SAFER PLYMOUTH

DOMESTIC HOMICIDE REVIEW

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of Missy in December 2013

Independent Chair

Dr Jane Monckton Smith

Final Draft

October 2019

Restricted / Official Sensitive

Please do not circulate

Glossary

- AAFDA - Advocacy After Fatal Domestic Abuse
- CPS - Crown Prosecution Service
- CSP - Community Safety Partnership
- DASH - Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification
- DHR - Domestic Homicide Review
- DVPP - Domestic Violence Perpetrator Programme
- FLO - Family Liaison Officer
- FOIA - Freedom of Information Act
- GMPS - Government Protective Marking Scheme
- IDVA - Independent Domestic Violence Adviser
- IMR - Individual Management Reviews
- MARAC - Multi-Agency Risk Assessment Conference
- PCT - Primary Care Trust
- SHA - Strategic Health Authorities
- SIO - Senior Investigating Officer
- SMART - Specific, Measurable, Achievable, Realistic and Timely
- TOR - Terms of Reference

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1. Preface

I would like to begin this report by expressing my sincere sympathies, and that of the panel, with the family and friends of Missy who is remembered universally as a kind, gentle, and fun-loving person who is keenly missed. She was very popular and in her place of work there is a memorial to remember the caring and innovative work she did for vulnerable and bullied children. This gives some insight into the way that Missy lived her life and is remembered. She leaves behind a child who has suffered the ultimate in loss, but despite this trauma, is a credit to Missy and her family.

The purpose of a Domestic Homicide Review (DHR) is to identify improvements which could be made to community and organisational responses to victims of domestic abuse, and hopefully to try and prevent a tragedy like this from ever happening again. This report examines agency responses and support given to Missy, a resident of Plymouth prior to the point of her death in December 2013. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer and summarise the circumstances that led to a review being undertaken in this case.

I would like to thank the panel, and those who provided chronologies and information, for their time, patience and co-operation. I would also like to thank Missy's family for welcoming me into their home and speaking to me about Missy and her relationship with them and Alf.

The name Missy, is a pseudonym decided upon by the family. Alf (the perpetrator) and Marie (his former partner) are names decided upon by the Independent Chair. Missy's child will simply be referred to as a child so as not to identify them.

Jane Monckton Smith

Independent Chair

2. Summary

2.1. Missy was 36 years old at the point of her murder and was sole carer for her school age child.

2.2. She had been in a relationship with Alf, who was 41 at the point of her murder, for around three years. He had been living with her and her child. Around a month prior to her death Missy ended the relationship with Alf, and although he moved out, he would not accept her decision.

2.3. In December 2013 in the early hours of the morning, Alf gained access illegally to Missy's home and killed her by strangulation and putting his hand across her mouth. Missy's child was upstairs at the time.

2.4. Missy attempted to get help by calling 999 when she discovered Alf in her home, but because she did not speak directly into the phone, her call was put through to an automated system and no police attended because of this.

2.5. Alf called the police the following morning to confess to killing Missy. He had stayed in the house overnight without calling for paramedics or medical help for her. He had covered Missy's body, which was on the front room floor, to look as if she was sleeping.

2.6. Missy's child saw her body covered with a duvet and was told by Alf to go to school and that their mother was sleeping.

2.7. He was charged with murder and subsequently convicted. He was given a life sentence with a minimum tariff of 21 years, reduced to 17.5 years because he pleaded guilty.

3.0 Timescales

3.1. This review was commissioned by Safer Plymouth on behalf of Plymouth City Council in response to the death of Missy in December 2013. The review followed the key processes outlined in the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

3.2. The decision on whether to hold a review was taken by the Chair of Safer Plymouth within one month of the homicide of Missy coming to their attention and it was decided a review was unnecessary. This decision was reversed after an intervention from AAFDA on behalf of the family in June 2015, and it was finally decided, by the Chair of Safer Plymouth, to hold a review in June 2015.

3.3. The Home Office was informed of the decision to conduct a DHR.

3.4. The first panel meeting was held in July 2015 with the first Independent Chair.

3.5. Due to unforeseen circumstances the first Chair had to resign and the DHR was pended whilst a replacement was found.

3.6. Dr Monckton Smith was appointed in November 2015.

3.7. The inquest was adjourned in April 2016 and will not resume.

3.8. Some further delays have occurred in this case the most time consuming of which was waiting for the completion and sight of an IPCC report. Devon and Cornwall police would not allow sight of their IMR or any information until this was completed.

3.9. The first panel meeting with Dr Monckton Smith was in January 2016 and the Terms of Reference were discussed and drafted.

3.10. Communication with the family was done through a specialist AAFDA advocate.

3.11. The Chair met with the family four times and provided regular updates to them via the AAFDA advocate.

3.12. The panel met on four occasions. An opportunity to meet the panel was extended to the family but they did not feel able to attend.

3.13. The Chair met with the family and the police and an IPCC representative in April 2017 when it was decided that the police would give a face to face apology to Missy's family.

3.14. The family were given the draft report and invited to comment and contribute, which they did at a meeting with the Chair in April 2018.

3.15. A final draft was produced in June 2018

3.16. All final comments and contributions from the family, which took some time, were recorded in January 2019 via the AAFDA advocate

3.17. The report was submitted to Safer Plymouth in October 2019

4.0 Confidentiality

The findings of each IMR are confidential. Information is available only to participating officers/professionals and their line managers. Family are provided with a report of the final DHR prior to publication and are advised about confidentiality. The report is marked as 'official' as per the Government Protected Marking Scheme (GPMS).

5.0 Terms of Reference

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

Missy had been in an intimate relationship with Alf for approximately 3.5 years. Their relationship ended in November 2013. Safer Plymouth commissioned a DHR in accordance with a) above. The purpose of the Review is to:

1. Establish the facts that led to the events in December 2013 and whether there are lessons to be learned from the case about the way in which local professionals and agencies carried out their responsibilities and duties, and worked individually and together to safeguard Missy (victim), Alf (perpetrator) and Missy's child

2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

3. Apply any learning to the policy, procedures and practice of individual agencies, and inter-agency working locally and to inform national policy and practice where appropriate. This will include

4. Highlight any identified good practice.

5. Prevent domestic abuse and homicide and improve service responses for all victims, including children, by developing coordinated multi-agency approaches to identify and respond to domestic abuse at the earliest opportunity

6. Contribute to a better understanding of the nature of domestic violence and abuse

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

7. The review will address whether agencies that had contact with the victim, her child or the perpetrator could have done more to recognize signs of abuse and signpost to suitable support.

8. To seek to involve family including child, friends, key workers, colleagues and any other person who had significant contact, to participate in the review so that we can better understand the victims experience and establish whether there were any barriers in the victim or family reporting abuse or accessing interventions that might have helped.

9. To establish whether the perpetrator had any previous concerning conduct or a history of abusive behaviour to an intimate partner and whether this was known to any agencies

10. To give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator or family members.

11. To consider any other information that is found to be relevant

6.0 Method

6.1. The method for conducting a DHR is prescribed by Home Office guidelines. The DHR followed those guidelines in the usual way once it was decided to hold a review, which was in June 2015.

6.2. All agencies in the area were contacted to search for any contact they may have had with Missy and her immediate family, and with Alf. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies with contact considered of importance to the panel were asked to provide an Independent Management Review (IMR). This allows the individual agency to reflect on their dealings with the victim, her family, and the offender, and identify areas which could be improved in the future and make recommendations.

6.3. In this case only Devon and Cornwall Police were requested to provide an IMR, although information was gathered from Missy's GP and her child's school.

6.4. The IMR author for the Devon and Cornwall Police was a panel member but was not directly involved with the case. She presented her report to the DHR panel and was available to answer questions about the reflections and recommendations that she had made. There was some delay with the Devon and Cornwall Police IMR as they would not allow the panel to have sight of it, or any information within it, until the IPCC report was completed. This is not standard practice but the Chair and the panel complied with this stipulation by the police. This further delayed the start of the review as there was only this IMR to consider and was the basis for most of the data to be considered by the panel.

6.5. In addition to this the Independent Chair received copies of statements made to the Police by Missy's friends, and some of Alf's friends.

6.6. The Chair was also able to visit with Missy's family and talk with them about Missy and her relationship with Alf. Other people, including Alf and some of his friends were contacted to invite their participation in the review via the police, but no-one accepted this offer.

6.7. The IPCC produced their report in November 2016 and then the IMR was presented.

6.8. All panel members were asked to present their own perspectives on recommendations which they thought should be made in the final report. Each of these suggestions were discussed by the panel.

7.0 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

Missy's family contributed to the review and the Independent Chair met with them on four occasions. The family were represented by a specialist advocate from Advocacy After Fatal Domestic Abuse (AAFDA).

Some of Alf's friends were asked to contribute but did not reply to invitations.

Missy's child's school provided information about pastoral care for children

8.0 Contributors to the Review

- General Practitioner of Missy
- Devon and Cornwall Constabulary
- Family members
- Missy's child's school

9.0 The Review Panel Members

Sue Warren Area Partnership Crime Reduction Co-ordinator,

Safer Plymouth.

The Area Partnership Crime Reduction Coordinator for Safer Plymouth was given delegated authority to make decisions on behalf of Plymouth City Council and was responsible for;

- Maintaining a dialogue with members of the family (if applicable)
- Liaising with the Independent Chair to ensure she is able to carry out the remit within the agreed timescale
- Securing the resources required to undertake the Review
- Liaising with the Home Office on matters that are relevant to the roles and responsibility of the Commissioning Body
- Receiving the final overview report from the Independent Chair

All other responsibility relating to the Commissioning Body, namely any changes to the Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report, are the collective responsibility of Safer Plymouth.

The Area Partnership Crime Reduction Coordinator provided the Chair of the Safer Plymouth Board with regular updates setting out progress of the review against the timescale that has been extended.

Chloe Webber Serious Case Review, Public Protection Unit, Devon and Cornwall Police (Detective Sergeant)

Kerri-Ann Alee Senior Probation Officer, Devon and Cornwall Probation Trust, Safeguarding Champion

Jason Preece Plymouth Domestic Abuse Services Local Service Manager

Katy Bradshaw Plymouth Domestic Abuse Services Local Service Manager

Gillian Scoble Safeguarding Nurse Primary Care, NEW Devon CCG (northern, Eastern and Western Devon Clinical Commissioning Group)

Jo Brancher Safeguarding Adults Operational Manager

Plymouth Hospitals NHS Trust

Gary Wallace Senior Specialist Drugs and Alcohol Team Manager,

Office of the Director of Public Health.

None of the Panel members had direct involvement in the case nor had line management responsibility for any of those involved.

The administration of the DHR was supported by Dr Jane Monckton Smith's personal assistant, Sue Haile. Sue is also an employee of AAFDA but was not involved with this case in that capacity, ensuring no conflict of interest.

10.0 Author of the Overview Report

Dr Jane Monckton-Smith was appointed by Safer Plymouth as Independent Chair and Author of the Overview Report in November 2015. Jane is a Forensic Criminologist specialising in domestic homicide. She lectures and advises in homicide, forensic criminology and criminal investigation, and is an active researcher in the area of domestic homicide. This research has been published. Jane also works with a number of homicide and stalking charities, as well as police and probation services, helping victims and professionals understand domestic homicide, and domestic abuse and stalking.

Additional evidence of enhanced knowledge of domestic violence and abuse issues is evidenced in Jane's published works, included as appendix 2.

Jane has had no previous involvement with Safer Plymouth nor any of the agencies involved in the domestic homicide review into the death of Missy, but she is chairing another Plymouth DHR that is running in parallel with this one.

11.0 Parallel Reviews

11.1. An IPCC review was conducted into the death of Missy. This report was published in November 2016

11.2. An inquest was opened and adjourned. The Coroner decided that the inquest would not be resumed as the DHR Terms of Reference are broader than that of an inquest. The coroner obtained information on the running of the silent system by the Metropolitan Police which was used in this review.

11.3. There was a criminal trial and some of the information gathered for the trial by Devon and Cornwall Police has been used in this report.

12.0 Equality and Diversity

12.1. Section 4 of the Equality Act 2010 defines protective characteristics as:

age
disability
gender reassignment
marriage and civil partnership
pregnancy and maternity
race
religion or belief
sex
sexual orientation

12.2. Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—
P has a physical or mental impairment, and
The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

12.3. No agency held information that indicated Missy or Alf lacked mental capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them.

12.4. Missy's GP records indicate a history of depression and she was on prescribed anti-depressants at the time of her death. Her condition was being managed through primary care. The DHR panel did not see evidence that this constituted a substantial impairment.

12.5. Missy was white British with English being her first language.

12.6. Alf is white British with English being his first language.

12.7. Missy and Alf had been in a relationship, which Missy ended a month prior to the homicide. Alf had previously been married and had 2 children. Missy had a child from a previous relationship.

12.8. The panel received no indication that either Missy or Alf held any religious beliefs. The panel did not beleive that age or sexual orientation were factors relevant to this review.

12.9. Sex is always relevant in Intimate Partner Homicide (IPH) because of the significance of the statistical breakdown between offenders and victims. Men predominate as both perpetrators and victims of homicide globally (90% and 80% respectively) except in the IPH category where: women predominate as victims (70%) (UNODC 2013) and men make up around 95% of perpetrators. Between 2009 and 2015 in the UK 936 women were killed, and of those 598 were killed by an intimate partner (Brennan 2016). Global homicide numbers have decreased, whilst femicide has increased.

12.10. Alf's violence was directed at women and this also makes sex relevant. There were allegations of sexual offending and violence towards women in his past. This was known by police and official records show that offending was directed towards women in particular.

12.11. The relevance of this pattern was not always considered in any agency response, and this is a national, rather than local problem, and is not isolated to this case. Patterns of offending are often considered as a pattern towards partners with the relevance of sex not recognised. In this case and many others, the fact that the victim was a partner overshadows consideration that those partners were also women. This could perhaps have more relevance as it tends to show that violence is not generalised, but specific in such cases. When considering whether Missy's sex may have been a barrier to receiving service, the term 'partner' or 'former partner' did seem to impact on the service received. The potential for Alf to hurt Missy was assessed through the notion of partner violence which is often (on a general and national basis) seen as less dangerous.

12.12. In this case the extra barriers created by Missy's sex were not considered. Missy did not receive any specific help or consideration because of her sex. However, it is accepted that women have less access to many forms of social and financial capital. In addition, gender roles and gender socialisation have an impact on the way women respond to violence and threat. Specific consideration by professionals of the increased vulnerability of women could help if they are given specific safety advice. For example, their physical capabilities to defend themselves or bar entry to their property; their extra fear when there are children to protect, not only from violence, but from any anxiety and disruption created in attempting to defend themselves or bar entry to their property. Missy could not have involved herself in a face to face violent confrontation with Alf and have been expected to achieve her aims. Special consideration should also be given where there are children present as women (or any carer) may behave in a manner designed to protect that child from fear, and allow access to a dangerous person who they cannot defend themselves from.

Brennan, D. (2016). Femicide Census. Retrieved March 30, 2018, from http://www.northwales-pcc.gov.uk/Document-Library/Advice/Femicide-Census-Report-2016.pdf

UNODC (2013). Global Study on Homicide. United Nations Office on Drugs and Crime. Retrieved March 30, 2018

13.0 Dissemination

This is the list of agencies and people who will be sent a copy of this review

Safer Plymouth

Devon and Cornwall Police and Crime Commissioner

Devon and Cornwall Police

Plymouth City Council – Early Years

Plymouth City Council – Adult Safeguarding

Devon and Cornwall Probation Trust

Plymouth Domestic Abuse Services

Plymouth Hospitals NHS Trust

Plymouth Community Healthcare

Devon and Cornwall Public Health

Family members

Coroner's office

IPCC

Education Department

Chartered Institute of Personnel and Development

14.0 Background Information (The Facts)

14.1. Missy lived in Plymouth and was killed in her home by Alf who was a former partner. Missy lived with Alf and her child for around three and a half years. Alf had a history of domestic abuse and stalking and became involved with Missy not long after the break-up of his marriage where he abused and stalked his former partner. There is an allegation that Alf broke into his ex-wife's home in the middle of the night and attempted to strangle her. Missy knew of some allegations of abuse made by Marie, the ex-wife, but did not believe they were true.

14.2. During the relationship there is evidence to suggest coercive and controlling behaviour, and a clear escalation in concerning behaviours, including stalking, when Missy attempted to separate from Alf. This mirrored his behaviour from the previous relationship.

14.3. Family and friends of Missy did not like Alf, and Missy's friends identified him as a stalker. Alf's friends were aware that he was not accepting the end of the relationship and was gaining illegal entry to her home with a key she was unaware he had. They did not inform Missy, or the police of this before her death.

14.4. Missy made it very clear to Alf that the relationship was over. She had a friendship which may have been developing into a new relationship, and which she hid from him through fear of how he would respond. Alf broke into Missy's home in the middle of the night, mirroring previous behaviours, and whilst her child was upstairs sleeping he strangled her. He sat with Missy's body until the following morning when he called the police to say what he had done.

14.5. Missy's child was upstairs the whole time. In the morning they saw their mother's body underneath a duvet and were told by Alf that she was sleeping.

14.6. Alf was charged with murder and convicted in July 2014 and received a life sentence with a tariff of 22 years reduced to 17.5 years for a guilty plea.

15.0 Chronology

This chronology begins with a tracking of the relationship between Alf and Marie, his ex-wife. The reason for this is the documented history of domestic abuse which existed between Alf and Marie, and the near identical attack Marie suffered when she ended the relationship. Then the history of the relationship between Missy and Alf is documented.

Alf had three children with Marie and one child with another partner. His youngest child was born in 2007. The police records show contact because of domestic abuse between Alf and Marie between September 2005 and January 2010. Analysis of the contact is in italics after each entry.

September 2005: Marie called police to allege that she had come home from work to be confronted by Alf who started to argue with her. The argument escalated and he threw a cup at her hitting her in the head. As a result, Marie went to get her child from the bedroom. Alf 'barged' her out of the way and stopped her from getting the child. Marie then went to another room to get her other children and this resulted in Alf assaulting her by grabbing her legs, and when she was on the floor, bending them so far her hip was dislocated.

This is the first recorded report to police about any problems with Alf's behaviour. It is quite possible that the reason for this was the serious nature of the injury caused, and the pain it must have inflicted. Future comments by Marie reveal that Alf was routinely abusive and that there had been previous police calls.

Alf was arrested, but Marie said she did not want to attend court, she just wanted him removed from the home. Marie was graded by police as High Risk, with the following risk markers identified: Jealous and controlling; threats to kill; financial abuse; strangulation/choking assault; separation occurring. There had been reports of abuse during the preceding twelve months but the details of this are not available.

Marie reveals in the risk assessment interview that there are a number of significant risk markers present. She was graded as High Risk which appears to be good practice and a correct assessment. However, there should be a note of the risk markers 'fear in the victim' and 'violence' as both are evidenced in the police report.

Alf denied all the allegations. He claimed that Marie was abusive to him. He alleged that Marie was suffering mental disturbance (Post Natal Depression). It was decided to give Alf a caution. A Women's Aid referral was made for Marie but it is not known if she ever went to them. 'Child coming to Notice' forms were also completed and sent to Children's Social Care.

May 2006: Marie called the police to report that Alf had thrown hot food over her. Marie was not willing to pursue the complaint and was not recorded as injured. Again Alf was removed from the home. He alleged that he merely spilled the food when Marie attacked him. Police note no corroborating evidence for either party so there was no further action taken. However, Marie was graded as High Risk. The children were recorded as not present.

In cases of domestic abuse, it is very common for abusers to allege that they have been attacked. This strategy can make the victim look unreliable. Alf also alleged that Marie had mental health issues, this particular allegation is very common in domestic abuse and again, is designed to make the victim look unreliable and a bad witness. It is said there was no corroboration, but often lack of corroboration is seen to be lack of witnesses. Corroboration can be evidenced in other ways – Where was the food? Was there disruption to the room? And so on.

May 2007: Marie called the police after an argument with Alf about money. She said she was frightened. Again Alf was removed from the property but no further action was felt necessary. The risk assessment was graded as Very High Risk. The indicators identified were: controlling and jealous behaviour; financial abuse; pregnancy; separation; child conflict; choking assault; escalation, suicidal ideation; history of abuse. Marie was referred to the domestic abuse unit but was not progressed to MARAC. A warning marker was placed on the address.

A pattern is beginning to build from the risk assessment interviews. These patterns should be given serious attention and tracked in future assessments, also in other relationships. Alf has demonstrated some of the key indicators for future homicide, the most serious of which are control, repeat offending, strangulation and choking assaults, threats to kill and suicidal ideation.

April 2008: Marie contacted police to say she had ended the relationship with Alf but he was refusing to accept it. However, even with the separation Marie was only graded as medium risk.

Whenever there has been the kind of behaviour demonstrated by Alf and then there is a separation, risk should not be downgraded, it is evidence of escalation not decline in risk. Research in this area is very clear that separation is a trigger for more serious behaviours and this is reflected on the risk assessment forms.

July 2009: 0430hrs Marie called 999 to report that she had argued that evening with Alf. He left the address but returned at around 0300hrs. He broke into the house and Marie awoke with him sitting astride her on the bed with his hands around her throat. She started to scream so he put his other hand over her mouth. She could not breathe and thought she was going to die. He said to her

'If I can't have you no one else is. I'm gonna kill you'.

Marie struggled with him and he banged her head on the wood of the bed and squeezed her throat so hard she lost consciousness. She awoke to find him still on top of her with a loosened grip. He then got a lighter and said he was going to burn the house. He said he had arranged for a third party to petrol bomb the house. Marie was so scared she told him they could try again and get back together. He remained in the house for about an hour and then left. Marie called the police when he left. Whilst on the phone he returned, she put the phone in her pocket and left it on. The police arrived and arrested Alf.

This incident is a strong indication of Alf's potential for homicide. Police assessed this as very high risk, and rightly. This assault should be a consideration in all future engagement with Alf by police. He broke into the property, he strangled Marie to unconsciousness and said he was going to kill her. This is the highest risk serious behavior and the clearest indication of how Alf responds to rejection and challenge. Irrespective of their perceived reliability in court, victims of such premeditated violence are still at high risk of serious harm.

This incident was so important it should have been paramount in the response to Missy.

In her statement Marie said 'I was so scared of (Alf). I honestly believe that he was trying to kill me. I feel I cannot stay in my own home or go to work as he will finish me off. I am frightened he will try and kill the children. Alf has been violent throughout our 6 year relationship'.

Alf gave a different account. He said that Marie attacked him, he was just trying to restrain her. As there were no independent witnesses to the assault and a detective considered her unreliable and disreputable this impacted on the decision by the CPS not to prosecute. This incident should have been taken more seriously and the danger presented to Marie given due consideration irrespective of her perceived reliability as a witness.

Alf's described behaviour, and his defence strategy, are recognized patterns in domestic abuse and particularly high risk abuse. Domestic abuse very often occurs behind closed doors and there are very often no independent witnesses or similar corroboration. The description of Marie as disreputable and unreliable, even if it were true, does not in any way reduce the risk to her life. Even if this assessment of her by one detective could be taken to reduce the chances of a prosecution, it does not reduce the risk to her life or safety. I have not had access to any documents which evidence why this detective made such statements about Marie - but the words imply that Marie's story was not believed. This is another problem identified in research. Victims are not believed and their behaviours often misinterpreted to their detriment.

July 2009: A non-molestation order was issued against Alf.

July 2009: Alf was arrested for breach of the order. There was some confusion over when the order became active and no further action was taken.

August 2009: Marie contacted police to say that Alf had breached the order again. He was arrested and interviewed. He admitted the offence. It was decided to give him another caution.

Breaches of non-molestation orders, even if considered non-serious, are an indication that the pattern of abuse is continuing and that Alf is happy to ignore formal instructions even where there may be a serious and negative sanction to himself. Breaches are serious from a risk perspective and this should be recognized at every level of the criminal justice system. This may be a point of note for recommendations.

Marie was again graded as very high risk and again referred to MARAC. However, the meeting did not take place and there was no further action.

September 2009: Marie called the police to say that Alf had smashed one of her windows. There was no corroborating evidence (independent witnesses) and no further action.

January 2010: Marie called police to say she could see Alf drinking outside in the car park and she was worried he would damage her new partner's car. No further action was taken.

These behaviours may now be considered stalking and given the attention they deserve.

March 2010 Alf started a relationship with Missy. Missy was 33 years old at this time and was sole carer to her school age child who lived with her.

Family report that during the course of the relationship they watched Missy change from a very outgoing and confident woman to someone much less so. They found that she behaved in ways which were out of character for her, especially when she was with Alf. She didn't want anyone to upset him.

The family found Alf to be anti-social and quiet. He would distance himself from the family, and tried to be alone at family gatherings. Missy's friends also noted a distance and isolation.

This is very common in coercive control and is often the first sign that there will be problems in the future with abuse and refusal to accept separation.

April 2013 Missy suffered a miscarriage. Pregnancy not reported to GP prior to loss.

It is suggested in medical records that Missy suffered with some depression around this time. She told friends of being very unhappy with her relationship with Alf and wanting him to leave. She said life was awful with him. Her child similarly said that Alf didn't treat them and their mum as he should have done.

October 2013 Missy ended her relationship with Alf. Unknown to Missy, Alf had an extra key cut to her home. He told his friends this. She was very clear with him that it was over and there are text messages which support this.

Despite this clarity Alf continued to tell his friends that Missy was sending 'mixed signals'. This is a common behaviour in domestic abuse perpetrators and can be difficult for victims to deny, even when they are absolutely clear, as Missy was. Alf was making it clear to friends he did not want the relationship to end.

November 2013: For the next three weeks Missy received a lot of texts and phone calls from Alf. She said they were amicable. Missy tried to explain nicely that the relationship was over on a number of occasions. There are screenshots of texts which support this. (Alf wiped all messages from his and Missy's phones on the night of the murder).

November 2013: Alf turned up at least four times late at night, on at least one occasion he was drunk. He was asking Missy where she had been and wanted to know what she was doing. He also made veiled threats about her car and suicide. Missy told a friend that she did not think the police would be interested in the stalking as Alf had not been violent.

The dangers of stalking behaviour, such as this, are probably more well known now, than they were in 2013.

November 2013: Missy called the police to report that her car had been damaged on two separate occasions whilst parked outside her house. Her wing mirrors had been smashed off, the rear wiper had been broken off and removed, the aerial had been bent. She told police she felt it was personal and directed against her, but felt silly saying so. She wanted to know if others had suffered the same type of damage. The police log noted that Missy's child was very upset by this and that Missy wanted an officer to visit.

By the time victims report stalking they are usually very frightened but may not trust their own intuition.

November 2013: A PCSO telephoned Missy to reassure her that this was very likely a random act as there were other Anti-Social Behaviour problems in the area. She was told that someone would visit her.

Around this time Alf is gaining entry to Missy's home without her knowledge and searching for 'evidence' of another relationship. He told friends this and even called them on at least one occasion when he was inside the house searching.

December 2013: A PCSO visited Missy at home. Missy told the PCSO that she felt Alf was responsible for the damage because he had said words to the effect 'you're not going to be able to keep your car safe'. Missy also mentioned taxis turning up which she had not ordered, and some deliveries, including pizzas. She also talked about things being moved around her garden, she felt she was being left a message that someone had been there. She told the PCSO that she was worried but felt stupid making a complaint. The PCSO said that they were concerned about Missy. However, this was not followed up.

The information given to the PCSO strongly suggests a pattern of behaviour acknowledged as stalking. This behaviour is also acknowledged as high risk after a separation.

A 'Homesafe' referral was made and a 'You matter we care' leaflet was left. The PCSO invited Missy to contact her should she have further concerns, and to phone 999 if Alf turned up at the house. The PCSO also said that there would be some patrols in the area.

A Homesafe referral is essentially a visit from a specialist to give advice about home safety. A 'You matter, we care' leaflet has advice to reassure people and numbers to call. See more information in s.17

December 2013: A Homesafe security fitter called Missy's mobile phone. She did not answer and a message was left. No return call was identified. The Homesafe referral team were not in possession of all the relevant information gathered by the PCSO.

Such visits may be very helpful in cases of stalking, especially where the stalker is a former partner who may have access to the home, as Alf did, because he had a secret key. Victims could be alerted to the fact that locks should be changed through such a visit. Follow up calls may be good practice where stalking is alleged.

December 2013: Alf turned up at Missy's home at midnight waiting for her as she returned from work. He asked where she had been and where her car was. He said he was suicidal.

Alf is now repeating the pattern shown when the separation was instigated by Marie. He is calling late at night and making threats. Threats of suicide are a high risk marker for homicide. This could have been identified in the documents available.

Around this time Missy is warned by her friend that Alf is a 'stalker'. There is also concern from her friend that he is concerned for her, telling her not to let Alf in the house. Missy stated that she is lying quiet with all the lights out so he does not know she is there.

December 2013: Missy called police on the 101 non-emergency number to report that Alf was stalking her. She said she was scared and it 'was beyond a joke'. She also said there had been no trouble during their relationship. She said that Alf's ex-wife (Marie) had made lots of allegations about him which were not true. The call handler said there was no pattern of criminal damage in the area like the damage Missy had reported to her car.

Missy was to be alone in the house that weekend and was frightened he would turn up. She wanted to stay somewhere where he could not find her.

The call was recorded as a domestic incident. The call handler did not believe that Missy was at risk. It was graded as routine and a response in those circumstances is within 48 hours.

An allegation of stalking where the victim declares they are scared should always be considered a concern. This is even more concerning when there is a history of such behaviour. It should be noted that criminal damage as referred to be the call handler is a different offence to Anti-Social Behaviour as previously referenced by the PCSO.The different nature of the roles of call handler and PCSO might also impact on response given.

Around this time Alf gained entry to Missy's home when she was not there and searched the premises for evidence of her seeing someone else. This was revealed after the homicide by a friend of Alf's who he called whilst there and told what he was doing.

This suggests two things, first that Alf was fixated on Missy, and obsessed with his own concerns about losing control of her; second, it reveals that Alf had no concerns about telling his friend about his illegal and obsessive behaviours. It indicates he feels justified in stalking which is concerning. The police were not aware of these things at this time.

December 2013: Missy said she would like to see the PCSO again. Alf's record was checked and it was noted that he had a violence warning marker. Later that day the police control room contacted Missy on her phone as the call had been cut off. Her mother answered but the call appeared to be cut off. There was no call back from Missy. Police called back but there was only an answering service. A message was left asking Missy to call 101. A text message was also sent asking Missy to ring.

Missy called the 101 number. A call for that evening was offered. Missy declined and said ' Um, I'd rather not, I'd rather do it tomorrow during the day if possible because I actually want to ignore my doors this evening so, so if I could do it during the day, I'd just feel a bit more, at ease if that makes sense'. An appointment was made for 7.12.2013. No checks were made on Missy or Alf. Missy wanted to pretend that she was not in, in case Alf came round.

Testimony after her death suggests that Missy did not want to answer her door, she did not want Alf to know she was there. She was convinced he was going to call and did not feel safe answering the door. She was not told that police could phone before calling at her house, or when they were outside

December 2013 Missy spoke with a PC about her concerns in the presence of her mother. The PC, after listening to these concerns, said that they were not concerned for Missy's safety and that Missy had been letting Alf into her home, and that he may have been confused by what he was and wasn't allowed to do.

She said she was told that if she was very frightened by Alf's behaviour and he was in the house she could excuse herself from the room and phone 999 and leave the phone out of the room. She was told that because her name and details were already on the system that the police would attend without Alf knowing she had called them. Missy's friend said that she felt that Missy gained a lot of confidence from this advice.

It is very common for victims who are frightened to comply with demands made by perpetrators, this may mean they allow access to their home just to stay safe and not create frightening situations. This is especially the case where a victim has children to consider.

The comments made here suggest that these patterns of behavior, and others employed by perpetrators in coercive control and stalking, were not understood at the time by the officer. This suggests that domestic abuse and stalking training may be required. This is discussed in more detail in s17 analysis.

Missy sent a Facebook message to a friend. The police were not aware of this message. It said 'he's behaving like a mad man, final straw on Thursday night. Knocking on my door at midnight and then to cut a long story short made out he was going off to kill himself told me he had resigned from work. It's over he won't accept it he is trying to emotionally blackmail me. Never thought he could stoop so low he scared the living daylights out of me'.

This communication was not shared with police so they could not have responded. This does raise a very important issue of public awareness of the danger presented by former partner stalking.

Alf's record was looked at by a PC but only one domestic incident was read. The PC called on Missy and a DASH risk identification interview was completed. This resulted in a 'standard' level of risk. The DASH form shows negative responses to key questions like 'are you very frightened?' Missy had told people she was very frightened yet did not share this with the police. She did talk about escalation and threats.

This assessment is clearly wrong but could be the result of failure to properly check Alf's history, and failure to properly interview Missy. A man with a history of domestic abuse, with a violence warning marker, who is also stalking a partner after a separation, with clear

escalation should be considered high risk for harm. This may be a training issue for the police.

Missy is recorded as saying that she did not wish Alf to be spoken to, and did not wish a referral for specialist services. Given the clear indications for future harm, Missy should have been advised strongly that these things were a good idea. She could have been asked why she did not want Alf spoken to. She may have been concerned about repercussions. The police could have given her some reassurance or considered this a risk marker in itself. This may have had a different outcome in terms of accepting that she might need help dealing with Alf.

Missy's family said that she had a history of not wanting to cause a fuss, and of questioning her own suspicions. She also had a history of trying to manage Alf in the nicest possible way which would create the least amount of disruption to others. It is quite possible that she may have thought she was causing the police too much trouble and felt a bit sorry for Alf. These approaches may not be the best in terms of safeguarding and police could have helped her realise this, especially as they are very common.

December 2013 Missy attended a family dinner at her mother's house and spoke with her family about the damage to her car. She stated that she was convinced the damage was caused by Alf, and that he had been turning up at her home unannounced late at night. She told family members that on at least one occasion she had let him into the house fearing that he would create noise and disturbance if she did not. She was concerned about her child being frightened.

December 2013 Missy sent an email to the PCSO asking that they visit. The PCSO did not respond.

December 2013 At some point after midnight Alf gained entry to Missy's home without her knowledge, whilst she was there. It is said in reports that it is not known how he got in, but it is now known that he had a key.

At 01:11 Missy made a 999 call from her mobile phone. This was answered by a BT call handling agent. Missy did not speak. The call was transferred to the Metropolitan Police Voice Response System known as the Silent Solution. About 30 seconds into this call Missy was recorded saying 'I don't know how you got in but you need to leave'.

Because Missy did not speak directly into her phone, some 6 seconds later the call was transferred to an automatic system. Missy did not follow instructions. She had not been told by the PCSO beforehand, nor could she hear the system's instruction, to press the number 5 twice. She was further recorded saying 'that's it put (inaudible) down' and 'this is freaking the (inaudible) out of me'. The call was then cut off by the automatic system.

It is not known how long the call handler listened to the call. Missy's voice was recorded by the Silent Solution system so there was sound.

Missy was murdered sometime after making this call.

Missy was given advice by the police (via a PCSO) that if she phoned 999 and was unable to speak, that help would still arrive. This was incorrect advice as further steps are necessary to secure a police response where a caller is unable to speak.

December 2013 at 09:48 that morning Alf called 999 to report that he had strangled Missy. He also stated that her child was upstairs unharmed. Police attended at 0955 and commenced CPR on Missy. Paramedics were present. Alf was arrested.

16.0 Overview (what was known)

16.1.1. In this case there was little agency involvement over the course of the relationship, but there were a number of opportunities for intervention when Missy requested help after the separation. There were also many missed opportunities in Alf's past which impacted on the predicament Missy found herself in. The opportunities to help Missy largely revolved around knowledge and understanding of the threat to her from Alf. Dangerous patterns which are common in domestic abuse when separation occurs were not recognised, had they been recognised there may have been more effective intervention.

16.2. There was also a lack of knowledge by the police around safety planning and the operation of silent 999 calls.

16.3. In this case Missy was given incorrect or partial information about the way the Silent Solution worked. Missy was not told that she needed to press the number 5 twice, and she did not have this information herself. This extra information, had it been in the possession of the victim, may have created an opportunity for the police to have been informed that a serious life-threatening situation was in progress. The victim was told that ringing 999 and remaining silent was sufficient to alert the police and secure their attendance.

16.4. Police had the relevant information that a dangerous pattern of abuse existed from what was recorded of Alf's history in their databases. They had access to information which warned that Alf was violent, and a high-risk abuser. A risk assessment interview was completed, and relevant information about Alf was gathered. Not all the information about Missy's fears was recorded. Much of the detail appeared to come out in the murder investigation. This information was however, in the possession of the officer receiving it, and could have helped inform the officer completing the risk interview and subsequent police response.

16.5. There was also information from the risk interview which was not given enough weight.

16.6. It can be concluded that the police had the relevant information about the dangerous pattern, and it was accessible to their officers. They also had the relevant information from interviews with Missy which was accessible to their officers. Police also had the relevant information around operation of the Silent Solution. Information was there.

16.7. No officer would deliberately put a victim in harm's way, so it seems reasonable to assume that the situation as reported by the victim did not seem serious enough to officers, to either take things further or seek further information from databases. This would suggest that a more developed knowledge around the dangers of domestic abuse and stalking is necessary for officers to be able to make informed assessments about risk.

16.8. This is about subject matter knowledge, but also about leadership and priorities in the wider service.

17.0 Analysis

17.1. This analysis considers the previous sections including the chronology of events and Alf's immediate history prior to meeting Missy. It also considers the issue of sex as a protected characteristic, the information that was in the possession of police discussed in s16, and the contextual information provided by family and friends.

17.2. The chronology provides a fairly comprehensive overview of the events which led up to Missy's death, and also what information was known by agencies. It would be easy to draw the conclusion that individual officers should, or could have known more, taken the reports more seriously, and better checked on the history of Alf. This aspect to the events has been considered and dealt with by the IPCC in their report. It may be more helpful for this review to consider the context in which individual officers were working and making the decisions that they did, to identify learning opportunities.

17.3. The first key area for analysis is whether there is good knowledge of domestic abuse and stalking, including how victims and perpetrators behave. This includes risk assessment and safety advice.

17.4. The second key area for analysis is whether there is strong leadership in the area of domestic abuse and stalking, which keeps these crimes a key priority for the service as a whole, and for individual officers who are taking reports and disclosures.

17.5. A third area is a history of Alf not being held accountable for his actions. This is said to be for a number of reasons including lack of evidence, lack of corroboration, an unreliable (victim) witness, and the reluctance of victims to support a prosecution or other intervention. These problems are well documented as dominating the response to domestic abuse nationally. Again, leadership in encouraging good evidence collection, and ensuring good safety planning knowledge, may be a way forward.

17.6. Also, we must also consider that Missy did not see herself as a victim of domestic abuse, largely because of the absence of violence. She was similarly unsure whether she was a victim of stalking. Looking at the comments made by Missy about her relationship with Alf, one can draw a fair conclusion that she was a victim of coercive control domestic abuse and this will be discussed, and she was definitely a victim of stalking. It must also therefore be considered that it is subject matter knowledge that will underpin good interviewing and instincts in such cases for professionals so that they need not rely on victims self-identifying. Victims often look to professionals to validate their experiences so it is important that they have the knowledge to help victims stay safe, and be aware of potential risks.

17.7. It was also mentioned by Missy to police that she did not believe Marie's accounts of abuse (Marie is Alf's former partner). This could have been discussed by police with Missy. They had the information which suggests Marie was not lying (as she was designated high risk status, and Alf had a violence warning marker). This could have been done through a so-called Clare's Law disclosure. This would also have been an opportunity to discuss safety with Missy.

17.8. We will also consider knowledge surrounding the silent system, and the issue of safety advice in respect of domestic abuse and stalking specifically, and the Homesafe scheme.

Analysis of the antecedents:

17.9. Missy is described by her family as someone who didn't like to make a fuss. She would downplay things and try to cause the least disruption to everyone. She was protective of her child and tried always not to challenge or upset Alf. This is an important observation, especially as many victims of partner abuse and stalking similarly downplay their experiences. Missy did not like to make a fuss, so the importance of her calls to police was more significant than realized at the time. This then reveals the importance of good subject knowledge and professional curiosity. Victims of abuse are very often reluctant to speak about abuse, and victims of stalking are very often questioning of their own experience. It is common for victims of stalking to feel some level of paranoia, until the stalking is identified and named. By the time many victims contact police things may have escalated.

17.10. The importance of professional curiosity is often cited in death reviews. It could be defined as asking more questions and digging deeper. Professional curiosity is more effective with better subject knowledge.

17.11. Subject matter knowledge is recognized as a national problem, but one that is often addressed at a local level given police organization and governance. Prioritising such subject matter knowledge and its application and encouraging frontline staff to see stalking and domestic abuse as organisational priorities, is largely a matter of leadership in any individual police service/force.

17.12. It is recognised that the murder of Missy happened in 2013 and that since that time there will have been some changes to policy and practice in domestic abuse and stalking processes for Devon and Cornwall Police. There have also been legislative changes from s.76 of the Serious Crimes Act in 2015 which criminalise the pattern of behaviour defined as Coercive Control. There were also wide ranging recommendations from the inspection of police responses to domestic abuse in 2014 by HMIC.

17.13. Problems related to silent 999 calls have also been addressed by the IPCC review and the Coroner in looking at the operation of the Metropolitan Police Silent Solution (see appendix 1). In this review we feel there are two key observations in respect of the silent system. The first is around its operation. If there is no sound – that is a silent call – then the call is manually diverted to an automated system and this is a practice defended by the Metropolitan Police. However, in this case there was not silence. There were voices identified on the recording. The question then is whether the call should have been handled by the silent system at all. Consideration must be given to the possibility that there could have been better monitoring of conversation. Similarly, in the case cited in the IPCC report of the murder of Hannah Foster in 2003, this 999 call from Hannah (who had been abducted and was subsequently raped and murdered) had talking in the background on the retrieved tape. Talking which could be transcribed and revealed the danger Hannah was in.

17.14. It may be that the Silent Solution needs review, especially the scrutiny given to 'apparently' silent calls. However, a number of questions are raised. It seems that requiring someone to press 5 twice is an extra action in addition to dialing 999. For people who cannot even speak, any extra action may be impossible. Only people who cannot speak but can use their phone in sight of a potential threat will be covered. This doesn't seem a particularly suitable process. In the case of Hannah Foster, and the case of Missy, both could not, or did not want, to let their attacker see them using the phone. Finding the central 5 button to press twice would take concentration and sight of the keypad. It would seem more sensible that someone could press any key twice as a compromise. Another problem is that most smartphones now have touch screens rather than buttons. The screen lights up when touched, and it would be impossible to search for a number on these phones without looking. The light would also draw attention to the phone. The requirement to press 5 twice seems to make it more difficult to receive help when you cannot speak. Alternatively, to increase the volume of any call to better detect talking or conversation for call-centre operatives should perhaps be standard for apparently silent calls.

17.15. If the talking could be heard when played back, why wasn't this available to the operator? Perhaps apparently silent calls should be monitored for longer, or software developed to alert the call handler to voices or sound, even after the call has been diverted.

17.16. The second observation revolves around the partial and false advice given to Missy and the response to silent 999 calls. This is around subject knowledge. As this system is specifically in place for 999 calls, which are emergency calls, then subject matter knowledge around its operation is absolutely crucial. All officers and support staff should know how the system operates.

17.17. The following analysis focuses on testimony which supports and suggests the presence of coercive control in the relationship between Alf and Missy.

17.18. In March 2010 Missy and Alf started a relationship. This was not long after his relationship with Marie had finished. He was known to have been stalking Marie and refusing to accept the relationship was over. He had also been accused of breaking into Marie's home and strangling her in her bed. This information is crucial in assessing the threat posed to Missy. This is exactly the behaviour he repeated when he killed Missy. A person's history presents many opportunities for assessing their risk. Alf had a history where he was given a violence warning marker; he was also known to be a stalker and abuser. These are crucial pieces of intelligence when assessing risk, which suggest Alf does not accept challenge or separation.

17.19. Information from Missy's family shows that Alf was repeating his controlling and isolating behaviours. They state that from the beginning Alf presented as a strange individual who did not like to mix with them and did nothing to be friendly or to integrate with the family. He would keep himself separate from them at family gatherings, preferring to stand by himself.

17.20. Missy, in contrast, was a very social and friendly person who was close to her family, but a distance grew when she began the relationship with Alf. Comments made by family, friends and officers who interviewed Missy suggest strongly that Alf was displaying a pattern of behaviour which could be described as coercive control. (It is acknowledged that at this time coercive control was not defined as a criminal pattern, but it was acknowledged as a risk marker in standard risk assessment tools). For example, Missy described how she had to constantly placate Alf and try to manage his moods and temper. She said that he would get very angry over trivial things regularly. Missy's child said to police after the murder that Alf 'didn't treat me and mummy how we were supposed to be treated'. Missy's child was not interviewed prior to the murder, but was known to be very distressed and frightened, and this is documented. This pattern underpins coercive and controlling behavior and creates a predicament for the victim where they dare not let anything happen to upset the perpetrator, for fear of the consequences. The consequences could be quite diverse and often include things like the threat of violence (actual or implied), tantrums, silence, withdrawal of resources and help, upsetting children and so on.

17.21. Missy also described being isolated from a social life and from contact with others because Alf didn't like to go out, and he didn't want her going out or meeting anyone either. In this pattern of behaviour, Missy going out would have had consequences for her. Victims of this behaviour often stop doing things which upset or antagonize the perpetrator. The difference between coercive control and ordinary marital compromise, is that the victim stops doing normal healthy things in order to placate someone they are afraid of. It also means that the compromise isn't over individual arguments but a pattern which dominates the victim's whole life and is a persistent pattern. The consequences of challenging the perpetrator are often menacing or disrupting.

17.22. A third common behavioural pattern in coercive control is for the perpetrator to constantly criticize the victim. Missy talked about Alf criticizing her appearance. This is often used to control eating, a way of dressing, stopping arguing, and reducing confidence.

17.23. Missy talked about being frightened of Alf and what he might do. Even though Missy stated there was no violence, there was clearly an unspoken (maybe demonstrated) threat of harm. She said she didn't know what he might do. The potential that she was afraid of violence cannot be disregarded. She certainly expressed fear of violence after they separated.

17.24. The atmosphere in the home, in this kind of circumstance, can change quite quickly and the needs and demands of the perpetrator eventually (and often quickly) dominate. Constantly managing and placating a perpetrator becomes a way of life and is the key cause of isolation, loss of resources, focused attention on the perpetrator and their moods, and fear of consequences for breaking the rules.

17.25. This pattern is well documented as being present in coercive control. Coercive control was not considered a criminal pattern in 2010 – 2013. It was only introduced in December 2015 in s76 of the Serious Crimes Act. The inclusion of coercive control in the act gave it considerable additional focus within force procedures. In 2013, which was prior to the act, it was not as widely known (outside of specialist domestic abuse services) that coercive control is a dangerous pattern with significant links to serious harm and homicide. However, controlling behaviour was recognized, and was included in the DASH risk assessment checklist in 2013. Control is noted as present in the DASH assessment and should have been given more weight.

17.26. It is also well acknowledged in research that when there is coercive control present, and the victim ends, or attempts to end, the relationship, this is when the danger to them often escalates significantly. If the perpetrator starts to employ stalking behaviours after a separation, this is a significant indicator that the victim is potentially at risk of serious harm. Alf started to employ stalking, and some key behaviours which indicate potential for serious harm, immediately after separation. The dangers of stalking, and of separation are also included on the DASH form. Stalking after separation should be given extra weighting in any risk assessment.

17.27. It was not known by Missy or the police at the time that Alf had a key to her home. It was known by his friends, and this information could have been passed to Missy by them, or to the police.

17.28. It was also known by Missy's friend that she was scared of Alf and the stalking, she stated this clearly in a Facebook post not long before her death. The police did not have this information but friends did, which again underlines the importance of public knowledge around dangerous behaviours after separation and a method for reporting it.

17.29. Missy was interviewed using the standard DASH questionnaire by police, and was assessed as standard risk, though evidence suggest she should have been assessed as high risk. Standard is the lowest risk possible in this process.

17.30. The DASH form (at that time) consisted of 27 questions. The positive responses revealed that Missy felt depressed; that there was a separation; that there was constant calling and texting; that there was escalation in concerning behaviours; that Alf was controlling; that he had a history of allegations against him that he had threatened suicide; that he had been in trouble with the police for domestic abuse. These positive responses strongly support the idea that Missy was a victim of coercive control and stalking and a high-risk victim.

17.31. The questions which received a negative response and perhaps shouldn't have done, were around whether Missy feared Alf (she said to other officers she did fear him and what he might do), whether she was isolated (she said to other officers she was isolated from going anywhere), and whether he breached court orders or bail conditions (he had a history of breaching injunctions which was documented on police records, and though were not in relation to this case as there was no injunction in place, show a propensity to ignore conditions); that he had a history of strangulation assault (this was known by police). This suggests that Missy is in fact a high-risk victim.

17.32. It may be argued that it requires specialist knowledge of coercive control, domestic abuse and stalking to identify the risk, and to ask the right questions to gain trust. However, even without this specialist knowledge the information was available to the police to gather enough risk factors to suggest that standard risk was not appropriate. Professional curiosity should be encouraged by police leaders with respect to stalking and domestic abuse.

17.33. This brings specialist subject knowledge, and meticulous intelligence gathering, to the centre of this analysis.

17.34. Alf was known to be violent and was known to have presented high risk of harm to his former partner and she was referred to MARAC. MARAC is a Multi Agency Risk Assessment Conference and is a meeting of professional who discuss risk in specific cases designated as high risk.

17.35. It may be that knowing this or having access to this information, a proactive Clare's Law disclosure under the 'right to know' scheme could have been suggested. This is where police can proactively tell partners of known abusers about their history and is more formally known as the Domestic Violence Disclosure Scheme. Missy was unaware of the danger presented to her and had said she didn't believe the allegations made by the former partner, Marie. Missy was making decisions based around her belief that police would not be interested due to the lack of violence. She stated this. She also stated she did not believe the allegations made by the former partner having only heard Alf's version of these allegations. This too is not helpful to her when making decisions about her own safety. A history of domestic abuse is the single most significant factor in assessing risk, repeating those patterns especially when they have previously been assessed as high risk, should influence a subsequent risk assessment.

17.36. Specific decisions which may have been taken by Missy due to this lack of knowledge about the danger, could also be related to Missy's continued attempts to placate, rather than upset or challenge, Alf. She allowed him into her home to placate him, she feared if she refused entry Alf would create a disturbance which might frighten her and her child. Missy knew that Alf posed a threat, though she was unsure of the seriousness of that threat. If she had been aware of his real history, and if police had helped her to understand the danger, she may potentially have taken different decisions.

17.37. Professionals should be made aware through specialist training that these patterns of behaviour displayed by Alf are dangerous. Early intervention in stalking is advised by specialists. There should therefore be clear identification of what training will include so that it not only helps professionals identify key high risk patterns but supports the use of professional curiosity to obtain the fullest story from the victim.

17.38. Professional curiosity needs strong organisational support. Professionals should have their curiosity supported and more importantly, explicitly encouraged.

17.39. This could be furthered through identified domestic abuse and stalking leads and close ties with public protection units.

17.40. This links closely to professional knowledge related to safety planning. A referral was made for Missy to speak with the Homesafe team.

Homesafe

17.41. In this case safety advice was almost entirely confined to situational methods. These methods generally increase the security of the home, using good door and window locks for example. Although a Homesafe referral was made, they were unable to contact Missy and no follow up call was made. This advice can only be helpful if the victim is going to bar entry to the home and have the support to deal with the consequences of that. In this case the perpetrator had a key and changing the locks would have been crucial because of this. Possession of a key and knowledge of weaknesses in home security should be assumed where the perpetrator has lived in the premises or has had access to a key at any time, even if they say they have returned keys.

17.42. In this case the consequences of refusing entry were not acceptable to Missy. She was frightened to refuse entry. She also had no idea about the key. Safety planning advice should involve helping victims understand what they can do to manage the consequences of challenging perpetrators, and also to consider the possibility that they can gain entry. Alf had a history of breaking in to assault.

17.43. In this case Missy was advised to call the police if she was frightened by Alf. But she was not given fully accurate advice about how to call them. She was clearly concerned about letting Alf know she was calling the police. So if this was her position she needed to know exactly how to manage that situation. This is again about subject knowledge. Officers could be prepared with safety advice which goes beyond putting in locks, especially when the victim thinks it's safer to give entry.

17.44. If Missy was frightened to refuse entry, then she needed accurate advice about how to ensure police attendance; alternatively, she could have been given assurance that barring entry and calling 999 was the best option. In this case she was advised that if she did give entry, the police would attend if she called 999 and left the phone in another room. She did not give entry as Alf entered by other means and this is evidenced in the conversation recorded on the 999 system. The advice she was given turned out to be incorrect, but was the advice Missy followed.

17.45. A final and key characteristic to this case was the response to Alf's behaviour. He received fairly consistent responses (in that he was cautioned rather than prosecuted, or there was no further action) from professionals. There was little to deter him from behaving as he always had.

17.46. There have been ongoing campaigns which look to increase pressure on police and prosecutors at a national level to pursue domestic abuse prosecutions where possible, even where the victim is reluctant to attend court. This entails good evidence gathering, and clear supportive engagement with the victim.

17.47. It must also be considered that Alf was able to manipulate professionals to believing his version of events. For example, when Marie complained about his violence she was considered unreliable and disreputable. Officers should pursue lines of enquiry which might undermine (or support) an aggressor's version of events. Alf's known victims preferred not to challenge him rather than follow a more challenging response. The effect of this on Alf should not be underestimated. He was getting away with it.

17.48. When Alf illegally entered Missy's home to search it, this was a repeated behavior, as he broke into Marie's home too. He appeared to feel justified in this behaviour because he called a friend to tell him what he was doing. This pattern of revealing risky intentions and behaviours to friends is not uncommon. Important also, is that Alf's friend did not report this to anyone, did not tell Missy, and did not go to the police. This is possibly because the friend failed to recognize the danger. Police were not aware that Alf had done this, but his friends were. They had this information and this supports public awareness campaigns.

17.49.

17.50. The really important message from this analysis is that the dangerousness of stalking, even what appears to be low level stalking, after or during a separation, is not widely recognised. Neither is there much acknowledgement of the intentions, behaviours, and persistence of perpetrators.

17.51. In summary, specialist subject knowledge is crucial for professionals, victims and the public, so that police can act effectively. Professionals should seek, and have all information available, and use that to make informed judgements about risk, and give good safety advice to victims.

18.0 Conclusions

It can be concluded that there was enough known about Alf to suggest he was a danger to Missy. There were also opportunities to provide Missy with safety advice, enhanced resources (from a high risk of harm assessment) and information about Alf which may have helped her understand the risk he presented to her.

18.1. Given the information taken from friends and family it can be reasonably assumed that Missy was a victim of coercive control domestic abuse. Even though coercive control was not considered a criminal pattern at the time, its dangerousness and links to homicide were acknowledged and included in standard risk assessment checklists used by Devon and Cornwall Police.

18.2. There was enough information to identify a pattern of stalking and escalating risk.

18.3. The information held by police showed a history of abuse, as well as stalking, so revealing a pattern.

18.4. The police did not know that Alf had a key to Missy's home, but this should always be assumed in safety planning where the perpetrator has previously lived in the premises.

18.5. The police should have known about operation of the silent system.

18.6. Improvements could be made to the operation of the silent system for victims.

18.7. This leads to the conclusion that improved leadership in domestic abuse and stalking responses, professional knowledge, and public knowledge are strongly indicated as key learning opportunities.

19.0 Lessons to be learnt

The learning opportunities drawn from this case are listed by number. Each learning opportunity has a corresponding recommendation in s20. Learning Opportunities 1 – 5 are identified by Devon and Cornwall Police for themselves.

Learning Opportunity 1

Devon and Cornwall Police identified that PCSOs should receive training in domestic abuse and stalking in their initial training package. PCSOs are often the first officers to receive such complaints and to interview victims. Consequently, they need to be fully aware of the potential risks to victims.

Learning Opportunity 2

Devon and Cornwall Police recognized a need for disclosures or reports of stalking to be reviewed by senior officers, both duty Inspectors and Control Room Sergeants. A review of such disclosures gives a second line of knowledge to the reported incident and reduces the risk of high risk cases slipping through the net. We would suggest in addition that officers are actively encouraged by senior officers and domestic abuse and stalking leads and champions to seek specialist guidance and support when taking disclosures of domestic abuse and stalking if they are at all concerned.

Learning Opportunity 3

Devon and Cornwall Police identified that thorough checks were not done in this case, and should be done on the history of alleged offenders/perpetrators in all cases. The information was available to officers.

Learning Opportunity 4

Devon and Cornwall Police recognized that refresher training is required on domestic abuse and stalking. Despite having rolled out comprehensive training to frontline officers, there appeared to be a lack of understanding around the risks posed by stalkers, especially former partner stalkers.

Learning Opportunity 5

Devon and Cornwall Police identified a need for initial and refresher training to be included in a wider safeguarding training plan, thus giving domestic abuse and stalking strong strategic status.

Learning Opportunity 6

This review notes that awareness of the prevalence of domestic abuse and stalking is not sufficient for professionals working on the frontline, or for more senior leadership roles. Training packages should be scrutinized so that officers and training staff receive adequate tools to respond effectively to disclosures. If officers were equipped not only to recognize, but respond to, domestic abuse and stalking, this would have been helpful to Missy in this case. A clear need for officers to be aware of safety planning options, to understand safety options already in place, and understand victim fear and offender persistence is identified. It is also crucial that officers in detective roles are equally well trained. Domestic abuse is not confined to low level offending, it is implicated in the most serious offending, and in this case a homicide. The decisions and lack of knowledge of a detective impacted on a poor decision made about Alf's dangerous behaviours in the history of this case.

Learning Opportunity 7

Missy did not recognize the importance of Alf's previous behaviour. There are processes in place which could have been operationalized to help her to understand the risk posed by Alf. A Clare's Law disclosure with proper support may have helped her understand. This would have created an opportunity to talk to Missy about the dangers of allowing access.

Learning Opportunity 8

Alf's friends did not recognize the dangers in his behaviours. If there was more public knowledge around the dangers of stalking and domestic abuse after a separation, Alf's friends may have taken some sort of action and informed police or Missy about his actions.

Learning Opportunity 9

Throughout Alf's history he was not seriously sanctioned for his behaviour. He was able to manipulate others to believing he was the victim. Seriously high risk behaviours were demonstrated which revealed his potential for homicide. This panel recommends that it is important that offenders are consistently challenged, and that meticulous evidence gathering should accompany all potential prosecution attempts.

Learning Opportunity 10

The Homesafe team could have been crucial in this case as they may have been able to encourage Missy to change the locks on her house.

Learning Opportunity 11

It is known that Missy's child was frightened, especially when the stalking started. The child was also concerned about Alf's behaviours in the home. Pastoral care, and support and guidance from the school may have encouraged the child to seek support or to disclose their concerns. A recommendation around school support could also include training in these matters for staff, governors, and students.

Learning Opportunity 12

For Metropolitan Police. There are problems with the way that the silent solution is required to be operated by victims. Some consideration to changing the requirement for victims to press the number 5 twice could be given. The number five could be difficult to find, especially on a touch screen, and would light up the phone indicating it is being used, or that the victim has a phone.

20.0 Recommendations

Recommendations 1 – 5 have been made by Devon and Cornwall Police for themselves.

Recommendation 1

An understanding of stalking and harassment risk assessment interviews will be embedded into initial PCSO training. We further recommend that the implications of scoring should be fully understood and that training should be ongoing.

Recommendation 2

All incidents perceived to be stalking will be reviewed by a duty Inspector and control room Sergeant. The panel further recommends that supervising officers must have received training in domestic abuse and stalking, including safety planning and evidence gathering.

Recommendation 3

All frontline officers will be reminded that thorough research on victims and suspects must be undertaken to inform the DASH risk assessment grade before any submission is made. The panel further recommends that officers are in no doubt that the DASH process cannot be a tick box exercise, and that certain characteristics are weighted more heavily than others.

Recommendation 4

A formal programme of refresher training will be introduced for all front line officers completing DASH risk assessments. The panel recommends that this should also include detective officers, supervising officers and control room staff.

Recommendation 5

Devon and Cornwall Police should embed domestic abuse risk assessment training and refresher training within a wider safeguarding training plan

Recommendation 6

The panel recommends that Devon and Cornwall Police ensure that training goes beyond awareness, and covers safety planning, safety advice, and knowledge of existing safety options like the silent solution. This should include taking consideration of victim fear and perpetrator persistence. If this training is not resource effective there should be clearly identified officers on duty who can be consulted on this type of subject knowledge. Identified officers could be clearly identified in a high profile manner. We recommend domestic abuse and stalking specialists/champions throughout departments. Training and specialism should be represented in detective departments.

Any training package should be scrutinised to ensure that it will provide officers not only with awareness, but with skills to effectively carry out risk assessments and to be fully aware of all response options.

Recommendation 7

Where a history of stalking or domestic abuse is revealed officers should consider the option of disclosing this history to a victim at risk. There is a process for this. Victims could be supported to understand the risks posed by repeat abusers.

Recommendation 8

Public awareness of stalking and domestic abuse and the specific risks posed to victims, and dangerous behaviours in perpetrators is not high enough. Repeated public awareness campaigns through advertising or high profile posters, social media and TV, also to employers, could help people feel confident to disclose, and for perpetrator friends and family to challenge or report risky behaviours. Also public awareness around how to use the 999 system and the implications of the silent solution should be part of an immediate campaign.

Recommendation 9

This panel recommends that it is important that offenders are consistently challenged about their behaviours, and that meticulous evidence gathering should accompany all potential prosecutions. Victims who are described as unreliable or are unwilling and frightened to support prosecutions, should still be supported. A clear policy on prosecution should be available.

Recommendation 10

Homesafe teams should be sufficiently trained to recognize the importance of their visits to victims of domestic abuse and stalking. These should be prioritized. They should recognize that lock changes should always be carried out where a perpetrator has lived in the premises, or has ever, at any time, had access to a key.

Recommendation 11

The panel recommends that all schools are aware that many children will be suffering domestic abuse in their homes and that there should be safe spaces for children to disclose, and pastoral care from informed practitioners

Recommendation 12

It is recommended that the Metropolitan Police consider updating their Silent Solution given that most phones are now touchscreen. There may be difficulties in attempting to find the number five on a touch screen phone, and the automatic lighting up of the screen if touched. These things make it very difficult in some circumstances to make a call in secret.

Appendix 1

Silent Solutions

The Metropolitan Police operates Silent Solutions on behalf of the country. Silent solution was introduced in September 2001 to deal with calls to 999 &112 when there is no request for service (Police, Ambulance, Fire and Coast Guard) and there are no other aggravating factors(sounds of disorder etc) in order to help filter out accidental calls. The overwhelming majority of such calls are accidental calls or customer misdials, but there is always a possibility of a genuine caller who cannot speak.

When an emergency call is received from a mobile phone and there is no request for service, the caller does not engage with the call handling agent (BT operator) questions and only background noise is present, then the BT operator cannot decide if an emergency response is required. These calls are transferred to the Police Voice response system (Silent solution)

The Silent solution is an automated system. When the call is transferred to it, an audio recorded message is played which advises the caller that they are through to the Police and instructs them to press 55 in the event they require and emergency service. The recorded message lasts for 20 seconds, The BT operator remains on the line listening to the call whilst the automated message is played.

If 55 is pressed by the caller, the system will detect this and the BT operator will be notified and they will transfer the call to the relevant Police force as there is an indication of a genuine emergency.

If the caller does not press 55, the system will detect this and the recording will instruct the BT operator to terminate the call. This is because the call is considered to be an accidental activation. Failing to respond to any of the prompts means the call will be terminated. The Police Force which covers the area where the call is made from will not be notified in these circumstances.

If at any point during the process of dealing with a call without service request, including following the transfer to silent solution, the caller subsequently requests a particular service, the caller taps the handset or suspicious noises are heard by the BT Operator, they can override the Police Voice Response recording and connect the call to the appropriate Police Force.

There are fail safes in place for the possibility of a genuine emergency where the caller cannot respond to the call handling agent's commands. These include a strategy to notify the relevant police force when repeated calls from the same number, BT flags silent calls from the same mobile phone within a 30 minute period. On receipt of the third silent call from a mobile, the BT Operator will connect the call to Police.

Emergency services are not dispatched to every silent 999 to conduct a welfare check. It is important that officers and staff are aware that the police do not automatically get notified of all silent 999 calls. Officers should be mindful of this when providing safeguarding advice for victims, as they may not be aware of Silent Solutions. Members of the public should never be advised to dial 999 and simply leave the call open, as the call will not result in emergency services automatically being sent to the caller's location. The advice that should be given is that callers should speak if they are calling 999 or carefully listen to the instructions of the BT operator.

Appendix 2

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