator stated that he had been "surviving on cigarettes" and had "no reason to live'. However, the perpetrator stated that things were better since M had moved into a rented property and the perpetrator stated that he had accepted the situation, and all was amicable. The perpetrator stated that he still did not feel his "normal self", but "massively" better than he had been. The perpetrator stated that he was sleeping better and had not needed to use sleeping tablets for 1 week. The perpetrator also stated that he had no suicidal ideas and that he had had his gun licence revoked. A review appointment was booked.

January 2018 (19th)
West Mercia Police updated their log: "spoken briefly to M, she is rushing to get to work, she has asked that we call her back in one hour."

At 09:05 M was called but the calls went to voicemail and no message was left on this occasion. At 09:07 a text message was sent to M asking her to make contact with her availability for the next few days. The log was updated thus: 'further action required at 17:00hrs on the 19th of January 2018 to chase up if nothing heard'.

At 18:00 a call handler spoke with M and she said that she was confused as to the police contact because someone was supposed to call her on Wednesday (17th). She provided the police with updated availability that did not include the weekend as she had social commitments. M asked to receive a call beforehand in order to know when the police would be attending. The log was updated, thus: 'further action required at 18:00 on the 22nd of January 2018 as per availability'.

January 2018 (22nd)
West Mercia Police updated their log: further action required at 15:00 – available between 18:30 and 22:00. At 15:04 the status was changed to un-resourced. At 21:07, the log was updated: "response officers all committed; not been able to deploy to this so far." The log then read: "M is available tonight until 22:00". At 21:43 the log was updated: "we are not going to make the 22.00 PM availability. Further action required at 18:00 on the 24th of January 2018.

January 2018 (24th)
The West Mercia Police log was updated, thus: "Officers committed." At 21:17 it was noted that M's availability was usually before 22:00 and the log stated: "we are not going to get to her before this time. Can she be called and apologised to for non-attendance please and obtain her availability for the rest of the week."

At 23:04, an officer updated the log: - "Threat made by estranged husband, who lives in the Staffordshire Police area, to self-harm; he has also caused damage to property at the Staffs address, no threats to M or L and no harm caused. I note this is a grade 2 (Priority response required – which we have missed). We still need to see M and L and conduct a 'safe and well' and record any offences disclosed.

January 2018 (25th)
A Communications Officer spoke with M on the phone. M said she was free that evening between 18:30 and 21:30 and would not be available again until the 28th of January in the afternoon. The log was allocated to a Police Constable who commenced duty at 14:00 that day. At 19:19 the log was updated: 'I have not been out yet due to handover. I will contact M'.

The Senior Investigating Officer (SIO) leading the investigation agreed to share the following piece of intelligence with the DHR Panel:

> At 20:27 that day M sent a message via 'What's App' to a friend saying: "*Police coming in 15 mins for a statement. L wants me to tell them everything; if I do he'll never get his licence back; dilemma what do you think xxx"*

The Panel and the SIO also agreed to include an extract from the de-brief undertaken with the Police Constable (PC) who visited M. The Panel considered it appropriate to describe the de-brief, in abridged form, at this point in the review:

> *"At 20:45, the PC visited M and L at their home and spoke to them together. M explained to the PC that she had called the police on the 12th of January on the advice of the school L attended. She explained that she had not been married long to the perpetrator and the marriage had broken down over Christmas and they had moved to their current location.*
>
> *M did not give any reason for the separation, but only that she needed to make arrangements for L to speak about it independently, which is why she arranged for them to speak to someone at school.*
>
> *When speaking to a member of staff at school L had explained that they were concerned that the perpetrator wasn't taking the break up very well and that they were worried he might do something to himself as he was a firearms holder. (It was this disclosure that prompted the school to tell M to contact the police[6]).*
>
> *The PC asked M and L what their main concerns were and they both stated that their main concern was the welfare of the perpetrator. M explained to the PC that when they separated it was agreed she could keep the car,*

[6] This will be referred to in the analysis section in a little more detail because both L and the perpetrator's step child 3 were disclosing different things at different times to different people and their respective schools were not connecting them together as one family unit.

which was leased to the perpetrator's business, registered at the matrimonial home. She stated that whilst the vehicle was parked outside her parents address it was removed without her knowledge by the perpetrator who kept it for a period of time. The perpetrator returned the vehicle and M thought nothing more than it was the perpetrator trying to spite her.

The PC discussed this with M and they came to a consensus this was a civil issue rather than a TWOC, as this was a lease vehicle to the business and he would have had permission to use the vehicle on that basis.

January 2018 (25th)
Staffordshire Police noted that West Mercia Police had visited M. A Police Officer from the West Mercia force contacted Staffordshire Police Control Room and the Staffordshire Incident Log was updated, stating that M had been seen and that no offences had been committed, with a recommendation for review by the Local Policing Team Vulnerability Hub for any further support for M. A serial record was printed for the attention of the Stafford Vulnerability Hub. Staffordshire Police recommended a review by the vulnerability hub to see if M required any action or support from Staffordshire Police.

The school attended by L noted a record in their file stating that the safeguarding lead had been in contact with L and M. The record noted that M was at work and preferred to be called back. L had advised the school that West Mercia Police had visited the previous evening. The school noted that they intended to continue to monitor and support.

Later in **January** the murder occurred.

3.4. Over-view and Service Narrative

This section of the overview report is divided into two parts. The first part considers a narrative provided by the agencies that had contact with the subjects of the case, regardless of how limited this may have been. The second part is a critical analysis, by those services whose contact was relatively limited, followed by a more structured response to the key lines of enquiry by those agencies whose contact was more frequent and/or more concentrated.

3.4.1 Hindsight bias

The Panel was acutely aware that hindsight bias can lead to over-estimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do the "right thing". The Panel made every effort to avoid hindsight bias and has, as best it can, viewed the case and its circumstances as it would have been seen by the individuals at the time.

One of the key characteristics of this case, when considering the contact that the subjects had with relevant agencies, is that involvement with organisations

and services was, relatively, infrequent. Consequently, those services whose contact with M, the perpetrator and their children was limited, have constrained their analysis into a simple narrative and have provided the Panel with an analysis of their involvement on that basis rather than address each individual 'key line of enquiry'.

All the agencies involved in this review provided candid accounts of their involvement in order to identify any lessons that can be learned. The Panel analysed each agency's involvement. The involvement of each agency covered different periods of time and some of the contacts contained in some of the Individual Management Reviews hold more significance than others. This section is constructed in light of this fact.

3.5 Service Narrative – what the services involved knew about the subjects of the case

3.5.1 Clinical Commissioning Group (CCG) and Primary Care:

In terms of contact, M consulted with her GP on general health matters and had what may be considered as infrequent consultations and reviews throughout the period between1st January 2015 to the date of the murder in January 2018. Her last documented contact with her GP was on the 28th of April 2017 when she attended an out of hours (OOH) walk in centre for an assessment of abdominal pain. An OOH report was subsequently forwarded to her own GP highlighting the attendance, diagnosis and recommendations made.

The perpetrator registered with the same medical practice in July 2014. From the date of registration, there is one entry for the 14th of February 2017, when the perpetrator attended the surgery with back pain, diagnosed as lumbago.

The perpetrator's next attendance at the surgery was on the 21st of December 2017 when he sought support from his GP following the breakdown of his relationship with M. His GP record identifies the diagnosis at the time as 'adjustment reaction'.

During that consultation his GP documented that he explored thoughts around suicidal ideation, and none were identified.

3.5.2 Staffordshire Police

Staffordshire Police had no record of M prior to January 2018.

The perpetrator was known by Staffordshire Police prior to the murder occurring. In 2006, he applied for a Shotgun Certificate. The Report included, at that time, details that the perpetrator was divorced from a previous wife and in a relationship with another person. Research revealed that the perpetrator's ex-wife had been the Victim, at the hand of the perpetrator, of an Aggravated Burglary in 2004 (categorised following a West Mercia Police investigation). The application for a firearm was not supported.

In July 2013, Staffordshire Police considered another application made by the perpetrator for a Shotgun Certificate. This was allocated for enquiry and

reported upon by a Firearms Enquiry Officer. The report made reference to the previous application made by the perpetrator. The Staffordshire Police Firearms Licensing Manager granted the Shotgun Certificate for a five-year period expiring on the 23rd of July 2018.

3.5.3 West Mercia Police

M

West Mercia Police were in contact with M for the first time in January 2018. From the information transferred to them from Staffordshire Police, West Mercia Police knew that M had contacted the school which L attended to inform them of the separation from the perpetrator and that M had informed Staffordshire Police of an incident before Christmas 2017 during which both M and L were present.

The Perpetrator

West Mercia Police knew the perpetrator because he was a firearms certificate holder. The perpetrator's most recent firearm license was revoked in January 2018, and at this time, his firearms were handed over to one of his associates, referred to in this report as M2.

The perpetrator came to police attention after his relationship with his ex-wife ended and he entered her home armed with a carving knife and confronted her and her boyfriend and threatened to kill them both.

The perpetrator then formed a relationship with a new partner and when this relationship ended, the perpetrator accused this ex-wife of having an affair, and subsequently caused injuries to their wrists (from an incident dated the 23rd of February 2007).

3.5.4 West Midlands Ambulance Service

West Midlands Ambulance Service (WMAS) have a record of one contact with M. The details concern their attendance at the scene of the murder. WMAS also have one record of contact with the perpetrator. The details concern their attendance at his address – following the murder of M – in order to provide emergency lifesaving support when the perpetrator attempted suicide.

3.5.5 Family Connect

Family Connect received one call from the school attended by L. This call concerned the information received by the school from L about an incident of domestic abuse between M and the perpetrator. L had shared with the school that M had left the relationship with the perpetrator and that M and L had moved to a different address. The school advised Family Connect that they would support M in respect of the information shared by L. Family Connect had no other contact with M, the perpetrator or L.

3.5.6 The Education and Skills service and the schools attended by L and the perpetrator's step child

The school attended by L was made aware by M of incidents of domestic abuse occurring in the family home. M shared this information with the school in January 2018. The school sought advice from Family Connect and continued

to monitor L and to offer advice to M and removed the address where M and L had moved to from their records. The school shared relevant information with key staff in order to provide support to L.

The school attended by the perpetrator's step child were supporting the perpetrator's step child by providing counselling and academic support. The perpetrator's ex-wife (the perpetrator's step child's mother) was in communication with the school and they were working on a support plan together.

3.6 Responses to the Key Lines of Enquiry

It is important to note that the responses set out below are determined by the line of enquiry and the agencies that were able to respond to the enquiry. If an agency (listed elsewhere in this report) had no pertinent comment to make, or if responses are described in detail in the Analysis section of this Review, then to avoid repetition, no response is offered in this section.

3.6.1 Did any agency know or have reason to suspect that the Victim was subject to domestic abuse by the perpetrator at any time during the period under review?

Family Connect

The service had received information concerning L from the school that they attended. The information shared with Family Connect was presented as a general concern. Family Connect offered advice to the school to enable them to support L, and to advise M to contact the police, particularly if there were further incidents of abuse or concern.

Education and Skills service

In January 2018, the school attended by L was made aware that M, in December 2017, was subject to an incident of domestic abuse. The school attended by the perpetrator's step child was in a slightly different position to the school attended by L. They were not in contact with the perpetrator and, understandably, M had not contacted the school attended by the perpetrator's step child. Hence, they were not aware of the incident in December 2017 at the same time that the school attended by L knew. The perpetrator's step child did inform the school of the incident later in January 2018, prior to the murder of M.

Clinical Commissioning Group (CCG)

Throughout the period under review, the GP practice did not know that M was subject to domestic abuse by the perpetrator.

M made no disclosures to her GP concerning domestic abuse and no indicators of potential abuse were identified by the Practice. Additionally, there were no MARAC markers brought to the attention of the GP within the period under review, nor any period prior to the formal scope of this Review, which may have indicated that she was a Victim of domestic abuse at any point in the past.

Staffordshire Police
M telephoned the police and reported being separated from her husband and that she had informed the school attended by L that the perpetrator had smashed a television, threatened to kill himself and had taken her car without her knowledge. She referred to being followed, intimidated and explained that her husband, the perpetrator, was receiving help from his Doctor and friends. L was being helped at school.

The Call Taker recognised a '*domestic incident' and* explained that M would have to be seen and the call taker decided to

> *'….pass the incident over to West Mercia for them to take a statement for Staffordshire to then deal….'*

West Mercia Police
On receipt of the request from Staffordshire Police, a message was sent to M from the Control Room asking her to contact West Mercia Police and the log was marked for the Call Taker to obtain her availability.

Following this request, checks were made on the system of the West Mercia Intelligence Team (i24).

3.6.2 If so, what actions were taken to safeguard the Victim and were these actions appropriate?

Family Connect
The information provided by the school suggested that plans had been put in place by M to separate from the perpetrator, as a protective measure. The information also suggested that whilst there were domestic abuse issues, both M and L had not been harmed. However, there was a suggestion made from the school to Family Connect that L wanted CCTV fitted in the new house due to their own concerns. The school was encouraged to support M to ensure that this was followed up with the police. The school representative agreed that they would ensure this happened. M contacted the police after receiving this advice from the school.

The Education and Skills service
L's school gave appropriate advice and contact details to M. They made the appropriate contact to Family Connect and shared the advice received from Family Connect with M. They continued to monitor L and M, whenever she contacted the school. The school of the perpetrator's step child had no contact with M, the perpetrator or L.

Clinical Commissioning Group (CCG)
There were no indicators or reports of abuse for both party, and so no specific actions concerning domestic abuse were taken by the Practice.

On each visit that the perpetrator made to the Practice, the GP explored the perpetrator's state of mind and encouraged him to use the services of the Improving Access to Psychological Therapies (IAPT) service. The GP also considered a referral to crisis support, but, following consultation with the

perpetrator, this was not pursued. The GP made arrangements for reviews and identified in their submission that they had no reason not to believe the perpetrator when he said he had no suicidal ideation.

The GP was clear that the perpetrator's presentation on the 19th of January 2018 gave no indication of the events that were to follow. He attended all appointments and appeared to be open and engaged. Additionally, the perpetrator identified that his firearms license had been revoked and he had previously identified to the GP that his weapons had been placed in storage. The GP stated that if they felt that the perpetrator had posed a threat, either to himself or others, the GP would have disclosed such information to the police, on the basis of wider public protection.

Additionally, the GP stated that had M, when she contacted the surgery on the 19th of January (prior to the attendance at the Practice by the perpetrator), disclosed any concern in respect to her own safety or welfare or the safety or welfare of L, the GP would have made referrals both into the local domestic abuse service pathway and into Family Connect if the GP had any safeguarding concerns.

Staffordshire Police
Following notification of the incident in December 2017 (when the TV was smashed), the Staffordshire Police Call Taker immediately contacted West Mercia Police with a request to visit M and take a statement from her and then pass this to Staffordshire Police in order for them to manage the process from that point. West Mercia acknowledged receipt of the request and a Cross Referenced West Mercia Police Incident Log number was noted. Staffordshire Police automatically generated a Crime Report and handed over the resourcing to West Mercia Police and waited for their deployment response.

West Mercia Police
On receipt of the request from Staffordshire Police, a message was sent to M asking her to contact West Mercia Police with details of her availability. The log was then marked for the Call Taker to obtain her availability.

3.6.3 What happened as a result of these actions?

Family Connect
Following the advice offered to the school, Family Connect had no further contact with the subjects in this case.

Education and Skills service
The records held by the education and skills service do not indicate if M contacted the Police Domestic Abuse Co-ordinator, as advised by the school. The records do show that the school did try to contact M to clarify if she had contacted the police and the records show that M had arranged to call the school, but the incident occurred before M was able to do so.

Clinical Commissioning Group (CCG)
There were no indicators or reports of abuse for either party, and so no

actions specifically concerning domestic abuse were taken by the Practice.

Staffordshire Police
Aside from the deployment of the Firearms the Enquiry Officer, Staffordshire Police did not deploy personnel to either the Domestic Incident or the threat of suicide. From the point of view of Staffordshire Police, following referral to West Mercia, the resourcing of this incident remained with West Mercia Police.

On the 25th of January 2018 West Mercia Police informed Staffordshire Police of the results of their enquiries and the Incident Log was updated. The Log remained closed for Staffordshire Police.

West Mercia Police
West Mercia Police received an e-mail from Staffordshire Police asking for M to be contacted and a statement taken. West Mercia Police stated that they expected to undertake this task so that Staffordshire Police could then deal with the matter.

West Mercia Police created their own log on the West Mercia Operational Information System (OIS). The log contained a précis of the Staffordshire Police log.

A DASH risk assessment was required, and consideration was to be given regarding safeguarding measures, such as Gazetteer warnings (these are location markers which can denote the grading of pre-existing risk). The Local Policing Area retained command for the management of this request.

3.6.4 Was the perpetrator known to any agency as a perpetrator of domestic abuse?

Family Connect
Family Connect knew of the perpetrator, but only to the extent that M and L shared information with the school and the school shared this information with Family Connect.

Education and Skills service
The school attended by L had no interaction with the perpetrator. The school attended by the perpetrator's step child had no interaction with the perpetrator, M or L and had no record of the perpetrator being a perpetrator of domestic abuse. They were aware that there had been a difficult divorce between the perpetrator and the perpetrator's ex-wife in 2013, and the perpetrator's step child did share with their school – in January 2018 – that they had witnessed their father (the perpetrator) and M arguing. The perpetrator's step child also referred to the perpetrator writing suicide notes and M shouting at the perpetrator: "move the gun".

Clinical Commissioning Group (CCG)
On the 19th of January 2018, M contacted the surgery to identify that she had concerns for the perpetrator's health but did not identify concerns about the perpetrator in terms of his interactions with her. The concern expressed by M

was in respect of his not having eaten since Christmas, surviving, she said, on cigarettes. M stated that the perpetrator had indicated he had '*no reason to live'*. The perpetrator was seen in the practice later that same day by his GP at a previously arranged appointment, when these concerns were discussed. The GP stated that he did not inform the perpetrator about the call from M but used the information shared by M to speak in general terms about his health. The perpetrator identified that things were better, stating that:

'*since his wife moved into a rented place, feels he has accepted it'*.

The perpetrator then went on to identify that all was amicable. There were no indicators that the perpetrator was subjecting M to any form of domestic abuse. As with the Victim, there were no MARAC markers on the perpetrator's records either in his history or more recently within the review period.

West Mercia Police

West Mercia Police was aware that M had concerns about the behaviour of the perpetrator, following their separation. M had contacted L's school, and Staffordshire Police and informed them of the details. The Intelligence section of West Mercia Police (I24) undertook a number of checks and became aware that the perpetrator had a number of 'markers' on his record for violence, threats of violence, threats of suicide and that he was a licensed firearms holder. However, it is important to note that these 'markers' referred to incidents that had occurred in 2004. West Mercia Police were not aware of an episode of suicidal ideation in 2017-18.

In their latter submission, West Mercia Police referred to the research undertaken by the Home Office concerning the analysis of previous domestic homicide reviews. They noted in particular that in almost 75% of the cases reviewed, the perpetrator had a history of violence and issues concerning mental health were present in approximately 75% of cases.

West Mercia Police recognised that if a higher degree of professional curiosity had been applied to the perpetrator's police record, it would have revealed that he exhibited the hallmark behaviours of a controlling and coercive domestic abuse perpetrator – the relationship had ended, his Victim had moved on, he had access to weapons and had made threats to kill and threats of suicide.

West Mercia referred to the DASH training and research undertaken by Laura Richards, noting that threats made by a perpetrator to commit suicide is highlighted as factor in domestic homicide: "A perpetrator who is suicidal should also be considered homicidal."[7]

West Mercia and Staffordshire Police

In February 2007, the perpetrator's ex-wife reported a Domestic Abuse Incident at their home in Staffordshire. The report stated:

"*….my husband has got me around the throat, he has hurt me…..and I am scared….a 6 year old child is at the address…."*

7 http://www.womensviewsonnews.org/2015/06/dv-risk-assessment-tool-training-crucial/#sthash.cy3YVjUn.CnRi7qyR.dpuf

The initial call type was categorised by Staffordshire Police as a Domestic Incident, by the Partner. This was given a Priority Grade 3 – Standard but this was corrected to Immediate and an automated Crime Report of 'Assault' was generated. A child was referred to as being at the location. A domestic abuse risk assessment (referred by the acronym DIAL) was completed and an entry was recorded onto the Guardian system. The perpetrator's ex-wife declined to Support a Prosecution and provided a witness statement – the Crime Report was filed.

3.6.5 If so, what actions were taken to reduce the risks presented to the Victim and/or others?

Family Connect
Family Connect was aware that M had separated from the perpetrator and moved to a new house with L. The school advised Family Connect that they would support M in respect of the concerns shared by L.

Education and Skills service
Advice was provided by the school to M in relation to contacting the Police Domestic Abuse Team and also ensured that the address where M and L were living could not be shared with anyone.

Staffordshire Police
The incident was recorded by the call-taker and West Mercia Police were requested to visit M and to obtain a statement.

The Firearms Licensing Department took measures for the perpetrator to voluntarily surrender his shotguns and license whilst the circumstances of the incident were reviewed.

3.6.6 Were the Victim and/or the perpetrator known to misuse drugs and/or alcohol, including misuse of prescription medication?

Family Connect
Family Connect had no record or intelligence to suggest either M or the perpetrator were misusing substances.

Education and Skills service
The Education and Skills service had no record or intelligence to suggest either M or the perpetrator were misusing substances.

Clinical Commissioning Group (CCG)
Neither M nor the perpetrator were known to misuse drugs and/or alcohol, including the misuse of prescription medications.

3.6.7 Have mental health issues been self-disclosed by the Victim and/or perpetrator?

Family Connect
Family Connect had no record or intelligence to determine whether M or the perpetrator had any mental health issues.

Education and Skills service
Mental health issues do not seem to have been disclosed to either of the schools. However, L's school does note that M shared that she had "low mood" in January 2018.

Clinical Commissioning Group (CCG)
The GP record for M identified a history of "anxiety" dating back to 1998. M was prescribed appropriately and remained on this prescription until her death in January 2018. This prescription remained under the routine review of her GP and there are no records indicating referral to or management by mental health services.

The perpetrator sought support from his GP regarding an 'adjustment reaction' and disclosed that he had had a similar response to the breakdown of his previous marriage. There were no GP records indicating a referral to or management by specialist mental health services.

3.6.7 Were there any other issues that may have increased the Victim's risks and vulnerabilities?

None were identified by the agencies in contact with M

3.6.8 Did the Victim, the Victim's child or the perpetrator's step child disclose domestic abuse to family and/or friends, employer, school? If so what action did they take?

Family Connect
L shared with her school information concerning an incident of domestic abuse. The school advised that they would support M in respect of the concerns shared by L.

Education and Skills service
In January 2018, immediately following the Christmas holiday, M shared with L's school the recent incident of domestic abuse. The school provided the police domestic abuse contact details and subsequently, following a disclosure by L, contacted Family Connect for advice.

The perpetrator's step child shared with their school – in January 2018 – that they had witnessed their father and step-mother arguing and a row where a TV was broken. The support provided to the perpetrator's step child was through the offer of counselling. The perpetrator's step child's mother was aware of the issue and of the support provided by the school.

The independent school counsellor

The Counsellor did have contact with the perpetrator's step child at the end of 2014 and the beginning of 2015[8]. The Counsellor engaged with the perpetrator's step child for eight sessions of counselling. Occasionally, the mother of the perpetrator's step child would attend the sessions and on one occasion she made reference to a history of domestic violence between her and the perpetrator.

The Counsellor shared with the Panel that the perpetrator's step child stated that they loved their father and were happy to live with him. These counselling sessions occurred before the incident in the family home in December 2017.

The Counsellor was scheduled to see L before Christmas 2017 because L had spoken to their school regarding the situation in the family home and the incident that had occurred in December 2017. However, for a number of reasons, the scheduled session did not take place. The Counsellor was contacted by the Head-teacher in January 2018, following the death of M. The Counsellor informed the Panel that, because a specific homicide therapist had been appointed to talk to L, they stepped down from the scheduled appointment in order to avoid complicating matters.

The Counsellor informed the Panel that, following the murder, they had seen L in school – briefly and informally – on a number of occasions since the DHR Panel had been convened. The Counsellor asked L if they could share with the Panel a number of insights garnered from their conversations. L agreed to the request and these points are set out below:

- The Cognitive Behavioural Therapy (CBT) offered was considered by L to be 'too soon' and the therapy 'made them feel much worse';
- L felt that nobody listened to them, or took them seriously;
- L said that it seemed to them that M was always told that there wasn't enough evidence to do anything about the perpetrator;
- L understood (though the Counsellor did not know how) that the perpetrator had been convicted or cautioned for stalking someone else in the past and that L was bitter that this was not 'flagged-up' at the time.

Clinical Commissioning Group (CCG)

The CCG had no record of M sharing information concerning domestic abuse with her family or friends.

West Mercia Police

West Mercia Police provided an extract from a de-brief undertaken with the Police Constable who visited M, thus:

> The PC visited M and L at their home and spoke to them together. M explained to the PC that she had called the police on the 12th of January on the advice of the school attended by L. She explained that she had

[8] During the period when the perpetrator separated from his wife

not been married to the perpetrator for long and the marriage had broken down over Christmas and so M and L had moved to their current location.

The PC asked M and L what their main concerns were and they both stated that their main concern was the welfare of the perpetrator. They both stated that he had never threatened them or assaulted either of them but his behaviour in the past was a cause for concern. They explained that the perpetrator had smashed a television when they lived with him and described an episode where he took M's car away without her knowledge. M stated that whilst the vehicle was parked outside her parents address, it was removed by the perpetrator without M's knowledge or consent and the perpetrator kept it for a period of time and then returned the vehicle.

3.6.9 Did the perpetrator make any disclosures regarding domestic abuse to family and/ or friends/ employer, if so what action did they take?

No record was held by any of the agencies involved of the perpetrator making disclosures of domestic abuse to family or friends.

3.6.10 Are there any matters relating to safeguarding vulnerable adults and/or children that the review should take account of?

Family Connect

The information presented to Family Connect from the school attended by L was followed by a request for advice and guidance. The assessment by Family Connect was that, considering the information received, it appeared that the threshold for support from early help services had been met, but not a specific need for a social care intervention. M and L lived in the Telford area for only a few weeks prior to the murder happening and therefore, Family Connect held only limited information on them. When M and L lived with the perpetrator, they resided in Staffordshire.

Family Connect stated that there may have been information known at the time by the police, or others, in the area where M and L lived prior to moving to Telford. If there was any information concerning domestic abuse or violence, this could have been shared with Telford Harm Assessment Unit (HAU) in order to alert the authorities in Telford that a vulnerable adult and child were now living in their area. If information had been held by the MARAC in Staffordshire, then this would have been transferred – but only high-risk cases of domestic abuse are discussed at MARAC and M's case was not referred into the MARAC.

Education and Skills service

The Education and Skills service held no formal safeguarding record but were aware of the contact the school attended by L had with Family Connect

Clinical Commissioning Group (CCG)

The CCG had no formal safeguarding record concerning vulnerable adults or children in this case.

Staffordshire Police
Staffordshire Police noted that M was not the only potential Victim of Domestic Abuse. The Call Taker of the incident over the Christmas period 2017-18 accurately recorded details of L and the opportunity to liaise with Partner Agencies. Both the Education and Skills service and the Health Services were included on the Incident Log, specifically referring to interventions and support already believed to be in place by the relevant school and GP. The Incident Log was brought to the attention of Staffordshire MASH and the Firearms Licensing Unit by use of electronic Tags.

West Mercia Police
The Police Constable (PC) who visited M stated that during their visit there was nothing raised that caused them concern and it did not appear to be an emotional domestic abuse situation or a 'Taking a vehicle With-out Consent' (TWOC). The PC stated that it appeared to be a vulnerable adult incident, specifically, however, a vulnerable adult incident in relation to the perpetrator.

The PC stated there was no mention by M of being stalked or tracked by the perpetrator and that there were no "alarm bells ringing" and the matter seemed to be a genuine call for concern for the perpetrator.

3.6.11 Were there any issues concerning the purchasing, licensing and storage of fire-arms that the review should take account of?

Clinical Commissioning Group (CCG)
Previous correspondence with West Mercia Police dated back to 2013 in relation to the licensing of firearms. This preceded the perpetrator's registration with his current GP practice (he registered in 2014). Although his GP was aware he held weapons there was no formal flagging/coding marker on the perpetrator's record as the letter concerning this matter had not been coded by the perpetrator's previous practice. It should be noted that if a firearms holder moves to a new GP practice, there is no obligation placed upon the previous GP to inform the new GP.

However, both the GP and Practice Manager have confirmed that they are aware of the current BMA guidance and that they, as a practice, do READ code firearms registrations on receipt of appropriate letters from the police. The practice does this as part of their own staff welfare and safety arrangements.

Staffordshire Police
Staffordshire Police has a current Firearms and Explosives Licensing Policy, which was reviewed in June 2017. It is comprehensive and – relevant to this DHR – addresses the *'Seizure of Licensed Weapons'.*

A Firearms Administrator identified the electronic tag on the incident log and Staffordshire Police Firearms Licensing Unit took action. The matter was elevated to an Office Supervisor and documentation prioritised and prepared

for the Firearms Licensing Manager. The circumstances were considered, and the following decisions made:

- Suitability Review by Firearms Enquiry Officer
- Temporary Surrender of Certificate and Firearms
- Refusal to comply with Temporary Surrender to result in Revocation and Firearm seizure
- Request to GP for information relating to suicidal ideation and mental ill health

The Firearm Enquiry Officer assessed available information and telephone contact was made with the perpetrator. He was asked to remove the shotguns from his house and place them with another Shotgun Certificate holder and to voluntarily surrender his Shotgun Certificate until the circumstances were reviewed. The risk of harm was understood, and his suitability fully assessed. The perpetrator agreed to the proposals. As a contingency, a Revocation Order had been prepared – in the event that the perpetrator had not been compliant with the requests made.

West Mercia Police (concerning the visit made by the Police Constable (PC))
M stated to the PC that her main concern was the welfare of the perpetrator but both she and her child were less concerned now as they believed the perpetrator had surrendered his firearms to a friend for safekeeping which was felt to be less of a risk to him.

It was noted by I24 that the perpetrator was recorded on the National Firearms Licensing Management System (NFLMS) as being in possession of six shotguns at his address. A further entry followed immediately to state that an update on the notes section of NFLMS dated the 5th of January 2018 recorded the guns were in storage with the West Midlands Shooting Ground, a registered firearms dealer. There is no record of NFLMS being re-checked, after the initial assessment by I24. The Panel were made aware by the submission from West Mercia Police that the system is dynamic and would record the movement of any weapons held by the perpetrator. The Panel noted the submission from West Mercia Police that it is not standard practice to re-check the NFLMS during an incident unless **new** information has come to light that requires a re-check to occur or following a specific request from an investigating officer.

3.6.12 Were issues of race, culture, religion and any other diversity issues considered by agency when dealing with the Victim and perpetrator?

The services in contact with M during the scope of this Review noted – either as a part of their initial assessment or during case notes – that she was a white British, heterosexual woman who spoke English as a first language. M was not recorded as having any physical disabilities.

There were no issues reported by the services involved in this case that prevented them from offering appropriate and consistent support during the consultations they had with M.

The Panel noted that whilst none of the agencies contacted in relation to this Review identified any diversity issues concerning M – or the perpetrator – that impeded their access to, or use of, available services. The agencies and services involved in this Review are aware of Disability discrimination as it pertains to the Equality Act 2010.

Under the terms of the Equality Act[9], a disability means a physical or a mental condition which has a substantial and long-term impact on a person's ability to do normal day to day activities. A person is covered by the terms of the Equality Act if they have a progressive condition and/or if they have had a disability in the past. For example, if a person had a mental health condition in the past, which lasted for over 12 months, they are still protected from discrimination because of that disability.

The Panel recognised that it is important to note that discrimination does not have to be intentional to be unlawful.

As already noted, the Panel were aware that that sex (gender) is a protected characteristic under the terms of the Act, as is the right to religious expression, which was pertinent in this case. The Panel were cognisant of the fact that there is a disproportionate prevalence of women as Victims of domestic abuse and violence.

The Panel did not identify that M was discriminated against by any of the services in contact with her on the grounds of her sex or her religion. In reaching this conclusion, the Panel noted that M, though intermittently, had good engagement with her GP, and, latterly, with the West Mercia Police Services.

[9] https://www.equalityhumanrights.com/en/equality-act/equality-act-2010

Section 4 Learning from the Domestic Homicide Review: the analysis of events

The contact between M and the school attended by L, where M described the incident where a TV was smashed in December 2017, was considered by the Panel to be a pivotal event. This contact led to the communication with Staffordshire Police, on the 12th of January 2018, and subsequently a referral to West Mercia Police.

As an aide-memoir, following contact with the school, M contacted the Staffordshire Police and said (this is abridged):

> *I've been advised by my child's school to log some activity with you. There is nothing physical but there has been intimidation. I have gone through a separation with my husband and things that have happened have made my child uncomfortable. It started with him smashing the TV. He has also threatened to kill himself. And then he took my car without me knowing.*
>
> *When the TV was smashed my child was in a different room. My child wasn't there with the suicide attempt, but they was there when I discovered my car was taken.*
>
> *My child is worried that he (the perpetrator) is going to follow us around and watch us. I have got my car back now – he said I could have it – he said he didn't know why he did it; to a child, it's un-nerving and had an impact and I want to make sure my child is going to be OK going forward."*

4.1 School for L and the perpetrator's step child

With regard to the response of the schools, guidance concerning the procedures to be followed in such circumstances was available at the time leading up to the murder. The suite of guidance includes "The Child's Journey in Telford and Wrekin: A Partnership Model"; "Telford and Wrekin Safeguarding Children Board – Multi-Agency Safeguarding Procedures"; and the West Midlands Procedure Guidance concerning arrangements for child protection enquiries.

This guidance was shared with the Panel and a number of elements were considered as pertinent in this case. These are described, for the benefit of context, and in a significantly abridged format below:

4.1.1 Thresholds guidance

The threshold document in operation at the time had been developed based upon a continuum of identified need. The approach utilises a four-tier model that takes account of the different stages of need and types of intervention, which are available to all children and their families.

The guidance is clear that the indicators used in the assessment process are not exhaustive and that practitioners should not use these as a simple tick list, but also apply their professional judgement.

By way of example, from the suite of guidance, the Panel considered the threshold for 'vulnerable' children:

> **"**Children and young people at this level may be in need of receiving support from early help services. These services can be accessed directly or by using the Integrated Working Common Assessment Framework process:

Examples described in the guidance of when to refer directly to Family Connect Safeguarding Advisors include the following:

Allegations/reasonable suspicions about

- physical abuse;
- sexual abuse;
- emotional abuse, for example, witnessing domestic abuse;
- serious neglect;
- a child that has been injured (even if inadvertently) during an incident of domestic abuse;
- a child who has witnessed one serious or three minor domestic abuse incidents;
- a child who is at risk of exploitation

The guidance applied at the time of the murder, also referred to the opportunity to 'Step-up' and 'Step-down' the levels of support offered to clients in circumstances such as those shared by M in January 2018.

4.1.2 'Step up'

"The step-up process refers to a need for a change in the level of response after initial engagement that requires involvement from agencies including specialist and targeted services due to indications that the child may be at risk of significant harm".

4.1.3 'Step down'

"Stepping down refers to the process of passing a family from an intensive or statutory led assessment or co-ordinated support plan to other more appropriate support services generally within universal, early help and targeted services

At the time of the murder, Telford and Wrekin also applied the "West Midlands Procedure Guidance" concerning arrangements for child protection enquiries. The guidance suggests that sharing information between professionals and local agencies is essential to provide effective early help and to put in place child protection services[10]. It was also noted by the Panel that the West Midlands Procedure Guidance re-iterates that responsibility for section 47 enquiries rests with the local authority children's social care service for the area where the child is living.

[10] It is also worth reading the government guidance on information sharing: **Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers** (refreshed in July 2018).

The Panel considered that, because of the disclosure made by the perpetrator's step child in January 2018, a Section 47 screening procedure could have been commenced and should have been considered. The school attended by the perpetrator's step child had assumed that the Police were involved in the safeguarding of the perpetrator's step child, but this was incorrect. The school provided pastoral and academic support and an offer of counselling.

The situation was different for the school attended by L because they submitted that they were not entirely sure if the disclosures made by L were current or historic and the information shared was done so over a period of time. The school felt they were fully appraised of some elements of the situation, but they were not entirely sure if they had a full picture. Clarity was only provided when M contacted the school, primarily about the welfare of L, and the school then contacted Family Connect for advice and advised M to contact the police.

4.2 Staffordshire Police

The Staffordshire Police graded response policy states that call handlers will use the Professional Discretion Framework known as "THRIVE"[11]. This framework encompasses their knowledge, experience, and the National Decision Model to determine an incident grading.

The information provided by M suggested that the perpetrator's behaviour could fit the definition of 'controlling and coercive' as stated in the Staffordshire Police Domestic Abuse policy

The review undertaken by the IOPC identified that the incident log created immediately following M's contact did not seem to have referred to the perpetrator's history (threats of suicide and a previous incident of domestic abuse). Had this information been included in the communication with West Mercia Police, it may have influenced the risk assessment conducted for this incident and altered the priority and the way in which this incident was dealt with.

In their latter submission, made in 2021, the West Mercia Police have engaged in a programme of enhanced training concerning THRIVE (described in Appendix One). This has been done to ensure that staff are confident and comfortable with the use of the National Decision Model (NDM) and THRIVE as the means by which incidents and graded and subsequent deployments are made.

This was an area of development highlighted by the Domestic Abuse Reality Testing (DART) – a model of service development put in place following the murder of M and the completion of this DHR. DART has been completed in July 2020 and February 2021 in two Local Policing Areas (LPA).

[11] It should be noted that West Mercia Police have also introduced THRIVE and provided enhanced training to staff within the OCC throughout 2019. A description of THRIVE is provided in Appendix 1

The DART model's final report includes a number of recommendations drawn from the analysis of the information gathered during the survey phases.

The DART recommendations are driven every month by the Domestic Abuse Delivery Group (DADG) with the departmental and LPA leads feeding back each month to the group on what has been delivered.

DART 2021 Recommendation: Continue inputs to OCC on the importance of gathering information to THRIVE and how THRIVE should be viewed, and utilised to appropriately manage demand for all calls.

DART 2021 Recommendation: Further OCC training to cover compliance with supervisor escalation within the control room, in order to ensure appropriate review of the log, THRIVE assessment, application and deployment. Also, review of the escalation protocols to see if they are still fit for purpose and focused on priorities.

DART 2021 Recommendation: Training for the OCC about the importance of their actions at the initial call, the THRIVE, and the deployment of DA to the outcome of the case.

4.2.1 The Cross Border Protocol

Staffordshire Police have stated that there is no specific policy in relation to cross border incident handling. West Mercia Police submitted information to the Panel describing that certain prescriptive cross border protocols do exist for specialist areas – such as firearms responses and pursuit management – but not for everyday Policing activity. Ad hoc arrangements between police forces are very well established and provide an important means of ensuring that assistance can be provided where there is no special demand on force resources and that direction and control (and liability) does not transfer with such assistance. There will be a caveat regarding the capacity of the Force asked to carry out the response, which should be assessed in line with the threat, harm and risk presented at the time of the request.[12]

In this case, given the proximity of where the murder took place and the home location of M and L, coupled with the on-going firearms licensing enquiry, Staffordshire Police could have retained and resourced the incident response. It is not known if this response option was considered. However, it is acknowledged by the Panel that cross border co-operation would have become necessary in respect of responding to the risk associated with M and L.

The home of the perpetrator (where the incidents occurred in December 2017) and the home where M lived following her separation from the perpetrator) are approximately five miles apart. In this respect, the cross-border co-operation

[12] West Mercia Police stated that their policy, adopted from July 2019, is that whilst they will no longer **routinely** deploy to out of force enquiries, using the principles of THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement), described in Appendix 1, they will support forces where their request carries an immediate threat or significant risk of harm.

request made by Staffordshire Police to West Mercia Police was in line with expected procedure.

There was a significant delay in M being seen by West Mercia Police and there was only one review done regarding this (on the 15th of January 2018), which prompted Staffordshire Police to obtain an update from West Mercia Police.

Whilst cross border arrangements for assistance are established, there does not appear to be a process in place by which actions sent to another force to complete are reviewed and performance managed to their conclusion. As West Mercia Police noted, this matter comes down to one of incident ownership, the recognition of risk and how this is proactively managed.

4.2.2 Firearms Management

In January 2018, having reviewed the information available, it was decided that removing the perpetrator's access to firearms and obtaining possession of his shot gun certificate could be achieved on a voluntary basis.

The Panel learnt that the perpetrator had collected his firearms from the West Midlands Shooting Ground on the 15th of January, but the letters sent, notifying Staffordshire Police's Firearm Licensing Unit of this fact, were not received by Staffordshire Police until the 19th of January. The Firearms Enquiry Officer contacted the perpetrator on the 17th of January and was informed by him that he had collected his firearms. This meant that Staffordshire Police were not aware that he was in possession of his firearms for number of days.

On considering the Staffordshire Police's Firearms and Explosives Licensing Policy, it may be the case that a spontaneous seizure of the perpetrator's firearms would have been appropriate. This was due to the previous domestic incidents and the disclosures made by M to Staffordshire Police, which could have placed a question mark against the perpetrator being fit to legally hold a firearm.

4.2.3 The Storage of firearms

The Author contacted with the West Midlands Shooting Ground (WMSG) in order to understand their role and procedure with regard to storage and retrieval of licensed firearms.

The WMSG informed the Author that they receive guns for the purposes of storage for a wide range of reasons – for safe keeping, for service during a break in the shooting season, for convenience and for safety. They stated that the majority of people tell them the reason why they wish to have their guns placed in storage, but WMSG do not make a note of the reason.

WMSG confirmed that they do not hold any information concerning the health, including the mental health, of any of their customers. WMSG hold information from a valid certificate and contact details for the certificate holder – usually an e-mail address and/or telephone number.

When asked by the Author if WMSG should be told if the certificate holder has a history of violence or may be considered a risk to others, they suggested that if such an issue arose and needed to be resolved – it should be done so by the relevant authorities. In this respect, WMSG did confirm that they had, on one occasion, been in communication with the relevant authority because they considered a certificate holder to be 'unstable'. This communication had led to the certificate and firearm of the customer being revoked. The Panel, taking account of the operational parameters described by WMSG, considered this to be a case of good practice by the Shooting Ground, but also a case where such a responsibility should not have been placed upon them.

4.2.4 Call handling and logging

When Staffordshire Police received the telephone call from M on the 12th of January 2018, the Call Taker immediately contacted West Mercia Police with a request to visit M. This was acknowledged by West Mercia and a West Mercia Police Incident Log number was noted. The request made to West Mercia Police was a 'Response Option'. The Panel noted that this was a complex internal process and were informed that other options available would have included ownership and resourcing by Staffordshire Police personnel. That decision appears to be a turning point in so far as progress to a resolution was concerned. Staffordshire Police automatically generated a Crime Report and handed over the resourcing of the incident to West Mercia Police and waited for their deployment.

Staffordshire Police Control Room did not deploy any personnel – to either the Domestic Incident or the Threat of Suicide. Resourcing remained with West Mercia Police. Three days elapsed and neither M, L nor the perpetrator had been seen. Nevertheless, a Staffordshire Police Supervisory Police Officer recorded that the Incident Log could be closed.

Staffordshire Police Force Procedure mandates a DIAL to be completed for all Domestic Incidents – a Risk Assessment form designed and used by Staffordshire Police to assess and mitigate the risk of harm to Victims of Domestic Abuse. There was the added concern that the perpetrator was a Shotgun Certificate holder with a potential for self-harm. It appeared from the submission made to the Panel that engagement with the Local Policing Team Vulnerability Hub – whilst touched upon – was minimal.

Staffordshire Police Crime Administration Department actively sought information and encouraged the Control Room to contact West Mercia Police. West Mercia Police could not contact M and asked Staffordshire Police what they should do. The rationale of the Staffordshire Police was clear, as described by the narrative concerning the actions of the 'call-taker' when M contacted Staffordshire Police on the 12th of January 2018. Their intention was to leave the incident with West Mercia Police.

On the 22nd of January 2018, Staffordshire Police noted that:

> *"it would appear from the updates on STORM that West Mercia have not 'crimed' anything on their area and that all the incidents are on the*

Staffordshire area. West Mercia have not obtained any statements and the STORM serial on us has been closed. It may be best to allocate this to an officer so that they can chase this up with West Mercia because nobody currently has ownership".

M disclosed two incidents, the smashing of a TV and the taking of a vehicle by the perpetrator. She also disclosed having since left the relationship.

Could the Staffordshire Police call taker have enquired about the locations of the events, to be clear on where they had happened, before contacting West Mercia Police? This question and responses (known later), i.e. a disclosure of an incident before the relationship ended (Staffordshire) and an incident at a location since the relationship ended (West Mercia Police), may have influenced the ownership of the initial response.

It may have also signalled an increase in risk of harm, by highlighting the controlling, obsessive and escalating behaviour of the perpetrator. *Establishing this information during the initial call would establish the perpetrators behaviour and ascertain the extent of the issues, without which the THRIVE approach could not have been fully followed. Understanding this context would have been vital to latter risk assessment (had the DASH-RIC been completed) as risk factors can mean different things in different contexts.*

It is also possible, of course, that the West Mercia OCC call taker, when receiving incoming cross border domestic abuse incident requests for action, should apply the incident logging system Domestic Abuse question set, to improve understanding and to assist in correctly applying the National Decision Model and THRIVE.

West Mercia Police considered that it would be very difficult to apply the NDM and THRIVE if the questions required to complete a risk assessment have not been asked.

4.3 West Mercia Police

Having received the request from Staffordshire Police, West Mercia Police agreed to help but the West Mercia Police call taker did not record the request for a statement verbatim and omitted it from the West Mercia command and control log, substituting it with the phrase:

'Staffs are asking we attend to record this matter for forwarding back to them".

This may have unwittingly created ambiguity. Recording the matter and taking a statement can be perceived as two different tasks. Obtaining a statement is a specific element in the evidence gathering process in criminal investigations, whereas the phrase 'recording the matter' implies a less formal information gathering process. It would therefore appear that West Mercia Police may have been working to achieve the wrong task, which could have influenced the way in which the incident was managed.

The Crown Prosecution Service (CPS) Domestic Abuse Guidance is ALWAYS to take a statement as if the Victim will not be in a position to support a prosecution, thereby securing the evidence required to proceed with an evidence led case prosecuted by the Crown.

West Mercia's current Domestic Abuse Aide Memoire available to officers when deployed to such incidents contains the header of 'Evidence Gathering' under which is 'Statements' including evidence of controlling behaviour with examples, monitoring; isolation; body language.

There is also a section on Coercive Control legislation, Section 76 Serious Crime Act 2015 and 'coercive control; threats and intimidation' under the DASH section.

The force may benefit from a Coercive Control Aide Memoire for officers with some more detail on incidents/offences/ information that examples the range of behaviours that are controlling in the context of IPV (including recently separated parties, considered a 'current' relationship).

The Domestic Abuse Aide Memoire also includes 'Children' under the header 'First response' - Who they are; where they are; how they are; and, are they a witness? And, as part of the DASH and the referral process, includes Operation Encompass notification to schools.

West Mercia considered that this could be more explicit and include direction in following through on the 'First Response', which asks if the child is a witness. Listening to the voice of the child, that being, speaking separately with the child witness present (and to those not present when possible, who may also be witnesses), including hearing events (M stated that L had not witnessed the smashing of the TV, but L informed the review that she did hear the event and felt the perpetrator's intention was that she was supposed to hear it) as well as seeing events and how those events have made them feel. Force procedure should be followed in obtaining initial disclosure and; national procedure in the formal recording of this information as evidence.

The Staffordshire Police log articulated an on-going domestic abuse situation that had continued after the couple had separated ([13]a potential risk indicator) with the perpetrator attempting to locate M and L (a potential risk indicator) and taking M's car without her consent (Coercion and Control – a potential risk indicator).

The need to rapidly assess the risk to the Victim against the behaviour of a perpetrator – including capacity and capability for further offending when either Victims or perpetrators re-locate across force areas – is a cross-cutting theme which has been identified in DHRs that West Mercia Police have contributed to. The following recommendations (x2) are now in place and lend themselves to providing additional reassurance when aligned with this review that policy and practice will change for the better to make the future safer for Victims of

[13] According to the Authorised Professional Practice guidance from the College of Policing.

domestic abuse. Actions linked to these existing Recommendations include specific training inputs with additional accountability responsibilities across managerial, supervisory and frontline practitioner roles.

- When information is received that High Risk Victims have re-located from another force area ensure supervisory oversight is applied in dynamic assessment of perpetrator risk to support proactive tasks and actions to ensure Victims are safeguarded.

- When a DA Victim re-locates to a different force area, immediate communications should take place across forces with specialist investigators and other relevant teams to discuss and agree risks and share DASH assessments to support DA management plans capable of identifying perpetrator activity and supporting and safeguarding Victims.

Following receipt of the request from Staffordshire Police, West Mercia Police recorded the following note onto their log:

> *'Upon reviewing the narrative, officers are to be deployed to fully debrief the injured party (IP) and L regarding unreported allegations of taking without consent (TWOC); etcetera and that they should record and investigate any offences disclosed. A DASH risk assessment was required, and consideration given to safeguarding measures such as Gazetteer warnings. Local Policing Area to retain command."*

The West Mercia Police OCC deployment principles policy (September 2019) dictate that during deployment of patrols to any Domestic Abuse Incident, after NDM and THRIVE have been applied, the log must be shared with the Operation Contact Centre Inspector (OCCI). It should also be noted if any weapons are involved and if any Firearm's Licence holder is involved/weapons held at the property.

West Mercia Police will consider the current force policy to ensure that there is a clear instruction to share the domestic abuse incident log with the OCCI, where a system check of the NFLMS or other relevant records (for example the PNC) identify that weapons are held by a known domestic abuse perpetrator.

On the 15th of January the perpetrator was in possession of his firearms. This was not reflected on the NFLMS. However, there were updates on the NFLMS regarding Staffordshire Police making enquiries and proceeding to obtain a voluntary surrender of firearms from the perpetrator. It is possible that if this procedure had been shared with I24 (that the perpetrator was in possession of his firearms and that Staffordshire were taking steps to remove them), this may have heightened the perception of the potential risk to M and L as perceived by West Mercia Police, and so increased the priority with which West Mercia Police were to complete their task with M.

Although the changing of the incident code by West Mercia Police from a domestic incident to general enquiry is not in breach of their policies, there was

a significant delay from the point at which West Mercia Police were given the action to speak with M and M actually being seen.

The time in which West Mercia Police had this action was approximately 13 days. During that time, Staffordshire Police, who still recorded this matter as a domestic incident, requested an update from West Mercia Police on the progress of their action once, on the 15th of January.

4.3.1 Making contact with M

Between the 12th and 25th of January 2018, West Mercia Police recorded on the incident log their attempts to contact M, their telephone communications with M, and the progress of their enquiries. This included the detail of when M was available and the times that were not convenient for officers to attend (late at night or very early in the morning). It also included detail of an update M provided to West Mercia Police on the 16th of January 2018 where she explained there had been no further problems, her estranged husband had had a conversation with L and M was hoping things were going to get better.

West Mercia Police met with M in person on the 25th of January. The Panel noted that the officer did not fully follow policy because a DASH form was not completed with M at the time of being seen. However, this was due to a system failure during the visit. Although this form was not completed, the officer asked M questions that they knew were on the DASH form and used their professional judgement when applying M's risk level. Following the face-to-face meeting, this was recorded as low. The officer also discussed this incident with their management lead, and they were satisfied with their handling of the incident.

4.3.2 The meeting with M

When the Police Constable met with M on the 25th of January 2018, she stated that her main concern was the welfare of the perpetrator and that she and L were less concerned now as they believed that the perpetrator had surrendered his firearms to a friend for safekeeping.

The PC stated that during their visit, there was nothing raised that caused them concern and it did not appear to be an emotional domestic abuse situation or a TWOC, but more of a vulnerable adult incident in relation to the perpetrator.

Following the meeting with M, the PC updated the log, thus:

> *''Log can be closed. No offences and No domestic incidents. I will update Staffs''*.

At 22:35 on the same day, the PC updated the log:

> *"The above update is incorrect there are no offences. However, a domestic has occurred, but not on West Mercia. M has moved to the Shropshire address approximately 2 weeks ago; she and the perpetrator separated whilst living in Staffordshire. M and L were most concerned about the welfare of her husband, the perpetrator. M is aware that staffs licencing has been involved and temporarily he is no longer in possession of his firearms. M and L have both been clear they have not been intimidated nor threatened by him. A TV belonging to the*

perpetrator was smashed at the Staffs address. This is not criminal damage nor is M claiming it is. As regards the mention of potential TWOC this was a vehicle which was jointly owned by M and the perpetrator and registered to the business…..M now has this back in her possession there is no complaint of a TWOC, no damage was caused to it."

The PC clarified that they were first informed of the incident at 15:40 on the 25th January 2018. The PC did not have access to the email sent by Staffordshire or the original Staffordshire log. The PC stated that their understanding of the action that was required was that the incident log had referred specifically to possible offences of Criminal Damage and a possible TWOC of a motor vehicle. The PC initially needed to debrief M as to whether any offences needed to be recorded and assess any risk to M and L.

Having spoken about the situation with both M and L, the PC was satisfied that there were no offences to investigate. The PC asked M directly whether she feared the perpetrator may be violent towards her or L and she stated she had no concerns about this. M said the perpetrator had never been violent towards her and had not threatened her at all. M stated that she previously had concerns about the perpetrator possibly harming himself, but her concerns had been alleviated due to the time between the disclosure and their discussion and the fact she was aware the perpetrator's firearms were no longer in his possession.

The SIO leading the investigation agreed to the following information being made available to the Panel:

After meeting the PC, at 21:33, M contacted her friend via WhatsApp saying:

"*Yes just gone. Told the truth but played it down. The PC said as long as we weren't threatened and that I didn't feel in danger. PC said they would submit their report to Staffordshire Police. Hopefully he will get his licence back eventually. PC was really lovely so glad that's over with. They have called me nearly every day for two weeks*

On their return to the Police Station, the PC telephoned Staffordshire Police at 22:38 and spoke to a call taker concerning the incident that had been recorded by Staffordshire Police on the 12th of January 2018. The call taker asked for the DASH (or their equivalent) but was informed by the PC that they had been unable to complete it for technical (IT) reasons. The call taker stated that a referral would not be put into Children's Services by Staffordshire Police as L was not attending a school in the Staffordshire area.

The PC then recorded a domestic incident on the West Mercia system because, other than the incident log, they could not see any reference on the West Mercia Systems linking M, the perpetrator and L and thought the relevant referrals should be completed. The PC was aware that, when recording a domestic incident, a DASH would have to be recorded on the West Mercia system and therefore the risk assessment would have to be completed with M at a later time.

The Home Office report on Key Findings from Analysis of Domestic Homicide Reviews, December 2016, Section 19, Professional and practitioner competence – DHR Identified Failings in Individual Practitioner Competence (police being the most frequently mentioned agency) under 'Common issues related to incompetence', provides the point where cases were being incorrectly classified as anti-social behaviour and criminal damage without taking into account the wider context or pattern of the domestic abuse.

West Mercia Police recognised a vital opportunity to incorporate learning thoroughly amongst LPAs and every front line team, with bespoke training that contains relevant examples, in order to embed the understanding of the dynamics of domestic abuse into the mind-set of officers, enabling them to be well prepared when being deployed to record and gather evidence of domestic abuse.

As previously outlined – subsequent to this DHR – West Mercia Police instigated and completed a comprehensive review and analysis of Domestic Abuse recording and investigation processes through the DA Reality Testing (DART) model. DART Recommendations provide additional reassurance when aligned to this DHR of improved DA training – with actions which include the need to include greater awareness relating to coercive and controlling behaviours.

DART 2021 concluded that ALL ranks believed that service to Victims would be improved with bespoke training inputs.

Knowing how to recognise offences of domestic abuse and offences that are the 'markers' of domestic abuse (for example, coercive control), should empower officers with the confidence and competence required to intervene at the earliest opportunity (as per Force Policy) and to build an evidence-led narrative where patterns of abusive are identified (rather than single incidents).

DART 2021 concluded that the initial response to an incident was one of the highest scoring phases. It noted that Police Officers had been Victim-centric; with a positive approach, not dis-similar to that of the initial response from specialist vulnerability and CID teams, with a focus on providing a positive experience, regardless of issues that often arise. DART noted that many of the front line teams were made up of young, new officers with fresh and positive ways of working.

Supervisors MUST be trained; knowledgeable, tested and competent in dealing with Domestic Abuse and able to lead on such incidents. This provision will also allow for local autonomy and may be more effective in developing officers as part of a team.

DART 2021 Recommendation:
More intrusive supervision of DA crimes is required on each LPA, in particular, repeat Victim reports, to ensure compliance with policy, correct and full

assessment of risk, delivery of investigative leadership, driving evidence led investigations and develop staff through supervision.

As a result of DART 2021 recommendations, there is process in place, driven through the DADG, whereby the LPAs now have Scrutiny Panels. A number of Domestic Abuse crimes are picked monthly and a local lead, such as the DI for Vulnerability, shares any feedback with any supervisors.

DART 2021 Recommendation: Drive the compliance with quality REVIEWS for all supervisor reviews.

DART 2021 Recommendation: Bespoke supervisor training to include cover of; ATHENA reviews, DASH and post recording processes for Victims. This will equip supervisors with the tools to provide staff direction and support.

Supervisors must feel organisationally reassured that their officers have received the bespoke domestic abuse training that provides them with the best possible foundation of knowledge and skills required to deliver on expectations of levels of service.

Training and guidance should be continuous and more practical, building on those theoretical training foundations, continuing on the local policing areas, provided by strong team leadership; mentoring from supervisors and from colleagues with a proven ability to lead locally on Domestic Abuse.

West Mercia submitted (in 2021) that since this DHR had been completed, the West Mercia Police no longer train practitioners within a shift role as “Domestic Abuse Champions”. The ‘DA Champions’ role has been elevated and is a function incorporated into the managerial oversight provided by Local Policing Area Vulnerability Detective Inspectors.

4.4 Family Connect

The Family Connect Service provides a single point of contact for all enquires relating to the safeguarding of children, young people and families. From June 2016, Family Connect was also the point of contact for adult safeguarding.

The Panel were informed, via the submission from and attendance by a manager from the Family Connect Team that the service aims to facilitate a smooth and seamless service that will ensure access to appropriate services and will do this by:

1. Providing advice and guidance in relation to appropriate and proportionate help and support to children, young people and their families;
2. Reducing the number of inappropriate referrals to the Family Connect Safeguarding Advisor;
3. Screening the calls received and redirect them, if appropriate, to the most appropriate service(s).

Additionally, the Panel were informed that Family Connect Advisors are supported by a multi-agency triage team which comprises of professionals from local authority services and external partnership agencies. The Agencies that sit alongside and support Family Connect, include:

- The West Mercia Police – Harm Assessment Unit (HAU)
- Representatives from the NHS
- The Telford and Wrekin Education and Skills service
- The National Probation Service
- The Community Rehabilitation Company
- Relevant Housing services

The Panel were informed that the HAU screen all police information and share this, as appropriate, "within the room". Such information includes reports of domestic abuse, concerns for child safety and welfare, and other relevant police intelligence.

The Panel considered that all of the information held by both Staffordshire and West Mercia Police (for example, information concerning the perpetrator's pattern of behaviour when separating from a partner; his threats to self-harm; the taking of M's car without her consent) was not referred into Family Connect because the safeguarding service included within the Staffordshire Police area is not the same safeguarding service included within the West Mercia Police area. Hence, this prevented Family Connect from screening all the Police intelligence and, therefore, Family Connect believe this prevented them from being in a position to review the needs of the whole family. This may have prevented Family Connect from applying the threshold of need using the threshold documents and guidance referred to previously in this Review.

West Mercia Police currently, and at the time of the incident, employ an alert system called 'Operation Encompass'[14]. The incident witnessed by L (and the perpetrator's step child) in December 2017, was in Staffordshire and Staffordshire Police do not employ Operation Encompass. Family Connect considered this may have been a barrier to sharing contemporaneous information between the Police services involved, and other agencies that form part of Family Connect, but the magnitude of that barrier is difficult to quantify. The Panel formed the view, however, that this could have been overcome by other means.

Family Connect held limited information on M and L. Family Connect considered that if there had been any information of domestic abuse or violence, this could have been shared with Telford Harm Assessment Unit to alert the authorities in Telford that a vulnerable adult and child were living in their area.

[14] Operation Encompass is an initiative enhances communication between the police and schools where a child is at risk from domestic abuse. The purpose of the information sharing is to ensure schools have more information to support safeguarding of children. By knowing that the child has had this experience, the school is in a better position to understand and be supportive of the child's needs and possible behaviours. Operation Encompass will complement existing safeguarding procedures

4.5 Clinical Commissioning Group (CCG) and Primary Care

Throughout the period under review there were no entries which identified that disclosures were made by M to either GPs or practice staff in respect of domestic abuse.

The perpetrator registered with the same medical practice in July 2014. His registration with the same practice as M was coincidental. His GP documented that they explored thoughts around suicidal ideation, and none were identified. The perpetrator did identify that he had felt similar feelings of poor sleep, poor appetite and poor concentration after the breakdown of his first marriage. Whilst this was a disclosure of 'repeat symptoms' following the breakdown of a relationship', the GP did not know about the violence that had followed the break-up of the perpetrator's previous marriage.

On the 2nd of January 2018, the GP record identified a telephone consultation between the GP and the perpetrator who at that point identified that his wife was moving out permanently and that he was struggling with poor sleep and not eating. During that conversation it was identified that the perpetrator had not made contact with IAPT and was not taking the Diazepam prescribed for him. The GP recorded that the perpetrator denied suicidal intent and the GP made arrangements to have a consultation with him the next day with a view to commencing anti-depressants.

The perpetrator attended the surgery the next day, the 3rd of January 2018, and stated that he and his wife were to have a 6-month separation. The record identified that "IAPT was again discussed" with the perpetrator stating he was "*going to contact IAPT".* The GP, at this point, prescribed Sertraline and a trial of an alternative sleeping tablet, Zopiclone.

On discussing the case notes with the Author of the IMR, the GP identified that they recalled being made aware by a third party (the GP was unable to recall exactly who provided the information and so did not document the source of the information) that the perpetrator had been overheard saying that he planned to kill himself by 'hanging or shooting himself'. As a result of being made aware of this information, the GP contacted the perpetrator and requested he come into the surgery as soon as possible. The perpetrator returned to the surgery on the 4th of January 2018 and identified that he was '*feeling more upbeat'*. He identified that he had started to take the anti-depressant and had slept well the previous night. He denied making suicidal threats.

The perpetrator informed the GP he was aware of the concerns of others regarding his firearms so had made arrangements for them to be taken into storage to remove these concerns. His GP recalled that the perpetrator was open and gave appropriate eye contact and responses and in their professional opinion, at that time, was not presenting as a suicide risk, nor did the GP feel there were any indicators that he might present a risk to others. The GP also identified that they were aware that the perpetrator had access to firearms and had they felt there was a risk they would have contacted the police on the basis of a public safety issue.

The next and final consultation between the GP and the perpetrator took place on the 19th of January 2018. The GP record identified that the perpetrator stated:

> *'Spoke to wife; concerned for him as says not eating since Xmas, "surviving on cigarettes" and "no reason to live"'*

The GP stated that they had received a call from M on the same morning and she had "raised concerns for the perpetrator but not about him". The GP confirmed that they did not and would not disclose to the perpetrator that M had made contact with the surgery expressing these concerns. The perpetrator attended the surgery later that day for a scheduled appointment and once again identified that things were *'better'* and that he had accepted the split describing things as *'all amicable'.* The perpetrator identified that he was still not his normal self but felt *'massively'* better. He identified that he was eating better and had stopped losing weight. Once again, the perpetrator denied suicidal ideas.

The GP recalled that up until that point the perpetrator had not attempted to self-refer into the IAPT service and did not go on to do so in the period between 19th January and 26th January 2018.

4.6 West Midlands Ambulance Service (WMAS)

The West Midlands Ambulance Service (WMAS) received a 999 call in late January 2018 to attend an incident in Shropshire where a woman, M, was unconscious**.** WMAS dispatched 3 resources to the scene. It was reported that M had been shot and was unresponsive. It was reported to WMAS that the offender had driven away from the scene. On arrival at the scene, WMAS staff identified a man with a mobile phone in his hand flagging down the ambulance, and a young person (later identified as L). WMAS arrived at the same time as the police. On primary examination there was no obvious pulse. The Victim had a gunshot wound. CPR commenced immediately. A short time later, the MERIT team (this team comprises of a Doctor and a specialist Critical care paramedic) arrived at the scene and took over control of the patient.

Additional lifesaving treatment was administered, but sadly there was no improvement and attempts at resuscitation ceased. All clinicians agreed with this course of action.

A safeguarding referral was completed following this incident and sent to Telford and Wrekin Children's Social Services. The details submitted were as follows:

> *"A woman (M) has been shot tonight by the perpetrator. A child was present (L) and possibly in the car when M was shot. The perpetrator then tried to kill himself using the gun and is now in a critical condition. The police have taken custody of L."*

A little while later, WMAS then received a 999 call to attend an incident in Staffordshire involving a man who had sustained a gunshot wound. It was noted that armed police officers were in attendance and had seized the weapon used.

The specialist trauma team were dispatched, followed by an operational manager and an ambulance. On arrival, it was noted the patient had shot himself. The patient, identified as the perpetrator, was conveyed to hospital for further assessment and treatment.

4.7 The licensing of firearms

The perpetrator was a licensed shotgun holder and his certificate was registered with the Staffordshire Police. There was nothing to suggest that the perpetrator's ownership of a number of shotguns was anything other than lawful. He was granted a license to own and use a shotgun because of the nature of his work.

The Panel noted that, whilst there is nothing to mandate the GP to inform the police of any concerns they may have, in this case, the GP stated that they would do so if any concerns had been confirmed following their surgery consultations with the perpetrator. The Panel noted that notification by a GP to the police is entirely voluntary. The GP had discussed this disclosure with the perpetrator and, following the consultation, the GP had no concerns about the safety of the perpetrator, the safety of M or L, nor for the safety of the public.

The Panel considered the context of the visits made by the perpetrator to his GP towards the end of 2017 and early 2018 and wondered whether the manifestation of his 'adjustment reaction' would have led to the GP making some communication to the police? The GP made consistent enquiries of the perpetrator concerning suicidal ideation, the GP prescribed appropriate medication, actively encouraged the perpetrator to refer to the IAPT service and offered referral to crisis support. In these circumstances, when reflecting on whether the symptoms described would have reached the threshold for referral in terms of the perpetrator being a risk to himself and others, the answer is probably no.

However, it is not beyond doubt that licensed firearm holders do become ill and present to the health service with conditions that may put people at risk if their continued possession of the firearm is allowed. A similar situation arose in a Domestic Homicide Review completed in 2013 by the Safer Durham Partnership and also by a DHR completed by the Herefordshire Community Safety Partnership in March 2017. The following recommendation was made by Durham and the same recommendation was repeated by the Herefordshire Review. This is set out below:

'Recommendation 6:

a) The police firearms licensing departments explore the feasibility of carrying out checks both internally and externally with other agencies in particular primary health care i.e. GPs, to help them make decisions in relation to the granting of either a shotgun or firearm's licenses. In order to help them to do this and risk assess appropriately, consideration should be given to establishing a system so that consent is sought for the disclosure of information from every person in that household from primary care services. This will enable information to be shared relevant to domestic abuse,

substance misuse, physical harm and mental health issues.

b) Once a firearm or shotgun certificate has been awarded, the police firearms licensing department should notify the individual's GP so that they are proactive in their information sharing if they have concerns about the certificate holder and their appropriateness to continue to hold these certificates.

c) During the course of those discussions the police representative should also seek permission for a 'flag' to be placed upon the individuals medical record which identifies that if granted a license it is clearly visible to those accessing the record.

During the completion of the Herefordshire DHR, the West Mercia Police were asked to comment on the Durham recommendation and made a submission in response. An abridged version of their reply is set out below:

"All Police Force Firearms Licensing Units operate according to Firearms Licensing Law and the Home Office Guidance provided around the law. Legislation determines the form of Firearms applications. Therefore any change to consider others in the household as part of the application process and obtain their consent re disclosure of medical information, would require an amendment to the Firearms (Amendment) Rules 2013 and the Firearms (Amendment) (No. 2) Rules 2013.

Internal checks are already conducted regarding the applicant that includes any known intelligence or convictions. The applicant also has to provide consent to medical records and the GP is notified of the license being granted and asked to provide any information of concern. The GP's response however is not mandated at present within legislation, and there is a reliance on individual practices to be proactive.

If a GP responds that there are mental health issues, or the applicant themselves has stated they have these issues, then other agencies would be contacted.

The Herefordshire Review, in light of the considerations outlined above, and the limitations as to what West Mercia Police are able to directly change, proposed the following recommendation to appear in the Police Action Plan of that DHR:

> *West Mercia Police to amend the post grant letter to reinforce that the consent of the certificate holder for the sharing of medical information throughout the life of the certificate has been given*.

The Panel in this Review carefully considered the recommendation made in both the Durham and Herefordshire Reviews and the response offered to Hereford by the West Mercia Police. These considerations helped to inform the recommendations made in this Review.

Section 5. Summary and Conclusion

Taking account of the submissions received by the Panel, and the interviews undertaken by the Author, the Panel have approved the following conclusions. These conclusions are not in any order of priority:

1. In the weeks prior to the murder, M and L expressed concern for the welfare of the perpetrator. They thought that he was having difficulty coping with the breakdown of the relationship with M and they were both keen to ensure that he be supported to make the adjustment.

2. The perpetrator had a history of abuse. It could be said that a pattern of behaviour could be identified following a breakdown of his relationships characterised by a period of adjustment, an episode of stalking, alongside violence or threats of violence and threats to take his own life.

3. The perpetrator held a firearms license and 6 shotguns were listed on that license. None of these registered firearms were used as the murder weapon. The perpetrator's license had been refused in the past and his most recent license would have been revoked had he not voluntarily transferred his firearms and license to a friend.

   It was not clear if the information concerning access to other firearms (secured via his employment, his lifestyle or other members of his family) was recorded as police intelligence or disclosed via other routes.[15]

4. During December 2017 and January 2018, there were frequent consultations between the perpetrator and his GP. These consultations did not identify any suicidal ideation, or risk to himself, to those close to him nor to the public at large.

5. M was encouraged – certainly by her employer, her work colleagues and friends – to contact the police when they witnessed the perpetrator at M's place of work, sitting in the car with a shotgun on the passenger seat. M was reticent to contact the police because she was anxious that the perpetrator may lose his firearms license and, consequently, his livelihood.

6. M contacted the school attended by L to inform them of the incident that occurred in December 2017. The school contacted Family Connect and advised M to contact the police. Family Connect contacted M and encouraged her to contact the police. The school attended by L retained the services of a professional counsellor who was made available to help L. By coincidence, the same counsellor had been providing their

[15] *Antique Firearms Regulations 2021. The law on antique firearms has changed. As of 22nd March 2021, some firearms previously regarded as antique, and therefore exempt from control, no longer qualify as such and must now be licensed. Owners of these firearms must act by 23:59 on 21st September 2021, to license them or lawfully dispose of them.*

services to the perpetrator's step child, though for a different set of circumstances.

7. West Mercia Police experienced significant delays in making contact with M. There was not a singular cause for this delay. Some of the delay was due to staff and resource constraints. Additionally, the panel noted that a misinterpretation may have occurred during the transfer of responsibility and resourcing of the incident from Staffordshire Police. Staffordshire Police requested that a statement be taken from M and West Mercia Police recorded their actions to be focused on 'reporting on the matter and responding to Staffordshire Police'. West Mercia Police have submitted that this will require them to review their call-handling systems and this will develop an opportunity for an improvement to the service.

8. Prior to the murder, the school attended by L pieced together the various incidents that had occurred and sought advice from Family Connect to ensure that they were following the correct procedure. The school of the perpetrator's step child did not do this and, instead, offered pastoral support and an offer of counselling to the perpetrator's step child. It appeared to the Panel that neither school made the connection that L and the perpetrator's step child were a part of the same family.

9. In the weeks prior to the murder, M lived in Telford and the perpetrator lived in Staffordshire. Hence, Staffordshire Police transferred responsibility for resourcing the response to the call from M to West Mercia Police and West Mercia Police accepted that responsibility.

10. It is apparent to the Panel that the relationship between M and the perpetrator deteriorated from the point of the incident where the television was smashed in December 2017. From this point, the situation rapidly escalated to a homicide in just a short number of weeks.

Section 6 Key Themes and Lessons Learnt

6.1 Knowledge of the perpetrator, antecedent events and knowledge of the Victim

Prior to the murder leading to this DHR, there were two precursor incidents reported to or known by different agencies. One of these incidents was violent, though not directly towards M, and involved the smashing of the television in December 2017. Following this incident, there were incidents of controlling behaviour – specifically, the taking of M's car without her permission – stalking and threats of self-harm (often a pre-cursor or coercive control) made by the perpetrator. Additionally, M's employer recalled a number of incidents, one concerning the perpetrator arriving at M's place of work and sitting in their car with a shotgun.

The perpetrator was, in 2004 and 2007, under investigation by the West Mercia and/or the Staffordshire Police – for incidents of domestic abuse associated with his previous partners.

It was noted by the Panel that on a previous occasion when the perpetrator had been violent, he had used a knife as a weapon to threaten his ex-wife and her new partner (despite possessing lawfully held firearms). The perpetrator also threatened suicide with the use of a firearm.

The Panel considered what may have been the best predictor of the perpetrator's behavior and noted that the two incidents where he was the perpetrator of abuse contained similarities, namely the separation from a partner, the stalking of that partner, confrontation of the ex-partner when in the company of a new partner or close friends, the use of a weapon and the attempt or alleged attempt to commit suicide by the use of a firearm.

6.2 The DASH-RIC procedure

The police service has an agreed risk assessment form - the domestic abuse, stalking and harassment (DASH) form. It is important that the completion of the DASH form is not seen as a compliance exercise, rather than one that is necessary to protect the Victim. The measure of a successful police response to a domestic abuse incident should not be whether a form has been filled in, it should be whether the service has correctly recognised and identified the level of risk, has taken appropriate action to keep the Victim safe and has obtained or protected evidence necessary for an appropriate criminal justice outcome.

The proper and consistent application of the DASH-RIC (or DIAL process in Staffordshire) and the application of its outcome is pivotal to the management of all cases of domestic abuse. It is recognised that risk is not always consistent over time and professional judgement can be applied to over-ride the outcome of the RIC, if intelligence from other sources determines this to be the correct course of action. The role of the Police Constable who visited M is pertinent in this respect.

West Mercia Police Force policy advised the Panel that a DASH risk assessment should have been completed by the officer who visited M and L. West Mercia Police informed the Panel that this was not completed, although they stated that the record of the domestic abuse incident (the crime report) showed the DASH assessment as 'medium risk'. The Panel discussed this matter at length when West Mercia Police suggested that this may be a unique Athena system default position[16], when a DASH risk assessment has not been submitted. The Panel concluded that if this were the case, then this default position should not be relied upon as an accurate assessment of risk. The Panel has asked that West Mercia Police clarify this matter as one element of their single agency action plan.

As of 21st December 2018, the West Mercia Police IMU (Incident Management Unit), quality assure all DA/Child/Vulnerable Adult Incidents for completion of the DASH-RIC (or equivalent). Any Domestic Abuse classified crime report where a DASH-RIC is not completed will be linked and returned to the OIC with a task to complete the relevant assessment.

Research[17] suggests that a Victim's own assessment of their risk is as accurate as some of the predictive tools used by agencies involved in the management of domestic abuse and violence. Most risk assessment tools include a question asking Victims if they are frightened and what they are afraid of. Officers should carefully consider the Victim's own assessment of risk alongside all other relevant information, including previous history and their own observations and judgment.

6.3 The role of the schools (attended by L and the school attended by the perpetrator's step child)

When considering the detail of this incident, the school attended by L was the first point of contact for M to disclose the details of the abuse she had experienced.

The Panel considered that the Telford and Wrekin Safeguarding Protocols would suggest that the school, rather than telephoning Family Connect for advice, could have made a formal referral of this disclosure to Family Connect through the agreed inter-agency information sharing protocol. A formal referral in accordance with the protocol may have led to consideration, via a multi-agency discussion, of M's concerns.

The school attended by the perpetrator's step child, a different school to the one attended by L (though still within Telford and Wrekin), were informed by the perpetrator's step child that they had seen M and the perpetrator arguing, that they were aware of the perpetrator writing a suicide note and had heard M shouting at him to "move the gun". It appeared to the Panel that the school of the perpetrator's step child responded to this disclosure by offering academic

[16] ATHENA is the information technology system employed by West Mercia Police
[17] Risk Assessment: Exploring the Success of DIAL and its capabilities in comparison to other methods (for example, DASH). Janos Kerti and Dr Claire Gwinnett, Staffordshire University. Available from: www.library.college.police.uk

and pastoral support and an offer of counselling to the perpetrator's step child and not making a formal referral to Family Connect.

The Panel recognised that L and the perpetrator's step child had different parents and that, with the relationship between M and the perpetrator, they were related. The schools attended by L and the perpetrator's step child did not, at the time, connect them as a family. Coupled with this, it is recognised that L and the perpetrator's step child were disclosing different details of the incidents they had seen and heard to different people at different times and it would have been difficult for the schools to piece all the elements together. This may have led the school attended by the perpetrator's step child to consider the most appropriate response to be pastoral and academic support.

Nevertheless, the Panel considered that the school attended by the perpetrator's step child should have made a formal safeguarding referral and requested that a Section 47 screening and inquiry process be commenced. Inter-agency guidance to safeguard children in operation at this time stated:

> *"…..Local authorities, with the help of other organisations as appropriate, also have a duty to make enquiries under section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard and promote the child's welfare. There may be a need for immediate protection whilst the assessment is carried out."*[18]

The school attended by the perpetrator's step child assumed that the West Mercia Police were either actively undertaking, or were responsible for, initiating safeguarding procedures for the perpetrator's step child. This was an incorrect assumption. The perpetrator's step child made significant disclosures to their school and the school was responsible for responding to these disclosures in accordance with guidance and policy.

6.4 Communication between the Police Services of West Mercia and Staffordshire and protocol for cross border work

West Mercia Police accepted in good faith a request from Staffordshire Police to conduct enquiries on their behalf. The enquiry appeared straight forward, but it should perhaps have been apparent that there were inherent risk factors that should have prompted a re-assessment of the agreement by West Mercia Police to conduct the enquiry.

The nature of the known risk factors, including domestic abuse, child protection, support for a vulnerable adult, a suicide risk, and the ownership of firearms, should have prompted a strategy discussion between the two Forces and an agreement on a clear direction for the investigation, including timescales and management of any risk.

[18] Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. HM Government. March 2015

Having accepted the enquiry on the first day, the review by the Inspector based at the control room, identified a risk and directed positive action to be taken by the Local policing area. However, the subsequent downgrading of the enquiry on the command and control system led to delays in taking this action.

The submission made by West Mercia Police recommended that West Mercia Police, and its alliance partner Warwickshire Police, should consider a Service Level agreement with adjacent forces in respect of ad hoc requests for mutual aid falling outside of their legal obligations.

The IOPC report into this incident, when considering this issue, made the following observation and recommendation:

> *"There also does not appear to be a process in place when dealing with cross border incidents and assistance in which actions sent to another force are reviewed. For this incident, only one review was carried out by Staffordshire Police in the 13 days West Mercia Police had this action to assist. In light of this, it is recommended by the IOPC that Staffordshire Police continues to identify and explore opportunities to improve cross border liaison and mutual assistance with neighbouring forces. Staffordshire Police have responded…..stating that they are keen to explore and review what safeguards have already been and indeed can be adopted to expedite processes. They will be pursuing this with the relevant control room leads and firearms licensing."*

The Panel recognised that management systems vary from one police force area to another and that, in this case, noted that there are eight police force areas adjacent to West Mercia. The Panel concluded that this may make one service level agreement extremely difficult to achieve. Nevertheless, the Panel did agree that cross-border communication systems should be reviewed to ensure that responsibilities and obligations are very clear when operational responses are transferred from one police area to another.

Additionally, when considering this specific incident, during the 13 days when West Mercia had responsibility to take action in this case, only one review was undertaken by Staffordshire Police. The Panel agreed that a process of cross border performance review, in conjunction with a clear communication protocol should be considered by both police force areas.

6.5 Making contact with M, coercion and control and assessing risk

West Mercia Domestic Abuse policy states that a Domestic Abuse incident should be recorded before the officer finishes their tour of duty. It should be the case that when accepting an out of force enquiry, it should be categorised and treated as if it had been generated within the force area and risk assessed accordingly.

West Mercia Police informed the Panel that, because the property was a new build property, it had not been registered on the police address system.

Despite text and telephone contact to establish the availability of M and L, West Mercia Police did not make face-to-face contact with them until 13 days after receiving the report. The underlying reasons for the slow response in dealing with this incident was that it was perceived as a task linked to a domestic incident in another Force, and, as noted from the submission, pressure on available resources.

As previously stated, of paramount importance is the initial information gathering and correct risk assessment (to apply NDM and THRIVE and professional judgement) at the point the incident is reported to the OCC. This will lead to the correct identification of a suitable and, where applicable, specialist resource to be deployed.

Acknowledging the number of factors that contributed to this incident not being managed in a timely manner by the police, and so the failure to identify potential risk was concerning for the panel.

The Panel was informed that, in 2019, domestic abuse scheduled appointments were introduced by West Mercia Police whereby those incidents that did not hold immediate risk would be scheduled at an appropriate time with the Victim and within 48 hours. West Mercia Police continue to seek to reduce this to 24 hours.

West Mercia Police, in their latter submission, noted that the DART 2021 Strategic Recommendation stated that: The force should immediately cease the use of a 'diary' for the allocation of Domestic Abuse incidents. This decision should be authorised by Chief Officers to prevent the re-installation of this deployment option. This DART 2021 strategic recommendation has been actioned and therefore, all incidents of Domestic Abuse should be responded to according to the Deployment Principles Policy for a Priority Response (60 minutes).

The removal of M's vehicle was seen in the context of the crime of Taking a Vehicle Without the Owners Consent (TWOC). The Panel recognised that, within the parameters of the law, this was entirely correct because the car was leased by the company owned by the perpetrator and M was registered to drive the vehicle. However, the Panel also recognised that this event could have been considered as a crime coupled with an act of domestic abuse. The perpetrator had displayed a consistent pattern of behaviour by his acts of assault, damage, threats, and intimidation both towards M and previous partners, which demonstrates an intention to harm, punish or frighten them. The Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an on-going relationship between intimate partners or family members.

The Panel, in the amendments made in 2021, were aware that the Domestic Abuse Act 2021, extended the coercive or controlling behaviour offence to cover post-separation abuse.

The West Mercia Police noted that acts of controlling and coercive behaviour are a 'layer' of domestic abuse, with a requirement for police officers to apply professional curiosity to these circumstances and to sensitively and professionally pursue the detail of what happened, how, and how this made the Victim feel. Officers must be professionally curious enough to recognise the signs of domestic abuse, including where there has been no physical harm or fear of physical harm; of what is not being said/disclosed by the Victim and, to exercise their professional judgement, and include this in their risk assessment.

West Mercia Police recognised that, when the perpetrator took the vehicle used by M and L, regardless of ownership, this should have been considered as an act of control by the perpetrator to deprive M and L of the means needed for independence. When the vehicle was recovered, following the murder, it was found to have been fitted with a tracker, still in situ.

The perpetrator knew the vehicle was used for M's independence and he wanted to know more. He needed to regain control. This is a pattern of escalating behaviour – coercive controlling behaviour – which is a strong indicator of domestic abuse and homicide.

The West Mercia Police Force Orders[19] dated 13/11/17 disseminated information from academic research on a working model of 'Understanding Coercive Control', ('Seeing What is Invisible in Plain Sight') intended to transform the approach to policing intimate partner violence and issued to the force by the DI lead for Domestic Abuse. Within the various stages of the model was 'coercive control' and information including that Victims are subjected to surveillance, by perpetrators who use technology, tracker devices and apps or persistently make contact with the Victim at their workplace or with their associates in order to monitor a Victim's movements.

This highlights that the use of West Mercia Police Force Orders is too 'informal' for force wide 'training' or 'guidance' and is insufficient for dissemination to identify escalation, risk and the identification of offences concerning Domestic Abuse. Relevant information must be capable of reaching officers and supervisors, perhaps via a daily shift briefing, so that the intelligence may be understood and deployed by any officer on the same shift.

The Panel recalled pertinent events in relation to coercive control – for example the incident when the perpetrator arrived at M's place of work and was seen by M's colleague with a shotgun on the passenger seat of the car; the Panel also noted M's reluctance to share all of the behaviours of the perpetrator with the Police; and that M had shared her new address with the perpetrator.

The Staffordshire log detail inferred a minimisation or reluctance M to share the behaviours of the perpetrator with an emphasis very much on L's concerns and disclosures.

[19] Force wide internal publication containing updates on legislation; policy and procedure; learning; training requirements, etc.

DART 2020 identified from the front-line phase of the reality testing model that some officers felt “awkward” when completing the DASH-RIC with Victims.

DART 2021 reflected that there was now a high degree of confidence in assessing risk with DA incidents. There was less understanding on risk management.

Officers require training in how to appropriately probe for further information and to utilise all the information available to them from the initial information reported; the wider intelligence picture on the perpetrator and from the DASH-RIC responses that should help them to identify coercive and controlling behaviours. This will assist in informing the risk management process.

perpetrators of coercive control can switch between charm and aggression/violence, leading a Victim to believe at times of charm that the perpetrator is not that bad and not always like that (Refuge have identified such behaviours in their research describing a Victim’s barriers to leaving a relationship).

The Panel considered whether M’s perception of safety and limited disclosures about the perpetrator stemmed from having left the relationship and moved on. This, of course, would threaten the perpetrator’s control.

Additionally, of course, it is noted that a Victim will often tend to underestimate their risk of harm from perpetrators of domestic violence. They may not recognise themselves as a Victim of coercive and controlling behaviours, even though they know that what is happening is not right. (see: Domestic Abuse High Risk Factors – Laura Richards, DASH training).

It does not appear that West Mercia Police nor Staffordshire Police considered a DVDS (Domestic Violence Disclosure Scheme, 2014 or Clare’s Law) ‘Right to Know’ disclosure to M. The Home Office have reviewed the DVDS scheme and the Domestic Abuse Act 2021, has placed the scheme on a statutory footing, placing a duty on the police to have regard to the guidance.

In this context, the Panel referred to the research conducted by Jane Monkton-Smith concerning the timeline leading to the potential for intimate partner homicide.[20]

Monkton-Smith identified eight stages in the timeline to a potential homicide. These are described below:

- Pre-relationship history – a criminal record, historical allegations of abuse;

[20] Monckton-Smith, Jane ORCID: 0000000179255089 (2018) Intimate Partner Femicide Timeline. In: UN Day Opposing Violence against Women Seminar and launch of the Femicide Watch 2018, 23 November 2018, Dublin. Official URL: http://www.womensaid.ie/download/pdf/jane_monckton_smith_powerpoint_2018_compatibility_mode.pdf

- Behaviour during the early part of the relationship;
- Behaviour in the relationship – markers describing risk
- A potential homicide trigger – separation, financial problems, threats and rumours;
- An escalation – seriousness of events, stalking, persistence;
- A change in thinking;
- Planning – buying weapons, manipulate meetings, send letters, etc;
- A homicide/suicide, denial, accident, multiple Victims.

Considering this research, the Panel recognised a number of these stages in this case.

When the police arranged to speak to M and L, they were spoken with together. This is recognised by West Mercia Police as not best practice. If L was a potential witness to an incident requiring police investigation, either as an observer or a Victim, they should have been interviewed in accordance with the guidelines set out in Ministry of Justice guidance[21] (2011). Given that L had disclosed domestic abuse to their school and this had been the catalyst for M contacting the police, this was a missed opportunity to engage with L and 'hear their voice'. This issue was discussed with L during their conversation with the Author of the Review. It was clear from this conversation that L felt that, whilst being spoken to alone would not in all probability have prevented the murder from occurring, it may, as they stated, have heightened the sense of risk perceived by the police and other agencies, it may have helped the perpetrator and it may have helped the police exercise a little more 'control' over the perpetrator.

6.6 Making contact with the perpetrator and assessing risk

The Panel noted that throughout the scope of this Review, contact with the perpetrator tended to focus upon his firearms license and the management and/or transfer of those firearms.

The schools attended by L and the perpetrator's step child were aware of the incident in December 2017, as were West Mercia Police and Staffordshire Police. The GP was aware that the perpetrator had separated from M and was experiencing an 'adjustment reaction' and, via a third party, knew that he had been overheard suggesting that he may take his own life.

The employer of M knew of a domestic incident in December 2017 when the perpetrator attended M's place of work and sat outside in their car with a shotgun.

Staffordshire Police and West Mercia Police were aware that the perpetrator had – albeit 14 years prior to the murder under review here – stalked and threatened his ex-wife and they knew that he had taken M's car without her consent.

[21] "Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses". Ministry of Justice, March 2011. www.cps.gov.uk

Apart from the procedure concerning the transfer of the perpetrator's firearms and firearms license, at no point during the period between December 2017 and January 2018 was the perpetrator interviewed concerning these other incidents and their potential bearing upon his interactions with M and L.

6.7 Information sharing between services

Family Connect submitted that, in hindsight, they may not have been in receipt of all the information available to all the partners co-located with the Family Connect service. The Panel noted this concern and acknowledged that agencies record and retain intelligence on different systems. It was also noted that any cases discussed within a local MASH, or within Family Connect, are done so in accordance with the expected convention that all relevant and necessary intelligence is shared in a timely fashion. It is expected that any referral submitted by any agency would be considered by Family Connect and then discussed within the MASH to ensure all agencies were "in the loop".

Additionally, there were safeguarding concerns for L, which could have been pursued more vigorously. The same concerns were recognised for the perpetrator's step child, whose welfare, it appears, was not considered at any stage in the management of this case.

When the perpetrator consulted his GP (on the 21st of December 2017), no suicidal ideation was noted. The GP had received information from a third party suggesting that he did have suicidal thoughts and M had contacted his GP prior to his visit in January 2018 informing them that the perpetrator was experiencing emotional difficulties with the separation. The GP specifically explored this topic at each subsequent consultation.

The Panel noted that the requirement for Doctors to inform the police of medical conditions affecting a patient's ability to hold a Firearms Licence is entirely voluntary. The Panel also noted that Doctors are reminded, in British Medical Association (BMA) guidance and support document offered to them, that they have a general duty of care.

The Panel were made aware that BMA guidance strongly advises Doctors to encourage holders of firearms licences, who may represent a danger to themselves or others, to surrender their licence. The guidance further advises that where a licence holder refuses such advice, that a doctor should consider breaching usual protocols of patient confidentiality and inform the police firearm licencing department as a matter of urgency. The GP in this case was prepared to do that but were assured by the perpetrator that his guns had been removed to a place of safety.

The Panel, taking account of the volume of information held by each agency and the efficiency with which it was shared across the public service architecture, considered the possibility that the current system for sharing information could be improved. The possibility for improvement would rest on the capacity to adequately join intelligence together. It was apparent to the Panel that different agencies had different pieces of information concerning

domestic abuse, child safeguarding, coercive and controlling behaviour, the separation of a vulnerable adult, the threat of suicide, and the availability of firearms. The Panel concluded that this will be a key learning points from the Review.

6.8 The management and licensing of fire-arms

The intelligence assessment of the perpetrator contained gaps and it was not recognised by I24 (the West Mercia Police Intelligence Department) that the National Firearms License Management Service (NFLMS) was a dynamic database that needed to be checked and updated at regular intervals.

With the benefit of hindsight, it appears that at one point in time, the entry within the West Mercia OIS lacked precise information on the location of the six shotguns held by the perpetrator (that the weapons were located at a registered firearms dealer within the West Mercia Police area). However, West Mercia Police submitted that the details of the request made by Staffordshire Police (i.e. describing the nature of the incident and the task requested) would not have required any intelligence concerning the storage of firearms to be on the incident report and that following a NFLMS check by I24 showing that the perpetrator was a licensed firearms holder and the guns had been removed, would have been sufficient at that stage.

The Firearms Licensing System allows for a period of 48 hours to elapse before weapons lodged with a Registered Firearms dealer are required to enter them on the National Firearms Licensing system. The NFLMS is a 'live' system that is subject to change on a very frequent basis. The NFLMS 'interfaces' with other databases the police have access to, such as the PNC. The NFLMS automatically informs police if any of their Certificate holders become involved with the police (e.g. through arrest, domestic abuse, being 'bound over', etc.) or if a prosecution is mounted against them. The Panel noted the submission from West Mercia Police that it is not standard practice to re-check the NFLMS during an incident unless new information comes to light that requires a re-check, or there is a specific request from an investigating officer.

The Panel concluded that, during the scope of this Review, due to the storage and retrieval of firearms, the transfer of the firearms license, etc, it would have been prudent to check the NFLMS more frequently.

Section 7. Recommendations

The Panel recommends:

a. The Telford and Wrekin Community Safety Partnership and the Telford and Wrekin Safeguarding Partnership should review the provision of training for all partners, in relation to Domestic Abuse. The training provided should consider positively the inclusion of accounts from people who have survived domestic abuse and emphasise that domestic abuse is not limited to urban areas but is an issue for rural communities. Additionally, schools should ensure that domestic abuse is included within the curriculum and that they are promoting awareness of it and what to do if domestic abuse is suspected.

The Panel recommends:

b. All schools within Telford and Wrekin should be reminded of and then confirm with the Telford and Wrekin Safeguarding Partnership that they adhere to the relevant statutory guidance and local protocols concerning child safeguarding procedures.

The Panel recommends:

c. Procedures for the management of safeguarding referrals operated by the school attended by the perpetrator's step child and for the school attended by L should be reviewed. Where necessary, the training of staff should be provided and the provision of this training, along with a clear procedure for the referral process, should be confirmed to the Telford and Wrekin Education and Skills service.

The Panel recommends:

d. Staffordshire and West Mercia Police should continue to identify and explore opportunities to improve cross border liaison and mutual assistance with neighbouring forces. This should include a clear process for the transfer of necessary information, clarity concerning the ownership of deployment, which police service resources are deployed and responsibilities for managing the response to its conclusion. This matter is to be brought to the attention of the National Contact Management Steering Group in order to inform the debate at a National level.

The Panel recommends:

e. The importance of sharing information between agencies concerning relevant incidents of domestic violence, stalking, coercion and threats of harm were underlined in this case by, amongst others, Family Connect. The requirement to share relevant information should be underlined by the re-enforcement of available statutory guidance and local protocols. Consequently, all agencies within the Community Safety Partnership should review their information sharing practices and ensure that information sharing protocols are in effect. In the first instance, this review should be undertaken by West Mercia and Staffordshire Police, Family Connect and General Practice to ensure that, if a similar situation

were to arise again, necessary information would flow freely through the system.

The Panel recommends:

f. The CCG should ensure that the Draft Guidance, issued for consultation by the British Medical Association (in July 2019[22]) is brought to the attention of all General Practitioners. The draft guidance states that GPs will still be asked to provide medical information if a firearms applicant has a history of a relevant mental or physical condition and will also be asked to alert the authorities if their patients develop a medical condition that could affect their ability to hold a firearms licence after it has been issued.

The Panel recommends:

g. The CCG should re-emphasise and promote awareness of the safeguarding duty of independent clinical practitioners if they consider that employees have been exposed to a risk of domestic abuse

The Panel recommends:

h. All agencies that have contact with children should review and reinforce the procedures to be adhered to when undertaking face-to-face interviews concerning domestic abuse where children are involved. The voice of L and the perpetrator's step child was not clearly audible in this case.

The Panel recommends:

i. The Panel noted that the murder weapon in this case was not one of the firearms for which the perpetrator had a valid license. Nevertheless, the Panel noted that during the scope of this Review it would have been prudent to check the National Firearms Licensing Management System (NFLMS) more frequently. The Panel recommends that communication is passed to all relevant staff (including registered premises that hold firearms) to ensure that they are aware of the nature of the NFLMS, when and how to access it and update the data it holds and how to escalate a response if the data it holds is likely to alter significantly – if, for example, information is shared by other agencies that indicates that the nature of the risk posed by the license holder has altered.

The Panel recommends:

j. The proper and consistent application of the DASH-RIC or any equivalent process and the application of its outcome is pivotal in the management of all cases of domestic abuse. The Panel noted that the officer who visited M and L did not fully follow policy because a DASH form was not completed with M at the time of being seen, though there was a valid reason for this.

[22] https://www.bma.org.uk/advice/employment/ethics/ethics-a-to-z/firearms

Although the DASH was not completed, the officer asked M questions that they knew were on the DASH form and used their professional judgement when applying M's risk level. From the information the PC had, they considered the risk assessment would have been a standard assessment as there were no offences reported, no threatening behaviour and M and the perpetrator no longer lived together. The Panel recommends that all services in contact with the subjects of this case should be reminded of the purpose of the DASH assessment, how the assessment can be undertaken and with whom.

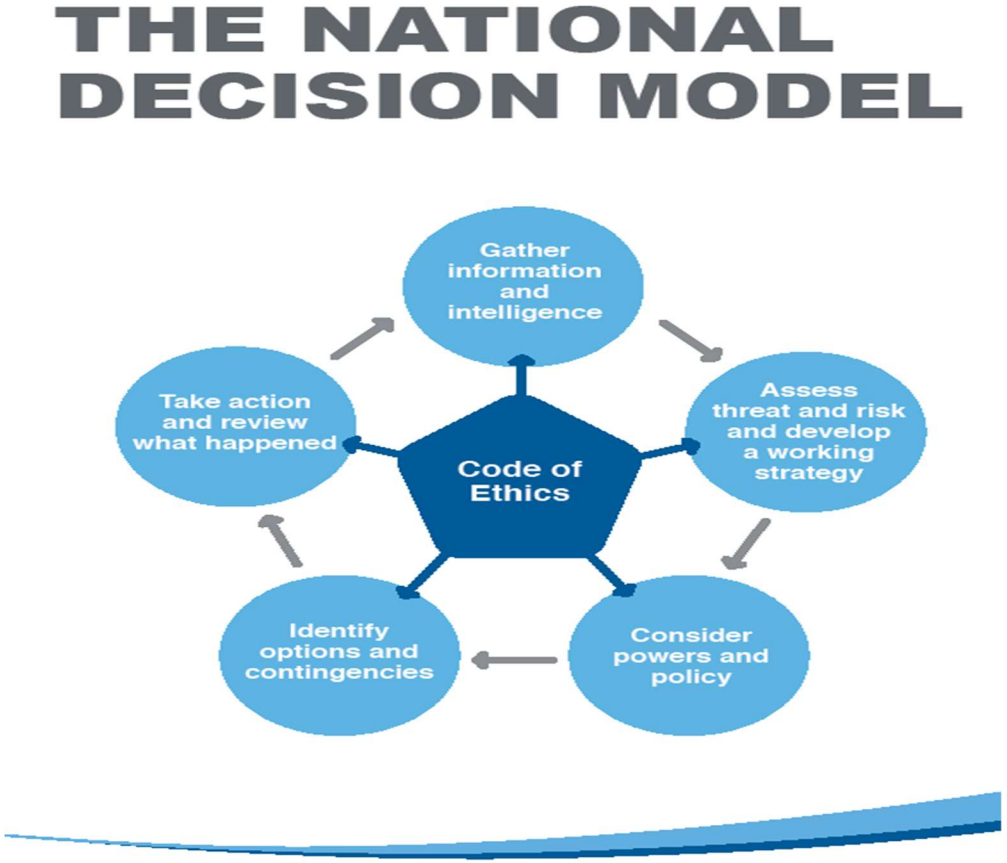
The Panel recommends:

k. The research conducted by Dr Jane Monckton-Smith ('Domestic Homicide eight-stage pattern') will be issued force-wide by the West Mercia Police via the means of a 60 second learning bulletin with attached YouTube video/s from Dr Jane Monckton-Smith. A dissemination will also be made electronically, via the means of text/email to every officer/staff member front-line mobile device and to the OCC. This will provide an immediately available reference source to support staff in their initial information gathering; preparation for the allocation of resources; and for any officer to refer to in being prepared for deployment to a DA incident and identification and investigation of offences of Domestic Abuse, including Coercive Control and, Stalking offences.

The Panel recommends:

l. perpetrator checks via OCC staff for all DA reported incidents to be assessed to identify any historical or recent firearms information / firearms licence revocations including current NFLMS checks. Additionally perpetrator lifestyle / sporting interests / employment status where access to firearms may still be possible. Where information held/disclosed suggests that the perpetrator may still have access to firearms / shotguns this should be escalated to the OCC CI for Risk Assessment and Deployment decisions.

Appendix 1
The THRIVE Model and the National Decision Model



Gather information and intelligence	• What is happening or what has happened • What do I know so far? • What are the caller's needs? • What do force systems tell me? i.e. intel checks
Assess threat and risk and develop working strategy	• What is the level of **THREAT** to whom / what? • If the threat is carried out or circumstances deteriorate, what is the likely level of **HARM**? • How probable is the **RISK** of harm? • Is an **INVESTIGATION** required, and in what form? • **VULNERABILITY** *"a person is vulnerable if as a result of their situation or circumstances, they are unable to take care or protect themselves, or others, from harm or exploitation."* • **ENGAGEMENT** What is the safest means of engagement for the Victim and what is the most effective means?
Consider powers and policy	• Who has the appropriate legal powers to deal with this? • Is this situation for the police alone to deal with? • Is there an OCC working practice? • Is there a formal force policy to follow in this instance or can I use my discretion?

	Identify options and contingencies	**What am I trying to achieve?** • What options are open to me **What is the most appropriate response?** • Emergency • Priority • Scheduled • IPT • Resolution without deployment
	Take action and review what happened	**RESPOND** • Transfer incident to controller • Transfer to IPT • Book a diary appointment • Escalate to Supervisor, Sergeant or OCCI **RECORD** • Your rationale for the selected response grade including your THRIVE rationale

THRIVE.

	THREAT	**HARM**	**RISK**	**INVESTIGATION**	**VULNERABILITY**	**ENGAGEMENT**
If not sure of appropriate response, seek the advice of a supervisor	What is the overall threat posed by the report: Victim, immediate family, children, property public safety community cohesion and location?	What is the impact of the threat? Consider not just the Victim or witnesses, but also the community impact.	What risks are obvious or yet to be determined? What resources, specialist assets are needed to safeguard the Victim or community?	What is the legality, necessity, proportionality in relation to the offence being reported?	What are individual or community vulnerabilities? Identify how police and partners best safeguard against harm.	What is the safest means of engagement for the Victim and what is the most effective means?
EMERGENCY RESPONSE **Grade 1**	• There is an immediate threat to the Victim as the offender is present or in the locality and is making threats. • There is an immediate threat to the public as there is a dangerous offender at large who is armed and making threats.	• Serious injury to a person or property has, or is likely to happen if we do not intervene immediately. • Suspect's behaviour and actions are likely to provoke or have provoked others.	• The crime is or is likely to be serious and is in progress or imminent, or the offender has been detained:: - Danger to life. - Use, or immediate threat of use, or violence. - Serious injury to a person and/or serious damage to property.	**Having assessed the threat, harm and risk:** *Consider the needs of the investigative processes:* • What action needs to be taken, if appropriate to	**Having assessed the threat, harm and risk:** *A person is **vulnerable** if as a result of their situation or circumstances, they are unable to take care or protect themselves, or others, from harm or exploitation."* *Including:*	**Having assessed the threat, harm and risk:** *Consider the safest and most appropriate form of engagement:* • An emergency or priority response is required.

	THREAT	HARM	RISK	INVESTIGATION	VULNERABILITY	ENGAGEMENT
	• An injury road traffic collision on a major road may threaten persons present with serious injury in the event of a further collision.	• Suspect is a known persistent offender and it is thought likely they may continue offending.	• An RTC where the road is blocked or where there is a dangerous or excessive build-up of traffic.	preserve and secure evidence? • Is the offender known, prolific or in the vicinity? • Is there a risk that the offender may make contact or intimidate Victims or witnesses • Is there any CCTV? • Is the crime suitable for Crime Bureau or IPT, Resolution Centre?	• Those unable to protect themselves due to drugs, alcohol or mental health • Child in Care, child abuse or neglect • At risk of or Victim of CSE • Hate Crime, • Female Genital Mutilation (FGM), Forced Marriages, Honour Based Violence • Human Trafficking/Modern day slavery • Domestic Abuse, stalking and harassment • Repeat Victim • A distressed or upset caller	• It is suitable to engage with the Victim/ witnesses either over the phone or via a scheduled appointment • Hard to reach group/vulnerable person would benefit from a reassurance visit • Relates to an SNT Problem Solving Plan • Requirement for a community impact assessment.
PRIORITY RESPONSE **Grade 2**	• Tangible threat to the Victim, although not immediate. • Public order offence where the offender isn't immediately present. • A road collision, where there are injuries or a serious obstruction. • Non injury RTC allegations or refusal to exchange details.	• There is a likelihood of future harm without police intervention. • There is a genuine concern for somebody's safety.	• Without police attendance there is still a threat of further harm. Risks cannot be negated or mitigated.			
SCHEDULED RESPONSE / IPT **Grade 3**	• No continued threat to the Victim or the public and is unlikely to reoccur. police intervention is however required but can be dealt with over the phone or via a scheduled appointment.	• The likelihood of future harm can be managed within known or assumed time constraints due to the nature of the threat.	• The risk or likelihood of harm is minimal and can be managed through a scheduled policing response.			
RESOLUTION WITHOUT DEPLOYMENT **Grade 4**	• Resolved over the phone by the call handler. • Not a police matter/ referred to alternative agency. • For information only.	• It is unlikely that there is a continued threat of harm and does not require a physical presence.	• There is no risk of harm.			

APPENDIX 2

DOMESTIC HOMICIDE REVIEW 3 IN THE CASE OF M

MULTI-AGENCY ACTION PLAN

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
1. The Telford and Wrekin Community Safety Partnership, along with the Safeguarding Partnership, should review the provision of training for all partners, in relation to Domestic Abuse. The training provided should consider positively the inclusion of accounts from people who have survived domestic abuse and emphasise that domestic abuse is not limited to urban areas but is an issue for rural communities.	LOCAL	Update online training including coercive and controlling behaviours	T&WC Shropshire Domestic Abuse Service West Mercia Women's Aid Shropshire Chamber of Commerce	March 2021	Completed Forming part of our commissioned Domestic Abuse Community Support Service, Citizens Advice delivered training to local community organisations, on signs and impaction of DA. This training was supported by people with lived experience. The service has also developed the Domestic Abuse Community Ambassador Programme, which continue to raise the awareness of Domestic Abuse, through

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
Additionally, schools should ensure that domestic abuse is included within the curriculum and that they are promoting awareness of it and what to do if domestic abuse is suspected.					programmes such as Working with WM Women's Aid and Shropshire Domestic Abuse Service as volunteers, to develop hairdresser programme to raise awareness of domestic abuse.
		Development of wider training offer with specialist providers (Shropshire DA Service)	T&WC Shropshire Domestic Abuse Service, West Mercia Women's Aid, Shropshire Chamber of Commerce	March 2021	Forming part of our commissioned Domestic Abuse Community Support Service, Citizens Advice delivered training to local community organisations, on signs and impaction of DA. This training was supported by people with lived experience. The

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
					service has also developed the Domestic Abuse Community Ambassador Programme, which continue to raise the awareness of Domestic Abuse, through programmes such as Working with WM Women's Aid and Shropshire Domestic Abuse Service as volunteers, to develop hairdresser programme to raise awareness of domestic abuse.
		Expect Respect Training implemented in schools across the borough. One funded place per school, to include a domestic abuse policy for the workplace, to	Severn Teaching Alliance T&WC Education Service	March 2021	Completed December 2020 Further sessions provided up to March 2021. Very positive feedback from all delegates.

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
		support and safeguard staff who may be surviving/survivors of DA and resources for the classroom to support the statutory elements of the RE-RSE-HE curriculum linked to healthy relationships			Loudmouth theatre in education have been commissioned to provide performances/ workshops of 'Helping Hands' staying safe in relationships (including domestic abuse) for year 5 pupils in targeted primary schools. Over the last 12 months (with the last session in June 21) a total of 25 primary schools have taken part with a total of 1,240 pupils. This will enhance the programme that has also been developed by Severn Teaching School Alliance as part of the statutory PSHE education using the Women's Aid 'Expect

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
					Respect' educational toolkit.
		Training developed for all schools as part of their Raising Awareness programme			Completed November 2020 Following on from the 'White Ribbon day' Severn Teaching School Alliance has delivered a number of sessions with a total of 42 schools attending to discuss all aspects of domestic abuse and how the 'Expect Respect' educational toolkit can be implemented. Each session has included the lived experience of L.
2. All schools within Telford and Wrekin should be reminded of and then confirm with the Telford and Wrekin Safeguarding	LOCAL	Through specific training in the DSL Refresher training, through updated training within the |Raising	T&W Education Service All schools	March 2021	Completed Autumn 2020 All Raising Awareness training and DSL refresher training covers Domestic Abuse. The Raising

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
Partnership that they adhere to the relevant statutory guidance and local protocols concerning child safeguarding procedures.		Awareness training			Awareness training is developed alongside the TWSP to ensure consistent messages are delivered across Telford and Wrekin.
		Roll out of CPOMS to ensure effective and timely notifications through Operation Encompass	T&W Education Service All schools	March 2021	Completed Autumn 2020 CPOMS updates are provided at each Domestic Abuse sub-group, to keep track of progress of the project roll-out.
3. Procedures for the management of safeguarding referrals operated by the school attended by the perpetrator's step child and for the school attended by L should be reviewed. Where necessary, the training of staff should be provided and the	LOCAL	DA Sub Group to review how information about DA incidents is shared and acted upon by schools and relevant partners (e.g., Healthy Child Programme)	school L attended Telford & Wrekin Education Service	March 2021	Telford & Wrekin Council Education Safeguarding met with DSL and Head teacher of both schools in November 2020 to review procedures for managing DA incidents. All schools in Telford have implemented revised Child Protection & Safeguarding procedures. Both schools have received up to date Child

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
provision of this training, along with a clear procedure for the referral process, should be confirmed to the Telford and Wrekin Education and Skills service.					Protection training that includes Domestic Abuse.
		CPOM pilot roll out as part of Operation Encompass	Telford & Wrekin Education Service	March 2021	CPOMS pilot completed 2019, roll out scheduled for 2021-22 academic year.
		Training update for all schools and accessed by both schools	T&WC Education Service	March 2021	New DA training developed June 2021. Delivered to one of the schools in June 2021. Booked for the second school for November 2021.
4. Staffordshire and West Mercia Police should continue to identify and	NATIONAL	This action has been reviewed in the Strategic	West Mercia Police and	March 2021	National agreement between forces in relation to mutual co-operation

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
explore opportunities to improve cross border liaison and mutual assistance with neighbouring forces. This should include a clear process for the transfer of necessary information, clarity concerning the ownership of deployment, which police service resources are deployed and responsibilities for managing the response to its conclusion. This matter is to be brought to the attention of the National Contact Management Steering Group in order to inform the debate at a National level.		Vulnerability and Safeguarding Team. There exists a national agreement between forces in relation to mutual co-operation and separate arrangements will not be negotiated between local forces given the number that border West Mercia. OCC staff are being reminded of the responsibility in receiving or requesting mutual aid requests that there is clear ownership agreed	Staffordshire Police		OCC staff have been trained around THRIVE assessments. OCC staff receive regular training every 10 week cycle. This is a continual drive around safeguarding with Recommendations identified from the Domestic abuse reality testing within force which have been referred to in the DHR3 report. The next cycle is looking to reinforce previous training which will look at managing demand**, understanding risk**, identifying the policing role.

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
		and that the response is subject to an appropriate THRIVE Assessment. Further THRIVE Training is currently being explored under the DA Action Plan and a response from L and D is awaited. As appropriate national guidance is in place the National Contact Management Group cannot add anything further to support this, it relies on personal responsibility and			

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
		clarifying specific requests for action and escalation if required.			
5. The importance of sharing of information between agencies concerning relevant incidents of domestic violence, stalking, coercion and threats of harm were underlined in this case by, amongst others, Family Connect. The requirement to share relevant information should be underlined by the re-enforcement of available statutory guidance and local protocols. Consequently, all	LOCAL	Briefing on information sharing and relevant statutory guidance and local protocols	TWSP Partnership Team, All CSP agencies, West Mercia Police,	March 2021	West Midlands Regional Procedures for Adult and Children's Safeguarding, including Domestic Abuse and Information Sharing Procedures, have been developed and circulated. Richmond Fellowship have been commissioned to deliver 'My Time' Telford's first perpetrator programme. Experienced staff from the programme are co-located as part of the strengthening families' locality teams sharing specialist advice and training on Domestic

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
agencies within the Community Safety Partnership should review their information sharing practices and ensure that information sharing protocols are in effect. In the first instance, this review should be undertaken by West Mercia and Staffordshire Police, Family Connect and General Practice to ensure that, if a similar situation were to arise again, necessary information would flow freely through the system.					Abuse to support referrals into the programme. West Mercia does recognise cross border co-operation will focus upon the delivery of nationally agreed principles determined by the 'National Contact Management Steering Group', which should enable the police to deliver improved cross border service. It is recognised that is the individual understanding of what is necessary to share to ensure risks are appropriately recognised. There are current Recommendations in place from other reviews which

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
					West Mercia Police have participated in which should look to reassure that policy and practice will be changing for the better which has been identified within the DHR 3 report.
		Partners review information sharing practices through the TWSP DA Multi-agency case file audit (MACFA)	TWSP	March 2021	DA MACFA audit completed March 2021 and reported to QPO Sub Group June 2021. Evidence of good communication between professionals. All of the cases had MARAC risk management plans where information was shared and actions were agreed.
6. The CCG should ensure that the Draft Guidance,	LOCAL	Following Consultation of	CCG		CCG circulated information to GPs

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
issued for consultation by the British Medical Association (in July 2019[23]) is brought to the attention of all General Practitioners. The draft guidance states that GPs will still be asked to provide medical information if a firearms applicant has a history of a relevant mental or physical condition and will also be asked to alert the authorities if their patients develop a medical condition that could affect their ability to hold a firearms licence after it has been issued.		draft guidance. Final British Medical Association (BMA) Guidance on Firearms licensing Process was published in September 2020 and is on the national Home Office Website and to be presented at GP Forum January 2021			Designated GP provided update to GP forum At the Telford and Wrekin GP Forum, Safeguarding Lead GPs discussed the case on 9 December 2020, with the licensing aspect in particular. The GPs were in general agreement that coding was applied to indicate a firearms license was held and the BMA guidance for firearm licensing procedures were highlighted. The GPs present raised a point at the meeting on the nature of the flagging process (whereas the firearms

[23] https://www.bma.org.uk/advice/employment/ethics/ethics-a-to-z/firearms

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
					procedure indicates an application rather than that the license had been granted).
7. The CCG should re-emphasise and promote awareness of the safeguarding duty of independent clinical practitioners if they consider that employees have been exposed to a risk of domestic abuse	LOCAL	GP surgeries policies include Domestic Violence referrals to Family Connect if consider employees or patients including children at risk of domestic violence.	CCG	March 2021	Designated GP provided update to GP forum Information was circulated by the Named GPs for Safeguarding to Shropshire, Telford & Wrekin Safeguarding Lead GPs in June 2021 regarding an NHS England & Improvement webinar on supporting colleagues who may be experiencing domestic abuse. A further presentation at the Forum for Lead GPs in July 2021 discussed GP roles, and responsibilities listed employee domestic abuse policy as one of the key

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
					safeguarding policies in the organisation. A note will be circulated to GPs regarding the recent approved BMA guidance (updated July 2021) to emphasise the importance of procedures and processes in relation to identifying those bearing firearms. A draft policy for employees involved in domestic abuse will be circulated as an example for practices/PCNs to adapt.
8. All agencies that have contact with children should review and reinforce the procedures to be adhered to when undertaking face-to-face interviews concerning		Shropshire Domestic Abuse Service PCC funding to work with children and young people affected by DA (where adult is	Shropshire Domestic Abuse Services Telford & Wrekin Council	March 2021	Through Home Office Funding Richmond Fellowship will be working with CYP between the ages of 5 – 18 years who are Victims of domestic abuse and of which the adult perpetrator is

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
domestic abuse where children are involved. The voice of L and the perpetrator's step child was not clearly audible in this case.		supported by service) 12 month programme	Strengthening Families teams.		engaged in the 'My Time' programme. The model will work with CYP using trauma informed practice, creative play, and resilience work for up to 24 weeks of holistic support (including post programme intervention), structured through a care plan, with underlying principles to reduce the impact of DA on CYP, through increasing protective factors, decreasing risk domains and introducing coping strategies where appropriate.
		Family Safeguarding Model set to go live in May 2021. Domestic abuse	Family Safeguarding Team, Telford & Wrekin Council	May 2021	Family Safeguarding Model went live on 28 June 2021. Domestic Abuse Practitioners are in place to support

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
		practitioners will become part of multi-disciplinary teams (Family Safeguarding Teams) in Children's Safeguarding and Family Support.			Victims/survivors of Domestic Abuse. Social Workers within the MDT are able to focus on direct work with children, as the needs of the adults are now being met by Adult Practitioners. Probation Officers are due to join Family Safeguarding Team to work with perpetrators of Domestic Abuse, thus creating a holistic approach to Domestic Abuse.

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
9. The Panel noted that the murder weapon in this case was not one of the firearms for which the perpetrator had a valid license. Nevertheless, the Panel noted that during the life of this incident it would have been prudent to check the National Firearms Licensing Management System (NFLMS) more frequently. The Panel recommends that communication is passed to all relevant staff (including registered premises that hold firearms) to ensure that they are aware of the nature of the NFLMS, when and how to access it and update	LOCAL	Current Service Level agreement is being drawn up between Firearms Licensing (Ops) and HAU teams (LP) to ensure that wider checks are made and risks recognised in incidents involving vulnerable people and in respect of licence applications.	West Mercia Police	March 2021	Current Service Level agreement is being drawn up between Firearms Licensing (Ops) and HAU teams (LP) to ensure that wider checks are made and risks recognised in incidents involving vulnerable people and in respect of licence applications.

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
the data it holds and how to escalate a response if the data it holds is likely to alter significantly – if, for example, information is shared by other agencies that indicates that the nature of the risk posed by the license holder has altered.					

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
10. The proper and consistent application of the DASH-RIC or any equivalent process and the application of its outcome is pivotal in the management of all cases of domestic abuse. The Panel noted that the officer who visited M and L did not fully follow policy because a DASH form was not completed with M at the time of being seen, though there was a valid reason for this.	LOCAL	DASH training being explored by L and D as currently no CPD to ensure refresh. Update on how they propose to deliver this due in NY.	West Mercia Police	March 2021	DASH training is now in the L and D calendar for delivery. This will begin in Quarter 4 2021.

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
11. Dr Jane Monkton-Smith's Domestic Homicide eight stage pattern is to be shared with all West Mercia Police frontline staff	LOCAL	West Mercia DA lead to complete 60 second learning bulletin with attached YouTube video/s from Dr Jane Monckton Smith. Consideration to be given to dissemination be made electronically, via the means of text/email to every officer/staff member front-line mobile device and to the OCC. This will provide an immediately available reference source to support staff in	West Mercia Police	November 2021	Request has been made for the 60 second learning product to be prepared. Target/review date of November 2021

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
		their initial information gathering; preparing to allocate resources; and for any officer to refer to in being prepared for deployment to a DA incident and identification and investigation of offences of Domestic Abuse, including Coercive Control and, Stalking offences.			
12. perpetrator checks via OCC staff for all Domestic Abuse reported incidents to be assessed to identify any historical or recent firearms	LOCAL	OCC to review considering the OCC staff (Incident Recording, Systems Scrutiny) – OCCI (Escalation for THRIVE Review	West Mercia Police	November 2021	OCC management are aware, and further instruction has gone out to all staff and further training given during OCC staff regular training days every 10 weeks.

ACTION PLAN Recommendation (RAG rating)	Scope of the recommendation i.e. local or regional	Action to take	Lead Agency	Target Date and report to CSP	Date of completion and Outcome
information/firearms license revocations, including current NFLMS checks. Additionally, perpetrator lifestyle/sporting interests/employment status where access to firearms may still be possible. Where information held/disclosed suggests that the perpetrator may still have access to firearms/shotguns, this should be escalated to the OCC CI for Risk Assessment and Deployment decisions		and Deployment considering Deployment Principle Policy)			Target/review date of November 2021

APPENDIX 3

The Home Office Definition of Domestic Violence

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

“Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

“Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their Victim.”

This definition, which is not a legal definition, includes so-called 'honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that Victims are not confined to one gender or ethnic group.

A member of the same household is defined in Section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as:

1. A person is to be regarded as a “member” of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
2. Where a Victim lived in different households at different time, “the same household as the Victim” refers to the household in which the Victim was living at the time of the act that caused the Victim’s death.

APPENDIX 4

Glossary of Terms

A&E – Accident and Emergency Service
CSP – Community Safety Partnership
DHR – Domestic Homicide Reviews
GP – General Practice
HAU – Harm Assessment Unit
IMRs – Individual Management Reviews
MARAC – Multi Agency Risk Assessment Conference
MASH – Multi-Agency Safeguarding Hub
WMAS – West Midlands Ambulance Service
RIC – Risk Identification Checklist (part of the CAADA process)
I24 – the West Mercia Police Intelligence unit
NFLMS – National Firearms Licensing Management System

Appendix 5
Review by the Independent Office of Police Conduct:

Terms of Reference
To investigate the decisions and actions of Staffordshire Police and West Mercia Police with M and her estranged husband from when she first reported her concerns on 12/01/18 until her death on 26/01/18. In particular to investigate

a) Whether M's risk was correctly identified and managed by officers in a timely and proportionate manner
b) Whether E's risk around holding a firearms licence and the potential to offend were correctly identified and managed by officers
c) Whether officers' decisions and actions were conducted in line with national and local policies, procedures and guidelines
d) Whether any change in policy or practice would help to prevent a recurrence of the event, incident or conduct investigated
e) To consider and report on whether there may be organisational learning, including
f) Whether the incident highlights any good practice that should be shared

These terms of reference were approved on 26/02/18

Appendix 6

Extract from the West Midlands guidance for managing child protection referrals (specifically where domestic abuse is cited)

Independent Domestic Violence Advisors (IDVAs)
Independent Domestic Violence Advisors **(**IDVAs) provide primary and essential support to the MARAC. The IDVA service is available to all sectors of the community aged over 16 who are assessed to be at high risk of DVA, including those from minority ethnic groups, forced marriage, honour-based violence, those involved in sex work, same-sex relationships and male Victims.

To contact the IDVA Service refer to your local Council website for further information on Domestic Abuse support services.

Domestic Violence Protection Notices and Domestic Violence Protection Orders
These notices and orders may be used by the police following a domestic incident to provide short-term protection to the Victim when arrest has not been made but positive action is required, or where an arrest has taken place but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action, or when the suspect is bailed without conditions. They may also be considered when a case is referred by MARAC. The DVPN/DVPO process can be pursued without the Victim's active support, or even against their wishes, if this is considered necessary to protect them from violence or threat of violence. The Victim also does not have to attend court. This can help by removing responsibility from the Victim for taking action against their abuser.

With DVPOs, a perpetrator can be banned with immediate effect from returning to a residence and from having contact with the Victim for up to 28 days, allowing the Victim time to consider their options and get the support they need.

Domestic Violence Disclosure Scheme ('Clare's Law')
The Domestic Violence Disclosure Scheme (DVDS; also known as 'Clare's Law') commenced in England and Wales in 2014. The DVDS gives members of the public a formal mechanism to make enquires about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner. This scheme adds a further dimension to information sharing about children where there are concerns that domestic violence and abuse is impacting on the care and welfare of the children in the family. This process should only be used for those with concerns whom are not already engaged with any agencies who can provide help and share information.

Members of the public can make an application for a disclosure, known as the 'right to ask'. Anybody can make an enquiry, but information will only be

given to someone at risk or a person in a position to safeguard the Victim. The scheme is for anyone in an intimate relationship, regardless of gender.

Partner agencies can also request disclosure is made of an offender's past history where it is believed someone is at risk of harm. This is known as 'right to know'.

If a potentially violent individual is identified as having convictions for violent offences, or information is held about their behaviour which reasonably leads the police and other agencies to believe they pose a risk of harm to their partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

Safety Planning
Developing a safety plan is a way of helping the Victim to protect themselves and their children by planning in advance for the possibility of future violence and abuse. It also helps the Victim to think about how they can increase their safety either within the relationship, or if they decide to leave.

Women's Aid offer advice on making a safety plan via their website.

Appendix 7
West Midlands Domestic Violence and Abuse Standards

Statutory organisations and specialist domestic abuse services across the West Midlands region (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall & Wolverhampton) are committed to 11 standards of good practice. These West Midlands Domestic Violence and Abuse Standards are intended to identify and promote evidence-based, safe and effective practice in working with adult and child Victims of domestic abuse, and to ensure perpetrators are held to account.

The 11 standards are:

1. Organisations address domestic abuse within their policies.
2. Organisations have pathways and procedures to respond to domestic abuse.
3. Staff are trained, supervised and supported in domestic abuse commensurate with their role.
4. Creating safe spaces.
5. Avoiding unsafe responses.
6. Responding to diversity.
7. Working with domestic abuse perpetrators.
8. Multi-agency working.
9. Data collection.
10. Workplace policy.
11. Commissioning and service design.