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

Prepared for the ACPO Homicide Working Group

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1. Acknowledgements

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

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

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

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

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

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

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

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Commander Andre Baker  
Head of Homicide Investigation  
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09/10/03
2. Caveats

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

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

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

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

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

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

3.1 Domestic homicide\(^1\) accounts for approximately 25\(^2\) of all homicides in London and 35\(^\%\) in England and Wales. Victims have often been in contact with key agencies for assistance prior to their death. The speed and/or quality of service providers’ responses to abused individual’s emergency requests may have a direct bearing on whether or not a serious assault becomes a homicide. Research suggests certain characteristics could be more predictive of homicide than others. As physical violence is the most frequent precursor of spousal homicide, it makes intuitive as well as practical sense to design an instrument/model around characteristics related to the abuse.

3.2 The Understanding and Responding to Hate Crime team (URHC) have analysed data generated by the Multi-agency Domestic Violence Murder Review panels, which were set up to examine and explore the positives and negatives of the support previously offered to victims. Furthermore, the Metropolitan Police Service (MPS), in conjunction with Philippa Sully at City University, have also analysed five cold case domestic violence murder reviews. The combined murder review analysis has informed the MPS Domestic Violence\(^3\) Risk Assessment Model [Appendix III].

3.3 The MPS Domestic Violence Risk Assessment Model was developed by the Understanding and Responding to Hate Crime Team\(^4\). As well as incorporating the findings from the murder review analysis into the model, in-depth behavioural analysis was undertaken on 253 domestic violence sexual offences for the first four months of 2001, as well as 149 ‘serious’ domestic violence offences (allegations of ABH and above) for the first two months of 2001. This entailed offender profiling in every case, as well as analysing the context of the violence, behaviour, lethality and dangerousness. By profiling the offenders, it is possible to learn lessons about dangerousness, lethality, prevention, protection and enforcement.

3.4 From this in-depth analysis, Laura Richards and Professor Betsy Stanko have identified six high risk factors for domestic violence. They can be remembered by using the mnemonic SPECSS:

- Separation (child contact),
- Pregnancy,

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

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

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

\(^4\)This was a joint project funded by the Home Office Targeted Policing Initiative.
3.5 The factors should be mainstreamed into frontline policing. A tactical menu of intervention options [Appendix IV] has also been compiled which sits alongside the MPS Risk Assessment Model detailing options around risk management (this compliments the MAPPPs\(^5\) tactical menu of options). However, risk management in the form of RARA (Remove, Avoid, Reduce, Accept the risk) must be employed in every case. Furthermore, the model was also built on a thorough review of existing international research and literature, developed through a comprehensive consultation exercise involving leading academics and practitioners, and includes contributions from victims of domestic violence.

3.6 The argument for the requirement of a risk assessment process is based upon the need to enhance safety, manage lethal situations, to make better use of intelligence and to increase the standard of the investigation and supervision. Increased understanding of the nature of risk will enable service providers in partnership to plan those resources. The model is about prevention, not prediction. It ensures that a risk management plan aimed at specific risk variables is put into place. When properly applied, risk assessment can serve as a paradigm for effective case management to domestic violence.

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

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

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

\(^5\) Multi-agency Public Protection Panels. In April 2001, the Criminal Justice and Court Services Act placed a statutory duty on police and probation to establish inter-agency protocols for the management of the risks posed by sexual and violent offenders. Multi-agency Public Protection Panels were formed in every London borough to monitor and share information on the most dangerous offenders.
3.10 The murder review and risk assessment must remain dynamic. The MPS Risk Assessment Model must be constantly reviewed to allow for learning as our knowledge base increases, as well as new patterns/trends that might emerge in the future.

3.11 The MPS instigated multi-agency murder reviews. The guidelines for review can be found at Appendix V. However, the introduction states:

‘When a victim of domestic violence dies, agencies should consider whether there are any lessons to be learnt from the tragedy about the ways in which they work together to safeguard other victims. Consequently, when a victim dies in such circumstances the Borough Domestic Violence Forums (BDVF) should always conduct a review into the involvement of the victim and family of agencies and professionals. Additionally, the BDVF should always consider a review where a victim sustains a potentially life-threatening injury or serious and permanent impairment of health and development, or has been subjected to a particularly serious sexual assault’.

3.12 The purpose of the reviews is to:
- establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies work together to safeguard victims;
- identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and as a consequence;
- to improve inter-agency working and better safeguards for domestic violence victims.

3.13 Reviews will vary widely in their breadth and complexity, but in all cases lessons should be learnt and acted upon as quickly as possible. Within one month of a case coming to the attention of the BDVF Chair, there should be a Review Panel discussion to advise on whether a review should take place and subsequently to draw up terms of reference. Individual agencies should secure case records promptly and begin work quickly to draw up a chronology of involvement with the victim and family.

3.14 Reviews should be completed within a further THREE months, unless an alternative time scale is agreed.

3.15 In some cases, criminal proceedings may follow the death or serious injury of a domestic violence victim. Those co-ordinating the review should discuss with the relevant criminal justice agencies how the review process should take account of such proceedings, i.e. how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), and who should contribute at what stage. Case reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding
decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. **In some cases, it may not be possible to complete or to publish a review until after Coroners’ or criminal proceedings have been concluded but this should not prevent early lessons learnt from being implemented.**

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

3.17 In essence the SMRG mirrors the make up of the local borough review panel. However, voluntary organisations are only invited to attend if recommendations are relevant to them. The SMRG then decide which recommendations should be taken forward and at which level. Three levels were identified by the Group:

1. The individual agency or agencies.
2. Nationally.
3. The Home Office (for legislation).

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

3.19 **It was recorded within many of the review reports that some agencies are sceptical of the aims and objectives of multi-agency murder review.** This has had an impact on the effectiveness of the process.

3.20 **Some agencies voiced concerns about creating a blame culture and took legal advice regarding participation.** The agencies that obtained legal advice were told not to participate in the process due to the potential detrimental effect it might have, possibly culminating in litigation, if an agency had prior contact with the family and had not dealt with it according to their policy.

3.21 **Many review panels felt that agencies did have relevant information to the review, and this is precisely why some chose not to participate.** Hence, there are real information gaps leading to an incomplete picture of events, making it at times almost impossible to draw any learning lessons from the review, other than lack of multi-agency information sharing and a lack of trust.
3.22. **Some agencies refused outright to attend** the murder reviews citing confidentiality issues: 73% of GPs, 30% of Housing, 31% of Police Child Protection Unit (CPU) and 23% of Social Services.

3.23. In some cases, the relevant **agencies were not invited** to attend the review: 70% of review panels did not invite Probation, 83% did not invite the CPS, 53% failed to invite Education and 54% did not invite the police CPU. It is crucial that the relevant agencies are identified and invited to attend the review, particularly voluntary sector agencies.

3.24. **The SMRG recommend that a register of voluntary organisations involved in domestic violence should be maintained by the local MAPPP.** This would allow the chair of the review panel to search their local database to establish which organisation could potentially assist the review. This would ensure that all those who had contact with the victim/family were contacted and invited to attend the review.

3.25. **Some Domestic Violence Forums appear to be a smokescreen for inertia.** This could be due to lacking power and senior membership. DV Forums need to be streamlined to ensure they are best value, cost effective and to prevent duplication of work and effort. We need to create viable multi-agency forums. They need to refocus on their core business: ensuring the safety of women and children experiencing domestic violence and increasing the support available to them.

3.26. **Part of the core business of a Multi-agency Domestic Violence Forum could be to conduct regular inter-agency reviews of victims identified as being at ‘serious’ risk.** This could take the form of a monthly MAPPP meeting, whereby agencies know the names of victims and offenders to be discussed to ensure research prior to attendance. Information shared should be shared under ‘serious risk to life’. A series of solutions should be sought according to the needs of the victim.

3.27. Cases that are not as ‘serious’ should be discussed at the Domestic Violence Action Group Forum or similar/most appropriate Forum. The victim’s consent should be obtained. If it is not obtained, then cases should be discussed anonymously and general advice given. This could be an effective way of dealing with lower-level chronic offending in a multi-agency environment.

3.28. **Several boroughs recommended that independent advocates should provide a 24-hour service to victims.** This is due to the fact that accessing services is currently a lottery, with staff acting as gatekeepers filtering victims out and not explaining to them what their entitlements are.
3.29. **Police and agencies need to effectively risk assess and manage cases.** Risk factors are present in the majority of cases, however, they are not identified due to little guidance/research about what they are, compounded by not being able to gain a holistic and accurate picture of what is occurring.

3.30. **Only four out of the thirty cases were risk assessed by the Police Community Safety Unit (CSU).** Identification of risk factors is an integral part of an effective investigation of all domestic violence cases. Further, all mechanisms and processes to assess and manage risk must have a sound knowledge and evidence base. Risk assessment and management should occur in every case. At present, this area of policing is hugely lacking and will continue to remain so until the Risk Assessment Model is implemented across the MPS. These lessons also apply to other police services.

3.31. **Nine (30%) police investigations of offences prior to the murder lacked positive action and suspects are not being arrested where sufficient evidence exists to do so. Safety plans should be discussed with the victim. This should occur in every case.**

3.32. Form 78s\(^6\), Non Crime Book Domestic Incidents and CRIMINTs\(^7\) are consistently not being completed for DV incidents by Police. The Control Room staff and Crime Reports should be rigorously supervised to ensure compliance with MPS policy and the Minimum Standards of Investigation for Hate Crime (Special Notice 15/00). More stringent Police staff supervision and accountability is required. It is important to note that these are also the findings and recommendations of the independent and statutory inquiry into the circumstances leading to the death of Victoria Climbie in order to prevent such a tragedy happening again (http://www.victoria-climbie-inquiry.org.uk/).

3.33. Children were resident at the home address in thirteen (43%) cases. However, the analysis highlights that child protection issues tend to be missed by police. Police officers do not always ask if children live at the home address or complete Form 78s. Furthermore, 30% of children are actually witnessing the murder. Many of the murders are happening as a result of disputes over separation and child contact/custody.

3.34. **The long-term impact of children witnessing and experiencing such crimes is not being considered or addressed by some statutory agencies.** The SMRG recommend that offenders are charged with separate offences against the children, when children are present and witness domestic violence.

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\(^6\) Children coming to police notice
3.35. Training is required for first contact officers and Crime Management Unit (CMU) officers. Additionally, there should be a review of Community Safety Unit (CSU) and Child Protection Unit (CPU) training, given that some of the fundamental lessons (for example the links between DV and child protection and the importance of completing Form 78s and intelligence) have still not been learnt. This is worthy of note given it is post Victoria Climbie and Laming Report (Chapter 14 in particular), hence the recommendations from this inquiry should have been implemented.

3.36. The overall picture regarding the antecedents to murder normally becomes apparent at the trial. It is vital that this information is used to its maximum benefit when learning how to develop and improve safeguards for victims. There should be a mechanism nationally to share information about potential child protection and domestic violence issues arising from information available to a court in a criminal trial. The information should be fed back to child protection and domestic violence agencies after the trial.

3.37. Early warning signs and symptoms of domestic violence will continue to go unrecorded until nurses, health visitors, General Practitioners and health workers are taught to include these in their observations.

3.38. Victim vulnerability features prominently. It should be the duty of the State to deal with offenders appropriately when victims are too vulnerable or unable to do so. The decision to charge and prosecute offenders should not be dependent and solely reliant on the victim’s willingness or capability of pursuing the allegation.

3.39. There were three cases involving young vulnerable African-Caribbean men who killed their mothers. They appeared to follow very similar patterns in terms of their mental health deterioration and the gaps in the multi-agency service provision. The recommendations from the ‘Untoward Serious Incident Inquiries’ instigated by individual Health Trusts should be disseminated across all Health Trusts, as well as amongst practitioners working within the DV field.

3.40. Risk assessment should occur whether offenders are prosecuted or not. There should always be pre-release risk assessment reviews in domestic violence cases between Probation, Police and Prisons when offenders serve a custodial sentence. The prisoner should always be contacted to undertake this prior to release. N.B. Two offenders who had received a brief sentence for domestic violence offences on their partners, went straight round to the victim’s home address when released and killed the victims.

7 Criminal Intelligence log
3.41. Magistrates are continually bailing offenders who are dangerous and violent and have a history of offending on bail. They do not get remanded in custody, and go straight round to the victim’s address and re-offend. The magistrate needs the full case history in order to inform decision-making and risk assessment. The prosecutor should also have access to any type of documented risk assessment that has been conducted and should be reminded of their rights to appeal bail applications.

3.42. Judges and magistrates should be required to attend appropriate targeted multi-agency training so they get exposure to the issues and complexities surrounding domestic violence. They should be ticketed if they fail to attend.

3.43. There should be fully evaluated and accredited perpetrator programme provided to all domestic violence offenders, particularly given 20-40% of the prison population have a domestic violence background (Offender Assessment System Research, OASys, Probation). Work needs to be taken forward with some urgency to accredit the programmes. The SMRG recommend that any accredited perpetrator programme must adhere to Respect’s minimum standards.

3.44. Furthermore, over half the offenders within this analysis had previous convictions for other types of crime ranging from drugs to offences against the person. There were also many intelligence reports for involvement in other types of criminal activity. Hence reported domestic violence offenders are not ‘specialists’ in the sense they are solely ‘beating their partners’, but commit other crimes as well. This identifies other opportunities for policing in terms of joining up investigations and intelligence.

3.45. In just under half of the cases, the context of the argument preceding the murder was regarding separation, with child contact featuring strongly in cases where children were resident in the household.

3.46. ‘Honour killings’ have been flagged as an area meriting further research and analysis to draw out good practice when dealing with such cases. There are, however, particular implications for multi-agency working regarding this type of crime and killing. This is in terms of developing good partnerships when working with community groups. Commander Baker has set up a group to deal specifically with this issue and a work plan is already underway. It is important to highlight that practitioners and academics have yet to come up with a more appropriate and shared name/label for this type of killing, or a common definition. It must be emphasised that there is no ‘honour’ in murder. The group will be looking at these issues as well as trying to identify signposts to murder.
3.47. ‘Family wipe out’ or ‘homicide-suicide’ has also been flagged as a special kind of domestic violence. Homicide-suicide rarely involves strangers. The homicide victims in such cases are almost always female. The person who usually kills, tends not to be able to let the victim go. The most common factor in homicide-suicide is that the male needs to control the relationship. If a wife or girlfriend tries to leave, the man will often threaten to kill himself. This is a manipulative move and one that needs to be taken seriously. He should be assessed not just for suicide but possibly homicide-suicide. Work is also underway to unpack the dynamics of this phenomenon. Further research could look at whether there are links between mental health issues, depression and suicide/homicide in particular.

3.48. Contrary to common belief, the most common method of killing was stabbing with a sharp implement rather than strangulation. Fifteen (27%) victims were stabbed, eleven (20%) died from head injuries and six (11%) were strangled. With additional data from the next financial year (2002-2003) this pattern remains consistent: 31%, 20% and 10% respectively.

3.49. Murder review should be put on a national footing. It makes both intuitive and practical sense for the murder reviews to be undertaken by MAPPA\(^8\), given that MAPPPs should already be risk managing the most dangerous and high-risk offenders with domestic violence offenders falling into this category (albeit this is still patchy across regions).

3.50. MAPPA guidance for information sharing already exists and more importantly works. It would be ideal for MAPPA to incorporate this area of work. However, it must be made more specific to cover murder review and risk assessment and be put on a statutory footing.

3.51. A recommendation for a ‘national register’ of domestic violence offenders has come out of the reviews. This is to address the problem of when offenders/victims move areas. However, rigorous thought is needed around how such a ‘register’ would work and what it is aiming to achieve. For example, if only those who had served a twelve or six month sentence were to go on to the register, it would not capture the majority of domestic violence offenders; given that most do not get a custodial sentence. Those that do, and they are few and far between, tend not to be sentenced for very long. For example, only two of the offenders served custodial sentences for domestic violence: six months for a GBH and three months for an ABH respectively. Hence careful consideration would have to be given to how it would work on a practical level.

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\(^8\) Multi-agency Public Protection Arrangements
3.52. The development and imminent roll out of the Violent and Sexual Offenders (VISOR) database would be more suitable and meet these needs, given that all those coming to the attention of MAPPPs would be entered onto the database. This would also include high-risk domestic violence offenders, once they have been risk assessment and flagged to the Public Protection Unit (PPU). This again is reliant on the Risk Assessment Model being used, as well as offenders being flagged to MAPPPs.

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

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

3.55. The key aim of the murder reviews is murder prevention. It is not about creating a blame culture, but rather about identifying how to improve inter-agency working and better safeguards for victims. This report documents the findings of the reviews and lessons to be learnt for the future. Consideration should be given to inviting friends and family of the victim(s) to the review. As well as providing good information it might also help shift away from the idea of blame.

3.56. The two-pronged approach of multi-agency murder review and risk assessment has already shown its benefit and value. This is in terms of learning the lessons about the antecedents to domestic murder, identifying risk factors, highlighting the realities and practicalities of information sharing and pinpointing potential ways to facilitate better multi-agency working to ensure better safeguards for victims in the future. This new evidence-based approach to crime prevention needs to be mainstreamed and employed to enhance policing and inter agency partnership in the 21st century.

3.57. In terms of the Police, the recommendations from the reviews have been accepted and are to be taken forward by the Diversity Directorate for consideration at the MPS Management Board. There are also ramifications regarding the National Intelligence Model (NIM) and risk assessment. This deserves careful consideration and further liaison with the MPS NIM Team.
3.58. The findings have also been shared with Assistant Chief Constable (ACC) Jim Gamble, the ACPO Domestic Violence portfolio holder. They will also be discussed with the Solicitor General Harriet Harman, MP, for consideration on a wider basis across multi-agencies.

3.59. The findings will also be submitted for consideration in the feedback regarding the Safety and Justice paper (published in June 2003) as well as the Children’s Green Paper produced by the Government. This document should be used as an evidence base to inform decisions being made by the Home Office, with regards to the DV Bill in particular.
4. Introduction

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

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

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

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

4.4. Domestic homicide cannot be separated from domestic violence. Victims have often been in contact with key agencies for assistance prior to their death. The speed and/or quality of service providers’ responses to abused individual’s emergency requests may have a direct bearing on whether or not a serious assault becomes a homicide. Research suggests certain characteristics could be more predictive of homicide than others. As physical violence is the most frequent precursor of spousal homicide, it makes intuitive as well as practical sense to ground any predictive instrument around characteristics related to the abuse experienced. The work around risk assessment and murder review analysis is inextricably linked and seeks to inform each other.
4.5. The Understanding and Responding to Hate Crime Team (URHC) has analysed data generated by the Multi-agency Domestic Violence Murder Review panels, which were set up to examine and explore the positives and negatives of the support previously offered to victims. The MPS Risk Assessment Model developed by URHC has been compiled simultaneously with the murder review analysis undertaken in conjunction with the MPS and City University.

4.6. Any model that can assess potential levels of risk/lethality to the victim is extremely important for informing tactics around intervention and prevention. Given the huge number of cases involved, start with a gold/premium standard of intervention when dealing with the most serious offences (the volume of serious cases is relatively low⁹) and once systems are in place, mainstream across to all domestic violence related offences.

4.7. Cases that are not ‘serious’ should be discussed at the Domestic Violence Action Group Forum or similar/most appropriate Forum. The victim’s consent should be obtained. If it is not obtained, then cases should be discussed anonymously and general advice given. This could be an effective way of dealing with lower level chronic offending in a multi-agency environment.

4.8. The issue facing the police service today is not underreporting or being able to keep adequate records of domestic violence incidents, but rather not being able to make use of the vast amounts of information that is available to them. It is anticipated that in the longer term, the Risk Assessment Model will prove a vital tool for identifying victim needs by providing a focused mechanism to identify and respond effectively to serious assaults, repeat victims and chronic offenders.

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

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

5.2. Aims and Objectives of Multi-agency Domestic Violence Murder Review
Critical incidents of domestic violence are subject to review in order to:
- Establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies work together to safeguard victims of domestic violence;
- Identify clearly what those lessons are, and how they will be acted upon, and what is expected to change as a result and as a consequence;
- To improve inter-agency working and better safeguards for victims.

5.3. Process

5.3.1. Domestic violence murders which occur in London are routinely identified by the Specialist Crime Directorate’s Operations Room (SCD). Notification for review, along with the operational procedures and guidelines for review (Appendix V) and the murder review template, is disseminated to the relevant borough. The borough Multi-agency Domestic Violence Murder panel or forum then undertakes the review and the reports are forwarded to Laura Richards for analysis. The recommendations and analyses are fed straight back into the Risk Assessment Model as well as presented to the Strategic Murder Review Group (SMRG). The SMRG then decide which recommendations are relevant for:
1. The appropriate agency
2. Nationally
3. Legislation

5.3.2. The reviews vary widely in their breadth and complexity, but in all cases lessons should be learnt and acted upon as quickly as possible. Within one month of a case coming to the attention of the BDVF Chair, there should be a Review Panel discussion to advise on whether a review should take place and subsequently to draw up terms of reference. Individual agencies should secure case records promptly and begin work quickly to draw up a chronology of involvement with the victim and family.
5.3.3. Reviews should be completed within a further THREE months, unless an alternative
time scale is agreed.

5.3.4. In some cases, criminal proceedings may follow the death or serious injury of a domestic
violence victim. Those co-ordinating the review should discuss with the relevant criminal justice
agencies how the review process should take account of such proceedings, e.g. how does this
affect timing, the way in which the review is conducted (including interviews of relevant
personnel), and who should contribute at what stage. Case reviews should not be delayed as a
matter of course because of outstanding criminal proceedings or an outstanding decision on
whether or not to prosecute. Much useful work to understand and learn from the features of the
case can often proceed without risk of contamination of witnesses in criminal proceedings. In
some cases, it may not be possible to complete or to publish a review until after
Coroners’ or criminal proceedings have been concluded but this should not prevent early
lessons learned from being implemented.

6. An Overview of the Domestic Murder Analysis

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

6.2. In 73% of the cases, there was a recorded or reported history of domestic violence. It
must be borne in mind that this figure, however, would probably increase given that it was felt
that not all agencies shared the relevant information with the review panel. Furthermore, risk
factors were present although not identified at the time. In these cases the police, along with a
number of other agencies, appear to have fallen somewhat short in terms of identifying the
‘true’ level of risk posed to the victim and family. The main problem with lethality centres on
gaining all the information in a timely fashion as well as accurate information about the
context and behaviour along with understanding what constitutes ‘risk’. It is very difficult to
risk assess and risk manage when there are information gaps or the information is inaccurate
or misleading.

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

6.4. One of the recommendations consistently highlighted by the borough panels, was the
need for a corporate risk assessment tool/model across the MPS and partner agencies.
Practitioners need to start using a common language when talking about risk.
6.5. The need for a Risk Assessment Model also became apparent from the domestic violence sexual assault and serious incident analysis. It became clear that there were risk factors present in cases but they were not being identified locally due to insufficient guidance and research: this situation was further compounded by not being able to gain a holistic picture of the context of the violence. This was highlighted as a practice/policy issue in the first instance.

6.6 Factor Analysis (n=30)

**Vulnerability**
- In two cases (7%) the victims were children.
- Five cases (17%) involved elderly victims.
- Fourteen cases (47%) involved cultural issues/sensitivity.
- Twelve cases (40%) it was recorded that the perpetrators had ‘mental health’ issues.\(^{10}\)
- In one case (3%) the two victims\(^ {11}\) had mental health issues.

**High risk indicators**
- In sixteen of twenty-one\(^*\) cases (76%) there was an intimate relationship cases involved separation (in four cases the details were not recorded).
- In two out of twenty-one \(^*\)cases (10%) there was pregnancy / new birth.
- Twenty six cases (87%) involved escalation (in one case it was not recorded).
- Fourteen cases (47%) involved cultural issues and sensitivity.
- Twelve cases (40%) involved stalking (in one case it was not recorded).
- Two cases (7%) involved sexual assault\(^{13}\) (in seventeen cases it was not recorded).

**Context of the argument preceding the murder**
- Fourteen (47%) argued about separation (with issues of child custody and sexual infidelity/jealousy also featuring strongly).
- In two cases (7%) the argument was solely about child contact/custody.
- In one case (3%) the argument was solely about perceived infidelity.
- In seven cases (23%) there were mental health issues.
- In one case (3%) the motive for murder was that one cousin found out that the other cousin had previous convictions for sexual assault (there was no history of DV).
- In five cases (17%) no information was recorded about the events leading up to the murder.

\(^{10}\) In some cases it was recorded in the review report and obtained from the murder investigation. In others, it was known and recorded in a psychiatric assessment or within the ‘Serious Untoward Incident inquiry’.

\(^{11}\) An elderly couple asked their son to kill them both due to deteriorating health.

\(^{12}\) N=21 when counting intimate relationships (present or past).

\(^{13}\) Officers will only know if a factor has been occurring if it is disclosed to them or if they ask a question about it. Some factors may have been occurring, but those conducting the review may not have been aware of it. For example, with regards to sexual assault we do not know how many women who have been killed by partner have been victims of partner rape. I would suggest it is a lot more prevalent than is reported and recorded by police. It is certainly is a high-risk indicator for serious injury and serial abuse.
Children

- In thirteen cases (43%) there were children resident at the home address.
- In nine cases (30%) the children actually witnessed the murder.

Other factors

- Sixteen offenders (53%) had previous convictions for other offences ranging from drugs to offences against the person.
- Thirteen offenders (43%) had also been violent to other people, which did not always result in a conviction (in eleven cases it not recorded).
- Only two offenders (7%) had previous convictions for DV: GBH sentenced to six months; ABH sentenced to three months.
- In three cases (10%) there was intelligence recorded regarding DV on previous girlfriends.
- Two offenders (7%) committed the murder when on bail.
- One victim (3%) had an injunction out against offender at time of murder.
- Three offenders (10%) had just come out of prison.
- Seven victims (23%) had previous convictions for offences ranging from theft to drugs.
- In twenty-two cases (73%) there was a previous history of DV (in one case it was not recorded).
- In fourteen out of twenty-one cases (67%) the offenders exhibited jealous and controlling behaviour (in six cases it was not recorded, in ten cases it was not applicable as a factor)\(^\text{14}\).
- Twelve offenders (40%) abused alcohol/drugs\(^\text{15}\) (in eleven cases it was not recorded).
- In only four cases (13%) risk assessments were undertaken.

‘Honour Killings’

- This has been identified as an issue meriting further research and analysis from the murder reviews.
- An ‘honour killing’ can be triggered from a range of actions: women exercising their right to choose a spouse, seek a divorce, or engage in any behaviour which breaches family or community norms, in particular sexual conduct.
- Practitioners and academics have yet to come up with a more appropriate and shared name/label for this type of killing, or a common definition. It must be emphasised that there is no ‘honour’ in murder.
- Working with community partners is a key requirement in identifying good practice when dealing with these cases.

\(^{14}\) Predominantly the mental health cases involved three sons killing their mothers, a carer killing their partner, a daughter-in-law killing her mother-in-law. One cousin also killed the other, a new partner killing the old partner and a new drug being tried resulting in suicide/homicide. There were no previous reports of DV in the last case.

\(^{15}\) It was not qualified within the review reports how often/frequently the abuser was drinking or taking drugs.
A specific group chaired by Commander Baker has been set up in London to tackle this very issue. A work plan is currently in progress.

*Family wipe out* or *Homicide-Suicide*

- Two cases (7%) involved the offender killing members of the family and then himself.
- One case (3%) involved the offender killing members of the family and then attempting to kill himself.
- This has also been identified as a special form of domestic violence and is being closely monitored and analysed to unpick the dynamics of this phenomenon.
- It is perpetrated by men and tends to occur at the point of separation. The notion of *'If I can't have you, no-one can'* features strongly throughout these cases. Offenders who are suicidal can quickly turn homicidal. The two are inextricably linked.
- Further research could look at whether there are links between mental health issues, depression and suicide/homicide in particular.
7. Emerging Findings and Recommendations

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

7.1.1. At the inception of the project, many borough review panels requested on site presentations regarding the process of multi-agency domestic violence murder review. The majority of boroughs also called up with questions about the process and protocol to completing a murder review. This was resource intensive for the three officers involved in the project. In response to the demand, a template for murder review and a fact sheet of the most commonly asked questions and answers was produced to help practitioners.

7.1.2. There were also additional issues, given that there were no extra resources available for the panels to complete the reviews. This was in terms of who would chair the panel, who would compile the report, who would pay for the administration and the practitioner's time in order to attend the review, refreshments and so forth. Therefore, the panels who have conducted the murder reviews should be commended given the limited resources at their disposal.

7.1.3. Due to the fact that the reviews were undertaken on a voluntary basis, many took a long time to be undertaken and completed. Ensuring the reviews were being undertaken and continual chasing of the reviews reports was resource intensive at times.

7.1.4. Initially it was stated that the reviews should be completed within one month of coming to the attention of the BDVF chair. However, via monitoring of the process and discussions with the practitioners, the time scale of three months appeared to be more realistic for completion of the review reports. Hence the time scales were amended accordingly.
7.2. Multi-agency information sharing: is it working?

7.2.1 On first appearance (see Table 1) it seems there has been compliance regarding sharing and disclosing information for the reviews. However, this is misleading. It was felt by many of the panels that where agencies replied stating that they did not have information, that this was not always the case. This was thought to be true of Health and Social Services in particular, but not just these two agencies exclusively.

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

<table>
<thead>
<tr>
<th>Agency</th>
<th>Attended or replied to Murder review request for information</th>
<th>Failed to attend, reply or disclose information to the review</th>
<th>Not asked to attend or supply information to the review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent (%)</td>
<td>Number</td>
</tr>
<tr>
<td>Health (PCT)</td>
<td>18</td>
<td>60</td>
<td>6</td>
</tr>
<tr>
<td>GP</td>
<td>5</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Social Services</td>
<td>23</td>
<td>77</td>
<td>7</td>
</tr>
<tr>
<td>Probation</td>
<td>6</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Education</td>
<td>13</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>Housing</td>
<td>17</td>
<td>57</td>
<td>9</td>
</tr>
<tr>
<td>CPS</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CPU Police: relevant where children present at the home address</td>
<td>2</td>
<td>15</td>
<td>4</td>
</tr>
</tbody>
</table>

7.2.2. Until specific guidance is given by the government regarding information sharing, risk assessment and murder review, this will continue to be problematic. MAPPA guidance already exists and should incorporate this area of work, however, it must be made more specific to cover murder review and risk assessment and be put on a statutory footing.

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

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

7.2.5. Several boroughs recommended that independent advocates should provide a 24-hour service to victims. This is due to the fact that accessing services is currently a lottery, with staff acting as gatekeepers filtering victims out and not explaining to them what their entitlements are.
7.2.6. The holistic picture of the chain of events and antecedents to murder normally becomes apparent at the trial. It is vital that this information is used to maximum benefit when learning how to develop and improve safeguards for victims. **There should be a mechanism nationally to share information about potential child protection (and domestic violence) issues arising from information available to a court in a criminal trial.** The information should be fed back to child protection (and domestic violence) agencies after the trial.

7.2.7. Forums could conduct regular inter-agency reviews of victims identified as being at serious risk. **Offenders should be referred to the monthly MAPPP meetings.** Agencies know which cases they will be discussing in advance of the meeting to enable them to conduct the research prior to attendance. Information can be shared under ‘serious risk to life’ and a series of solutions should be sought according to the needs of the victim.

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

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

7.3. **Health**

7.3.1. Health do not seem to be active and consistent members of the Borough Domestic Violence Forum (BDVF).

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

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

7.3.4. Early warning signs and symptoms of domestic violence will continue to go unrecorded until nurses, health visitors, GPs etc are taught to include these in their observations, particularly health visitors when they visit early post natal mothers. Risk assessment must be undertaken. Information must be shared appropriately and
joint intervention and management strategies put into place to protect women and children.

7.3.5. Health visitors should have a checklist/risk assessment to pick up early signs of domestic violence when visiting early post-natal mothers. All visits to clients by health workers should be fully documented by the health worker, including suspicions of domestic violence.

7.3.6. The Primary Care Trust (PCT) for child protection should increase the awareness about domestic violence.

7.3.7. Health Trusts should review their information sharing practices. There is a need for a more co-ordinated approach for medical staff to inform Social Services / Police when dealing with victims of domestic violence suffering from serious injury. It has been recommended that when victims present themselves to health practitioners, medical staff should consider support for victims and ensure that the victim is aware of Refuges'.

7.3.8. Once health practitioners are aware of a ‘serious’ injury in domestic circumstances, they should then refer to Social Services Duty Officer. This will also enable support services and plans for re-locating victims to be put in place at a far earlier and crucial stage.

Cases where mental health is identified as an issue

7.3.9. Whilst assessing the care and mental state of the patient\textsuperscript{17}, continual and dynamic risk assessment should be undertaken, taking into account the risk posed to their family in parallel to that of the patient’s health.

7.3.10. If there is knowledge that a patient is abusing controlled drugs, intervention and drug counselling initiatives should be triggered.

7.3.11. In cases where patients are unwilling to comply with medication, they should be seen by medical and nursing staff on a more frequent basis to monitor their progress. The issue of balancing patient choice with safety and security should be carefully considered during the Care Planning Process. When patients refuse help, all decisions and discussions with patients should be recorded.

7.3.12. Trusts have an overriding duty to prevent harm to others if there is a significant risk over and above the respect for patient’s autonomy and right to consent/refuse to treatment (Human Rights Act 1998, Article II: Right to Life). The patient can only make a sound judgement if they have all information. Some Trusts put the patients’ rights first.

7.3.13. Trusts should pay more attention to what the family/carer is saying about a patient and the impact on them, rather than ignore their pleas for help or not take situations seriously. Risk assessment is crucial and should always be conducted.

\textsuperscript{16} This may be due to hand-held notes. However, suspicions relating to the presence of domestic violence should be recorded.

\textsuperscript{17} This is in the context of the perpetrator but should also apply to others as well.
7.3.14. Mental Health Services should adopt a policy of sharing information with the CSU in relation to risk assessments in mental health cases involving dangerous and violent offenders. Once a decision has been made to return a family member to the home or to live with another, there should be immediate liaison between the agencies. This should help ensure that the CSU are aware of vulnerability issues. **A joint strategy can then be adopted to monitor the impact on the family and intervene if appropriate when risks are identified.**

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

7.3.16. The need for senior management involvement in negotiations is helpful to ensure the transfer of care is completed speedily. This has been identified as a priority by one reviewing Health Board and they have put training in place to ensure there is no re-occurrence of such an incident.\(^{18}\)

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

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

- Start truanting at school in early adolescence, suspension and exclusion follows due to anti-social behaviour and violence at school;
- Alcohol and drug misuse/abuse;
- Violent offences and involvement with the Police. Mental health assessments follow and they are admitted as in-patients;
- The patient is returned home and discontinues their medication. This is flagged up by the mother to the Mental Health Team, but the need for medication and taking of the medication is not reinforced by the Mental Health Team;
- Start abusing drugs/alcohol again, have violent outbursts and become withdrawn;
- The mother calls for assistance and for a mental health assessment to be undertaken stating they cannot cope and their sons’ mental health is deteriorating;
- Lack of joined up working and service provision;
- Lack of multi-agency decision making and risk management strategies and police not notified when/if the patient has been classified as ‘dangerous and violent’;
- Murder of the mother by the son.

\(^{18}\) Although similar issues were identified in two other murders across different Health Trusts.
7.3.19. In each case a ‘Serious Untoward Incident Inquiry’ has been triggered and the recommendations have been very similar in each Inquiry. A holistic approach is required when disseminating those and future lessons across all Trusts and practitioners working the field of domestic violence.

7.4. General Practitioners (GPs)

7.4.1. GPs refused to attend in 73% of cases. Historically and anecdotally, this has always been flagged as a contentious area regarding the lack of information sharing.

7.4.2. It is crucial for GPs to participate in the reviews. There is an overwhelming reluctance for them to involve themselves when they often hold a lot of information about domestic violence victims.

7.4.3. Comprehensive guidance is available to GPs regarding information sharing. However, there appears to be a very apparent lack of compliance, with GPs possibly not knowing where/how to access this guidance.

7.5. Social Services

7.5.1. Social workers are not always participating in the murder reviews. In 23% of cases, they refused to share information with the review panel. Even when Social Services do respond with information, some panels feel that on occasion they might be withholding information.

7.5.2. Social workers in certain boroughs frequently state that it is problematic to retrieve information from the archive system.

7.5.3. Social Services should risk assess child case conferences and have an exit strategy for the family members involved. Risk assessment should not be solely based on previous meeting outcomes as things may have changed since then.

7.5.4. Social Services need to develop ways of managing high-risk family conferences and creating a safe environment (namely ensuring uninvited parties do not participate).

7.5.5. In conjunction with the CPUs, Social Services should devise a way of effectively sharing information and updating on changes. The supervisor should ensure that notification occurs.

7.6. Probation

7.6.1. Probation were not invited to attend the majority of reviews (70%).

7.6.2. When Probation are asked to prepare a pre-sentence report regarding offenders’ appearance at Court, officers should make concerted efforts in every case to locate the offenders in order to do so.

7.6.3. Judges should wait for the report prior to sentencing in order to be able to make informed decisions.

7.6.4. There should always be a pre-release risk assessment review in domestic violence cases between Probation, Police and Prisons. The prisoner should always be
contacted to undertake this prior to release. Administrative errors within the prison record system should be rectified. **N.B. Two offenders who had been convicted for domestic violence and served brief sentences for domestic violence on their partners went straight round when released and killed the victims.**

7.6.5. There should be fully evaluated and accredited perpetrator programmes provided to all domestic violence offenders, particularly given that 20-40% of the prison population have a domestic violence background (Probation Offender Assessment Research, OASys). Work needs to be taken forward with some urgency to accredit the programmes.

7.7. **Education**

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

7.8. **Housing**

7.8.1. In 30% of cases, Housing **were not willing to supply information** to the review panel and they were not always being invited to attend the reviews.

7.8.2. Housing should review their procedures for referral to Social Services of families and of vulnerable pregnant women where there are potential child protection concerns.

7.8.3. Housing should establish a procedure for the referral of young women and couples who are offered housing as result of pregnancy or parenthood to the relevant Health Service. Health professionals can then assess whether an appropriate level of support is being offered.

7.8.4. There appears to be failure in the Housing system when identifying those victims who are truly ‘at risk’. An agency should not have someone on the priority list for six months. **The priority list should be regularly reviewed.**

7.9. **Crown Prosecution Service (CPS)**

7.9.1. On occasions, the CPS has discharged serious domestic violence offences when the victim has been reluctant to proceed.

7.9.2. **It should be the duty and responsibility of the state to deal with offenders appropriately when victims are too vulnerable or unable to do so. The decision to charge and prosecute offenders should not be dependent and solely reliant on the victim’s willingness or capability of pursuing the allegation.**

7.9.3. Paperwork seems to have gone missing in some cases hence the CPS representatives have stated that they cannot participate in particular reviews.

7.10. **Police**

7.10.1. **Nine (30%) police investigations of offences prior to the murder lacked positive action.** Suspects should be arrested where sufficient evidence exists to do so. Safety
planning should occur in every case. Form 78s, Non Crime Book Domestic Incidents and CRIMINTs are consistently not being completed for domestic violence incidents. **Control Room and Crime Reports should be supervised properly to ensure compliance with MPS policy.**

7.10.2. **In only four (13%) cases risk assessments were undertaken by police.** All cases should be risk assessed, risk managed and supervised appropriately. A risk assessment should be undertaken regardless of whether there is a prosecution or not.

7.10.3. Offences are not always being flagged as domestic violence, so they cannot be picked up by CSU.

7.10.4. Appropriate cases are not always referred to Victim Support Services (VSS).

7.10.5. Incidents are consistently being treated as isolated incidents rather than considering historical incidents and the pattern of behaviour.

7.10.6. Training is required for first contact officers and Crime Management Unit (CMU) officers. Furthermore, there should be a review of Community Safety Unit (CSU) and Child Protection Unit (CPU) training, given that some of the fundamental lessons have still not been learnt.

7.10.7. **Supervision is lacking at every level, from front line to specialist CSU staff. More stringent supervision of police staff and accountability is required.**

7.10.8. Duplication of Police systems resulting in double/triple keying. There is a very real need to co-ordinate and integrate systems to minimise patrol officers’ time completing reports.

7.10.9. There appears to be duplication of CRIMINTs stating the same information, in the rare event when they are created for domestic violence incidents.

7.10.10. Officers should consider interviews with the extended family when dealing with family violence. This requires better availability of interpreters where there are language barriers. Officers should have access to Language Line. Where they have had access to Language Line, there appears to be a lack of availability of interpreters.

7.10.11. If Police are to increase the trust and confidence in policing amongst ethnic minority communities, they need to improve the support available for communities where there are language barriers.

7.10.12. On occasions, the Murder Investigation Team has held up the review process by delaying dissemination of information pertinent to the review.

7.10.13. CPUs should contribute to the review when children are involved.

7.10.14. Children should not be used as interpreters at the crime scene.

7.10.15. **International police checks should be undertaken on adults from abroad when there are child protection issues.**

7.10.16. Officers should include all information in the report to CPS. In particular, history of offending, allegations, where offender lives in relation to victim, risk assessment, any intelligence and so forth.
7.10.17. Cards should be given to victims listing support groups / agencies details by frontline officers, particularly Refuge/Women’s Aid help line.

7.10.18. Police need to share information with Social Services so individuals / situation can be risk assessed accurately.

7.10.19. If high-risk offenders move geographical areas, the relevant Police Domestic Violence Unit should be informed.

7.11. **Judiciary and Magistrates**

7.11.1. Judges and magistrates should be required to attend appropriate targeted multi-agency training so they get exposure to the issues and complexities surrounding domestic violence. They should be ticketed if they fail to attend.

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

7.11.3. The prosecutor should also have access to any type of documented risk assessment that has been conducted and should be reminded of their rights to appeal bail applications.

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

7.12. **Relate**

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

7.13. **Victim Support Service (VSS)**

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

7.14. **Refuge Provision**

7.14.1. Each refuge has its own policy on older male boys getting into refuges’ with their mothers. The cut off ranges from twelve to eighteen year olds over the sixty-eight London refuges.

7.14.2. One borough review panel raised this as an issue stating that the victim, who had a teenage son, was unable to get into the local refuge. This was problematic given that she had been ostracised from her family and community and it was stated in the report that she had no where else to go, so she returned home. Shortly after this, she was killed by her partner in front of the children.
7.14.3. There should be a better awareness about service access and service provisions available to victims. This would be aided if independent advocates could provide a 24-hour service to victims.

It is interesting to note the profile of domestic murder. The profile in London and the UK is very different from the research produced from the Washington State Fatality Reviews\(^{19}\) where the weapon of choice is a gun. It is also important to understand the profile of domestic murder, particularly when there are issues of ‘staging’. How are victims being killed? Is the most common method strangulation? Does it differ by gender or by relationship type?

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

<table>
<thead>
<tr>
<th>January 1st 2001 – April 6(^{th}) 2002</th>
<th>Total Number of Incidents</th>
<th>Total Number of murder victims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Incidents</td>
<td>Percentage of Incidents (%)</td>
</tr>
<tr>
<td>Shot</td>
<td>2(^{20})</td>
<td>3.5</td>
</tr>
<tr>
<td>Stabbed</td>
<td>15(^{21})</td>
<td>27</td>
</tr>
<tr>
<td>Throat cut</td>
<td>1(^{22})</td>
<td>2</td>
</tr>
<tr>
<td>Pushed through window / down stairs</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Head injuries: implement used or beaten</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Strangled</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Suffocated</td>
<td>3(^{23})</td>
<td>5</td>
</tr>
<tr>
<td>Fire</td>
<td>4(^{24})</td>
<td>7</td>
</tr>
<tr>
<td>Forced drug overdose</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Shaken baby</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Drowned</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Failure to thrive</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Not stated</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>100%</td>
</tr>
</tbody>
</table>


\(^{20}\) Four victims in one family.

\(^{21}\) One incident involved two victims.

\(^{22}\) Pregnant female.

\(^{23}\) One incident involved two victims.

\(^{24}\) Mother killing daughter and then herself.
The process of homicide review has highlighted an inconsistency regarding the commonly held notion that domestic homicide is about strangulation. The information suggests that the most common method of killing is being stabbed with a sharp implement. 15 (27%) victims were stabbed, 11 (20%) died from head injuries and six (11%) were strangled. When adding the data from the next financial year (2002-2003) this pattern remains consistent: 31%, 20% and 10% respectively.

Does the pattern change when looking at relationship, gender and method of killing?
The picture remains fairly consistent\textsuperscript{25}. Men are more likely to stab their (female) current / ex-partners. They are also more likely to kill their (female) current / ex-partners by strangulation. Women are more likely to kill their (male) current / ex-partners using a sharp implement or by causing head injuries.

This outlines the value of a two-pronged approach: murder review and risk assessment. It must be noted, however, that these two approaches must remain dynamic. In time, methods and patterns may change, for example the recent identification of ‘honour killings’ and ‘family wipe out’ which came to notice through the process of murder review. Hence the Risk Assessment Model must be consistently reviewed in order to incorporate new learning as our knowledge base increases as well as new trends/patterns that may emerge in the future.

\[\text{No. of Incidents}\]

\[
\begin{array}{c|c|c|c|c|c|c}
\text{Method of Killing} & \text{sharp instrument} & \text{head injuries} & \text{strangulation} & \text{shooting} & \text{other} \\
\hline
\text{female victim/male suspect} & 2 & 1 & 9 & 0 & 0 \\
\text{male victim / male suspect} & 2 & 1 & 9 & 0 & 0 \\
\text{female victim / female suspect} & 2 & 1 & 9 & 0 & 0 \\
\text{male victim / male suspect} & 2 & 1 & 9 & 0 & 0 \\
\end{array}
\]

\textsuperscript{25} The graph excludes inter-generational murders, i.e. infanticide and killing of a parent by a child. This should be included in future analysis to identify potential patterns or trends in methods.
Table 3: Gender and Method Analysis: January 1st 2001 to April 6th 2002

<table>
<thead>
<tr>
<th>Gender of Victim and Offender</th>
<th>Shot</th>
<th>Stabbed</th>
<th>Throat Cut</th>
<th>Pushed</th>
<th>Head Injuries/Beaten</th>
<th>Strangled</th>
<th>Suffocated</th>
<th>Fire</th>
<th>Forced drug</th>
<th>Shaken baby</th>
<th>Drowned</th>
<th>Failure to thrive</th>
<th>Not stated</th>
<th>Total Number (n=56)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim Female / Offender Male</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Victim Male / Offender Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Victim Female / Offender Female</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>4</td>
<td>(3 sisters killed their sister, 1 daughter-in-law killed mother-in-law)</td>
</tr>
<tr>
<td>Victim Male / Offender Male</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>(not partners)</td>
</tr>
<tr>
<td>Family killed by Male Offender</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Parent(s) killed Female Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td></td>
<td>5</td>
<td>(4 mothers killed daughters)</td>
</tr>
<tr>
<td>Parent(s) killed Male Child</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Parent(s) killed by son</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Parent(s) killed by daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Victim Male / Gender of Offender not recorded</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (granddaughter)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Victim Female / Gender of Offender not recorded</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS:** 2 | 15 | 1 | 2 | 11 | 6 | 3 | 4 | 3 | 2 | 1 | 2 | 4 | N = 56 / 56
9. Risk Assessment and Risk Management:

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

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

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

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

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

Victims who are assaulted whilst pregnant or when they have just given birth should be considered as high risk. This is in terms of future harm to them and to the child. The Violence Research Programme also found that 2.5% of pregnant women (892 women took part in the research) had experienced an assault during the current pregnancy and the lifetime prevalence of assault was 13.4%. Further, women were ten times more likely to experience domestic violence in the current pregnancy if they had also experienced domestic violence during the last 12 months (Mezey, 2002).
Pregnancy was seen as an opportune time to ask women about domestic violence as some women commented that it made them think seriously about their future and how their children might be affected in the long-term (Mezey and Bewley 2000). Women say they would not voluntarily disclose domestic violence to a health professional without routine screening.

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

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

4. Cultural issues and sensitivity
There is a need for cultural awareness and sensitivity when dealing with ethnic minority victims. Organisations often make assumptions about victims from minority ethnic communities based on their lack of understanding around cultural issues. This can lead to an unwillingness to intervene in cases of domestic violence. Police must increase the trust and confidence in policing amongst minority ethnic victims. There may be an issue of perceived racism, which is preventing the victim from seeking help. Needs may also differ and centre on language, cultural, immigration and/or structural issues. 47% of cases reviewed involved cultural issues and sensitivities (MPS/URHC Domestic Violence Murder Review Analysis, 2003).

For example, in some cases if an Asian victim leaves her partner then he, friends, family and the community at large may exclude her or force her to return home. This means she may face being ostracised or, in extreme cases, tracked by bounty hunters or family members via networks in the widespread yet tight-knit Asian Community. Issues of shame and honour, the total acceptance of patriarchy and rigid gender roles can combine lethally to raise unique risks and barriers for some Asian women. In 'honour cultures', sexual assault and failed

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26 This is solely an example to depict the context and meaning of cultural issues. However, it is not unique to the Asian community but can also apply to many communities, for example, Turkish, Kurdish, African, Middle Eastern, Afghani and Eastern Communities.
marriages are seen to dishonour not just the woman or girl but the family as well (Hayward 2000).

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

Further questions should be asked of victims who are particularly vulnerable or socially isolated in terms of:

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

**5. Stalking**

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

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

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

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

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

9.2. Risk Management: RARA

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

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

Domestic violence is a primary health care issue as well as a social and human rights issue. It is a criminal offence and should be treated as such in every case. It must be ‘criminalised’ in the same vein as drink driving and treated as serious crime by the government and Criminal Justice system as a whole.

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

The Crime and Disorder Act 1998, for local police authorities and others to develop effective strategies for tackling crime, should have already created an opportunity for developing measures for improving women’s safety in which multi-agency forums can be involved. However, the murder reviews have highlighted the fact that information sharing is not occurring across the board, with many agencies refusing to participate in the murder reviews.

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

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

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

The two-pronged approach of murder review and risk assessment has already showed its value. This is in terms of learning the lessons about the antecedents to domestic murder, identifying risk factors, highlighting the realities and practicalities of information sharing and pinpointing potential ways to facilitate better multi-agency working to ensure better safeguards for victims in the future. This new approach to crime prevention needs to be mainstreamed and employed to enhance policing and multi-agency partnership in the 21st century. The risk factors identified from the reviews, supported by the domestic violence sexual and serious assault analysis should be disseminated to all those working with victims of domestic violence.

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

The recommendations from the reviews have been accepted and are to be taken forward by each agency on a local level. In terms of policing, the recommendations are being taken forward by Detective Chief Superintendent Rod Jarman from the Diversity Directorate for consideration at the MPS Management Board. There are also implications for implementation and compliance with the National Intelligence Model (NIM).

The findings have also been shared with Assistant Chief Constable Jim Gamble, the ACPO DV portfolio holder. They will also be discussed with the Solicitor General Harriet Harman MP for consideration on a wider basis across the agencies. The MPS has been the driver for this project work. However, specific guidance is now needed from the responsible ministry at the national level. This report has also been submitted as part of a response to the Safety and Justice consultation paper (June 2003) as well as the Children’s Green paper published by the government. The analysis of the findings from the murder reviews, as well as the domestic violence sexual and serious incident analysis provides a substantial evidence base that should enable the Government to make decisions regarding the Domestic Violence Bill.

Yet to be published.
11. Appendices

1. Appendix I: List of members of MPS pan London Domestic Violence Working Group

2. Appendix II: List of members of Strategic pan London Murder Review Group

3. Appendix III: MPS Domestic Violence Risk Assessment Model

4. Appendix IV: Tactical Menu of Options for Domestic Violence offenders and victims

5. Appendix V: Guidelines for Multi-agency Domestic Violence Murder Reviews

6. Appendix VI: Domestic Murder by Borough: January 2001-June 15th 2003 Borough Codes in MPD

7. Appendix VII: Glossary of Terms