

Centre for Women's Justice submission to the VAWG Strategy call for evidence

19 Feb 2021

Summary

Centre for Women's Justice (CWJ) is a lawyer-led charity focused on challenging failings and discrimination against women in the criminal justice system. We carry out strategic litigation and work closely with frontline women's sector organisations on using legal tools to challenge police and prosecution failings around violence against women and girls.

This response to the call for evidence is limited to a number of issues on which CWJ has carried out detailed work, and two wider topics we wish to highlight. We strongly support the joint principles for the VAWG strategy which have been presented on behalf of a large number of women's sector organisations.

Our submission has four sections, three within this document and one in a separate document. There are also links to some of our other published work and some appendices, all of which we invite you to consider as part of this call for evidence.

Section 1: Failure to implement the law in VAWG cases so that legal measures are not translated into improvements for women and girls on the ground (p.2)

Our over-arching submission is that the failure to implement many of the laws on VAWG is the single largest failing creating a huge gap between policy and practice. We will then refer to a number of areas of CWJ's work:

- a) Our police super-complaint on systemic failure to implement protective measures – link provided to our super-complaint report.
- b) Our work on charging in rape cases – link provided to the Shadow Rape Review report prepared by us in conjunction with other second tier women's sector organisations.
- c) Misapplication of the law on corroboration, primarily in sexual violence cases but also in domestic abuse – our overview report is appended.
- d) Failure to incorporate the online harms identified in the VAWG strategy within the criminal injuries compensation scheme (CICS) – our response to the CICS consultation of October 2020 is appended.

Section 2: The need for the Domestic Abuse Commissioner to establish a post-death investigations oversight mechanism in VAWG cases (p.8)

This is based on the work of CWJ and others within the Femicide Working Group, which is a coalition of specialist NGOs and lawyers who support and represent bereaved families in post-death investigations, including inquests. This submission includes five detailed case studies.

Section 3: The need for disaggregated data on male victims and female offenders in VAWG cases (p.18)

This was absent from previous VAWG strategies and the reasons why it is required are addressed, with links to our work in Section 4 below.

Section 4: The criminalisation of survivors as a result of their experiences of VAWG (separate doc)

This issue was not adequately covered within the previous VAWG strategies and arguments in favour of addressing this are set out, along with evidence and recommendations. This is in a separate document attached, which also contains two appendices. Section 4 also includes a link to CWJ's recently published research report on the criminal justice response to women who kill their abusers, which forms part of our response to this call for evidence.

Section 1

Failure to implement the law so that legal measures are not translated into improvements for women and girls on the ground

Our overarching concern is the implementation gap between legal measures introduced and the realities on the ground. Since the first VAWG strategy in 2010 a raft of measures have been introduced in a range of legislation. However, statutory provisions and strategies are not an end in themselves, and there is little purpose in adding more powers and laws to the statute books if they do not impact on the lives of women and girls.

The last VAWG strategy in 2016 followed the prosecution figures for 2014/15 which present a high-water mark in the criminal justice response to VAWG. That strategy confidently asserted that outcomes by 2020 would include increased victim confidence in and access to the criminal justice system, continued increases in prosecution and an embedded robust approach to tackling perpetrators. What we have seen since 2016 is the reverse of this and the sharp decline in prosecutions bears this out.

CPS figures for the five years from 2014/5 to 2018/9 show that:

- In domestic abuse cases the number of cases referred by police dropped consistently, the number of cases charged dropped from 85,000 to 67,000,

the number of convictions dropped and average time to charge almost doubled

- For rape the position is even starker as the number of cases charged plummeted from 3,648 to 1758 (a reduction of 52%) and the number of cases referred by police to CPS dropped from 4,104 to 3,375 (an 18% reduction), whilst reports of rape have soared during over these years so the proportions resulting in referrals and charges have dropped even more steeply

Levels of reporting of VAWG have increased over this time, partly due to greater public awareness, but this has contributed to a system under strain without the resources to respond. There are high levels of attrition, which frontline women's services tell us often results from survivors experiencing lack of support and long delays and losing faith in the criminal justice system. We do not have national figures but are aware that in some areas the proportion of domestic abuse cases closed because "victim does not support" has risen steeply.

Examples of lack of implementation of VAWG measures introduced over the past decade include the following:

- The most recent available statistics show that Domestic Violence Protection Orders (DVPOs) are used in only 1% of domestic abuse crimes¹. Without proper funding and training the new Domestic Abuse Protection Orders will meet the same fate and have little impact. Research is needed on why DVPOs have been so little used, but anecdotally we hear that it is due to officers not being aware of them, or seeing them as complex and time-consuming, as well as the expense of court fees. These are issues of training and resourcing;
- Stalking Protection Orders (SPOs) were introduced in January 2020. We have heard from Paladin, the national stalking advocacy service, that they have seen only a small handful during 2020;
- New offences of stalking (both summary and 'either way' offences) were introduced in 2012, however we regularly hear reports that women approach the police with accounts of stalking but no criminal file is opened, and instead they are advised to obtain a civil injunction. The offence under s.4A Protection from Harassment Act of serious stalking without fear of violence is very rarely used in our experience. The Joint Inspectorates' report of 2017 was highly critical of the police and prosecution response to stalking and a Protocol between CPS and police was introduced in 2018, but two years later we continue to hear regular complaints of poor criminal justice responses to stalking;
- Breach of a non-molestation order (NMO) has been criminalised but we hear accounts from frontline domestic abuse workers around the country that police regularly fail to take action on such breaches, either to arrest or charge.

¹ HMICFRS update report on police response to domestic abuse 2019 and Office for National Statistics domestic abuse data tool

This is probably the most widespread complaint we hear from domestic abuse workers;

- The offence of coercive and controlling behaviour is still little used several years after its introduction in 2015. In 2018/19 such cases made up only 1.75% of all domestic abuse prosecutions – 1,177 out of more than 67,000.² Frontline domestic abuse workers tell us that police still primarily focus on cases involving physical injuries;
- Evidence-led prosecutions were presented as an important tool to bring perpetrators to justice where survivors are too frightened or unwilling to co-operate with the criminal justice process. Frontline workers report that they rarely see these, despite the roll-out of body-worn cameras, and a Joint Inspectorate report on this in January 2020 criticised a lack of such prosecutions;
- We hear from support workers that police often do not act on reports of ‘revenge porn’. One solicitor who specialises in bringing civil claims against perpetrators in such cases informs us that policing action is never taken in his client’s cases;
- The wide variation in recording, arrest and charge rates in domestic abuse cases between different police forces demonstrates an unacceptable lack of robustness in police responses in some areas. For example, West Yorkshire Police recorded almost three times the rate of domestic abuse-related crimes as Surrey Police.³ Arrest rates in domestic abuse cases were almost three times higher in Lincolnshire than in Hampshire and charge rates in Cumbria were four times those in Hampshire.⁴ In its last progress report on policing of domestic abuse HMICFRS expressed concern about the enormous disparities between rates of cases closed because “victim does not support” between forces.⁵ Rates ranging from 15% to 58% in our view indicate vastly different service provision to survivors between forces, as we know from frontline support workers that poor police response increases attrition rates.

CWJ carries out training for local domestic abuse and sexual violence services around England and Wales. Over the past two years we have trained over 40 organisations at 32 training days and remote training programmes (during lockdown) in London, the Midlands, North East and North West of England, North and South Wales and the South East. Our experience is based on discussions with the frontline support workers who take part in our training, as well as legal enquiries we receive from them.

Domestic abuse workers report that not only have things not improved but they have seen a deterioration in the criminal justice response over recent years, the period covered by the last VAWG strategy. In particular, we hear that in many police forces specialist or dedicated domestic abuse units have been disbanded or are so small

² CPS VAWG report 2018/19

³ 2019/20 Office for National Statistics domestic abuse data tool

⁴ HMICFRS update report on police response to domestic abuse 2019

⁵ Ibid

that they only deal with the most serious cases. Most routine cases are dealt with by generalist officers with little understanding of VAWG and little knowledge of the specialist tools available. In areas where most of the work is carried out by a specialist police domestic abuse unit we hear much better feedback from support workers. At one service support workers described how, when they feel especially frustrated by the poor response of a generalist frontline officer, they contact their force's specialist unit (which handles only a small minority of cases) and ask them to intervene. With such a vast array of new offences and powers it is not surprising that generalist officers are unaware of how to provide a high-quality response. They may have had no training on domestic abuse, or such training is just a small part of a huge range of training they receive on all the various crime types they deal with. Specialist tools for addressing VAWG, such as DVPOs and SPOs, may be off their radar, or they do not have the confidence or the resources to use them. There is also a problem with myths and stereotypes that need to be addressed through education and culture-change. Delivering a high-quality response to VAWG which utilises the complex raft of powers available requires skilled trained officers.

We believe that the use of generalist officers is a key reason for the implementation gap for many of the new offences and powers introduced over the last decade. We presume that this stems from cuts in funding. We believe that chronic under-resourcing is primarily responsible for the implementation failure, both because we hear that officers struggle to deal with huge caseloads, so it is unsurprising that they are not interested in using all available tools to tackle VAWG, and because culture change within the criminal justice system requires financial investment. A poor service impacts directly on levels of attrition and outcomes generally, as well as women's safety. A poor service also fails to provide a deterrence and allows continuing high levels of abuse, violence and homicide. Under-resourcing at a time of rising reporting rates also creates a powerful incentive to under-charging, as staff cannot cope with increased case numbers. As far as we are aware, the 20,000 new police officers promised by the current Government does not include any ring-fencing for VAWG cases. We also note that only about half of the police forces in England and Wales take part in the "DA Matters" training provided by Safelives. This should be mandatory, and indeed there should be training on all aspects of VAWG with input from women's sector specialists.

For these reasons the VAWG strategy must be underpinned by a commitment to implementation, especially:

- a) Fund criminal justice agencies effectively**
- b) Create specialist dedicated police units**
- c) Invest in training of police and prosecutors**

Without this the VAWG strategy risks being little more than empty words that do not make a significant difference to the lived experience of survivors.

In this context we also mention that in areas that have specialist domestic violence courts we hear far better feedback from frontline domestic abuse workers. It is only through creating specialist pools of knowledge and practice within the criminal justice system that the various tools introduced to combat VAWG will be used effectively. We are also heartened by the Government's agreement to introduce a new stand-

alone offence of non-fatal strangulation, however without effective implementation this could be another power that sits on statute books unused. Over 20,000 women per year report non-fatal strangulation⁶ so this should be a high-volume offence, not a niche measure used in isolated cases.

Further work by CWJ illustrates implementation failures:

a. Systemic failures in use of protection orders

In March 2019 we submitted a police super-complaint about the systemic failure to use protective measures, namely bail conditions, enforcement of breaches of NMOs, use of DVPOs and restraining orders: <https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5c91f55c9b747a252efe260c/1553069406371/Super-complaint+report.FINAL.pdf>. This is still under investigation, however the issues on pre-charge bail have been addressed by the Home Office bail review and fresh legislation is expected shortly. There is agreement across the board that the law on pre-charge bail which came into force in April 2017 was misconceived and dramatically reduced protections for survivors of VAWG. That legislation was passed by Parliament during the period of the last VAWG strategy without securing any input from women's sector organisations or from any victim's groups during the consultation process. The VAWG strategy failed to reach relevant parts of Government.

b. Catastrophic failures in rape charging

CWJ provides training to Rape Crisis Centres and other specialist organisations providing support to victims of rape and other serious sexual offences. We receive a large number of requests for assistance from those organisations and others in relation to failures in the criminal justice system around the investigation and prosecution of these offences. This is hardly surprising when we see the statistics showing a deteriorating situation in this area which has led many to describe it as an effective decriminalisation of rape.

In March 2019 the Government announced a comprehensive 'end to end Rape Review' to examine what is happening at each stage of rape investigation from report to court. The review is yet to be published, but in the meantime CWJ joined with End Violence Against Women, Rape Crisis England & Wales and Imkaan to produce our own Shadow Rape Review: <https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/C-Decriminalisation-of-Rape-Report-CWJ-EVAW-IMKAAN-RCEW-NOV-2020.pdf> This 200-page report looks at what is going wrong and makes recommendations for improvement. CWJ's contribution focuses on the law and includes an analysis of what is wrong legally and why women are being

⁶ Safelives have calculated this figure from their records which show that 37% of survivors assessed as high-risk who report physical abuse have experienced strangulation, suffocation or attempts at this.

failed. We have included within this report a summary of evidence we gathered for a judicial review of the Director of Public Prosecutions about an unlawful policy on rape charging, which was heard by the Court of Appeal in January 2021 (judgment is awaited). The Shadow Rape Review also includes an analysis of our criticisms of the disproportionate downloading of digital data when women report rape and other sexual offences, which was the subject of a separate legal challenge by CWJ. We would invite those considering this consultation to consider the full report as part of the evidence for the VAWG strategy.

c. Misapplication of the law on corroboration

CWJ assists in a large number of Victim's Right to Review requests, mostly in rape and other sexual offences, but also involving domestic abuse and other VAWG cases. We frequently see cases closed by the police without referral to CPS on the grounds that there is no corroboration and that the case is "your word against his" and therefore the case cannot proceed. This is a fundamental error of law, as section 32 of the Criminal Justice and Public Order Act 1994 abolished the need for corroboration. We are appending a separate overview document that CWJ has prepared to highlight this issue, which has been presented to policing bodies in London with a dossier of cases.

d. Failure to incorporate the online harms identified in the VAWG strategy within the criminal injuries compensation scheme (CICS).

The previous VAWG strategy rightly treated online harms clearly as part and parcel of VAWG and we anticipate that the same approach will be taken in the new VAWG strategy. However, we wish to highlight how this approach is not reflected in an important Government scheme relied upon by survivors, the CICS. The definition of "crime of violence" which identifies who qualifies for the scheme excludes online child grooming cases. For example, we are aware that where a child is groomed online and manipulated into sending explicit pictures of herself to an older man this can result in a conviction for a serious offence. It can also have a devastating impact psychologically on the young victim. However, in such a case the Criminal Injuries Compensation Authority refuses compensation on the basis that there is no "crime of violence" because there was no physical contact. This applies to other online abuse situations. The "crime of violence" definition is not fit for purpose and should be revised so that the CICS dovetails with the Government's VAWG strategy and to reflect the serious impacts that such offending has on the mental health of survivors. We addressed this in more detail in our submission to the consultation on CICS in October 2020, a copy of which is appended (see page 13).

Section 2

The need for a post-death investigations oversight mechanism

It is well known that on average two women a week are killed in the UK by a current or former partner, and whilst the figures appear to have dropped slightly over the past decade⁷ they remain stubbornly high. Alongside concerns about lack of implementation of legal tools, we are concerned about a failure to implement the lessons learnt and the fruits of the many investigations conducted into these homicides. A broad range of agencies and formats now exist for investigating deaths yet there is no over-arching mechanism for drawing their many conclusions and recommendations together. Many valid recommendations seem to disappear into the ether and there is no process to ensure they are followed through into real change on the ground.

We owe it to the families who have lost loved ones to ensure that their experiences help prevent future deaths, and the recommendations made would not only prevent deaths but improve the experiences of those many survivors who do not lose their lives, as the fatal cases represent the tip of an iceberg. Whilst not all deaths can be prevented, we would expect a greater reduction following a decade of new legal tools, and we believe that many lessons from fatal cases are not currently feeding back into improved practice. Domestic homicides have become normalised, our society would not tolerate this number of deaths from terrorism every week. We need to invest in more effective systems, and also ensure that the considerable resources that already go into these investigations do not go to waste. The current lack of an over-arching system means multiple missed opportunities. This submission provides just a few illustrations drawn anecdotally from a limited pool of cases, and there will be many more. We focus on criminal justice issues as that is our area of specialism at CWJ.

The Domestic Abuse Commissioner is keen to utilise her role to establish a post-death investigations oversight mechanism that spans the range of investigations that currently exist, draws together common themes, and works with public bodies around implementation. This submission will address why it is essential that this role goes beyond Domestic Homicide Reviews and illustrates how the current systems fall short in translating failings that have been identified into changes which impact on the lived experience of survivors.

The limitations of Domestic Homicide Reviews (DHRs)

DHRs play a valuable role in examining in detail the circumstances surrounding a death and very often important recommendations are made. We do not deny their validity but wish to highlight why there are inherent limitations in the DHR model so that it is essential that any oversight role goes beyond DHRs and includes other investigations that take place alongside or following on from many DHRs, in

⁷ [Office for National Statistics](#) figures (England and Wales only) show a slight decline, whilst those of the [10 year Femicide Census](#) (UK-wide) do not, each is calculated with different parameters

particular investigations by the Independent Office of Police Conduct (IOPC) and Coroners' inquests.⁸

The DHR process is a paper exercise that is based on reports (known as IMRs) provided to the DHR panel and Chair by each public body concerned, summarising its own involvement in the death. Whilst many IMRs are self-critical and provide valuable insight, there is nothing to prevent public bodies from presenting the information in a way that suits them, and information can be omitted, either deliberately or due to lack of rigorous searches. The panel and Chair have no way of going behind the information provided in the IMR, and it is rare for them to see primary materials. In contrast, an IOPC investigation examines all the primary materials, for example officers' notebooks, risk assessments, computer records of checks made on force databases, and IOPC investigators may interview officers to explore their accounts, sometimes in interviews under caution where there is potential misconduct. Inquests go even further as live evidence is heard from police officers and other staff of public bodies, they can be questioned at length by barristers acting for the family of the deceased, following extensive pre-inquest disclosure of documents to the family's lawyers. Families can, and often do, raise fresh matters which are explored by the Coroner which were not considered by the DHR. The findings at an inquest can go far beyond those of the DHR.

In addition, whilst many DHRs do set out criticisms of public bodies and other agencies, we have also heard concerns from some panel members and DHR Chairs about a lack of independence of DHRs. We have heard that in many cases Chairs are former police officers who carry out large numbers of DHRs for the same Community Safety Partnership (CSP) and almost all those on the panel are in one form or another on the payroll of the local authority associated with the CSP, creating a culture that resists criticisms and recommendations for change. We know independent panel members who have felt under pressure not to raise criticisms and when they have done so have been disinvited from panels. We also know Chairs who have faced considerable resistance from public bodies to having certain recommendations included in their reports, and felt that if they do not 'tow the line' they may no longer be commissioned to carry out DHRs in future.

It is therefore essential that the Domestic Abuse Commissioner's office is resourced to extend its work to cover a range of post-death investigations beyond DHRs, in particular IOPC and inquest outcomes.

We refer to the cases of Anne-Marie Nield and MV below, which illustrate the limitations in the DHR process raised here.

DHR oversight

The arrangements that currently already exist for an overview of DHRs are not effective in bringing about systemic change and improved practice. The Home Office have produced two overview reports on DHRs, one in 2013 and one in 2016. The 2016 report contains a statistical summary of common themes emerging from DHRs, however the data is analysed at a very high level of generality resulting in superficial

⁸ Other relevant investigations include local authority Safeguarding Adult Reviews, Serious Case Reviews, NHS Serious Incident Investigations and internal investigations and disciplinary hearings for example within the Probation Service, CPS and police forces

conclusions. For example, findings are clustered into categories including failures with record-keeping, failures in communication and information sharing, issues with organisational policies, failings in individuals' competence. A great many of the actions simply consist of broad statements, such as "the need to improve awareness of domestic abuse" and the "need to support improvements in responses" which have little practical implications. The section on issues with agencies' organisational policies simply identifies that there were 19 DHRs which noted either a lack of policy or a failure to understand or apply policy. There is no substantive discussion of any of the content of any of these policies or their practical application.

A shallow overview such as this carried out once every 3 or 4 years is an enormous missed opportunity. A far more meaningful deep dive is required to pull out practical systemic issues and raise them for discussion with national bodies, to explore steps to address them and follow through on sustained change so that the issues identified are translated into improved guidance, training and supervision. For example, we have seen two DHRs which raise a failure by prosecutors to seek a restraining order at the conclusion of the criminal case. This is a systemic failure identified by CWJ in our police super-complaint on protective measures⁹, and we are not aware of this issue being raised at a systemic level previously. In another example, a brief enquiry amongst a handful of DHR Chairs revealed that two had made very similar recommendations about vetting of gun ownership. The case studies below identify several other concrete issues: providing replacement phones to survivors when their phones are handed to police for downloads, ensuring that insecure doors are repaired in high-risk cases, improving the MARAC system. These are all practical and measurable actions.

Furthermore, there is limited follow-up of DHR recommendations to national bodies, so where learning is identified it will often be limited to the local level. We understand that a general recommendation in a DHR report that a large public body, for example the MoJ, should do something often does not elicit any feedback. If the CSP writes to the MoJ with the DHR findings highlighting learning for the MoJ there will be a response, however the family and the CSP will need to chase for updates to find out whether there was follow-through and often this will not take place unless tenacious individuals decide to pursue this. There is clearly a role for the Domestic Abuse Commissioner to establish and follow through lines of communication. We also understand that during the Home Office DHR quality assurance (QA) process, all national recommendations are collated each month and discussed at the QA Panel. A member of that panel has informed us that she does not know if there is any further follow up after that. Again, the Domestic Abuse Commissioner could provide a valuable link between such a process and action by the various national bodies.

Follow-up of inquest and other investigation outcomes

As with DHRs, a huge amount of work goes into the examination of individual deaths, but at the end and once recommendations have been made it is not the job of any of those concerned to do the following up. The investigation team will close the file, the Coroner will get onto the next inquest, and valuable learning is often

⁹ See section on restraining orders

<https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5c91f55c9b747a252efe260c/1553069406371/Super-complaint+report.FINAL.pdf>

simply lost or dissipates. At the conclusion of an inquest the Coroner has the power to write a Prevention of Future Deaths (PFD) report to any organisation where lessons could be learnt from the individual death. There is a requirement on those organisations to provide a response within 56 days. Beyond that the Coroner takes no further steps. Families always find inquests deeply traumatic and need to put the matter behind them, and in any event it is not their role, and neither do they have the tools, to follow through on recommendations.

When responses are provided to PFDs at 56 days they often state that an issue will be reviewed, training will be carried out or other actions will be taken. 56 days is not long enough to actually take those steps. There is no follow-up to find out whether these are then done, or what the outcome of any reviews may be. PFD reports and responses are placed on the Chief Coroner's website, but the Chief Coroner's office does not carry out any follow-up work. It is not even possible to identify all these cases on the Chief Coroners' website. The website is organised into subject areas, eg: road deaths, accidents at work, which include "police-related deaths", "community health care and emergency services related deaths", "mental health related deaths" and "other related deaths".¹⁰ There is no one category that covers domestic homicides, they may be spread across categories and many of the cases known to us are in the "other related deaths" section. A known case can be found by doing a search on the name, but the only way to identify cases not already known would be to read every single case within each category, a hugely time-consuming task. There is not even a summary in each case, only the name, category and PFD.

CWJ is only aware of those cases where lawyers we know have acted for the family. There will be many where families have other lawyers or are unrepresented. There is no central pool of Coroner's recommendations in PFD reports in domestic homicide and other VAWG cases. This is an absurd waste of valuable knowledge given the intensity of the examination of issues in the inquest process. Many inquests take several weeks and a large number of witnesses are questioned at length on the fine details of their actions and omissions. Coroners spend time considering the evidence they have heard and preparing reports for relevant bodies. Where this careful learning is kicked into the long grass this is a huge loss and lets down the families and those who work hard to put together investigations and outcomes. PFD reports should be treated as a rich source of learning that is picked up and acted on robustly. The IOPC also gathers valuable data that could be utilised more widely.¹¹ A centralised body such as the Domestic Abuse Commissioner' office, which has an arms-length role with Government, is ideally placed to carry out this work.

¹⁰ <https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/https-www-judiciary-uk-subject-community-health-care-and-emergency-services-related-deaths/> We also have some concerns that not all PFDs are included on the Chief Coroner's website. In 2016 the writer worked as a researcher for the Angiolini review into deaths in police custody and found that many relevant PFDs were not on the website.

¹¹ Domestic related deaths are included within their 'other deaths following police contact' category but it is not known whether any broader learning is taken forward on a thematic level beyond recommendations in individual cases. See most recent annual report on this category from 2018: https://policeconduct.gov.uk/sites/default/files/Documents/statistics/Guidance_IOPC_Annual_Death_Report.pdf. From our enquiries with the IOPC it also appears that there is no link between their "core work" involving independent investigations into deaths with their "thematic work" which includes complaints relating to domestic abuse (ie non-fatal cases).

There are many other benefits of a centralised collation and follow-up by the Domestic Abuse Commissioner's office. For example, Coroners PFD reports often include a number of recommendations, but the responses address some and ignore others. No-one responds to these replies to ask raise recommendations that were not dealt with. If a response to a PFD report deliberately obfuscates there is no-one who will respond to that. There are also useful recommendations made by Coroners to local bodies such as their local police force or NHS Trust that it would be beneficial to share nationally. The Domestic Abuse Commissioners' office, with its broader understanding of domestic abuse issues, is best placed to identify those recommendations that have wider implications and enter into dialogue with national bodies such as the College of Policing (CoP) and the National Police Chief's Council (NPCC) leads about changes to guidance, training and supervision that can bring the issues identified into frontline policing.

Finally, it is also important to note that inquests are usually the final post-death investigation that takes place, often several years after other investigations such as DHRs, IOPC investigations etc have concluded. At the inquest stage it sometimes becomes clear that earlier recommendations have not in fact been implemented, even though they were accepted by the public bodies concerned. This is illustrated in the cases of Anne-Marie Nield and Katrina O'Hara. A post-inquest review of all recommendations that arose from a death would be an ideal opportunity to take stock, and review matters several years down the line. A broad post-death oversight mechanism that includes not just DHRs but all other investigations would be an invaluable tool to put lesson learning from deaths into practice and ensure there is a feedback loop that reaches those who work directly with survivors. This short submission illustrates the potential for extensive far-reaching work and this needs to be resourced if the Domestic Abuse Commissioner's office is to carry out this role.

We now set out five detailed case studies which illustrate the various issues raised above:

MV

MV was a vulnerable woman with a young daughter. Her partner AK was a serial perpetrator of domestic abuse and violence against women including a conviction for rape and a previous charge of murder. Over the course of their three year relationship he assaulted her numerous times, including strangulation. A pattern emerged where MV would attend the police after violent assaults but then retract her allegations. In April 2011 following an assault and strangulation, the police were called again and MV was identified as high risk. AK was charged with ABH but this time despite her retraction the CPS proceeded with the charge. In June 2011 MV admitted to her social worker that AK was pressuring her not to give evidence and that he had in fact strangled her to near unconsciousness. Her social worker identified that her life was at risk and that by informing agencies she was fuelling his wrath. She made clear that MV needed support to stay safe. AK was convicted of ABH and a restraining order was imposed prohibiting contact between them. The relationship resumed but no action was taken for breach of the restraining order despite Social Services being informed that AK was seen at the school, and AK telling his probation officer twice that he had contact with MV. MV was murdered on 15 October 2011.

A DHR was published in November 2013, approved by the Home Office Quality Assurance Panel. When she saw it MV's mother raised a number of omissions that she was aware of because she had applied for disclosure of records relating to her daughter from Social Services under the Data Protection Act. The DHR contained no mention of the meetings between MV and her social worker in June 2011, which identified serious risks to MV and her daughter, and also the fact that various actions were not followed up, including that the child should be removed if MV continued to have contact with AK. Police actions were also given very little scrutiny in the DHR and important evidence from the police complaints process was not mentioned. MV's mother instructed a solicitor and eventually, following a threat of judicial review, it was agreed that a new DHR was required.

A new Chair was appointed in November 2016 and a second DHR finalised in April 2018, which was a vast improvement on the previous report. This would not have come about if MV's mother had not obtained primary materials herself, identified information that was not shared by agencies involved during the first DHR process, and pushed hard for the DHR to be reviewed. The final report included a number of multi-agency failings, many of which had not been identified in the original DHR:

- a) A missed opportunity by Social Care to support MV and her daughter following the assault in April 2011;
- b) Failure on the part of the police Dangerous Persons Management Unit to take account of AK's history of violence and properly assess his risk;
- c) Failure to refer MV to a MARAC;
- d) Failure to communicate information about AK breaching his restraining order.

Anne-Marie Nield

Anne-Marie died on 8 May 2016 during a sustained assault by her partner, who had previously subjected her to non-fatal strangulation. Officers who dealt with the previous incidents failed to appreciate the significance of strangulation as a risk factor, and graded the risk as standard rather than high. There was no support offered to her and no referral to MARAC.

The DHR, dated December 2016, identified a significant number of errors and omissions made by police and the recommendations were accepted in their entirety by the local force, Greater Manchester Police (GMP). However, following the inquest on 25 January 2019 the Coroner wrote a PFD report expressing concern that not all the recommendations had been implemented, over two years later.

The DHR did not address the issue of non-fatal strangulation at all. The Coroner did examine this issue in detail when it was raised by the family at the inquest, and officers who dealt with Anne-Marie were questioned about their understanding of it. In her PFD the Coroner noted that there is no reference to non-fatal strangulation within the GMP domestic abuse policy, and that police officers involved with Anne-Marie failed to appreciate the significance of non-fatal strangulation as a specific risk factor for domestic homicide. The response to the PFD in March 2019 stated that the force domestic abuse policy requires updating and will include non-fatal strangulation as a heightened risk factor. It is not known whether this has been done. Later that year CWJ received the GMP domestic abuse policy under the Freedom of Information Act, but approximately 90% was redacted. As a charity CWJ is unable to research implementation. Anne-Marie's case was later widely cited in the campaign for a stand-alone offence of non-fatal strangulation (including by the Mirror when the first announcement was made by the Lord Chancellor that a new offence would be introduced¹) which illustrates how much can be achieved beyond the DHR process.

Katrina O'Hara

Katrina was killed on 7 January 2016 by a man she had been in a relationship with, Stuart Thomas. In November 2015 police were involved after a violent incident. In November and December 2015 Katrina contacted police to report harassment by Thomas and concerns for her safety. On 7 January 2018 the IOPC made a recommendation that when a victim's mobile phone is seized for the investigation this leaves them without a means of emergency communication and that police forces should have arrangements to enable emergency calls. The NPCC and CoP accepted the recommendation. The NPCC said that police forces would be called to actively address it and the CoP said it would "ensure the wording used achieves the intended outcomes". An inquest concluded on 19 February 2020 and the Coroner made a PFD report with four recommendations. One of these was that since this death Dorset Police had begun providing replacement phones, but the Coroner was concerned that this may not be in place across England and Wales. The NPCC responded to the PFD report addressing some recommendations but nothing was said about phones. The CoP response said only "*College DA and stalking APP have been amended to alert forces to the risks of removing a victim's means of communication and that replacement should be considered.*" There was nothing to indicate that any action was taken beyond one short amendment to the guidance and that in itself merely flags the issue and does not require any actions by officers.

CWJ asked frontline domestic abuse services in four police force areas around the country¹ whether their clients are provided with replacement phones when their phones are taken for evidence-gathering. Some said that this happens occasionally but not routinely, sometimes when they push for it in a particular case, some said it was very rare and one service had never known a replacement phone to be provided. One domestic abuse service said they seek donations from a large supermarket to provide replacement phones. Another reported that they themselves found it difficult to maintain contact with their clients when their phones are taken and they have to chase the police to ask for phone numbers of relatives. A third service stated their clients often refuse to hand over their phones for evidence gathering as this would leave them in an unsafe situation and unable to maintain their support networks. One service stated that some clients were issued with TECSOS phones that enabled survivors to call police but could not be used for other purposes (and added that most are left without a phone). This is clearly an important issue where survivors are put at risk without a way to call 999, unable to maintain support at a critical time, or the effectiveness of the investigation is undermined if they (sensibly) refuse to provide their phones. Useful practical recommendations have resulted in nothing more than an amendment to a written policy and there is nothing to indicate whether any work has been done by national policing bodies directly with police forces to change their practices and if so what.

Donna Williamson

Donna was stabbed to death on 13 August 2016. There were multiple reports of violence and threats to kill by her ex-partner Kevin O'Regan in the months before her death. The inquest jury found a persistent failure to assess risk and to make referrals to multi-agency bodies. On 16 July 2016 O'Regan was charged with assault and released with bail conditions. On the evening of her death Donna called 999 to report that someone was trying to gain entry, but had now left. The same evening police were called to a fight at a takeaway 400m from her home. O'Regan was identified but despite a PNC check the bail conditions were not mentioned and he was not arrested despite being in breach of bail conditions. Donna called 999 again 30 mins later saying she was being beaten and died shortly after.

At the conclusion of the inquest on 18 February 2019 the Coroner made four recommendations in a PFD report. These included that several agencies knew that Donna's door was insecure and that she was afraid to raise this with her private landlord for fear of eviction, but no agency took responsibility for securing the door. There was a failure to inform Donna that her ex-partner had been released on bail, which should be raised more widely amongst police forces. There were failings in the MARAC process and a need for a national review of the MARAC system. A response from the local authority Local Government Association addressed their attempts to have central Government consider the effectiveness of MARAC and how it could be improved. In relation to securing the door the response asked the Coroner to explain which legislation creates a duty on a local authority to repair the door if the private landlord did not. It is not known whether the Coroner responded or if any further steps were taken by any agencies on the door issue. The Coroner's office has confirmed that there was no response received from the National Police Chief's Council, which was a respondent in the PFD. CWJ regularly hears from frontline domestic abuse workers that survivors are not consulted or informed by police about suspects' bail conditions.

Alex Malcolm

Alex was aged 5 when he was killed by his mother's partner, Marvyn Iheanacho on 22 Nov 2016. Iheanacho had a string of convictions for serious violence offences against women and children. He had been released from prison five months before the death and begun a relationship with Alex's mother, who was unaware of his history. Under his licence conditions probation officers were supposed to monitor any new relationships with women and he was not allowed to have unsupervised access to children under 16. Alex's mother was not identified as a person at risk and although a probation officer was aware she had a child, no steps were taken despite the breach of licence conditions. Probation failed to share information with agencies who would have notified her about his history and put in place safeguarding measures. The probation officer also failed to challenge him and to recall him to prison.

We are aware of several other deaths where men who have served prison sentences for killing a woman have been released on licence, and have gone on to kill a partner after probation officers failed to properly supervise the offenders' new relationships. Cherylee Shennan was murdered by Paul O'Hara two years after he was released on life licence following the murder of a former female partner. The Probation Service did not supervise him effectively and did not recall him to prison when reports were made of violence against Cherylee. Another death where the perpetrator had killed a woman partner previously, where an inquest is due to take place shortly, also raises a common theme of statutory agencies failing to identify new relationships and relying on the perpetrator to self-report on his own risk.

The Coroner who heard the inquest into the death of Alex Malcom issued a PFD report on 15 October 2019 with several recommendations. This included the need to strengthen arrangements around MARACs. This was the same Coroner who had heard the inquest into the death of Donna Williamson and he commented in his report that he had raised this issue in a PFD earlier that year in Donna Williamson's case (8 months previously) but that the response from the Ministry did not specifically address that issue. There is no response to the PFD in Alex Malcolm's case on the Chief Coroner's website that addresses MARACs either. The Home Office DHR overview report from 2016 identified 41 DHRs which raised issues with multi-agency working practices. The conclusions on multi-agency working did not include a review of MARACs.

Section 3

The need for disaggregated data on male victims and female offenders in VAWG cases

The lack of disaggregated data prevents an informed and constructive debate on male victims and female offenders, perpetuates false assumptions and can distort policing responses.

The way the data is currently presented is misleading. Without disaggregation the discussion within society at large, within the criminal justice system, and by women's sector organisations, is generally based on the assumption that male victim cases represent a mirror image of most female victim cases - heterosexual intimate partner abuse.

The headline figures suggest that whilst obviously there are more female victims, rates for male victim are relatively high. For example, the CPS VAWG strategy for 2017-2020 quotes:

- 4.4% of men (716,000) and 7.7% of women (1.27m) aged 16 to 59 were victims of domestic abuse in the year ending March 2016; with 2.8% of men (451,000) and 5.4% of women (891,000) experiencing partner abuse (non-sexual);

This suggests that there are about half as many male victims as female, which appears to be an extremely high number.

However, the true picture is very different and far more nuanced when the limited available data is examined in more detail:¹²

- A high proportion of male victims have male perpetrators. We can see this by comparing figures for male victims with female offenders for domestic abuse, however actual figures for sex of the perpetrator are not provided therefore rates for same sex cases cannot be identified. For sexual offences it is clear that perpetrators are overwhelmingly male;
- Many domestic violence cases are not intimate partner abuse but involve male family members such as sons, fathers, brothers. Again, data on the sex of the perpetrator is not available;
- The data on female offenders also provides a misleading picture and the reality is more complex. Some female offenders have female victims, whether in same sex relationships or other family members. Some appear to be trans women, as rape statistics record 1-2% of convictions as having female offenders. For the offence of rape to be made out there must be penetration by a penis. In trans perpetrator cases the victim may be male, female or trans.
- Research demonstrates that when it comes to heterosexual intimate partner cases with male victims and female perpetrators the abuse reported is far

¹² CPS VAWG tables for 5 years to 2018/19 accessed via CPS VAWG report 2018/19

more minor than for female victims and male perpetrators.¹³ Data on referrals to MARACs, which represents only high-risk cases, shows rates of between 2-9% across different police forces¹⁴ (average of 5.5%), and these will include cases with male perpetrators. The figure for high-risk cases with female perpetrators is not known.

- CPS data on female offenders in domestic abuse cases has a rate of 8%, but given that this includes cases with female victims and trans offenders, the proportion of “mirror image” cases where there is a male victim and female perpetrator¹⁵ will be lower than 8%.
- CWJ receives enquiries arising from cases where female victims have called the police and counter-allegations are made by a male perpetrator. There is no data on what proportion of cases recorded as having a male victim or a female offender are cases involving counter-allegations and self-defence, where there is a dispute about who is the ‘primary aggressor’. Please see section 4 of our submission which addresses in more detail cases where female survivors have been wrongly criminalised and provides case studies.
- The lack of data on same sex domestic and sexual abuse prevents an informed debate on the issue within LGBT+ communities

Clearly this kind of disaggregation can create a more nuanced and helpful discussion around male victims, particularly the understanding that many of them are victims of male violence. It would also feed into an improved response to women in situations where counter-allegations are made, or women act in self-defence. Police perceptions, when faced with such situations may be influenced by the belief that genuine male victims of female abuse are relatively common. As shown above this is not actually the case when the figures are examined in more detail. The notion of ‘mutual abuse’ is also adopted by some officers, and this is not considered an accurate concept. We have seen one police force domestic abuse policy that encourages dual arrests when there are counter-allegations, which goes against national guidance. There is also a lack of guidance within many force policies on the importance of identifying the ‘primary aggressor’ and how to do this.¹⁶ This issue sits alongside our submission in Section 4 on how some female survivors are wrongly criminalised where there are counter-allegations or they have acted in self-defence.

¹³ Hester, M (2013) ‘Who Does What To Whom’ European Journal of Criminology

<https://journals.sagepub.com/doi/10.1177/1477370813479078>

and Women’s Aid ‘Abuse is a Gendered Crime’ <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/>

¹⁴ 2019/20 Office for National Statistics domestic abuse data tool

¹⁵ For the purposes of this submission we refer to female perpetrators as not including trans women because we are seeking to address the “mirror image” assumption around the mainstream traditional notion of domestic abuse in society at large of heterosexual couples with female victims and male perpetrators, and therefore we put to one side for this limited purpose other types of relationships.

¹⁶ For an example of good practice, the Metropolitan Police has helpful guidance on this within its “Domestic Abuse Q&As” page 5

<https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5e1371b3cb4feb021c725280/1578332624286/08+Met+DA+Policy+Toolkit+-+Questions+and+Answers.pdf>

Only a national VAWG strategy, which sets the tone and requirements for all the various agencies involved in the criminal justice system, can ensure that properly disaggregated data is gathered and published. This is essential to improve the policy debate and ensure better understanding of issues and responses in individual cases.

Please see our separate document on Section 4 of our submission.