femicide census

Femicide in Merseyside: 15 years of failing women

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Introduction

Between 2009 and 2023, 61 women were killed by men across Merseyside and a further two Merseyside women were killed by their male partners during short trips outside of the area. Every one of these women were failed in a multitude of ways: by the men who killed them; by controlling men who punished attempts to leave; by state agencies that did not fulfil basic levels of duty of care; by systems that fail to lock up, or release early, violent men; by poorly managed or untreated problematic substance use; by a pervasive gangland culture; by failing to assess risk; by a lack of professional curiosity and by commissioning processes which fail to support specialist independent organisations established to help.

This report is dedicated to those 63 women, and to their families and friends who live with their loss every day. In addition to these killings, 6 girls have been killed across Merseyside and while the Femicide Census does not document cases killings of girls under 14[1], it is important to acknowledge these girls as part of wider efforts to tackle and end men's fatal violence against women and girls.

Three (4.7%) women killed by men were killed by strangers in 14 years - lower than the national average of 8% of all killings of women by men. This has important implications for women's sense of safety and risk. There is public fear of stranger killings, fuelled by mass media coverage and Merseyside's killings of women in random attacks have had almost blanket coverage in the national media. The previous (Conservative) government referenced stranger killing in its Violence Against Women strategy - even when the strategy failed to mention homicide outside the domestic sphere at all.

There have been two multiple killings involving women and girls in Merseyside in 14 years. The recent killings of three girls in Southport in 2024 attracted intense media speculation and given the numerous reported references to mental health should be subject to some form of state scrutiny independent of the trial of the suspect. However, the 2018 killing of Arena Saeed and her two children by her husband did not generate one public report identifying where failures occurred and where lessons could be learnt. And while an internal review was undertaken relating to the children, no Domestic Homicide Review or NHS report was commissioned, despite the perpetrator's reported diagnosis of schizophrenia which should have been identified as a risk factor and subject to scrutiny regarding how and why protective measures were not put in place. High profile cases capture headlines, but failures can be swept aside when triple murders only generate press when the location of the killing is a Beatle's former flat or is believed to be an immigrant killing children.

As the Femicide Census has continually shown nationally, and the Merseyside data is a particularly stark reminder, women are more at risk of femicide from someone they know and invariably cared for. In Merseyside 60 of the 63 women killed by men knew, in most cases intimately, the man who killed them: he was a partner or ex-partner, a son, a father, uncle, neighbour or acquaintance. These figures differ from other comparable areas in the UK and where relevant the report compares Merseyside data with national data, as well as data from the four largest police forces in England and Wales, when highlighting regional disparities.

[1] Infanticide the crime of killing a child is predominately carried out by parents or stepparents. It is rare for a stranger to carry out such killings.

The phrase ‘what isn’t counted doesn’t count’ could be said to underpin our work. The new Labour Government’s commitment to halve violence against women over 10 years is welcome. But to fulfil this pledge an understanding of femicide, and what patterns are evidenced in femicide, is critical to prevent future deaths. It is the model used by Domestic Homicide Reviews, Inquests, Independent Office of Police Conduct (IOPC) reports, and Safeguarding Reviews and a critical part of the Police’s own Homicide Prevention Framework. All of these reviews consider different elements of homicide, but no state agency is looking at the complete picture of why women are killed by men. If you do not understand the social and cultural context of why and how a woman was killed, there is little chance of preventing future killings. Understanding femicide regionally enables us to highlight areas of concern, as well as possible interventions where women are potentially at known risk of femicide.

There was an identifiable risk of serious harm against women by the men who killed them evident in all the cases of femicide in Merseyside where they were known to the authorities. As a result, this report is critical of the authorities - but our criticisms echo what has already been said in the DHRs and by His Majesty’s Inspectorate of Constabulary and by the local domestic abuse organisations who have consistently raised serious issues with the police, local authorities, the Police and Crime Commissioner, MPs and the Metro Mayor. We recognise there is no one else to do this job. It is a relentless, all consuming, repetitive, and frustrating task. Policing does not cause the problem of violent men, but the police, the Probation Service and the NHS are tasked with preventing them from doing harm, and to pick up the pieces when they do. It is imperative that these bodies learn from mistakes when they are made, reinforce good practice throughout their operations, are funded to a level that saves lives, not contributes to death, and prioritises victims so women have the space and safety to become survivors. This is femicide prevention.

Police forces have been tasked to use the Homicide Prevention Framework[2], but homicide prevention has to be the goal of every statutory and sector agency – not just the police. This report goes some way to evidence the patterns and commonalities evident in femicide and highlights those women who appear most at risk. It is up to those agencies to use this report, build on it, fund services that support it and above all recognise those patterns and commonalities when directly faced with a situation in front of them that all too often has occurred many times before. Not every failure to act has led to a killing, but as this report shows every killing of a known victim has involved a failure to act.

[2] https://hmicfrs.justiceinspectorates.gov.uk/publications/inspection-of-the-police-contribution-to-the-prevention-of-homicide/

Key findings

- 95% of women knew their killers.

- 56% of all killings of women were by men with whom they were or had been in an intimate relationship. This is slightly less than the national average 60%.

- Matricide - son to mother killing - accounted for 17% of all killings of women in Merseyside in the years reviewed. This is more than double the national average of 8% in the same period and significantly higher than other police force areas per percentage of the population.

- Of 11 sons who killed their mothers, eight had significant mental health problems and one was described as having depression. Critically, where a review had been carried out, all those families evidenced significant failures in care and oversight of their mentally ill sons who went on to kill.

- Mental illness was identified as being present in 28 out of the 63 killings, with schizophrenia in nine cases, this being the most frequently identified diagnosis.

- In cases of domestic homicide, at least 68% of men had a known history of violence against women including the women they ultimately killed.

- 63% of perpetrators involved in intimate partner homicides had problematic substance use, rising to 82% in cases where the victim and perpetrator were not married. Problematic substance use in all femicides was 55%. The actual figure could be higher given not all cases were subject to statutory review which would highlight problematic substance use.

- 64% of femicides of women by current or former partners had left or taken steps to leave the relationship before they were killed.

- In all cases (100%) where a DHR, IOPC or NHS report was published and the victim and perpetrator were known to the authorities, serious failures in the investigation, treatment or conduct of the police, NHS services, social services or probation was identified.

- All but one of the perpetrators convicted of murder are still incarcerated, though one who received 10.10 years and had the sixth shortest sentence for female homicide in the UK in 15 years was released on licence early this year[3].

[3] This report has been amended to exclude reference to a perpetrator who we believed at the time to have been recalled to prison following release. We understand he is still on licence in the community.

Background to commissioning this report

Domestic violence and abuse organisations in the region have long raised the issue of the high number of women killed in Merseyside. In 2021, an article in the Observer reported on an emergency meeting of Merseyside MPs following the killings of three women over a single weekend.[4] Aside from this meeting, the organisations working at the front line to support women subjected to violence and abuse felt they were getting little traction with the state, while seeing the situation deteriorate.

In March 2023, in the International Women's Day parliamentary debate, Jess Philips MP read out the names of all women killed where a man had been charged, convicted or identified as being responsible if he could not be charged (for example if he had died). Among those names were eight women from Merseyside, including three women from one constituency alone - Knowsley. As a result, in that year Merseyside held the ignominious title of the worst region for femicide in the whole of the UK, with Knowsley, the worst constituency in the country. To put this in context, there were 588 constituencies in the country where no women were killed between 2022-2023. All the MPs from constituencies where a woman was killed were written to by the Femicide Census. In Merseyside, despite raising the unprecedented levels of femicide, none of the MPs we wrote to responded.

Together with Caroline Grant from First Step, the only independent specialist domestic violence and abuse organisation covering Knowsley, on 27 March 2023 we reached out to the Metro Mayor Steve Rotheram, the PCC Emily Spurrell, and the Chief Constable of Merseyside Serena Kennedy. We also contacted Angela Eagle MP, Conor McGinn, Paula Barker and George Howarth MP again. This correspondence led to a meeting with the Metro Mayor and the PCC and we followed up with a proposal to conduct this study. While supportive of our work, the Mayor and the PCC declined to fund such a study.

As the 2023 Labour Party conference was in Liverpool, we wanted to draw attention to the high numbers of killings in Merseyside. Jess Philips MP engaged with The First Step, visited the site and contacted the service.

Months later, we were contacted by a representative of Merseyside Police's Knowledge Hub with a proposal for engagement (but no funding unfortunately) by which time, and in the absence of statutory funding for a review on femicide in Merseyside, the main violence against women organisations had already come together to commission this report. We decided it was best to maintain independent control of the work and to proceed on this basis.

Now that the report is completed, we would be happy to engage with any organisation to take the conclusions and recommendations forward.

[4] https://www.theguardian.com/society/2021/mar/14/merseyside-calls-crisis-talks-on-rise-in-domestic-abuse

Femicide Census methodology

Femicide Census data is built up from Freedom of Information (FOI) requests to every police force in the country submitted yearly since 2015. With our first FOIs in 2015, requesting data from 2009-2014. We build upon this data with information from Domestic Homicide reviews, inquests, IOPC reports and safeguarding reports. We follow criminal justice outcomes, updating when there has been a conviction and sentence. We scour press reports relating to homicide: local press does an incredible job in covering local news and trials, even when the national news is not particularly interested. Given they often sit in the trial, they can pick up details on mental health, problematic substance use and previous convictions, when such information may be lacking in statutory reviews and subject to the lengthy time delays that these processes inevitably entail.

We hold the data on a secure database managed by Deloitte LLP, our pro bono partner. Our systems and processes for data collection were reviewed by Freshfields Bruckhaus Deringer LLP, our pro bono lawyers, and we have consulted with the Data Protection Commissioner's office on how we hold our data.

We have used this data for the basis of this report. We have spoken to several families about their experience. We have spoken to the organisations that instructed us about their experience of working in Merseyside.

All the women featured in this report had been identified to us under Merseyside Police's FOI response. Merseyside has been consistent in its response to us since our first FOI in 2015. However, this year it has failed to respond to the FOI request despite repeated reminders. Consequently, Merseyside Police is currently in breach of its obligations under the Freedom of Information Act.

We have included in this report the two Merseyside women who were killed outside of Merseyside. The location of their killing was only temporary, while visiting friends for the evening or on a short trip. These cases were not identified to us by Merseyside police but were discovered through a review of Domestic Homicide Reviews held on the Home Office's domestic homicide review repository. They and their male partners were from Merseyside and understanding the circumstances around their killing involves a review of services in Merseyside. It would have been Merseyside, as the authority in which they lived, which should have been supporting the victim and/or holding the abuser to account. A further woman - Esther Porter was killed in 2023, a 78-year-old male, who has not been named publicly, was arrested and detained under the Mental Health Act. There have been no further publicly available updates in this killing.

This report has included the voices of family members who have gone through the horror of losing a loved one through violence and abuse. Many have had to sit through trials and inquests and Domestic Homicide Reviews, hearing about the immense suffering that their daughter, mother, aunt, or friend went through.

Merseyside's demographics

The population of Merseyside at the last 2021 census was 1,423,718[5].

The breakdown of ethnic groups within the region is as follows:

White: 1,304,797 (91.64%)
Asian: 44,452 (3.12%)
Black: 21,902 (1.54%)
Arab: 10,086 (0.70%)
Mixed/multiple: 30,495 (2.14%)
Other ethnic groups: 11,554 (0.81%)

Merseyside is broken down into five distinct regions controlled by a local authority. Liverpool City Council, Wirral, Sefton, St Helens and Knowsley. Merseyside police cover all these areas.

Knowsley is considered to be one of the most deprived areas in the UK according to the Index of Multiple Deprivation. Ranking second in the country on score and third in the country on rank[6].

Liverpool is the third most deprived local authority (out of 371) in the UK's Index of Multiple deprivation and the third most deprived for health.

[5] https://www.citypopulation.de/en/uk/merseyside/

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf

Merseyside's female homicide statistics

The data in this report covers a 14-year period between 2009-2024. Our statistics differ from official homicide statistics because the sex of the victim and killer are female, and male respectively and only include cases where there has been a judicial conclusion. Official homicide statistics include cases that are unsolved, and those that have not yet been judicially resolved.

Sixty-one women were killed in Merseyside during this period, and two further women were killed on a single night/day away from Merseyside but were living in Merseyside at the time. For these statistics, we have included the 3 Southport girls and 'Esther' killed in 2024 although both these cases have not yet gone to trial and so there is no criminal justice conclusion in either case. We have also included two known unsolved cases.

Category	Killed within Merseyside	Killed on trips	Female child victims	Homicide cases awaiting trial	Unsolved
2009	1				1
2010	2				
2011	8	1			
2012	8				
2013	2				
2014	4				
2015	5				
2016	3		1		
2017	5				
2018	6				
2019	1				
2020	3				
2021	5		1		
2022	8		1		1
2023	1	1			
2024				4	
Grand Total	**61**	**63**	**3**	**4**	**2**
Femicide Census Statistics	63 Merseyside women over 14 where a man has been convicted or judicially held responsible.				
Merseyside female Homicide Statistics	69 women and girls including cases awaiting trial and unsolved and excluding 2 cases of Merseyside women killed outside of the area and investigated by other police forces.				

The data that Merseyside police and other police forces submit to the Home Office to compile the Homicide Index is not collected from a calendar year (Jan-December) but from April - March. This data is only publicly available from 2012/2013 onwards. As we have collected dates of death in our database, we can reformat our data to make a comparison between the total number of homicides reported by Merseyside to the Home Office and our data to disaggregate the Merseyside data by sex. The Merseyside data submitted to the Home Office

will also include the 2022 unsolved cases of Jacqueline Rutter, as well as the child murders of Olivia Pratt Corbel, Ava White and Shahida Salem (6) so we have included these. We have not included the two women killed out of the region as they were investigated by other police forces, so Merseyside would not have included them in their figures and would not have submitted these to the Home Office.

Data submitted to the Home Office by Merseyside police compared with Femicide Census data for the same time period.												
April/ March	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total
Total Homicides[7]	17	13	26	10	19	25	20	16	15	18	24	203
Women & Girls Killed	3	3	4	4	2	8	5	2	4	3	9	46
% of women killed	17.64 %	23%	15.8%	40%	10.5%	32%	25%	12.5%	26%	16.5%	37.5%	22.66 %

The Office of National Statistics reports that nationally 71% of victims of homicide are men and 29% are women. It is evident from the table above that this has not been the case in Merseyside in some years, although in other years the figures are lower than the national average. Since the high number of killings of women in 2022, the Femicide Census is only aware of one woman killed in Merseyside in 2023, and one woman killed this year (2024) where a man has been arrested, not yet charged, but detained under the Mental Health Act. There is no evidence to suggest that annual fluctuations in the numbers of women killed by men reflect efforts to tackle violence against women.

We recognise the limitations of trying to draw yearly trends from a small pool of data. As the Office of National Statistics comments in the yearly published Homicide Index8: 'As homicide is a relatively low-volume offence, there will be fluctuations in numbers from year to year. This is especially true where data has been broken down further for analyses. Figures should therefore be interpreted with caution.'

The table overleaf shows the 10 police force areas with the highest rates of femicide per population in 2022, the most recent year with complete data9. In the first report we published in 2015, Merseyside ranked fifth by Femicides per 100,00010. In our 10-year report (covering 2009 to 2018) it also ranked fifth. The spike in femicides in 2022/2023 saw the region become that with the highest rate of femicide for the year in question.

[7] https://www.statista.com/statistics/1337912/homicide-rate-by-region-england-and-wales/

[8] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/appendixtableshomicideinenglandandwales

[9] Taken from our forthcoming 2022 UK femicide report.

[10] https://www.femicidecensus.org/wp-content/uploads/2020/02/Femicide-Census-Redefining-an-Isolated-Incident.pdf page 13

Police force areas with the highest rates of femicide per population in 2022

Police force area	Percentage per 100,000
Merseyside	0.485
Gloucestershire	0.459
Dyfed-Powys	0.385
West Yorkshire	0.336
Norfolk	0.324
Durham	0.313
North Wales	0.29
Metropolitan Police	0.281
Nottinghamshire	0.257
Northamptonshire	0.252

This report focuses on 63 femicide victims, however, there were three additional homicide victims killed at the same time who do not form part of our data set. Paul Brown was killed alongside his wife Dorothy Brown by their son in 2014. The children of Arena Saeed, aged 6 and 4, were killed alongside their mother by their father in 2017.

There were 52 single killings, four double female homicides from the same incident, and one double homicide where women were killed by the same perpetrator on different days. There was one triple homicide of Arena Saeed and her two children.

Killings by constituency

Street addresses of the women killed were obtained from press reports (mostly her home), or the press reported on where the woman was from. We believe three constituencies in Merseyside Birkenhead, St Helens North and Wirral West have no reported femicides since at least 2009.

MP & Constituency	Number of femicide victims	Names of victims and year of death	
Maria Eagle Garston and Halewood (abolished) Liverpool Garston	9	Edna Gadsby 2010 Anne Coffey 2011 Lisa Jane Hoolahan 2012 Kelsey Shaw 2012 Shirley Mercer 2014	Vikki Hull 2017 Elizabeth Lacey 2018 Janice Child 2020 Gillian Hughes 2024
Damien Moore 2017-2024 **Patrick Hurley 2024 -** Southport	9	Kate Mott 2010 Angela Holgate 2011 Alice Huyton 2011 Margaret Biddolph 2012 Anne Leyland 2012	Rebecca McPhee 2012 Anne Marie Cropper 2015 Cassie Hayes 2018 Rose Marie Tinton 2021
George Howarth 1983-2024 **Anneliese Midgley** **July 2024-** Knowsley	8	Stephanie Owen 2013 Sharon Hayter 2013 Teresa Wishart 2017 Valerie Turner 2017	Magdalena Pacult 2020 Lorraine Cullen 2022 Karen Dempsey 2022 Courtney Boorne 2022
Angela Eagle Wallasey	6 (1 unsolved)	Anne Marie Clearly 2011 Sarah Williams 2012 Debra Johnson 2012 Jill Sadler 2018	Helen Joy 2021 Elle Edwards 2022 (Jacqueline Rutter 2022 Unsolved)
Kim Johnson Liverpool Riverside	6 2 Children	Natalie O'Donoghue 2011 Dorothy Brown 2014 Kay Diamond 2015	Unnamed woman 2016 Arena Saeed 2017 & 2 children Valerie Wallach 2017
Connor McGin St Helens North	5	Heather Dyer 2011 Edith Gravener 2014 Samantha Gosney 2018	Rachel Evans 2019 Jaki Forrest 2022
Paula Barker Liverpool Wavertree	5	Maxine Showers 2015 Julie Owens 2018 N'Taya Elliott-Cleverley 2021	Malak Adabzadeh 2021 Ashley Dale 2022
Mick Whitley Birkenhead	4	Mary Woolley 2009 Hannah Windsor 2012	Glenda Jackson 2018 Karen Wheeler 2022
Ian Byrne Liverpool West Derby	4 1 unsolved 1 Child	Gaynor McGlynn 2011 Emma Burns 2011 Jade Hayles 2016	Karen Hayles 2016 (Paula Hounslea Unsolved) 2009 (Olivia Pratt-Korbell) 2022
Dan Carden Liverpool Walton	2	Sharon Winters 2014	Catherine Wardleworth 2021
Marie Rimmer St Helen's South and Whiston	2	Paula Leather 2020	Dawn Robertson 2023
Peter Dowd Bootle	2	Bernadette Fox 2015	Sarah Fox 2015
Bill Esterson Sefton Central	1	Paula Clinton 2012	

Relationship to perpetrator

The relationship between the victim and perpetrator has been identified in all of solved Merseyside femicides. The broader categories set out below breakdown the relationship further because there are distinctions to the risk factors according to the status and history of the relationship, including but not limited to formal(legal) or informal separation, custody or contact with children and division of assets relevant to the killings of spouses.

Relationship to Perpetrator	Total	Percentage	
Intimate Partner	36	57%	Domestic abuse related killings account for 85% of all femicides in Merseyside. The % nationally is 75%
Intimate Partner connected	3	4.7%	
Mother	11	17.4%	
Wider family	4	6.3%	
Acquaintance/neighbour	5	8%	
Friend/acquaintance	1	1.6%	
Stranger	3	4.7%	

Relationship to Perpetrator	Grand Total
Intimate Partner	17
Spouse	15
Relative - Mother	11
Former Intimate Partner	4
Neighbour	3
Acquaintance (regular taxi)	2
Mother of Perpetrator's Former Intimate Partner	2
Stranger	2
Acquaintance - Friend or Social Acquaintance (knew family)	1
Escort/Prostituted Woman - no prior contact	1
LGB Partner of perpetrator's ex-partner	1
Relative - Daughter	1
Relative - Grandmother	1
Relative - Niece	1
Relative - Sister	1
Grand Total	**63**

In three key relationships there are distinctions between Merseyside data and the Femicide Census' national data, and data for West Midlands, Greater Manchester and West Yorkshire and the area covered by the Metropolitan police.

	National	Merseyside	West Midlands	Greater Manchester	West Yorkshire	Metropolitan Police
Intimate Partner	58%	57%	60%	58%	64%	53%
Mothers	8.7%	17% (11)	8.26%	7.75%	2.1% (2)	10% (36)
Strangers	8.7%	4.5% (3)	8.2%	18% (21)	7.5%	10%
Total Femicides	2160	63	121	116	93	334

While Merseyside's intimate partner homicide statistics reflect national trends, Merseyside's data on matricides is significantly higher than any comparator. Stranger killings in Merseyside of women over 14 is significantly lower than the national statistics, it is beyond the remit of this report to assess the possible reasons behind such differences, but we believe that the significant failures identified in the treatment and handling of the mentally ill sons of eight of the mothers killed has been a contributory factor to the high number of matricides.

Matricide: Son to mother killing

The definition of matricide is the killing of a mother by a child; however, the Femicide Census only looks at the killing of women by their sons in this context. Eleven women were killed by their sons in Merseyside between 2009 and 2023. In two cases the sons had also killed their fathers, one at the same time as their mother and the other a couple of years previously. In one case (Bernadette Fox) the perpetrator killed his sister alongside his mother. As indicated above, these killings constitute 17% of all femicides in Merseyside.

In terms of the percentage of mothers killed out of all femicides, Merseyside is fourth in the country, although as has been previously discussed, where there are relatively low numbers of total femicides, such as in Gloucester, Cumbria, and Lincolnshire, this can lead to a distortion of the figures:

1. Gloucester 27% (3 mothers out of 11 women killed 2009-2024)
2. Cumbria 23% (4 mothers out of 17 women killed 2009-2024)
3. Lincolnshire 19% (5 mothers of 26 women killed 2009-2024)
4. Merseyside 17% (11 mothers out of 63 women killed).

Across Merseyside, six of the mothers killed lived in the area covered by Liverpool City Council, three of the mothers killed lived in the area covered by Knowsley Council and two in the area covered by Sefton council. There were no known killings of mothers in St Helens or the Wirral.

Year	Matricide Victim	Age	Criminal Justice Outcome.	Context of killing
2010	**Edna Gadsby**	70	Manslaughter on the Grounds of Diminished responsibility. Detained under mental Health act	Paranoid Schizophrenia. Had previously killed father. “No risk management around mother’s safety”
2011	**Ann Coffey**	54	Killed himself at time of offence	Inquest heard that suffered from depression and low mood and had previously tried to self-harm.
2014	**Dorothy Brown**	66	Guilty of Manslaughter on the Grounds of Diminished responsibility. Indefinite Hospital Order	Paranoid schizophrenic - long term diagnosis. Killed father in the same incident. Serious Errors identified.
2015	**Bernadette Fox**	57	Guilty of Manslaughter on the Grounds of Diminished responsibility. 12.5 years	Paranoid schizophrenic. Also killed his sister in the same incident.
2017	**Valerie Turner**	61	Guilty of Manslaughter 10.5 years	Parents suffered significant abuse over years. Demanded money for drink and drugs. Mother suffered a cardiac arrest after beating.
2018	**Julie Owens**	52	Guilty of Manslaughter 4.5 yrs.	Obsessive Compulsive Disorder and was diagnosed with Schizophrenia and Asperger's syndrome
2018	**Elizabeth Lacey**	63	Guilty of Manslaughter. Indefinite Hospital Order	Health workers twice 'missed' the paranoid schizophrenia behind killing.
2020	**Janice Child**	64	Guilty of Murder 30 years	Financial Gain
2021	**Rose Marie Tinton**	82	Guilty of Manslaughter on the Grounds of Diminished responsibility. Detained under the mental health act	Son Had contact within 6 months prior. Suffered from schizophrenia. Appointments impacted by lockdown.
2022	**Lorraine Cullen**	43	Guilty of manslaughter on the grounds of diminished responsibility. Detained under the mental health act	Judge "The previous responses of clinicians appear to have been pathetically inadequate” Misdiagnosed with Autism. Diagnosed with paranoid schizophrenia
2022	**Karen Dempsey**	55	Guilty of Manslaughter 19 years	Killed in a fight between son and another man

Seven out of the 11 men responsible for killing their mothers were diagnosed with schizophrenia either before the killing or, after the killing and following an initial misdiagnosis of Autism or Asperger’s. There are many similarities in the cases of Elizabeth Lacey and Lorraine Cullen some four years later. It is evident that the failures identified in the mental health review of Elizabeth Lacey’s son had not been implemented and were therefore not in place to protect Lorraine Cullen. The patterns of failure to identify risk to the mother/parents are evident throughout the reviews into the killings. Yet it is known widely in the mental health community and even repeated in the NHS reviews into the killings, that such risk factors have not been understood, or ignored by those treating or responsible for the care of these mentally ill men.

The 2017, independently commissioned NHS report into the killing of Dorothy Brown and her husband by their son, specifically looked into parricide and the connections with schizophrenia. Unable to find statistics in Merseyside, the report commented: [68]

> *'The criminal statistics for England and Wales do not provide separate statistics for parricide. However, as most authors on this subject have noted, it is a relatively rare form of homicide. The rate that is quoted in most studies varies between 2 to 4% of all homicides. Double parricide, which is the killing of both parents by one child is even rarer and no figures are quoted for this. However, in one large study from Canada (Bourget et al 2007)65, which looked at the numbers of all parricide offences committed over a 15-year period, out of 74 parricide offenders, 9 had killed both their parents.'*

The recommendations of the 2017 report include the following:

> *'The trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide'.*

Caroline Grant, CEO, First Step believes there is a significant level of unmet need in response to domestic abuse that mothers are experiencing from their adult sons. State intervention for many mothers is the last resort, if one at all and not a support intervention many would consider for various reasons. For some, criminalising their child, adult or not, is not something they would consider. Equally when the mother believes that their adult child is not well and in need of support, they will often manage an escalating risk whilst they try their best and obtain this support. Reaching out to specialist service independent of the state can be a preferred choice in this instance. Caroline believes bespoke services, managed by the independent sector, could alleviate this barrier and provide much needed support and routes to safety for these women. This model, recognising the differences in support required by women at risk of harm by their sons, compared to those at risk of harm by partners or ex-partners, has been piloted elsewhere. The Nia Project in London was commissioned to run an IDVA service for older women (with specialist knowledge of the needs of women at risk of harm from their sons) in Haringey and it is a model that should be replicated across the UK.

Method of Killing

Men kill women with whatever means they have to hand. While some perpetrators seek out weapons in advance of killing the woman, many use kitchen knives, strangle their victims or hit/kick/stamp their victims to death. It is significant that while "knife crime" is most frequently associated with youth and gang crime, it is by far the most frequent method of killing in femicides in the UK.

National figures from our 10-year report 2009-2018

Sharp instrument	47%
Strangulation	20%
Blunt instrument	16%
Kicking/Hitting Stamping	15%
All other	2%

Merseyside figures

The methods of killing women used by men in Merseyside broadly follows the patterns in the UK, where the use of a sharp instrument is the most common method. We have consistently called for femicide/violence against women to be included in national and local knife crime strategies given the high level of killings using this method.

Method of Killing	Grand Total	Percentage
Sharp instrument	19	30%
Strangulation/Asphyxiation	13	21%
Kicking / hitting / stamping	7	11.3%
Blunt instrument	8	12.7%
Strangulation and Stamping/hitting	6	9.5%
Strangulation and sharp instrument	2	3.3%
Shooting\Firearm	3 (5)[11]	4.7% (7.7%)
Blunt instrument and sharp instrument	1	1.5%
Arson - setting fire and causing death by fire	1	1.5%
Other - head injuries	1	1.5%
Other - neglect	1	1.5%
Secondary cause resulting from assault	1	1.5%
Grand Total	**63**	

[11] Figures in brackets include the gunshot killing of Olivia Pratt-Korbel and the unsolved killing of Jaqueline Rutter both of whom were shot.

It has been widely discussed in the media that the killing of women in drugs/gang related crime had disproportionately impacted Merseyside in 2022, with three shotgun killings of Ashley Dale, Elle Edwards and Olivia Pratt-Korbel using illegal firearms, and one shooting where the assailant has not been identified. In comparison, nationally there was only one other killing of a woman using a gun in the whole of 2022. In the previous year, 2021, there had been one shooting of a woman in Merseyside with the use of a licensed shotgun and one other shotgun killing of five people by one gunman, Jake Davison, in Plymouth.

The 2022 killings of Ashley Dale and Elle Edwards have been widely publicised in the media, but the 2021 killing of Catherine Walderworth who was killed by her husband who then shot himself, garnered less attention. Her husband had applied for a renewal on his licence on 1 June 2021, some 20 days before he killed her. A renewal of a licence requires further checks from the police. From press reports his neighbours had reported to the coroner that he was a heavy drinker, that they had heard him talking to himself in the garden, and they had heard arguments. We understand a Domestic Homicide Review has been carried out, but we have been unable to locate it. Press references to the DHR states that 'after 2 years of investigation there is still no reason why he killed his wife'. However, it is clear that access to a legally held firearm gave him the means. The Gun Control Network has long campaigned that guns used for sport/jobs should be kept in a secure locker outside of the home and connected to the sport. "The *tragic loss of life among women at the hands of licensed firearm owners is unacceptable. A home should be a sanctuary, not a place of potential fatality due to legal loopholes around gun storage,"* Gill Marshall-Andrews, Chair of the Gun Control Network.

The method used for killing has a direct link to the minimum term starting point imposed if convicted of murder. Use of a gun carries a minimum term of 30 years. Use of a knife or weapon brought to a scene carries a 25-year minimum term. Yet using a weapon found at the scene carries a 15-year minimum, which is the same as the starting point for all homicides without a gun or knife taken with intent. This is relevant because there have been campaigns to include the use of a knife found at the scene in the 25-year minimum starting point and is the subject of a government consultation under the last Government. The Femicide Census believes this would create a distinction between those that used their hands and feet as a weapon and those that used a physical weapon, with the former resulting in lower sentences. Using the figures from Merseyside:

- Use of l weapon (including other methods of hitting/stamping): 52.2%
- Use of hands/: 44.8%
- Arson/neglect: 3%.

For Merseyside, this could mean that just under half of all cases of femicide would automatically receive a lower minimum sentence as starting point for murder. This does not in any way reflect the histories of abuse, including pain and torment, these women experienced and the prolonged way they met their death.

Commonalities in fatal intimate partner violence

Ending of the relationship

It is widely understood that leaving an abusive partner is a risk factor for being a victim of femicide[12]. Jane Monckton Smith's Homicide Timeline identifies separation as being a common Stage 4 "trigger" of the eight-stage homicide timeline[13]. In the Femicide Census 10-year report of those women killed by partners or former partners, 43% had taken steps to leave the relationship. Of those women who had made steps to leave, 38% were killed within a month of acting on that step.

In Merseyside, 64% of women killed by current or former partners had taken steps to leave. In the cases of 15 killings of current spouses we have reviewed, only two of the women were known to services and both these women were taking steps to leave. There were six further killings where the women were taking steps to leave and, in some cases, had spoken to solicitors, financial advisors and had produced divorce papers. This is where it is critical that all advice agencies and solicitors are aware of the potential for escalation in an abusive relationship and be able to advise accordingly[14].

For many women this is the point they may seek support from specialist services. However, due to restricted resources as a result of underfunding, such specialist services in Merseyside, have waiting lists for access to support. In some areas (for example Knowsley), this is as long as nine months. This clearly prevents the services from being able to act, for example to work with the women to produce a safety plan, when the risk to her is elevated.

Ending of the relationship			
		Length of relationship	**Steps to leave**
Current Spouse	15	2-40 years	8 cases. 2 were killed on the day of divorce or a day prior.
Intimate partner	17	10 days - 15 years	11 cases 3 were killed on day of moving out. 4 had got back in contact.
Former intimate partner	4	18 months - 10 years.	All had left. 1 Perpetrator moved back in with victim as lodger. Other 3 would not leave victim alone.
			64% had made plans to leave or had left.

Targeting of vulnerable victims

In 30% (11) of cases it could be inferred that the perpetrator had specifically targeted the victim because she was vulnerable through repeated domestic violence with the perpetrator and

[12] World Health Organisation https://apps.who.int/iris/bitstream/handle/10665/77421/WHO_RHR_12.38_eng.pdf;jsessionid=4DD39FB77FD32FE6CC03FE9 8F3A27D79?sequence=).

[13] https://homicidetimeline.co.uk/what-is-the-homicide-timeline.php

[14] https://www.womensaid.org.uk/information-support/the-survivors-handbook/i-want-to-leave-my-relationship-safely/

other partners, problematic substance use, and mental health. This mostly occurred in shorter-term relationships with intimate partners and in only one case where the perpetrator and victim were married. Vulnerability targeting was specifically referenced in two of the DHRs '*perpetrator identified victim as a vulnerable person he could exploit, dominate and abuse*'. These cases should have been flagged up by the authorities as high risk following a known pattern of abuse and control. All these relationships were known to the authorities, but as we highlight further on in this report, all were subject to failures in how their cases were handled by those authorities who knew of the abuse.

	Total	Vulnerable victim	Violent Perpetrator targeted victim
Current Spouse	15	1	1
Intimate partner	17	9	9
Former intimate partner	4	1	1
Victim was a multiple victim of DA. Mental health or learning disabilities. Alcohol or drug dependency. Not lost contact with family but being purposefully isolated.			Perpetrator previous convictions for violence against partner, multiple convictions, alcohol dependency, call outs don't result in convictions.
Threats to Kill - either victim, others or pets - 5 victims reported threats to kill.			

Other similarities between the victims

Several women referenced not wanting to be separated from their dogs in attempting to leave the relationship, and at least one woman was given incorrect advice that a dog would not be accepted in a refuge. In three cases the perpetrator had made threats against the victim's dogs, and in one case had himself harmed dogs in his care although never prosecuted.

Five women told the authorities (police and/or health professionals) that threats to kill had been made against them. In all of those cases, the women were sufficiently aware of what the perpetrator would ultimately succeed in doing, but none of the perpetrators were ever charged with the offence of threats to kill.

Stranger femicides

As we outlined above, there were three stranger killings in Merseyside of women over 14 since 2009. The killings of Elle Edwards and Ashley Dale were linked to drugs and gangs in Merseyside and while Elle was shot at random, it appears Ashley was targeted because of her relationship with her boyfriend. Maxine Showers was a prostituted woman and killed by a sex buyer. As we have already highlighted this figure is significantly lower than the national average of 8% of femicides by strangers.

Killings of grandmothers

One woman, Mary Wooley, was killed by her grandson in 2009, the motivation was said to be a family feud. figure now at 16 of the total number of killings.

Older women killings – robbery/financial gain

Three older women were killed for financial gain by acquaintances. Two women Margaret Biddolph, 78, and Anne Leyland, 88, were killed by a taxi driver known to them. The perpetrator had a problem with gambling and had failed to pay rent on the family home. He was seen smiling coming out of the 'bookmakers' after murdering the two women.

Another woman, aged 80, was killed by a known drug user who lived close by. He also sexually assaulted her and ransacked her home. The link between sexual violence and robbery has been identified by Scully ([1990]), in a study which included interviews with 114 convicted rapists. She found that 39 per cent of the convicted rapists had also been found guilty of robbery or burglary in relation to the rapes that they had committed. Her research found that in the majority of cases the men's original intention was rape, and that robbery was an afterthought.

Killings of lesbians and bi-sexual women

There were two killings of lesbian women in Merseyside between 2009-2024, which accounts for 2% of all killings of women in Merseyside. Nationally, seven women were killed who were known or thought to be lesbians by men between 2009-2024. The two lesbian women killed in Merseyside account for 29% of all known killings of lesbian women. We note again, that with smaller numbers such percentage rates are distorted.

Glenda Jackson was stabbed multiple times by two brothers staying next door to her flat after she reported homophobic abuse and assaults to the police earlier that evening.

Cassie Hayes was in a relationship with the perpetrators ex-partner when she was murdered in front of work colleagues. The perpetrator had been convicted the previous day of harassing his ex-partner. He had made repeated threats to kill Hayes. It is unclear whether Cassie's sexuality was an element in the killing.

Ethnicity and nationality of victims

Recording the nationality and ethnicity of femicide victims is important in understanding potential barriers to accessing support, as well as understanding if a particular ethnicity is overrepresented in homicide statistics and therefore highlighting a particular problem. in the absence of disclosure of ethnicity data from Merseyside Police, we have conducted an exercise based on the 'officer observed' method, the basis upon which police forces across the country record the ethnicity of homicide victims.

The current statistics for ethnicity in Merseyside are 91.6% white, so all other ethnicities total 8.36% of the remaining population. Currently we believe four of the women killed in Merseyside were either Black or mixed heritage British and two women were originally from the Middle East and had recently settled in Merseyside. These killings accounted for 6.36% of all the Merseyside femicides - a figure just under the regional ethnicity statistical breakdown for the area. In addition, one victim, Magdalena Pacult, was of Polish nationality.

Two women killed in Merseyside had come to the UK only relatively recently. Both Malak Adabzadeh who was an Iraqi refugee, and Arena Saeed who was from Yemen, had been living in the country only for a couple of years before their murder. It was claimed that Malak had 'embraced' the freedom in the UK. She was known by an English name 'Katy' and had recently begun seeing another man. It was claimed by the prosecution in the trial against her husband that Malak was in the process of leaving the relationship. Her Iraqi husband had reportedly told police *"Culturally in the past it was unacceptable this matter and you could be stoned to death."*

Arena Saeed had come to Merseyside from Yemen in 2015, to join her husband who was already in the country. She was described as being isolated, did not speak English and was not part of the local Yemini community. A more in-depth look at Arena's specific case has been conducted under the Domestic Homicide Review section below. Neither Malak or Areena accessed services, and only Malak's case was subject to a Domestic Homicide Review where services for minoritised women was mentioned but not explored fully because she was not known to the authorities.

Two femicide victims were Black British: Maxine Showers and N'Taya Elliot Clearly. Maxine was a prostituted woman who was killed by a sex buyer. There was no evidence to suggest she had met her killer before. N'Taya was in a relationship with the perpetrator of her murder and had recently had a child. There is no suggestion in the available information that race had been considered as playing a part in their killing, or as a barrier to their ability to access services.

Children & child witnesses to the killing or who found their mother's bodies.

Sixteen women had children under the age of 18 when they were killed. Two women had children taken into care after domestic abuse in a previous relationship, and they were reluctant to repeatedly engage authorities after abuse in their current relationship because of a fear of the negative impact on contact. Both perpetrators used that fear against their victim. One perpetrator used their recently born baby as a means of control, reporting neglect of the child to the police and implicating his partner. Correctly, the police officer saw this as manipulation and recorded it as a domestic abuse incident - although the officer failed to conduct any prior research to identify that the perpetrator was a risk of harm to partners.

Six children witnessed their mother's killing. One 16-year-old hid in a cupboard and called the police. Another boy tried to put himself between his mother and his father when he was repeatedly stabbing her. Two perpetrators allowed their children to find their mother's body as a means of trying to pretend they were innocent.

The Femicide Census estimates at least 80 children a year in the UK are left motherless by femicide. "Bereavement through violence has a profound impact on children, even more so when the perpetrator is your father. In addition to the trauma of loss, there are the questions of identity, loyalty and genetic inheritance. "[15]

There is no formalised programme of support in Merseyside to address the needs of children left motherless by femicide.

[15] what-happens-to-the-children-of-women-killed-by-men https://www.theguardian.com/society/2021/aug/22/

Perpetrators

The age range of the perpetrators spans from 18 to 78 years old.

Problematic substance use, mental health and previous violence

The World Health Organisation identifies both "problematic alcohol use and illicit drug use" and "mental health problems" as risk indicators for perpetrating femicide, with the latter a risk indicator for femicide-suicide, in which the male perpetrator kills himself after killing his female partner[16]. In the Femicide Census 10-year report (2009 - 2018), just under a fifth (18%, no = 263) of all perpetrators were known to have problematic substance use. Of these, over a quarter (27%, no = 70) also had mental health issues.

In the most recent His Majesty's Inspectorate of Constabulary report on Homicide Prevention it states

> *'recent analysis has suggested that drugs may play a far less prominent role in homicide....its influence on homicide may be overstated"[17].*

There is no mention of alcohol in the report. However, in Merseyside, 63% of all perpetrators of all intimate partner killings involved problematic substance use either drugs, alcohol or both. For men who kill their spouses, alcohol was the significant problem. However, in intimate partner relationships drugs and/or alcohol use was evident in 82% of all killings. Across all femicides the rate is 55%. These figures are only on known cases where there has been a review or specific mention in the press. The true figure may be higher.

Problematic substance use in Merseyside femicides						
		Drugs	**Drugs & Alcohol**	**Alcohol**		
	Numbers				**Percentage**	
Current Spouse	15	1		6	46%	63% of IPV had combination of substance use/ alcohol
Intimate partner	17		7	7	82%	
Former intimate partner	4	1		2	75%	
Sons	11	3	3		54%	
Intimate partner connected	3	1			33%	
Acquaintance/ Neighbour	6	2			33%	
Wider family	4	1			25%	
Strangers	3	1			33%	
	63				55%	

[16] https://iris.who.int/bitstream/handle/10665/77421/WHO_RHR_12.38_eng.pdf

[17] https://hmicfrs.justiceinspectorates.gov.uk/publications/inspection-of-the-police-contribution-to-the-prevention-of-homicide/

		Mental Health & Problematic substance use in Merseyside femicides	
Current Spouse	15	7	46%
Intimate partner	17	8	47%
Former intimate partner	4	1	25%
Sons	11	6	54%
		45% had combined mental health and problematic substance use	

Mental health as a factor in all Merseyside homicides

In cases of intimate partner femicides, it has been argued that diagnosis or deterioration of either partner's mental or physical health can act as potential "triggering" factors. A 2016 analysis of 24 Domestic Homicide Reviews examining perpetrator and victim characteristics found that fifteen out of 24 perpetrators and fifteen out of 24 victims had mental health issues[18].

However, in the context of Merseyside 28% of all perpetrators of all killings had evident mental health issues ranging from 22% in respect of Intimate Partner killings to 72% of all killings of mothers. This is higher than the national average as cited in the 2023, National Confidential Inquiry into Suicide and Safety in Mental Health which reported that:

> *"Around 11% of homicides in England are committed by those who have been in contact with mental health services in the last year. This figure varied a little across the UK countries, being highest in Scotland and Wales where the general population homicide rates are also higher. 6% of the homicides were by people with schizophrenia (compared to a population rate of schizophrenia of around 1%). The number was broadly similar across the UK countries, taking into account population size[19]."*

[18]https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5efb6ce1d305a44006cb5ab9/1593535715616/STADV_DHR_Report_Final.pdf

[19]https://documents.manchester.ac.uk/display.aspx?DocID=66829

Relationship to Perpetrator	Total	Mental Health Diagnosis
Intimate Partner	36	8 (22%)
Intimate Partner connected	3	0
Mother	11	8 (72%)
Wider family	4	1
Neighbour	5	1
Friend/acquaintance	1	0
Stranger	3	0
Total	63	18 (28%)

Previous violence as a factor in all Merseyside homicides

The Femicide Census' 10-year report (2009 – 2018) found that almost half the perpetrators (46%, n=658) were known to have histories of perpetrating abuse and violence against women, either the victim and/or other women[20]. For such violence to be documented in the report there would have to be a specific mention of past violence against women or abusive behaviour in media reports or official documents, but not necessarily convictions. As we know, most of the violent crime is not reported to the authorities and when it is most reported cases do not always result in convictions. The most recently published Crime Survey in England and Wales on Domestic Violence[21] has the incidents of Domestic Violence at 2,307,000, incidents recorded by police: 851,062, referred to the CPS: 72,641, charged: 49,046 and convicted: 38,776. This means the conviction rate for all estimated cases is 0.0016%.
In Merseyside, previous violence against the victim or others was found in 68% of all cases and in 78% of all cases involving intimate partners.

Relationship to Perpetrator	Total	Previous Violence
Intimate Partner	36	28 (77%)
Intimate Partner connected	3	2
Mother	11	6
Wider family	4	1
Acquaintance/neighbour	5	2
Friend/acquaintance	1	1
Stranger	3	2
	63	43 (68%)

[20] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

[21] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2024

Criminal justice outcomes

Fifty-nine men were held criminally or legally responsible for the femicides of 63 women, and homicides of two children and one man. For men charged with the killing of their mothers, only one was convicted of murder, the remaining three cases for Manslaughter, and 6 cases of Manslaughter with diminished responsibility and one man killed himself. Within the 36 intimate partner killings recorded, four men killed themselves at the time of the offence or while on remand. One man died of cancer before he could be interviewed for the murder although he had been charged with assault and was on remand. Of the remaining 31 intimate partner killings, five men were found guilty of manslaughter and one man found guilty of gross negligence manslaughter. The remaining 25 men were found guilty of murder.

Sentences for Manslaughter

Perpetrator	Conviction	Length	Victim	Jury Trial/Plea accepted	Context
James Donohue	M/S	9yrs	Emma Burns	Prosecution offered a Manslaughter plea.	Medical evidence could not pinpoint which of the two assaults caused the fatal injury. Attacked Emma in the street and returned to her house with a claw hammer.
John Clinton	M/S	14yrs	Paula Clinton	Cleared of murder by the jury. Guilty to M/S	Husband was an alcoholic. Stabbed wife after she was planning to leave him. Claimed she mocked him
Richard Wallach	Gross Neg M/S	8yrs	Valerie Wallach	Found Guilty by a jury.	Victim covered in maggots and faeces. had not moved for months. "Worst conditions paramedics had seen" died of breast cancer and sepsis.
David Saddler	M/S	7yrs	Jill Sadler	Cleared of murder by the Jury. Plead Guilty to M/S	Drank 12 pints before attack. Victim Suffered 50 injuries. Claimed that victim was abusive and abused alcohol and had hastened the death of his terminal daughter.
Stuart Robertson	M/S	6yrs	Dawn Robertson	Cleared of murder by the Jury. Plead Guilty to M/S	Claimed he had been the victim of long-term abuse by alcoholic wife. Had been 70 call outs to the couple over the course of their marriage.
John Meadows	M/S	5.8yrs	Jillian Hughes	Pleaded Guilty	"One punch' killing in the street. Had previous convictions for violence, and for battery against Jillian

It is significant that in the cases of John Clinton, David Sadler and Stuart Robertson, the prosecution believed there was enough evidence to charge with murder, but the jury cleared the three men of murder and found them guilty of manslaughter instead. Each perpetrator portrayed their wife negatively: excessive alcohol use and being a perpetrator themselves all of which are example of 'victim blaming' - defined as 'the transference of blame from the perpetrator of a crime to the victim-survivor, who is held entirely or partially to blame for the harm they suffered[22]'. A culture of victim blaming is imbedded into the criminal justice system in England and Wales and while it has been widely debated as problematic in investigations and prosecutions for rape[23]. It is also evident in cases where prosecutions for manslaughter over murder have either been accepted by the Crown Prosecution Service or where the jury has rejected a murder conviction. One of the partial defences to murder in England and Wales is loss of control[24] and for this defence to succeed the perpetrator needs to show that there is a qualifying trigger. In the cases referred to above this trigger would have been introduced to effectively paint the victim negatively. She was 'violent', 'contributed to the early death of their daughter' or 'mocked' him.

Sentences for murder

Sentencing for murder follows general principles the sentencing judge must have regard to as set out in Schedule 21 to the Sentencing Act 2020, although was introduced in the Criminal Justice Act 2003, allowing 20 years to establish a pattern of sentencing. As a result, the average minimum term that a perpetrator stays in prison has risen from 13 years in 2000 to 21 years in 2021.[25] There are multiple starting points for murder depending upon the weapon used, whether a weapon was taken to the scene, number of victims, motivation for financial gain, profession of victim and the age of the perpetrator as well as mitigating and aggravating factors which can impact on sentence, as well as credit for a guilty plea.

Twenty-five men were found guilty of murder of their intimate partners. Of these three were found guilty of double murder which included other family members of the victim: two mothers of the victim, daughter, and one man found guilty of a multiple murder of his wife and two children. In general, the minimum term, the time the perpetrator spends in prison before an application to be released on licence, ranged between 10.5 years-25 years for a single murder, and 23 years to 31 years minimum term for double or triple murder. In Merseyside, the average minimum term set for a single homicide was 17.5 years (well below the current national average) and the average minimum term for a double multiple murder was 27.5 years. Overall, these terms are lower than the average term now being reported in murder sentences.

One perpetrator, Cathal Comerford, received the 6th shortest sentence for the murder of a female in the whole of the UK. He was released on licence by the parole board at the beginning of 2024 in spite of the family of Sara Williams' concerns about his release[26].

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[22] William Ryan 1971

[23] See for example https://www.centreforwomensjustice.org.uk/new-blog-1/2022/1/18/cwj-manifesto-7-explore-and-implement-reforms-to-the-criminal-court-system-to-ensure-proper-equality-before-the-law-and-an-end-to-victim-blaming

[24] https://www.cps.gov.uk/legal-guidance/homicide-murder-manslaughter-infanticide-and-causing-or-allowing-death-or-serious

[25] Sentencing for Murder - A review of policy and practice. Sentencing Academy April 2024.

[26] This report has been amended to exclude reference to the perpetrator who we believed at the time to have been recalled to prison following release. We understand he is still on licence in the community.

Post-homicide scrutiny

Once the perpetrator is identified and processed through the criminal justice system, the scrutiny of the circumstances surrounding the killing can be undertaken via a number of possible statutory reviews: Domestic Homicide Reviews, Adult Safeguarding Reviews, Mental Health Reviews, Child Safeguarding Reviews, and reviews by the Independent Office of Police Conduct (IOPC). Inquests also provide a significant level of scrutiny if undertaken. All of which to varying degrees look at whether there were any institutional failures/interventions by statutory bodies and state agencies that played a role in the killing.

A catalogue of failures

Of the Domestic Homicide Reviews, NHS reviews and IOPC reviews that were considered for this report there are 21 where there was recorded prior contact with statutory agencies: police, mental health, Adult Safeguarding, Probation, GP or hospitals. Of those 21 all (100%) evidence failures within the state support systems for victims of violence or perpetrators with mental health issues.

Three DHR's have not been published - two at the request of the family and one because the daughter who witnessed the killing is a looked after child and the authorities took the decision to protect her. It is therefore unclear as to whether these would have evidenced any failures. There is no record of a further three DHRs being carried out, which would have fulfilled the criteria for conducting a DHR. The respective councils do not have a central repository, and enquiries are ongoing as to whether DHRs were carried out or not. In the process of collating DHRs for this report, we were informed that it was agreed that five DHRs would not be carried out into killings that would ordinarily fit the criteria. We believe the decisions not to conduct a DHR in these cases is a mistake.

As other published reports of Domestic Homicide Reviews have highlighted, there are a number of common themes which have had a serious impact on the standard of service women have received by the authorities in supporting them prior to homicide[27]. These include lack of multi-agency working and information management, improving risk assessments, developing practice including increasing professional curiosity and training for staff. There were only two Independent Office of Police Conduct reviews identified, but there were three further cases where the police had contact with the victim and/or perpetrator hours before the homicide.

In Merseyside the following repeated failures have been identified across the police, health, adult social care, and support services.

- Incidents dealt with in isolation - failure to look at bigger picture
- Agencies working in silos
- Forms not filled out, not filled out properly, not handed in or not processed,
- No risk management/failure to identify risk
- Small incidents not logged to build a picture.
- Missed opportunities
- Lack of professional curiosity
- Lack of information sharing.
- Policy not followed, or not aware of policy.
- Failure to charge/prosecute/charges dropped
- Failure to recognise escalation in violence
- Delays

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- Inaction
- Systems not updated.

We understand the following reviews have taken place or are currently ongoing:

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
Sefton Council 12 women Killed			
Kate Mott 2010	Spouse	IOPC report. Only a summary available.	Yes - Major Systems not updated Missed Opportunity Policy not followed, not aware of policy Failure to identify risk
Angela Holgate 2011 Alice Huyton	Former IP Her Mother	DHR	Yes - in managing perp convicted of assault of former partner and managed by probation while living with victim. Failure to treat previous case and incidents seriously. Failure to record breach of bail.
Paula Clinton 2012	Spouse Depressive Alcoholic	DHR	Not known to services Killed one hour after financial advisor called about division of assets.
Rebecca McPhee 2012	Spouse	DHR IPCC	Yes major Failure to recognise escalation Lack of professional judgement. Failure to charge/Prosecute Missed opportunities Calls dealt with in isolation “Murder preventable”
Margaret Biddolph Anne Leyland 2012	Acquaintance [Taxi Driver] Problematic Gambling	No Does not meet criteria.	
Bernadette Fox Sarah Fox 2015	Son Brother	DHR and combined Mental Health review	Yes Perp had no contact with mental health System not updated wanted for breach Cautioned Failure to identify risk
Anne Marie Cropper 2015 Vulnerable victim.	Intimate Partner Convictions and substance abuse	DHR	Yes Forms not actioned Domestic Abuse policy not followed - advice ‘wholly inappropriate’ Major missed opportunity

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
			Small incidents not logged to show pattern. No risk management.
Cassie Hayes 2018	Lesbian/bisexual Partner of Perps Former Intimate Partner	No DHR	Not reviewed under DHR but killed in context of linked domestic abuse of perpetrator and former partner. Numerous threats to kill the victim. Day prior to killing perpetrator had been convicted of harassing former partner.
Rose Marie Tinton 2021	Son	DHR	Awaiting Publication
Liverpool City Council 23 women killed & 1 resident			
Edna Gadsby 2010	Son	NHS report	Yes Major No risk management Failure to follow policy Clinic failed in Duty of Care.
Gaynor McGlynn 2011	Acquaintance	None found.	Not known Perp had contact with police 40 minutes before killing where he was removed from house before returning. Should have been a mandatory IOPC referral?
Natalie O'Donogue 2011	Uncle	None found	Not evident. Killed on the day asked to leave. Disagreement over money.
Emma Burns 2011	Intimate Partner	No DHR Killed after DHR provision came into force	Unknown
Kelsey Shaw (Resident of Speke but killing outside of MSP) Vulnerable victim	Intimate Partner Previous convictions	Serious Case Review involving DHR	Yes Perpetrator Charges dropped Incidents seen in isolation. Failure to see bigger picture Policy not followed.
Lisa Jane Hoolahan 2012 Vulnerable victim	Intimate Partner Previous convictions substance misuse.	DHR	No Not known to authorities. Relationship only 8 weeks.
Shirley Mercer 2014	Intimate Partner	DHR	Yes Domestic incidents not recorded Inappropriate advice given Missed opportunity.

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
			Failure to recognise escalation in risk. Adult Social care no record of referral.
Sharon Winters 2014	Intimate Partner	DHR	Yes - but in lack of support as a vulnerable woman prior to meeting the perpetrator.
Dorothy Brown 2014	Son	NHS report	Yes No recognition of escalating risks Errors in risk assessments Lack of information sharing.
Kay Diamond 2014	Intimate Partner	DHR	Yes Systems not updated No safety planning Failure to prosecute Confusion about ownership of case
Maxine Showers 2015	Sex buyer	No	Not relevant
Jade Hales Karen Hales 2016	Former Intimate Partner Mother of IP	DHR	Yes major Failure to prosecute/charge Lack of professional judgement Risks escalating Multiple missed opportunities No risk assessment on mother Policy not followed (probation) Working in silos Adult Social Care flawed.
Unknown	Former Intimate Partner	DHR	Yes Failure to update records on violent incident. VPRN form lost/not filled in No record of prior violence on system
Vikki Hull 2017	Intimate Partner	DHR	Yes missed opportunity to use right to know Failure to follow policy - no research on first call out. No information sharing - police and health visitor
Arena Saeed 2017 [and her two children]	Spouse	No DHR Single Agency review on children not published	Unknown Perp Contact with Hospital and GP and Housing. Failure to conduct a DHR
Valerie Wallach 2017	Spouse	DHR	No

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
			Not known to police or adult social care. Perp was receiving a carers allowance.
Julie Owens 2018	Son	DHR NHS England Report	Yes Critical missed opportunities Agencies working in silos No risk assessment Forms not received by Adult Social Care Little information sharing.
Elizabeth Lacey 2018	Son	No DHR Mental Health Report	Yes Working in silos Lack of Professional Curiosity Lack of training Lack of medical oversight. “Lack of clarity around why the police decided to discharge him from custody” hour before killing.
Janice Child 2020	Son	No DHR No Mental Health Report Murder for financial gain	
N’Taya Elliott-Cleverley	Intimate Partner	DHR	Yes Lack of curiosity No information sharing Areas of risk not considered Significant mental health issues not recorded at MASH Incident of abuse not pursued. No consideration of Evidence Led Prosecution
Catherine Wardleworth 2021	Spouse	DHR Press reports a DHR commissioned	Authorities unable to locate a copy.
Malak Adabzadeh 2021	Spouse	DHR	No Unknown to services May have been an unrecognised victim of ‘honour’ abuse. Was about to leave that day/imminently.
Ashley Dale 2022	Stranger	No	
Gillian Hughes 2024	Intimate Partner	To confirm	
St Helens 6 Women Killed			
Heather Dyer 2011	Neighbour	No.	

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
Edith Gravener 2014	Spouse	DHR	No Not known to services. Reference to mental health issues and role as a carer for wife.
Samantha Gosney 2018	Intimate Partner	DHR	Yes Missed opportunity Lack of information sharing No risk assessment Lack of professional curiosity Incidents dealt with in isolation
Rachel Evans 2019	Former IP	DHR Serious Incident Review	Yes - Carers/Adult Safeguarding Missed opportunity Failure to share information No risk assessment by mental health
Jaki Forrest 2022	Intimate Partner	To be confirmed	
Dawn Robertson 2023	Spouse	To be confirmed.	
Wirral 10 Women Killed			
Mary Woolly 2009	Grandson	Pre DHR. No review found	Not apparent from press reports
Anne Marie Cleary 2011	Spouse	DHR	No Not known to agencies. Perp Self referred org for drug addiction had kept secret & money problems. Perp had moved out. Making plans to leave.
Hannah Windsor 2012	Intimate Partner	Local Safeguarding Children Report	Yes Not following policy Delay Failure to identify risk
Sara Williams 2012	Intimate Partner	DHR	No Not known to agencies. Killed on the day leaving the relationship. Perpetrator received 6th shortest sentence for murder of woman in the whole of the UK(10.10 years) was released from prison after 11 years early this year but returned to custody after breaching licence.
Debra Johnson 2012	Spouse	DHR	Yes - 1 contact with police DV policy not followed. VPRN not completed. No information sharing Missed opportunity. Failure to record crime.

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
Glenda Jackson 2018	Neighbour	IOPC referral. Decided investigation not required.	Police contact with victim within a couple of hours prior to death. The case was referred to The Independent Office for Police Conduct (IOPC) by Merseyside Police and assessed but it was decided an investigation was not required.
Jill Sadler 2018	Spouse	No DHR	Wirral council could not locate a DHR. Unknown
Helen Joy 2021	Intimate Partner	DHR Not published due to family request.	Unknown Family released extensive statements: https://www.birkenhead.news/family-of-helen-joy-issue-statement-following-guilty-verdict/
Karen Wheeler 2022	Spouse	DHR Currently with the Home Office	Unknown
Elle Edwards 2022	Stranger	No	Does not fulfil criteria for review.
Knowsley 10 Women Killed			
Ann Coffey 2011	Son	No DHR/No Mental Health Review	Unknown
Stephanie Owen Sharon Hayter 2013	Spouse Father	DHR summary only available	No, not known to agencies. Victim had called a DV organisation. Both victims had serious health issues. Perp only carer for 8 years. Relationship “stormy” with money worries.
Teresa Wishart 2017	Neighbour	DHR Does not meet criteria for existing review processes	No mental health investigation. Perpetrator had mental health issues.
Valerie Turner 2017	Son	DHR Completed but not published publicly at family request	Unknown
Magdalena Pacult 2020	Intimate Partner	DHR Completed but not published publicly	Unknown

Victim	Perpetrators Relationship	Review/ DHRs Undertaken	Failures evident from the reviews across health, police and Adult Social Care
Paula Leather 2020	Spouse	Summary published Nov 2024	No - no contact with authorities But family experienced failures post homicide.
Lorraine Cullen 2022	Son	Due to commence Nov 2024	Unknown
Karen Dempsey 2022	Son	Confirmed DHR not carried out.	Unknown
Courtney Boorne 2022	Intimate Partner	DHR commenced July 2024	Unknown

The need to commission a DHR report in all cases of domestic abuse

There are notable gaps and inconsistencies in the commissioning of Domestic Homicide Reviews across Merseyside. The ability for local councils to decide whether or not to commission a report, a decision which is then reviewed by the Home Office, brings in a level of subjectivity that should be open to wider challenge. In Merseyside, this has meant that cases which on their face meet all the factors that should trigger a DHR review have been rejected. As a result, that in-depth assessment as to what statutory decision making contributed to failure to prevent this killing is lost, or if the victim was not known to statutory authorities, why the victim was isolated or whether she, or wider friends and family, did not know she was at risk when there were known risk factors present.

On a few occasions in Merseyside, the commissioning authority declined to review because neither the victim or perpetrator was known by authorities, but was told by the Home Office that it was important to conduct a DHR because "*it should conduct a domestic homicide review involving friends and family to look at whether they had any knowledge of abuse and if they did, why they did not try to seek help*". Even where friends, family and all statutory agencies have no knowledge of abuse, Liverpool City Council was told to commission a report by the Home Office to specifically look at the issue of access to services and religious/cultural impediments. As the DHR sets out *"The panel felt that it was important to try to understand whether religion and culture may have presented "Alex" with challenges in accessing support."*

There were eight DHRs carried out where the victim and perpetrator's relationship were not known to authorities. Common themes were highlighted around the role of family and friends and whether there is sufficient support and knowledge of domestic abuse that might lead those with knowledge of the abuse to seek information and support.

In addition, there appears to be a tendency to refrain from commissioning a DHR where mental health is a factor, and NHS England has commissioned a report. The difficulty here is that NHS Reports do not have the same powers to compel engagement from other authorities necessary to give a complete picture. The report is into the treatment of the patient, not the killing of the woman, a significant difference.

The Femicide Census believes that all femicide killings should be subject to a form of statutory review, but until such a policy change is accepted and implemented then at least all domestic homicides should be subject to DHR review. There are two striking examples from Merseyside where it is our view where a DHR should have been carried out but was not: the killing of Elizabeth Lacey by her son Christian, and the killing of Arena Saeed by her husband Sami Salem in 2017.

Elizabeth Lacey was killed by her son after being misdiagnosed twice with Asperger's. Critically she was killed one hour after attending the police station. We understand that at the time that commissioning a Domestic Homicide Report was discussed and rejected there was opposition to that decision from local services who felt that focussing solely on mental health would miss some of the important aspects of this case. We believe this representative was asked to leave the meeting. Our scrutiny of the subsequent NHS Independent report published in this case illustrates the problem that a DHR would have undoubtedly probed further. The report noted "*There is a lack of clarity around why the police decided to discharge him from custody*" but there is no further scrutiny of this crucial piece of information. Christian killed his mother only an hour after being released without charge by the custody officer after a serious assault on his brother and father the previous day. The NHS report noted the police appear to have downplayed the seriousness of the assault'. There has been no public scrutiny of Merseyside Police's decision to release him.

The ‘lack of professional curiosity” into the murder of Arena Saeed and her children

Given the 2017 murder of Arena Saeed and her children was Merseyside’s only multiple killing between 2009 and 2023 we were surprised that we could not find any published DHR, serious case review or mental health report relating to the killings. We contacted Liverpool City Council as well as the mental health team to determine if one had been commissioned. We were informed that a DHR had not been commissioned because she was not known to authorities and the family were reluctant to engage.

This explanation raises serious cause for concern. The authorities stance is all the more problematic because the basis for securing a murder conviction in Sami Salem’s trial was due to the prosecution’s ability to demonstrate beyond reasonable doubt that although her husband had been diagnosed with paranoid schizophrenia and had seen a mental health team 10 days before the murders, and his GP twice a couple of days before, that his motivation for the killing was not related to his mental state, but due to the control and abuse of his wife, and her desire to leave. Through witness testimony, and text messages between the victim and perpetrator, the prosecution was able to demonstrate that there was significant coercive control inflicted on Arena which restricted her movements in Liverpool and isolated her from her family in Yemen, and that as a result she was looking to divorce him. A significant ‘trigger’ for an abusive male partner.

The families stated reluctance to engage with the DHR process should not have precluded scrutiny of what was already known by the police and prosecution in order to build the case for murder against her husband. All of this evidence was disclosed in open court and as such could/should have been accessible to the DHR and used in place of direct contact from friends and family who might be suspicious of engaging with another state managed process. In a recently published DHR (‘Alex’) the only other murder of a woman in Liverpool who had gone through immigration/refugee application where similar difficulties of contacting family and friends was apparent, Merseyside police provided access to statements from the criminal trial obtained from friends and other witnesses which is an example of good practice.

In the absence of any published statutory review on Arena Saeed and her children’s murder, we have attempted to recreate a summary of what was known about her life, and the circumstances surrounding her death from a review of the extensive press reporting on the trial. All of the statements in italics are taken from the press reports of the trial. Even from the publicly available picture there are significant areas outlined below that should have prompted a DHR. The fact that the only mass killing in Merseyside in 14 years did not prompt one public review is unacceptable.

From the press reporting of the case, it can be summarised that: Salem was working as a delivery driver. Salem was also experiencing financial difficulties and had been served with an official notice to quit his flat by the Canning Housing Cooperative. While Salem has no convictions, he had cautions for possession of an offensive weapon, a knife, and possession of cannabis. The court heard that Arena had spoken to some people about feeling isolated and unhappy because she couldn’t speak English and because Sami tried to control what she did and text messages between the two were read out in court.

The fact that it was known by the state that Arena had been abused, isolated, controlled, and had wanted a divorce, and that her husband was presenting to two health providers with serious mental health issues within days of the murders, the failure to conduct a DHR is deplorable. There is much condemnation in many of the DHRs of the “lack of professional curiosity” exercised by the various authorities that had contact with victims prior to their

murder. The same criticism can be directed towards Liverpool's Safety Partnership's decision to forgo a DHR in this case.

The impact on families of the homicide and the post-homicide review process

Families are a critical part of the review process - they provide evidence, context, and an insight into the dynamics of the relationship. Many families do not want to get involved in the post-homicide process, perhaps seeing it as prolonging the pain of mourning the deceased. Others see it as an important process in understanding why the killing happened and an attempt to prevent future killings. It is also the last chance for the victim's voice to be heard and so for those families it is crucial that the authorities get this part right at least.

The Femicide Census spoke to representatives from three families during this review who had different experiences in the lead up to the homicide, of the investigation process as well as the post-trial scrutiny.

The stepmother of Christian Lacey spoke about the lack of support that they as a family got in trying to get help for Christian, as well as for Elizabeth the mother he killed when taking him to get help. At the time of the killing Christian was living with his father, stepmother, and stepbrother. He was experiencing increasing paranoid behaviour. His mother had taken him to A&E where the mental health crisis team had diagnosed him with Asperger's, but there was no follow up and they were getting increasingly concerned. After a serious attack on his stepbrother and father, the family barricaded themselves into their bedroom and called the police the next day. In the meantime, his stepmother took him to the GP. There had been no update on Christian's medical records that he had seen the crisis team which the family had assumed would happen. The GP told him to work on anger management. When the police visited while initially reluctant to process him, the police did arrest him and detained him overnight. The family were told he was going to be assessed by a psychiatrist, but the next day was released into his mother's custody. She had told the father she was going to take him to A&E but she was killed before that happened. The family believes that nobody took any notice of them when they said Christian was dangerous and that he was going to do something. As the family is not the direct family of Christian they have not been involved in any decisions about whether to hold a DHR, but remain concerned about why Christian was released by the police on the day of the killing and why the mental health screening focused on Asperger's - which he does not have - and did not diagnose paranoid schizophrenia.

The brother of Sara Williams killed in 2012 by the partner she was trying to leave spoke to us about the support that they received from Merseyside Police during the investigation into his sister's killing. He thought the police were incredibly professional and supportive of his family throughout. One of the family's main concerns was the fact that neither Sara nor the family had appreciated the danger to Sara in leaving a relationship with an abusive man. He had spoken to his sister only an hour before the killing to discuss her plans to leave the relationship that night and had discussed getting a car to take her to her mother's that night or to leave the next morning. Sara opted to stay until the morning. Her brother would always advocate for a safety plan for women to leave relationships and believes that knowledge should be more widespread. The family was also incredibly surprised at the short sentence the perpetrator received for Sara's murder. They thought 10 years and 10 months was not sufficient for the violence and damage he had caused. To add to their concern, they were informed the perpetrator had been released on licence early this year, and while they had been asked to put in a victim statement, were led to believe it would not have much impact.

Finally, we spoke to the family of Paula Leather who was killed by her husband in 2020. The family has just been through a bruising DHR process. A summary of the DHR was only published this November after a four-year drawn-out process. The family feel that there is little support for families post femicide. The DHR process was protracted and confrontational. At one point the family overhead negative comments being made about them because someone had failed to mute their zoom. The family are concerned about the absence of their mother's voice throughout the process and in the final DHR. Even now a dedication to their mother has been omitted from the report. [Most of the DHRs reviewed for this report contain a dedication of some description as to the woman's memory and loss]. As her mother was not known to authorities, there was a lot of information and insight that the family could contribute to the story to build up a picture of how controlling and coercive behaviour manifests in families. With hindsight, behaviour that was obviously controlling and coercive over the years was put down to her father 'just being him'. The family were aware her mother was very unhappy and was taking steps to leave her father, explaining that in Merseyside you do not 'grass' and that her mother had never wanted to criminalise her father. The family also expressed concern at the behaviour of Merseyside Police post-homicide, in particular the failure of officers to prevent further harassment from her father who was sending letters from prison. The family maintains that officers spoke to them about stopping correspondence from the perpetrator in front of witnesses, then denied that ever happened leading to repeated contact and efforts to perpetrate further abuse from a man who had just killed their mother. This is the subject of an ongoing complaint. The family also wants there to be much more emphasis and knowledge sharing on coercive and controlling behaviour in education and support so that families, and the women themselves, can recognise it as criminal behaviour. They believe it is always minimised and is considered not as bad as violent conduct.

Why so many failures?

With a 100% rate of identified failures in all the published DHRs, IOPC reports and NHS reviews that document contact between the victims, perpetrators, and state agencies in Merseyside, it would appear the system has not been functioning effectively for some time. The Femicide Census is acutely aware of the scale of reported abuse that Merseyside Police are dealing with, as well as the mental health need causing pressure on mental health services. The vast majority of cases that the police investigate, or mental health practitioners see, do not lead to homicide, but it is telling that all femicides where the victim and perpetrator was known evidenced failures.

Is the system failing?

Consistent and repeated indicators evidenced in inspections of Merseyside police, in NHS reports and DHRs that standard procedures are not being adhered to is an indicator of a system that is not working. When DHR authors repeat findings from previous DHRs and when His Majesty's Inspector of Constabulary refers to a current backlog in processing and assessing Domestic Violence Disclosure Forms, which it also did in 2019, then there needs to be a root and branch appraisal as to whether the services it provides are currently fit for purpose.

Merseyside's last Police Effectiveness, Efficiency and Legitimacy (PEEL) assessment was performed back in 2023. It was rated for the following categories:

- Outstanding: Disrupting serious organised crime
- Good: Police powers and treating the public fairly and respectfully. Preventing and deterring crime and anti-social behaviour and reducing vulnerability. Building supporting and protecting the workforce.
- Adequate: Responding to the public. Investigating crime. Leadership and management.
- Requires improvement: Protecting vulnerable people. Managing offenders and suspects.

At the time of inspection, the force had 457 applications under the Domestic Violence Disclosure Scheme and only five staff and two officers. A backlog in processing VPRF forms was also identified. It was reported there was a two-week delay which would only increase without steps taken to address it. Yet it is exactly the failures of these processes which are referred to repeatedly in DHRs as creating a lack of up-to-date information for officers to make and up to date risk assessment.

Financial resourcing is a critical issue for Merseyside. The Institute of Fiscal Studies analysis of police funding found that more densely populated areas lost more funding than the forces serving smaller populations. For example, Merseyside's funding per capita is down 11% while Surrey experienced a 2% reduction[28]. Lack of institutional memory is also a critical issue. A high percentage of Merseyside Officers have been on the force less than five years. It is critical that the force finds a way to ensure learning is reflected in changes to practice and that this is embedded and effective, despite turnover in personnel.

Two of the earlier matricide cases identified failures in Merseyside's Scott Clinic, one of the main mental health treatment clinics, and contributed to its closure in 2015 after being considered 'not fit for purpose[29]'. Two of the more recent matricide cases involved

[28] https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/peel-assessment-2023-25-merseyside.pdf

[29] https://www.liverpoolecho.co.uk/news/rainhills-scott-clinic-close-after-8434035

misdiagnosis of young men who presented symptoms of schizophrenia that were missed. The learning from the 2017 case of Christian Lacey who killed his mother documented in the NHS review should have led to a review of how such cases were handled. Yet the 2022 killing of Lorraine Cullen by her son has striking similarities. As the sentencing judge in the Cullen case pointed out:

> "*But the views of the consultant psychiatrists in this case, and certainly the views of the family, are that there has been a wholesale failure of mental health provision and numerous missed opportunities to identify and attempt to treat your serious and enduring chronic condition of paranoid schizophrenia"*.

Therefore, while a DHR and NHS review has yet to be undertaken in this case, any statutory review should consider the Christian Lacey NHS review to understand how far its recommendations were taken.

Given 75% of the femicides in Merseyside occurred in a domestic context, the Femicide Census is also concerned that Merseyside removed domestic abuse from the Serious Violence Duty obligations[30]. The Serious Violence Duty places a statutory obligation on local services to

> *"work together to share information and allow them to target their interventions, where possible through existing partnership structures, collaborate and plan to prevent and reduce serious violence within their local communities"*.

[30] https://www.merseysidepcc.info/media/zbqchnmr/accessible-serious_violence_duty_strategy_merseyside_2024.pdf

Conclusion

Most national and regional reviews of the killings of women focus on domestic homicides[31] and not femicides more widely. This approach fails to take account of the full context of men's fatal violence against women. Indeed, these reviews do not even consider all domestic homicides, as in some cases a decision is made not to conduct a review. Moreover, not all DHRs are published. In Merseyside, we could not locate three historic DHRs that should have taken place despite contacting the local authority responsible for commissioning. A further three cases will not be published, three cases are 'underway' and in the three most recent cases we are waiting for confirmation that a DHR will be carried out. It is only information obtained from published Domestic Homicide Reviews, IOPC reports and NHS reviews that can therefore be subject to external scrutiny. In many instances the press reports of the trial have been illustrative of common factors that have informed this review. This is not acceptable.

Thus, from this starting point, we have a biased sample. This means that potential information highlighting commonalities between the cases and evidence of failures in how the case was handled by the authorities, for example, may not be fully explored. This is simply not good enough. The involvement of the Domestic Abuse Commissioner and the Home Office in bringing together all of the reviews on one database is commendable, but as a result of this review, we have identified Merseyside DHRs that have not made it on to the national database (Local Authorities have a responsibility to make sure all DHRs have been forwarded to the Home Office for upload). Even with the limited scrutiny, the critical issue for Merseyside is that the learning from these reviews should not be siloed because they are dependent on different local authorities and different state agencies practice, procedure, and publication.

However, in spite of these limitations, a strong picture emerges of women failed by the systems that are supposed to be there to protect them, of children who are impacted without statutory support, and families left to wonder why, what went wrong, and what next. Even families that have only had a positive experience of the police investigation and the DHR process are now in a position that the perpetrator has been released from prison and subsequently recalled without any information about what this means.

There must be scope for some optimism that the situation will improve. Thirteen years of scrutiny through DHRs means that most failures that could happen have been identified and measures should have been put in place to fix them. NHS reports highlighting failures in treatment of mental illness have flagged procedures that need addressing. There is a mountain of evidence demonstrating the problem and providing guidance and support for improvement. Even this report is part of that process. It should not be the case that failures identified in 2012 are being repeated in 2022. If they are, then this can only lead to a conclusion that the failures are systemic, and that all agencies have a responsibility, collectively, to address them. The goal must be that less women are killed every year because the authorities did all they could.

[31] https://domesticabusecommissioner.uk/wp-content/uploads/2023/12/Summary-of-Findings-Criminal-Justice-Domestic-Homicide-Oversight-Mechanism.pdf

Recommendations

1. Femicide to be recognised in all strategies. Not restricted to a focus on domestic homicides.

2. Domestic abuse to be included in Merseyside's Serious Violence Duty Strategy

3. Funding for femicide prevention needs to be increased to a level that saves lives, not contribute to death. For example, this means that all problems identified in the PEEL reports are addressed by dedicated funding to combat the delays, and that local services are fully funded.

4. Merseyside should be the first area in the country to conduct Femicide Reviews commissioned by the Police and Crime Commissioner where learning from all femicides is subject to scrutiny to include the commonalities of mental health, prior violence, and substance misuse common to nearly all femicides.

5. All the learning and recommendations from every DHR, IOPC and NHS review over 15 years to be collated and published with a plan to address all failures identified. A senior officer with responsibility to ensure implementation should be identified.

6. This core document should form part of a learning tool for Merseyside police, Local Authorities, NHS provision and local services. Training for all such agencies will incorporate this document, and all subsequent state reviews will refer to this document to track repeated incidents of failures.

7. A DHR should be commissioned in the case of Arena Saeed to specifically address the issue of isolated victims of abuse.

8. A formalised programme of support in Merseyside to address the needs of children who are themselves are the victims of their mother's killing should be introduced.

9. Secure funding should be made available for specialist independent services for women who have been subjected to domestic violence and abuse. It is critical that the funding available is sufficient to meet need. Given that 63% of femicides by current or former intimate partners in Merseyside occurred after the victim had taken steps to leave, it is clear that waiting lists for access to specialist services is a femicide risk. It is recognised best practice that the service should be fully independent of statutory agencies as provision of such services by state agencies, even if 'arm's length' is a barrier to access for many women.

10. A dedicated service for older women, including mothers at risk or suffering violence from their sons, should be commissioned. This service would carry a lower caseload and longer service engagement than general Independent Domestic Violence Advocate (IDVA) practitioners in recognition of the complexity of the work. The launch of the service should be accompanied by a Merseyside wide publicity campaign to highlight the problem of mothers suffering abuse on their own.

11. The link between problematic substance use and femicide is evident in Merseyside femicides. Measures to address problematic substance use must be a factor in femicide prevention. Women only services should be available.

12. A core review of mental health services is required to reinforce the link between mental health, in particular schizophrenia, and matricide/parricide so that the risk to families and mothers, is recognised in safety planning and treatment.

13. The profile of multiple conviction and perpetrators with problematic substance use in a relationship with a vulnerable woman should be recognised as high risk for the duration of the relationship and the subject of an immediate gold rating MARAC status irrespective of the level of risk perceived with each individual incident reported.

14. Domestic Homicide Reviews and other statutory reviews should be made available to the Parole Board when deciding on release on licence once eligible of perpetrators convicted of murder. This will provide a more comprehensive picture of risk and behaviours given that most cases of abuse and violence do not result in a criminal record.

15. Women leaving relationships with coercively controlling men are known to be at risk. All potential points of contact for women seeking advice to leave including domestic abuse organisations, solicitors, advice centres, should be advising on how to leave safely even if domestic abuse is not disclosed.

About the Femicide Census

The **Femicide Census** the most compressive single source of UK information about women who have been killed and the men who have killed them.

Launched in 2015, the **Femicide Census** was founded by Dr Karen Ingala Smith and Clarissa O'Callaghan and became a separate legal entity in 2019. Since then, the **Femicide Census** has become established as a leading articulation of men's fatal violence against women in the UK. The Femicide Census is supported by Freshfields and Deloitte.

Men's violence against women is a leading cause of the premature death for women globally but research in the UK and Europe is limited and unconnected. The **Femicide Census** improves upon currently available data by providing detailed comparable data about femicides in the UK, including demographic and contextual factors and the methods men selected to kill women.

The **Femicide Census** does not limit its recording and analysis to information about women killed by current or for partners (intimate partner femicide) or family members. Instead, it records all women killed by men, as these killings share foundations beyond and in addition to the pathology and choices of individual men. Femicide is rooted in the sex inequality, sexism and misogyny inherent in patriarchal societies. Men's violence against women is systemic in nature and is both caused by and reinforces structural sex inequality.

The collected data is stored on the software platform Relativity, a sophisticated, interactive software platform hosted by Deloitte which facilitates analytical searches and statistical breakdowns. The platform is used by organisations around the globe, typically to review and analyse data for litigation, investigations, government requests and more. It provides a secure document repository with highly customisable access permissions and allows us to easily link external documents such as news articles, Freedom of Information responses and other reports to information about the victims and perpetrators, enabling us to analyse and access all information in a central secure location.

The **Femicide Census** has a range of uses to contribute to improving knowledge, strategy, policy and practice, a crucial step towards prevention, including:

- Raising awareness of men's fatal violence against women
- Providing a clearer picture of men's fatal violence against women in the UK by factors including relationship between perpetrator and victim, age, form of violence selected, location of fatal incident and justice outcome
- Utilisation of the information to create advocacy tools based on concrete data on intimate partner violence homicides and other forms of familial or non-familial killings of women
- Providing a resource for academics, journalists, policymakers and others researching femicide
- Identify state failings
- Remembering and raising the status of women killed by men.

The **Femicide Census** is pleased to state its voluntary adherence to the Code of Practice for Statistics.