Civic Offices
Merrial Street
Newcastle-under-Lyme
Staffordshire
ST5 2AG

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

A

Born 1992

Sue Lane
December 2013
Updated October 2014

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1 Introduction

1.1 Context of the Domestic Homicide Review

1.1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements, was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* in April 2011[1]. This defined a Domestic Homicide Review[2] (DHR) as:

- a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by,

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

- a member of the same household as himself

- held with a view to identifying the lessons to be learnt from the death.

1.1.3 The purpose of a DHR is to:

- 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;

- 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;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.1.4 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of

[1] www.homeoffice.gov.uk. The statutory guidance was revised in August 2013.
[2] Domestic Violence, Crime and Victims Act (2004) section 9 (1).

individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

1.2 Circumstances of the review

1.2.1 This review follows the murder of A by B in February 2012. They had recently separated. On the day she died, having been out with her father for some hours she returned with him, to his home. B had travelled by bike from their shared flat some 5 miles away and waited for her return. He killed her in a single stab wound with a knife he brought with him. Her father, child and friend were all present and witnessed the attack.

1.3 Terms of reference

1.3.1 A DHR Scoping Panel met on 27 March 2012 to consider the circumstances leading to the death of A. The Panel were unanimous that the criteria for commissioning a Domestic Homicide Review had been met. This recommendation was endorsed by the Chair of the Newcastle-under-Lyme Community Safety Partnership (CSP) who was present at the meeting and the decision was recorded.

1.3.2 The full terms of reference are available at Appendix A.

1.3.3 The scope of the DHR was agreed as commencing from 1 July 2008 (during which month A and B met) up to and including the date of A's death. The focus of the DHR was maintained on the following subjects:

Name	**A**	**B**	**Child of A and B**
Relationship	Victim	Ex Partner / Perpetrator	Child
Date of Birth	Age 19	Age 19	Age 18mths
Ethnicity	White British	White British	White British

1.3.4 Contributors were asked to particularly comment on

- "Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims, perpetrators and their children, and for dealing with threats to kill others? Were those assessments correctly used in the case of this victim, perpetrator and

their child? Were these assessment tools, procedures and policies professionally accepted as being effective?

- Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?

- What was known about the perpetrator? Was or should he have been identified as posing a risk of physical harm to others. Were the responses to any identified risk appropriate? Was such information recorded and shared, where appropriate?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- Had the victim disclosed domestic violence to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration of vulnerability and disability necessary?

- Were senior managers or other agencies and professionals involved at the appropriate points?

- Are there ways of working effectively that could be passed on to other organisations or individuals?

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- How accessible were services for the victim, perpetrator and their families? Did the deafness of family members impact on this?

- To what degree could the homicide have been accurately predicted and prevented?"

1.3.5 It has not been necessary to amend the terms of reference in the course of the review.

1.4 Contributors

1.4.1 Individual Management Reviews were required from the following agencies known to have had contact had with the victim, perpetrator or their child:

- Staffordshire Police
- Staffordshire County Council Families First.
- Staffordshire PCT Cluster (Primary Care Services)
- Newcastle-under-Lyme Housing Advice Services
- Aspire Housing Association
- Staffordshire County Council Education Transformation.

1.4.2 Enquiries were also made with the following services to establish what contact they had with the victim, perpetrator or their child:

- Devon Children's Social Care Services
- South Yorkshire Police
- Devon and Cornwall Constabulary
- Devon District Councils
- Devon Housing Associations
- Devon Domestic Violence services
- NHS Trusts providing services in Devon
- University Hospitals Bristol NHS Foundation Trust
- Yorkshire Youth Offending Service.

1.4.3 All agencies submitted IMRs or reports as requested and the Panel are satisfied that these make appropriate recommendations for their agencies. No other agencies have been identified as having had involvement as a result of the IMRs.

1.5 DHR Panel members

Agency	Job Title
• Arch (North Staffs) Ltd	Chief Executive
• Aspire Housing Association	Deputy Neighbourhood Manager
• Newcastle-under-Lyme Borough Council	Partnerships Manager
• Newcastle-under-Lyme Borough Council	Community Safety Officer - Domestic Violence Lead

Agency	Job Title
• NHS Staffordshire Cluster Of Primary Care Trusts	Lead Nurse Adult Safeguarding (North Staffordshire)
• Staffordshire and Stoke-on-Trent Partnership NHS Trust	Head of Safeguarding Children
• Staffordshire County Council - Community Safety	Principal Community Safety Officer
• Staffordshire County Council - Education Transformation	County Improvement Manager
• Staffordshire County Council - Strategic Safeguarding	Specialist Safeguarding Development Manager
• Staffordshire Police	Detective Chief Inspector
• Staffordshire Police	Family Liaison Officer - Detective Constable (also assisted the Panel in engaging with family members)

1.5.1 The DHR Panel was chaired by Chris Few, an Independent Consultant and Chair of a Local Safeguarding Children Board. He has chaired Serious Case Review and Domestic Homicide Review Panels, undertaken agency management reviews and prepared overview reports for a number of Local Safeguarding Children Boards, Community Safety Partnerships and their partner agencies. In Staffordshire Mr Few has chaired three other Domestic Homicide Review processes and two Serious Case Reviews. He has no other personal or professional connection with any agency in the County.

1.5.2 The Report Author, Susan Lane, has undertaken similar enquiries and training commissions previously for safeguarding boards and is not employed by any of the agencies or associated bodies. She is an experienced and registered social worker and has previously held senior positions within children's social care and the Probation Service. She currently works part-time as an associate lecturer for the social work degree with the Open University.

1.6 Review Process

1.6.1 The Panel met on 3 occasions and had the full support of the Borough Council and the participating agencies.

1.6.2 A timetable was agreed to complete the review within 6 months. The requirements of criminal proceedings resulted in some delays in the completion of IMRs until after the trial. The final Panel meeting was on 4 October 2012. At this point further delay was considered necessary pending police professional standards processes being completed.

1.6.3 The Overview Report and Action Plan were discussed with the CSP Chair on 26 November 2012. Final approval was delayed until the completion of police professional standards and IPCC[3] complaints processes. The Overview Report, Executive Summary and Action plan were approved by Newcastle Community Safety Partnership on 13 December 2013. The report was updated in October 2014 to reflect interviews during which the report was shared with family members of A and B.

1.7 Parallel Processes

1.7.1 B has been tried and convicted of murder. He was acquitted of attempted murder in respect of the father of A who was present at the incident.

1.7.2 Staffordshire Police initiated a professional standards investigation following the death of A, which after mandatory referral was supervised by the IPCC. There were no immediate concerns about the actions of officers; however following preparation of the police IMR details emerged that required formal action within a professional standards investigation. The Investigating Officers report was completed in March 2013. The family of A pursued a formal appeal with the IPCC regarding the outcome of the investigation. The appeal was concluded in September 2013 and was not upheld.

1.8 Family involvement

1.8.1 All members of the immediate families of A and B, plus B himself, were notified of the DHR and invited to contribute. Only the father and sister of A and the father of B decided to do so. Chris Few, Chair of the DHR Panel, and the Newcastle-under-Lyme Borough Council Community Safety Officer met with family members. These meetings were conducted using a sign language interpreter. The views of family members were sought and incorporated into the content of this report.

1.8.2 Family members of A were provided with detailed feedback from the police following the professional standards enquiry and their appeal against the outcome.

1.8.3 Following endorsement of the Overview Report by the Newcastle-under-Lyme Community Safety Partnership all members of the immediate families were offered access to the report and a further opportunity to meet with the Chair of the DHR Panel, and the Newcastle-under-Lyme Borough Council Community Safety Officer. In addition to those who had originally contributed to the report, the mothers of A and B availed themselves of this opportunity. These meetings were also conducted using a sign language interpreter. The report was thereafter updated in October 2014 to reflect the interviews.

1.8.4 The father of A queried the accessibility of emergency services via the 999 system for those who are deaf and also have literacy issues preventing them using text message arrangements. This did not impact on the events

[3] Independent Police Complaints Commission

under review but was considered to be an issue that should be followed up. Funding for a project to improve the arrangements was secured by Newcastle-under-Lyme Borough Council and progress is included in the action plan from the Review.

2 The Facts

2.1 Relevant Events from July 2008 to April 2011

2.1.1 A lived with her parents in Devon until their separation in 2006. Her father returned to Staffordshire at this time and both of his daughters came with him. He is profoundly deaf and the family's social network was centred on the deaf community in the area. His first language is British Sign Language (BSL) and A was also fluent in this language, as is her sister.

2.1.2 B grew up in Yorkshire where his mother still lives. In July 2008 he came to live with his father in Staffordshire following a period of troubled behaviour including incidents of violence towards other young people. This violence and a propensity for B to lose his temper were attributed by his mother to bullying suffered at secondary school because of him having two deaf parents. He had received a Final Warning from the police in respect of an incident of assault in 2006. His school attendance had been poor and his mother had been prosecuted for his failure to attend. B's father introduced B (then aged 15) to the deaf community in Staffordshire where he met A (then aged 16). The relationship between A and B become an intimate one over the summer holiday period and their families were aware of this. B is also fluent in BSL.

2.1.3 There was prompt action to provide an education placement for B in September 2008 and he started at an appropriate school in Staffordshire. B quickly compromised these arrangements in a single serious aggressive incident and the educational support from mid September onwards was provided on a 1 to 1 basis away from school premises. At all other times his behaviour was reasonable and he was polite to staff.

2.1.4 On 30 November 2008, following an incident where he threatened his father and his father's partner, B was arrested on suspicion of criminal damage. He had smashed a glass deliberately and threatened them. He then ran away and threatened to harm himself with the broken glass when found by the police.

2.1.5 B was subsequently bailed by police to his mother's address in Yorkshire but instead arranged to live with A and her family. B's father informed the police of this breach of the bail condition. No enforcement action was taken in respect of this but appropriate action was taken to inform children's social care services of B's residence arrangement. B's father and his father's partner did not subsequently support a prosecution and B's bail was discontinued.

2.1.6 Children’s social care initiated assessments and private fostering checks were triggered. These background checks were not completed before B left Staffordshire in February 2009. No effective risk assessments could be undertaken as a result and information available about B was restricted to those matters he and his parents disclosed.

2.1.7 In January 2009 B was taken to visit alternative accommodation but he preferred to remain with A’s family who were happy for him to continue living there and this was not challenged either by children’s social care or his family.

2.1.8 Education services made arrangements for B’s transfer to a school closer to A’s home. In the event he never started there and his formal education ceased.

2.1.9 In January 2009 an incident occurred which resulted in A’s father being arrested for an offence of which he was subsequently convicted in April 2009. The potential child protection issues arising from this offence and the need to complete risk assessments resulted in A and her sister returning to their mother’s address in Devon in February 2009. B accompanied them. The private fostering assessment ceased at that point with the core assessment in respect of B not fully completed and the risk assessment never started.

2.1.10 Agencies in Devon were alerted by Staffordshire children’s social care about the move and in particular that B was a ‘child in need’. This did not result in the provision of any significant services. No attempt was made to engage him in education although he was still of school age and he was not referred to the local Connexions service. His failure to start school in January 2009 in Staffordshire meant that he was not on any school roll at that time.

2.1.11 A and B remained in Devon; both found work and eventually established a home together. In late 2009 A became pregnant. She received appropriate support and health care in respect of her pregnancy and the birth of their child in July 2010. This included provision for around 6 months, starting during A’s pregnancy, of supported accommodation for young parents. There were complications in the pregnancy which meant that delivery was at a specialist care unit in Bristol. The family appeared to be coping well, despite the immediate post delivery concerns for the baby. They cooperated well with the intensive health visiting and other support offered to them as teenage parents.

2.1.12 After her separation from B in early 2012, A confided to her father and sister that there had been problems in the relationship when living in Devon which she had not shared with them at the time. She told her family that B had hit her and threatened to harm her if she left him or disclosed information to anyone. These problems did not come to the attention of any of the agencies at that time either.

2.1.13 In her interview with the Review Panel Chair in October 2014 A's mother disclosed that she had been aware of the threats and had witnessed B punch A on one occasion, but had not done anything about it or told anyone as she did not want to get involved in their relationship.

2.1.14 In Spring 2011 A, B and their child returned to Staffordshire. She told family that she had been promised work but this did not materialise.

2.2 Events from April 2011

2.2.1 Following their return to Staffordshire A and B temporarily returned to the home of A's father whilst they applied for social housing. Their decision to return to Staffordshire resulted in them being considered 'intentionally homeless' and this restricted the assistance available. In June 2011 they acquired a private tenancy some 5 miles from the address of A's father and jointly claimed housing benefit.

2.2.2 The Devon health visitor contacted health visiting services in Staffordshire to transfer responsibilities for A's child. The Staffordshire services identified the child protection concerns from 2009 and referred the situation to children's social care in respect of the suitability of the family living with A's father. The previous social care assessments were reviewed but no contact was made with A or B and the referral was not progressed to assessment of the current circumstances.

2.2.3 A had routine health appointments but there were no further contacts with agencies until November 2011 when B was caught shoplifting low value items of fishing tackle. He was issued with a fixed penalty notice by the police officers attending the incident.

2.2.4 Around Christmas and New Year 2011 family and friends were aware that A had been hit by B and had a bruise on her face. This was not reported to police nor was any medical assistance sought.

2.2.5 In February 2012 A left B and returned to live with her father. After A left B, she told her family that she was afraid of him.

2.2.6 A informed agencies of her separation from B and that he had been violent and abusive towards her. She sought advice about housing and benefits as well as assistance from the police to secure property which she had left at the shared flat and which she feared would be damaged; disclosing previous violence and threats to harm herself and her child, although stating in relation to the threat to her life that B often said things he did not mean. The police Threat to Life policy and procedures were not engaged.

2.2.7 A also sought advice from children's social care about the care and contact arrangements for their child and as advised eventually consulted a solicitor.

She disclosed to social care that he had been 'abusive' and to housing that he was 'vile' to her. None of the public service professionals who spoke to her asked her for details of the abuse or advised her about support services in respect of domestic violence that she could access.

2.2.8 B contacted children's social care on the same day as A to express his concerns about A's father caring for their child while A was working. This referral was not progressed on the basis of previous assessments although senior management intervention subsequently identified that it should be. B was not informed of either decision.

2.2.9 The contact with the police resulted in a visit to the joint tenancy by the police where there appeared to be no damage to property despite A's concerns. A was subsequently interviewed and the police recorded that there were no crimes to pursue. Information which A gave to the police about threats to her safety in the initial phone call was not fully recognised or recorded and information that might have provided evidence of domestic violence was not pursued.

2.2.10 These contacts with agencies culminated in the events, eleven days later, when A sought police assistance to visit the flat she had shared with B to remove her belongings. There had been an exchange of phone calls between B and A during the day about this and his contact with their child. The police advised her not to go without assistance but also that they were unable to attend for some time.

2.2.11 A returned to her father's home, accompanied by her father, child and a friend. She was attacked by B who was waiting there, having cycled from their shared flat armed with a knife, and a single stab wound resulted in her death. Her father disarmed B before he realised his daughter had been stabbed and he believes that B could have killed them all.

2.2.12 In her interview with the Review Panel Chair, A's mother disclosed that she had had a telephone conversation with B two days before the murder during which he stated that he had been visiting the address of A and her father over the previous few nights and looking into the bedroom window. Her mother stated that she did not warn A of this or take any other action as she did not believe that B would travel that distance on a bike. This information had not previously been brought to the attention of any professional or included in her statement to the police conducting the homicide investigation.

2.2.13 B was subsequently convicted of murdering A. He was acquitted on a charge of attempting to murder A's father.

2.3 Context of these events

2.3.1 Both the victim and perpetrator in this incident are hearing adults brought up by deaf parents: in B's case it was both parents who were deaf while in A's

case, only her father. Their social life as young people centred on the deaf community and both were fluent communicators in BSL. This meant some degree of isolation of both from the mainstream community. This appears to have been more of a hazard for B than A, probably attributable to her having one hearing parent. She appears to have been able to move easily between the two worlds whereas B found refuge in the deaf community and isolated himself from other young people. His school attendance had been so poor in Yorkshire that his mother had been prosecuted. He was unable to sustain positive relationships with peers in the protected world of a specialist unit on arrival in Staffordshire. He effectively left school before the end of year 11 by moving to Devon and there were no checks that he was even safe and well by education services. He did not receive any services that should have been available to school leavers. He was able to find work in Devon but not after the return to Staffordshire. While A had friends and family in the area with whom she talked and found support, B had limited contact with his father and there is no indication that he had any friends.

2.3.2 These two young people started their relationship well before B was 16. There was a pregnancy scare at an early stage in the relationship and their child was born when he was still only 17 and she was 18. This raises issues about the reach of initiatives on sexual health and the reduction of teenage pregnancy to young people outside mainstream education and in the deaf community.

2.3.3 The responsibility of providing a safe home for a young child is one both of them took seriously and they appear to have provided good care for their child. It was however an additional source of stress and tension within the relationship. They did not have contact with any services for teenage parents in Staffordshire although they received good support in Devon and the services there made appropriate referrals to Staffordshire when they left.

2.3.4 These events involve young people who have moved between local authority areas in different regions of the country. The transfer of information from Yorkshire to Staffordshire in respect of B when he was 15 was very limited despite requests from Staffordshire agencies. The limited information available and B's moves restricted the ability of agencies in Staffordshire to make accurate risk assessments. The transfer of information between Devon and Staffordshire appears to have been less problematic but in both areas the arrival of vulnerable young people did not result in the provision of support services.

2.3.5 In view of the significance of BSL as the first language of the families, the Panel sought information from agencies about the provision of interpreter services in their contacts with the parents of A and B. The Panel was satisfied that proper arrangements were made to ensure interpreting was made available and that services were not significantly compromised by this additional need. Where this factor is relevant to events, the analysis makes clear any impact.

3 Analysis

3.1 Analysis of Events prior to April 2011

3.1.1 B has a record of a series of violent, aggressive or threatening incidents between the ages of 12-16 which were sufficiently serious to come to the attention of the police. While living with his mother, B failed to attend school for a substantial period. There is no record available which refers to the bullying at school disclosed by B's mother. He had been involved in a variety of criminal incidents in Yorkshire including motor theft and public order offences. In 2006 he had been part of a group who assaulted without reason another young person who was not a group member.

3.1.2 Within weeks of starting school in Staffordshire there was a serious incident that resulted in his temporary exclusion and restricted educational attendance subsequently. There are elements of that incident and ones that occurred earlier that suggest these were more than impulsive events or simple loss of temper; there appeared to have been time for reflection and planning of the incident.

3.1.3 He also threatened his father and his father's partner but that matter did not, at their request, progress to a prosecution. Police information tended to emphasise the damage to property rather than the threat to individuals.

3.1.4 While quite explosive incidents occurred that were frightening to those immediately present, his behaviour was otherwise reasonable and he acknowledged the need to avoid such incidents. It is this latter presentation of a reasonable young man trying to behave well that seems to have impressed those helping him. He did not have had any therapeutic interventions directly addressing the issue of his behaviour through youth offending services, CAMHS or educational support either in Yorkshire or Staffordshire. Similarly, children's social care intervention at this time did not consider whether there was a need for therapeutic services to support B in modifying his behaviour.

3.1.5 If the incident at his father's home in November 2008 had resulted in prosecution, assessment by the Youth Offending Service could have resulted in appropriate interventions and cooperation within a sentence would have been more likely to achieve engagement. No-one in contact with B considered whether any intervention was needed to prevent the occurrence of future problems.

3.1.6 Following the incident at his father's home, bail conditions required him to return to Yorkshire, intended to remove him from the scene of the incident/victim's home. Instead he moved in with A's family. The police were informed promptly by his father's partner of his location and there was an opportunity to enforce the bail condition but this was not taken, as A's father was providing an alternative address for B away from the home of his

own father. At this time B appeared to be aware that his behaviour was unacceptable and stated he wanted to turn over a new leaf. His remorse and good intentions are also part of the pattern of incidents. He gave a full account of his previous problems in meetings convened by children's social care. Indeed the IMR comments on his honesty in this.

3.1.7 In meetings with children's social care following B's move interpreters were present, the meetings were recorded and A's father received copies of the notes. Notwithstanding this A's father believes that his deafness may have led to him missing relevant information that might have made him less willing to help B. He is clear that he was not aware of the level of problems B had demonstrated at school and home at the time. It would have been good practice to make sure that he had fully understood all the relevant information by further discussion outside formal meetings with independent interpreters and without A and B present.

3.1.8 The professional focus at this time was on the formal requirements of a private fostering arrangement, rather than conducting risk assessments in respect of B entering the household or on a thorough assessment of the needs of B. More specific attention to verifying his offending history and the circumstances of known incidents both in Yorkshire and Staffordshire at an early stage could have brought more focus on the risks he presented. The fact that his education was being provided on a one to one basis without contact with other young people does not appear to have raised the level of concern about the arrangements with A's family.

3.1.9 This contrasts sharply with what would have been necessary if A's family had refused to help at this point. Had it proved necessary to accommodate B in local authority care, thorough risk assessments of the circumstances would have been expected by fostering or residential care providers. With his history, particularly in school, it is probable that securing a placement would have been difficult and expensive. There needed to be a much more thoughtful approach that recognised the short-term nature of the legal issues and which focussed on B's need for interventions to support positive and pro-social development.

3.1.10 There also seems to have been little consideration of whether support to return to either of B's parents would have been a better option. Both fathers needed to be involved jointly in a discussion of present and previous behaviours and the risk management issues for anyone in close contact with B at this point. With hindsight it is apparent that all the adults, family and professionals, accepted with varying degrees of willingness the solution offered by the two young people.

3.1.11 There was an over-optimistic belief amongst the professionals about A's family's ability to cope with B's behaviour when his parents struggled. Family relationships do not break down without reason and it needed thoughtful reflection of the likely difficulties from the professionals. B was

not presenting any problems to A's family at that time so the professionals needed to prompt the discussion.

3.1.12 A's father had allowed the relationship between the young people to become a sexual relationship over the summer and autumn as far as both families were concerned. This was not commented on or considered in the children's social care assessments taking place. The risks of this particular aspect of the situation should have been explicitly addressed during the social care contacts. A appears to have been a mature and sensible young woman but B was a vulnerable and chaotic young man. While she seems to have been a positive and stabilising influence on him, his vulnerability means that he was dependent on her emotionally. In allowing him to remain with her family on a private fostering basis, there was collusion with this situation.

3.1.13 The DHR Panel accept that choices were limited at this time and that significantly different decisions may not have resulted even if greater consideration had been given to other options.

3.1.14 The children's social care IMR recognises these weaknesses and the failure to assess the impact of B on A and her family in particular. Both professional practice and procedural matters requiring attention that have been identified. Changes in procedures since 2008/9 make these problems less likely, and the IMR makes recommendations that deal with the remaining issues to the satisfaction of the DHR Panel.

3.1.15 This was a **missed opportunity** to assess B and to provide services that dealt with causes not symptoms.

3.1.16 Following the move to live in Devon, agencies had no significant engagement with this couple apart from the support provided to them as teenage parents. There was good cooperation with agencies and they seemed to professionals to be coping with their responsibilities well. It is however now clear that there were problems in the relationship that were not disclosed to professionals or by A's mother, who was the only family member to be aware of them.

3.1.17 The support offered during and following the pregnancy was substantial and there would have been opportunities for A to confide difficulties if she had wanted to. Her health visitor, who saw her regularly, did not however follow agency procedures for routine enquiries intended to discover if there are domestic violence concerns in a relationship. These procedures seemed to the Panel to be well designed to make it easier to disclose something difficult or to offer a suggestion that it can happen to prompt future disclosure. It is essential that professionals understand the reasons for such requirements and that they are properly followed in every family however warm and caring the presentation to professionals. This was the **second missed opportunity.**

3.2 Events following April 2011

3.2.1 Agency contacts with B and A following their return to Staffordshire did not suggest any significant problems in the relationship at that time. None of these contacts had much substance and there was little opportunity offered for her to share the detail of any difficulties. A did not confide in her family at this time although family and friends in Staffordshire were aware that there were growing financial tensions and that this had also been a problem in Devon.

3.2.2 The Health Visitor receiving the transfer identified the previous concerns about A's father and promptly alerted children's social care to the return of a child to the household. The decision not to re-assess at this point has been identified by children's social care as a weakness arising from too much focus on the previous offence by A's father and insufficient focus on the youth of the parents and their change of address and community. These factors increased the risks and should have ensured face to face contact with A and B to be confident that they could protect their child. The Panel concur with this view. At this stage it seems unlikely that A would have told a social worker of any concerns about her relationship with B. Contact would however have shown her that she might expect assistance in more acute circumstances. This episode shows a lack of 'agency curiosity' about this family; why they had returned to Staffordshire and whether there were matters that were not being disclosed. This was the **third missed opportunity** to understand what was happening to this family or to signpost them to services such as a children's centre or teenage parents support services available in the area.

3.2.3 The first criminal incident after December 2008 involved B shop-lifting for fishing equipment of low value in November 2011. A was working at this stage but B was not. B, according to family members, was however spending a great deal of money, which was needed for domestic necessities, on fishing, an activity he shared with A's father, and it became a source of tensions.

3.2.4 Both families were aware of increasing tensions and arguments between A and B about money matters and sharing the care of their child in the months before the separation. The families were aware also that B hit A in December 2011 although she did not report this incident to police or any other agency at the time and did not access medical intervention. There were however witnesses to the injuries caused which could have enabled action to be taken subsequently. After A left B, she told her family that she was afraid of him.

3.2.5 Shortly after their separation in February 2012 A contacted police alleging that B was damaging the flat they had shared. The Police IMR explores what happened in depth and identifies weaknesses in the recognition and recording of information that had an impact on officers' actions subsequently. A disclosed in her initial contact that there had been

incidents of personal violence in the past and threats to kill more recently; but told the police in relation to the threat to her life that B often said things he did not mean. The police response focussed on the immediate issues of alleged criminal damage and no crime was recorded as the flat had not been damaged. The police Threat to Life policy and procedures, which would have led to robust risk assessment by a manager, were inappropriately not engaged on the purported basis that A did not take the threat seriously. The fact that she had been injured by him previously and that there were witnesses to the injury caused also did not receive attention. The police IMR properly considers that there was opportunity to review the risks to A and her child, to provide advice about her safety and consider whether there was evidence for a prosecution in respect of the previous incidents. These matters were subject to police professional standards enquiries which have concluded that the omissions were the result of weaknesses in staff awareness, systems and processes. The Panel were struck by the similarity with the incident at B's father's home in 2008 where focus also shifted from danger to people to damage to property, on both occasions reducing the appreciation of risk. The police IMR identifies these events as a missed opportunity and the DHR Panel agree. It is the **fourth missed opportunity.**

3.2.6 Also at this time A and B separately contacted children's social care for advice about care and contact arrangements for their child. A was advised to take legal steps to deal with contact but no discussion took place with her about violence despite her disclosure that the relationship was 'abusive'. B raised the issue of A's father and again social care declined to assess on the basis of the 2009 assessments. Agency quality review processes brought B's referral to the attention of a senior manager who directed that an assessment was required but this action had not been undertaken before A's death and was not related to the potential for domestic violence. Parents do not usually contact social care unless they have serious concerns for the safety of their child and A's fears needed to be properly understood. B's concerns about As father may have been real but this was also a matter around which he could threaten and bully A. There is no indication that the staff dealing with his referral considered this although face to face contact may have brought this to the fore. This compounded the missed opportunity arising from police contacts to understand the situation or provide supportive advice. Had either police or social care taken action to deal with the allegation of domestic violence there could have been interagency discussion and a proper face to face interview with A which might have revealed more.

3.2.7 A, with her father, also sought advice about housing at this time and disclosed information, although less explicitly, about her relationship with B. Again the advice given focussed on the immediate practical matters and the opportunity to give information about domestic violence services was missed. Their concern to talk with someone fluent in BSL meant that the member of staff was less aware of domestic violence issues and the service provided was less sensitive to this than might otherwise have been the case. This contact alone would not have been sufficient to change events

but it could again have encouraged A to talk with a domestic violence specialist. These events have prompted further training on domestic violence recognition for all staff in contact with the public by the Newcastle-under-Lyme Housing Advice Service.

3.2.8 The Panel have considered carefully whether the situation at this point would have reached the threshold for MARAC referral had agencies responded differently to the information available. It is just possible that if an individual from any organisation with good domestic violence knowledge had discussed the situation with A, they may have recognised the risks or she may have revealed additional information that would have raised greater concerns. In fact no single professional had sufficient knowledge of the circumstances to appreciate the growing risks but if everything had been collated it could just have reached the threshold. The DHR Panel are not confident however that it would have been sufficient to merit any priority within the MARAC process. The Panel are however satisfied that there was a significant opportunity at this point to provide more specific advice about the risks to A and that this could have alerted police officers dealing with A on the day that she was killed. The agencies involved have all acknowledged the failure to pick up on domestic violence and have taken action and make appropriate recommendations in this respect. This was the **fifth missed opportunity.**

3.2.9 In summary, in the fortnight before A's death, agencies should have arrived at a better understanding that there was an escalating risk of serious violence as a result of the separation. Sadly the fact that she had taken steps to protect herself and her child by moving to her father's home led, inappropriately and contrary to all research evidence, to professionals believing that the level of risk was reduced. She may have been economical in describing her concerns but she told three different organisations that there were significant problems and more thorough enquiries could have been conducted, in particular by children's social care and the police, in response to the contacts from her. A probably felt that agencies were not interested in the issue as the statements she made were not picked up.

3.2.10 Had any of the three agencies picked up on the information it would have been more likely that she was referred to a specialist service with greater understanding of domestic violence, including appreciation of risks associated with ending a relationship. This could have helped A to both understand the situation better herself and disclose information that might have enabled professionals to better analyse the risks of the situation. The Panel were satisfied that good local arrangements are in place for onward referral to domestic violence services directly and there is contact information for victims to pursue matters themselves but these actions were never considered in respect of A.

3.2.11 The Panel have concluded that this tragic incident was not reasonably predictable on the information available to agencies at the time. The Panel have also considered if all available information had been thoroughly

explored whether sufficient information would have been known to significantly change events.

3.2.12 The agencies' IMRs indicate that there were missed opportunities to provide services which might have reduced the opportunity for its occurrence and could certainly have ameliorated other domestic violence and child protection risks. The Panel think it unlikely however that even with the full information available to this review that this event would have been prevented.

3.2.13 A would have needed to have been removed to an address unknown or inaccessible to B to be safe. It is highly probable that if B had not found A that day he would have pursued her on another occasion. He equipped himself with a weapon, waited close to her father's home for her to return realising they were all out. He had travelled over five miles by bike to be there. This was not a spontaneous or impulsive action. Only his detention in custody would have been likely to prevent him seeking to harm her and there was no information that could have provided any legal basis for this. The incident occurred very quickly with little opportunity to protect A at that stage. It is possible that all involved could have been more risk aware but it seems likely on the basis of what is now known that B, if deterred at this point, would have waited until an opportunity arose to harm her another time.

3.3 Common issues

3.3.1 In addition to the management of specific events and responsibilities by individual agencies, the Panel consider that a number of professionals had opportunities in the course of contacts to discover more about the relationship between A and B that were not pursued. The focus of professionals was on the specific agency task or event rather than on developing rapport with these young people and understanding their situation, hopes and fears. This is particularly evident in children's social care and police contacts where information was not explored further or not recorded when volunteered. These omissions had impacts on later contacts where there was a tendency to underestimate the problem. Domestic violence is not an easy matter to tell anyone about. Professionals need to be alert to its possibility, including when relationships are breaking down or have ended and ensure their enquiries are sufficient to evaluate the risks of serious incidents occurring.

4 Lessons to be learned

4.1 Individual Agencies

4.1.1 The Panel endorses the learning identified by individual agencies in the IMRs. The Panel has also received an addendum from the police following the completion of the professional standards enquiry. This learning is properly reflected in agency actions and recommendations and the Panel

supports the recommendations made in their reports. Each agency's conclusions are summarised below with the individual recommendations. The recommendations and the associated actions are set out in the Action Plan at Appendix B.

4.1.2 **Staffordshire Police**

- Any view of police actions must be considered in the light of an interview with A in February 2012 (ten days prior to her death) when she told the police in relation to the threat to her life that B often said things he did not mean. Effectively she did not wish the police to take further action and signed the officers Pocket Note Book (PNB) to that effect. From that point further investigation ceased.

- Insufficient weight was given to the previously unreported domestic abuse which A's friend could corroborate. It should have been made clear to A what was available should the threats be repeated or escalate.

- The significance of a threat to kill a partner and other family members in a domestic abuse context where there was previous abuse was not fully understood.

- More precise probing and recording by police of A's account, the nature of the earlier abuse and threat to kill may have changed the understanding of the safeguarding options available to both the police and A.

Recommendations

a. Domestic Abuse risk assessment to change from DIAL to DASH and better use of lateral research database checks.

b. Learning and Development to make the Threats to Life Training available for all staff who have contact with public, and to monitor completion of the training package.

c. For there to be a clear protocol between IMR authors and Professional Standards investigators for speaking to staff involved in IPCC enquiries where:-
   1) It is known from the outset that the IPCC have an interest in the case;

   2) Where an initial scope of the case indicates that identified staff involved in the case may be subject to a disciplinary investigation

d. There should be a clear process and guide lines to ensure that a Managed Crime Investigation (MCI) is used only when it is appropriate to do so. Where a report involves a threat to kill someone the default position should be that the MCI process is not to be used unless a supervisor has viewed the incident and given a rationale for MCI use.

Recommendations arising from IPCC supervised Investigation

a. Operational Communications Department managers to ensure that all staff, regardless of role have an understanding of how to receive and record emergency calls.

b. Operational Communications Department managers should also ensure that there is a good and comprehensive understanding of the Threat to Life Policy and the National Decision Making Model by ACR staff.

c. Operational Communications Department managers ensure that ACR positions are adequately staffed to ensure operator efficiency.

d. Operational Communications Department managers review the failure rate of attendance at priority incidents to establish if this can be improved upon and also to ensure that the current gradings are appropriate given the outcome of this particular case.

e. Operational Communications Department managers ensure that ACR operatives are aware of their duty of care in respect of domestic abuse and threat to life incidents. It is not merely good enough to close an incident if they have any concerns or realise that appropriate accountability is not present they should notify their supervision for advice.

f. The role of the Real Time Intelligence (RTI) Officers based within the ACR are explored in relation to researching force and national police systems to assist and inform risk assessments for domestic violence and threats to life incidents.

g. The Investigating Officer recommends that the Domestic Abuse Policy is reviewed to ensure clear lines of supervisory accountability and ownership and this should be linked to the Threat to Life policy.

h. An allegation of a threat to life or incident where there may be a threat to life or personal safety is a heavy burden to rest on the shoulders of a constable or ACR operative. The Investigating Officer recommends that the importance of supervisory accountability is disseminated to members of Staffordshire Police so that there is no misunderstanding in the application of professional judgment, no matter how low a risk assessment may, on the face of it, appear and in such circumstance supervisory accountability is an absolute requirement.

i. There is an NCALT training package now available for the threats to life policy. The Investigating Officer recommends that all staff in contact with the public, intelligence and ACR operatives complete the training package, to ensure that there is robust understanding in relation to threat and risk.

j. The Investigating officer recommends that the Managed Crime Incident MCI process is not adopted where ownership and accountability is required in respect of personal safety and where there may be a current or future risk to a victim. This is to avoid a silo approach in dealing with risk unless there is an identified owner of the issue who has a holistic view.

4.1.3 **Staffordshire County Council Families First (Children's Social Care)**

- The private fostering assessment for B in 2008 was not robust in that lateral and police checks were not carried out with any urgency and there was no consideration of the risks which he may have posed to A or her family. There was an overreliance on B's own account of his history in the absence of any formal checks and it was also clear that whilst B and A clearly had an intimate relationship when he was still 15 years of age the private fostering and other assessments alluded to them as 'friends'.

- When the couple returned to Staffordshire in 2011 as 'young parents' of a young child there was an opportunity to engage with them which was detracted from by a disproportionate focus on grandfather's offending history and a corresponding lack of professional curiosity about their situation.

- This lack of professional curiosity extended to their last contacts with the authority in February 2012 which did not recognise a third significant change in their circumstances and that they had not been seen or spoken to. It took the intervention of a senior officer to direct that an initial assessment take place although it should be noted that this last referral was only raised on the basis of, again, disproportionate concerns about grandfather's offending.

Recommendations

a. In Private Fostering arrangements which are unplanned or provided in an emergency the Child Protection team based in Headquarters must be asked to include in checks:
    i. The LADO (local authority designated officer) database
    ii. PPRC (persons posing a risk to children) database
    iii. Checks with Staffordshire Police PPU (public protection unit) relevant to the making of an emergency or unplanned placement

b. In Private Fostering arrangements there should always be consideration of any risks the child being fostered may pose to existing children in the household including carrying out lateral and other checks as appropriate and this should be emphasised in the Local Authority Policy and Procedures in relation to Private Fostering Arrangements.

4.1.4 **Staffordshire PCT Cluster (Primary Care Services)**

- The author of the IMR could find no evidence of any gaps in primary medical practice services or poor practice. In fact it appears from the record that A received appropriate care when she did engage with the service. Consequently there were no recommendations to make in terms of the care provision from the general practices.

- The family were not eligible for family partnership services on arrival in Staffordshire. Child protection matters were correctly identified at first contact by the health visiting service. There are no recommendations in respect of this service.

4.1.5 **Newcastle Housing Advice**

- The review revealed that the records in this case were not explicit about the presence or absence of domestic violence and that this is not prompted by the recording arrangements or procedures. Officers should make an explicit judgement based on disclosures and observations in interview.

Recommendation

a. Changes will be made to make it clear whether domestic violence is or is not identified at the housing advice interview; the Newcastle Housing Advice procedures and paperwork will be updated to include a section to complete to show if there is any evidence of DV or any statements that led the officer to believe there was an issue of safety.

4.1.6 **Aspire Housing Association**

a. All staff, whatever their role, need to be alert to gathering information and to encourage disclosure where there is domestic violence or threats to safety. Aspire Housing has recently reviewed its Domestic Violence Policy and procedures.

Recommendation

a. All internal and customer facing roles will be considered and included with regard to Domestic Violence awareness and training, including Officers with specific skills or roles, e.g. sign language.

4.1.7 **Staffordshire County Council Education Transformation**

- B's education placement was appropriate given his educational history and taking into account his non-attendance at school in Yorkshire. B had not been considered for referral to mental health services as he was not there long enough for staff to have a view on this and also because

for most of the time there was not a reason to do so. The provision has been identified by Ofsted as good with outstanding features.

- Guidance has been given to schools to ensure that students are kept on roll until evidence is received of placement at an alternative educational establishment.

4.1.8 **Torbay and Southern Devon Health and Care NHS Trust**

- A report was received from **Torbay and Southern Devon Health and Care NHS Trust** in respect of health visiting services and the Panel make recommendations at 4.2.3 in respect of this information.

4.2 The DHR Panel

4.2.1 In addition to the above the Panel have considered whether there are recommendations that it should make. Each missed opportunity identified in the analysis has been considered by the Panel to determine if there are matters that are not dealt with by individual agency recommendations.

4.2.2 The **first missed opportunity** (see 3.1.15) occurred when B was assessed as a privately fostered child with A's family. In practice an approach which could have ensured that B returned to his mother in Yorkshire was undermined by his and A's fathers' agreement to the private fostering arrangement. Both fathers now regret agreeing to this arrangement and greater challenge from professionals at the time would have helped them to think the situation through. The Panel have no specific recommendation to add beyond those in the social care IMR; only to note that assessments were barely begun and had little information on which to base any view of risk before the defacto position was accepted.

4.2.3 The **second missed opportunity** (3.1.16) concerned routine enquiries about domestic violence by the health visitor when personal observation and judgement resulted in a failure to follow procedures. This is a problem that can occur in any agency at any time and requires sustained managerial oversight. **The Panel recommend that**:-

1) ***The Torbay and Southern Devon Health and Care NHS Trust must ensure that all staff follow fully its procedures in respect of routine screening for domestic violence issues through management review at key points, supervision and audit.***

2) ***CSP agencies should consider whether there is a need to review compliance with routine domestic violence procedures.***

4.2.4 The **third missed opportunity** (3.2.2) occurred when A and B returned to Staffordshire with their child. The social care IMR comments appropriately on the failure to adequately assess the situation. The Panel consider that social care and the health visitor should have been more active in ensuring

that this young family had contact with their local children's centre or services for teenage parents rather than focussing on the previous offence by A's father. Both young families and those that move around are at greater risk of developing problems and **the Panel recommend that**:-

3) Agencies in contact with families arriving in the area should ensure that they are informed of supportive services in their area relevant to their circumstances and assisted to access them.

4.2.5 The **fourth missed opportunity** (3.2.5) occurred when the police failed to recognise or respond appropriately to disclosures of violence and threats to kill. This matter has been thoroughly considered by the police IMR and the Panel have no recommendation to add.

4.2.6 The **final missed opportunity** (3.2.8) occurred between the separation of the couple and A's murder. The police IMR comments appropriately on their actions at this time. The Panel consider that had there been more consultation between social care and the police more considered decisions could have been made jointly, but only if the circumstances had been fully explored and evaluated. This was the point at which A could have been advised about contact with domestic violence services that might have helped her to understand the risks better and take steps to protect herself and inform others. Agencies involved have proposed measures to deal with the issues and the Panel have no further observations. The Newcastle-under-Lyme Community Safety Partnership may however wish to consider how it can support staff in agencies to be sensitive to the domestic violence concerns of people seeking advice and services.

4.2.7 The thread that runs through these missed opportunities is one of an absence of curiosity about the human story behind the formal responsibilities staff members were fulfilling. The police IMR explores the need for active listening and identifying key facts but there is also a need for sensitive questioning to generate trust and to help distressed people work out what really matters themselves. It is possible that A had much more that she could have disclosed that might have raised the levels of concern for her safety. This is about professional skills, judgement and curiosity which when exercised effectively can ensure action is focussed where it will have most impact. This does not sit easily with the day to day pressures on staff in agencies to complete tasks and move on to the next.

4.2.8 The police professional standards enquiries highlight the significance of operational systems and managerial oversight in helping front line staff achieve the level of competence expected. All agencies might also consider the relevance of this analysis in implementing their recommendations.

4.2.9 This review has highlighted weaknesses in the services provided to A and B which the recommendations in the IMRs and from the Panel are intended to address. There is no guarantee that these measures to improve the service

could have so changed the course of events as to have prevented the death of A but they can reduce risks presented by domestic violence.

Susan Lane
Independent Social Care Consultant
Report author

Appendix 1

TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke Multi-agency Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as “the Guidance”.

1.2 The relevant Community Safety Partnership (CSP) should always conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An ‘intimate personal relationship’ includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a “member” of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, “the same household as V” refers to the household in which V was living at the time of the act that caused V’s death.

1.5 The purpose of undertaking a DHR is to:

- **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;
- **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;
- **Apply** these lessons to service responses including changes to policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 From around July 2008 A and B were in a relationship. Between then and February 2012 they lived together at the home of A's family in Staffordshire, at addresses in Devon and, later, independently in Staffordshire. They had one child together. In February 2012 A left B and returned to her father's address. Eleven days later, B visited that address, followed A into the house when she returned there, and stabbed her once. A was confirmed dead at the scene. B was arrested shortly afterwards and has been charged with her murder.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 27 March 2012 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	X
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	X
The alleged perpetrator is a member of the same household as the victim	

3.2 The recommendation to commission this Review was endorsed by Cllr Stephen Sweeney, the *(then)* Chair of Newcastle-under-Lyme Community Safety Partnership who was present at the meeting and minuted.

4 Scope of the DHR

4.1 The Review should consider the period that commences from 1 Jul 2008 up to and including February 2012. The focus of the DHR should be maintained on the following subjects:

Name	A	B	Child of A and B
Relationship	Victim	Ex Partner / Perpetrator	Child
Date of Birth	Age 19 yrs	Age 19 years	Age 18 mths
Ethnicity	White British	White British	White British
Address of Victim:	Staffordshire		

4.2 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.3 An Overview Report will be prepared in accordance with the Guidance.

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel.

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims, perpetrators and their children, and for dealing with threats to kill others? Were those assessments correctly used in the case of this victim, perpetrator and their child? Were these assessment tools, procedures and policies professionally accepted as being effective?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
- What was known about the perpetrator? Was or should he have been identified as posing a risk of physical harm to others. Were the responses to any identified risk appropriate? Was such information recorded and shared, where appropriate?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- Had the victim disclosed domestic violence to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration of vulnerability and disability necessary?

- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were services for the victim, perpetrator and their families? Did the deafness of family members impact on this?
- To what degree could the homicide have been accurately predicted and prevented?

5.2 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- Staffordshire County Council Families First.
- Staffordshire PCT Cluster (Primary Care Services)
- Newcastle-under-Lyme Borough Council Housing Services
- Aspire Housing Association
- Staffordshire County Council Education Transformation.

5.3 Enquiries are to be made with the following services to establish what contact they have had with the victim, perpetrator or their child. Should they have had relevant contact during the scope of the review an IMR will be required:

- Devon Children's Social Care Services
- South Yorkshire Police
- Devon and Cornwall Constabulary
- Devon District Councils
- Devon Housing Associations
- Devon Domestic Violence services
- NHS Trusts providing services in Devon
- University Hospitals Bristol NHS Foundation Trust
- Yorkshire Youth Offending Service

5.4 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. IMRs and Summary Reports should confirm the independence of the author, along with their experience and qualifications.

5.5 Where an agency has had involvement with the victim and perpetrator and/ or other subject of this Review, a single Individual Management Report should be produced.

5.6 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Sharon Moore, Staffordshire County Council Commissioner for Safer Communities to facilitate the prompt commissioning of an IMR.

5.7 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.8 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed and who have provided a witness statement to the Police in connection with this case to Sharon Moore, Staffordshire County Council Commissioner for Safer Communities who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.9 Where staff are the subject of other parallel investigations (Disciplinary, SUI, etc) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Sharon Moore, Staffordshire County Council Commissioner for Safer Communities.

5.10 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Summary Reports

6.1 Where an agency has had no direct contact with the identified subjects within the period under review, but has had historic involvement with them or involvement with their extended family, a Summary Report should be prepared.

6.2 Summary Reports are required from the following agencies:
None required at present beyond information initially provided to the review scoping process. Summary reports may be required from those agencies listed at 5.3 above.

6.3 Summary Report Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. IMRs and Summary Reports should confirm the independence of the author, along with their experience and qualifications.

6.4 The Summary Report should commence from the point at which the agency first became involved with the subjects until that involvement ceased. A chronology of **significant** events relating to family members should be attached to the report.

6.5 The purpose of the Summary Report is to provide the Independent Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.6 Summary Reports should be quality assured and authorised by the agency commissioning manager.

6.7 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Sharon Moore, Staffordshire County Council Commissioner for Safer Communities to facilitate the prompt commissioning of an IMR.

7 Parallel Investigations:

7.1 Where it is identified during the course of the Review that policies and procedures have not been complied with, agencies should consider whether they should initiate internal disciplinary processes. Should they do so this should be included in the agency's Individual Management Review.

7.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

8 Independent Chair and Overview Report Author

8.1 Chris Few, an independent Consultant, has been appointed to Chair this Review.

8.2 Sue Lane, an Independent Consultant, has been appointed to write the Overview Report for this Review.

8.3 Both the Overview Author and Chair are independent of Newcastle-under-Lyme Community Safety Partnership, Staffordshire Safeguarding Children Board and Staffordshire Vulnerable Adult Safeguarding Board, and are not employees of any of the agencies involved in this review.

9 Domestic Homicide Review Panel

9.1 The Review Panel will comprise senior representatives of the following organisations:

- Staffordshire Police
- Staffordshire PCT Cluster
- Staffordshire Families First
- Staffordshire County Council Education Transformation
- Arch (Independent member)
- Newcastle Borough Council
- Aspire Housing
- Stoke-on-Trent City Council (observer)
- East Staffordshire Council (observer)

9.2 Representatives of other agencies contributing IMRs to the Review (see 5.3 above) may be invited to join the Review Panel.

10 Communication

10.1 All communication between meetings will be confirmed in writing and copied to dhr.admin@staffordshire.gov.uk to maintain a clear audit trail and accuracy of information shared.

11 Legal and/or Expert Advice

11.1 Sharon Moore, Staffordshire County Council Commissioner for Safer Communities, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

11.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

11.3 The Overview Author should include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

12 Family Engagement

12.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

12.2 The Review Panel will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review. The Review Panel will also give consideration to the support needs of family members in connection with publication of the Overview Report.

13 Media Issues

13.1 Whilst the Review is ongoing the Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department for comment.

14 Timescales

14.1 The review commenced with effect from the date of the decision of the Chair of the Community Safety Partnership, 27 March 2012 and should be completed and submitted to the Community Safety Partnership by 27 September 2012.