PENNINE LANCASHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Marianne

Died August 2017

OVERVIEW REPORT

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1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to, and supported, Marianne a resident of Rossendale prior to her death in late summer 2017. Marianne's Mother provided the following tribute about her-

'Marianne was my eldest daughter and the day she was taken, so was part of me. I write this on behalf of all her family, including her two young children.

Since losing Marianne the whole family has been affected in so many ways. Grief follows us around like a shadow. Complete happiness and contentment in our lives is no longer within our reach because of what has happened to Marianne. Our whole lives have changed beyond recognition not only losing Marianne but becoming 'parents' to our grandchild when our own children are all flying the nest. Our well-planned future is no longer our own. There is a huge Marianne sized hole in all our hearts, a void that will never heal, memories and photographs are all we have left. Even happy memories are painful to think about now because we know she should still be here making many more memories and nurturing her children, all she ever wanted to be was a mummy.

Marianne was such a wonderful, loving mum. Family, especially her children were her absolute world and everything Marianne did she did for them or other members of her family. Her children have the very difficult task of not only growing up without a mummy, but inevitably, growing up knowing what happened to her. Her little children will grow up having no real memories of her as they are so young, and they have a lifetime of issues to face without their mummy. To hear them still crying out in the night "Mummy, Mummy", a call that she cannot answer just adds to our already broken hearts.

Marianne loved life, she was mischievous and funny. She worked full-time and was a single mum of two little children. She filled her spare time with trips for the children or messy play at home which she loved as much as they did. She loved family time when we were all together and we would often holiday all together.

As a family we cannot possibly put into words how the loss of Marianne has made us feel. It affects every moment of our everyday lives. The horrific circumstances in which she died are still beyond our comprehension. "Our lives will never be the same" these words seem such a cliché but are so true. NOTHING is ever going to be the same. Nothing is 'normal', we try to create a new normal for the sake of Marianne's children, but we struggle every day.

Every day we face new challenges without Marianne and struggle to function at a level that was taken for granted before the events of that awful night. The sickening events of that night often plague our waking and sleeping moments, the horrific, shocking and brutal last moments of her life. She is missed more than words can say'.

1.2 Marianne had been in a relationship with Ajaam between November 2014 and April 2017. Child 2 was born in September 2015. The family, along with Marianne's elder child [Child 1] from a previous relationship, had lived at several addresses across Lancashire. At the time of Marianne's death, she was no longer in a relationship with Ajaam and was living on her own with her daughters at address one where she died.

1.3 Marianne was a bright and intelligent person who had studied to degree level in teaching. The DHR panel found evidence that Ajaam was a moody, controlling and abusive man who inflicted physical harm upon Marianne and tried to control her life. Marianne had no contact with statutory or voluntary agencies in respect of the domestic abuse that was perpetrated upon her.

1.4 The report considers why Marianne's abuse was not known to agencies. It considers how, for the future, agencies can take measures to ensure friends, family and colleagues are better informed about what they can do if they suspect a loved one is being abused.

1.5 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer'.[1]

1.6 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'.

1.7 In September 2019 Marianne received the Queen's Commendation for Bravery [posthumous]. The official citation contained the following information. '…neighbours heard someone screaming for help and on further investigation, found that they were coming from her home where she lived with her small child. Inside the premises, Marianne was subject to a sustained, brutal attack by her former partner who earlier came to her home for that purpose, armed with a kitchen knife. The attacker then

[1] Home Office Guidance Domestic Homicide Reviews December 2016.

doused Marianne with petrol and subsequently set the house on fire. The neighbours attempted to open the door but found that it was locked. As a result, the landlady and the police were called to the scene.

The attacker then started a fire which quickly spread throughout the house. Her child was found by a police officer sat upright on the kitchen counter in wet clothing. The tap was running and the window was open, suggesting that Leanne had doused her daughter in water and attempted to get her out of the window, away from the fire.

Once the police arrived, an officer was able to pull Marianne’s daughter to safety quickly through a window. Marianne was also rescued but later sadly died in hospital from her injuries.

Her family said they were "immensely proud and honoured that Leanne's final actions as a devoted mum have been acknowledged in such a way".

2. TIMESCALES

2.1 On 5 October 2017 Pennine Lancashire Community Safety Partnership determined the death of Marianne met the criteria for a domestic homicide review [DHR].

2.2 The first meeting of the review panel took place on 14 December 2017.

2.3 The DHR covers the period 1 November 2014 [when it is believed the relationship between Marianne and Ajaam started] to 10 August 2017. The end date is after the death of Marianne and caters for child safeguarding.

2.4 The domestic homicide review was presented to the Chair of the Pennine Lancashire Community Safety Partnership on 23.01.19 and concluded on 20.02.19 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Marianne's Mother was eager to be involved in the review. She was visited by the Chair and a colleague in the presence of a member of AAFDA[2]. Her contribution and that of her family appears later within the report in section 14.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym.

3.3 This table shows the age and ethnicity of the victim, her children, the perpetrator of the homicide and other key individuals. The pseudonyms were agreed with Marianne's family.

Name	Relationship	Age	Ethnicity
Marianne	Victim	25	White British Female
Ajaam[3]	Perpetrator	39	British Asian
Child 1	Marianne's eldest child	n/a	White British
Child 2	Child of Marianne and Ajaam	n/a	Mixed race [Defined by Maternal Grandmother]
Marianne's Mother	Mother of victim		White British
Marianne's Father	Father of victim		White British
Marianne's Step Father	Husband of Marianne's mother		White British
Marianne's previous partner	Marianne's previous partner and Father of eldest daughter		White British Male
Address one	Marianne's home and the scene of her homicide		

[2] [AAFDA] Advocacy After Fatal Domestic Abuse. www.aafda.org.uk A centre of excellence for reviews into domestic homicides and for specialist peer support. The DHR panel is grateful for the assistance provided by AAFDA, a representative from which provided support to the family and gave helpful feedback and suggestions to the DHR panel on the content of this report.

[3] Marianne's family chose her pseudonym and the DHR Panel chose the offenders.

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 14 December 2017. They were shared with Marianne's family who were invited to comment on them.

4.2 The review covers the period 1 November 2014 [the date it is believed the relationship started] to 10 August 2017, a date which caters for the need to plan child care after the homicide.

The purpose of a DHR is to:[4]

a] Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d] Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Marianne as a victim of domestic abuse and what was the response?

2. What is your agency's policy on 'routine enquiry'[5] and was it followed in this case?

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[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

[5] Routine Enquiry is where a professional asks the person they are providing services to a direct question of whether they are (or have) experienced domestic violence and abuse.

3. What knowledge did your agency have that indicated Ajaam might be a perpetrator of domestic abuse and what was the response?

4. What services did your agency offer to Marianne and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Marianne from seeking help for the domestic abuse?

5. What knowledge or concerns did the victim's family, friends and employers have about Marianne's victimisation and did they know what to do with it?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Marianne and Ajaam?

7. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Marianne and Ajaam, or on your agency's ability to work effectively with other agencies?

8. What learning has emerged for your agency?

9. Are there any examples of outstanding or innovative practice arising from this case?

10. Does the learning in this review appear in other domestic homicide reviews commissioned by Rossendale?

5. METHOD

5.1 Lancashire Constabulary notified Pennine Lancashire Community Safety Partnership on 5 August 2017 of the homicide and that the case potentially met the criteria for a domestic homicide review. A meeting held on 5 October 2017 determined the criteria had been met for a Domestic Homicide Review to be undertaken.

5.2 A referral was also made in respect of consideration of a Serious Case Review [SCR] regarding Child 2. The decision was made that the case for an SCR had not been met and that any learning would be incorporated into the Domestic Homicide Review process.

5.3 The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made.

5.4 The written material was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought. The DHR panel Chair and a colleague visited Marianne's mother and spoke to colleagues at the nursery she worked at. Additionally AAFDA negotiated with three of Marianne's friends to contribute and by 14 June 2018 the panel Chair had spoken with two of them. The contribution of all three friends appears at section 14 of the report.

5.5 The DHR panel chair asked Ajaam, through the National Probation Service, if he wished to contribute to the review. Ajaam declined to be involved in the review. Advice to DHR panels on the involvement of perpetrators and their family is contained within Home Office Guidance – *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'*. https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews. The Panel Chair and Author had access to statements provided to the murder investigation from family members, and relevant information has been included within Section 14.1

5.6 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with the representative from AAFDA and Marianne's family and they were invited to make any additional contributions or corrections.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES NEIGHBOURS AND THE WIDER COMMUNITY

6.1 The DHR Chair wrote to Marianne's family inviting them to contribute to the review. The letters were delivered by the Lancashire Police Family Liaison Officer. Also delivered at the same time was the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet. Similar letters were also sent to Marianne's former partner [the father of Child 1] and to the guardian ad litem of Child 2.

6.2 Marianne's mother wished to be involved in the review. The panel chair, author and a representative from AAFDA saw her at her home in April 2018. She provided useful background information on the relationship between Marianne and Ajaam, the details of which are included within Paragraph 14.1.

6.3 Marianne's work colleagues were seen and provided useful background information on the relationship between Marianne and Ajaam during the time they were together and after their separation in April 2017. Three of Marianne's fiends contributed to the review. Details of these events are included within Paragraph 14.1. Ajaam and his family declined to take part in the review.

7. CONTRIBUTORS TO THE REVIEW.

7.1 This table show the agencies who provided information to the review.

Agency	IMR[6]	Chronology	Report
Lancashire Constabulary			✓
Lancashire County Council Children's Services			✓
Lancashire Care NHS Foundation Trust [Health Visiting]			✓
Lancashire Care NHS Foundation Trust [Mental Health]	✓	✓	
East Lancashire Clinical Commissioning Group (CCG)	✓	✓	
East Lancashire Hospitals NHS Trust [ante-natal care]	✓	✓	
Bolton NHS Foundation Trust [Midwifery]	✓	✓	
Bright Futures Day Nursery [Private]	✓	✓	
North West Ambulance Service [NWAS]	✓	✓	

7.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

[6] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Paul Cheeseman	Support to Panel chair and author	Independent
Dee Conlon[7]	Operations Manager	Lancashire Victim Services
Jill Cooper	Specialist Safeguarding Practitioner	East Lancashire Hospitals NHS Trust
Carol Ellwood	Support to Panel chair and author	Independent
Andrea Hull	Senior Manager Children's Social Care	Lancashire County Council
David Hunter	Panel Chair	Independent
Damian McAlister	Review Officer	Lancashire Police
Sam McConnell [first meeting only]	DA Lead	Pennine Lancashire Community Safety Partnership/Burnley Borough Council
Yvonne Jackson	Specialist Safeguarding Practitioner	East Lancashire Clinical Commissioning Group
Robert Ruston [first meeting only]	Victims and Vulnerable People Lead	Office of Police and Crime Commissioner Lancashire
Sandra Thompson		Lancashire Care NHS Foundation Trust
Alison Wilkins	Community Projects and Partnership Manager	Rossendale Borough Council
Sarah Wright	Safeguarding Practitioner	North West Ambulance Service (NWAS)

[7] Dee brought expertise to the panel from her training and position as an Independent Domestic Violence Advocate [IDVA]. An IDVA is a person that is trained to provide support and safety planning to victims of domestic abuse.

8.2 The chair of Pennine Lancashire Community Safety Partnership was satisfied that the panel chair was independent. In turn, the panel chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met four times and matters were freely and robustly considered. Outside of the meetings the chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

9.2 The chair completed forty-one years in public service [the military and a British police service] retiring, from full time work in 2007. The author completed thirty-five years in public service [British policing and associated roles] retiring from full time work in 2014. Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews. The Chair was also supported by Carol Ellwood who was gaining experience in the role of domestic homicide reviews. She completed thirty years' service with a British police force retiring in 2017 and has extensive experience of child protection and domestic abuse policy and practice.

9.3 Neither the Chair, author or Carol Ellwood have previously undertaken a domestic homicide review in Rossendale nor worked there or for any agency providing information to the review.

10. PARALLEL REVIEWS

10.1 Her Majesty's Coroner for Rossendale opened and adjourned an inquest into Marianne's death. Following the criminal trial, the inquest will not resume.

10.2 Lancashire Constabulary completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.3 The chair is not aware that any other agency has conducted a review or investigation into Marianne's death nor intends to do so.

11. EQUALITY AND DIVERSITY

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

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

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[8]

11.3 Marianne attended at her GP surgery in March 2015 suffering from stress relating to her work place. Marianne stated that she was looking for alternative employment and she was advised to seek support within her work place. There was nothing to suggest this incident impaired her ability to carry out normal day-to-day functions.

11.4 Ajaam attended at his GP surgery in 2015 and 2017 complaining of 'low mood.' Ajaam was referred to Mental Health Services in 2015 for an assessment. There is nothing to indicate that any of these incidents impaired his ability to carry out normal day-to-day functions.

11.5 Marianne is white British with English as her first language. Ajaam self-described himself as a Muslim and while his first language is not known he was fluent in written and spoken English. Ajaam's parents are believed to be Muslims. They were born in Pakistan and have lived in the UK for several years.

11.6 No agency held information that indicated Marianne or Ajaam lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them.[9]

[8] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.
[9] Mental Capacity Act 2005

12. DISSEMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- Marianne's family
- Lancashire Police and Crime Commissioner's Office
- Constituent agencies of the Pennine Lancashire Community Safety Partnership
- All agencies contributing to the DHR
- The perpetrator's Offender Manager

13. BACKGROUND INFORMATION [THE FACTS]

13.1 Marianne met her former partner in 2010 whilst they were both studying at University. Their daughter, Child 1, was born in January 2013, which was in the final year of the couple's degree course. After leaving University Marianne, her partner and their daughter moved into Marianne's mother's house where they stayed until they moved into their own house at the end of April 2014.

13.2 At the end of September 2014 Marianne and her partner separated and he moved out of the family home. Around October 2014 Marianne started a relationship with Ajaam who she had met through her work. By Christmas 2014 Ajaam had moved into the family home that Marianne had previously shared with her partner and he began to live with her and Child 1.

13.3 Marianne and Ajaam lived at numerous addresses during the timescales of this review, including living for a short period of time in Manchester with Ajaam's parents. Around March 2015 Marianne discovered that she was expecting her second child. Ajaam was the father of this child. Shortly after finding out that she was pregnant, Marianne agreed to undertake a 'Nikah' ceremony[10] with Ajaam. The ceremony took place at the home address of Ajaam's parents, none of Marianne's family were present at the ceremony as they were not invited. The family state that Marianne only participated in the ceremony under pressure from Ajaam's family. In September 2015, Marianne gave birth to Child 2.

13.4 At the end of March 2016 Marianne and Ajaam moved into Marianne's mother's address where they lived until Easter 2017 when their relationship ended. Ajaam moved out of this property on Easter Monday. Marianne continued to live with her mother along with her children until around May/June 2017 when she moved into her own house [address one]. This is where she lived with both her daughters at the time of her homicide.

13.5 Lancashire Police had no contact or information concerning Marianne and her relationship with Ajaam. He was also unknown to Lancashire Police who had no record of any contact with him. There was no record of Ajaam on the Police National Database. No other agency in Rossendale, as far as the panel can ascertain, held information to indicate there was any domestic abuse in the relationship between them.

[10] In a Muslim wedding ceremony, the marriage contract is signed in a *Nikahh*, in which the groom or his representative proposes to the bride in front of at least two witnesses. The bride and groom demonstrate their free will by repeating the word *qabul* ["I accept," in Arabic] three times. Source: https://www.theknot.com/content/muslim-wedding-ceremony-rituals

13.6 During the timescale of this review other agencies had contact with Marianne, Ajaam, Child 1 and Child 2. Most of these contacts were for routine medical appointments. Marianne received ante and post-natal care during her pregnancy and following the birth of Child 2. Marianne and Ajaam also sought medical treatment for Child 1 and Child 2, none of which were for any safeguarding concerns.

13.7 Ajaam attended at his GP surgery on several occasions. There are two issues from these visits that are relevant to the terms of reference for this review. In July 2015 Ajaam attended complaining of low mood and suicidal thoughts and was referred to Mental Health Services. On the second occasion, in July 2017, prior to the death of Marianne, Ajaam attended complaining of 'low mood.' These events are covered further in Section 15.

13.8 At 22.44 hours on a date in the summer of 2017 Lancashire Police received a call from a neighbour of Marianne stating that they could hear screaming, the sound of a fire alarm and her house was on fire. Police officers attended address one, they noticed smoke coming from the house. Marianne and Ajaam were lying on the kitchen floor and Child 2 was sitting on the worktop. The kitchen was alight. All three were rescued from the house and taken to hospital with significant injuries.

13.9 Sadly, three days after the incident Marianne died in hospital. A post mortem examination found Marianne died from burns and multiple stab wounds. Child 2 was later discharged from hospital into the care of the maternal family. She suffered severe injuries that still require further treatment.

13.10 Lancashire Police commenced a homicide enquiry. They established that Ajaam had been planning to attack Marianne for several weeks. On the night he carried out the attack he went to address one with Child 2 claiming the child wanted to see its mother. Once inside he attacked Marianne and started a fire in the kitchen with petrol he brought with him in a fuel canister.

13.11 The police officer in charge of the homicide enquiry said he believed Marianne had tried everything possible to protect Child 2 and get it to safety. He was in no doubt that Marianne's brave actions that evening saved the child's life.

13.12 Ajaam was seriously injured in the fire he set. He was arrested on suspicion of the murder of Marianne. When he was well enough to leave hospital, he was interviewed and charged with the murder of Marianne, the attempted murder of Child 2 and an offence of Arson with Intent to Endanger Life.

13.13 Ajaam appeared at a Crown Court in spring 2018 and pleaded guilty to the offence of murder and arson with attempt to endanger life. Ajaam was sentenced to life imprisonment for murder with a minimum tariff of 30 years and 10 years to run concurrently for the offence of arson. The charge of attempt murder of Child 2 was left to lie on file. He will not be released from prison until he has served at least 30 years.

13.14 Marianne's family released the following statement following Ajaam's conviction –

"As a family we will never get over what happened to Marianne. She was strong, vibrant, mischievous and beautiful inside and out. She was the most amazing mum, daughter, granddaughter, sister and friend and has left a huge void in all our lives. Marianne was taken from us in the most violent and shocking manner that will haunt us all for the rest of our lives. We miss her more than words can say, and her two little children must grow up without such a wonderful role-model. She will forever be with us in our hearts and thoughts and we will focus on all the good memories that we have as a family, but the reality is she should be here with us making many more memories."

14. CHRONOLOGY

14.1 Background to

Marianne
Marianne is one of three daughters born to her parents. Marianne's parents separated and her mother re-married and Marianne was brought up in a lively household with her siblings and stepsiblings. As a young girl Marianne always said she wanted to be a Mummy and a teacher. She was very mischievous and a practical joker who liked to have fun. Marianne attended Carlisle University to undertake a degree course to qualify as a teacher and it was here, during her first week that she met her former partner. In January 2013, during her final year, Marianne gave birth to her eldest child [Child 1], she remained at University after the birth caring for the child, with her partner, and she completed her course. Following completion of her degree course Marianne, her partner and Child 1 moved into Marianne's mother's house to live and during this time Marianne completed an eight-week work placement as part of her teacher training. In 2014 her partner purchased a house, which all the family helped to decorate and at the end of April 2014 Marianne, her partner and Child 1 moved into the house. By September 2014 the relationship between the couple ended and Marianne's partner moved out of the family home. In October 2014 Marianne started a relationship with Ajaam whom she had met at work and by December 2014 Ajaam had moved into the house where Marianne was living with Child 1. Marianne and Ajaam formed an intimate relationship. Marianne's mother described Marianne as being a vocal person who would always speak her mind. Once she started a relationship with Ajaam she changed and would not speak out or challenge anything that was said. In February 2015 Marianne, Ajaam and Child 1 moved to Manchester to live with Ajaam's parents, where they stayed for approximately four weeks. In March 2015 Marianne discovered that she was pregnant as a result of which, around March/April 2015, Marianne agreed to a 'Nikah' ceremony with Ajaam which was undertaken at Ajaam's parent's house in Manchester. It was understood that Ajaam came under pressure from his parents for Marianne to participate in this ceremony, given the fact that she was pregnant with his child. Their daughter was born in September

2015.

Between March 2015 and March 2016 Marianne and Ajaam lived at several addresses within Lancashire, one of these addresses is described by family as being very remote and isolated. In March 2016 Marianne and Ajaam moved to live with Marianne's mother, this followed them temporarily living at Marianne's mother's house whilst she was away on holiday in February 2016.

In April 2016 Marianne began working full time at a local nursery. Both of Marianne's children also attended at the nursery.

Marianne and Ajaam continued to live with Marianne's Mother until their relationship ended in April 2017 and Ajaam was asked by Marianne's Mother to leave the house.

Around May/June 2017 Marianne moved into her own house [address one] with her two children.

Ajaam

Not a lot is known about Ajaam and the Chair and Author have not visited any of Ajaam's family or previous partners as part of this review. Ajaam declined to be involved in the review.

The Panel Chair and Author had access to statements provided to the Police investigation from some of Ajaam's family members which confirm that Ajaam was born in the UK. Information also stated that Ajaam's parents did not approve of the long-term relationship he was in at the time of meeting Marianne, nor the relationship he had with Marianne, due to cultural differences.

Ajaam has no convictions recorded against him in the UK and he was not known to UK Police Forces prior to the incident with Marianne.

Ajaam was working as a Carer at the same work place as Marianne when they met in October 2014. At the time of meeting Marianne, Ajaam was in a relationship with another female. The couple had been together for a long time, they were not married and did not have any children. Information gathered during the homicide enquiry indicated there was no known domestic abuse in this relationship.

Ajaam has not previously been married, although there was a 'Nikah' ceremony between Ajaam and Marianne in March 2015. The ceremony is understood to have taken place because of Ajaam receiving pressure from his family, because Marianne was pregnant with their child. Ajaam is not known to be the Father of any other children, apart from Child 2.

Marianne's Mother described an incident the first time she met Ajaam during a family meal, where he challenged her and pointed his finger at her when she was speaking about Marianne's ex-partner. A sibling of Marianne's interjected and told Ajaam to show some respect to Marianne's Mother as they were at her house.

Ajaam visited his GP on two occasions [July 2015 and July 2017] reporting suicidal thoughts [2015] and low mood. Ajaam received services from his GP including a referral to Mental Health Services – these events are covered further in Section 15.

Marianne and Ajaam's Relationship

Marianne and Ajaam met through their work place in October 2014. This was a vulnerable time for Marianne, as she had recently separated from her partner and there were other personal factors that were having an impact on her.

Ajaam was still in a long-term relationship with his partner of 17 years, and during the early stages of his relationship with Marianne he maintained his contact with that partner.

In December 2014 Ajaam moved into Marianne's home, where she was living with Child 1. In February 2015 Ajaam and Marianne moved from this house and went to live with Ajaam's parents in Manchester. Ajaam's parents do not speak English and Marianne found this move difficult due to the language and cultural barriers.

After four weeks, Marianne and Ajaam moved back to Lancashire into a property owned by Ajaam's employer, and it was shortly after this move that Marianne discovered she was pregnant. At this time her mother said Marianne was receiving pressure from his family for her and Ajaam to get married. Marianne told her Mother that neither she nor Ajaam wanted to get married and so, with some reluctance, Marianne agreed to a 'Nikah' ceremony. Marianne told her Mother she did this to 'keep the family quiet.' No one from Marianne's family was present at this ceremony which

took place at Ajaam's parent's home in Manchester.

From information provided to the review, it appears Ajaam's Mother told him he could not marry Marianne unless she became a Muslim. Prior to the ceremony, Marianne was seen at Ajaam's parent's house by the local Imam to 'teach her Islam.'

Marianne and Ajaam lived at a property owned by Ajaam's employer for a couple of months before they moved to another property which was found by Ajaam. He explained to the family the reason for moving was because he did not like beholding to his employer, the family stated the move was to isolate Marianne more.

The property they moved to is described as an attic flat, in a very isolated and rural location, with the nearest shop being 3 miles away. The location meant there was only parking available for one car and so Marianne had to leave her car at her mother's and rely on Ajaam for transport. The property was damp and there was visible mould on the walls.

During this time Marianne was seen by a Health Visitor and was asked about domestic abuse as part of a routine enquiry. Marianne did not make any disclosures.

In April 2016 Marianne and Ajaam moved into Marianne's mother's house, where they lived together until their separation in April 2017. Marianne also started work in April 2016 at a local nursery, which both of her children attended.

Staff at the nursery described how Ajaam would often sit outside the nursery in his car whilst Marianne was at work and wait for her to have her lunch break; upon which she would join him to either eat in the car or outside as part of a picnic. On one occasion Marianne is reported to have told a member of staff that Ajaam would not let her come to work unless he came with her. The panel found this controlling behaviour insidious.

Marianne's family also described how Ajaam would not let Marianne go to work unless he went with her and he would sit outside the nursery all day waiting for her. Marianne's family described this as coercive control and spoke about how he would also tell her to 'cover her shoulders' as well as isolating her by not babysitting for her.

There were other incidents that occurred between Marianne and Ajaam which are detailed within the events table at 14.2.1, some of which relate to acts of physical violence by Ajaam. None of these were reported to an

agency or resulted in a safeguarding referral.

Marianne's Mother described Ajaam as being very moody and he would often storm around the house when arguing with Marianne. Marianne and Ajaam went on holiday in June 2016 and after their return Marianne's mother noticed cracks were starting to appear in their relationship. Marianne's mother spoke to her about her relationship with Ajaam. Marianne told her she did not want to be a single mother with two children.

Marianne's friends Emma and Jamie [a female] and Jessica, [The names are pseudonyms agreed with the friends] described how Marianne's relationship with Ajaam began very soon after her split from her partner.

Jamie had been friends with Marianne since secondary school and they grew really close. Jamie knew Marianne's family and the father of her first child.

Jamie believed Marianne met Ajaam at work and was a little surprised at the speed the relationship developed. However, Jamie was pleased and content that Marianne had found some happiness.

The frequency of Jamie and Marianne's contact slowed after Ajaam became involved. At the time, Jamie thought that was just the natural course of events and did not think anything sinister was happening.

When Marianne broke up from Ajaam in April 2017, a group of friends had lunch with her. Marianne did not seem quite herself; she was quiet and appeared stressed out. Marianne reassured the friends she was alright and Jamie wondered if she really was.

Marianne seemed to be settling into the life of a single mum. Jamie thought Marianne had a few concerns about how others would perceive her, because she had two children to different fathers when the relationships broke down.

Marianne was very kind, conscientious, talented and worked hard; she always put other people's needs before her own.

Emma met Marianne at university and became best friends. Emma recalls Marianne meeting Ajaam who was initially charming; Marianne was besotted with him. As the relationship developed, Emma thought Marianne was frightened of him and gave the following example. One evening Marianne locked Ajaam out of the house [Emma did not know

why] and telephoned Emma to say Ajaam was climbing up a drainpipe trying to get in. Emma thought Marianne was scared.

Emma spoke with Ajaam about his unfounded concern that Marianne was seeing or would meet someone else. He was extremely jealous and Emma told him that his behaviour would push Marianne away. Emma felt Ajaam took advantage of Marianne's very kind nature and her vulnerability brought about by her pregnancy.

Emma thought Marianne struggled to deal with Ajaam's jealousy and his controlling behaviour. Emma recalls Ajaam constantly flitting between Marianne and his former partner and the stress this caused Marianne. Emma felt Ajaam wanted to isolate Marianne, as evidenced by the move to a remote property; bombarding her with telephone calls and text messages and waiting outside her place of work.

Emma described Marianne as a much happier person once she left Ajaam.

Marianne told Emma about Ajaam dragging her by the hair. Emma wanted Marianne to go to the police about this, and his controlling behaviour. Marianne asked Emma not to report the matters. Emma understood that Marianne did not want to get Ajaam into trouble. Emma indicated that, if such circumstances happened again, she would go to the police against the wishes of the person.

Jessica met Marianne whilst at University and along with Emma they became very good friends, which continued after their graduation. Jessica also knew Marianne's former partner, the father of Child 1.

Marianne told Jessica she met Ajaam whilst working for the same care organisation. Marianne and Ajaam's relationship developed very quickly and they moved in together, when Marianne soon became pregnant. Jessica described Marianne as being happy with Ajaam and looking forward to having child 2. At first Jessica liked Ajaam but as he began to isolate Marianne, Jessica came to dislike him.

Jessica was aware Ajaam left a long-term relationship when he started to see Marianne, but that he kept going to and fro, between his previous partner and Marianne. Jessica knew Marianne gave Ajaam an ultimatum, to choose between his previous partner and her. It was after this that Jessica saw less and less of Marianne who changed her telephone number.

When Jessica did see Marianne, she was always with Ajaam. Jessica knew that Ajaam met Marianne daily for her lunch, which Jessica thought was

unusual compared to her own relationship in which they were comfortable doing separate things.

Jessica discussed with Emma the growing isolation of Marianne that had developed over the course of two years. Jessica did not want to interfere in Marianne's life as, at the beginning of the relationship, Marianne appeared to be content. She was also having a second child and Jessica did not want to cause an argument.

Jessica understood Ajaam was controlling and Marianne had spoken to her about leaving the relationship. Jessica and Emma both felt Ajaam would not allow her to leave, as he would not be able to cope without Marianne. Jessica described how Ajaam bombarded Marianne with text messages and telephone calls. Jessica felt there would be consequences if Marianne left Ajaam, but she did not think that it would lead to injuries or death.

Jessica was told by Emma about an incident when Ajaam had put his hands around Marianne's neck when he had questioned her about her parenting skills.

Marianne had told Jessica that Ajaam was happy for Child 2 to be brought up as a Christian as it was wrong to have two children in the same household being brought up in different faiths.

Jessica said she spoke with Marianne after the separation with Ajaam and told her to remain strong. Following the separation, Jessica noticed Marianne was a different person and described her as having reverted to her happy, bubbly and content self.

It was also clear to Jessica that Marianne was conscious that people might have thought bad of her, because she was a single mum with children to different fathers.

In hindsight, Jessica said she would have spoken with Marianne's mother about her concerns, even if that risked her friendship with Marianne. Jessica also said she would have encouraged Marianne to seek independent advice and call the Police.

In August 2016 Marianne's Mother went on holiday leaving Marianne, Ajaam and the children at her house. Several incidents occurred during this time between Marianne and Ajaam. Marianne's ex-partner visited the house to collect Child 1 and saw Marianne had a black eye. He spoke to Child 1 and asked if 'Mummy' was ok. The child told him they [Marianne and Ajaam] were always arguing. Marianne's sibling came to the house

and saw Ajaam 'squaring up' to Marianne. This happened in front of the children and she took the children out of the house away from the situation. When Marianne's mother returned from holiday, she noticed damage to door handles inside the house. She described this as being caused by someone holding on to the handle to prevent a door from opening, whilst someone else was pulling on the other side. Marianne was asked by her mother how the damage happened, and she said she did not know.

By the end of March 2017 Ajaam was sleeping in a separate bedroom at Marianne's mother's house. The arguing between them both was continuing. Marianne's mother described how, during these arguments, Ajaam would not be as vocal with Marianne when her partner was in the house. Marianne's mother said the relationship completely broke down by Easter 2017 when she asked Ajaam to move out of the house.

On the evening Ajaam attacked her, a group of Marianne's friends had a pampering session at Jamie's parents' house. Ajaam was looking after Child 2 for the first time. Marianne said she did not trust Ajaam to have the child on his own [she did not say why] so he took it to his parents.

During the evening, Marianne said Ajaam had been violent, not necessarily hitting her, rather more like squaring up and being verbally loud and aggressive. Looking back Jamie can now see that, despite appearing polite and quiet, Ajaam had been exercising control over Marianne.

14.2 Events Table

14.2.1 The following table contains important events which help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review, from witnesses that were seen during the homicide review and from the memories and recollections of Marianne's family.

Date	Event
September 2014	Relationship between Marianne and her partner ended. He moved out of the family home.
October 2014	Relationship between Marianne and Ajaam commenced.
December 2014	Ajaam moved into family home with Marianne and Child 1.
February 2015	Marianne, Ajaam and Child 1 moved to Manchester to live with Ajaam's parents where they stayed for about

	one month.
February/ March 2015	Marianne, Ajaam and Child 1 moved to a property owned by Ajaam's boss.
02.03.2015	Marianne attended at her GP surgery complaining of stress at work. Marianne was 10 weeks pregnant.
March/April 2015	Marianne agreed to a Nikah ceremony, which took place at Ajaam's parents' home.
April/May 2015	Marianne, Ajaam and Child 1 moved to an address in Lancashire.
17.05.2015	A health visitor saws Marianne and asked her about domestic abuse. Marianne made no disclosure.
08.06.2015	Marianne attended the GP out of hours service following a fainting episode in a local supermarket. Marianne was 24 weeks pregnant and reported that she had not felt baby move since she fainted. Marianne was advised to attend the hospital Urgent Care Centre for further checks. Marianne's Mother recalls that she attended. Marianne gave Ajaam's details as next of kin.
June/July 2015	Ajaam was seen on several occasions by a work colleague sitting outside the Nursery where Marianne worked. Marianne was pregnant at the time with Child 2 [approximately 25 weeks]. Ajaam was seen to look at his watch and back at the nursery if Marianne was not out on time. Marianne would go and join Ajaam to have her dinner in the car. [This is a different Nursery to the one Marianne was working in at the time of her death].
03.07.2015	Ajaam attended his GP with low mood and strong suicidal thoughts. He described the breakdown of a long-term relationship. His current partner was pregnant which he said was a protective factor. Ajaam consented to contact with the Mental Health Team. The Mental Health team agreed to contact Ajaam within an hour. The GP provided Ajaam with a contact number for the Crisis Mental Health Team. The GP planned for a further review within a week.
03.07.2015 10.08 hours	Duty worker from Lancashire Care NHS Foundation Trust Mental health telephoned Ajaam and arranged for a face to face assessment.
03.07.2015 11.00 hours	Ajaam attended face to face assessment with Lancashire Care NHS Foundation Trust Mental Health. Follow up call arranged for 14.07.2015.

09.07.2015	Ajaam attended a review meeting with his GP. He reported feeling slightly better, going on holiday with his partner and awaiting the birth of baby. Ajaam refused anti-depressants. The GP issued 'fit note'[11] for one week. Ajaam confirmed contact from the Mental Health Team and that he was aware he needed to contact them if the situation worsened. He agreed to see the GP for a review after his holiday.
14.07.2015 14.32 hours	Follow up telephone call by Mental Health Team to Ajaam. He stated his thoughts of self-harm had reduced. Referral in place for 'Mindsmatter'[12] appointment.
20.07.2015	GP record states a letter was received from the Mental Health Team that Ajaam had been seen in Psychiatry.
19.08.2015	GP record states Ajaam did not attend his Minds Matter appointment.
07.09.2015	Marianne gives birth to Child 2.
12.10.2015	Universal Health Visiting Service undertake a 4-6-week contact at home with both parents and Child 1 as per Healthy child Programme. No safeguarding concerns or relationship problems were identified between the parents.
26.11.2015	Child 2 is admitted to hospital with Sepsis.
February 2016	Marianne, Ajaam, Child 1 and Child 2 moved into Marianne's Mother house for one week whilst the family are on holiday.
March 2016	Marianne, Ajaam, Child 1 and Child 2 moved permanently into Marianne's Mother house.
15.04.2016	Marianne started work at a second Nursery [henceforth known as Nursery Two].
April 2016	Nursery staff recall that Ajaam would meet Marianne for lunch and they would either sit outside the nursery or have their lunch in Ajaam's car. On some occasions Child 2 would have dinner with them, but not Child 1.
April/May	Marianne told a member of nursery staff that she

[11] Doctors issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work.

[12] This service is provided by Lancashire Care NHS Foundation Trust. It has dedicated teams of Psychological Wellbeing Practitioners [PWPs], Cognitive Behavioural Therapists and Counsellors who offer a range of support to help clients make positive changes to reduce stress and anxiety and improve their wellbeing. These include Stress control classes, wellbeing workshops, group therapies, one to one support and telephone support.

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2016	argued with Ajaam and he had not let her come to work unless he came in her car. Ajaam was seen sitting outside the nursery in the car whilst Marianne was at work.
June 2016	Marianne was seen crying at the Nursery and told a member of staff that Ajaam had been pulling Child 1 around the kitchen by her hair. Marianne had asked him to stop and he then pulled her around the kitchen by her hair. Marianne told her nursery colleague that she was going to take her sister on holiday. On the same day Ajaam was seen sitting outside the nursery in his car until dinner time and Marianne was reported as being unsettled.
July 2016	Marianne, Ajaam, Child 1 and Child 2 went on holiday to Gran Canaria.
August 2016	Marianne's Mother and family go on holiday for two weeks leaving Marianne, Ajaam and the children at home alone. Marianne's former partner stated that he saw Marianne with a black eye during this time when he had gone to pick up Child 1. Child 1 told him that Marianne and Ajaam were always arguing. Marianne's sibling contacted her Mother to state that Marianne and Ajaam were constantly arguing and that she heard Ajaam tell Marianne he would take Child 2 from her and take it to Pakistan. Marianne's sibling told her Mother on one occasion she came home to find Ajaam 'squaring up' to Marianne, and she left the house taking the two children with her. Marianne later sent her Mother some video footage of Ajaam playing and laughing with the children. Marianne's Mother said when she came home from holiday she noticed damage to the door handles in the house, which she described as if someone had been pulling on them hard from both sides.
August 2016	Marianne told a member of staff at Nursery Two that she wanted to leave the relationship with Ajaam.
October/ November 2016	Marianne telephoned work to say she was going to be late to work as Ajaam had been violent and grabbed her in front of the children. Marianne told the Nursery she did not want to leave Child 2 with Ajaam. Marianne was advised to come to work with the children. Once at the Nursery Marianne told a member of staff it had not happened before. Marianne was advised to leave the children at the nursery and go and see her mother. Marianne returned to Nursery Two a few hours later, a

	lot happier.
April 2017	Marianne and Ajaam separated. Ajaam moved out of Marianne's mother's house. Marianne's mother said the relationship had completely broken down by this time and she asked Ajaam to leave.
April 2017	Marianne was seen by a member of staff at Nursery Two with a black eye. Marianne told the member of staff that Ajaam had been aggressive during the night. [It is not known if this is the same injury as described by another member of staff in May 2017].
May 2017	Marianne was seen by a staff member at Nursery Two with a bruise under her eye. Marianne was asked how the injury had happened and she said Child 1 had done it. Another staff member was told by Marianne that she was receiving text messages from Ajaam asking for them to get back together. Marianne described the texts as annoying.
May/June 2017	Marianne moved into address one with Child 1 and Child 2.
June/July 2017	Marianne told a work colleague she had taught Child 1 how to use the emergency function on her telephone, which directed the call to Marianne's Mother. Marianne also talked about how long it would take for someone to come to the house to check on her if she did not come in to work, or if the children were heard by the neighbours to be constantly crying.
05.07.2017	Ajaam visited his GP with low mood. Ajaam described poor sleep, no-self harm, no drug or alcohol use. The GP prescribed medication and issued Ajaam with a 'fit note' for two weeks.
18.07.2017	Ajaam visited his GP reporting he was still feeling the same and that medication had not helped. The GP prescribed different medication and issued a further 'fit note' for review in four weeks.
A date in summer 2017 22.44 hours	Call to Lancashire Police from a neighbour reporting hearing screaming, the sound of a fire alarm and Marianne's house on fire. Police attended address one and recovered Marianne, Ajaam and Child 2 from the house with significant injuries. All taken to hospital. Police commence major investigation.
A date in late summer 2017.	Children's Social Care informed that a major incident had taken place. A strategy discussion is held with the Police and Health. Children's Social Care make the appropriate practical and legal arrangements for the

	care of the children in line with policy and expected practice.
A date in late summer 2017.	Marianne died from the injuries she sustained.

15. OVERVIEW

15.1 Introduction

15.1.1 This section of the report summarises what information was known to the agencies and professionals involved with the victim and perpetrator. The structure adopts a chronological approach in which each issue of significance is described, and the input of each agency considered. The events are cross referenced to table one. Detailed analysis of the contacts appears at section 16.

15.2 Contact with health services

Marianne

15.2.1 Marianne and her two children were registered with a GP practice in Rossendale. Ajaam was not registered at this practice although he did attend with Child 2 for medical appointments. During the timescale of the review Marianne attended her GP practice on six occasions, as well as an out of hours clinic and a hospital appointment. Most of these consultations were for routine matters which were not related to the terms of reference for this review.

15.2.2 On 2 March 2015 Marianne attended the GP practice complaining of stress at her work. It was recorded she was ten weeks pregnant and worked as a carer. During an appointment with a Health Visitor on 17 May 2015, Marianne was asked about domestic abuse and made no disclosures. There are no records of Marianne being asked 'routine enquiry' during her maternity care[13].

Child 1 and Child 2

15.2.3 Both children had several routine engagements with health services none of which were of a safeguarding concern.

Ajaam

15.2.4 On 3 July 2015 Ajaam attended his GP surgery complaining of suicidal thoughts and low mood he said he had ended a 17-year relationship with another female and was now in a relationship with another woman who

[13] Records in hand-held notes show Marianne was accompanied by Ajaam for all her appointments/episodes of care, apart from one, and on this occasion, there is no record as to who accompanied Marianne. There was a potential opportunity for Marianne to be asked when she was admitted to the ward for induction of Labour, as there were occasions when Ajaam was absent; however, timing and appropriateness of asking a 'routine enquiry' need to be considered within the presenting medial circumstances and the enquiry made in the sole presence of the person receiving the service. At the time of Marianne's maternity care there were no Trust guidelines in place for midwives to inform service users that they would be seen on their own during pregnancy.

was currently 27 weeks pregnant. Ajaam said he was troubled by the breakdown of his relationship with his ex-partner. There is no reference in the GP records that questions were asked of Ajaam in relation to domestic abuse, family details and his current living arrangements.

15.2.5 The same day, and within an hour of the GP referral, Ajaam attended for a face to face appointment with the duty worker from Lancashire NHS Foundation Trust Mental health team. He told the worker his family had disowned him, as they did not agree to the two relationships. He said he had no friends and no support other than his new partner. Ajaam agreed for a referral to be made to 'Mind Matters' for talk therapy and for access the 'on-line mood gym'.

15.2.6 Ajaam was reviewed by his GP on 9th July 2015. He said he was feeling slightly better, was sleeping most of the time and felt fine whilst he was asleep. Ajaam told his GP he still had feelings of guilt although he was not having as much thoughts of suicide as before. He told the GP he was awaiting the birth of his baby in September and that he and his partner were going away on holiday the following week.

15.2.7 Ajaam had a follow up telephone call with the Mental Health Team on 14 July 2015. His thoughts of self-harm had reduced, and he declined medication. He was referred to a 'Minds Matters' appointment, however a letter sent to his GP states Ajaam did not attend this appointment. There is no record to indicate why he did not attend nor was the failure to attend followed up.

15.2.8 Following the birth of Child 2 Universal Health Visiting Service undertook 4-6-week contact at home with both parents and Child 1. No safeguarding concerns or relationships problems were identified between Marianne and Ajaam. In December a further home visit took place and again no safeguarding or relationship issues were identified.

15.2.9 On 5 July 2017, Ajaam visited his GP complaining of low mood. He told his GP he was going through a bad period; his partner had left him in April 2017. He said he could not face work as a carer. Medication was prescribed to Ajaam and he was issued with a 'fit note' for two weeks. There was no referral or contact with Mental Health services. Ajaam attended a follow up appointment with his GP on 18 July and said the medication had not helped and he did not feel well enough to go back to work. He was prescribed further medication and a further 'fit note' for four weeks. There was no referral or contact with Mental Health Services as the GP thought one was unnecessary. The DHR panel felt the GP should have asked about domestic abuse.

Contact with other agencies

15.2.10 Ajaam had no previous convictions. There was no information held that Marianne and Ajaam were known to the Police. Children's Social Care had no record or contact in relation to Marianne, Ajaam or the two children until after the incident on 30th July 2017.

15.3 Events following the incident in late summer 2017

15.3.1 Marianne, Ajaam and Child 2 were all recovered from the property on the night of the incident and taken to different hospitals. Lancashire Constabulary commenced a major investigation. Sadly, Marianne never recovered from her injuries and died in late summer 2017.

15.3.2 Following the incident Lancashire County Council Children's Social Care Department commenced an assessment under Section 47 Children Act[14] 1989. They made the necessary practical and legal arrangements for the placement of the children with family members. The DHR panel are satisfied that the speed and way Children's Social Care responded to this crisis was appropriate and in line with expected policy and practice in relation to the safeguarding of children following serious incidents. The DHR panel do not believe it is necessary to outline the detail of the care arrangements for the children.

[14] When the local authority social worker receives a referral and information has been gathered during an assessment in the course of which a concern arises that a child maybe suffering, or likely to suffer, significant harm, the local authority is required by Section 47 to undertake enquiries. The purpose of this multi-agency enquiry and assessment is to enable the agencies to decide whether any action should be taken to safeguard and promote the welfare of the child. Any decision to initiate an enquiry under Section 47 must be taken following a Strategy Meeting/Discussion. Responsibility for undertaking Section 47 enquiries lies with the Local Authority Children's Social Care in whose area the child lives or is found.

16. ANALYSIS USING THE TERMS OF REFERENCE

16.1 Term 1

What indicators of domestic abuse did your agency have that could have identified Marianne as a victim of domestic abuse and what was the response?

16.1.1 The DHR panel were satisfied that, except for the nursery[15] where Marianne worked, no statutory or voluntary agencies within the Rossendale area knew of any indicators that might have identified Marianne was a victim of domestic abuse. There had never been any calls for police attendance. Her limited contacts with other agencies were, in the main, related to routine medical matters that were unconnected to domestic abuse. However, there was one missed opportunity to ask Marianne 'routine questions' [see paragraph 16.2.3 post].

16.1.2 The homicide enquiry found clear evidence, from family, friends and work colleagues, that in the weeks leading up to Marianne's death, Ajaam perpetrated domestic abuse upon her, and prior to that had shown coercive and controlling traits/behaviour. It was not reported to, nor picked up, by agencies. The panel recognised that one of the purposes of a DHR is to find the trail of abuse. In that respect the panel differ from those close to Marianne who in their busy lives find it harder to identify and label behaviour in the same way as the DHR. The DHR panel recognised that third parties can be nervous about reporting domestic abuse for many different reasons. For example, the fear of doing the wrong thing and repercussions of that on their loved one, including putting them at greater risk. The DHR panel acknowledged that in a small number of cases the actions of perpetrators are simply unknown to statutory agencies. This was the case here.

16.1.3 The DHR panel heard that, had there been direct indicators that Marianne was a victim of domestic abuse, agencies within Rossendale have policies and procedures in place for responding to those indicators.

[15] All nurseries are subject to inspection by Ofsted under sections 49 and 50 of the Childcare Act 2006 on the quality and standards of provision that is registered on the Early Years Register. The registered person must ensure that this provision complies with the statutory framework for children's learning, development and care, known as the early year's foundation stage. The common inspection framework sets out how Ofsted will inspect providers on the Early Years Register. Inspectors will always have regard for how well children and learners are helped and protected so that they are kept safe. Although inspectors will not provide a separate numerical grade for this key aspect of a provider's work, inspectors will always make a written judgement under leadership and management about whether or not the arrangements for safeguarding children and learners are effective. Source: www.gov.uk/government/organisations/ofsted

16.1.4 The DHR panel decided to test how effective the mechanisms are within the CSP area, for third parties who have concerns that someone is a victim of domestic abuse to share that information. Given that social media is usually the first resource that enquiries now use, a search was carried out on the internet using Google and the phrase 'Rossendale domestic abuse'. This returned three relevant hits on the first page.

16.1.5 The first hit, which fell at number three on the page, took the user to the Rossendale Borough Council webpage. This contained a concise statement about domestic abuse and clear advice on contacting either Victim Support or the National Domestic Violence helpline. The advice was orientated towards victims [both male and female]. The links to the other two sites both contained references to 'other people' who might have information about domestic abuse.

16.1.6 The second hit, which fell at number four on the page, took the user to the 'Together we are Safer Lancashire' page. This contained extensive information about domestic abuse, including what comprises abuse, and links to Lancashire Victim Services that is supported by Lancashire Police and Crime Commissioner. There were also links to various other services supporting victims. There was no specific reference or advice as to what to do if the enquiry related to reporting abuse by third parties such as family or work colleagues.

16.1.7 One of three links on that page brought the user to the Lancashire Victim Services web page[16]. This was well set out, easy to use and provided a great deal of information on the different forms of domestic abuse. Examples included psychological abuse, emotional abuse, physical abuse, financial abuse, sexual abuse and verbal abuse. There was clear information on how to get advice. There was no reference as to how a third party such as friends, work colleagues or family should deal with a disclosure.

16.1.8 The third hit, which fell at number seven on the page, related to REAL, a community web site for services in Rossendale. The page contained information about domestic violence and hate crime and links to three services that provided support; the HARV domestic violence team, Victim Support Lancashire and Lancashire Victim Services. As with the other two hits, the information was directed towards victims and there was no specific advice about what to do if a third party held information or needed advice. The DHR panel felt it would be helpful if some prominence could

[16] https://lancashirevictimservices.org/?s=domestic+abuse

be given to such advice by the CSP and the partners who maintain these websites.

16.1.9 A search was also carried out on Facebook using the same parameters. While some national domestic abuse services were returned there was nothing relating to the Rossendale area. Widening the parameters to Lancashire domestic abuse, the search brought up the Facebook page for the Lancashire Police and Crime Commissioner. The profile picture for the Facebook site relates specifically to Lancashire Victim Services and domestic abuse. It contains the following simple message;

'Domestic abuse. There is a way out of abusive relationships, we can help you find it. Take the step. Make the call. Call: 0300 323 0085'

16.1.10 The DHR felt the information available locally in Rossendale and Lancashire about domestic abuse services was good. It is primarily orientated directly to victims. The DHR panel felt domestic abuse services using social media may wish to consider how they can enhance what they offer by providing more information for third parties. They have identified a lesson and a recommendation [see lesson one and recommendation one].

Term 2

16.2 What is your agency's policy on 'routine enquiry'[17] and was it followed in this case?

16.2.1 All the agencies that had contact with Marianne and Ajaam were asked to articulate their policy on 'routine enquiry'. Marianne had two periods of engagement with East Lancashire Hospitals NHS Trust [ELHT]. The first covered her pregnancy, labour, birth and immediate postnatal period in 2015. The second period occurred in 2017 when Marianne was seen within one of the Trust's clinical services for a routine matter. Ajaam had no contact with the Trust. The two children had contact that was unrelated to this review.

16.2.2 ELHT ask 'routine enquiry' within maternity services, Emergency Dept and Urgent Care [since 2006] and occupational health [since 1 December 2016]. Their policies and procedures are comprehensive and are informed by national documents and recommendations. A coded system within the maternity hand-held notes allows midwives to record whether the routine enquiry has been made or not.

16.2.3 There is no record of Marianne being asked routine enquiry during her maternity care. Records show she was accompanied by Ajaam for all her appointments and episodes of care, apart from one. On this visit nothing is recorded in the appropriate box in the notes to identify who accompanied

[17] Routine Enquiry is where a professional asks the person they are providing services to a direct question of whether they are experiencing domestic violence and abuse.

her to this appointment. The Trusts IMR author believes this could have been a missed opportunity for Marianne to have been asked routine enquiry and potentially disclose domestic abuse. Marianne was admitted to the antenatal ward for induction of labour and there was potential for her to be asked routine enquiry while Ajaam was absent.

16.2.4 At the time of Marianne's maternity care there were no Trust guidelines in place for midwives to inform service users that they would be seen on their own during pregnancy. Marianne was seen in a clinic at the hospital a few months before her homicide. The visit to the clinic was unconnected to maternity issues and was for an issue unrelated to domestic abuse. Routine enquiry is not in place in the clinic Marianne visited in 2017 for this routine matter.

16.2.5 Bolton NHS Foundation Trust had three contacts with Marianne. All these related to 'post-natal' maternity services. The Trust confirmed 'routine enquiry' takes place at the initial contact with all pregnant women and may be conducted several times during the pregnancy. It is not routine practice to enquire in the 'post-natal' period. The Trust held nothing of relevance to this case.

16.2.6 Lancashire Care NHS Foundation Trust [LCFT] had contact with Ajaam in relation to a referral from his GP. A telephone assessment took place with Ajaam on 3 July 2018, followed later that day by a face to face assessment. The Trust has a safeguarding policy in place. This includes 'routine enquiry'. The IMR author for LCFT states there is evidence in the records that safeguarding was considered in the case of Ajaam and no issues were identified. Ajaam was encouraged to talk about his relationship and an opportunity would have been given for him to raise any issues. There is no evidence that he gave any information that would raise concerns he presented a risk to Marianne.

16.2.7 LCFT Health Visiting Service has a policy of "routine enquiry" when providing Health Visiting services. The policy is that a Mother should be seen alone and asked if domestic abuse is an issue in her relationship. A visit took place to see Child 2 shortly after it was born in 2015 and no safeguarding concerns were noted. Ajaam and Marianne were present, and no relationship problems were identified.

16.2.8 The Trust's policy was followed in July 2015 when a Health Visitor saw Marianne alone. When asked, she expressed no concerns regarding her relationship with Ajaam. She said he was a supportive partner. Further visits took place during October and December 2015, and May 2016. None of these visits disclosed any issues of concern in relation to relationship problems and no indicators that Marianne might be a victim of domestic abuse.

16.2.9 The IMR author for the CCG made enquiries with the medical practices used by Marianne and Ajaam. In the case of Ajaam's GP practice, the manager there stated that clinicians routinely inquire about domestic abuse in consultations relating to pregnancy and mental health and at new patient checks. This is reinforced in discussions at the practice's monthly safeguarding meetings.

16.2.10 When she visited her GP practice, Marianne made no disclosures of domestic abuse. She did not present with any symptoms to suggest abuse was taking place. On 2 March 2015 Marianne consulted her GP in relation to stress at work. It is documented in the GP records that she had no anxiety or stress in life outside of work. The IMR author says this suggests that the GP asked Marianne about her home life, although there was no specific inquiry about domestic abuse.

16.2.11 At the time of the consultation Marianne would have been ten weeks pregnant. The IMR author states that pregnancy has been shown in several studies to be an independent risk factor for domestic abuse. Pregnancy within the previous 12 months was found to double the risk of physical violence[18]. Pregnancy and mental health presentations are two of the situations in which NICE guideline 50 recommends routine inquiry about domestic abuse, even where there are no indicators of abuse. Even if there is no disclosure made, or abuse is not happening at that time, it gives a message of support to the patient.

16.2.12 Marianne's medical practice does not have a domestic abuse policy and specific enquiry about domestic abuse is not made. Safeguarding issues are discussed with the Health Visitor at the weekly baby clinic and at the doctors' weekly meeting. Learning points are entered on the practice register and appropriate action taken. The DHR panel has identified a lesson and recommendation in respect of the role of GPs and raising their awareness of the heightened risk factors associated with pregnancy [see lesson and recommendation 6].

Term 3

16.3 What knowledge did your agency have that indicated Ajaam might be a perpetrator of domestic abuse and what was the response?

16.3.1 No agency held any information to indicate that Ajaam might be a perpetrator of domestic abuse [although there were some missed opportunities by health agencies to ask him relevant questions]. He had no

[18] Richardson, J; Coid, J; Petruckevitch, A; Chung, W S; Moorey, S. & Feder, G. [2002] Identifying domestic violence: cross sectional study in primary care. British Medical Journal. 324. 274-277

previous criminal convictions and was not known to Lancashire Constabulary or, as far as can be ascertained, any other UK police force.

16.3.2 The panel believe that Ajaam's presentation to his GP with mental health issues in 2015 and 2017 should have prompted some exploration about domestic abuse. The GP IMR author states that mental health problems have been cited in several studies as a risk factor for perpetrating domestic abuse[19]. In 2015 Ajaam presented with complex issues, as Marianne was pregnant, and he regretted ending his previous long-term relationship.

16.3.3 Ajaam expressed strong suicidal thoughts. However, the unborn child was seen as a protective factor. There is a view that GPs [and maybe other clinicians] should ask patients presenting with suicidal thoughts whether they pose a risk to other people. The IMR author was not able to identify that any routine enquiry was made about domestic abuse in relation to Marianne or to Ajaam's previous partner. In June 2017 Ajaam told his GP that he no longer lived with Marianne.

16.3.4 In July 2017 Ajaam presented to his GP with low mood saying he was going through a 'bad patch' since Marianne had left him. The GP did not explore Ajaam's feelings towards Marianne. Separation has been shown to increase the risk of domestic abuse says the IMR author[20]. The DHR panel concur and recognise this has been a feature in many other DHRs including the death of Chan that occurred in Rossendale in 2014 [see section 16.10 post].

16.3.5 The IMR author also highlighted that there appeared to be no mention of Child 2. Parental mental health is known to be one of the "toxic trio" of risk factors for child abuse and it would have been good practice to ask about any children[21]. The author recognised the GP displayed good practice with regards to asking about substance misuse and suicidal thoughts.

16.3.6 Finally, the author says it would have been good practice if the GP had used a formal assessment tool for depression. This would have been useful in gauging the severity of any depressive disorder and monitoring the response.

Term 4

[19] Oram S, Trevillion K, Feder G et al. [2013] Prevalence of experiences of domestic violence among psychiatric patients: systematic review. The British Journal of Psychiatry 202: 94–9

[20] Smith K [ed], Coleman K, Eder S et al. [2011] Homicides, firearm offences and intimate violence 2009/10: supplementary volume 2 to Crime in England and Wales 2009/10 [2nd edition]. London: Home Office

[21] Royal College of General Practitioners "Keep Me Safe": RCGP child protection strategy [2005]

16.4 What services did your agency offer to Marianne and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Marianne from seeking help for the domestic abuse?

16.4.1 There is no evidence that Marianne ever sought support for domestic abuse from a statutory agency or that they held information that she was a victim. Consequently, the DHR panel are not able to comment upon the quality of these services in respect of Marianne's needs. The IMR author for the CCG has highlighted that, while GP services were appropriate and sympathetic to Marianne's needs, there should have been some direct inquiry about domestic abuse when she attended for a consultation for stress and post-natal review.

16.4.2 The DHR panel has already commented within term 1 [section 16.1 above] about the accessibility of information on domestic abuse services within the Rossendale area. They are satisfied that services are in place for the victims of domestic abuse and have received assurances from agencies represented at the DHR panel that they are accessible, appropriate and sympathetic.

16.4.3 Marianne was an intelligent and articulate person who had successfully studied at university to obtain a degree in teaching. The panel felt that, had she sought advice or help using the internet, she would have been successful in finding her way to the appropriate service. The panel did not feel that Marianne had any disabilities as defined within the Equalities Act, nor any other characteristics that meant she was not capable of articulating her needs.

16.4.4 There are many reasons why victims of domestic abuse do not access services such as fear of reprisals, concerns over child contact, stigma etc. Marianne's family raised the point that if you felt you would not be viewed as a victim, or the 'right kind of victim' that this could also be a barrier to accessing services. The family felt that because Marianne was lively and tenacious, no one asked her about domestic abuse as they felt she could fight her own corner.

Term 5

16.5 What knowledge or concerns did the victim's family, friends and employers have about Marianne's victimisation and did they know what to do with it?

16.5.1 As set out in the chronology and background information within section 14 of this report, there was information known to Marianne's family friends and employers. Some of this information contained subtle details that might have pointed towards Marianne being a victim of domestic abuse,

other information was much more direct evidence that she was a victim of abuse at the hands of Ajaam.

16.5.2 The detail of this information will not be repeated here. In summary the salient issues are;

- Marianne's Mother described a 'change' in her daughter's behaviour after she met Ajaam: she would not speak out or challenge anything he said;
- Marianne went through a 'Nikah' ceremony which she may have been under pressure to participate in;
- Ajaam was aggressive towards Marianne's Mother on one occasion;
- Ajaam was very moody and would storm about the house;
- Ajaam would often sit outside Marianne's place of work all day. He would sit with her during her lunch break at work;
- Marianne told work colleagues Ajaam would not let her come to work unless he was with her;
- Marianne's ex-partner saw her with a black eye and their daughter told her father that Ajaam was always arguing;
- Marianne's ex-partner saw Ajaam 'square up' to Marianne;
- Marianne told a work colleague that Ajaam pulled Child 1 and her around the kitchen by their hair. Marianne also spoke about an incident when Ajaam had put his hands around her throat during an argument about parenting;
- Marianne's Mother noticed that a door was damaged in her house as though someone had tried to pull it open with force;
- Ajaam insisted they move to an isolated location;
- Ajaam tried to deprive Marianne of her savings;
- Towards the end of the relationship Ajaam was described as always arguing with Marianne and threatening to take Child 2 away from her to Pakistan;
- Marianne's Mother noticed a positive change in Marianne's well-being after the separation, saying '…the old Marianne is back';
- Marianne told work colleagues Ajaam had been violent and grabbed her in front of the children. She did not want to leave Child 2 with Ajaam;
- Marianne was seen at work on at least two occasions with a black eye. She said Ajaam had been aggressive during the night;
- After the separation Marianne told a colleague she had taught Child 1 how to use the emergency function on the telephone to call her Mother.

16.5.3 The list of events above displays a clear and unequivocal portrait of Marianne as the victim of serial domestic abuse at the hands of Ajaam. The occasions when Marianne presented with physical injuries, which she said were caused by Ajaam, was clear evidence which if reported to the

police might have led to Ajaam being arrested and possibly convicted and sentenced for offences of assault upon Marianne.

16.5.4 If convicted, he may have received a custodial sentence. He may also have been subject to several remedies to prevent him approaching Marianne, such as a restraining order or a domestic violence prevention order[22].

16.5.5 Of significance, is the incident when Ajaam put his hands around Marianne's neck. This incident was not reported to or known about by any agency until after the homicide. Attempted strangulation is a factor that significantly increases the risk that victim's face. Research by Strack and Gwynn[23] found that victims of prior attempted strangulation are seven times more likely to become homicide victims.

16.5.6 Other behaviours that Ajaam displayed towards Marianne, while not involving physical abuse, were evidence of other forms of domestic abuse. For example, sitting outside her workplace all day, and threatening to take their daughter to Pakistan. Such acts might have amounted to coercive and controlling behaviour as set out in Appendix A. There are now specific legal remedies that address such behaviour contained within The Serious Crime Act 2015 [see Appendix B]. Again, had information about that behaviour been reported to agencies, Marianne could have been given advice about how to deal with Ajaam's behaviour and that might have included the implementation of a protective measure such as a DVPN. Marianne could also have been given support by an IDVA.

16.5.7 The DHR panel were eager to understand whether those who held this information knew what to do with it. As well as visiting Marianne's family, the DHR chair and a colleague visited Nursery 2 where Marianne worked. Here they spoke to staff who provided much of the information within the chronology and background for this report.

16.5.8 The nursery had safeguarding procedures in place at the time of these events and there was a safeguarding officer in post. The nursery did not recognise Marianne was at risk. This was the first time a member of staff had made a disclosure like this. Consequently, nothing was recorded or reported in respect of what Marianne said. When she told colleagues that

[22] Domestic Violence Protection Orders [DVPOs] and Domestic Violence Protection Notices [DVPNs] were rolled out across all 43 police forces in England Wales from 8 March 2014. DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions. A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator.

[23] On the Edge of Homicide: Strangulation as a Prelude. Gael B. Strack And Casey Gwinn Published in Criminal Justice, Volume 26, Number 3, Fall 2011. © 2011 by the American Bar Association

she had separated from Ajaam, Nursery 2 thought she was out of danger. Child 1 was also at risk because Marianne told colleagues Ajaam had also pulled it around its hair. Child 1 was also a pupil at the same nursery where Marianne worked. The nursery should have recognised the risks to both Marianne and Child 1.

16.5.9 Research carried out by Nicky Stanley[24] found that, while not all children suffer adverse effects in response to exposure to domestic violence, there is evidence to support theories that the impact of exposure is cumulative and that the longer exposure produces the most severe impact.

16.5.10 The impact of domestic violence on children differs by developmental stage and it will have different effects on infants and pre-school children from adolescents. Stanley concludes that childhood experience of domestic violence is associated with depression in adult life and the likelihood of being an adult perpetrator or victim of domestic violence increases for those who experience domestic violence as children.

16.5.11 The DHR panel feel that Stanley's research highlights how important it is to recognise as soon as possible when a child is being exposed to domestic abuse so that appropriate measures can be put in place to protect them from the immediate and longer-term risks they may face.

16.5.12 Since these events the nursery has introduced chronology sheets were any concerns about staff members can be recorded and held within the office. The nursery has a new safeguarding Officer. Staff have undergone e-learning safeguarding training at varying levels[25]. Marianne herself had undergone Level 1 safeguarding training in 2016. She was both a member of staff, as well as the Mother of a pupil and, it was acknowledged within the nursery, the content of training that had been completed did not recognise the link between child protection and domestic abuse[26].

16.5.13 Despite a member of staff having researched and undertaken an online course regarding domestic abuse, the panel Chair and his colleague did not leave Nursery 2 confident that they had a good grasp and understanding about the circumstances under which a referral for domestic abuse could be made. The DHR panel have therefore recommended that the nursery would benefit from a safeguarding professional from the local authority reviewing its child and adult safeguarding policies and procedures [see panel recommendation 3 and 4].

[24] Children Experiencing Domestic Violence: A Research Review. Darlington Research in Practice 2011

[25] There are three recognised levels of training. Level One: Introduction; Level Two: Advanced Safeguarding and Level Three: Designated Safeguarding Officer.

[26] One of the themes identified within other DHRs is that adult safeguarding training is not being prioritised compared to child safeguarding training. Source: Domestic Homicide Reviews Key Findings from Analysis of Domestic Homicide Reviews. Home Office December 2016.

16.5.14 The DHR panel felt another point of learning from this review was that, following the death of Marianne, none of the agencies involved in the investigation and prosecution of Ajaam recognised the nursery did not deal appropriately with the information concerning the abuse of Marianne and Child 1. The DHR panel felt that demonstrated a wider gap in understanding by criminal justice agencies of their accountability in escalating concerns if other agencies do not have safeguarding policies in place or do not follow safeguarding procedures.

16.5.15 The DHR panel believes a vitally important piece of learning from this case, and one that is repeated on occasions in many DHRs, is the increased risk that victim's face when they separate from their perpetrators. This was exactly the case in the death of Chan [see section 16.10] who was killed when the perpetrator broke into her house and attacked her.

16.5.16 In the case of Marianne, Ajaam displayed preparation and planning, he purchased petrol and enticed himself into address one. The DHR panel recognise this has been a feature of other DHRs both nationally and locally. Had Marianne been seen by a professional and a risk assessment carried out using the DASH[27] process, the fact she had separated from Ajaam would have been identified as a factor that significantly increased the risk she was at. That in turn might have allowed support services to help develop a plan to protect Marianne. Such a plan might have included advice not to meet alone with Ajaam.

16.5.17 The risk to victims of domestic abuse can also be raised following separation and during child contact. Women's Aid have undertaken research in relation to domestic abuse and child contact granted through the Family Court[28]. Whilst there were no legal child contact arrangements in place between Marianne and Ajaam, had a professional completed a risk assessment using DASH, potential risks could have been identified and safety plans put in the place.

16.5.18 The Chair of the DHR contacted the company that employed Ajaam. He worked providing domiciliary care and had been with the same employer for many years. He was viewed as an excellent employee who was very well liked by his colleague and those clients he visited in their homes. The company never had one complaint about him.

16.5.19 Prior to the homicide Ajaam had been off work for several weeks with depression. His manager at the company did not know the cause of his illness nor did Ajaam's manager have any idea that he was a perpetrator of abuse. The company do not have any direct policies on domestic abuse.

[27] Domestic Abuse, Stalking and Harassment and Honour Based Violence [DASH, 2009] Risk Identification and Assessment and Management Model.

[28] Women's Aid [2017] Child First: Save Child Contact Saves Lives

Ajaam's manager said, had they known that Ajaam [or any other employer], posed a potential danger to clients they would have considered what it meant for their clients' safety and taken a decision on what he could and could not do.

Term 6

16.6 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Marianne and Ajaam?

16.6.1 Marianne did not seek services nor was she assessed in relation to her victimisation at the hands of Ajaam. The DHR panel is not therefore able to comment upon the extent to which any diversity issues might have been considered in relation to domestic abuse services. Marianne identified in documentation she completed for ELHT that she was 'White British'. English was her first language and the DHR panel believe that, had she sought the support of services in relation to abuse, then all her needs would have been considered.

16.6.2 In relation to routine medical services that Marianne accessed from agencies, the DHR panel are satisfied her needs were considered.

16.6.3 As far as Ajaam was concerned, he identified in documentation held by ELHT that he was 'British'. It is believed English was his first language. He did not access any services in relation to domestic abuse. He did seek help and support from his GP and from mental health services. The support they provided appeared to be appropriate to his racial and cultural background.

16.6.4 The CCG author identified that Marianne and her two children were registered at a different GP practice to Ajaam. Although Ajaam often accompanied Child 2, a GP would not necessarily be aware of their inter-racial relationship when seeing either of them alone. Research has suggested that inter-racial relationships may be more vulnerable to domestic abuse for several reasons[29]. These are:

- Discrimination and prejudice from society;
- Other negative attitudes from outsiders;
- Struggles to gain acceptance of relationship;
- Cultural differences that lead to conflict;
- Communication differences;
- Feelings of racism and discrimination from partners;
- Lack of support from family members.

[29] Martin,B.A., Cui,M, Ueno,K. & Fincham,F.D.[2013] Intimate partner violence in interracial and monoracial couples. Family Relations,61 [1]:202-211

16.6.5 The panel considered this research and whether any of the factors above were present in this case. The DHR panel did not find any evidence that suggested either Ajaam or Marianne had suffered prejudice, discrimination or negative attitudes. However, they could not completely exclude the possibility that might have happened outside the contact they had with agencies.

16.6.6 The panel did recognise there may have been some issues in relation to the acceptance of the relationship by family members. Both Ajaam and Marianne appeared to feel under pressure to go through the 'Nikah' ceremony. Marianne told her Mother that neither Ajaam nor herself wanted to get married, and with some reluctance Marianne agreed to a 'Nikah' ceremony. Marianne told her Mother she agreed this to 'keep the family quiet.' No one from Marianne's family was present at this ceremony which took place at Ajaam's parents' home in Manchester.

16.6.7 The DHR panel also recognised the possibility of cultural differences. For example, Ajaam had spoken of taking Child 2 away to learn the language used in Pakistan[30] and teach it the Koran. He also spoke about taking Child 2 to Pakistan. However, it is not clear whether Ajaam was acting as a genuinely concerned parent, who wished to induct the children into his faith, or whether he was saying these things as a threat designed to coerce and control Marianne. The DHR panel believe it is more likely these things were said as a threat as they saw no evidence that, in other ways, Ajaam expressed his faith.

Term 7

16.7 Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Marianne and Ajaam, or on your agency's ability to work effectively with other agencies?

16.7.1 Most agencies involved in this review did not identify any capacity or resources issues relating to services provided to Marianne and Ajaam. The author of the IMR for the CCG identified that staff at Ajaam's medical practice have completed the appropriate level of safeguarding children and adults training. The practice's safeguarding champion has attended a session on domestic abuse, although no other members of staff have had

[30] It is not clear which language he was referring to. Pakistan's national language is Urdu which, along with English, is also the official language. The country also has several regional languages.

specific domestic abuse training. The practice advertises domestic abuse services on notice boards and in staff and patient toilets.

16.7.2 All staff at Marianne's medical practice have received the appropriate level of safeguarding children and adults training. The safeguarding lead GP and deputy have received specific domestic abuse training. Posters are regularly used to promote access to services. Other than the lack of specific domestic abuse training, there were no issues in relation to capacity or resources.

Term 8

16.8 What learning has emerged for your agency?

16.8.1 Agency learning is set out within section 18.1 of this report.

Term 9

16.9 Are there any examples of outstanding or innovative practice arising from this case?

16.9.1 The DHR panel did not identify any examples of outstanding or innovative practice. This was because agencies had no contact with Marianne or Ajaam in relation to services relating directly to domestic abuse.

16.9.2 LCFT identified that their START [Mental Health] service acted very quickly in taking an urgent telephone referral from Ajaam's GP. They triaged Ajaam within the same hour of the referral and assessed him within two hours of that referral being made. The service was commendable in offering such a quick response.

Term 10

16.10 Does the learning in this review appear in other domestic homicide reviews commissioned by Rossendale?

16.10.1 The DHR panel identified there has been a previous report published concerning a domestic homicide within the Rossendale area. This was the case of Chan[31]. The homicide occurred in early 2014. Chan was killed by her partner, a perpetrator that had been released from prison and was on life licence having served a sentence for murdering a previous partner. Like Marianne, Chan was killed by her former partner within a short time of separation. Once again this reinforces the lesson about separation significantly increasing the risks that victims face.

16.10.2 The circumstances of the case of Chan differed from Marianne in that statutory agencies held much more information about the perpetrator and his relationship with Chan. However, the DHR panel identified similarities in two pieces of learning. In the case of Chan that DHR panel identified

[31] See https://www.rossendale.gov.uk/downloads/file/13911/case_of_chan_report

that friends and family of Chan held information that she had been the victim of domestic abuse at the hands of her partner who subsequently killed her. The Chan DHR panel concluded that family, friends, neighbours and others who may be aware of domestic abuse being perpetrated require immediate and ongoing support and reassurance to enable them to make disclosures and share information in a way that does not compromise the safety of the victim or the third party.

16.10.3 The Chan DHR panel therefore made the following recommendation [recommendation four within the Chan report];

'The CSP should ensure that work is undertaken to facilitate an increase in third party reporting and increase confidence amongst family and friends of victims of domestic abuse'

16.10.4 The second piece of shared learning found within the Chan report related to routine enquiry. Chan had frequent contact with her GP. Chan never made a disclosure of domestic abuse to her GP, nor did her GP make a routine enquiry. In contrast, in Marianne's case, it was Ajaam that presented to his GP with symptoms of depressive illness that should have prompted the GP to make further routine enquiries.

16.10.5 In the case of Chan, the DHR panel there made the following relevant recommendation [recommendation six within the Chan report];

'The CCG should implement a programme of work to achieve GP compliance with NICE and RCGP guidance in relation to domestic abuse'.

16.10.6 The DHR panel for Marianne therefore asked Pennine Lancashire Community Safety Partnership [the CSP] to satisfy the panel that both these recommendations had been implemented. In relation to Chan recommendation four, the CSP reported that Lancashire Victims Service are leading work on this area with support from the Police and Crime Commissioners Office [PCC] and other domestic abuse practitioners through the Pennine Domestic Abuse Forum.

16.10.7 In relation to Chan Recommendation 6, Level 3 training regarding Domestic Abuse was offered to GP practices across East Lancashire, attendance at which was optional. All GP practices across East Lancashire have been given a sample Domestic Abuse Policy which was developed by the CCG. The CCG have recently implemented a Safeguarding Assurance Framework for GP practices in East Lancashire and recognising and responding to Domestic Abuse is included within that framework. The Safeguarding Assurance Framework and sample Domestic Abuse Policy reflect guidance of NICE and the RCGP. There has been a recent training event delivered to some GP Practices and practice staff regarding coding of domestic abuse disclosures and MARAC information. That training also included a section on Routine Enquiry.

17. CONCLUSIONS

17.1 Ajaam killed Marianne and badly injured his own child, Child 1, after he enticed his way into address one. He came with petrol and other items the police believe he acquired some time before, having planned his act. His attack upon Marianne with a knife and his attempt to burn down the house with all three of them within were cruel and evil acts. In contrast to his wickedness Marianne acted bravely and selflessly managing to save the life of Child 1 although sadly not her own.

17.2 The DHR panel have seen evidence from the homicide enquiry and from their conversations with family, friends and work colleagues of Marianne that demonstrate that she was subjected to domestic abuse at the hands of Ajaam. The abuse started almost as soon as their relationship did. Some of the abuse was subtle. For example, sitting outside Marianne's work place, not letting her go to work on her own, moody behaviour and 'storming' about the house.

17.3 As the relationship continued Ajaam's behaviour appears to have escalated. He constantly argued with Marianne, he 'squared' up to her and there was evidence to suggest there had been a struggle between the couple because of damage to doors at her Mother's house.

17.4 Ajaam's behaviour then involved physical abuse upon Marianne: she was seen with a black eye on at least two occasions, she told work colleagues she and Child 1 had been pulled around by their hair. Marianne was clearly in fear of Ajaam as demonstrated by her programming an emergency number into her telephone and teaching Child 1 to use it.

17.5 While Nursery 2 had procedures in place for protecting their children they had never had to deal with disclosures from a member of staff. They did not recognise that what Marianne told them Ajaam was doing, was domestic abuse. When Marianne left Ajaam, her employer at Nursery 2 mistakenly believed she was out of danger. In fact, as has been identified in many other reviews and is embedded in practice, the risk to a victim increases at the point of separation. That was exactly the case with Marianne and in a previous DHR in Rossendale when Chan was killed by her partner.

17.6 Families often feel confused, conflicted and concerned about how to support their loved ones without pushing them away. Victims feel that they cannot open up to their families without actions being taken. As in the case of Chan, the DHR panel believe there is some important learning here about raising the awareness of friends, family and work colleagues about how domestic abuse can manifest itself and what to do with that information if it is disclosed.

17.7 The DHR panel have considered the cultural issues in this case. Marianne was British and White, Ajaam was British from a Pakistani background. Marianne had no religion and the DHR panel saw no evidence that Ajaam was strongly attached to his Muslim faith. During their relationship the couple moved between several addresses including Ajaam's parents. Neither Ajaam nor Marianne were said to want to be married. It seems they may have been under pressure to go through with the Nikah ceremony to satisfy his family.

17.8 Marianne said she agreed to do so to keep Ajaam's family happy. To what extent she was put under pressure and where it came from is unclear. If it was Ajaam who acted as a proxy for his family wishes and put pressure upon Marianne that would certainly have been domestic abuse and coercive behaviour by him.

17.9 Whether cultural issues were a factor in the couple's separation is unclear. The DHR panel believe that Ajaam's threats to take Child 1 to Pakistan were another form of coercion and control. While he may have dressed these threats up as a necessary part of developing his child's spiritually, for example to teach her about the Koran, the DHR panel believe they were no more than crude threats intended to frighten and intimidate Marianne. This was yet another example of what a cruel and controlling person Ajaam was.

17.10 The DHR panel saw no evidence that agencies had knowledge of what Marianne had to endure at Ajaam's hands. Marianne never spoke to agencies about her suffering and, on the few occasions she was asked routine questions, she did not disclose any information to indicate their relationship was unstable. There were some missed opportunities when Marianne was not asked routine questions [see paragraph 16.1.5].

17.11 However, the panel conclude that there is no connection between the lack of routine enquiry and Marianne's homicide. There are simply too many other variables and unknowns. For example, Marianne would have had to have chosen to say something. The panel recognise there are many reasons victims choose not to disclose their experiences. If Marianne had made that choice, the action that could have been taken would have depended very

much upon the scale of what she disclosed. The important learning is that victims often suffer in silence through many episodes of abuse before they make a disclosure[32]. That is why it is important that at every opportunity routine questions are asked.

17.12 There was no information within agency records to indicate Ajaam might be a perpetrator of domestic abuse. He had no previous convictions and no records about him exist within police files. When he visited his GP and then Mental Health Services he did not provide any information that might suggest he posed a threat to Marianne or Child 1.

17.13 Never the less, Ajaam's GP should have asked routine questions of Ajaam about his relationship and questions that would identify whether there was domestic abuse. Mental Health is an issue that can increase the risk of domestic abuse[33]. Similarly, Marianne's GP should have asked these routine questions when she attended with work related stress and at the time was pregnant. Pregnancy is a factor that can significantly increase the risk of domestic abuse.

17.14 Again, the DHR panel finds that the absence of routine enquiry of Ajaam does not automatically lead to a conclusion that there was a connection with Marianne's death. There are also too many variables. For example, the action that the GP took in response would have relied upon the nature and gravity of what Ajaam chose to tell the GP. It would not have automatically followed that what Ajaam disclosed to his GP would have led to an intervention by any agency such as the police.

17.15 The important learning is that opportunities need to be taken to ask questions. It is often only by agencies asking these questions and sharing information that a richer and wider picture can be built up about what is happening in the life of a victim. With Marianne and Ajaam, the DHR panel conclude there was simply no information available to agencies that would have allowed them to put measures in place to protect her. Sadly, the DHR panel conclude that in some homicides that is sometimes the case. That does not mean that nothing has been learned from this tragic case. Far from it, the DHR panel believe that the events set out in this report and the recommendations made has illuminated the past to make the future a safer place for other victims.

[32] The Crown Prosecution Service reported that women suffer on average 35 incidents of domestic violence before reporting their experiences.

[33] For example, Mental health issues were present in 25 of the 33 intimate partner homicides reviewed by the Home Office: Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

18. LESSONS IDENTIFIED

18.1 Agencies Lessons

Bolton NHS Foundation Trust

- Receipt of transfer information needs to be clearly documented;
- Transfer to Health Visiting Service to be documented;
- Update Post-Natal Care Planning standards [Trust Standard Operating Procedure SOP];
- Investigate the possibilities of 'routine questioning' when women are 'unknown' in the postnatal period.

East Lancashire Clinical Commissioning Group

Learning for both GP practices

- Mental health consultations with the GP did not include DA enquiry;
- There was no enquiry about existing children when Marianne and Ajaam presented with stress and low mood respectively;
- It is not known if clinicians were aware of Marianne and Ajaam's inter-racial relationship and whether cultural differences were taken into consideration.

Learning for Marianne's medical practice

- Post-natal consultation did not include DA inquiry;
- Not all consultations included details of who had brought the child.

Learning for Ajaam's medical practice

- There does not appear to have been any follow up after Ajaam did not attend his Minds Matter appointment;
- There did not appear to be recognition of increased risk of DA following separation.

East Lancashire NHS Health Trust

- At maternity booking appointment women [and their partners/family] are told that it is Trust policy that the woman is seen at least once on her own [for all, or part of an antenatal appointment]. There is space for this to be documented on page 4 of Antenatal Book 1;
- At the 28-week appointment there is a reminder to check if routine enquiry has been asked [Page 23 of Antenatal Book 1];
- ELHT is considering how the guidance included in NICE Guidance PH50 Domestic Violence and Abuse, can be implemented, specifically recommendation 6 which states: "Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service

users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.";

- Marianne was seen within a clinic and could have been asked Routine Enquiry at this time;

N.B. Some of the learning identified in this IMR has already been acted on and implemented between Marianne's contact with maternity service and her final attendance, namely:

- Clear documentation of who accompanies a woman when she attends each antenatal appointment.
- All women and their families/partners are told that Trust policy is that ALL women are seen on their own for all or part of at least one antenatal appointment.

18.2 The Domestic Homicide Review Panel's Lessons

18.2.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at paragraph 18.1. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson 1 [Panel recommendation 1 and 2]
Narrative
Marianne was at risk from Ajaam because he perpetrated domestic abuse upon her and Child 1. He exercised coercive and controlling behaviour as well as physically abusing Marianne and Child 1. Family and friends knew about some, although not all, of his behaviour. Marianne's family and friends did not appear to recognise at the time that Ajaam's behaviour amounted to domestic abuse.
Lesson
It is not unusual for family and friends not to recognise when the actions of a perpetrator may amount to domestic abuse. This is particularly so when the perpetrator engages in coercive and controlling acts. Agencies need to recognise this, and the need to change the public perception about domestic abuse particularly to increase knowledge about the dangers of coercive and controlling behaviour and what to do with that information.

Lesson 2 [Panel recommendation 3]
Narrative
Marianne told colleagues at the nursery where she worked about some of the domestic abuse she suffered at the hands of Ajaam. She also told

them that Ajaam had pulled Child 1 by the hair. The nursery and its staff failed to separate the personal relationship they had with Marianne from the professional relationship they should have had with her as a colleague and employee and as a Mother of Child 1 who was a pupil there. The nursery and its staff failed to follow safeguarding practices.
Lesson
Nurseries as places of early learning need to have robust policies, procedures and training in place. These need to recognise the duty of care to safeguard the wellbeing of their staff and all their pupils.

Lesson 3 [Panel recommendation 1]
Narrative
When Marianne separated from Ajaam she was frightened he may come after her. She programmed an emergency number into her telephone and showed Child 1 how to use it. Ajaam used subterfuge to gain entry to address one after he had separated from Marianne. While in the house he attacked Marianne and set fire to the property killing her and injuring Child 2.
Lesson
The risk to Marianne increased significantly after she separated from Ajaam. This is a lesson that has been learned in many other domestic homicide reviews.

Lesson 4 [Panel recommendation 4]
Narrative
Ajaam was employed as a carer. He was therefore in a position of trust and responsible for the welfare of vulnerable people. The controlling and coercive behaviour he displayed towards Marianne and other examples of his abusive behaviour towards her and Child 1 meant that he was also potentially a risk to those he cared for. That was not recognised by those who knew about his behaviour, including Marianne's family, friends and colleagues at the nursery.
Lesson
Perpetrators of domestic abuse who are in a position of trust and who are caring for vulnerable people such as the elderly or children may present a risk to them as well. When agencies, such as the nursery, become aware of such information they need to ensure it is referred through safeguarding processes.

Lesson 5 [Panel recommendation 5]
Narrative
During the enquiry into the homicide of Marianne, part of the focus of the investigation was upon the nursery where Marianne worked.

Criminal justice agencies identified that Marianne made disclosures about domestic abuse to the nursery and staff there. Criminal justice agencies did not recognise that the disclosure Marianne made concerning domestic abuse, and safeguarding of her children, was not dealt with appropriately by the nursery.
Lesson
As well as concentrating upon the core task [investigation of the homicide] criminal justice agencies should have recognised the wider safeguarding issues for children exposed to domestic abuse and acted in relation to the nursery's none-compliance with safeguarding practice.

Lesson 6 [Panel recommendation 6]
Narrative
Victims who are pregnant may be at increased risk of domestic abuse. Marianne consulted her GP about stress at work at which time she was ten weeks pregnant. While she was asked about her home life there was no specific record that she was asked direct questions about domestic abuse.
Lesson
Pregnancy within the previous 12 months was found to double the risk of physical violence. Pregnancy and mental health presentations are two of the situations in which NICE guideline 50 recommends routine inquiry about domestic abuse, even where there are no indicators of abuse. Even if there is no disclosure made, or abuse is not happening at that time, it gives a message of support to the patient.

19. RECOMMENDATIONS

19.1 Agencies Recommendations

19.1.1 Agencies recommendations are set out within the tables at Appendix C and are not repeated here.

19.2 The Panel's Recommendations

19.2.1 The DHR panel identified the following recommendations. The panel have been careful not to replicate or duplicate agency actions that appear in Appendix C.

Number	Recommendation
1	Pennine Lancashire Community Safety Partnership review the ways in which they use social and other forms of media to increase the understanding and knowledge of family, friends and colleagues about the type of behaviour that comprises domestic abuse, including coercive and controlling behaviour.
2	Pennine Lancashire Community Safety Partnership explore ways in which it can increase the understanding and knowledge of family, friends and colleagues about the importance of sharing information and concerns about domestic abuse with agencies. This should include ensuring information is provided to them on what steps they can take to safely support victims of domestic abuse.
3	Pennine Lancashire Community Safety Partnership work with the Lancashire Safeguarding Children's Board to assist this and other nurseries in their area to review their policies, systems and training so the risk pupils, employees and their children face from domestic abuse is recorded and, when appropriate, referred through safeguarding processes.
4	Pennine Lancashire Community Safety Partnership work with the Lancashire Safeguarding Children's Board to assist this and other nurseries in raising awareness and increasing their understanding of domestic abuse as well as in training them about the need to recognise and report the risks presented by perpetrators of domestic abuse who are in a position of trust and therefore might present a risk to vulnerable people in their care.
5	Pennine Lancashire Community Safety Partnership work with the Lancashire Criminal Justice Board who should use this case as an example to their partners about the importance of identifying non-compliance with safeguarding practice when undertaking investigations or considering the results of investigations.

6	East Lancashire Clinical Commissioning Group consider ways in which they can raise GP's understanding of the heightened risk factors of pregnancy and improve the use of direct questions and signposting or follow up in appropriate cases. For example by highlighting good practice or making use of the Identification and Referral to Improve Safety [IRIS] programme.
7	Home Office to consider a national campaign aimed at families and friends who have knowledge of domestic abuse on how they can report those concerns to safeguarding professionals.

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[34]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;

[34] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Pennine Lancashire Community Safety Partnership review the ways in which they use social and other forms of media to increase the understanding and knowledge of family, friends and colleagues about the type of behaviour that comprises domestic abuse, including coercive and controlling	Local	Undertake a publicity campaign to raise awareness and increase understanding and knowledge about the types of behaviour that are domestic abuse	Pennine Lancashire Community Safety Partnership	Identify lead from Media team. Agree the messages to be publicised and media to be used. Deliver the campaign.	31.01.19 31.03.19 30.06.19	31.12.18 DA signposting posters distributed to GP's across Rossendale. 04.13.19 Contact made with Rossendale BC media lead and Lancashire OPCC Campaign planned in conjunction with Lancashire OPCC.

	behaviour.						
2	Pennine Lancashire Community Safety Partnership explore ways in which it can increase the understanding and knowledge of family, friends and colleagues about the importance of sharing information and concerns about domestic abuse with agencies. This should include ensuring information is provided to them on what steps they can take to safely support victims of domestic abuse.	Local	Undertake a publicity campaign to raise awareness and increase understanding and knowledge about the importance of sharing information and concerns about domestic abuse with agencies.	Pennine Lancashire Community Safety Partnership	Identify lead from Media team. Agree the messages to be publicised and media to be used. Deliver the campaign.	31.01.19 31.03.19 30.06.19	04.13.19 Contact made with Rossendale BC media lead and Lancashire OPCC Campaign planned in conjunction with Lancashire OPCC.
3	Pennine Lancashire Community Safety Partnership work	Local	Write to Lancashire Safeguarding Children Board	Pennine Lancashire Community	Letter written and sent.	30.06.19	Letter sent 11.01.19

	with the Lancashire Safeguarding Children Board to assist this and other nurseries in their area to review their policies, systems and training so the risk pupils, employees and their children face from domestic abuse is recorded and, when appropriate, referred through safeguarding processes.		setting out the recommendation's background. To support Lancashire Safeguarding Children's Board in how it decides to deal with the recommendation.	Safety Partnership	Initial written feedback from Lancashire Safeguarding Children Board on the request. Identification of what support might be needed for the review and how it can be delivered. Provide support to the Board with the delivery of any training.	30.06.19	20.01.19 Chair, Lancashire Safeguarding Children Board has confirmed that she is happy with the recommendations and will support them, perhaps with a Joint Seven Minute Briefing.
4	Pennine Lancashire Community Safety Partnership work with the Lancashire Safeguarding Children Board to assist this and other nurseries in raising	Local	Write to Lancashire Safeguarding Children's Board setting out the recommendation's background. To support	Pennine Lancashire Community Safety Partnership	Letter written and sent. Initial written feedback from Lancashire Safeguarding Children Board on	30.06.19	Letter sent 11.01.19

	awareness and increasing their understanding of domestic abuse as well as in training them about the need to recognise and report the risks presented by perpetrators of domestic abuse who are in a position of trust and therefore might present a risk to vulnerable people in their care.		Lancashire Safeguarding Children's Board in how it decides to deal with the recommendation.		the request. Identification of what training might be needed and how it can be delivered. Provide support to the Board with the delivery of any training.	30.06.19	20.01.19 Chair, Lancashire Safeguarding Children Board has confirmed that she is happy with the recommendations and will support them, perhaps with a Joint Seven Minute Briefing.
5	Pennine Lancashire Community Safety Partnership work with the Lancashire Criminal Justice Board who should use this case as an example to their partners about the importance of	Local	Write to Lancashire Criminal Justice Board setting out the recommendation's background and asking them to consider putting the issue on the Board's agenda so that its	Pennine Lancashire Community Safety Partnership	Letter written and sent. Feedback from Lancashire Criminal Justice Board on the request. Confirmation that	30.04.19	

	identifying non-compliance with safeguarding practice when undertaking investigations or considering the results of investigations.		constituent agencies can benefit from the learning.		the Board shared the learning.		
6	East Lancashire Clinical Commissioning Group consider ways in which they can raise GP's understanding of the heightened risk factors of pregnancy and improve the use of direct questions and signposting or follow up in appropriate cases. For example by highlighting good practice or making	Local	Any templates used by the practice for antenatal or postnatal consultations should be amended to include domestic abuse screening questions.	ELCCG	Templates produced	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18 08/02/19 Audit visit to W practice – GP does not routinely see ante natal women RE completed by midwifery service. If ante natal and see's GP for another reason any family stress would initiate RE of DA and GP would use RE if other indicators present – there are no

	use of the Identification and Referral to Improve Safety [IRIS] programme.						ante natal templates. RE is included on post-natal assessment template. 21/02/19 Audit visit to F practice – Ante natal checks do not take place – these are completed by Midwife. GP uses RE in postnatal checks and info about Domestic Abuse included in information given to new parents.
7	Home Office to consider a national campaign aimed at families and friends who have knowledge of domestic abuse on how they can report those concerns to safeguarding professionals.	National	Write to the Home Office Domestic Violence Unit setting out the background to the recommendation. Feedback from the Home Office.	Pennine Lancashire Community Safety Partnership	Letter written and sent. Home Office Feedback received.	31.01.19	

Bolton NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1.	Update Post Natal Care planning standards [SOP] to include transfer of care information and requirement to document family/household members and social support and who is present at visits.	local	Revised SOP	Maternity	Updated SOP to be implemented and disseminated to all staff Audit of compliance to be completed after 6 months	May 2018 November 2018	Updated in April 2018 however is again under review as part of planning for EPR Completion date May 2019 Audit of written notes and electronic information system completed in November 2018 for cases discussed at Learning and Improvement Panel To be reviewed annually and is included on Trust Safeguarding Audit Plan for 2019
2.	Consider the value	Local/	Review evidence	Maternity	Identify practice	July 2018	Completed November

	of routine enquiry in post- natal contacts	region al	base for post-natal routine enquiry and consider implications for midwifery practice		regionally in respect of routine enquiry to inform midwifery practice		2018 Named Midwife link to colleagues in other Maternity Units to share good practice Additional domestic abuse training provided to all maternity staff by Named Midwife/Safeguarding Team

East Lancashire Clinical Commissioning Group							
No	**Recommendation**	**Scope local or region al**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Complet ion**	**Completion Date and Outcome**
NB – any recommendation on routine enquiry should not be implemented until staff have had the relevant training. The practice to which a recommendation refers is denoted by a letter, F for the medical practice attended by Marianne and W for the Medical Practice attended by Ajaam							
3.	Enquiry about family/relationships	FW	This recommendation	ELCCG	Audit undertaken, any necessary	31.03.19	ELCCG discussed recommendations with

	/social circumstances should be made in mental health consultations as there may be a "child behind the adult". [Keep Me Safe RCGP 2005]. This would enable any risk to children or vulnerable adults to be identified.		should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG. After allowing a suitable period for this practice to become embedded, there should be an audit of random mental health consultations to ensure this is taking place.		changes implemented, and audit cycle completed		both GP surgeries. Both surgeries have specific DA policies and guidelines in place which are up to date. 09.11.18 Training delivered to staff at W practice regarding DA and implementation of the recommendations. W practice has developed the use of Routine Enquiry and are linking DA concerns with children's records and following up mental health referrals. 08/02/19 Audit visit to W practice: random check of records shows exploration of social circumstances and involved children. GP has monthly HV meeting and information sharing

							processes. Safeguarding concerns would be addressed via safeguarding policy 21/02/19 Audit visit to Fairmore Medical practice. Met with Safeguarding Lead GP. Assurance given that GP explores family/relationships and social situations in mental health consultation and evidence visualised in records.
4.	There should be an awareness of possible increased risk of DA in inter-racial relationships.	FW	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG	ELCCG	All staff received domestic abuse training	31.12.18	09.11.18 Training delivered to W Practice regarding DA and implementation of the recommendations. DA in inter racial relationships included in training package 13.12.18 Domestic Abuse Training delivered to F practice

							and learning from DHR shared.
5.	All practice staff should receive domestic abuse training.	FW	This should be for all staff, both clinical and administrative, facilitated by East Lancashire CCG	ELCCG	All staff received domestic abuse training	31.12.18	Training on DA given to staff at W and F Practices on 09.11.18 and 13.12.18
6.	NICE guideline PH50 recommends that enquiry about Domestic Abuse should be made in mental health consultations, including when a patient presents with stress, even where there is no indication that such abuse is taking place. Clinicians should incorporate this into their practice. This recommendation is also in accordance	W	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG. After allowing a suitable period for this to become embedded, there should be an audit of random mental health consultations to ensure this is taking place.	ELCCG	Audit undertaken, any necessary changes implemented, and audit cycle completed	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18 08/02/19 Audit visit to W practice – random sample seen of implementation. When issues related to mental ill health and stress are discussed a prompt for asking about domestic abuse appears on electronic record and specific template for domestic abuse is completed if DA present 21/-2/19 Audit visit to

	with findings from the 2016 Domestic Homicide Review Case Analysis.						F practice. Evidence seen in GP records that RE takes place in Mental Health Consultations. New GP's will shortly be joining the practice and this will be included in their mandatory training package
7.	NICE guideline PH50 recommends screening for DA both ante and postnatally as several studies have shown there is increased risk of domestic abuse at those times. The practice should incorporate DA screening questions into any ante or postnatal protocols.	W	Any templates used by the practice for antenatal or postnatal consultations should be amended to include domestic abuse screening questions.	ELCCG	Templates produced	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18 08/02/19 Audit visit to W practice – GP does not routinely see ante natal women RE completed by midwifery service. If ante natal and see's GP for another reason any family stress would initiate RE of DA and GP would use RE

							if other indicators present – there are no ante natal templates. RE is included on post-natal assessment template. 21/02/19 Audit visit to F practice – Ante natal checks do not take place – these are completed by Midwife. GP uses RE in postnatal checks and info about Domestic Abuse included in information given to new parents.
8.	All records of consultations involving a child should include details of any accompanying adult. Where this is another family member, the clinician should	W	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG.	ELCCG	Audit undertaken, any necessary changes implemented, and audit cycle completed	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18 08/02/19 Audit visit to W practice – record search of 1 month sample shows 327 children attended –

	confirm that this person has consent for examination and treatment of the child from someone with parental responsibility.		After allowing a suitable period for this to become embedded, there should be an audit of random children's consultations to ensure this is taking place.				none were unaccompanied by a parent. All stated on record who was accompanying child. Practice have a protocol for ensuring consent for examination/treatment in place 21/02/19 Audit visit to F practice - protocols in place. Evidence seen on records and GP gave verbal examples of practice
9.	The practice should incorporate routine screening questions for domestic abuse into its new patient checks.	W	The practice's new patient template should be amended to include domestic abuse screening questions	ELCCG	Template produced	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18 08/02/19 Audit visit to W practice – RE included in New patient check template as standard practice 21/-2/19 Audit visit to

							F practice – Information about DA is discussed and given at New Patient checks – written evidence seen
10.	The practice should implement a policy for following up mental health DNAs	F	The practice should produce and implement a written policy for following up mental health DNAs	ELCCG	Policy produced	31.03.19	08/02/19 Audit visit to W practice up to date DA policy in place and staff aware. Policy accessible on GP team net 21/02/19 Audit visit to F practice – There is a policy in place for follow up of Mental Health patients and vulnerable people who DNA appointments. These patients are also given priority access to a GP

11.	Clinicians should be aware of the increased risk of DA following separation particularly in the initial post-separation period	F	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG.	ELCCG	All staff received domestic abuse training	31.12.18	Training on DA and the recommendations from the DHR given to staff at W practice by CCG on 09.11.18. GP has also delivered to staff who could not attend. F Practice 13.12.18 received training from CCG
12.	Clinicians' practice of routine enquiry needs to be evidenced and incorporated into the standard EMIS templates	F	The surgery should provide its new patient and any antenatal/postnatal templates to evidence that these include domestic abuse screening questions	ELCCG	Templates produced	31.03.19	Audit visit to W Practice 08/02/19 – RE now incorporated into standard EMIS templates and evidence shown. 21/02/19 Audit visit to F practice – have not been able to incorporate into standard templates on instruction of IT Governance but have shown evidence of RE in records. Also have developed new patient and new parent

							information regarding DA. `All clinical computers have an alert on reminding staff to ask about domestic abuse. GP team net includes up to date information regarding DA in line with NICE and also advises on Clare's Law Posters signposting for DA support and tear off contacts given to both surgeries

ELHT East Lancashire NHS Hospital Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
13.	All women receiving maternity care from ELHT are asked routine enquiry at	Local	Audit of current routine enquiry practice to be completed for	ELHT	To provide assurance that changes made to routine enquiry	August 2018	Audit completed August 2018. Results showed a decline in compliance from 83%

	least once during their maternity care episode		maternity services. Policy to be updated to ensure Routine Enquiry is carried out on at least one occasion during maternity care. Policy and Practice Guidelines for Domestic Abuse C112		from August 2017 have been embedded into practice. Policy ratified by Policy Council Re-audit carried out within 6 months of ratification shows all women are being asked routine enquiry	August 2019	in November 2015 to 72%. Action plan put in place and completed. To be presented at Audit meeting 5.2.19. Due for re-audit Jan-May 2019. Re-audit to be completed Jan-May 2019
14.	Implementation of NICE recommendation 5	Local	Policy updated Policy and Practice Guidelines for Domestic Abuse C112	ELHT	Routine enquiry is asked in areas identified by NICE recommendation 5, specifically gynaecology department.	August 2019	

Nursery Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
15	Have chronology sheets on hand to record any concerns that maybe disclosed by anyone.		Keep well documented evidence.	Nursery Two	Being able to refer when necessary with all relevant information.	ASAP	30.04.18 Staff Safeguarding Policy now in place and file for documenting any concerns regarding staff or children, including chronology sheets.

End