CWJ submission to the Government VAWG Strategy

19 February 2021

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 decade[1] they remain stubbornly high. We are concerned about the 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.

This submission is based on the work of the Femicide Working Group, a coalition of NGOs and lawyers who support and represent bereaved families in post-death investigations, including inquests. This includes the charity INQUEST, who first developed the concept of a National Oversight Mechanism for post-death investigations in state-related deaths.[2]

[1] 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
[2] https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331

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 particular investigations by the Independent Office of Police Conduct (IOPC) and Coroners' inquests.[3]

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 MV and Anne-Marie Nield at the end of this submission, which illustrate the limitations in the DHR process raised here.

[3] 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 National Probation Service, CPS and police forces

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 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 measures[4], 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 so 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.

[4] See section on restraining orders https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5c91f55c9b747a252efe260c/1553069406371/Super-complaint+report.FINAL.pdf

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 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".[5] 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.[6] A

[5] 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 for INQUEST as a researcher for the Angiolini Review into deaths in police custody and found that many relevant PFDs were not on the website.

[6] 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

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.

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 that there is a feedback loop that reaches those who work directly with survivors at the frontline. This short submission illustrates the potential for extensive far-reaching work and this needs to be properly 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:

independent investigations into deaths with their "thematic work" which includes complaints relating to domestic abuse (ie non-fatal cases).

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 introduced[1]) 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 country[1] 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.